year; a new tax on medical device manufacturers, which will raise $2 billion per year.

Other taxes kick in 1 year from now. These include an increased penalty on withdrawals from Health Savings Accounts and a new $2,500 cap on FLEX spending accounts.

These new limits and penalties make no sense to me. Why would we want to impose a penalty on Americans who use money from their FLEX spending accounts to buy over-the-counter medicine? How is that going to help make health care more affordable?

But that is not all the bill does with respect to taxes. In 2013, the bill imposes several more taxes, including a reduction in the tax deductibility of medical expenses, a new high cost insurance excise Tax—the so-called Cadillac tax, and an increase in the Medicare payroll tax for high earners.

These tax increases total $73 billion before 2014, before anyone gets a dollar of subsidy to purchase health insurance in the new exchanges.

These taxes will be paid right away by Americans in the form of higher health insurance premiums. This is not just my opinion; this is what the Congressional Budget concludes too. Here is what the CBO said about the $6.7 billion annual fee on health insurance providers, which is scheduled to begin next year:

We expect a very large portion of [the] proposed insurance industry fee to be borne by purchasers of insurance in the form of higher premiums.

It is not just taxes on insurance that will be passed on to consumers. Taxes on pharmaceutical manufacturers and medical devices makers will also be passed on.

This means that American consumers will see price increases for everything from insulin pumps, to pacemakers, to power wheelchairs and drugs like Prilosec.

As the CBO Director has said:

Those fees would increase costs for the affected firms, which would be passed on to purchasers and would ultimately raise insurance premiums by a corresponding amount.

The Joint Committee on Taxation shares the CBO's view these tax hikes will be passed along to consumers.

Once again, I do not see how imposing these new taxes now—before the exchanges are set up and the chief benefits of the bill are supposed to become available—makes health care more affordable.

For all of these reasons, I will be voting in favor of the Hutchison-Thune motion to recommit, and I would urge my colleagues to do the same.

MOTION TO COMMIT

Mr. SANDERS. Madam President, I now move to table Senator HUTCHISON's motion to commit, and I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The question is on agreeing to the motion.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. DURBIN. I announce that the Senator from West Virginia (Mr. BYRD) and the Senator from Massachusetts (Mr. KERRY) are necessarily absent.

Mr. KYL. The following Senator is necessarily absent: the Senator from Oklahoma (Mr. INHOFE).

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

The result was announced—yeas 56, nays 41, as follows:

[Rollcall Vote No. 379 Leg.]

YEAS—56

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

NAYS—41

Alexander	Crapo	McCain
Barrasso	DeMint	McConnell
Bayh	Ensign	Murkowski
Bennett	Enzi	Nelson (NE)
Bond	Graham	Risch
Brownback	Grassley	Roberts
Bunning	Gregg	Sessions
Burr	Hatch	Shelby
Chambliss	Hutchison	Snowe
Coburn	Isakson	Thune
Cochran	Johanns	Vitter
Collins	Kyl	Voinovich
Corker	LeMieux	Wicker
Cornyn	Lugar	

NOT VOTING—3

Byrd	Inhofe	Kerry

The motion was agreed to.

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

The motion to lay on the table was agreed to.

(At the request of Mr. REID, the following statement was ordered to be printed in the RECORD.)

VOTE EXPLANATION

● Mr. KERRY. Madam President, I was necessarily absent for the vote on the motion to table the Hutchison motion to commit to the health care bill, H.R. 3590. If I were able to attend today's session, I would have voted to table the Hutchison motion to commit.●

DEPARTMENT OF DEFENSE APPROPRIATIONS ACT, 2010

Mr. REID. Madam President, I ask the Chair to lay before the Senate a message from the House with respect to H.R. 3326, the Department of Defense Appropriations Act.

The PRESIDING OFFICER. The Chair lays before the Senate the message from the House.

H.R. 3326

Resolved, That the House agree to the amendment of the Senate to the bill (H.R. 3326) entitled ''An Act making appropriations for the Department of Defense for the fiscal year ending September 30, 2010, and for other purposes'', with a House amendment to Senate Amendment.

CLOTURE MOTION

Mr. REID. Madam President, I move to concur in the House amendment, and I send a cloture motion to the desk.

The PRESIDING OFFICER. The clerk will report the motion.

The legislative clerk read as follows:

CLOTURE MOTION

We, the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, hereby move to bring to a close debate on the motion to concur in the House amendment to the Senate amendment to H.R. 3326, the Department of Defense Appropriations Act for Fiscal Year 2010.

Daniel K. Inouye, Harry Reid, Max Baucus, Patrick J. Leahy, Sheldon Whitehouse, Carl Levin, Patty Murray, Mark Begich, Maria Cantwell, Mark L. Pryor, Jack Reed, Edward E. Kaufman, Al Franken, Tom Harkin, Jim Webb, Paul G. Kirk, Jr., Michael F. Bennet.

AMENDMENT NO. 3248

Mr. REID. Madam President, I move to concur in the House amendment with an amendment, which is at the desk.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Nevada (Mr. REID) moves to concur in the House amendment to the Senate amendment with an amendment numbered 3248.

Mr. REID. Madam President, I ask unanimous consent that reading of the amendment be dispensed with.

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

The amendment is as follows:

At the end of the House amendment, insert the following:

The provisions of this Act shall become effective 5 days after enactment.

Mr. REID. Madam President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

AMENDMENT NO. 3252 TO AMENDMENT NO. 3248

Mr. REID. Madam President, I have an amendment at the desk.

The PRESIDING OFFICER. The clerk will report.

The Senator from Nevada (Mr. REID) proposes an amendment numbered 3252 to amendment No. 3248.

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

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

The amendment is as follows:

Strike ''5 days'' and insert ''1 day''.

MOTION TO REFER/AMENDMENT NO. 3249

Mr. REID. Madam President, I have a motion to refer, with instructions, at the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada (Mr. REID) moves to refer H.R. 3326 to the Committee on Appropriations with instructions to report back with the following amendment No. 3249:

At the end, insert the following:

The Appropriations Committee is requested to study the impact of any delay in implementing the provisions of the Act on service members' families.

Mr. REID. Madam President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

AMENDMENT NO. 3250

Mr. REID. Madam President, I have an amendment to my instructions at the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada (Mr. REID) proposes an amendment numbered 3250 to the instructions of amendment No. 3249.

Mr. REID. Madam President, I ask unanimous consent that reading of the amendment be dispensed with.

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

The amendment is as follows:

At the end, add the following:

''and the health care provided to those service members.''

Mr. REID. Madam President, I ask for the yeas and nays on the amendment.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

AMENDMENT NO. 3251 TO AMENDMENT NO. 3250

Mr. REID. Madam President, I have a second-degree amendment at the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada (Mr. REID) proposes an amendment numbered 3251 to amendment 3250.

Mr. REID. Madam President, I ask unanimous consent that reading of the amendment be dispensed with.

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

The amendment is as follows:

At the end, add the following:

''and the children of service members.''

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

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

Mr. ENSIGN. I object.

The PRESIDING OFFICER. Objection is heard. The clerk will continue calling the roll.

The assistant legislative clerk proceeded to call the roll.

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

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. REID. It is my understanding that the Senator from Texas wishes to speak for up to 5 minutes. I ask unanimous consent that she be recognized, and following that Senator DURBIN be recognized.

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

The Senator from Texas is recognized.

Mrs. HUTCHISON. Madam President, I thank the majority leader for allowing me to speak because I am very concerned about a precedent that has been set on the floor in this last vote.

When the Senator from Vermont withdrew his amendment and started talking, my motion to commit was the measure pending on the floor. I did not have notice—which is the normal procedure here—to be able to talk on my motion. We had no idea there would be a motion to table my motion before I had a chance to close.

Here is my point. The measure that was tabled, the Hutchison-Thune motion, would have assured the American people that there would not be 4 years of tax collection before any kind of program would be put forward under the health care reform package. I thought it was very important that Senator THUNE and I be able to close on that. That is a concept we have always had in the Senate—that a program starts when it starts. That means if taxes are included, the taxes will start when the program starts. That is not the case in the underlying bill. The underlying health care reform bill has 4 years of taxes. There will be taxes on insurance companies that will surely raise the premium of every insurance policy in America. There are taxes on prescription drug companies, so that prescription drug prices will surely go up. There are taxes on medical device companies, so the prices on health care equipment will also go up. How much are we talking about? We are talking about $100 billion in taxes that will start in 3 weeks—in January of 2010. Again, we are looking at taxes that will start in 3 weeks, next month, which will accumulate up to $73 billion before a program is implemented that will give anyone a choice of an affordable health care option.

That is the motion that was tabled 10 minutes ago. I want to make sure everyone knows I never had a chance to close on the motion. Senator THUNE didn't have a chance to close, because it was a motion made that could not be objected to. That is not the way things have operated here in the past, and I think it is time we bring back the traditions of the Senate, where we have time that we agree to, everybody has their say, and then we go forward.

I am very concerned about that process. I hope it is not setting precedent because I think we can resurrect health care reform if we have a bipartisan health care effort. If we have an effort that will bring down the costs, that will increase the risk pools so that an employer will be able to afford to offer employees health care coverage, bring down the costs of health care with medical malpractice reform that would save $54 billion in the system, we can do things without a government takeover of health care. But the bill that is before us has $½ trillion in Medicare cuts—Medicare cuts, $½ trillion—and $½ trillion in new taxes—taxes on businesses that offer not enough coverage, businesses that offer too much coverage, a 40-percent excise tax on policies that give what is called Cadillac coverage, the high benefit plans. So if you have a good insurance policy, you have a 40-percent tax on top of the premium you pay. And if you have too little coverage, you also get taxed. You are whipsawed in this bill.

I think the small business people of this country know what this bill is about because that is the comment we are getting. They are the people calling into our offices. They are the people I see on the airplanes as I go back and forth to try to make sure we are covering the bases on this bill and trying to let the American people know what is in it.

I am concerned about the precedent that was set, but more than that, I am concerned that the American people must know that if this bill passes as it is on the floor today, the taxes will take effect in 3 weeks, that insurance premiums will surely go up, prescription drugs will surely go up, prices on medical equipment will surely go up, and there will not be an affordable insurance plan for people to choose to take for 4 years. It is like buying a house and having the mortgage company hand you the keys and say: Come back in 4 years, and we will let you unlock the door.

I don't think that is transparency, and it is certainly not health care reform. I hope there is still a chance that we can bring this body to a bipartisan effort that will allow lower premiums, more health care options for the people of this country but, most important, that will keep the quality of health care, the choices we have in health care that Americans have come to expect and not start going on the road to a single-payer system because in the end, that is what the bill before us will lead to. It will be a single-payer system. It will take choices out. It will take quality out.

It will add taxes and burdens on our small businesses at a time when they need to be able to hire people to get our economy going and to get that jobless rate down. We need them to employ people. We need to encourage our employers to employ people. They cannot do it if we put more taxes and burdens on them, which is what the bill before us does.

I thank the majority leader for allowing me to speak since I did not have a chance to speak before my motion was tabled. I hope the American people

are listening because we have a chance to do this right. The bill on the floor today is not that bill.

I yield the floor.

The PRESIDING OFFICER (Mr. BURRIS). The Senator from Illinois is recognized.

Mr. DURBIN. Mr. President, I thank the Senator from Texas. I am glad she had an opportunity to speak. We disagree on this issue, but I am glad she had her opportunity to speak.

I hear from different people. Obviously, we must ride on different planes because the people I speak with are anxious to see some change in this health care system and know that 14,000 Americans lose their health insurance every single day. They know that most people cannot afford health insurance because of the increase in costs.

I say to the Senator from Texas, she is my friend and we have worked on many issues in the past, but we disagree on this issue.

I am coming before the Senate with a holiday proposal. Recently there was a book that was published about World War I. It was about trench warfare that went on and on with horrendous casualties and lives being lost. Then there came a moment, a Christmas moment, when they decided to call a truce because of Christmas and play a soccer game. The Allied and Axis troops came out and, for a brief moment, stopped the war, played the soccer game, and went back to the trenches and the next day started shooting again.

I am looking for a holiday truce here for our troops because what we have before us right now is the Department of Defense appropriations bill. Although Senator HUTCHISON and I clearly disagree and many Members on both sides clearly disagree when it comes to health care, there is no disagreement when it comes to our troops. Every one of us supports our troops. Every one of us wants to make sure they have what they need, the resources they need to perform their mission successfully and come home safely.

This bill that is before us, this Department of Defense appropriations conference report, is an attempt for us to do something to help these troops in time of war. I would hope I could appeal to my colleagues on the other side of the aisle that for one brief, shining moment in the spirit of the holiday we set aside our political differences for the sake of our men and women in uniform.

The point I am getting to is that if we go through the ordinary, tortured procedure and wait, it is going to take us days to complete this bill for our troops. I hope we can show good faith on both sides of the aisle and overcome that. I hope we could enter into a consent agreement among Republicans and Democrats because I know as I stand here that the Republicans feel as the Democrats do—that we should provide funding for our overseas operations of our men and women in uniform.

In this bill, $101 billion is included for operations and maintenance for ongoing military operations in Iraq and Afghanistan and to support the preparations to continue the withdrawal from Iraq.

In this bill, there is $23.36 billion for equipment. We want to make sure our men and women in uniform have the equipment they need to make certain they are safe and have what they need to come home safely.

There is also a pay raise in this bill, a 3.4-percent pay raise. Does anyone dispute the need that our military has to be recognized for what they have given our country and be given a pay raise?

When it comes to readiness and training, there is $154 billion for the defense operation and maintenance account to increase readiness.

In the field of military health care, there is $29 billion for the Defense Health Program to provide quality care for servicemembers and their families. It includes, incidentally, $120 million for traumatic brain injury and psychological health research.

These are issues we have all come together on. We are not arguing about these issues, and I do not think we should at this moment.

There is $472 million for family advocacy programs and full funding for Family Support and Yellow Ribbon to provide support to military families, including quality childcare, job training for spouses, and expanded counseling and outreach.

There is one other section of the bill—and I will yield for a question from my friend from Alaska when I complete this point—there is one other section that relates to the unemployment crisis facing this country. It is a modest extension of the unemployment benefits. The last time it was on the floor, I believe it passed 97 to 0. I do not believe there is any controversy to the fact that we want to extend unemployment insurance benefits through February 28 of next year. It is difficult to envision a situation where we would actually leave here to go home to our families for the holidays and not take care of the unemployed.

There is also a provision for their health insurance under COBRA and for food stamps on which we know so many unemployed families rely. It seems to me if there is one thing in the midst of this political turmoil we can agree on, it is let's stand behind our troops, let's make sure people who are unemployed have a happy holiday season. Why do we want a tortured process to reach a ''yes'' on this conference report? I appeal to my colleagues on the other side of the aisle to make this a bipartisan effort. Let's do this part. We can return to the health care bill and the debate. But let's get this done and do it without all the necessary motions and time that may be spent.

I yield for a question from the Senator from Alaska.

The PRESIDING OFFICER. The Senator from Alaska is recognized.

Mr. BEGICH. Mr. President, I appreciate the Senator from Illinois bringing up what I consider a very most important piece of legislation to Alaska. Eleven percent of our population are veterans. We have thousands of military individuals in our State.

I am new to the process. One of the questions I have for the Senator—and I hope he can enlighten me and also enlighten the whole public watching—this is probably one of the most important departments at this time. We are in two wars. Can the Senator give me an explanation? In the past—Senator DURBIN started to do it—the Defense bill seemed to be one of those bills where we all came together. It is a bipartisan approach. I know as members of the Armed Services Committee, it seems every time we deal with these issues we are unified.

Help me to understand why this is something that seems to be controversial and yet should be so simple for us to do.

Mr. DURBIN. I say in response to the Senator from Alaska, I think it is the moment. If we were in a different political environment, I think the Republican Senators and Democratic Senators would agree that this should go through and go through quickly. But we have been caught up for weeks now in debate and controversy, and this bill has been tossed into that environment. That is the explanation because I do not think there is a single provision I read here that Republican Senators do not support, as the Democratic Senators support. That is why I made my suggestion.

