United Nations, with the rank of Ambassador.

MILLENNIUM CHALLENGE CORPORATION

Daniel W. Yohannes, of Colorado, to be Chief Executive Officer, Millennium Challenge Corporation.

INTER-AMERICAN DEVELOPMENT BANK

Gustavo Arnavat, of New York, to be United States Executive Director of the Inter-American Development Bank for a term of three years.

DEPARTMENT OF STATE

Frederick D. Barton, of Maine, to be an Alternate Representative of the United States of America to the Sessions of the General Assembly of the United Nations, during his tenure of service as Representative of the United States of America on the Economic and Social Council of the United Nations.

Robert R. King, of Virginia, to be Special Envoy on North Korean Human Rights Issues, with the rank of Ambassador.

William E. Kennard, of the District of Columbia, to be Representative of the United States of America to the European Union, with the rank and status of Ambassador Extraordinary and Plenipotentiary.

Carmen Lomellin, of Virginia, to be Permanent Representative of the United States of America to the Organization of American States, with the rank of Ambassador, vice Hector E. Morales, resigned.

Cynthia Stroum, of Washington, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to Luxembourg.

Michael C. Polt, of Tennessee, 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 Republic of Estonia.

John F. Tefft, 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 Ukraine.

David Huebner, of California, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to New Zealand, and to serve concurrently and without additional compensation as Ambassador Extraordinary and Plenipotentiary of the United States of America to Samoa.

Peter Alan Prahar, of Virginia, a Career Member of the Senior Foreign Service, Class of Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Federated States of Micronesia.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Pamela S. Hyde, of New Mexico, to be Administrator of the Substance Abuse and Mental Health Services Administration, Department of Health and Human Services.

NOMINATIONS PLACED ON THE SECRETARY'S DESK

FOREIGN SERVICE

PN282–2 FOREIGN SERVICE nomination of Terence Jones, which was received by the Senate and appeared in the Congressional Record of April 20, 2009.

PN929 FOREIGN SERVICE nominations (126) beginning Andrea M. Cameron, and ending Aleksandra Paulina Zittle, which nominations were received by the Senate and appeared in the Congressional Record of September 10, 2009.

PN964 FOREIGN SERVICE nominations (168) beginning Laurie M. Major, and ending Maria A. Zuniga, which nominations were received by the Senate and appeared in the Congressional Record of September 17, 2009.

LEGISLATIVE SESSION

The PRESIDING OFFICER. The Senate will resume legislative session.

ORDERS FOR SATURDAY, NOVEMBER 21, 2009

Mr. DORGAN. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 9:45 a.m., tomorrow, Saturday, November 21; 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 the motion to proceed to H.R. 3590, with debate as provided for under the previous order. Finally, I ask that the Republicans control the time from 8 p.m. until 9:30 p.m. tonight.

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

PROGRAM

Mr. DORGAN. Mr. President, at 8 p.m. tomorrow, the Senate will proceed to a rollcall vote on the motion to invoke cloture on the motion to proceed to H.R. 3590, the legislative vehicle for the Patient Protection and Affordable Care Act of 2009.

ORDER FOR ADJOURNMENT

Mr. DORGAN. I ask unanimous consent that following the remarks of Senator ENZI, the Senate adjourn under the previous order.

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

The Senator from Kansas.

SERVICE MEMBERS HOME OWNERSHIP TAX ACT OF 2009—MOTION TO PROCEED—Continued

Mr. ROBERTS. Mr. President, I ask unanimous consent that I be permitted to engage in a colloquy with my Republican colleagues.

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

Mr. ROBERTS. Mr. President, this is the health care bill. There are a lot of things in this bill that I object to. The $2.5 trillion cost, the 24 million people still left uninsured, the unconscionable $½ trillion cuts to Medicare and our senior citizens, with another $½ trillion in job-killing tax increases, in my view, the stunning assaults on liberty, and the Orwellian policies making health insurance even more expensive—any one of these things would make me vote no on this bill. But one issue has me troubled the most; that is, the issue of rationing. We have several of my colleagues here who will speak to this subject, and we will engage in a colloquy. I don't think this issue has sunk in with the American people and, for that matter, the media.

I want everyone to understand something. This bill aims to control the government's spending by rationing your access to health care. Let me repeat that. This bill aims to control the government's spending by rationing your access to health care. There are at least four government entities—we decided to call them ''the rationers''—that will stand between you and your doctor, and these four entities are represented by the four walls on this chart behind me blocking the doctor-patient relationship. You can see a pair of senior citizens and with frowns on their faces and then we have the rationers. We have an institute, a board, a center, and a task force, some of which are in place now and some are not. But every Senator should know about them and every health care recipient or especially senior citizen should know about them. Senator REID's bill establishes the Patient-Centered Outcomes Research Institute—that is the first wall—to conduct something called comparative effectiveness research, or CER, which is research that compares two or more of the same treatment options for the same condition to see which one works best. That sounds like a good idea. But, unfortunately, when CER is conducted by a government under pressure to meet a budget, it can be manipulated in some very sinister and counterproductive ways, as has been demonstrated by the United Kingdom's CER Institute. They call theirs the National Institute for Health and Clinical Excellence. The acronym is NICE, but NICE is not very nice in Great Britain.

NICE is notorious for delaying or outright denying access to health care treatments based on CER that takes into account the cost of the treatment and the government's appraisal of the worth of the patient's life or comfort. Some of the more shocking CER decisions handed down by NICE over the years include: restricting access to drugs to save seniors' vision from macular degeneration until the patient is blind in one eye, inconceivable; denying access to breakthrough treatments for aggressive brain tumors; and refusing to allow Alzheimer's therapy until the patient deteriorates.

The Patient-Centered Outcomes Research Institute will be the American version of NICE using CER to save the government money by rationing your health care.

Over the past few months, I have offered several amendments, along with Senators KYL, COBURN, and ENZI, to protect American patients from NICE-style rationing, to prohibit this bill from valuing cost containment over the care of patients. Unfortunately, they have all been voted down on party-line votes in the HELP Committee, the Finance Committee, and previously on the floor.

Let's move to the independent Medicare advisory board. That is the second wall between patients and their doctor. The Obama-Reid bill establishes a new independent Medicare advisory board, an unelected body of 15 experts who

will decide Medicare payment policy behind closed doors with minimal congressional input—something that is happening all too often around here. Although the bill says this anonymous board shall not include any recommendation to ration health care, what else would you call denying coverage for Medicare patients based on cost? That is what this board will do—deny payment for knee replacements or heart surgery or breakthrough drugs, all to achieve an arbitrary government spending target. I don't know what you call that, but I call it rationing. Also notice that this board will necessarily ration access to health care based on age and disability. Its payment policies will only affect the elderly and disabled who receive Medicare.

What will be a patient's recourse if Medicare refuses to pay for an innovative new therapy that could save or prolong their life? These are the reasons why the Wall Street Journal has dubbed this board the rationing commission.

Let us move now to the CMS innovation center. We come to the third wall between the doctor and patients. The Centers for Medicare and Medicaid Services, or CMS—and every provider knows what that is—administers the Medicare Program upon which 43 million Americans rely. That is almost 15 percent of the population. CMS already rations care. This has already been referred to by Senator THUNE and others in their comments on the floor. It is not authorized to but it does so indirectly through payment policies that curtail the use of virtual colonoscopies, certain wound-healing devices, and asthma drugs. In fact, courts recently had to intervene to prevent CMS from rationing a relatively expensive asthma drug in Medicare because rationing is currently against the law.

However, the Reid bill establishes a new CMS innovation center which will, for the first time, grant CMS broad authority to decide which treatments to ration.

Let's go now to the U.S. Preventive Services Task Force. That is the last one right here. The U.S. Preventive Services Task Force is yet another panel of appointed experts—a lot of those in this bill—who make recommendations on what preventive services patients should receive.

Currently, the task force recommendations are optional, but the Reid bill bequeaths this unelected and unaccountable body with new powers to determine insurance benefit requirements in Medicare, Medicaid, and even in the private market.

The task force has already revealed the types of recommendations it will be making. Just last week it decided to reverse its longstanding recommendation that women get regular, routine mammograms to detect breast cancer starting at age 40. One has to wonder if the task force's abrupt about face has anything to do with the fact that the Federal Government's financial responsibility for these screenings and for the health care needs they could potentially reveal will be greatly expanded if this health care reform bill passes.

In the words of one prominent Harvard professor:

> Tens of thousands of lives are being saved by this screening, and these idiots want to do away with it. It's crazy. It's unethical, really.

The outcry from oncologists, the American Cancer Society, the American College of Radiology and breast cancer survivors and families across the country has forced our Health and Human Services Secretary, Kathleen Sebelius, to backpedal away from the task force recommendation, saying they do not affect government policy. As a matter of fact, Secretary Sebelius said: Let you and your doctor make the decision. But this bill relies on the task force's recommendation, some 14 times throughout the legislation, to set benefits and determine copayments and make grant awards. So contrary to the Secretary's assertion, if this bill passes, the recommendation of the task force will become government policy. Not only that, it will be forced onto private insurers as well.

Some may ask, after my comments: Why so cynical? Why not trust these tools that they will only be used for good, to advance medical science and patient care. I hope that is the case. To those folks I answer by showing this chart over here by Dr. Ezekial Emmanuel and his ''complete lives system.'' As many of you know, Dr. Emmanuel is the brother of White House Chief of Staff Rahm Emmanuel. He is a bioethicist, one of those special advisers to the President. Perhaps he could actually be the rationing czar.

Dr. Emmanuel has published very disturbing ideas on how to ration care, which could be summed up by this ''Brave New World'' humpback whale graph we have here, along with aging groups of the population.

Dr. Emmanuel's Complete Lives System—something that sounds a little bit like a cure-all elixir sold out of Del Rio, TX—basically works off the premise that the older you are, the more you have lived and, therefore, the less you deserve in terms of health care.

I would like to point out that the average age of a Senator is 62—just something for all of you to think about, as you look at this chart depicting the Complete Lives System.

As shown on this chart, if you are 10 years old, you are doing pretty good right here. Twenty years old, that is when you think you are bulletproof and you do not want insurance, but you have a lock under this plan. Thirty years old, you are in pretty good shape. Forty, here comes the roller coaster. Fifty, you are in trouble. Sixty, you might as well forget it. Seventy, well, you are off the chart.

President Obama has clearly listened to Dr. Emmanuel's counsel. Remember his observation in an interview this summer that, as patients get closer to the end of their life: ''Maybe you're better off not having the surgery, but taking the shots and the painkiller'' instead.

Well, as someone who falls toward the end of Dr. Emmanuel's bell curve here—as shown over here on this chart—this type of thinking is unbelievable: Telling someone they cannot have a knee replacement because they are too old? How old is too old, according to Dr. Emmanuel?

The Wall Street Journal reported on the age rationing that occurs in Canada. In that country, apparently 57 is too old for hip surgery. Perhaps they can drive south and find care right here in the United States. But I am not sure where they will go if this bill passes.

The White House may complain that I am taking Dr. Emmanuel's musings out of context. My response to that is this: This is the context right here. This is how the government will contain costs. All these policies must be viewed through the prism of these ideas: This institute, this board, this center, this task force follows that blueprint. This is the goal: to save the government money by rationing care, by basing that rationing on some pseudoscientific graph such as this. At least in the United Kingdom they are honest about it.

These are the tools of rationing. These tools will restrict your ability, and your family's ability, to get a knee replacement or a breakthrough cancer drug or treatment for Alzheimer's or a mammogram.

They will destroy the American health care system—the best health care system in the world. And they are the main reason why I will vote no on this bill.

I yield to Senator SNOWE.

The PRESIDING OFFICER. The Senator from Maine.

Ms. SNOWE. Mr. President, as I rise this evening after months of effort and countless hours of meetings, discussions, and markup in the Senate Finance Committee to craft a health care reform bill, I have come to the floor to talk strictly about the substance and policy of one of the most complex and intricate undertakings the Congress has ever confronted.

Instead, we are confronted with procedural gyrations that are as baffling to those living outside the beltway as they are, unfortunately, for those who would prefer to achieve broader agreement on some of the most critical elements of health care reform.

As one who has worked constructively to forge solutions to this endemic problem plaguing our health care system, I think it is absolutely an imperative to ensure affordable health insurance coverage to the people of this country. But it must be done in an effective, commonsense, and bipartisan way. It matters what is in those 2,000 pages.