Mr. BEGICH. Mr. President, if I may ask one more question. That last statement the Senator from Illinois made, I know as a member of the Armed Services Committee, I have not heard complaints about this bill from anyone from the other side. I am asking, from a leadership position, have we heard any complaints on this legislation? Is it just that, it is the moment in time?

Mr. DURBIN. I say in response to the Senator from Alaska, it does include some provisions relative to the unemployed. There were other things that could have been included by the House, but we reached out to the Republican side and asked: Are any of these problematic? By and large, they said here are the things you should not include, and we did not. We did our best to ensure we brought a noncontroversial bill for consideration.

Mr. BEGICH. I thank the Senator.

Ms. STABENOW. Will the Senator yield for a question?

Mr. DURBIN. I am happy to yield to the Senator from Michigan.

Ms. STABENOW. Mr. President, from the Senator's explanation and from what we have been working on, I want the Senator to clarify two things.

First of all, we could do this conference report today if there were a willingness and, secondly, we have a pay raise for our troops that is coming right before Christmas, the holidays,

help for families, help for those who have lost their jobs and are trying to figure out how they keep their health care going, and help for people who are trying to put food on the table for the holidays; is that correct? I ask the Senator to expand. As I understand it, we could actually get this done today and give people some peace of mind going into the holidays.

Mr. DURBIN. I say to the Senator from Michigan, yes, we could enter into a consent agreement now and pass this conference report without controversy, and I bet you it would get a unanimous vote.

As the Senator from Michigan described this, everybody here wants to make sure we take care of our troops. We received a unanimous vote, if memory serves me, the last time we extended unemployment benefits. I think most Members want to stand up and help those who are unemployed through this difficult time of unemployment in our country.

If there ever were a bill to bring us together in those two areas—helping our troops and helping the unemployed—this is the bill.

Ms. STABENOW. Mr. President, I wish to ask another question of the Senator from Illinois. If, in fact, the Senator from Illinois is finding the same thing I am right now—certainly, we have the highest unemployment rate in Michigan—and we are hearing it from all over the country; we are hearing from people that their unemployment benefits are about to expire. They are trying to figure out how they are going to make it through the next few months.

There are particular concerns that if we do not extend it by the end of the year that, in fact, many will have to go out and resign up with a new bureaucracy to continue benefits.

I wonder if the Senator has heard the same kinds of concerns and sense of urgency people have about being able to keep a roof over their head, keep food on the table, and keep their health care going—the same sense of urgency that I know we are feeling from people in Michigan?

Mr. DURBIN. I say in response to the Senator from Michigan, through the Chair, that I am happy to read the latest unemployment statistics showing the number of people declared unemployed each month is going down. We will not feel good about it until it is turned around and we are creating jobs again, which I hope is soon.

In the meantime, we have about six unemployed people for every job that is available. These people are in a market that is terrible, and they are trying their best. Some have gone back to school. Some are getting training courses. Some are trying to keep things together with their family and not lose their home because of unemployment.

I am sure the Senator from Michigan has met with the unemployed in Michigan, as I have in Illinois. Some are, little by little, exhausting the savings they have. Even with COBRA, many people find the COBRA provision, which gives people a chance to buy insurance at discounts, is still too expensive. They are without a job. They are running the risk of losing their home. They are without health insurance for their children and are desperately looking for a job. We certainly do not want to put them in a situation where there is a question mark as to whether after December 31 the unemployment check will be there next month. I think it is that peace of mind we owe these folks caught up in the bad circumstances of our economy.

Ms. STABENOW. If I may conclude, to clarify, we can get this done today. We can create that peace of mind for families going into the holidays, going into Christmas, into the end of the year. We could actually do that today in the next few hours?

Mr. DURBIN. That is correct, I say to the Senator from Michigan, we can. Earlier we were embroiled in the reading of an amendment that would have literally consumed the entire day and forced us into another day's time and run the risk of not providing money for the troops when the continuing resolution, the funding resolution, ran out.

The Senator from Vermont withdrew his amendment, and now we have moved to this bill. But there is nothing stopping us. A consent agreement can be entered into by both sides of the aisle that can move this through quickly and say to our troops: We are with you.

I yield to the Senator from Rhode Island.

Mr. WHITEHOUSE. Mr. President, will the Senator from Illinois yield for a question?

Mr. DURBIN. I will be happy to yield.

Mr. WHITEHOUSE. I am interested in the parliamentary situation that took place earlier whereby one of our Members was actually obliged to withdraw an amendment that was going to be voted on by all of us because of an insistence on the part of the other side that 800 pages be read by our poor clerk before that vote should take place.

I have also heard the other side say that we want to get going, we want to move toward votes. I would be interested in the reflections of the distinguished majority whip on the extent to which a procedural objection to force the clerk to read 800 pages of an amendment, and deny one of our colleagues his vote, fairly represents a desire to move forward and get through our votes.

Mr. DURBIN. I would say in response to the Senator from Rhode Island, we have heard repeatedly that people want amendment, debate, and a vote. What happened on the floor today, when Senator COBURN of Oklahoma refused to give consent to suspending the reading of the amendment, is that the clerk—clerks, I should say—were forced to start reading. As good as they are at reading, the fact is, it was going to take up to 10 hours to read this amendment. During that 10-hour period of time, nothing could happen—no debate, no amendments—nothing other than listening to the clerks' melodious voices. Fortunately for us, the Senator from Vermont stepped up and said: I withdraw the amendment. But if there was a true interest in debate and amendments on health care, it is inconsistent to say we are going to take a day out of the whole affair and read an amendment.

I can tell you, as I said to the Senator from Oklahoma, I can't believe there is a person in America who sat glued to the C–SPAN television listening to this amendment so they would understand it. It is a very complicated amendment page by page but, in general, understandable. The Senator from Vermont was seeking a single-payer health care system. It was not likely to pass, but it is something he believes in fervently and he wanted to offer it. So I would say the strategy on the floor today belies any request that we have more debate and more amendments.

Before the Senator from Rhode Island continues, I think this has been cleared on both sides, but I ask unanimous consent that the time until 6:15 p.m. be equally divided between the two sides, with Senators permitted to speak for up to 15 minutes each.

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

Mr. WHITEHOUSE. If the Senator from Illinois would yield for another question.

I was elected just about 3 years ago, and I came in with the new majority, so I did not have a chance to serve in this body when there was a Republican President and a Republican majority. I wonder if the Senator, who was here at that time, would reflect on how the other side viewed Defense appropriations for our troops during the Iraq war when they were in the majority. Were they desirous of delay and obstruction and debate and procedural maneuver on Defense appropriations at that time or is this a new strategy of theirs?

Mr. DURBIN. I would say to my colleague from Rhode Island that exactly the opposite was true. They wanted to move quickly to pass any appropriations bill to make certain there was no question in the minds of our men and women in uniform that we were standing with them, and we did. I don't believe even those of us who voted against the invasion of Iraq tried to stop the proceedings from funding the troops, regardless of what our votes might be.

So I think it would be consistent now for our colleagues on the other side of the aisle to join us, in a bipartisan fashion, to say whatever differences on other issues, such as health care, let's let the troops know this holiday season we stand behind them—Republicans and Democrats—and let's do it in an efficient and effective way.

Since this unanimous consent request has been granted, I am going to

yield the floor and any of my colleagues who wish to speak, it will be equally divided time for the next 2 hours.

At this time, I yield the floor. Mr. President, if no one seeks time, I suggest the absence of a quorum and I ask unanimous consent that during the time of the quorum the time be equally divided between both sides.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

The PRESIDING OFFICER. Without objection, it is so ordered. The Senator from Florida is recognized.

Mr. LEMIEUX. Mr. President, while we have been here discussing health care, the clock has been ticking on our national debt. Just in the first 2 months of this fiscal year, we have accumulated $296 billion in debt. We took in revenues of $268 billion, and we spent $565 billion. We spent double what we took in just in the first 2 months of the fiscal year.

I know you are new to this Chamber, Mr. President, as am I. I have only been here 90 days, but I have been here long enough to know this system is broken. It doesn't work. Neither this body nor the body across the Capitol has an ability to make ends meet. We continue to spend money we do not have. We spend the money of our children and our grandchildren. Right now we have a $12 trillion debt. It took us 167 years in this country just to amass a $1 trillion debt in 1982. Now we are at $12 trillion. Every family in this country is now responsible for $100,000 of debt.

Where are we getting this money? We are borrowing it from countries such as China, and it is hurting our standing in the world. Central banks that hold American currency are shedding those dollars because they no longer believe our country is a good investment. I worry about our children and our grandchildren. I have three sons, as you know, Max, Taylor and Chase—they are 6, 4 and 2—and we have a baby on the way in March. I am very worried that my children will not be able to experience the American dream like you and I have; to be able to be in the Senate, to be able to achieve all of our goals, whether in public service or in private. I do not believe America is going to be the same place for them, that it is going to hold the same opportunities because I believe this debt is going to strangle us.

If this body and the body across the Capitol don't figure out we need to start making ends meet and stop spending the dollars of future generations, this country will not be the leader of the world. It will not have the promise we have all enjoyed.

I rise today to speak about S.J. Res. 22, which I filed yesterday. It is a constitutional amendment that requires the Congress to balance its budget and also gives to the President of the United States a line-item veto so he, like most of the Governors in this country, can strike out inappropriate budget items, these earmarks that you hear about.

Senator MCCAIN spoke this weekend about $2.5 million to the University of Nebraska to study operations and medical procedures in space. We cannot afford that program under any circumstance, and we certainly can't afford programs like that when we are $12 trillion in debt. These dollar numbers are so big they are hard to comprehend.

What does $1 trillion mean? What does $1 billion mean? In Washington we throw these amounts around, and we do not even comprehend them. I know for the American people at home it is hard to get their minds around how much money this is. I have said this on the Senate floor before, and I am going to keep saying it so people understand that every dollar we spend is a choice.

One million dollars laid edge to edge on the ground would cover two football fields. One billion dollars laid edge to edge on the ground would cover the city of Key West, FL, 3.7 square miles. And $1 trillion would cover the State of Rhode Island—twice. If you stacked them on the ground going up into the sky, it would be 600 miles of one-dollar bills.

Every dollar is a choice, and these numbers are out of control. Just this past Saturday we voted on a spending bill, a spending bill that had a 12-percent increase and $40 billion more than last year. I want to give the American people the sense of what you could do with this kind of money, what good you could do or, better yet, you could give it back to the American people and they could decide what good they could do with those dollars for their families.

With $100 billion, we could give every Floridian a $5,000 tax cut.

With $200 billion we could pay the salary of every teacher for a year. With $300 billion we could pay first-year tuition at a university of their choice for every kid who is in K–12. With $400 billion, we could build high-speed rail for 10,000 miles. We could connect Key West to Anchorage and back.

Every dollar is a choice. We are spending money out of control. Similar to those who have come before me, I will sound the alarm because we still haven't done anything about this problem. There are good measures out there. Senator GREGG from New Hampshire has a measure, along with Senator CONRAD, to put together a commission. I support that. Senator SESSIONS has a measure to bring caps back. Up until about 2002, we actually were making headway against the budget. Then those caps expired and spending went out of control.

I support all those efforts. I support any effort to bring spending under control. This body doesn't have any leadership on spending. Look at what we spend. We don't look at the revenues coming in the door.

I served as chief of staff to a Governor in Florida. When the budget started to go bad in 2007, I was on the phone monthly with the person who determined our receipts. I knew in Florida we could only spend as much money as we had. This institution does not work that way. No one even checks to see what kind of money we are bringing in. We just spend.

I wish to talk to the American people about articles in the Wall Street Journal of today. This is not a Democratic problem or a Republican problem. This is a problem of this institution. The article is titled ''The Audacity of Debt.'' I wish to read one paragraph. I ask unanimous consent that the full article be printed in the RECORD.

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

[From the Wall Street Journal, Dec. 16, 2009]

THE AUDACITY OF DEBT

COMPARING TODAY'S DEFICITS TO THOSE IN THE 1980S

At least someone in America isn't feeling a credit squeeze: Uncle Sam. This week Congress will vote to raise the national debt ceiling by nearly $2 trillion, to a total of $14 trillion. In this economy, everyone deleverages except government.

It's a sign of how deep the fiscal pathologies run in this Congress that $2 trillion will buy the federal government only one year before it has to seek another debt hike—conveniently timed to come after the midterm elections. Since Democrats began running Congress again in 2007, the federal debt limit has climbed by 39 percent. The new hike will lift the borrowing cap by another 15 percent.

There is surely bipartisan blame for this government debt boom. George W. Bush approved gigantic spending increases for Medicare and bailouts. He also sponsored the first ineffective''stimulus'' in February 2008—consisting of $168 billion in tax rebates and spending that depleted federal revenues in return for no economic lift.

Democrats ridiculed Mr. Bush as ''the most fiscally irresponsible President in history,'' but then they saw him and raised. They took an $800 billion deficit and made it $1.4 trillion in 2009 and perhaps that high again in 2010. In 10 months they have approved more than $1 trillion in spending that has saved union public jobs but has done little to assist private job creation. Still to come is the multitrillion-dollar health bill and another $100 billion to $200 billion ''jobs'' bill.

We've never obsessed over the budget deficit, because the true cost of government is the amount it spends, not the amount it borrows. Milton Friedman used to say that the nation would be far better off with a budget half the current size but with larger deficits. Mr. Obama and his allies in Congress have done the opposite: They have increased the budget by 50 percent and financed the spending with IOUs.

Our concern is that the Administration and Congress view this debt as a way to force a permanently higher tax base for decades to come. The liberal grand strategy is to use their accidentally large majorities this year to pass new entitlements that start small but will explode in future years. U.S. creditors will then demand higher taxes—taking

income taxes back to their pre-Reagan rates and adding a value-added tax too. This would expand federal spending as a share of GDP to as much as 30 percent from the pre-crisis 20 percent.

Remember the 1980s and 1990s when liberals said they worried about the debt? We now know they were faking it. When the Gipper chopped income and business tax rates by roughly 25 percent and then authorized a military build-up, Democrats and their favorite economists predicted doom for a decade. The late Paul Samuelson, the revered dean of the neo-Keynesians, expressed the prevailing view in those days when he called the Reagan deficits ''an all-consuming evil.''

But wait: Those ''evil'' Reagan deficits averaged less than $200 billion a year, or about one-quarter as large in real terms as today's deficit. The national debt held by the public reached its peak in the Reagan years at 40.9 percent, and hit 49.2 percent in 1995—This year debt will hit 61 percent of GDP, heading to 68 percent soon even by the White House's optimistic estimates.

Our view is that there is good and bad public borrowing. In the 1980s federal deficits financed a military buildup that ended the Cold War (leading to an annual peace dividend in the 1990s of 3 percent of GDP), as well as tax cuts that ended the stagflation of the 1970s and began 25 years of prosperity. Those were high return investments.

Today's debt has financed . . . what exactly? The TARP money did undergird the financial system for a time and is now being repaid. But most of the rest has been spent on a political wish list of public programs ranging from unemployment insurance to wind turbines to tax credits for golf carts. Borrowing for such low return purposes makes America poorer in the long run.

By the way, today's spending and debt totals don't account for the higher debt-servicing costs that are sure to come. The President's own budget office forecasts that annual interest payments by 2019 will be $774 billion, which will be more than the federal government will spend that year on national defense, education, transportation—in fact, all nondefense discretionary programs.

Democrats want to pass the debt limit increase as a stowaway on the defense funding bill, hoping that few will notice while pledging to reduce spending at some future date. Republicans ought to force a long and careful debate that educates the public. Ultimately, the U.S. government has to pay its bills and the debt limit bill will have to pass. But debt limit votes are one of the few times historically when taxpayer advocates have leverage on Capitol Hill. Republicans and Democrats who care should use it to discuss genuine ways to put Washington on a renewed and tighter spending regime.

''Washington is shifting the burden of bad choices today onto the backs of our children and grandchildren,'' Senator Barack Obama said during the 2006 debt-ceiling debate. ''America has a debt problem and a failure of leadership. Americans deserve better.'' That was $2 trillion ago, when someone else was President.

Mr. LEMIEUX. Reading from the Wall Street Journal:

Democrats ridiculed Mr. Bush as ''the most fiscally irresponsible President in history,'' but then they saw him and raised. They took an $800 billion deficit and made it $1.4 trillion in 2009 and perhaps that high again in 2010. In 10 months they have approved more than $1 trillion in spending that has saved union public jobs but has done little to assist private job creation. Still to come is this multitrillion-dollar health care bill and another $100 billion to $200 billion ''jobs'' bill.

We can't afford the programs we have, let alone the programs we want. I filed this joint resolution to have a balanced budget. I filed the joint resolution to give the President the line-item veto like Governors do. I know I am tilting at windmills. I know there are very few people in this Chamber or the Chamber down the hall who have the courage to do this. They are part of the process. They go along and get along. But I am fresh enough to still remember how things work in the real world. We have to change things. Our children are not going to have this great country. I am so afraid that one of my kids is going to come to me when they are 18 or 22 and say: Dad, I am going to go to another country to make my living. I am going to go to Ireland or Chile or India because I have a better opportunity there to succeed. I can't pay 60 percent in taxes. I can't assume what will then be a $23 or $30 billion debt.

We are not even talking about all the entitlements we haven't paid for. We are not talking about all the money we have raided out of Medicare and Social Security in order to pay for current expenses. Some people say those obligations are more than $60 trillion, numbers we can't even comprehend.

I filed this resolution. I will send a letter to every Governor asking them to adopt it in advance of the Congress taking it up. A constitutional amendment requires two-thirds of both Chambers and three-quarters of the States. They can act first. They can send letters and resolutions from their legislators to this legislative body and say: Get your act under control.

It affects them too. This new health care bill is going to send an unfunded mandate to the States and increase Medicaid from 100 percent of poverty to 133 percent. They will have to pay that bill. It is going to cost Florida in 10 years almost $1 billion. Right now, in Florida, the No. 1 expenditure in our budget is Medicaid. Because we balance our budget, that means we take money away from teachers and education. That means we take money away from law enforcement. It is out of control.

I am here to say the siren is sounding. The ship is going to hit the iceberg. We can't make just incremental change because then we will just hit the side of the iceberg. We have to make substantial change. The people in this body have to have the courage to do it. We can't just go along and get along as we have before. We cannot be tone deaf. The American people are onto us. They understand we are spending money we don't have. I will not stand by and let this great country fall into decline without at least arguing and pushing as strenuously as I can for a solution. I am willing to work with men and women of good will on both sides of the aisle to solve the problem. I am new here. I might not have all the answers. I probably don't. But I will surely work hard. I know this is one solution. If every State can have a balanced budget amendment and 43 States can have a line-item veto, why can't this body?

I have filed this resolution. I look forward to talking about it more. I hope this body will take it seriously. I see my friend from Massachusetts is here. He also is new to this body, although he spent many years working here. We have to do things differently. We throw around billions and trillions like it is just nickles and dimes in our pockets. It is not. Every dollar is a choice. It is a choice to make. If we don't make the right choice, it will be a choice our children and grandchildren will suffer under.

I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KIRK. Mr. President, ''The need for comprehensive national health insurance and concomitant changes in the organization and delivery of health care in the United States is the single most important issue of health policy today.'' Those are not my words. Those are the words of Senator Edward M. Kennedy. The ''today'' of which he spoke was December 16, 1969, exactly 40 years ago today. It was his first major speech on health care reform, and I was privileged to be a young member of his staff. He delivered that speech to a group of physicians at Boston University Medical Center.

Senator Kennedy went on to say:

If we are to reach our goal of bringing adequate health care to all our citizens, we must have full cooperation between Congress, the administration, and the health professionals. We already possess the knowledge and the technology to achieve our goal. All we need is the will. The challenge is enormous, but I am confident that we are all equal to the task.

The world has progressed in many ways since he spoke those words four decades ago, but our health care system has not. In 1969, the United States spent $18 billion on health care. Today we spend over $2 trillion a year. Senator Kennedy pointed out, in 1969, that the Nation faced a shortage of primary care doctors. The reimbursement rates for physicians treating Medicare and Medicaid patients were too low. There was a need to support greater innovation in delivering care, and neighborhood health centers were underfunded. He said we needed to develop an effective means of providing quality, affordable care to all Americans, regardless of their standing in life.

Does all this sound familiar? Yes. But that was then and this is now.

In recent weeks, Senators on both sides of the aisle have come to this floor to debate the merits of the Patient Protection and Affordable Care Act. We have had our differences of opinion, to be sure. But on one issue there is no dispute. When it comes to our health care system, there is no such thing as a status quo. We will move forward or we will continue to fall behind.

Here is what we will face, if we do not pass this reform. Premiums will skyrocket and could consume as much as 45 percent of a median family's income by 2016. Bankruptcies will increase due to families not being able to

afford their medical costs. More Americans will be uninsured. Small and large businesses will suffer financially due to health cost increases. Health care could constitute as much as 28 percent of our Nation's GDP by 2030. Fifteen percent of the Federal budget could be dedicated to Medicare and Medicaid by 2040.

Ted Kennedy had a keen sense of history. He knew Germany adopted the idea of national health insurance in the 1880s, that Britain, France, and a number of other European nations embraced the concept after the First World War, that Canada has had a publicly funded system since the 1950s. He would ask, as he did in 1969 and again in 2009: If all these nations understood long ago that their economic health was ultimately tied to the health of their people, why does the United States stand alone as the only major industrial nation in the world that fails to guarantee health care for all its citizens?

It is not that we have never sought this goal in the past. Presidents, Republicans and Democrats, over many decades, have proposed national health insurance in America. Presidents Theodore Roosevelt, Franklin Roosevelt, Harry Truman, John F. Kennedy, Richard Nixon, and Bill Clinton all made health reform a part of their agenda. Now we stand on the threshold of history. Never has this country been so close to bringing affordable, quality health care to millions of America's families. Today, under President Obama's leadership, the goal is within our reach. Failure is not an option. All interested parties have been brought to the table. Physicians, hospitals, insurance companies, small businesses, pharmaceutical companies, and many others have had an opportunity to present their suggestions and offer their input. Dozens of hearings were held on all topics related to this issue.

The House of Representatives has acted. The Senate HELP Committee, through the diligence of Senators Kennedy, DODD, and HARKIN and the Finance Committee, under the leadership of Senator BAUCUS, held lengthy executive sessions that discussed all areas of reform and delivered and developed their respective bills. Due to the hard work and tireless patience of the majority leader, we have one merged bill before us, a single piece of legislation which will improve the lives of millions of Americans in the following ways. It expands coverage to an additional 31 million Americans, bringing health insurance to almost 94 percent of our citizens. It saves money by rewarding the quality and value of care, not the quantity and volume of care. It controls the cost of skyrocketing premiums and limits out-of-pocket expenses. It reduces the Federal deficit by an estimated $130 billion in the first 10 years and an estimated $650 billion in the second 10 years. It stimulates competition in the health insurance marketplace through establishment of exchanges. It strengthens Medicare by reducing unnecessary spending, lowering prescription costs, and closing the so-called doughnut hole. It attacks fraudulent and wasteful spending and helps to correct abuses in the system. It rewards wellness and prevention by expanding access to advice on how to live a healthy lifestyle by practicing good nutrition, increasing physical activity, and quitting smoking.

It eliminates unfair discrimination against patients by preventing insurance firms from denying certain coverage to women or to individuals with preexisting conditions.

It promotes flexibility and innovation in new health care technologies. It introduces a self-funded, voluntary choice for long-term services and support for the elderly and disabled. Most of all, it saves lives by providing affordable, quality care for individuals, families, and small businesses.

In my State of Massachusetts, because of our successful reform, the rate of the uninsured has been reduced to 2.7 percent of the population, and the lives of thousands of citizens of our Commonwealth have been immeasurably improved.

Carol's case is one example. Carol did not realize the importance of having quality, affordable health insurance until she was confronted with the gravity of her own health problems. She is a 24-year-old woman suffering from seizures and desperately in need of help.

She remembers having occasional seizures as a child. They occurred mostly when she was overtired. As Carol grew older, the seizures became more frequent. One day, she had an episode when driving her car. Fortunately, her passenger was able to assist her. But that frightening incident convinced Carol to seek professional help.

She learned about the assistance of Health Care For All, the Massachusetts organization dedicated to making quality, affordable health care accessible to everyone. She applied and was declared eligible for Commonwealth Care. She immediately went to see a specialist and was given the health care she needed.

Carol expressed her gratitude in these words:

I definitely feel blessed to be a Massachusetts resident. I can't thank Health Care For All and MassHealth enough for all the support given to me. The Helpline counselors literally held my hands and brought me to live a healthy life, where there is no fear or embarrassment, but there is knowledge and a total control of my seizures. So, thank you so much all of you who make this happen in people's lives.

We should all think about Carol and the millions of working families across the country when we vote for this legislation. It is our responsibility to enact laws that make a positive difference in people's lives, and that is what this bill is all about.

Senator Ted Kennedy envisioned a better America where, as he said:

[E]very American—north, south, east, west, young, old—will have decent, quality health care as a fundamental right and not a privilege.

This is a historic moment in our national life. We have the chance to finally complete the work that a respected Republican President called for over a century ago. Quality health care for all has always been needed in America but never more than now. The finish line is clearly in sight. The momentum and the energy are with us, and it is our obligation to seize this historic moment.

Every Member of this body is aware of the valiant fight Senator Kennedy waged for his own health during the last 15 months of his life. Many of you saw him, after receiving radiation and chemotherapy in the morning in Boston, walk into this Chamber that he loved to cast a deciding vote in the afternoon on the issue he proudly called the cause of his life.

While being treated at Massachusetts General Hospital, Senator Kennedy met a woman named Karen List. Her daughter Emily was one of many patients receiving a similar regimen of exhausting cancer treatments. They came from different walks of life, and cancer had touched them all.

In September 2008, after Emily's long summer of treatments, Karen wrote about Senator Kennedy and other patients he had met during his treatment. She wrote:

Now, it is almost fall, and little Caroline is starting kindergarten. Senator Kennedy, who came from a hospital bed to speak at the convention, is planning his return to the Senate in January. Alex, an Apache helicopter pilot, is back at Fort Campbell and expects to be deployed to Afghanistan in the New Year. And Emily hopes to be well enough by spring to return to her life in London. The dream, as Senator Kennedy promised, does live on.

Mr. President, I ask unanimous consent that the article by Karen List in the Daily Hampshire Gazette be printed in the RECORD.

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

[From the Daily Hampshire Gazette, Sept. 8, 2008]

A CHAMPION OF HEALTH COMFORTS HIS FELLOW PATIENTS

(by Karen List)

As Sen. Ted Kennedy's distinctive voice passed the torch at the Democratic National Convention and promised us that the dream lives on, all I could think of was that same distinctive voice several weeks ago calling out: ''Where's Emily?''

Ted was at the other end of the hall in the Proton Therapy Center, Dept. of Radiation Oncology, at Massachusetts General Hospital, where both the senator and my daughter Emily were being treated for cancer.

The proton beam is cutting-edge treatment for certain types of tumors, and the MGH center is one of only five in the country and a handful in the world.

We were lucky to be there, though it was getting increasingly hard to feel lucky as seven weeks of daily treatment took their toll on Emily and the other patients at the center.

They ranged in age from toddlers to the elderly. Little Caroline was 5. Senator Kennedy was 77. In between them were Emily, 23,

and Alex, 26, two of just a few young adults in proton beam treatment.

Radiation burn was the worst side effect for many patients, and it was now preventing Emily from eating or talking. She was at a low point, and she needed a lift.

We had seen Teddy come and go for several days, slipping in through a side entrance and out the same way, always accompanied by his wife, Vicki. When our eyes happened to meet, we exchanged a thumb's up and were treated to that Kennedy smile—as distinctive as the voice.

The day before Ted's treatment was to end, Emily's nurse stopped by the room where she was being treated and pulled the curtain aside. Several minutes later we heard him call from the other end of the hallway: ''Where's Emily?'' And then he was there, talking to her, encouraging her—and just as quickly, he was gone.

Emily was so excited that she was hopping up and down in the bed from a reclining position, if such a thing is possible. But because she couldn't talk, she hadn't been able to say a word to one of the few politicians she really admires.

The next day, our nurse delivered the card we'd written to the senator, explaining how thrilled Emily had been to meet him and how distressed she was that she couldn't tell him so herself. On the card was a photo of Emily at her favorite English pub, smiling her own distinctive smile. She had been home for a short break from her work interning in the London Theater when she'd been diagnosed with cancer. Now she was battling to get her work and her life back.

Teddy had just finished his treatment. This time, as he came down the hall for the last time, Emily was ready. On the slate that she'd been using to communicate, she'd written in purple marker: ''We love you, Ted.'' The senator laughed, walked to her bedside and whispered to her for a few minutes in solidarity, while Vicki talked to Emily's dad and me. We exchanged heartfelt good wishes for each other as they left the center to return home.

Emily had another week of treatment left. During that time, her nurse told us how concerned Sen. Kennedy had been about the other patients, especially the children and young people—and their parents. He had been through this same experience with his own son decades earlier when only one type of chemotherapy was available, unlike the cocktail of diverse chemo drugs that patients like Emily receive today.

This lifelong champion of health care for all Americans, especially children, had experienced once again—this time as the patient himself—what first-rate cancer care could mean. And he intends to continue fighting for its accessibility to everyone as the senior Democrat on the Health, Education, Labor, and Pensions Committee.

On Emily's last day at the center, there was a special gift waiting for her. Ted had left her a copy of his book, ''My Senator and Me: A Dog's-Eye View of Washington, D.C.,'' written by him and his dog Splash. It was inscribed: ''To Emily—Splash and I hope you enjoy.''

And she did. Ted had provided just the encouragement she needed. He'd also left a stack of books for other young patients and the book on tape for those whose vision had been compromised by their treatments.

Now it's almost fall, and little Caroline is starting kindergarten. Senator Kennedy, who came from a hospital bed to speak at the convention, is planning his return to the Senate in January. Alex, an Apache helicopter pilot, is back at Ft. Campbell and expects to be deployed to Afghanistan in the New Year. And Emily hopes to be well enough by spring to return to her life in London.

The dream, as Senator Kennedy promised, does live on.

Mr. KIRK. Karen's was a statement of hope—hope and promise for each of these patients in the face of daunting odds. Their age did not matter; their economic status did not matter; each received the highest quality of health care available. And so it should be for all our people.

Senator Kennedy understood that we are all connected to one another. He often referred to President Lincoln's words about our common humanity and the good that can come to us all when touched ''by the better angels of our nature.'' And he knew that on no issue are our futures more connected than on health care.

Ted Kennedy's voice still echoes in this Chamber. His spirit of hope and strength, of determination and perseverance is still felt here. He said:

For all my years in public life, I have believed that America must sail toward the shores of liberty and justice for all. There is no end to that journey, only the next great voyage. We know the future will outlast all of us, but I believe that all of us will live on in the future we make.

Let each of us in this Senate be moved by the better angels of our nature and make that future a better one for our generation and for generations to come. As Ted Kennedy said 40 years ago: ''All we need is the will.'' This is our time, Mr. President. Let us pass this legislation now.

Mr. President, I ask unanimous consent that the speech delivered by Senator Edward M. Kennedy on December 16, 1969, be printed in the RECORD.

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

ADDRESS BY SENATOR EDWARD M. KENNEDY, LOWELL LECTURE SERIES, BOSTON UNIVERSITY MEDICAL CENTER—LOWELL INSTITUTE, DECEMBER 16, 1969

I am delighted to be in Boston today under the auspices of the Boston University Medical Center and the Lowell Institute to address this distinguished audience of medical educators, private physicians, and lay men concerned with the quality of health care in America.