That is why I find it deeply disconcerting that the Senate, in its artificially generated haste to begin debate, has resorted to this convoluted

process before us in which we first vote to proceed to an empty shell bill, which is then replaced with actual health reform legislation that is the result of behind-the-scenes integration of the two bills that were passed by the Senate Finance Committee as well as the Health, Education, Labor, and Pensions Committee.

The reality is, beginning our deliberations in the Senate with tactics rather than transparency does nothing to enhance credibility with the American public at a time when so many are already understandably wary of the speed and direction of Congress on this transformational issue.

As I have mentioned on numerous occasions, it took a year and a half to pass Medicare to cover 20 million seniors. So we simply cannot address health care on the legislative fast track. I am truly disappointed we are commencing this historic debate on one of the most significant and pressing domestic issues of our time with a process that has drawn a political line in the sand and forestalled our ability to arrive at broad consensus on some of the most crucial elements of health care reform.

Again, I arrive at this moment as one who has been fully immersed in this issue with the Senate Finance Committee process and the so-called Group of Six within the committee, where we engaged in deliberations for almost 4 months, intensively, on a weekly basis—recognizing the perilous state of health care coverage in America and also recognizing the looming trajectory of unsustainable costs in our health care system is a critical problem that, indeed, must be solved.

Ten million more Americans have lost their insurance since the last attempt at health care reform in 1993. Today, 75 million Americans are burdened by inadequate or nonexistent coverage. Over the last decade, insurance premiums alone have risen by 131 percent—if you look at this chart, 131 percent, contrasting that with the growth in wages of 38 percent and inflation at 28 percent. That is what has happened over this last decade alone when it comes to health insurance costs.

In my home State of Maine, from 2001 to 2009, we have been hammered with a stunning 271-percent increase in average health insurance premiums in our small group insurance market. It has been estimated by the Business Roundtable that we can expect premiums to grow 166 percent by 2019, absent any reform.

So given this current trend, health care costs will continue to grow, and more than double the rate of inflation, further driving up premiums, sending the entirety of our health insurance system into a death spiral.

Health care spending could total over $33 trillion in the next decade, and average costs of an employer-based family health plan will reach $30,800 just a decade from now, should we fail to act.

So even as everyone has differing opinions on how to address this issue, virtually everyone I have encountered agrees the system is broken. In a recent poll that asked: ''How much, if at all, should the health care system in the U.S. be changed,'' an astounding 84 percent said either ''a great deal'' or ''a moderate amount''—84 percent.

The National Small Business Association reports that 62 percent of all small business owners want Congress to enact some kind of reforms—and no wonder, as our small businesses have experienced annual premium increases of at least 20 percent, year after year after year.

The reality that this is not simply a solution in search of a problem is what brought us together in the Senate Finance Committee in the so-called Gang of 6 that I—and I commend Chairman BAUCUS and Senator GRASSLEY as well. Chairman BAUCUS wanted to convene on a bipartisan basis earlier this year, which was the only bipartisan effort in any committee of the House or Senate. We met more than 31 times to debate policy, not politics, in attempting to reach a bipartisan consensus on reform legislation. This reflected the kind of extensive, meticulous process that an issue of this magnitude requires. Because the American people understand intuitively that when you are debating the future of one-sixth of our economy, and a matter of such personal and financial significance to every American, we should not be railroading solutions along partisan lines.

To that point, on a cautionary note for all of us, a recent Gallup poll concluded that neither party can boast that a majority of Americans are currently behind them on this issue. Without question, people are already apprehensive about Congress's ability to reform this system—with Gallup also finding that 66 percent of Americans also believe their Member of Congress does not have a ''good understanding'' of the issues involved in the current debate.

Well, if there is one thing I have learned from my more than 30 years of legislative experience, it is that the only way to allay people's fears is by systematically working through the concerns, the issues, and the alternatives. In fact, it was an adherence to those very tenants that led up to the Finance Committee markup that was reported out of the committee and which I supported because, while far from perfect, it produced watershed, bipartisan market reforms and navigated the ideologies on both ends of the political spectrum—by bolstering what works in our current system, building upon the employer-based system, and fostering choices, competition in coverage, and changing the accelerating cost curve of our health care spending.

At the same time, that was one, albeit significant, step in the process. As said in my remarks at the conclusion of the markup, it would be imperative moving forward that our course of action give deference to the scope and complexity of the issue—and there should be an inclination by the majority to earn broader support. The bottom line is, policies that will affect more than 300 million people simply should not be decided by partisan, one-vote-margin strategies.

Thinking back over the last century, just consider for a moment if Social Security, civil rights, or Medicare could have been as strongly woven into the fabric of our Nation had they passed by only one vote and on purely partisan lines. Instead, as you can see from this chart, these votes all occurred during a time when Democrats controlled both the Congress and the White House.

Social Security passed the Senate with 64 percent of Republican support, 79 percent of Republican support in the House; civil rights, 82 percent of the Senate Republicans, and in the House, 80 percent of Republicans; Medicare, when it passed, in 1965, had the support of 41 percent of Senate Republicans, and in the House, 50 percent of the Republicans.

So there was significant bipartisan support because it engendered a process that yielded bipartisanship and a consensus-based approach. Those are not only impressive numbers illustrating the strong bipartisan support that landmark legislation has garnered in the past, but they would be nothing short of mythological in today's political environment. Because at a time when we are supposed to be in a world of postpartisan politics, here we are facing a vote along partisan lines. When it comes to the subject at hand, the most consequential health care legislation in the history of our country and reordering $33 trillion in health care spending over the coming decade, surely, we can and must do better.

In a recent column, David Broder captured perfectly the path we should be following. He wrote:

> Scholars will also make the point that when . . . complex legislation is being shaped, the substance is likely to be improved when both sides of the aisle contribute ideas.

I could not agree more. So when it comes to procedural gymnastics designed to move us to a purely partisan bill as quickly as possible, on an issue as monumental as health care, that only serves to enhance public cynicism at a time when congressional approval ratings already hover consistently in the 20th percentile range and after a vote on the House reform bill that occurred after a grand total of two amendments and 12 hours 32 minutes of debate on almost 2,000 pages of a document.

Consider that it has been more than a month since the Finance Committee completed its work on legislation—even as it concluded that, work remained to be done—a month in which progress might have been made toward building greater consensus on some of the most critical and contentious matters in this debate.

But that opportunity was regrettably forsaken. I cannot support moving to a health care reform bill on a procedural motion designed to prevail not on policy grounds but on partisanship. Because the result is, this procedural vote tomorrow presents a serious obstacle if you have substantial concerns about the legislation—as the process going forward will likely require a threshold of 60 votes to add, change, or remove any major provision, including a public option plan, that was not included in the final Finance Committee legislation.

I think we all appreciate the impetus for the public option; that is, a fundamental mistrust of the insurance industry. That is a sentiment I strongly share, as many have been victimized by their egregious practices in denying coverage based on preexisting conditions, rescinding coverage because someone actually has the temerity to get sick, or discriminating based solely on one's gender.

In my home State of Maine, that mistrust couldn't be more profound—where two companies controlling 88 percent of the market has resulted not only in the inconceivable increases in premiums I described earlier but has forced thousands in my State to purchase plans with a remarkable $15,000 deductible for an individual and $30,000 for a family.

As I was told by one of our insurance companies—one of the two in Maine that dominate the market—it has become one of the most popular plans by virtue of its affordability, by virtue of the fact that it is all people can afford in the State of Maine and certainly among small business owners. Well, that is unconscionable. That is unacceptable. When we think of their basic coverage having a $15,000 deductible for an individual, $30,000 for a family, that is not what you would describe as reasonable coverage.

In response to that, I have worked to implement principles on which many of us have been adamant: ending flagrantly unfair practices so no American can be denied coverage, no policy can be rescinded when illness strikes, and no plan can be priced based on health status or gender.

To address the dearth of competition in the market, we created health insurance exchanges to become a powerful marketplace for creating competition and lowering premiums by bringing in potentially 30 million new customers, which CBO believes could reduce costs up to 10 percent. That is not even talking about the tax credits and the subsidies. So clearly the exchanges will have a significant effect on lowering prices through administrative changes in competition.

I would argue that we have taken these groundbreaking steps to alter the competitive landscape. I strongly believe that inserting a government-sponsored plan in today's dysfunctional marketplace—before reforms can work to improve the market—could actually inhibit the entry of new competitors and could undermine achieving the highly competitive environment we must have to make industry deliver lower cost coverage.

Just when we want to provide Americans a wide variety of competitive plans, can inserting a public option into smaller States such as my own actually encourage new plans to enter those markets or will we see just a pair of plans—the existing dominant insurer and the government, and is that limited option really the choice Americans want? When we also consider the difficulties we have experienced in improving care and assuring prompt, fair, and accurate payments in Medicare and Medicaid, we certainly must ask whether a public plan would spur the innovation that is so vital in health care coverage.

But we also cannot leave the performance of insurance companies and the success of reform to chance. I have proposed there is a role for a Federal safety net plan if affordable choices that are specifically defined aren't offered in a given State. Moreover, under my provision, companies would submit their pricing a year prior to the open enrollment period, and if it is determined that affordable plans aren't available in a State, the insurer would have 30 days to resubmit their bid. At that point, if affordable plans still aren't offered, a Federal fallback is provided without delay. This will provide the certainty that affordable options exist so that no one falls through the cracks, while CBO also reports that the threat of a fallback in a State would also pressure industry to lower premiums.

In stark contrast, the bill we will consider on the floor not only incorporates a public option but also a State opt-out provision that will allow any State at any time to drop that public plan for any reason whatsoever, irrespective of whether their residents in that State actually have access to affordable plans. So if affordability is our goal—and it certainly is—then will someone explain to me exactly how an indiscriminate opt-out achieves that end when a State could decide on a political whim it would not allow a public plan and leave its residents without affordable choices?

It simply makes no sense. Rather, we ought to take the safety net approach at the forefront as we did in Medicare Part D, which spurred competition and, as a result, it never was triggered, and to ensure affordability not just in some States but in all 50 States. I happen to believe a person's Zip Code should never dictate their ability to access affordable health care coverage.

So the public option provision is of paramount concern. At the same time, in examining the proposed legislation, it is not my only concern. There are practicalities to what we are doing, and I am concerned, quite frankly, that this legislation misses the mark as far as addressing the needs of Main Street America. Just yesterday, the NFIB released a statement opposing the bill—the National Federation of Independent Businesses—saying that enactment of it would make health care for small businesses more expensive than what they can afford today—a ''disaster for small business'' is how NFIB describes it. That is coming from a group that supported the Senate Finance legislation and has been a constructive voice throughout the debate, so that ought to grab our attention.

Furthermore, in the Finance Committee I insisted that CBO provide an affordability analysis of what a ''silver'' plan would look like, for example, and I used that analysis to do my own modeling on all of the plans. It helped me to assess premium affordability and render an informed evaluation about the approach overall. For the measure before us now, the CBO has yet to assess the question of affordability on this revised, integrated bill. So exactly how do we go forward on this legislation and consider it when we don't even understand some of the most fundamental aspects of this legislation? None of us can tell with adequate specificity at this point what an average plan will look like, which is what Americans are going to be asking us. What are the premiums? What are the deductibles? What are the copays? What are the coinsurance requirements?

These are questions Americans rightfully will ask and are asking. What will reform mean to them? What will it look like? What will they pay for? Those are the answers to the questions we do not have because we haven't had a chance to evaluate this legislation, and we are going to have a vote tomorrow night to move along party lines—to ram it, to jam it—and that is what I am hearing from my constituents. They say: Do you really know what is in those 2,000 pages? They are asking the right questions with great validity. They believe their lives are out of control because they see Washington and they think Washington is out of control because we don't have a profound understanding of what we are doing.

That is why it took so long in the Finance Committee for 4 months. It wasn't enough to be immersed in intensive discussions and deliberations. There were artificial deadlines that were set time and time again from March to April to May to June, July, August, September, October. It has gone on. Christmas now is the deadline. The State of the Union is the deadline. Why not just try to get it right?

I have heard time and again people say we just have to do something. Well, what I am hearing from my constituents and from many Americans is that it is not just doing something, it is doing the right thing. Every line and every word in this 2,000-page document matters because it is going to have profound ramifications and implications. There are unintended consequences. It is not just about cobbling something

together in the dark of night. It is about making sure those mechanics work and what it is going to cost the average consumer, what it is going to do to small businesses, what it is going to do in this time of perilous economic climate. We simply must ensure that an affordable coverage option is available to every individual and small business.