I am particularly pleased to be here because it gives me the opportunity to commend the many worthy accomplishments of the Boston University Medical Center and its School of Medicine. You have succeeded in breaking down walls that for decades have turned medicine inward toward the age-old trinity of patient care, research and teaching. You have expanded your horizon to embrace the equally important area beyond your walls—the community in which we live.

For more than 90 years, your Home Medical Service has taken students into the community and provided model health care and innovative medical services in the home. Your expanding programs of new hospital affiliation have brought modern urban medicine to outlying communities. You have helped to lead the way in efforts throughout the world to unify cancer care with cancer research, so that today's advances in the laboratory become tomorrow's accepted treatment. Your School of Graduate Dentistry, dedicated in September, will provide high quality dental care as part of the Medical Center's total health program for the community.

In the course of the past decade, your pioneering program in community psychiatry and mental health in the South End and Roxbury—launched long before the Great Society and the Office of Economic Opportunity came into being and made such programs fashionable—have become a model for the nation. You helped develop what is now the rallying cry for health planning in America—that new health programs must be designed with the people and by the people, not just for the people. As Dr. Handler has so eloquently stated, your far-reaching role in community involvement is like a man standing by a river watching people drown:

''Medicine traditionally wades in,'' he said, ''and tries to save them one at a time. After doing this repeatedly, you can't help but ask what is happening upstream. It seemed sensible to go back and find out why all the people were falling in, and try to do something about it.''

I commend you for your leadership in looking upstream, and for the remarkable efforts you are making in preventive community medicine and all the other major areas of this great center's activity.

Six weeks ago in Springfield, I had the occasion to discuss what I regard as the single overriding economic issue of the day—the war against inflation. As I have frequently stated, the war against inflation is a war that can and must be won without the cost of heavy unemployment. It is a war that can and must be won without cutting back on our important domestic priorities.

Nowhere is the impact of inflation more obvious than in the rising cost of medical care. Never has the gift of good health been more precious:

In the last three years, the cost of health has risen by 22 per cent, or nearly double the rise in general consumer prices.

Hospital daily service charges have soared by the astronomical rate of 55 per cent, or nearly five times the rise in consumer prices. The average cost of a hospital day is now $68. It will rise to $74 next year, and to $98 by 1973.

Physicians' fees have risen by 21 per cent. Doctors line up at lawyers' offices to form corporations and raid the Federal Treasury for hundreds of thousands of dollars a year in deferred taxes.

All of this inflation has occurred during the early years of Medicare and the troubled Medicaid program. The most rewarding experience of Medicare has been its success in solving the serious problem of health costs for our poor and our aged citizens. In spite of inflation, Medicare has been immensely popular. It is liked and accepted by the people.

The most painful experience of Medicare and Medicaid has been their unfulfilled promise. We sought to spread the benefits of medical science and technology to millions of Americans, without considering the anachronistic and obsolete structure of the system by which the health services would be delivered. Unwisely, as many experts have recognized, we assumed that all that stood between our poor and aged citizens and high quality medical care was a money ticket into the mainstream of modern American medicine.

We know now that we were wrong. The money ticket was important, but it was not enough to solve the problem. In the years since Medicare and Medicaid were enacted, we have learned that medical insurance and payment programs could not be translated instantaneously into more doctors, more nurses, more health facilities, or better organization of the delivery system.

In wedding new purchasing power to the already existing demand for health services, we did nothing to solve an already intolerable situation. The cost of health care began

to soar. In some cases, the quality of care declined, and an enormous strain was placed on the capacity of our existing health services and facilities. When an already overworked physician goes from seeing one hundred patients a day to seeing two hundred patients a day, the quality of his care is inevitably affected. His only escape is to consign more of his patients to hospital treatment, thereby increasing the strain on hospital facilities and hospital costs.

Today in the United States, health care is big business. Indeed, it is the fastest growing failing business in the nation—a $60 billion industry that fails to meet the urgent demands of our people. Today, more than ever before, we are spending more on health care and enjoying it less. By 1975, we may be spending $100 billion a year on health and be worse off than we are now in terms of the quality and responsiveness of our health care system.

Perhaps the most serious fault in the present situation is the failure of the Federal Government to play a greater role in improving the quality of the nation's health care. Health is big business in America, and the Federal Government has become a major partner in this business. The total outlays for medical and health-related activities in the Federal budget estimated for 1970 are $18 billion, or nearly one-third of the total health expenditures in the nation. The outlays for 1970 are divided among 14 principal departments and agencies. By far the largest amount—$13 billion—is expended by the Department of Health, Education and Welfare, but significant amounts are also expended by the Department of Defense—$2 billion—and the Veterans Administration—$1.7 billion.

In 1960, the total outlays for health in the Federal budget were only $3 billion. Thus, in the decade of the Sixties alone, we have had a six-fold increase in total Federal outlays for health. Indeed, almost 10 per cent of the total Federal budget now goes for health. The major share of the rise in recent years has been for Medicare and Medicaid. Yet, in spite of the dramatic increases in the health budget and the large amounts we are now spending, there is almost no one who believes that either the Federal Government or the private citizen is getting full value for his health dollar.

Of course, a significant proportion of the increase in health expenditures is being consumed by rising costs and our growing population. Between 1950 and 1969, personal health care expenditures increased by $42 billion. Of this increase, 50 per cent was attributable to rising coats, and another 19 per cent was attributable to population growth, so that only 31 per cent of the increase represents real growth in health supplies and services over the past two decades.

Although the conventional wisdom is content to blame our current medical inflation on Medicare and Medicaid and the excess demand created by these programs for health care, there is another, more controversial aspect to the rising prices. At Professor Rashi Fein and other experts in the field of the economics of medicine have made clear, the basic models used by economists are not appropriate when applied to health. The medical market. is characterized by the absence of competition, diverse products, and consumer ignorance. Comparisons of quality and performance are extremely difficult, if not impossible.

In other words, the medical marketplace is an area where the laws of supply and demand do not operate cleanly, and where physicians have a relatively large amount of discretion in setting their fees. Thus, at the time Medicaid and Medicare were instituted, fees rose for a variety of reasons, many of which were unrelated to the creation of excess demand:

Some physicians raised their fees in anticipation of a Federal fee freeze.

Some raised their fees in the face of rising hospital costs, in order simply to preserve their slice of the growing health pie.

Some raised their fees simply because they had the discretion to do so, and decided to take advantage of the instability and price consciousness generated by the new Federal programs.

As In the case of physicians' fees, the economic model of supply and demand does not tell the whole story of rising hospital costs. In part, hospitals took the opportunity to provide substantial—and wholly justified—wage and salary increases to their notoriously underpaid employees. In part, costs rose because the new Federal financing methods contained few incentives for improving efficiency, but simply encouraged hospitals to pass the higher costs on to Washington.

The high cost of medical care is but one aspect of the overall health crisis, In America today, it is clear that we are facing a critical shortage of health manpower. Indeed, at bottom, our crisis in medicine is essentially a crisis in manpower. The need is urgent for more physicians, more dentists, more nurses, and more allied health professional and technical workers. We must develop new types of health professionals and pare-professionals. We must make far more efficient utilization of our existing health manpower. Only if we succeed in these efforts will we be able to free our physicians and highly trained medical experts to perform the sort of intricate operations and sensitive counselling discussed by Dean Redlich in the inaugural lecture in this series.

The need is especially clear in the case of the shortage of doctors. Our low physician-population ratio means that unsatisfactory medical care is a way of life for large numbers of our people in many parts of our nation. In 1967, in the United States as a whole, there were 260,000 private physicians providing patient care for our 200 million people. This is a ratio of 130 physicians for every 100,000 citizens, or one doctor for every 700 people.

At first glance, the ratio appears to be fairly close to the satisfactory ratio generally recommended by many health experts, but the figures are misleading. The family doctor—the general practitioner—is fast disappearing, and is on the verge of becoming an extinct species. At the present time only one out of four of the nation's physicians is engaged in the general practice of medicine. Three out of four are specialists, most of whom accept patients only on a referral basis. The true doctor-population ratio, therefore, is more like one general practitioner per three thousand population, a ratio that is clearly unacceptable for adequate health care for our people. For far too many of our citizens, the only ''doctor'' they know is the cold and impersonal emergency ward of the municipal hospital.

To make matters worse, the geographic distribution of our doctors is highly uneven. Two-thirds of our physicians serve the more affluent half of our population. In some states, of course, the physician-population ratio is higher than the national average of 130 doctors per 100,000 population. In Washington, D.C., the ratio is 318; in New York it is 199; in Massachusetts, 181.

In sixteen states, however, the physician-population ratio is far below the national average. In Alaska and Mississippi, the ratio is an abysmal 69, or about one-half the national average. In Alabama, it is 75. Even in Texas, it is only 106. Clearly, therefore, extremely large groups of our population are receiving seriously inadequate medical care because of the shortage of physicians.

One of our most urgent needs to meet this crisis is a stronger Federal program to expand existing medical schools and establish new schools. We must substantially increase the output of doctors from our medical schools. At the present time, about 8,000 students are graduated from our medical schools each year. The Association of American Medical Colleges estimates that the number of students entering medical schools will increase by 25 per cent to 50 per cent by 1975, as a result of the construction of new medical schools already begun, and the expansion of existing schools already planned. Yet, if the physician-patient ratio is to be improved substantially, our goal should be to admit double the number of current students by 1975, with special emphasis on medical schools in regions where the physicians-population ratio is too low.

There is another reason why we must increase the enrollment in our medical schools, aside from the need to provide better health care for our people. Today in America, the medical profession is that one profession that flies in the face of the American credo that every man shall have the opportunity to join the profession of his choice. Today in America, if a poor black or white young American aspires to be a lawyer, he will have the opportunity to enroll in a law school somewhere in the nation that will give him the chance to fulfill his dream. It is the shame of American medicine that no such opportunity exists for the youngster who aspires to enter what is perhaps the most exalted and selfless of all our professions, the healing arts.

Ironically, at the very time we are denying this opportunity to our own citizens, we are importing thousands of foreign-trained doctors each year to meet our manpower crisis. Twenty per cent of the newly licensed physicians each year in the United States are foreign-trained. Forty thousand foreign medical graduates are now practicing medicine in the United States, or about 15 per cent of the total number of doctors providing patient care. Thirty per cent of all our interns and residents are foreign-trained.

These figures are appalling. I believe that at this crucial period in world history, it is deeply immoral for us to be luring physicians from the rest of the world to meet our own doctor shortage, when their services are even more critically needed in their own lands.

The landscape we see is bleak, but it is not without hope. If we are to be equal to the challenge, however, we must be prepared to take major new steps. As Hippocrates himself put it two thousand years ago, where the illness is extreme, extreme treatments may be necessary. I would like, therefore, to share with you my views as to the directions we should begin to take now, if we are to meet the challenge.

First, and perhaps most important, we need a new approach to the politics of health. Our single greatest deficiency in the area of health is our failure to develop a national constituency, committed to a progressive and enlightened health policy. As a prestigious Committee of the National Academy of Sciences has recently and eloquently stated with respect to the problem of the confrontation between technology and society, the issue is far more serious than the simple question of braking the momentum of the status quo. Today, all too often, whether the area be that of medicine, or education, or pollution, the vested interests are strongly ranged against innovation, and there is no champion capable of marshaling the diffuse advocates for progress and reform. When a better teaching organization threatens the bureaucratic status quo in education, we know there will be organized opposition from

school officials, but there is seldom organized advocacy by parents and children. When a new and more efficient development is offered that threatens the status quo in health—whether in the organization, financing, or delivery of health care—we know there will be opposition from organized medicine, but there is seldom organized advocacy by health consumers.

In these situations, a thorough consideration of the relative merits of alternative proposals is rendered difficult, if not impossible, by the presence of powerful spokesmen for the old, and the absence of effective spokesmen for the new. If we are to succeed in making basic changes in our health care system, we can do so only by creating the sort of progressive national health constituency that can make itself heard in the halls of Congress and the councils of organized medicine.

To be sure, there is cause for hope. The present generation of medical students is outstanding. They are already beginning to develop the commitments to public causes, the enlightment and social conscience so desperately needed in the health profession, And, in spite of the heavy responsibility that organized medicine must bear for the inadequacy of our health manpower and other resources, a few leaders have recently made progressive statements suggesting a new recognition and awareness of the problem.

Second, the Federal Government must play a far more active and coherent role in the formulation and implementation of health policy. We must develop a comprehensive and carefully coordinated national health policy, with an administrative structure capable of setting health goals and priorities for the nation, In the spring of 1968, I introduced legislation urging the creation of a National Health Council to be established in the Executive Office of the President with responsibility for setting health policies and making recommendations for the attainment of health goals, including the evaluation, coordination, and consolidation of all Federal health programs and activities. The National Health Council would be modeled along the lines of the Council of Economic Advisors, which has consistently played a superlative role in planning and coordinating the nation's economic policy.

Third, we must move away from our excessive emphasis on high-cost acute-care hospital facilities. We must make more imaginative use of innovative types of low-cost facilities, such as neighborhood health centers and other out-patient facilities, storefront clinics, and group health facilities. In spite of the active opposition of a substantial segment of the medical profession, group practice and hospital-based practice are probably the most efficient and economical means of delivering health care today. In many areas, the ideal arrangement consists of a teaching hospital in a medical center, with affiliations to community hospitals in the surrounding area. In turn, each of the community hospitals serves as the center of a series of satellite group practice clinics that can reach out directly into the entire community.

Fourth, while we are building the nation's overall health policy, we must give special attention to the health of our urban and rural poor. For too many of the poor, the family physician has disappeared, to be replaced by the endless lines and impersonal waiting rooms of huge municipal and county hospitals. Yet, there are few physicians today who were not trained on the wards and charity patients in our teaching hospitals. Too often, as Professor Alonzo Yerby has eloquently stated, our poor have had to barter their bodies and their dignity in return for medical treatment.

In America today, millions of our citizens are sick, and they are sick only because they are poor. We know that illness is twice as frequent among the poor. We know that the poor suffer three times as much heart disease, seven times as many eye defects, five times as much mental retardation and nervous disorders. Although our goal must be one health care system open to all our citizens, we have an obligation now to increase the range and efficiency of the health services and facilities available to the poor, with special emphasis on breaking down the barriers that have for so long divided our society into a two-class system of care—one for the rich and one for the poor, separate and unequal.

Specifically, I urge the Administration to create a National Health Corps, as an alternative to the draft for doctors, and stronger than the ''Project U.S.A.'' program recently recommended by the AMA. Today, doctors are exempt from the draft if they serve two years in the National Institutes of Health or other branches of the Public Health Service. The same exemption should exist for doctors volunteering for medical service in urban or rural poverty areas, Only in this way will we be able to meet the critical need for health manpower in depressed areas. And, once young physicians are exposed to the problems of health care for the poor, a significant proportion of them will be encouraged to remain and dedicate their careers to this service.

In addition, we should make a substantial new effort to expand the neighborhood health center program. At the present time, less than a dozen medical societies in the nation have become actively involved in neighborhood health centers. Yet, in recent weeks, prominent leaders of the AMA itself have called for a greater role for neighborhood health centers as a means of extending health care to the poor. A few imaginative pilot projects reaching in this direction have recently been funded by the Office of Economic Opportunity, including a program to reorganize the out-patient department at Boston City Hospital as a nucleus for community health care, but our overall effort has been inadequate. Tragically, at a time when even organized medicine is moving forward, we have been unwilling to allocate the resources so urgently needed for this program.

Fifth, within the critical area of health manpower, we must give special attention to training new types of health professionals. In far too many cases, highly trained physicians spend the overwhelming majority of their working day in tasks that do not require their specialized medical skills. One of the most promising methods of easing the shortage of doctors is to train new types of health workers to perform these non-specialized tasks, thereby freeing our physicians for other, more urgent needs. We must develop a broad new range of allied health professionals, such as paramedical aides, pediatric assistants, community service health officers, and family health workers.

At a number of our universities, imaginative new programs are under way to train medical corpsmen from Vietnam as physicians' assistants. In the State of Washington, hospital corpsmen are trained for three months in the medical school, and then sent into the field for nine months' further training in the offices of private physicians. A similar program now exists at Duke University. These programs are unique in their emphasis on combined training in the classroom and in the field. They are programs that must be greatly expanded if we are to meet the urgent demand for more and better trained health manpower.

Sixth, we must restore the severe budget cuts that have been proposed in Federal health programs by the present Administration. Later this week, the full Senate will vote on Federal health appropriations for the current fiscal year, 1970. None of us in Congress can be proud that almost half way through the present fiscal year, we are only now about to vote the funds that may be used. Our error is compounded by the knowledge that at this time of medical crisis, Federal assistance to health programs may be drastically curtailed, especially in the areas of research and manpower training.

Today, when every medical school and every other health school is being urged to expand its manpower programs, the Administration is requesting far less funds than Congress authorized as recently as 1968 for these vital programs.

The impact of the proposed cuts will be felt in medical schools, hospitals, research centers, and communities throughout the nation. It will be measured in terms of cancer research cut short, lives lost because coronary care units are un-funded, special hardship for the poor, and the loss of dedicated young students from careers in medicine and medical research.

Seventh, I come to what I believe is the most significant health principle that we as a nation must pursue in the decade of the Seventies. We must begin to move now to establish a comprehensive national health insurance program, capable of bringing the same amount and high quality of health care to every man, woman, and child in the United States.

National health insurance is an idea whose time has been long in coming. More than a millennium ago, Aristotle defined the importance of health in a democratic society, when he said:

''If we believe that men have any personal rights at all as human beings, then they have an absolute moral right to such a measure of good health as society and society alone is able to give them.''

Today, the United States is the only major industrial nation in the world that does not have a national health service or a program of national health insurance. The first comprehensive compulsory national health insurance was enacted in Prussia in 1854. Throughout the Twentieth century, proposals have been periodically raised for an American program, but never, until recently, with great chance of success.

National health insurance was a major proposal of Theodore Roosevelt during his campaign for the Presidency in 1912. Shortly before the First World War, a similar proposal managed to gain the support of the American Medical Association, whose orientation then was far different than it is today, During the debate on social security in the Thirties, the issue was again raised, but without success.

Today, the prospect is better. In large part it is better because of the popularity of Medicare and the fact that many other great national health programs have been successfully launched. The need for national health insurance has become more compelling, and its absence is more conspicuous. In part, the prospect is good because the popular demand for change in our existing health system is consolidating urgent and widespread new support for a national health insurance program as a way out of the present crisis.

For more than a year, I have been privileged to serve as a member of the Committee for National Health Insurance, founded by Walter Reuther, whose goal has been to mobilize broad public support for a national health insurance program in the United States. Two months ago in New York City, the Reuther Committee sponsored a major conference, attended by officers and representatives of more than 65 national organizations, to consider a tentative blueprint for

a national health insurance program. At the time of the conference, I commended Mr. Reuther for the extraordinary progress his Committee has made. I look forward to the future development of the program. Already, it offers. one of the most attractive legislative proposals that is likely to be presented for our consideration next year in Congress.

We must recognize, therefore, that a great deal of solid groundwork has already been laid toward establishing a national health insurance program. It is for this reason that I believe it is time to transfer the debate from the halls of the universities and the offices of professors to the public arena—to the hearing rooms of Congress and to the offices of your elected representatives.

Early next year, at the beginning of the second session of the 91st Congress, I intend to introduce legislation proposing the sort of comprehensive national health insurance legislation that I believe is most appropriate at the current stage of our thinking. The mandate of the Medicaid Task Force in the Department of Health, Education and Welfare has been expanded to investigate this area, and I urge the Administration to prepare and submit its own proposals.

Senator Ralph Yarborough of Texas has told me that, as Chairman of the Senate Subcommittee on Health, he will schedule comprehensive hearings next year on national health insurance. Our immediate goal should be the enactment of legislation laying the cornerstone for a comprehensive health insurance program before the adjournment of the 91st Congress. This is an issue we can and must take to the people. We can achieve our goal only through the mobilization of millions of decent Americans, concerned with the high cost and inadequate organization and delivery of health care in the nation.

Last week on the floor of the Senate, we witnessed the culmination of what has been one of the most powerful nationwide legislative reform movements since I joined the Senate—the taxpayers' revolution. It now appears likely that by the end of this month, there will be laid on the President's desk the best and most comprehensive tax reform bill in the history of the Federal income tax, a bill that goes far toward producing a more equitable tax system.

We need the same sort of national effort for health—we need a national health revolution, a revolution by the consumers of health care that will stimulate action by Congress and produce a more equitable health system.

Because of the substantial groundwork already laid, I believe that we can agree on three principles we should pursue in preparing an effective program for national health insurance:

First, and most important, our guiding principle should be that the amount and quality of medical care an individual receives is not a function of his income. There should be no difference between health care for the suburbs and health care for the ghetto, between health care for the rich and health care for the poor.

Second, the program should be as broad and as comprehensive as possible, with the maximum free choice available to each health consumer in selecting the care he receives.

Third, the costs of the program should be borne on a progressive basis related to the income level of those who participate in the program.

I believe there is no need now to lock ourselves into a specific method of financing the insurance program. There are distinct advantages and disadvantages to each of the obvious alternative financing methods that have been proposed—financing out of general revenues of the Treasury, out of tax credits, out of the Social Security Trust Fund, or out of another independent trust fund that could be created specifically for the purpose.

At the present time, I lean toward a method of financing that would be based on general Treasury revenues, with sufficient guarantees to avoid the vagaries of the appropriations process that have plagued the Congress so much in recent years.

I recognize the obvious merit of the tax credit and social security approaches. In particular, Social Security financing offers the important advantage that it is a mechanism that Americans know and trust. In the thirty-five years of its existence, Social Security has grown into a program that has the abiding respect and affection of hundreds of millions of Americans. In 1966, it demonstrated its capacity to broaden its horizon by its successful implementation of the Medicare program. To many, therefore, Social Security is the obvious vehicle to embrace a program for national health insurance, and soothe the doubts and suspicions that will inevitably besiege the program when it is launched.

At the same time, however, we must recognize the obvious disadvantages of Social Security financing. Under the Social Security system, the payroll tax is heavily regressive. The poor pay far too high a proportion of their income to Social Security than our middle or upper income citizens. Today, at a time when Congress is about to grant major new tax relief to all income groups, I believe it would be especially inappropriate to finance a national health insurance program through the conventional but regressive procedures of Social Security, rather than through the progressive procedures of the Federal income tax laws.

I wish to make clear, however, that I am not now rejecting an approach that would finance national health insurance by a modified approach through the Social Security System. By the use of payroll tax exemptions and appropriate contributions from the Federal. Government, it may be possible to construct a program that will build in the sort of progression that all Americans can accept. The important point here is that we must discuss these possibilities in a national forum, and weigh the alternatives in the critical light of open hearings and national debate.

We must be candid about the costs of national health insurance. In light of our present budgetary restrictions, the price tags applied to the various health insurance programs are too high. They range from about $10 billion for ''Medicredit,'' the AMA proposal, to about $40 billion for the Reuther proposal, It is therefore unrealistic to suppose that a total comprehensive program can be implemented all at once.

We can all agree, however, that it is time to begin. In light of the fiscal reality, the most satisfactory approach is to set a goal for full implementation of the program at the earliest opportunity. I believe that the goal should be 1975. The legislation we enact should reflect our firm commitment to this target date. Halfway through the decade of the Seventies, we should have a comprehensive national health insurance, program in full operation for all Americans.

I have already stated my view that legislation establishing the program should be enacted next year. In January, 1971, we should begin to phase-in a program that will reach out to all Americans by the end of 1975, To meet that timetable, we should establish coverage in the first year—1971—for all infants, pre-school children, and adolescents in elementary and secondary schools. In each of the following four years, we should expand the coverage by approximately ten-year age groups, so that by the end of 1975, all persons up to age 85 will be covered by the program, and the existing Medicare program can be phased in completely with the new comprehensive insurance.

The idea of phasing in children first should receive wide support, both from the population as a whole and from the medical profession as well. As a nation today, the United States is the wealthiest and most highly developed medical society in the world, but we rank 14th among the major industrial nations in the rate of infant mortality, and 12th in the percentage of mothers who die in childbirth. In spite of our wealth and technology, we have tolerated disease and illhealth in generations of our children. We have failed to eliminate the excessive toll of their sickness, retardation, disability and death.

Equally important, we are already close to the level of manpower needed to implement a national health insurance program for our youth. American medicine is equal to the challenge. We have a solid tradition of excellence in pediatric training, with a strong and growing supply of experienced pediatricians, pediatric nurses, and allied manpower.

Moreover, by beginning our new program with youth and child care, it will be easier for the medical profession to implement the changes in the delivery system that must accompany any effective national health insurance program. And, the changes that we make in the delivery system for pediatric care will give us valuable experience and insights into the comparable but far more difficult changes that will be necessary in the delivery of care to adults as the insurance program is phased in over subsequent years.

Finally, by phasing in the insurance program over a period of years, I believe we can avoid a serious objection that will otherwise be raised—that national health insurance will simply exacerbate our current inflation in medical costs by producing even greater demand for medical care without providing essential changes in the organization and delivery system.

We know from recent experience that changes in the organization and delivery of health care in the United States will come only by an excruciating national effort. Throughout our society today, there is perhaps no institution more resistant to change than the organized medical profession. Indeed, because the crisis is so serious in the organization and delivery of health care, there are many who argue that we must make improvements here first, before we can safely embark on national health insurance.

I believe the opposite is true. The fact that the time has come for national health insurance makes it all the more urgent to pour new resources into remaking our present system. The organization and delivery of health care is so obviously inadequate to meet our current health crisis that only the catalyst of national health insurance will be able to produce the sort of basic revolution that is needed if we are to escape the twin evils of a national health disaster or the Federalization of health care in the Seventies. To those who say that national health insurance won't work unless we first have an enormous increase in health manpower and health facilities and a revolution in the delivery of health care, I reply that until we begin moving toward national health insurance, neither Congress nor the medical profession will ever take the basic steps that are essential to reorganize the system. Without national health insurance to galvanize us into action, I fear that we will simply continue to patch the present system beyond any reasonable hope of survival.

The need for comprehensive national health insurance and concomitant changes in the organization and delivery of health

care in the United States is the single most Important issue of health policy today. If we are to reach our goal of bringing adequate health care to all our citizens, we must have full and generous cooperation between Congress, the Administration, and the health profession. We already possess the knowledge and the technology to achieve our goal. All we need is the will. The challenge is enormous, but I am confident that we are equal to the task.

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

Mr. President, I suggest the absence of a quorum and ask unanimous consent that the time in the quorum call be divided equally between the majority and minority.

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

The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

Mr. JOHNSON. Mr. President, I rise to express my support for the Patient Protection and Affordable Care Act and to encourage my colleagues to support this effort to address our health care system's immediate and long-term challenges in a fiscally responsible manner.

For decades, attempts have been made to reform the way our health care system works, but only incremental changes have been made. The result is a broken system where costs are rising out of control and millions of Americans are priced out of the health insurance market.

In the last 8 years, health care premiums have grown four times faster than wages. If health care costs continue to rise at the current rates, without reform, it is projected that the average South Dakota family will be paying nearly $17,000 in yearly premiums by 2016. That is a 74-percent increase over the current premium costs that so many already struggle to afford.

Throughout the ongoing health reform discussion, I have heard from far too many South Dakotans who currently face barriers in accessing quality health care. This can be due to exorbitant out-of-pocket costs, having no insurance coverage, being denied coverage by insurance companies, or limited or no health care providers in their area. The Patient Protection and Affordable Care Act addresses these barriers in part by extending access to affordable and meaningful health insurance to all Americans.

This legislation stands up on behalf of the American people and puts an end to insurance industry abuses that have denied coverage to hard-working Americans when they need it most. Insurance companies will no longer be able to deny coverage for preexisting conditions and will not be able to drop coverage just because a patient gets sick. Reform will ensure that families always have guaranteed choices of quality, affordable health insurance whether they lose their job, switch jobs, move, or get sick.

The bill allows Americans to shop for the best health care plan to meet their needs and provides tax credits to help those who need assistance. It strengthens our health care workforce, improves the quality of care, and reduces waste, fraud, and abuse in the health care system.

Every American is adversely affected in some fashion by the shortcomings of our existing system, and far too many have a false sense of security. The system costs us lives, and it costs us money. If we fail to act, health care costs will consume a greater and greater share of our Nation's economy and have tremendous potential to cripple our Nation's future.

The Patient Protection and Affordable Care Act puts our Nation on a more sustainable financial path. The nonpartisan Congressional Budget Office projects that this health reform bill will reduce the Federal deficit by $130 billion in the next 10 years and as much as $650 billion in the decade after that. CBO also projects that this bill will result in health care coverage for more than 94 percent of legal residents in our Nation. Our citizens deserve this basic security, while improving current Medicare benefits.

This bill is the product of months of research, committee deliberation, and bipartisan negotiation. I have listened to some of my colleagues' claims that they support health reform yet object to this approach. These protests echo those made nearly 50 years ago when a new program called Medicare was proposed to provide meaningful health benefits to seniors. The increasing cost of health care is unsustainable and the do-nothing approach hurts all Americans by robbing us of this historic opportunity to stop talking about the problems and finally find a solution.

This bill is not perfect, but a ''yes'' vote will allow the conference committee a chance to improve it. The United States is the only Nation among industrialized democracies to not have some form of national health care. Yet the Senate Republican Party is attempting to deny us the right to vote this historic legislation up or down. They want to kill it even before it has the chance to go to conference.

I urge my colleagues to support the Patient Protection and Affordable Care Act.

Mr. President, I ask unanimous consent that the time be charged equally.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from Ohio is recognized.

Mr. VOINOVICH. Thank you, Mr. President. I have been coming to the floor to remind my colleagues and the American people about the fiscal realities our Nation faces and to explain how this health reform legislation would make our fiscal situation worse and our economy suffer even more. I have been here before to highlight how this health care bill is chock-full of budget gimmicks to hide its true unmanageable costs.

As I have said before on the floor of the Senate, as a former mayor and a former Governor, many people have come to me over the years and said: Mayor, you have to do this; Governor, you have to do this. The plea they had was genuine, and the need they expressed was genuine, but the fact is we couldn't afford what they were asking us to do, and I had to say no. Unfortunately, this legislation, in my opinion, will increase the cost of health care, drive up our national debt, and contribute to unbalanced budgets as far as the eye can see in the United States.

As a former Governor and chairman of the National Governors Association, the past chairman of the National League of Cities, one gimmick I am particularly concerned about is the one that puts 14 million additional individuals into the Medicaid Program and then asks the States to pick up a portion of the tab. I am very familiar with what unfunded mandates can do to State and local governments, and I wish to highlight some of the potential consequences of the Medicaid expansion for my colleagues.

At a $374 billion cost to Federal taxpayers, the health care bill before us would expand Medicaid coverage to all people under 133 percent of the Federal poverty level. Because Medicaid costs are shared by the Federal and State governments, the States will be on the hook for $25 billion of this expansion during the first 10 years.

To put the $25 billion into perspective, let me spend a minute explaining the current fiscal situation of most States in this country. Most States such as my State—and I am sure the same is true in the Presiding Officer's State—are struggling to make ends meet. I have never seen anything like it in my entire life.

According to the National Governors Association, the States are in the deepest and longest economic downturn since the Great Depression. In the first two quarters of 2009, State revenues were down 11.7 and 16.6 percent, respectively. At the same time, Medicaid spending is growing, which already makes up, on average, approximately 22 percent of States' budgets, and enrollment in the program is skyrocketing at the levels it is today because more and more people are becoming eligible for Medicaid under the current Federal law.

In Ohio, for example, where the unemployment rate is hovering around 10.5 percent, 154,000 Ohioans enrolled in the Medicaid Program in the last year alone, an 8-percent increase over last year. This is hard to believe, but Medicaid now provides health coverage to nearly 2 million Ohioans, almost one out of five residents. Unbelievable.