I get back to the affordability question because that is the heart and soul of this matter. We have to be assured that we are going to provide affordable health insurance plans. That is why I recommended—and I am going to push that through the amendment process—that we open the ''young invincible'' or the catastrophic plan as described in the majority leader's bill. We should open up to everybody. It is now available to those under the age of 30, but we should open these plans to all to ensure that no one has to buy up into a more expensive plan if they don't choose to.

I have also advocated throughout this process for the very first time national plans which I included in the Finance bill, as small businesses should be able to purchase plans with uniform benefit packages sold across State lines which is vital to enhancing competition and increasing choices for consumers, and portability, and driving down premiums. In fact, we drive down premiums by more than 12 percent.

I will be introducing an amendment—because, regrettably, it is not going to be in the bill we will be considering—that States cannot opt out of these national plans because these plans should be able to be available to every State in the country.

Finally, with our mounting deficits and our struggling economy, if anything, we should be scaling back the scope of health care reform wherever possible. We should take our cues from the American people who rightly reject more taxes and expanded government bureaucracy that will constrain our future economic prosperity. So I am disturbed that the legislation we will be considering will increase Medicare payroll taxes by $54 billion over the next 10 years. That is diametrically opposed to the tack we should be taking. We should be finding ways for cutting back and scaling back. ''Practicality'' should be the word of the day.

Then we have the insertion of another new and costly program, the so-called CLASS Act. I understand its laudatory goals. If it is going to be providing long-term care, it is obviously very important. Proponents point to the fact that it will raise $72 billion over the first 10 years, but that is a bad timing shell game as it collects premiums in 2011 but doesn't begin paying benefits until 2016, near the end of our current budget window. CBO has concluded in the decade following 2029 the CLASS Act will begin to increase the deficit. How much sense does it make to create this new bureaucracy, this new program, that will begin providing similar benefits just 4 years before the Social Security disability insurance trust fund is expected to be exhausted as opposed to first fixing that program?

I intend to offer amendments as legislation is considered on the Senate floor, and the impending amendment process will be a true test of whether there is a will to improve this legislation in a nonideological, bipartisan manner. On that note, I hope the past is not a predictor of the direction we are headed because in the final analysis, no one has a monopoly on good ideas. It is not a conservative idea, moderate idea, or a liberal idea. It is a good idea to improve this legislation because that is what is going to be our most pressing, most focused, singular goal—to improve the legislation that will be before us, irrespective of who is offering the amendment or who has the votes or whether it is the 60 votes. That is my concern, if it is going to take 60 votes to undo and change those provisions that are absolutely essential to be modified.

The American people have expressed a sharp and legitimate note of caution as we pursue health care reform, especially during these challenging economic times. It is a message we would do well to reflect. So let the tone we set for this unprecedented debate rise to the level of the problems we have a responsibility to resolve. This is already an undertaking of historic proportions. Let's ensure this isn't the only historic legislation passed in the last half century on purely partisan lines.

Thank you, Mr. President. I yield to the Senator from Oklahoma.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. INHOFE. First of all, I thank the Senator from Maine. She used the very descriptive terms of ''ram it'' and ''jam it.'' That is essentially what is happening right now. I think everyone is aware—all the media have taken pictures of the closed doors. They know that just a handful of Democrats were in there. Ironically, there are a lot of Democrats who didn't know what was going on, either. But they came out with a product. It is not a good product, and I will talk more about the product in a moment.

But I think probably more significant and more concerning to a lot of the people I talk to is the manner in which this bill is being brought to the floor. It is beyond just being deceptive that the Democratic leadership plans to vote on Saturday night at 8 o'clock to proceed to H.R. 3590, a bill that has nothing to do with health care. This bill is one that passed the House in October of this year, 416 to 0. It would pass the Senate by a unanimous vote, I am sure. The bill is an eight-page bill to ensure that our military service members are not excluded from the first-time home buyer tax credits, and no one had any quarrel with that. The House side wouldn't have any quarrel, nor would we. But we all remember and America remembers that the House passed their health care bill, H.R. 3962, on November 7, late at night, on a Saturday night, the same type of thing we are looking at here.

Let me say one thing. I was surprised to hear the unanimous consent request that was made just a few minutes ago because it was an admission—and I appreciate their honesty—that what we are going to be voting on tomorrow night has nothing to do with H.R. 3590. Yet that is what we are going to be moving to.

They stated that at 8 p.m. tomorrow night the Senate will proceed to a roll-call vote on the motion to invoke cloture on the motion to proceed to H.R. 3590, the legislative vehicle for the Patient Protection and Affordable Care Act. My thinking was—and I still think there are a lot of Democrats who would end up voting for this tomorrow night and would send out a letter to constituents: Oh, this is a vote that is going to help our military with some of the problems they have.

This reminds me so much, the way this is taking place, of what happened in the Environment and Public Works Committee when they were trying to get through the massive cap-and-trade bill which they did and they voted it out without any Republicans there. It is on the Senate floor right now. It is not going to be brought up because it is dead on arrival. The people of America realize they don't want to have the largest tax increase in the history of America on something that would do no good.

But the point is, the deceptive method to bring up that bill is the same thing we are dealing with now. I think by virtue of the fact they rammed it and jammed it, to borrow the terms from the Senator from Maine, out of the Environment and Public Works Committee caused it to go down. I think the same thing is going to happen here.

The second thing is a motion to proceed at 8 p.m. on Saturday night. Well, Saturday night. What are people doing on Saturday night? They are not watching TV. They are not listening to the radio. They have ball games and other things the American people do in the American way of life on a Saturday night.

Do you think it is just coincidental? That is the same time of night they ended up voting on the House health care bill, on a Saturday night. Of course, it got out with barely a majority.

Now, not only is the way in which the bill is being brought up questionable, the substance of the bill is definitely questionable. It has been repeated—I am trying to make a couple of comments about this that have not really come to our attention as much as other issues, the government-run health care bill—that Republicans are working to ensure that Washington bureaucracy does not get between the patients and their doctors. That is the big issue.

Now, you are going to hear shortly from my junior Senator from Oklahoma, Mr. COBURN, who is an OB–GYN. He will talk about that.

I don't think you have to have a doctor explain to you that if you, as in my case, have a very large family, with a lot of grandkids—we don't want the government telling us what we can and cannot do. A government-run universal health care system or a socialized system is not the answer.

All you have to do is listen to some of the testimony from individuals who have come here, such as members of the Parliament in Great Britain, who came and addressed us in this building and said: We cannot believe that something that has been such a failure, that we are trying to get away from, is something you are now trying to move toward.

The other day, in the Wall Street Journal they talked about a Canadian citizen who waited in pain for more than a year to see a specialist for his arthritic hip. The specialist recommended a state-of-the-art procedure, but the government bureaucrats determined that the patient, who was only 57, was too old for that procedure. Rationing is alive and well. If you don't believe it, go up in the northern part of the United States, to the Mayo Clinic or some of those others, and you will see the large number of Canadians who come down to ''barbaric'' America, with our system, because they couldn't get the treatment they needed through rationing in Canada.

The Democrats' bill represents an unprecedented expansion of government's control over health care. Oklahoma physicians shared with me in a July 23rd letter that they are concerned a public option plan will unfairly compete with the private market and ultimately crowd it out. It is a no-brainer. You cannot compete with the Federal Government. All they have to do is change and the competition is gone.

Under this bill, the government will tell people what type of coverage they can and cannot have, mandate that every American have health care or pay a tax, mandate employers to provide a certain level of benefits or pay a fine, introduce a government-run plan designed to destroy the private market, include new policies designed to control what drugs and procedures Americans can receive, and require a historic expansion of Medicaid. According to the Oklahoma Health Care Authority, the ones who administer the Medicaid Program called Soonercare, they estimate that this type of expansion could cost Oklahoma an additional $128 million each year, resulting in harmful cost to existing State priorities. By the way, the Oklahoma Governor and the State legislature are talking about going into a special session because of the problems we have—the budget problems. Of course, we would then inherit this.

This bill violates the President's promise not to raise taxes. I think we have covered that. The fact that they have taxes such as the 40-percent excise tax on the so-called Cadillac plans—that means if you, through your own decision, decide that for your family you want to have more extensive coverage, you will get penalized. You could have a tax imposed upon you of 40 percent because you wanted to have better treatment for your family. The CBO and the Joint Committee on Taxation have testified that these taxes and fees would be almost entirely passed on to consumers. The fact is that they estimate, by 2019, 89 percent of the taxes would be paid by those making less than $200,000 a year. It reminds me of the regressive nature of the cap-and-trade tax, which would affect the poor people more than the wealthier people.

Anyway, with the penalties and everything else in there, we are going to be looking at something that the American people don't want and should not have. That doesn't mean Republicans don't want to have reforms. We need reforms. We need medical malpractice reforms. I have two friends in Tulsa, two man-and-wife teams. There is Rick and Lisa Lowry. He is a cardiologist and she is a dermatologist. They moved to Texas. They will tell you the only reason they did it is because of the tort laws in Oklahoma. Then there is Boris and his wife Kathy, another pair of doctors. Boris is an electrophysiologist, and she is a pain management doctor. They moved to Fayettville, AR. This is what is happening right now.

We know what reform is. We know that HSAs have worked, giving people choice. We want to have some reform. We should keep in mind for tomorrow that, at 8 o'clock, if just one Democrat would say, no, I don't want a government-run system—just one—they wouldn't have 60 votes. It is going to be interesting to see if there isn't one. They will never get by with saying it was just a motion to proceed to a bill having to do with housing for the military. It will not happen. People are smarter than that. I hope at least one Democrat will oppose a government-run system. We will find out tomorrow night.

With that, I yield to the Senator from Alaska, Senator MURKOWSKI.

The PRESIDING OFFICER. The Senator from Alaska is recognized.

Ms. MURKOWSKI. I thank my colleagues and I thank particularly the senior Senator from Maine for her long, arduous work as part of a small group of Senators who did try, honestly and with great integrity, to advance this process so we would have a bipartisan product to deal with. I appreciate her efforts. I heard a little bit of her frustration as she spoke on the floor this evening. I thank her for her leadership.

I concur with my fellow Senator from Oklahoma that we all agree reforms are needed in the health care world. We all agree that the status quo is not acceptable. But where we differ is certainly what leads us to the discussion this evening, and tomorrow, and up to the vote tomorrow evening at 8 o'clock.

Typically, this time of year, going into Thanksgiving and then the holidays that follow in December, we consider this the season of giving, where we give thanks and do a lot of giving back. Unfortunately, what we are looking at this particular November, with this particular bill, kind of makes it a season of taking—taking away your ability to choose the health insurance you want, taking away nearly $½ trillion by cutting from Medicare—a program that is already strapped, a program that provides so much for our seniors and the disabled. But we recognize that program is seriously underfunded and looking to literally go off a cliff by 2017—by taking more of your salary and increasing the Medicare payroll tax for government intrusion into your health care decisions.

This health care bill is a massive overreach by the Federal Government that will result in our government having more involvement in your family's health care decisions and greater government intervention, cutting into 16 percent of our economy.

Before we get into the policy debate on the health care bill, I asked one of the interns in my office to go down to the Dirksen post office. We had gotten an inquiry from a constituent from Alaska wanting to know if we could send a copy of the bill. The bill, as you can see on some of the Members' desks, is large. When it was weighed at the post office in the Dirksen building, it weighed in at 20 pounds 5.5 ounces. That is probably close to the size of the turkey my family and I will purchase for Thanksgiving. It is going to take about $45 to mail that by priority mail to Alaska. So we suggested that perhaps the Internet is a better option.

In this 2,000-plus page bill, you will find the government requiring that you comply with an individual mandate where the Federal Government is going to tell you you have to buy health insurance, regardless of whether the premiums are affordable. This goes back to the concerns of the Senator from Maine. So much of this is about the affordability. If we require individuals to purchase health care insurance but we have not done anything, or enough, to make it more affordable for them, all we are doing is setting them up for additional penalties. Failure to comply will result in a $750 penalty per person to a family.

We also know in this bill our government is going to be telling employers they have to comply with employer mandates, which place onerous penalties on a large number of our small businesses. These are businesses that have 50 or more employees. I think it is important to recognize that the SBA, Small Business Administration, defines a small business as one with 500 or fewer employees. But for the purposes

of the employer mandate, we are going to say that if you have over 50 employees, you will be required to provide for that insurance.

Let's use an example here. Say you have a small business, you employ 51 employees, and one of those employees receives a Federal subsidy for health insurance. Under this Democratic health care reform bill, the employer will be fined $750 for each of its 51 employees—not just the one employee who receives a subsidy but for all of them. So if you are a small business owner in Alaska, in Anchorage, or Fairbanks, or Juneau, who runs a restaurant or a small hotel, that employer needs to know he could be subject to a total of over $38,000 in penalties if only one of his employees seeks a government subsidy. This penalty provision alone in the bill is estimated to raise $28 billion to pay for the Democratic health program.

The bill before us today also subjects Americans to health insurance that the Federal Government is going to define that this is what you have to have. What the drafters of this 2,000-plus page bill declare is it is an insurance plan with a 60-percent actuarial value. In other words, all of the discussion about ''if you like the health care plan that you have, you can keep it''—yes, in fact, you can, but only if it meets the definitions we are setting forth within this, and the requirement is that it is 60 percent of actuarial value.

In Alaska, we have over 88 percent of the health benefits that are provided to individuals and small businesses by the largest insurance company operating there, Premera Alaska Blue Cross/Blue Shield. We are told that 88 percent will not meet this 60-percent threshold requirement. So what does that mean? You have had your insurance plan through Premera and your employer provided it. But if it doesn't meet this threshold requirement, what then happens is that those small business employees will not be in compliance with the provisions of the bill, so you are going to see penalties assessed. Many of my constituents will see those penalties assessed. They may lose the insurance they have, which they like, but the penalty will be a massive increase in health care insurance premiums.

When we talk about the promises of health care reform and what we are going to make available to you, I think most people believe that with health care reform would come a reduction in premiums, or at least not incredible increases in premiums.

In this bill, we raid the strapped Medicare Program to pay for expanding the role of government in health care reform. We raid future payments to the Medicare patients through increased payroll taxes. I think it is important to recognize that this is an unprecedented and dangerous step that plays a shell game with Americans. We are going to increase your taxes through the Medicare payroll tax, but then we are going to divert that money to pay not for keeping Medicare solvent—I mentioned earlier the insolvency cliff out there—and we are going to divert that money not to keep Medicare solvent, not to increase funds to Medicare, not to increase patient access to doctors and nurses, which so many of my constituents are suffering from but, instead, we institute a new Medicare payroll tax that is used to pay for expanding the size of the Federal Government and creating yet another federally run health plan. We recognize that the insolvency of Medicare is real. The Medicare trustees report from 2009 said that Medicare is going to be insolvent by the year 2017. But the drafters of the bill don't write a reform bill to fix Medicare insolvency. Rather, they are using this as an opportunity to tax Medicare funds to pay for the creation of another Medicare-like system. This is truly the height of hypocrisy. It is working against what is right and what should be done for Medicare.

The inclusion of a 5-percent Medicare payroll tax is bad enough, but when one realizes that the tax is not indexed to inflation, one can only cringe at the financial pain that is ahead for America's middle class.

There may be many people out there saying, oh, you are increasing taxes on the rich and individuals earning $200,000 or more, and couples earning $250,000 or more, but you need to put this in context and recognize how far from the truth this can be.

Back in 1969, Congress enacted the alternative minimum tax, the AMT, to ensure that fewer than 200 individuals paid their fair share of taxes. Unfortunately, the AMT was not indexed to inflation, and today we have nearly 30 million taxpayers who face the long hand of the AMT tax, with many of them falling squarely in the middle of the middle class.

Congress has consistently taken action to protect the middle class from the AMT. We do this, as we know around here, on a year-by-year basis, and each year it is costing more than the previous year with the number of people who face the tax growing each year. The recent 1-year patch cost $70 billion. A 10-year fix is expected to cost $447 billion. Sadly, history has a habit of repeating itself, and Congress has demonstrated a consistent inability to learn from its mistakes.

My prediction is if the Medicare payroll tax increase becomes law, Congress will, once again, need to spend large sums of money to protect the middle class from this onerous new tax.

Let's delve into the Medicare and Medicaid restrictions on doctors and nurses under these government health programs. In my State of Alaska, in our most populated city, Anchorage, we have very few general care doctors who are willing to accept Medicare patients. We had a study done not too long ago, and the number given in that study is there are 13 providers, 13 doctors who are taking on new Medicare-eligible individuals. In Alaska, if you are about to hit the magic age of 65, going on Medicare, you have Medicare as your primary insurance whether you like it or not.

What you learn when you are on Medicare is you have very few doctors willing to see you. Eighty-three percent of the primary care doctors in Alaska's largest city will not see Medicare patients. These individuals, who before they were 65 enjoyed unfettered access to care when on private health insurance, whether they had it through the municipality, Anchorage, or they worked for a private employer, they are now realizing the harsh realities of Medicare and that they are going to face some severe restrictions in access to a primary care doctor.

We are seeing it on a very accentuated basis in Alaska, but we are seeing it in many parts of rural America. It is almost unthinkable to me. A number of constituents have come up to me and have said: Look, just get us out of the Medicare system. Let us go out to the private market and purchase health insurance like we were able to do before we were on Medicare because, regardless of the contributions I make, regardless of how much I have paid into the Medicare system, it doesn't mean anything to me if I don't have access to care.

They are saying: I know I have worked all these years to pay in, but I want my old insurance back. It is because what we have done is restricted their access to services, and it is something they have never dealt with before.

This problem is not just in my State. According to GAO, we have States such as Colorado, Oregon, and New Mexico that are facing these major restrictions in access to primary care doctors. Senator Daschle, when he was doing his health care tour last year, when he was in Dublin, IN, and talking to doctors about how best to reform our health care system, the doctors in Dublin told the Senator that the Medicare reimbursement rates are not keeping pace with the costs of a medical practice. So if we know that private insurance pays significantly more than government insurance, then access under a government plan will undoubtedly be reduced. We have seen this both in the Medicare and the Medicaid Programs.

Under the Medicaid expansion program in this health care bill, we know that Medicaid is now going to include individuals up to 133 percent of poverty. Under the Democrats' health bill, the Federal Government pays all the costs covering newly eligible enrollees through 2016. This is good for the States. It will allow Alaska, for example, to expand the roll of the Medicaid Program and include more Alaskans on the State's Medicaid Program. CBO said after 2016, the share of the Federal spending is going to vary somewhat from year to year but ultimately would average about 90 percent.

If you are responsible for your State's budget and your State can no

longer afford the Medicaid Program in the year 2017, when the Federal Government drops that coverage to somewhere around 90 percent, if your State is a balanced budget State such as Alaska and your State revenues are going down because of what is happening with tourism or a bad fishing season or the price of oil, what then do the States do to continue the Medicaid Program?

It seems to me there are a couple options. They can either drop the expanded Medicaid population or they could reduce reimbursements rates and place the Medicaid enrollees who once had decent care in Alaska in the same predicament as my Medicare constituents are currently in.

There is a reason why Democratic and Republican Governors have said this Medicaid expansion is the mother of all unfunded mandates.

While all these provisions I mentioned are certainly enough for me to decide not to support this health care bill, the most troubling aspect we are seeing played out in the news right now is the impact of government rationing, which will allow the government to deny access to health care services.

This is something Republicans have been speaking about all summer with regard to various health care bills. We have all seen throughout the news a great deal of concern over the announcement from the U.S. Preventive Services Task Force that it no longer recommends routine mammogram screening for women between the ages of 40 and 49. This task force's recommendation is just a look behind the curtain of what we can expect if the government runs your health care.

Under this bill, we are going to provide one person, the appointed position of the U.S. Secretary of Health and Human Services. We are going to give her the ability to make a wide variety of determinations, both on the health exchanges as well as in the government-run plan.

I am very concerned about what we are finding from this task force and what it means for both men and women who suffer from this deadly disease. I can tell you, without a doubt, what this has caused is great confusion. The task force came out with their recommendations and then, shortly thereafter, Secretary Sebelius came out saying women in their forties should continue to get mammograms. The task force is saying women should not even conduct self-breast exams. We have constituents who don't know what they should or what they should not be doing. This is why we need a hearing to better understand how this task force came to their conclusions.

But the bigger picture is, what we need to appreciate is this ordeal we have been dealing with this week is a glimpse into the chaos of what we could see with a federally run health plan and a massive expansion of the Federal Government's role in your health care.

I wish to mention, because there have been multiple accounts in the media about, no, we are not intending that this task force recommendation is going to change in any way what coverage might be available to women. I know that some of my colleagues on the other side of the aisle have recognized, in fact, that these recommendations do hold great weight with the policymakers and the insurance companies.

One of my colleagues from Maryland has said she plans to offer an amendment that would address or limit the cost of breast cancer tests for women 40 and older. She said otherwise insurance companies may use this new recommendation as yet another reason to deny women coverage for mammograms.

In fact, in the bill, there are at least 14 references to the U.S. Preventive Services Task Force. In section 4105 is a provision that would authorize the Secretary to modify benefits under Medicare if consistent with task force recommendations and deny payment for prevention services the task force recommends against.

This could be a situation we should be very concerned about how, with recommendations such as we are seeing come out of the task force, they inadvertently or perhaps advertently will impact a woman's access to care.

I know I have probably gone over my time, and the Senator from Oklahoma is waiting. I will close my comments by saying we do need health care reform. I echo the remarks of the Senator from Maine. We need to do it the right way. Setting an arbitrary timeline, saying we have to get it done by this holiday or that holiday or moving down the calendar—we have to take the time to do it right.

We have to bring down the premium costs so everyone can have access to affordable health care. Imposing mandates on individuals or on employers, if we haven't done anything to provide for greater affordability, we haven't helped the situation.

Unfortunately, this bill does not help us with the affordability piece. I am focused, as many of my colleagues are, on an alternative, a step-by-step approach to reduce our health care costs to allow businesses to buy across State lines, allow co-ops to be formed so that fishermen in my State or other coastal States or employees of a small business can pool together to purchase affordable comprehensive coverage.

Just as important is certainly the need to preserve the rights of patients to see the doctors of their choice. We must make sure we are protecting Medicare coverage for seniors. We have to eliminate the discrimination based on preexisting conditions, ensure that expansion of government health programs will not result in restrictions in access to care because of reduced reimbursements to doctors and hospitals.

While this bill does attempt to address several of these issues—for instance, the one about eliminating discrimination based on preexisting conditions—it delays the implementations of some of the more worthwhile provisions until the year 2014.

We have bipartisan support on many of these pieces individually. So why would we not try to work on those areas where we do have agreement, where we do have consensus rather than waiting until 2014?

I held a townhall meeting in Chugiak, AK, last week. It was a pretty tough night. We had winds that were howling off the mountains, snow all over the place, and real slick and icy roads. Over 200 people decided to brave the weather to come and speak out on the issue of health care reform and what is happening in Washington, DC.

I will tell you, the one thing those constituents stood and repeated over and over was: Don't pass health care reform that is going to raise our taxes, that is going to increase our premiums, and that will cut Medicare.

We need to listen to these folks. We need to listen to the American people. We have an opportunity to do it right. There is a lot of good work that goes on by a lot of good people in this body and outside this Chamber. But we are at a point now where because of deadlines—artificial deadlines—we are forced to a process tomorrow evening where we are going to have a vote on a cloture motion on the motion to proceed. As my colleague from Oklahoma pointed out, it is a bit of a shell. We think we are going to this health care bill that is 2,000-some-odd pages, but, in fact, the vehicle we will be using on the motion to proceed is not what this is. I am not going to suggest it is bait and switch, but it could be bait and switch.

I do believe our opportunity to share our concerns about what is contained in this legislation is now. We need to take the time to explain to our constituents the concerns we have, the problems we have, the unintended consequences we believe are part and parcel of this legislation.

I thank the Presiding Officer for the time this evening and thank all my colleagues for their coordinated efforts to help provide a little bit of insight to the American people on what we are dealing with in the proposed legislation from the Democratic leader.

I yield the floor.

The PRESIDING OFFICER (Mr. KAUFMAN). The Senator from Oklahoma.

Mr. COBURN. Mr. President, first, I would like to say thank you for presiding. You drew the unlucky number tonight and I appreciate it.

We are embarking on a process that is going to start tomorrow night and people are going to cast a vote on a bill they have not read, and saying we ought to go on with it.

For just a little history, 97.8 percent of the time in the Senate that a cloture motion passed to proceed to the bill, the bill becomes law. That is an interesting statistic, especially when we are

going to hear those who say they just want to have the debate. The fact is, that is not what is going to happen.