Recognizing this increased demand, States have had some help from the Federal Government. Earlier this year,

Congress provided $87 billion in Federal aid to States in the so-called stimulus bill to help States deal with Medicaid costs. Yet this money was not intended to last forever. As it stands right now, in December 2010, States will face—that is next December—States will face a steep budget cliff when the temporary Medicaid payments coming from the stimulus package expire. In facing these realities, Governors across the country are already wondering how they will cover the cost of their existing programs.

I recently met with Ray Scheppach, who is the executive director of the National Governors Association. He said: Senator, Governor, Mayor, we are going to need some help when the money runs out or we will not be able to handle the Medicaid challenges we have.

Not surprisingly, my State's current Governor, Ted Strickland, a Democrat, has told me if Medicaid is expanded, he hopes the Federal Government will assume most, if not all, the costs. In fact, he told the Columbus Dispatch that he has warned officials in Washington that ''with our financial challenges right now, we are not in a position to accept additional Medicaid responsibilities.''

I suspect that almost every Governor in the country would make that same statement to us in the Senate. By the way, this is both Republican and Democratic Governors.

I ask: How can we in good conscience move forward with this bill and the new mandate it places on States? How can we force the States to make the difficult choices that we are unwilling or unable to make in Washington? Pass it on to them, we will pay for it a while, and then you guys pick up the cost.

I served the people of Ohio as Governor for 8 years, and I was forced to cut my budget in the beginning four times. I will never forget it. There were about 5,000 people outside my office screaming because we had made it more difficult or increased the cost of tuition for our colleges. I had to make countless difficult decisions across the board to be fiscally responsible. I understand the demands of soaring health care costs, and as I called that program then, it devoured—Medicaid devoured up to 30 percent of our State budget, and I referred to it as the Medicaid Pac-Man. I think some people remember Pac-Man. That was the Pac-Man just eating up money like crazy. It took away money from primary and secondary education, higher education, roads, bridges, county and local government projects, and safety service programs that we wanted to provide for the citizens of Ohio. We had to do it. It was a mandate. It just sucked up that money, and that meant we didn't have money for higher education, secondary and primary education, and some of the other responsibilities of the State.

With this experience, I became particularly concerned with the cost of Federal mandates, and I worked tirelessly with State and local governments to help pass the Unfunded Mandates Reform Act. In fact, the first time I ever set foot on the floor of the Senate is the day the unfunded mandates bill passed the Senate. It was a wonderful day for Ohio and for this country. I was in the Rose Garden representing State and local governments when President Clinton signed the legislation into law in 1995.

After that experience, you can imagine how it pains me to be standing here today debating legislation that provides for the largest single expansion of the Medicaid Program in our country's history and a brandnew fiscal liability for States at a time when the States can least afford it. I have serious concerns if this bill becomes law and States are required to take on more just as the extra stimulus funds disappear—which they are going to have to do or we will have to come up with the money—Congress will be forced to spend billions more to keep the Medicaid safety net from failing completely in the not too distant future.

So what I am basically saying is that when the stimulus money ends in December of next year, the Governors are going to be down here with a bathtub asking us to fill it because if we don't do it, they are going to have to knock off thousands of people, millions in the country, because they don't have the money to provide for the program.

Now, providing extra dollars to States—and I predict it is going to happen. It will become an annual ritual for Congress, just as the doctors fix has become an annual ritual for doctors. Every year they come in. We are not going to cut the annual reimbursement. Next year it is 23 percent, I think. We are not going to fill the hole, and the Governors are going to be asking for the same kind of help. It is not only a mandate for them, it is going to become a mandate for us at a time when we are least able to handle anything like that.

So as a former Governor and a former mayor, a former county commissioner, I urge my colleagues to consider the impact this bill will have on their respective States. Think about it. Talk to your Governors. See what it is going to do to your States. I hope each of my colleagues will give careful thought to the potentially devastating effects it could have on each of their State budgets and to consult, as I said, with their Governors and to talk about the fact that if this happens, what is going to happen in terms of the Pac-Man eating up more money in their State and their inability to take care of primary and secondary education, higher education, and all of the other responsibilities State governments have.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Hawaii is recognized.

Mr. INOUYE. Mr. President, I rise today to address the Department of Defense appropriations bill for fiscal year 2010.

As my colleagues know, this afternoon the Senate received this measure from the House which represents a compromise between the bill passed by the House last July and what we passed this past October.

Since passage of the Senate measure, Vice Chairman COCHRAN and I and our staffs have spent countless hours in discussion with our colleagues in the House to thrash out the differences between our two bills. The product the Senate will consider represents the work of our discussions. While this is a House measure, I can assure my colleagues it is a very fair and balanced product.

The Defense appropriations portion of this measure totals $636.3 billion in discretionary spending, including more than $128 billion for the cost of our ongoing efforts in Iraq and Afghanistan.

In total, the Defense bill is $3.8 billion below the request of the President and within the subcommittee's allocation.

This bill represents the hard work over the past year of all the members of the Defense subcommittee. It contains funds that we believe will best meet the needs of the men and women who volunteer to serve our Nation in the military. The bill provides funding to increase their pay by 3.4 percent. It provides more than $30 billion to care for their health and the health of their families.

It provides support to families with loved ones serving in harm's way overseas and funding to ensure that their workplaces and quality of life back home are protected.

Of equal importance, the funding in this bill ensures that our forces in the field have the equipment and other tools required to meet their missions. Funding has been added to the President's request to provide for more MRAP vehicles to protect our forces from IEDs in Afghanistan.

Funds are provided for more medical evacuation and combat rescue helicopters to save our wounded troops. Funds have been added to sustain production of the C–17 Program so our forces in the field can be adequately resupplied, no matter where they are based.

This bill enhances research in lifesaving technologies and increases funds to care for our wounded personnel. It fully funds the priorities of Secretary Gates and our military commanders.

While I know some will criticize the fact that funds have been included at the request of Members of Congress, I remind my colleagues that, in total, this amount is less than 1 percent of the funding in the bill.

Moreover, all the so-called earmarks in the defense portion of this bill were in either the House or Senate bills. There are no ''airdropped'' earmarks in the defense funding included in this measure.

In addition to the defense portion of the bill, the House has added a little

more than 1 dozen provisions to provide a 2-month safety net to unemployed and nearly impoverished Americans and to extend critical provisions which are set to expire this month.

For individual Americans, provisions were included to extend, through February 28, 2010, expiring unemployment insurance benefits that were established in the American Recovery and Reinvestment Act.

Likewise, provisions were included to extend the 65-percent COBRA health insurance subsidy from 9 to 15 months for individuals who have lost their jobs and to extend the job lost eligibility date also through February 28, 2010.

Further, a provision was included to freeze the Department of Health and Human Services' poverty guidelines at 2009 levels in order to prevent a reduction in eligibility for programs such as Medicaid, food stamps, and school lunch programs through March 1 of next year.

This provision keeps struggling families from falling through the cracks.

In addition, provisions were included to provide $125 million to extend the Recovery Act program for small businesses. The program reduces lending fees charged to borrowers under the Small Business Administration's guaranteed loan programs and increases the Federal guarantee on certain small business loans.

The Recovery Act supported a resurgence in SBA small business lending, but funds were exhausted in November. The additional funding in this bill will help support lending for small businesses during the economic recovery by continuing fee relief for borrowers and encouraging lenders to extend credit to small businesses.

Further, this bill includes a short-term extension of the highway, transit, highway safety and truck safety programs. Without this extension, the highway program would be brought to a standstill and the Department of Transportation would be unable to reimburse States for eligible expenses.

In addition, several agencies—including the Federal Highway Administration, the National Highway Traffic Safety Administration, and the Federal Motor Carrier Safety Administration—would not have the funds necessary to pay their employees.

This is not your typical end-of-the-year Christmas tree; to the contrary, it is the bare minimum of programs which must be continued to provide for our less fortunate and our struggling small businesses.

It also allows for a 2-month extension of laws such as the PATRIOT Act, in order to allow more time for our authorizing committees to come to agreement on more permanent legislation.

The House has passed a compromise measure and forwarded it to the Senate because of the calendar. Today is December 16, and our Department of Defense has been operating on a continuing resolution for more than 2 months.

It is time we get on with the process and get this bill to the President. It is a good measure. Our troops deserve our support. Let's show we support those who volunteered to serve all of us by voting today to send this bill to the President.

As I close, I wish to thank the Defense Subcommittee staff for their dedication and hard work in putting this bill together. I wish to put into the RECORD the names of these staff members who have worked on this bill in a bipartisan fashion. They are:

Charlie Houy, Nicole Diresta, Kate Fitzpatrick, Katy Hagan, Kate Käufer, Ellen Maldonado, Rachel Meyer, Erik Raven, Gary Reese, Betsy Schmid, Renan Snowden, Bridget Zarate, Rob Berschinski, Stewart Holmes, Alycia Farrell, Brian Potts, Brian Wilson and Tom Osterhoudt.

Mr. President, it is my pleasure and privilege to be chairman of the committee. It is a great honor. I wish to make certain we express our gratitude to all these staff people. Without them, I would not be standing here at this moment.

I yield the floor.

The PRESIDING OFFICER. The Senator from Mississippi is recognized.

Mr. COCHRAN. Mr. President, I am glad I was here to hear the remarks of the distinguished Senator from Hawaii. I serve on that subcommittee of Defense Appropriations with him and get to observe, at close range, the skill and effort and courtesy that is reflected in his service as chairman of our committee. It is a pleasure to serve with him and it is an honor. He has provided leadership and cooperation in working with all Senators—not just members of our committee—to move forward in carrying out of duties by the Department of Defense through our appropriations process.

It is very important that the Senate approve, as soon as possible, the funding that is contained in the bill that our committee has reported to the Senate. It will help support and provide the resources necessary to carry out the missions of our men and women have in Afghanistan, Iraq, and around the world, safeguarding our freedom, protecting our security interests.

The Department of Defense is now operating under a continuing resolution that expires on Friday. This is an inefficient way of managing the support for our Department of Defense. It causes too much effort to be made by employees and men and women in the Defense Department, focusing on management, how to manage day-to-day operating expenses dealing with the challenges that too few dollars are provided in a way that gives people time to plan and then execute efficiently their missions and responsibilities.

This affects the support that is available to the men and women who are overseas and in harm's way.

The act contains funds necessary to provide medical care as well as family support for members of our Armed Forces and their families. During this time of war, it is very important that every effort be made to provide good medical care for those who are injured and wounded serving our country.

It is also important we support the families. There are funds in this legislation that do just that, trying to address the stresses that are associated with combat and deployment and separation.

I am disappointed the normal process has been circumvented, or at least delayed, and the other body has not appointed conferees to the Defense Appropriations conference committee. It is a disappointment also that the Defense Appropriations bill is used as a vehicle to move other initiatives that seem to be slowing down the process. These measures should be considered separately and addressed in a more thoughtful way, based on their own merits, not on the legislation they are tied to, to carry them through the legislative process.

I think attaching nondefense-related legislation to the Defense Appropriations Act for this fiscal year has been a mistake. It has been unnecessary, unfortunate, and it has resulted in delays and uncertainty.

I am sure there are Senators who can make suggestions for improving this bill. We are open to hear those concerns and do our best to respond to the suggestions from all Senators. We don't individually support all aspects of the agreement, but we think that, in total, it is a good bill. It ought to be passed, and it ought to be passed as soon as possible in recognition of our respect for our service members and their families.

Mr. INOUYE. Mr. President, there is nothing in rule XLIV which governs a message between the Houses in regard to disclosing earmarks. However, as chairman of the Appropriations Committee it is my belief that the committee should none the less attest that all earmarks have been fully disclosed. Accordingly I note that in the bill H.R. 3326 as passed by the House and explained in the statement offered by the chairman of the Subcommittee on Defense of the House of Representatives on December 16, 2009, each earmark in the bill has been disclosed in accord with rule XLIV.

Mr. CONRAD. Mr. President, section 401(c)(4) of S. Con. Res. 13, the 2010 budget resolution, permits the Chairman of the Senate Budget Committee to adjust the section 401(b) discretionary spending limits, allocations pursuant to section 302(a) of the Congressional Budget Act of 1974, and aggregates for legislation making appropriations for fiscal years 2009 and 2010 for overseas deployments and other activities by the amounts provided in such legislation for those purposes and so designated pursuant to section 401(c)(4). The adjustment is limited to the total amount of budget authority specified in section 104(21) of S. Con. Res. 13. For 2009, that limitation is $90.745 billion, and for 2010, it is $130 billion.

The Senate is considering H.R. 3326, the Department of Defense Appropriations Act, 2010. That legislation includes amounts designated pursuant to section 401(c)(4). Since this is the last of the 12 regular appropriations bills for 2010, I am revising previous adjustments made to the discretionary spending limits and the allocation to the Senate Committee on Appropriations for discretionary budget authority and outlays to reflect the final amount of designations made pursuant to section 401(c)(4). When combined with all previous adjustments, the total amount of adjustments for 2010 is $130 billion in discretionary budget authority and $101.178 billion in outlays. In addition, I am also further revising the aggregates for 2010 consistent with section 401(c)(4) to reconcile the amount of outlays estimated by the Congressional Budget Office for designated funding with the amount originally assumed in the 2010 budget resolution.

I ask unanimous consent that the following revisions to S. Con. Res. 13 be printed in the RECORD.

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

CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 2010—S. CON. RES. 13; FURTHER REVISIONS TO THE CONFERENCE AGREEMENT PURSUANT TO SECTION 401(c)(4) ADJUSTMENTS TO SUPPORT ONGOING OVERSEAS DEPLOYMENTS AND OTHER ACTIVITIES

[In billions of dollars]

Section 101	
(1)(A) Federal Revenues:	
FY 2009	1,532.579
FY 2010	1,623.888
FY 2011	1,944.811
FY 2012	2,145.815
FY 2013	2,322.897
FY 2014	2,560.448
(1)(B) Change in Federal Revenues:	
FY 2009	0.008
FY 2010	−42.098
FY 2011	−143.820
FY 2012	−214.578
FY 2013	−192.440
FY 2014	−73.210
(2) New Budget Authority:	
FY 2009	3,675.736
FY 2010	2,910.707
FY 2011	2,842.766
FY 2012	2,829.808
FY 2013	2,983.128
FY 2014	3,193.887
(3) Budget Outlays:	
FY 2009	3,358.952
FY 2010	3,023.691
FY 2011	2,966.921
FY 2012	2,863.655
FY 2013	2,989.852
FY 2014	3,179.437

CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 2010—S. CON. RES. 13; FURTHER REVISIONS TO THE CONFERENCE AGREEMENT PURSUANT TO SECTION 401(c)(4) TO THE ALLOCATION OF BUDGET AUTHORITY AND OUTLAYS TO THE SENATE APPROPRIATIONS COMMITTEE AND THE SECTION 401(b) SENATE DISCRETIONARY SPENDING LIMITS

[In millions of dollars]

	Initial Allocation/Limit	Adjustment	Revised Allocation/Limit
FY 2009 Discretionary Budget Authority	1,482,201	0	1,482,201
FY 2009 Discretionary Outlays	1,247,872	0	1,247,872
FY 2010 Discretionary Budget Authority	1,219,651	1	1,219,652
FY 2010 Discretionary Outlays	1,376,195	−157	1,376,038

CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 2010—S. CON. RES. 13; FURTHER REVISIONS TO THE CONFERENCE AGREEMENT PURSUANT TO SECTION 401(c)(4) TO THE ALLOCATION OF BUDGET AUTHORITY AND OUTLAYS TO THE SENATE APPROPRIATIONS COMMITTEE AND THE SECTION 401(b) SENATE DISCRETIONARY SPENDING LIMITS—Continued

[In millions of dollars]

	Initial Allocation/Limit	Adjustment	Revised Allocation/Limit
FY 2009 Discretionary Outlays	1,247,872	0	1,247,872
FY 2010 Discretionary Budget Authority	1,219,651	1	1,219,652
FY 2010 Discretionary Outlays	1,376,195	−157	1,376,038

The PRESIDING OFFICER. The Republican leader is recognized.