As one of the two practicing physicians in the Senate, I thought I would spend a little bit of time tonight talking about what I see is wrong with our health care system as well as talk about what I see as good about our health care system and then talk about the approach this bill takes. My staff has been through the vast majority of this bill. I personally have not, but I will. I will talk about how it affects us.

What is the real problem in health care today? What is it that keeps people from getting care? The No. 1 problem that keeps people from getting care is cost. It costs too much. Fully either one-fourth or one-third of every dollar we spend on health care does not help anybody get well and does not prevent anybody from getting sick.

There is an interesting study out by the Thomson Reuters report that says that $600 billion to $850 billion is wasted annually in all American health care.

When you break it down, it is broken down like this: 40 percent is health care waste, unwarranted treatment, overuse of antibiotics, use of diagnostic lab tests to protect against malpractice exposure. That accounts for $250 to $350 billion in annual health care spending. It is attributed to extra tests and procedures generated mainly from defensive medicine or Medicare's fee-for-service system.

The second biggest factor out of this $800 billion we are wasting is health care fraud. It is 19 percent of health care waste—at least $125 billion to $175 billion a year, and most of that is in government-run health care programs. Not the private—the private sector has less than 1 percent of fraud. They also have a denial rate that is one-half to a one-third of Medicare's rate in terms of denial of payment claims.

The third most important thing in terms of waste is administrative inefficiency. The large redundant volume of paperwork in the U.S. health care system accounts for $100 billion to $150 billion in spending annually.

The fourth most important area, 12 percent of health care waste is health provider errors, errors we make caused by me as the doctor, or a hospital, that causes us to spend money we should not have to spend.

Six percent of the health care waste is preventable conditions, such as somebody with diabetes getting their blood sugar out of control and ending up in the hospital; whereas if they had good care, coordinated care, it wouldn't have happened.

Of course, No. 6 is 6 percent of health care waste, and that is lack of coordinated care, where we do not coordinate the care, where doctors don't talk to one another, doctors don't talk to the hospital, doctors don't get all the information, so consequently we waste money.

So the first problem that plagues us is that cost is too high. We fully know that $1 out of every $3 we spend on health care is not helping health care. That is our pot of gold. That is where we lower the cost. Just think what health care would cost if it costs one-third less today or if it costs the same for the next 5 years. That means we could cover everybody who is not covered for free and have about $400 billion left over if we just went after where the pot of gold is.

The second problem with our health care system is we have disconnected the purchase of health care from the payment of health care, so that when I go to make a purchase I no longer use the discrimination that I use in everything else that I purchase, such as seeing if it is of value to me. I don't ask what it costs, I don't ask if it is the best way to get this, if it is the most economical way to get there. I don't question to make sure—are you sure I have to have this done? I don't necessarily get a second opinion. I don't ask, if it has to be done, where is the best place as far as efficiency and dollars to get it done.

The reason we don't ask those questions is because most of the time the money isn't coming out of our pocket because we have this perceived false belief that our insurance company or the government is paying for it. If our insurance company is paying for it, we are paying for it because for every 3.5 percent cost our company is paying for insurance, 2 percent of that would have been our wages. And for every $1 that we spend on Medicare, our grandchildren and our children are paying into that fund to pay for our Medicare. In fact, it does cost us, but we have disconnected that cost.

The third thing we have done is we have a Tax Code that says if you are fortunate enough to have your employer pay for your health care benefits, you get $2,700 more in tax benefit than everybody who doesn't have their employer paying for their insurance. You get about $100 in tax benefit if you don't get your insurance through your employer. So we have a 27-fold discrimination that advantages those whose employer pays for their health care versus those who have to buy it on their own or their employer doesn't offer it.

That is wrong. It is not fair. It is unequal treatment, and it creates this maldistribution. But, even having said that, the cost for an individual plan versus the plan bought through your employer, if you buy it in a nationwide marketplace, if you could, it would be 20 percent less than what you could buy it for through your employer. Those are the real statistics.

Then the fourth thing I see that is wrong, as both a patient—I ought to stop here in a minute and tell everybody, at 61, almost 62 years of age, I am a two-time cancer survivor. I have had malignant melanoma and metastatic colon cancer. I also have atrial fibrillation. I have been a patient. I have been on the other side of my stethoscope as a patient.

What I see is, we have limited the options for people in this country. If your employer buys your health insurance, you have very limited options. You get take it or leave it most of the time. Here is what we are providing: You get to take it. If you don't take it, then you have to go outside and you loose that $2,700 advantage, so it comes out of your pocket.

We don't have the freedom to choose within our employer. We also have the States. We heard the Senator from Maine talking about the greatly increased costs in Maine. There is a reason Maine has the massive inflation in their health care insurance. They created the State plan that caused it, that truly limited the competition. So they have seen the results of limited competition because of what they installed. But every State has an insurance commission that both decides who is eligible to sell in the State but also follows the mandates; here is what the minimum is that you have to buy in your State.

Then, of course, if you have Medicaid, you have limited options because 40 percent of the physicians in this country will not see you. If you have Medicare, you have limited options because now about 15 percent of physicians, fast rising to 30 or 40 percent of the physicians in this country, aren't going to see you.

Then if you have VA, you get VA and that is it. You don't get to choose your doctor or you don't even get to choose your location. Here is where you will be, no matter how many miles it is, and here is the doctor you will see. The same thing with TRICARE essentially because TRICARE has limited coverage in terms of availability of all the physicians.

The fifth thing I see that is wrong is there is an absolute lack of transparency as to what something costs and what you can expect as far as quality outcome. That makes it hard to know how to buy, where to buy, or who to buy from. Who do you trust? So if there is no transparency in either quality or price, you are going to have a tough time making a decision. All of the things I am describing describe a lack of liberty, a lack of freedom.

We have government mandates. Have you ever gone to a hospital—this is a great question. One of my constituents wrote in and told me this, and I never had thought about it. Go to a hospital in the middle of the day and try to get a parking spot. Then go to a hospital at 10 o'clock at night, and the parking lot is almost empty. What you are seeing in the difference in the parking lot is the administrative bureaucratic overhead that is required in a hospital to manage the mandates that the government has put or the insurance company has put on the hospital.

If you look at it, fully one-third of the people in every hospital in this country don't do anything to help anybody get well. They are filling out forms, they are pushing the paper,

much like this study I mentioned from Thomson Reuters.

Then we have the insurance mandate. What is wrong? If, in fact, you have a preexisting illness, you don't get insured. That is wrong. We need to fix that. Or if you get sick, insurance companies have figured out a way to drop you. That can't be right. That is why you bought insurance in the first place, and that is not just in the health insurance industry. Try filing a claim for a new roof on your house and see what your insurance costs do next year or if they will insure you. We get hail all the time in Oklahoma and we get roof damage and a lot of times if you have that 2 out of 10 years, they will not even reinsure you. So you have to go find somebody else.

It is a practice of risk management that they are using that doesn't think about the potential market of who their customer is. So I agree we ought to fix those things.

Then we have the costs. Already the Senator from North Dakota tonight talked about drug prices. The one thing he didn't tell everybody is that the reason drugs are cheaper in Canada is because they threaten not to honor intellectual property of this country.

There is a real good way to make sure drug prices go down. Both the Bush administration failed on this and the Clinton administration failed on this—and this administration. If Canada wants to tell our drug companies what price they will pay, then we will tell them what we will pay for their lumber, and we will tell them what we will pay for anything else they want to import to our country. But we put all the focus on the drug companies instead.

So I am going to get to my point. The other thing that is wrong is, on average it costs $1 billion per new drug just to go through the FDA process in this country because we have such a litigious society, that it costs two to three times more to approve a drug in this country than it does anywhere else in the world.

We have drugs that are fantastic drugs that are made by companies in this country that are not allowed to be sold in this country that have passed all the safety and efficacy standards of the European common market, but they can't get them through our Food and Drug Administration because the Food and Drug Administration is worried about somebody criticizing them if they ever make a mistake. They met the standards, did it right, recalled it, now they are afraid to approve anything because they are afraid somebody will be critical of them.

Another thing that is wrong is we have the lack of any real market forces. Insurance companies really don't have to compete.

They really don't have to compete. The government sets the price for everything, essentially, because Medicare says what they will pay and everything else is priced off that.

Here is another thing that is wrong with our health care system. We are starting to experience it. There is a maldistribution of physicians both in terms of geographic location and physician specialty. One in 50 graduates of med schools last year went into primary care. Everybody else went into specialty and subspecialty residencies. Why did that happen? The reason it happened is because the earning power of somebody who has 7 years of medical training is one-third of somebody who has 8 or 8½ or 9. How did that happen? Because Medicare set the payment rates. Medicare set the payment rates, so they created a maldistribution in terms of the payment for physicians.

Another thing I noticed as a practicing physician and as a patient is that our whole system right now has its emphasis on sick care, not on preventing disease, not on prevention, not on the maintenance of chronic disease. We wait until people get sick and treat them. That is expensive. The reason it is that way is because Medicare won't pay for prevention. They refuse to pay for prevention. If you sit down with a patient in your office, a Medicare patient, and spend the time to go through the risk factors and the lifestyle changes and their medicines, the things they need to do, you will not be compensated enough to pay the electricity bill for that office visit. So what has happened is we have incentivized people not to spend time with the patient. We have incentivized them to see more patients for shorter periods of time and not listen to the patient and not spend the time on prevention because our dollars have been incentivized against it.

Then, finally, government systems are designed to be defrauded. If you think about it, it is easy to make $500,000 a month off Medicare; it is hard to get caught. All you have to do is know a whole lot about medicine, have a little bit of guts, and set up a vacant office somewhere and put one computer in it and run everything over the line, and you can rip off Medicare like crazy. We know the drug dealers in Florida are starting to shift away from drugs and into Medicare fraud because it is easier to do. They can make more money. It is harder to get caught, and when you do, the penalties are much less. It is designed to be defrauded, but we haven't changed that.

I have talked about the problems. Let me talk about what is great about American health care.

I want to make the point in a minute that the worst thing we can do in trying to fix what is wrong is destroy what is right. We have the greatest acute care anyplace in the world. If you get sick, there is no better place in the world to get sick than in the United States. I don't care where you are. The statistics bear that out. There is no question. If you get cancer in this country, you have a 50-percent greater likelihood of being alive 5 years from now than anywhere else in the world. It really doesn't matter what type cancer. There are some differences on some, but overall you are 50 percent more likely to be alive.

The third thing that is great about our country is, innovation in health care is two-thirds of the world. Actually, last year it was 74 percent of all innovation in health care came out of this economy. We have invested in the research. We have the scientists. We have the researchers who have pulled together technology, thought, experience, and research, and come up with great innovations that make big differences in life expectancy and quality.

The other thing is we have a very skilled workforce. We have some shortages. Our nursing shortage has been created by the government because we created a health care system that has both hospice care and home health care, but we made the only way that can effectively work is through registered nurses. So we sucked all the registered nurses out of the hospitals because of time constraints and lack of holiday work and lack of shift work. The best nurses want to go where they don't have any of those things. We created a shortage when we could have created a different class of somebody doing home health care rather than an RN. But that is what we have done. We have created this sucking sound, as Ross Perot used to say, and sucked the nurses out of the hospitals. Now we have this critical shortage of nurses in our country because of what the government did.

The other thing besides the skilled workforce, the nurse practitioners, the PAs, nurses, physical therapists, pharmacists, radiologists, doctors, surgical nurses—they are great in this country.

Then we have great medicines. If you think about it, the combination of medicines that saved my life with metastatic colon cancer were all developed here. Six months of chemotherapy, of being sick every day, has been worth every morning I see the Sun. It is this research, the investment in NIH, the quality of research, the committed doctors who will do the research, committed doctors who will take care of you when you are sick and you don't feel like communicating with anybody, but yet they are patient with you—they love you, they nurture you. We have a great system here.

If you have a cardiovascular event, this is the best place in the world to have one. If you have a heart attack, a stroke, if you get cancer, if you have an acute fracture of a limb or joint degeneration, this is the best place in the world to have it.

So I have outlined the problems, which are big, and the things that are good. What do we do with that? Our goal ought to be to not destroy all these good things while we fix the things that are not good.

How did we get in trouble? How did we get to where we have the highest percentage of our GDP, this thing that really limits people in care, cost—how

did we get where we are? Why is it? Part of it has been innovation. About 30 percent of the cost increase we see in our country is because of innovation. It takes money to get innovation. When innovation comes out, we have to pay for the research that was not paid for upfront. About 30 percent of the health care inflation we see is from new products, new innovation, new ideas, new treatments, new strategies or procedures. But the rest of it goes back to this Thomson Reuters, where we have this inefficient delivery system of health care.

A question I asked my staff—and we did the research—what was health care inflation before 1970? Do you realize that most of the time it was less than the regular increase in inflation? What was the difference? What happened? What happened is the government got involved in health care. We created demand that was price-controlled demand, and all of a sudden the bubble started squeezing up.

The other point I wish to make is that most people don't realize that 61 percent of the health care in this country today is run through the government. If we have a problem with health care, we have to look at not where the 39 percent of it is but where the 61 percent is. Let me explain what that is. That is Medicare, TRICARE, VA, Medicaid, Indian Health Service, SCHIP, DOD, and FEHPB. That accounts for 61 percent of the people in this country who have health care. They are getting it through the government now. Our answer is more government? Our answer to the solution is more government?

What should our goals be? Our goals should include access for everybody; affordable prices; liberty to choose what is best for you and yours, not limited by your State, not limited by the Federal Government, it should be your choice; freedom to choose your caregiver. You don't get that in Medicaid. You don't get that at the VA. You don't get that at Indian Health Service. You limitedly get it through Medicaid. Another goal is security in your health care, knowing that no matter what happens, you will have health care. Those are things I think the Presiding Officer would agree with.

I am joined on the floor by the other physician in the Senate, Senator BARRASSO from Wyoming. I welcome him.

I wanted to spend 1 additional second outlining a few things.

Here is the bill we have on the floor, the Reid substitute. I will not talk about the parliamentary shenanigans that have gone along with what we are doing. The fact is, we are going to have a debate on health care. It couldn't have been said any better than by Senator SNOWE. Every major piece of legislation that has affected most people in this country has occurred on a bipartisan basis. If this gets passed, you will see a revolt in this country because it is not what the vast majority across party lines want to see. We need to meet in the middle.

Just so I can tell you what is in here or what is not in here, there is no provision in here guaranteeing that taxpayers will not finance abortion. There is no provision prohibiting the rationing of health care. You will see rationing of health care with this bill. We are seeing it now in Medicare more every day. CMS is not supposed to be doing it, but they have a reason not to do it. There is a law that says they are not supposed to do it, but it doesn't prohibit them. Now they are rationing about 17 things. They have made a decision on practicing medicine. You will see that.

There is zero number of Senators who are going to be required to enroll in the health care bill we will put everybody else on. There are nine new taxes created in this bill, nine new separate taxes. There are 13 pages in the bill's table of contents, single-spaced. This bill weighs 20.8 pounds. There are 36 pages in the CBO explanation of what they think it might or might not do. It has 70 new government programs. Think about what that means in terms of bureaucracy and then think about your choices, about who you want taking care of you and whether you and that caretaker, that physician are going to get to decide what is best for you or some of these 70 new government agencies. And 1,697 times in this legislation we allow the Secretary of Health and Human Services to create, determine, and define critical things in this bill and write the regulations—1,697 times. There are going to be 1,697 new sets of regulations in health care in this bill alone. There are 2,074 pages. There are 2.5 million people who will lose their health insurance with this bill who have it today. They are going to get moved into some government program. There are still going to be 24 million people left without health insurance, if this is fully implemented, according to CBO. This bill costs $6.8 million a word. It is $1.2 billion per page. Ten billion will be needed every year for the IRS just to follow the regulations for the tax collection in this bill. That isn't even considered in the CBO score. There is going to be $8 billion in taxes levied on uninsured individuals. There is going to be at a minimum $25 billion a year in increased mandates on States for Medicaid; there is $28 billion in new taxes on employers not providing government-approved plans; there is $100 billion of fraud annually in Medicare; there is $118 billion in cuts to Medicare Advantage; there is $465 billion in total cuts to Medicare; there is $494 billion in revenue from new taxes and fees levied on individuals, on American families, and businesses. Mr. President, $2.5 trillion is the non-Enron accounting cost for this bill.

Finally, there is $12 trillion worth of national debt today, and this bill by itself will take it to $15 trillion in 10 years. It will increase the national debt in less than 10 years by $3 trillion.

So with 61 percent of the health care in this country already supplied by the government—and either bankrupt or going bankrupt or not giving the care that is promised; look at Native American care—we are going to do more government health care.

Senator MCCAIN had a great analogy the other day on this bill. This bill starts collecting taxes right away. The American people need to know the reason there is the delay in the onset of the benefits in this bill. It is because that is the only way they can make it score and look like it is not spending the amount of money it is spending.

But he used this analogy and I thought it was really great: This bill is like you buying a new home; you go get your mortgage, and you start paying on your mortgage, and you get ready to move in the house, and they say: Uh-oh, the deal was you can move in in 5 years, because that is when the benefits start, 5 years from now. But we want you to pay on it for 5 years before you get to move into it.

None of us would do that. Yet that is exactly what this bill does. It is not a bait and switch. It is just deceptive, and it is dishonest in its accounting. And, of course, Washington has been dishonest. We use Enron accounting. Anything that makes it look less expensive or us look better, that is how we account for it.

Finally, I would say this, and then I will yield to my colleague and fellow physician, Senator BARRASSO.

Of the things that are wrong with health care in America and the things that are right—the things that are right are because we have a patient-centered system; the things that are wrong are associated with a government-centered system.

This is a government-centered health care fix, and it is not even a fix. It does not address malpractice costs. It is somewhere between $100 billion and $175 billion a year in tests we are ordering that people do not need because we refuse to address the tort system in this bill.

What we need is a patient-centered result. What we need is meeting in the middle to solve this problem for the American people.

Abraham Lincoln said: America will never be lost by being destroyed from the outside. If we falter and lose our freedoms, it will be because we have destroyed ourselves.

This bill is the path to destruction for health care in America. Eighty percent of the people in this country will get along just fine with this bill. Twenty percent are going to suffer drastically under this bill because it totally ignores the clinical practice of the art of medicine. Everything is based on a government-run, government-mandated, government-controlled fiat that takes away your liberty, takes away your choice, takes away your freedom; and now we will move physicians from having to be 100-percent advocates for the patient to an

advocate for the government first and the patient second. That is the first health care outcome we could have.

Senator BARRASSO.

Mr. BARRASSO. Mr. President, continuing along this line—because both of us have practiced medicine—I took care of families in Wyoming as an orthopedic surgeon for the last 25 years; Dr. COBURN in Oklahoma for longer than that. We know there are things that need to be corrected. There are improvements that need to be made. We need to fix what is wrong with the system, and that is what I hear every weekend when I go home. It is what I have talked about in the surgeons' lounge in the hospital. That is what I have talked about in the office with my patients. So we need to fix what is wrong with the health care system. But whatever we do, we have to make sure we do not make matters worse. So I say to my friend from Oklahoma, absolutely, my concerns are that this absolutely is going to make matters worse. It is going to increase premiums for families who have insurance. It is going to take almost $500 billion away from our seniors who depend upon Medicare for their health care. It is going to raise taxes on everyone in America—not just on people above a certain income level, on everyone.

They all are going to be impacted when you look at all the taxes that are going to be thrown on this. It is going to be passed along. People in America understand that. People know exactly what is happening here. That is why when I had a telephone townhall meeting earlier this week and asked: ''Is this the right way or the wrong way? Do you think you are going to pay more?'' Everybody thinks they are going to pay more. When asked: Do you think your system is going to get better or worse? They think it is going to get worse. Americans do not want to pay more and get less. That is not the value we as Americans want. It is not what we expect.

People say: Don't cut my Medicare. Especially, if you are going to try to do anything with Medicare, do it to save Medicare, which is already going to go broke in the year 2017. Don't do it to start some whole new, big government program. They say: Don't raise my taxes. People want to know what is going to happen to them, what is going to happen to their family.

What happens if they get sick? Well, they look at this and they say: We want practical, commonsense health solutions, not higher insurance premiums, not higher taxes, not Medicare cuts, not more government control over health care decisions. We want to have lower costs, improved access to providers, more choices. That is the whole crux of why we are doing health care reform, at least that is what I was told 9 or 10 months ago. When they said: We need health care reform. I said: Yes, we do.

I served 5 years in the Wyoming State Senate. We did major pieces of legislation, always in a bipartisan manner, as the senior Senator from Maine has said. Now we are trying to find a way where somebody is trying to get just the minimum number of votes to pass this—not because they want to say, let's see what we have that will work for people.

As doctors, we try to find solutions that work for people. We do not say: What is the very minimum we can do? That is what we are seeing here. We are saying: What can we do to get it right? What this bill is saying is: What can we do to get 60 votes, the minimum we can do to get this, to drag it over the next step along the line—not to solve the health care issue that faces our country.

We know we need to deal with access to care, quality of care, and the cost of care. As my colleague from Oklahoma said earlier, it is the cost of care that needs the attention right now. Eighty-five percent of people like the care they have but they do not like the cost of that care. So what can we do to help get that cost down?

Everything I read and everything I know and everything I study and everything I believe from my years of practicing medicine and taking care of patients tells me this is going to drive the cost up for everyone in the country. And that is not just me.

The dean of Harvard Medical School said it just the other day. He gave the whole thing a failing grade. He said those ''people who favor the legislation are engaged in collective denial.'' And he went on to say that when you talk about the problems of cost and access and quality—with the cost, he said, this ''will markedly accelerate national health-care spending rather than restrain it'' and will ''do little or nothing to improve quality.''

Well, if you are going to spend much more money, you ought to get increased quality. But the problem is not that we are not spending enough money. We are spending enough money in the system. Half of all the money we spend in this country for health care goes for just 5 percent of the people—people who eat too much, exercise too little, and smoke. But there is nothing in this bill anywhere that gives an incentive to those individuals, to that one person to say: Hey, look, we want you to quit smoking. We want to help you lose weight. We want to help you get your cholesterol under control, through exercise get your diabetes under control, get your blood sugar down. There is nothing that gives an incentive to any one individual.

Now, there is a lot of money in here for roadways and streetlights and jungle gyms to encourage community health. But that does not work. What works better is an individual incentive to some person to say you are going to save this much money, get this much money, if you take responsibility for your own health. A lot of people try to do that on their own. But those are the 95 percent, not the 5 percent who are costing this country 50 percent of its health care dollars.

But I will ask my colleague from Oklahoma, do you see anything in here that focuses on that individual patient, a patient-centered approach, as opposed to a government-centered approach or an insurance company-centered approach? I see nothing here that is really focused on the individual patient, giving them incentives, giving them opportunities, giving that individual, American citizen more control, more freedom of choice, to help stay healthy and keep down the cost of their care.

Mr. COBURN. Mr. President, in answer to my colleague's question, there is not an incentive. This bill is full of mandates. And what it does not mandate it sets up panels to mandate. It sets up panels of bureaucrats to mandate. The real difference on this bill—and I believe we have big problems with the insurance industry, but I do not think you eliminate it. I think what you do is you clean it up and make it have to be competitive and fair and open and honest. What the bill does is it mandates.

Just this week, the Preventative Services Task Force came out with new recommendations for mammograms. If you are only thinking about cost, they are great recommendations. If you are looking at it only from cost—how do we most effectively spend the dollars—their recommendations are absolutely right. But if you are thinking about health, their recommendations are absolutely wrong.

You ask the thousands upon thousands of women last year under age 50 who had their breast cancer diagnosed early with a mammogram what they think about the Preventative Services Task Force's recommendation and listen to what they have to say. What they are going to say and what they are going to tell us is that would have made me odd woman out because I would not have had a mammogram. I am talking not high-risk patients. What they are talking about not screening—and that is what the majority of these mammograms find, with no symptoms, no increased risk—you are going to see that multiplied one-hundredfold in this system.

I know the Senator is old enough to have been trained in medicine the same way I was. There are three real tenets in medicine. The three tenets they drill into you are—the first thing is do not hurt anybody. Whatever you do, try not to hurt anybody. And in the practice of medicine and the art of medicine sometimes that happens, we do hurt people. Sometimes we hurt them on purpose to try to get them better. But the first is to do no harm.

The second is to listen to the patient. Well, the patient at this time in America is the American citizenry, where 85 percent of the people pretty well like what they have, and they want the good kept as we fix what is wrong.

Finally, the third tenet of medicine that almost every doctor is taught is,

if it has already been done and it is not working, do not do it again, and do not keep doing it.

Well, let me tell you something. Medicaid is not working. Indian health care is not working. Medicare is broke. The States are broke under the weight of Medicaid. We should give great pause as we break the three tenets of medicine in hopes of saying we reformed health care.