SETTING PRECEDENT

Mr. MCCONNELL. Mr. President, I rise to make some observations about a matter that occurred in the Senate earlier this afternoon.

The plain language of the Senate precedent, the manual that governs Senate procedure, is that unanimous consent of all Members was required before the Senator from Vermont could withdraw his amendment while it was being read—unanimous consent.

Earlier today, the majority somehow convinced the Parliamentarian to break with the longstanding precedent and practice of the Senate in the reading of the amendment.

Senate procedure clearly states:

Under rule 15, paragraph 1, and Senate precedents, an amendment shall be read by the clerk before it is up for consideration or before the same shall be debated unless a request to waive the reading is granted.

It goes on to state that:

. . . the reading of which may not be dispensed with, except by unanimous consent, and if the request is denied, the amendment must be read and further interruptions are not in order.

Nothing could be more clear.

You may have heard that the majority cites an example in 1992 when the Chair made a mistake and allowed something similar to happen. But one mistake does not a precedent make.

For example, there is precedent for a Senator being beaten with a cane in the Senate. If mistakes were the rule, then the caning of Senators would be in order. Fortunately for all of us, it is not.

It is now perfectly clear that the majority is willing to do anything—anything—to jam through a 2,000-page bill before the American people or any of us have had a chance to read it, including changing the rules in the middle of the game.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Georgia is recognized.

Mr. CHAMBLISS. Mr. President, I rise today to speak about the decision to move the remaining detainees held at Guantanamo Bay Naval facility, or Gitmo, to the Thomson Correctional Center in Illinois.

The decision to transfer Gitmo detainees to the heartland of our country is irresponsible, a waste of taxpayer dollars, and contrary to the wishes of the American people.

Congress has included language permitting the transfer or detention of Gitmo detainees to the United States only under certain limited conditions in every relevant appropriations bill passed this year, including the recently passed Omnibus Appropriations Act. That is one of the reasons I voted against every single one of those bills.

The President now has made the decision to purchase the Thomson Correctional Center from the State of Illinois for the purpose of transferring and detaining Gitmo detainees.

Further, the President stated he will need to expend millions of additional dollars renovating and securing the facility when much has already been invested in the state-of-the-art facility at Guantanamo Bay. This unnecessary spending is an abuse of our tax dollars and one that holds dire national security consequences.

The administration claims that many of these detainees will continue to be held by the military in the same prison where the Department of Justice will hold average, ordinary criminals. What the administration fails to tell the American people is that these detainees will obtain the same rights as U.S. citizens the moment they step inside the United States. We have already seen detainees attempt to gain these same rights as Americans in our courts and have seen the courts grant them limited rights without them being inside the United States.

In habeas corpus cases where the court has ruled, 30 out of 38 Gitmo detainees have been found to be unlawfully detained and their release has been ordered. After reviewing the classified biographies on some of these individuals, it is clear from these decisions that the courts are not in a position to judge matters of war and cannot when they are bound by our criminal justice system. It is not designed to handle war criminals.

The courts do not adequately consider the threat these individuals pose to U.S. interests or will pose in the future when they return to terrorism. President Obama cites the authorization for the use of military force as legal justification for continuing the detention of these terrorists. However, the courts have already indicated that these detainees cannot be indefinitely held. I wonder if the administration considered this when it decided to move Gitmo detainees to the United States.

This administration may face the same problem as the last administration did in justifying to a U.S. court the continuing detention of these terrorists. Only this time, the court will have a remedy.

It is foreseeable that some, and possibly many, of those detainees will be ordered released by our courts. The administration has tried to assure the public that our immigration laws will prohibit the release of those individuals into the United States. But, once again, this administration fails to appreciate the limits of our legal system.

Once these detainees are physically present in the United States, prior judicial precedent indicates that the government can only detain an individual while immigration removal proceedings are ongoing for a maximum of 6 months. If a detainee cannot be transferred or deported, they will be released, freed into the United States, after 6 months. This is much more than just moving Guantanamo north.

On the other hand, if the administration is able to secure the transfer of these detainees to another country, we can be sure to watch the recidivism rates rise. The Department of Defense's last unclassified fact sheet on recidivism reported that 14 percent of the former Gitmo detainees returned to terrorism after their release or their transfer. This is almost one out of every seven detainees transferred. This number is much larger now after 8 months and countless transfers of the most serious terrorists.

Some of the detainees transferred openly admit their affiliation with a terrorist organization or that they were combating U.S. forces in Afghanistan. Confirming this, two former Gitmo detainees transferred to Saudi Arabia announced earlier this year that they were now the leaders of al-Qaida in the Arabian peninsula. Another detainee, Ali bin Ali Aleh, lived with Abu Zubaydah in Pakistan and was identified on a list of names in Khalid Shaikh Mohammed's possession when KSM was captured. Ali bin Ali Aleh was determined not to be an enemy combatant and ordered to be released by a U.S. court in May of this year. He was transferred to Yemen in September.

Maybe some of my colleagues have seen the recent headlines indicating that some European countries are willing to accept these detainees. In fact, detainees have recently been transferred to Belgium, Ireland, Hungary, and Italy. However, the American people are not fooled by these headlines. Of the 779 detainees held since 2001 at Guantanamo Bay, our European partners have accepted only 37. The vast majority of detainees—almost 400—have been transferred to four countries: Afghanistan, Saudi Arabia, Pakistan, and Yemen. These four countries are either currently in conflict or actively combating al-Qaida. In all four of these countries, the threat from al-Qaida and associate militants has done nothing but increase over the past few years. Yet the United States is sending back hundreds of terrorists to the most volatile regions of the world—South Asia, which poses the greatest terrorist threat currently to the homeland and to the Arabian peninsula, which I believe will present itself as the next greatest threat to the United States.

The decision to move these terrorists to the United States may force the administration to choose between freeing terrorists into Illinois or transferring them back to the center of the battle. Is this the policy position we want to put our country in while we are still combating terrorism?

No one doubts the security of our prisons to safely hold these individuals. I doubt the ability of our laws and judicial system to ensure that these terrorists are convicted or kept in prison. Prohibiting the detainees from entering the United States is the only guarantee. However, the decision to move the remaining terrorists at Gitmo to the heart of this country shattered any remaining hope for this guarantee. This is yet another step in a series of poor policy decisions which is leading our country in the wrong direction.

I am disappointed by this decision, obviously. But I can only imagine how the residents of Illinois feel about it. I know Georgians would not be pleased with housing over 200 of the most serious and hardened terrorists in the world in their backyard.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER (Mrs. SHAHEEN). The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

Mr. DURBIN. Madam President, I wish to respond to my friend from Georgia, who just stepped off the floor, about the transfer of detainees from Guantanamo because he misstated a few things that I do not want to stay on the record.

First, he suggested that these detainees would be freed in Illinois. Not so. The plan of this administration is not to free them; the plan is to imprison them in the most secure prison in the United States of America. It is in Thomson, IL, 150 miles from Chicago. I was there a few weeks ago. It is a supermax prison built 7 years ago and never fully occupied. Now they are going to build an additional fence around it. It will be more secure than any prison in America. They will be freed into the most secure prison in America and they are not coming out until such time as there is a resolution of whatever their issues may be or they pass away.

I might also say that the current law in the United States prohibits the President of the United States from releasing these detainees in the United States. Those statements by the Senator from Georgia are just flat incorrect.

He is entitled to his position—and others share it—that we should not close Guantanamo. I believe we should. On my side of this argument would be the following people who have called for the closure of Guantanamo: President George W. Bush; Secretary of State and former Chairman of the Joint Chiefs of Staff Colin Powell; Secretary of Defense under President Bush and under President Obama, Robert Gates; former Secretary of State and domestic policy adviser Condoleezza Rice; GEN David Petraeus, and 33 other generals, in addition to President Barack Obama.

This argument that closing Guantanamo endangers the United States ignores the obvious. The people entrusted with the responsibility of protecting the United States have called for the closure of Guantanamo. Yesterday, Robert Gibbs, press secretary to President Obama, was asked about this decision to transfer. He said that on more than 30 occasions—I am not sure of the timeframe, whether it was this year or a longer period of time—but on more than 30 occasions, they have found direct linkage of terrorist recruitment activity and the use of Guantanamo as an illustration of why people needed to convert to terrorism around the world. It is still being actively used for recruitment.

If the Senator from Georgia would go back a few weeks and read Newsweek magazine, one of their reporters was captured in Tehran and held in captivity for almost 4 months. He told a story of how he was first incarcerated in a prison in Tehran. As he arrived, his jailer said to him: Welcome to Abu Ghraib and Guantanamo, American.

So for us to believe that the rest of the world does not have a negative image of Guantanamo and it is not being used against our troops is to ignore the obvious.

There are some in this body who are hidebound to keep Guantanamo open at any costs. I will tell you, the cost is too high. If the continuation of Guantanamo means danger to our troops, we owe it to them to close it. Presidents have reached that conclusion, people in charge of national security have reached that conclusion, and we should as well.

Then there is this notion about the danger of incarcerating terrorists in the United States. For the record, over 350 convicted terrorists are currently imprisoned in the United States, all over the United States. In my home State of Illinois, 35 convicted terrorists are in prison today. The most recent incarceration involves a man arrested shortly after 9/11 in Peoria, IL, an unlikely hotbed of terrorism and spy activity, but, in fact, this man going to school in Peoria, IL, through his communications was linked with al-Qaida. He served time in a Navy brig in South Carolina, if I am not mistaken, and eventually was tried in the courts of Peoria, IL, convicted and now incarcerated in Marion, IL, in southern Illinois.

I heard not one word of criticism when this took place under the previous administration. The belief was this man had to answer for the crimes he was charged with and serve time in our prison system as a result of it. Never—not once, not one time—did I ever hear any Congressman of either political party say: Boy, it is unsafe to try him in Peoria or it is unsafe to incarcerate him in southern Illinois. It has never been said.

What happens to these people when they go into our supermax prisons, where no one has ever escaped? They disappear, as they should. They are where they ought to be—isolated and away from causing harm to anyone.

When President Obama was looking for an alternative to Guantanamo, we came forward. One of the mayors of a small town in Illinois—Thomson, IL—with just several hundred people living there, wrote to the Governor of our State and to me and said: I have a big old prison the State built and never opened—built it in 2001. It has the capacity of several thousand prisoners, and the State could never afford to open it. We had hoped that this prison would create a lot of local jobs for us. Can you find a use for it at the Federal level?

The Obama administration took a hard look at this for a long period of time. Part of it was done confidentially, and then they came out publicly and said: We are seriously interested.

The Senator from Georgia said earlier: Well, the people of Illinois are against this.

Well, I would say to my friend from Georgia, come on down to Thomson, IL. Come down and see the people who are overwhelmingly supportive—and not just Democrats, believe me. Local State representative Jim Sacia is a Republican and a former FBI agent. He said we would be idiots not to take this offer from the Federal Government. He is right. Three thousand jobs. I don't know that there is a Senator here if you said to him: Would you be interested in 3,000 jobs in the midst of a recession, who wouldn't stand up and say: Let's talk.

Well, we did. So it is 3,000 new jobs at this prison when it is opened as part of the Bureau of Prisons and part of the Department of Defense.

How many Guantanamo detainees will be sent there? Fewer than 100. We have 35 in our prisons already. Life has not changed in my home State of Illinois, nor has it changed in any other State where they are incarcerated. It would not change in Thomson, IL. These people can be held safely and securely. I trust our men and women in the military to do that, and the Members of the Senate should do so as well.

These 3,000 jobs are going to be a Godsend to an area with 11 percent unemployment. First, there will be a lot of construction jobs, and we can use those. Those are good-paying jobs for Americans right here at home. Then those who work for the Bureau of Prisons are going to be paid a good salary and receive good benefits, the kind of salary you can use to build a family, a community, a neighborhood. These will be people who will be buying homes—3,000 of them. They will be buying homes, cars, shopping for appliances, and going to the local shopping malls. Is that going to be good for the economy? You bet it is. It is just what we need, and it is just what this area of the State wants. This argument that we somehow will oppose it is just wrong.

There is a local Congressman, who is a friend of mine—a Republican Congressman—who opposes it. We have talked about it. We just don't see eye to eye on it. But even in Rockford, IL, the largest city in his district, which is northeast of Thomson, the city council in Rockford passed a resolution of approval of this Thomson prison, 12 to 2. In county after county, State and local governments—I should say local county governments, are coming out in favor of this Thomson prison. Those who come to the Senate floor and argue otherwise don't know the facts. When they know the facts, they will realize we are prepared to do this.

Now the question is whether the Senate will stand behind the President, stand behind our security advisers who believe this is in the best interest of the United States. I think it is. It isn't the first time Illinois has been called on to do something extraordinary for our country. The first supermax prison in our Federal system was built in Marion, IL, years and years ago. There was controversy. This was the most secure prison in America. But I will tell you, the people of southern Illinois rallied behind it. It has been a prison with a lot of great professionals who have worked there. They have done their jobs and done them well.

When I go down to Marion, IL, and talk to them about Guantanamo detainees, they say: Senator, listen. Send them here. We will take care of them. We can point out among those who are incarcerated at Marion prison those who were engaged in al-Qaida terrorism, Colombian drug gangs, Mexican drug cartels, some of the meanest, toughest most violent gang bangers from the cities in the Midwest—and they are held safely every day.

I will tell you, when I hear people say they do not trust our prison system to hold a handful or 50 or whatever the number may be—less than 100—of these Guantanamo detainees, they ought to meet the men and women who do it every single day in America, and do it well. They should realize these detainees will be held by our military, the Department of Defense employees. Those are the ones we can trust to do it.

So I would urge my friends and others who have spoken earlier—Senator MCCONNELL came to the Senate floor earlier. It has become, unfortunately, a party position now that it is a bad idea. Earlier, Senator MCCAIN and Senator GRAHAM on the Republican side of the aisle didn't argue against the transfer of these detainees. They understand these prisoners aren't larger than life. They have been in prison for 8 years. Frankly, I don't know how much longer they will stay there. But as long as they are a threat to the United States, they will.

Madam President, I would like to at this point address an issue which came up earlier on the Senate floor.

Something unusual happened on the floor of the Senate today, Madam President. It happens but rarely. Under the rules of the Senate, amendments and bills can be read, if a Member requests, and we usually ask unanimous consent to dispense with the reading. And, routinely, that is done. It is done every day on scores of different things.

Today, Senator SANDERS of Vermont offered an amendment near and dear to his heart on single-payer health care reform, and it turned out to be a voluminous amendment—800 pages long. When the time came to ask consent that it not be read, there was an objection from Senator COBURN of Oklahoma. He insisted that it be read. Our poor clerking staff up here—the clerks of the Senate—started reading this bill, and they read on for almost 2 hours or more.

As they were reading it, it came to our attention that Senator SANDERS of Vermont had authority under the Senate rules to withdraw his amendment and to stop the reading of the amendment.

I wasn't aware of that because I can't recall that has ever happened since I have been here. But I made a point—since many years ago I was a parliamentarian of the Illinois State Senate and tried to at least read the rules from time to time—to turn to rule XV, section 2, in the Standing Rules of the Senate, and here is what it says:

> Any motion, amendment, or resolution may be withdrawn or modified by the mover at any time before a decision, amendment or ordering of the yeas and nays, except a motion to reconsider, which shall not be withdrawn without leave.

In other words, until action was taken on the Sanders amendment, he had the authority under rule XV, paragraph 2 to withdraw his amendment, which he did.

Some have come to the floor and protested and said this was extraordinary, and it can't be backed up by the Senate rules. But I refer them to this rule, which is explicit, and that no action had taken place on this amendment other than the introduction of the amendment and reading. So, as it says here, ''any time before a decision, amendment, or ordering of the yeas and nays.'' I think that is a clear case.