When President Obama spoke to us under a joint session of Congress, this is what I believe he should have said. This is an important matter for America. It is important to us economically. It affects every individual in this country. And what he should have said is: I have not been leading very well on this because we are way over here on one side on this issue, and I am going to admit I have not been leading very well. But here is what I am going to do. I am going to bring us together in the middle where we can all agree on—it is kind of like Senator ENZI's 80-percent rule. It is a great rule. Senator ENZI has joined us. He is the ranking member of the Health, Education, Labor, and Pensions Committee. I want to bring us together and find something on which 80 percent of us can agree.

Had he done that, he would have been a hero in solving the problems in which we find ourselves. Instead, we are going to try to pass something that, before we are through with it, the vast majority of Americans are not going to want. And if you do pass it, and he does sign it, they are going to revolt.

So as our friend LAMAR ALEXANDER said: What we ought to do is start over. We ought to fix one step at a time the things we know are most important, as the author and promoter of association health plans suggests, where we increase the buying power; transparency in the insurance market; risk reevaluation so people can't cherry-pick; eliminate preexisting illnesses so they can't cancel insurance. All of those things we can do without creating all of these new programs, all these 1,697 times that the Secretary of HHS is going to write the rules and regulations.

I thank Senator BARRASSO, No. 1, for his insight and experience. I would leave our colleague, the senior Senator from Wyoming, with this thought: You have two doctors down here who happen to be Senators, who have well over 50 years of practice experience. I had a business career in the health industry prior to going into medicine. We diagnosis this bill as sick. We diagnosis it as something that should be pulled from the market, just as the FDA pulled Vioxx. It will not solve the problem; it will make the patient sicker.

With that, I yield the floor.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. ENZI. Mr. President, I wish to thank the two doctors for their comments. I have been enthralled with what they have been saying. They have been doing a series of programs to help people understand what we could do with health care and how health care is being done. I am glad they point out that vast difference. Obviously, it was a very effective program. It was so effective that the other side decided to have a show too. They put up the two lawyers, and it shows one of the problems.

When the President did speak to us at the joint session, he talked about medical malpractice reform and how he was going to do it the next day. The only problem is what he was referring to was a bill I did with Senator BAUCUS that was ignored in the HELP Committee and it was ignored in the Gang of 6 and it was ignored in the Finance Committee, something that would have gotten some medical malpractice reform going. I think that only saves about $54 billion. That is still a lot of money to me. It is a lot of money even in this bill, although this is a $1 trillion bill.

I appreciate the doctors. I particularly appreciate my colleague from Wyoming who has been here all day adding comments from his medical background and making a substantial contribution to having the people of America understand this bill. But the people of America understand the bill better than the people in this Chamber. That is the problem. In August there were town meetings and people were appalled at the number of people who wanted to go to those town meetings and the way they wanted to speak, and they explained to us why this method won't work. It wasn't because anybody organized them. If Republicans were that good at organization, we would still be in the majority. These were people who were concerned about health care and where it was going. They had read a lot about what had been said, and they are still reading about it, and they are still mad. This isn't where they want to go. The average person in America thought we were going to cut their health care costs or at least keep them from escalating. That isn't what this bill does. This bill builds a whole bunch of new programs and taxes people and steals from Medicare. That is not where the country wants to go. I know that is not where the seniors want to go. I have been surprised at the AARP endorsing the bill. Their members don't think so. Their members are appalled at what is in here and how it is going to affect Medicare.

But my real intent tonight is to discuss this bill and how the increase in health care costs raises taxes and particularly affects small businesses. It makes them less competitive. Small businesses across America are the engine of the economy. I don't know how many times I hear that around here—the engine of the economy. If small business is growing, the economy is growing. If small business is stagnant, people are still losing jobs in big businesses, and it is usually the ones who lose the jobs in big businesses that eventually get absorbed into the small businesses. It is a shift of a brain trust and it makes the small businesses grow and they stay the engine in the economy.

As many of my colleagues know, before I came to the Senate I was a small business owner. My wife and I owned three small shoe stores in Wyoming and Montana. When I talk about small business, I don't talk about it in the vacuum of the Senate floor; I speak from my life experience. I know what it is like to manage a small business, to keep the books, to pay the vendors, and always to serve your customers. In the Small Business Committee I like to remind them that even though the Federal definition of small business is 500 employees or less, the real engines of the economy are much smaller than that. Some of them are the ones that are just starting, where the owner of the business sweeps the sidewalk, cleans the toilets, waits on customers, and does the books, and definitely not in that order. That is the small business. That is a small business growing. Those are the kinds of businesses that becomes the big businesses. A lot of them fail. A lot of them know they are taking a risk, but thank goodness they are willing to take that kind of risk. They never expect the government to add to their risk, but they know it does.

I faced the challenges of making payroll and trying to negotiate good, affordable benefits for my employees. I have had that experience of sitting bolt upright in the middle of the night and saying, Tomorrow is payroll. How am I going to meet payroll? Sometimes you do it without paying yourself, but the business keeps going.

I have to say in a small business the employees are very close to the business. They understand how tenuous it is. They work and they participate and in the good businesses, they are all like family. So they don't have some of the same choices that the big, flexible companies do. I see where a company in Virginia is about to lay off—America On Line is about to lay off 2,500 people. The person who lays them off, do you think they know those 2,500 people? No, they won't know those 2,500 people. I suppose that makes it a lot easier. But in small business, they know their people. They want to do whatever they can to keep that brain trust, that skill, that ability around, and they sacrifice a lot to get to do that.

As a former small business owner, I also understand that if we pass this bill, it will harm the engine of economic growth, and it will be a disaster for millions of Americans. This bill will impose $493 billion in new taxes, and those fall disproportionately on the backs of small business men and women.

For instance, the new $54 billion increase in the Medicare payroll tax will hit approximately one-third of the small business owners across the country. These are the same businesses that

employ over 30 million Americans. So why would this affect them? Do they make that much money? Well, that much money shows up on their books. Most of them are Subchapter S corporations, which means that every dollar of profit becomes their own income, even though they have to take most of it and put it back into the business in order to keep the business going and to grow the business. But some of them look like they make a lot of money.

There are some businessmen in Gillette, WY, and they started a restaurant. They now have six restaurants. I happened to be in one of their restaurants in Casper. Sanford's is the name of it. It is a brandnew restaurant, and when I was there, the owner happened to be there and he recognized me and he came over and visited. He knew we were working on this. He said, You know, they keep piling stuff on us. They think we are rich. Sometimes the things we have to file with the government because of our Subchapter S corporation make us look rich and cost us a lot in taxes. We are helping them to keep this government going, but we don't get to put it in our pocket. He said, When we started that first business, we each had $200 in our pocket and we were able to borrow enough money to start that restaurant. Each restaurant that we built has been a little fancier and a little nicer. The one you are sitting in right now cost $500 million to build. He said, You know, me and my partner still only have $200 bucks in our pocket. The rest of it we have had to plow back into the business. And when we plow it back into the business, it creates more jobs. There are more people working. I will tell you, those are good jobs, too.

I don't understand at a time when small business owners are struggling to pay their bills and to keep the lights on, the majority leader has decided we ought to increase their taxes. These businesses are fighting for their very survival. This bill makes it harder for them. Small business owners are also health care consumers like the rest of us. They take prescription drugs to treat diseases such as cholesterol and hypertension from the stress they are under, and they might also use a pacemaker or have a hip or a knee replaced. If this bill is passed, the prices they pay for all of those items will increase. They increase for the employees they have too who have those same things done.

This bill contains over $40 billion in new fees for prescription drugs and medical devices. The nonpartisan Joint Commission on Taxation has said these types of fees will ultimately be passed through—to whom? To the consumer, meaning that the small business owner is going to pay more for his health care and for the health care of his employees.

Many small businesses still manage to provide health insurance coverage for their employees, despite the ever-increasing cost of health insurance. I understand how hard it is to pay those ever-increasing costs. That is why I fought for years to help small businesses band together so they would be able to get the same kind of discounts that insurers typically provide for the large employers. How would that work? Businesses would be able to band together through their associations across State lines, even nationwide, and build a big enough pool that they could effectively negotiate with the insurance companies or with the providers. I have to tell you, when I proposed that, the insurance companies didn't like it. We went ahead with it anyway. I got it through committee. I brought it here to the floor of the Senate, and I understand how hard it is to get health care reform done. I had a bill that was filibustered on the motion to proceed. I got 55 votes. I had three people who would have voted for it who weren't here. I got 55 votes. That wasn't enough. You have to have 60 in order to move on.

Here is the real irony. OLYMPIA SNOWE was ready to do the amendment that probably would have taken care of 80 percent of the concerns of the people, but because we couldn't do the motion to proceed, we couldn't offer that amendment. We couldn't finish the bill. As a result, there are no small business health plans that cross State lines. Yes, there are small business health plans. Ohio is the laboratory that I used to work the idea. Ohio already had this kind of thing within its State boundaries. There is a lot of population in Ohio. Wyoming doesn't have much population so we can't form these big pools, but Ohio could. I looked at what they had done and it was marvelous. It saved money. It gave more benefits than most of the insurance plans in the State. You know what they said to me? We could do better if we could cross that State line. If we could go nationwide or even across to one more State, we could do better for every one of our people, because we would have a little bigger pool and we could save more money. They said, in the initial phase of this, you know where most of the money is saved? I said, No, where? They said, In administrative costs. Each of those little businesses having to do their own buying, figuring, paying, costs a lot of money, about 38 percent of health care. That doesn't show up in premiums; that is a cost. Do you know what the Ohio small businesses were able to save? Twelve percent. Twelve percent. That is a huge savings, just in administrative costs. But, no, we weren't able to pass that on to these small businesses. Instead, we are coming up with a way to tax them more, regulate them more, which is not exactly my idea of how to fix health care.

Rather than lowering the costs, this Reid bill will actually increase the cost of insurance by creating a new $60 billion tax on insurers. Just like the new taxes on drugs and devices, the cost of the new insurance tax will be passed through to the consumers, meaning that small businesses will see their health insurance premiums go up even more.

The damage this bill will do to small business is, unfortunately, not limited to the new taxes it creates. The bill will also impose expensive new mandates and requirements on insurance that will have the effect of dramatically increasing costs for small employers. One of the worst provisions dealing with insurance market reform is the so-called shared responsibility for employers. What the authors of the bill are trying to hide behind and what sounds harmless is a $28 billion job-killing tax on employers.

Under the bill, if an employer doesn't provide health insurance benefits to any employee eligible for the new insurance subsidies, which includes families making up to $90,000 a year, then the employer has to pay a fine. The penalty is equal to $750 per employee for all the employees.

Let me say that again. If an employer doesn't provide benefits to an employee eligible for the new insurance subsidies, which includes families making up to $90,000 a year, that employer has to pay a fine. The penalty is equal to $750 per employee for all the employees, not just the one eligible for a subsidy.

The nonpartisan scorekeepers at the CBO plus nationally recognized economists have said the costs of this new tax bill will ultimately be paid by workers. Businesses that cannot afford to provide health insurance will pass the costs of these new penalties on to their workers in the form of stagnant or lower wages, reduced hours, and eliminated jobs.

According to one recent study by the Heritage Foundation, this new job-killing tax will place more than 5 million low-income workers at risk of losing their job, or having their hours reduced, and an additional 10 million workers could see lower wages and reduced benefits. That is what they have to do to stay in business.

The bill contains a narrow exemption for small businesses with 50 or fewer employees. Similar to many of the other poorly conceived provisions of the bill, even this exemption is likely to create unintended and harmful consequences.

What is the likelihood that a small employer with 50 employees right now will agree to expand their business if by adding that single extra employee they expose themselves to this new job-killing tax? Small businesses are the engine of economic growth. I cannot say that enough. They create the jobs in this country. But this provision will discourage the creation of new jobs.

Fifteen million Americans are currently unemployed and 19 percent of small businesses have reported that they reduced employment in their firms in the last 3 months. If this bill is passed, the Reid job-killing employer tax will mean that more Americans

will lose their jobs. We ought to be concentrating on jobs. Instead, we are focusing on something that will kill jobs.

The Reid bill will also impose sweeping new regulations over the health insurance marketplace. Similar to most new regulatory schemes imposed on small businesses, this one will also mean increased costs for small businesses.

Small business owners know the current market for health insurance is not sustainable. According to a recent Kaiser Family Foundation report, costs for small businesses, those with less than 200 employees, rose by 5 percent from 2008 to 2009, and they are expected to rise again next year.

We all agree the status quo for health insurance is not acceptable. Equally unacceptable, however, should be any proposals that make the current situation worse. Unfortunately, that is exactly what the Reid bill will do.

The nonpartisan Congressional Budget Office, the administration's own actuaries, the National Association of State Insurance Commissioners, and at least six other private studies have all looked at provisions similar to what is in the Reid bill, and they all found that these provisions will drive up health insurance costs.

Actuaries at the consulting firm Oliver Wyman, which did one of the studies, estimated these provisions will increase premiums for small businesses by at least 20 percent. Last year, they had an increase of 5 percent. This is going to do 20 percent. I suspect most small businessmen will notice that, and they will also know where the blame lies. WellPoint, the largest Blue Cross/Blue Shield plan in the Nation, looked at their actual claims experiences in the 14 States in which they operate and concluded that the premiums for healthier small businesses will increase in all 14 States—in Nevada by as much as 108 percent.

The bill also eliminates consumer choices, requiring Americans to buy richer types of plans that cover more deductibles and out-of-pocket expenses. These plans typically have much higher premiums. That is right. Washington is going to tell you what kind of insurance you have to have, even if it is a lot better than what you have now and you like what you have now. That is not good enough. Washington knows better for you what you need in the way of health insurance. They are going to see that you get it. Boy, are you going to get it. These plans typically have much higher premiums. We have looked at the studies to see how many people have the quality of insurance we are talking about at the lowest acceptable level. If you don't do that, you get fined. OK.

Well, these new mandates will make it more difficult for small businesses to adopt new, affordable, high-deductible health plans. These plans, when combined with health savings accounts, have been enormously successful in recent years in helping small businesses control health care costs. I know a secret here in the Senate. There are quite a few employees—particularly the younger ones—who did a little evaluation, because in the Senate everybody has the same choices and everybody gets to buy from the private market and everybody can pick how much they want to pay in premiums compared to deductibles. You can pay more premium, less deductible, or less premium and more deductible. The two balance out. People know that. Some of the astute kids in my office took a look at buying the insurance as opposed to doing the high deductible and putting it in a health savings account. They found out they could take the money it would cost for the regular plan and, instead, buy this high deductible and take the difference and put it in a savings account. The savings account grows tax free. It has to be used for health care, but it pays for health care things as they come up. In less than 3 years, the one putting in the least covered the entire deductible. So for the rest of the time, she would not have to put any more into that savings account. But she is smart. She said: I am putting that in there tax free, and someday I will need it. So she is continuing to grow that.

We have decided that is a bad deal. I will tell you, people around here are smarter than us. They are figuring out how to save money on health insurance already. I don't think they are going to like that.

Another thing you can do as an employee here is have a flexible savings account. That happens in a lot of businesses across the country. If you have company insurance, you can do a flexible savings account. This bill is going to do away with that too. That is the way to do it if you know you are going to have health expenses the next year that don't fall within your policy. You can put that money in the bank tax free and use it as those bills come due.

We are going to limit that, and that limit isn't going to have any fluctuation dealing with inflation, so in 2 or 3 years that program is gone. I don't know why these ones that encourage people to save and plan for the future are such bad ideas.

According to the Kaiser Family Foundation, 11 percent of small business employees are enrolled in HSAs. Average HSA premiums for small businesses are 20 percent lower than the traditional PPO plans, and the number of employers offering HSAs has nearly doubled over the last 3 years.

If you work for Starbucks, that is one of the small companies—not really. But Starbucks provides insurance to their people. They do it through HSAs. We are talking about getting rid of that, saying it is not good enough. There are going to be upset people.

The new mandates in the bill will prevent some high-deductible health plans from being sold because they do not provide a rich enough benefit.

Small businesses are not just purchasers of health care, they are also providers. Doctors, home health aides, and nursing home owners are all small business owners. They have a significant stake in how this bill turns out. You can tell from the two practitioners we have here who understand and had small businesses, they understand how this works. That is without even getting into the fact that the government, in Medicaid and Medicare, cuts what they pay so it is below their cost. You know how hard it is to run a business below cost? It is impossible. You have to shift the cost somewhere else so the people under private insurance pick up the costs.

I am reminded of some farmers who decided they could make a killing and drive the truck over to North Dakota and buy some eggs for just 24 cents a dozen. They could bring them back to their home State and they could sell them for a lot more. Of course, when they sold them and figured in the expense of picking them up, they found out they were only getting 20 cents a dozen for them. If that is the case, you cannot just buy a bigger truck and solve the problem. That is what doctors are finding. They are saying: I cannot afford to take Medicaid patients or Medicare patients. If you cannot see a doctor, you don't have any insurance at all. That is where we are driving this thing.

Unfortunately, a number of the provisions in the Reid bill will devastate these small health provider businesses. The bill cuts over $460 billion from Medicare over the next 10 years, slashing Medicare payments to hospitals, nursing homes, and home health agencies.

The Reid bill will cut over $15 billion in Medicare payments to the nursing homes. In a rural State such as mine, this level of cut will destroy many small business nursing homes and force the closure of the facilities that currently provide nursing home care to hundreds of Medicare patients.

Connie Jenkins, the executive director of the Star Valley Senior Center, south of Jackson, WY—a lot of people know where Jackson is, over on the western side of the State; it is the home of the Grand Teton National Park, below Yellowstone National Park. The director recently wrote to me about the important role nursing homes play in rural small towns in Wyoming. She noted that many small communities depend on nursing facilities to provide a large portion of the available jobs. She wrote that ''in a rural State, such as ours, closing of nursing homes would mean families traveling further to visit loved ones and, in some cases, loss of access altogether.'' It is important to be near the people who are in a nursing home. We have great distances and very small towns.

The Reid bill would also cut more than $40 billion in Medicare payments to home health agencies. According to the analysis done by one industry association, this level of cuts could put

nearly 70 percent of all home health agencies at risk of having to close their doors.

Home health agencies provide valuable assistance to disabled individuals, allowing them to receive their care in their home. It is a lot cheaper than a nursing home. If these cuts are enacted and these agencies are forced to close, the patients will have to go back into institutional facilities to receive their care. In addition to devastating these small businesses, this proposal would clearly break the President's promise to protect Medicare beneficiaries and not reduce their benefits.

Many doctors, such as my colleague, JOHN BARRASSO, who has been on the Senate floor all day, have also been small business owners. Doctors are currently facing a 21-percent reduction in Medicare payments that is slated to go into effect in January. Despite cutting $460 billion from the Medicare Program, the Reid bill does nothing to fix the Medicare payment formula for physicians. Since 40 percent of doctors will not take Medicaid patients, that is now moved into Medicare, and I think 20 percent will not take Medicare patients. How would you like asking for an appointment and they say: Are you Medicare? And if you are, we are not taking you.

It can happen. That is not health insurance at all. Also, it is fascinating that Medicare doesn't have catastrophic coverage. We will talk about that. Unlike the Federal Government, small business owners cannot lose money on every Medicare patient and then hope to make it up on volume. A 21-percent payment cut is not sustainable, and it highlights why we need to fix the broken Medicare physician payment formula. Rather than stealing $460 billion from Medicare to create a new entitlement program for the uninsured, we should use those moneys to strengthen and improve Medicare.

Medicare is going broke. You saw the charts over there earlier. It is going broke. We are going to take $460 billion from it. Oh, but don't worry. The bill has a little provision in there where we are going to form a commission that, every year, will give us suggestions on how we ought to cut Medicare so that it stays solvent.

I don't know any other way you can put that: Cut Medicare to stay solvent. We had to form a commission to do that after we steal $460 billion from the program. It cannot afford to have that taken out.

Another interesting thing on that commission is they already made a deal with the hospitals, and they cannot cut them, and the doctors were supposed to have a deal, although I think the deal has been broken because the low payments did not get fixed and the medical malpractice did not get included as they were promised. So I don't know if they are still in there. In exchange, they were supposed to not get any cuts.

The pharmaceutical companies were not supposed to get any cuts. I would love to have the time to explain the deal they have. Do you know whom that leaves? That leaves the nursing homes, the home health, and the Medicare patients themselves. They are going to pick up those costs that are each year prescribed to us to pass to save Medicare. Medicare money should go to Medicare.

The Reid bill also drives up health care costs for small businesses by its massive expansion of Medicaid. This bill includes the largest expansion of the Medicaid Program since it was created in 1965. In addition to trapping 15 million low-income Americans in the worst health care program in America, this Medicaid expansion will also increase costs for many small businesses.

Medicaid uses government price controls to set private rates far below what private insurers pay, often below the cost of what it costs to provide the care. According to one estimate, Medicaid pays only 60 percent of the rates paid by private insurers. This forces doctors to make up for their losses on Medicaid patients by increasing their costs to other purchasers. According to a recent estimate by the accounting firm Milliman, inadequate Medicaid payment rates resulted in physicians shifting $23.7 billion in costs onto private sector purchasers.

Enrolling 15 million more Americans into the broken Medicaid Program will only worsen this cost shift. That means if this bill is enacted, small business owners will see their health care costs increase as physicians and hospitals struggle to make up for inadequate payments for many more Medicaid patients.

In addition to doctors and hospitals, States also cannot afford to pay for this expansion of the Medicaid Program. The Reid bill imposes approximately $25 billion in new unfunded Medicaid costs on State budgets at a time when the States are facing a worse economic crisis in general than perhaps our economic crisis because they cannot just print the money.

When we were working with the Gang of 6, we had a table that showed how the $25 billion was distributed among the different States. The CBO estimate of the $25 billion never changed. But every day, we got a new sheet and the different States paid different amounts. Did you know that finally New York and Nevada got theirs down to what they thought was a workable level? I don't know if that is actually the way it will come out if people are just jimmying the numbers.

What this will mean for small businesses will be even higher taxes and fees, as States struggle to close the estimated $22 billion budget shortfall they will face in fiscal year 2011. According to the National Association of State Budget Officers, States have already enacted $23.8 billion in new taxes and fees in the current fiscal year. These numbers are only expected to increase as States see no end in sight to their current fiscal crisis.

Increased State and Federal taxes, higher health care costs, and Medicare payment cuts are the results small businesses are most likely to see if the Senate passes the Reid health care reform bill. While these would never be welcome changes, the Senate will be debating these policies at a time when small businesses face their most severe economic challenges since the Great Depression.

As I mentioned, unemployment is already at 10.2 percent. Even that number, which is the worst we have seen in 26 years, may actually understate the severity of the situation. The government estimates that up to 17.5 percent of the population may be entirely without a job or underemployed.

Other economic indicators paint a grim picture for a potentially jobless recovery. In October, new housing starts fell 10.6 percent, which is 30 percent lower than 1 year ago. Federal Reserve Chairman Ben Bernanke recently noted that the ongoing financial crisis has led to the reduction or elimination of bank credit lines for many small businesses. He also noted that the fraction of small businesses reporting difficulty in obtaining credit is near a record high, and these conditions are expected to tighten further.

Small businesses are the engine of economic growth that can lead this Nation out of its current economic crisis. Unfortunately, the Reid bill will have the effect of sand being poured into the gears of that engine.

The recent statement of the National Federation of Retail Businesses does the best job of summarizing the impact of the Reid bill on small businesses. They said:

> We oppose the Patient Protection and Affordable Care Act 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's clear to us that at the end of the day, the costs to small business more than outweigh the benefits they may have realized.

I see I have run a few minutes over. I apologize to the Chair.

ADJOURNMENT UNTIL 9:45 A.M. TOMORROW

The PRESIDING OFFICER. Under the previous order, the Senate stands adjourned until 9:45 tomorrow morning.

Thereupon, the Senate, at 9:36 p.m., adjourned until Saturday, November 21, 2009, at 9:45 a.m.

NOMINATIONS

Executive nominations received by the Senate:

DEPARTMENT OF DEFENSE

MARY SALLY MATIELLA, OF ARIZONA, TO BE AN ASSISTANT SECRETARY OF THE ARMY, VICE NELSON M. FORD.

PAUL LUIS OOSTBURG SANZ, OF MARYLAND, TO BE GENERAL COUNSEL OF THE DEPARTMENT OF THE NAVY, VICE FRANK R. JIMENEZ.

SOLOMON B. WATSON IV, OF NEW YORK, TO BE GENERAL COUNSEL OF THE DEPARTMENT OF THE ARMY, VICE BENEDICT S. COHEN, RESIGNED.