I have since read an earlier ruling by the Chair relative to the same rule that goes back several decades, so the ruling of the Chair today, or at least the finding of the Chair, was consistent with the rules of the Senate. But the strategy that came out in the ordering of this amendment to be read is pretty clear when it comes to health care. The Republican strategy is clear to anyone who is watching the debate: They do not want amendments. In fact, they just don't want us to vote on health care reform. There comes a time when people make the best arguments they can and the Senate makes a decision, and that is what we are facing. That is what we want. We would like to do that in a timely fashion.

Members here believe we can do that in a responsible way and move this health care reform bill to a point of a vote—a cloture vote, with a 60-vote requirement—and do that in a way that we can find the sentiment in the Senate on this important measure and just maybe go home for Christmas, which a lot of us would like to do. We have been away from our families for quite a while.

During the course of this debate, we have been spending a lot of time on the bill itself. I usually like to give people an idea by holding up this 2,074-page bill. It took a lot of work to get to this point. The managers' amendment to this will be several hundred pages, I imagine.

People say: Why is it so big? It is big because we are changing the health care system in America, which is one-sixth of our economy. You can imagine all the different moving parts in this complicated health care system that we address with this bill.

During this period of time, the Republicans have not offered any alternative or substitute. I thought that would be their first motion, to come forward and say: That is the Democratic plan to change the health care system in America, but you should see the Republican plan, how much better it is. They didn't do that because there is no Republican alternative. There is no Republican substitute.

Last week, when I went to the Senate Republican Web site—and I invite people to do the same—I found there was only one bill printed there on health care reform. It was the Democratic bill, not any bill that has been offered by the Republican side. The reason is this is hard work. Putting a bill like this together, getting experts to look at it and decide whether it is going to save money or cost money, it takes time. We have taken that time to do it, and do it right, and they have not. So they are either not up to the challenge of preparing an alternative bill, or they are content with the current system.

I guess some people are content with the current system. Among those who are content with it are the CEOs of health insurance companies. They like this system. They make a lot of money. They do it at the expense of a lot of people who need health care and end up being turned down. So, unfortunately, the Republicans have no constructive proposals to improve our bill. Each and every amendment, almost without exception, has been to send the bill back to committee; to stop working on it, and let's do this another day. All they want to do on the bill is to delay it, as they tried to do today with the reading of the Sanders amendment.

Senator JUDD GREGG of New Hampshire is a friend of mine. He and his wife Kathy and my wife Loretta and I have traveled together on official business of the Senate. I like him. He is a smart guy. He is going to retire, and he, in his wisdom, decided to leave a playbook for the Republican side of the aisle, which they shared. It is page after page of ways to slow down and stop the Senate from acting. Senator GREGG is entirely within his rights as a Senator to do it. What I read in his memo was accurate, but the intent and motive are clear: He wanted to stop this bill from moving in order, and that became the real cause on the Republican side of the aisle. They took a page out of Senator GREGG's playbook today with Senator COBURN's demanding the amendment be read. But it didn't work.

Madam President, I ask unanimous consent to have printed in the RECORD a colloquy between former Senators Adams and Packwood on the floor of the Senate on September 24, 1992.

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

TAX ENTERPRISE ZONES ACT

(Senate—September 24, 1992), [Page: S14919]

The Senate continued with the consideration of the bill.

The PRESIDING OFFICER. The Senator from Washington is recognized.

AMENDMENT NO. 3173

(Purpose: To amend the Internal Revenue Code of 1986 to deny the benefits of certain export subsidies in the case of exports of certain unprocessed timber, and to establish rural development programs for certain rural communities and small businesses that have been adversely affected by a declining timber supply and changes in the timber industry in the Pacific Northwest)

Mr. ADAMS. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Washington [Mr. Adams] proposes an amendment numbered 3173.

Mr. ADAMS. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

Mr. PACKWOOD. Mr. President, I object.

The PRESIDING OFFICER. Objection is heard. The clerk will read the amendment.

The assistant legislative clerk continued reading the amendment.

Mr. ADAMS. Mr. President, I ask unanimous consent that further reading of the amendment be dispensed with.

Mr. PACKWOOD. I object.

The PRESIDING OFFICER. Objection is heard.

Mr, ADAMS. Mr. President, parliamentary inquiry? I have a parliamentary inquiry of the Chair. Is it in order, during the reading of the amendment, without it being dispensed with, for the floor leader and the opponent of the amendment to have a discussion?

The PRESIDING OFFICER. The regular order, as the Chair is advised by the Parliamentarian, is that the amendment is to be read because objection has been heard to the unanimous-consent request.

The clerk will read the amendment.

The assistant legislative clerk continued reading the amendment.

Mr. ADAMS. Mr. President, I ask permission to withdraw the amendment.

The PRESIDING OFFICER. The Senator has a right to withdraw the amendment.

Mr. ADAMS. I withdraw the amendment.

The PRESIDING OFFICER. The amendment is withdrawn.

The amendment (No. 3173) was withdrawn.

The text of the amendment (No. 3173) is as follows:

At the end of title VIII, insert the following new sections:

Mr. DURBIN. Incidentally, Madam President, that is the colloquy I referred to earlier where the Chair made exactly the same ruling on that day as was made today, the finding in terms of rule XV, paragraph 2.

I also ask unanimous consent to have printed in the RECORD the memorandum prepared by Senator GREGG for the Republican side of the aisle concerning the rights of the minority in the Senate, which I have mentioned earlier, and largely includes the rights to slow down and stop the activity of the Senate.

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

FOUNDATION FOR THE MINORITY PARTY'S RIGHTS IN THE SENATE (FALL 2009)

The Senate rules are designed to give a minority of Senators the right to insist on a full, complete, and fully informed debate on all measures and issues coming before the Senate. This cornerstone of protection can only be abrogated if 60 or more Senators vote to take these rights away from the minority.

I. Rights Available to Minority Before Measures are Considered on Floor (These rights are normally waived by Unanimous Consent (UC) when time is short, but any Senator can object to the waiver.)

New Legislative Day, An adjournment of the Senate, as opposed to a recess, is required to trigger a new legislative day. A new legislative day starts with the morning hour, a 2-hour period with a number of required procedures. During part of the ''morning hour'' any Senator may make non-debatable motions to proceed to items on the Senate calendar.

One Day and Two Day Rules—The 1-day rule requires that measures must lie over one ''legislative day'' before they can be considered. All bills have to lie over one day, whether they were introduced by an individual Senator (Rule XIV) or reported by a committee (Rule XVII). The 2-day rule requires that IF a committee chooses to file a written report, that committee report MUST contain a CBO cost estimate, a regulatory impact statement, and detail what changes the measure makes to current law (or provide a statement why any of these cannot be done), and that report must be available at least 2 calendar days before a bill can be considered on the Senate floor. Senators may block a measure's consideration by raising a point of order if it does not meet one of these requirements.

''Hard'' Quorum Calls—Senate operates on a presumptive quorum of 51 senators and quorum calls are routinely dispensed with by unanimous consent. If UC is not granted to dispose of a routine quorum call, then the roll must continue to be called. If a quorum is not present, the only motions the leadership may make are to adjourn, to recess under a previous order, or time-consuming motions to establish a quorum that include requesting, requiring, and then arresting Senators to compel their presence in the Senate chamber.

II. Rights Available to Minority During Consideration of Measures in Senate (Many of these rights are regularly waived by Unanimous Consent.)

Motions to Proceed to Measures—with the exception of Conference Reports and Budget Resolutions, most such motions are fully debatable and 60 votes for cloture is needed to cut off extended debate.

Reading of Amendments and Conference Reports in Entirety—In most circumstances, the reading of the full text of amendments may only be dispensed with by unanimous consent. Any Senator may object to dispensing with the reading. If, as is often the case when the Senate begins consideration of a House-passed vehicle, the Majority Leader offers a full-text substitute amendment, the reading of that full-text substitute amendment can only be waived by unanimous consent. A member may only request the reading of a conference report if it is not available in printed form (100 copies available in the Senate chamber).

Senate Points of Order—A Senator may make a point of order at any point he or she believes that a Senate procedure is being violated, with or without cause. After the presiding officer rules, any Senator who disagrees with such ruling may appeal the ruling of the chair—that appeal is fully debatable. Some points of order, such as those raised on Constitutional grounds, are not ruled on by the presiding officer and the question is put to the Senate, then the point of order itself is fully debatable. The Senate may dispose of a point of order or an appeal by tabling it; however, delay is created by the two roll call votes in connection with each tabling motion (motion to table and motion to reconsider that vote).

Budget Points of Order—Many legislative proposals (bills, amendments, and conference reports) are subject to a point of order under the Budget Act or budget resolution, most of which can only be waived by 60 votes. If budget points of order lie against a measure, any Senator may raise them, and a measure cannot be passed or disposed of unless the points of order that are raised are waived. (See *http://budget.senate.gov/republican/pressarchive/PointsofOrder.pdf*)

Amendment Process

Amendment Tree Process and/or Filibuster by Amendment—until cloture is invoked, Senators may offer an unlimited number of amendments—germane or non-germane—on any subject. This is the fullest expression of a ''full, complete, and informed'' debate on a measure. It has been necessary under past Democrat majorities to use the rules governing the amendment process aggressively to ensure that minority Senators get votes on their amendment as originally written (unchanged by the Majority Democrats.)

Substitute Amendments—UC is routinely requested to treat substitute amendments as original text for purposes of further amendment, which makes it easier for the majority to offer 2nd degree amendments to gut 1st degree amendments by the minority. The minority could protect their amendments by objecting to such UC's.

Divisible Amendments—amendments are divisible upon demand by any Senator if they contain two or more parts that can stand independently of one another. This can be used to fight efforts to block the minority from offering all of their amendments, because a single amendment could be drafted, offered at a point when such an amendment is in order, and then divided into multiple component parts for separate consideration and votes. Demanding division of amendments can also be used to extend consideration of a measure. Amendments to strike and insert text cannot be divided.

Motions to Recommit Bills to Committee With or Without Instructions—A Senator may make a motion to recommit a bill to the committee with or without instructions to the Committee to report it back to the Senate with certain changes or additions. Such instructions are amendable.

After Passage: Going to Conference,Motions to Instruct Conferees, Matters Out of Scope of Conference

Going to Conference—The Senate must pass 3 separate motions to go to conference: (1) a motion to insist on its amendments or disagree with the House amendments; (2) a motion to request/agree to a conference; and (3) a motion to authorize the Chair to appoint conferees. The Senate routinely does this by UC, but if a Senator objects the Senate must debate each step and all 3 motions may be filibustered (requiring a cloture vote to end debate).

Motion to Instruct Conferees—Once the Senate adopts the first two motions, Senators may offer an unlimited number of motions to instruct the Senate's conferees. The motions to instruct are amendable—and divisible upon demand—by Senators if they contain more than one separate and distinct instruction.

Conference Reports, Out of Scope Motions—In addition to demanding a copy of the conference report to be on every Senator's desk and raising Budget points of order against it, Senators may also raise a point of order that it contains matter not related to the matters originally submitted to the conference by either chamber. If the Chair sustains the point or order, the provision(s) is stricken from the conference agreement, and the House would then have to approve the measure absent the stricken provision (even if the House had already acted on the conference report). The scope point of order can be waived by 60 Senators.

Availability of Conference Report Language. The conference report must be publicly available on a website 48 hours in advance prior to the vote on passage.

Mr. DURBIN. Madam President, I would just say that when Senator MCCONNELL came to the floor after the ruling and the decision of the Chair, he said the plain language of the Senate precedent—the manual that governs Senate procedure—is that unanimous consent of all Members was required before the Senator from Vermont could withdraw his amendment while it was being read. He said it required unanimous consent. But that is not what the language of the Senate rules say that I have read. They say a Senator has, as a matter of right under rule XV, paragraph 2, to withdraw his amendment before action is taken. In this case, as I mentioned earlier, the argument back in 1992 backs up the Parliamentarian's decision in that interpretation of the rule.

So I would say it didn't work today to stop or slow down the Senate. Currently, we are not technically debating health care reform. What is before us now is the Department of Defense appropriations bill from the House, which I hope we can move on quickly. I think it is not controversial. It is a matter of finding money for our troops who are risking their lives overseas and supporting their families at home and providing health care for members of the military and their families. I don't think there is much debate about that.

It also extends the unemployment benefits that people need across America, which passed with a 97-to-0 vote, if I am not mistaken, not that long ago—the last time it was considered. So these are matters which should move along, and we should be able to do it in a fairly straightforward way. I would hope we can show some bipartisanship when it comes to our men and women in uniform and approve the Department of Defense appropriations bill, which does not contain anything controversial beyond what I have just described. We can then get back to the health care reform bill. I think it is important that at some point we bring this to a vote, to find if we indeed have the 60 votes for health care reform. I sincerely hope we do.

I will close by saying this health care reform bill has its critics, but it also has several features which can't be denied.

The first of those features that have been verified by the Congressional Budget Office: This bill does not add to the deficit of the United States; it reduces the deficit by $130 billion over 10 years and $650 billion, moreover, the following 10 years.

We have also received reports from the Congressional Budget Office that the result of this bill will be a decline in the increase in the cost of health insurance premiums—something we desperately need.

It is a bill that will also extend health insurance coverage to 30 million more Americans who do not have it today—50 million uninsured Americans; 30 million of them, 60 percent of them, will have the protection of health insurance coverage. Ninety percent of Americans will have health insurance coverage—the highest percentage in the history of the United States of America—as a result of this bill.

This bill addresses directly the issue of whether health insurance companies can continue to deny coverage when people need it the most. We know stories from our own life experience and our families' and people who write to our offices, that people in the most need of health insurance protection are often turned down by the companies. They pore through the applications and say: You failed to disclose a preexisting condition. They say: Your amount of coverage has lapsed; your child is too old to be covered by your family plan—the list goes on and on.

Finally, some of the most egregious abuses by health insurance companies are addressed in this bill, and consumers across America are given the legal power to fight back and the legal power to be protected. That is why this bill is important and why it is worth passing, all the criticism notwithstanding.

I might also say that it is a bill that is critically important for the future of Medicare. If we do nothing, Medicare is going broke in 7 or 8 years, but we are told this bill will extend the life of Medicare up to 10 more years. That is good news, to put Medicare on sound financial footing, so our seniors like that.

The majority leader of the Senate came to the floor 2 days ago to announce something else that will be part of the conference committee here. The so-called doughnut hole, that gap in coverage for prescription drugs under

Medicare, is going to be filled so that seniors will no longer have that period of uncertainty where their bills have reached a level where they are disqualified from payment—the so-called doughnut hole. It will be filled. It will give them peace of mind that if they have expensive pharmaceuticals, they will have no interruption in coverage in the future when it comes to those pharmaceuticals.

For seniors, these are two major things—to put Medicare on sound financial footing and to fill the doughnut hole under the Medicare prescription part of the program.

It also is going to give seniors for the first time access to the kind of preventive care—regular checkups—they need for peace of mind and so doctors and professionals can catch problems before they get worse.

This bill is a positive bill, a positive step forward.

Yesterday, we had a chance as a Senate Democratic caucus to meet with President Obama. We went to the White House, the Executive Office Building, and the President talked to us about what this bill means. He reminded us that seven Presidents have tried to do this and failed. He told us when he started this trek that he wanted to be the last President to deal with health care reform because he wanted to get it done. I feel the same way. I think the American people feel the same way.

I am sure there is confusion. There have been a lot of misstatements made about death panels and things that really have no basis in fact. But people should be confident that when the AARP, the American Association of Retired Persons, stands up and says this is a good bill for the seniors in America under Medicare and Social Security and for their families; when medical professionals, doctors and medical professionals, stand up and say this is a good bill, that we have the kind of support we need to say to the American people that this is an important step forward in health care protection in America.

It is time for us to make history and pass this bill. Let's do it and do it in time for Members to enjoy Christmas with their families.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

MORNING BUSINESS

Mr. DURBIN. I ask unanimous consent that the Senate proceed to a period of morning business, with Senators permit to speak for up to 10 minutes each.

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

HONORING OUR ARMED FORCES

Mrs. BOXER. Madam President, I rise today to pay tribute to three young Americans who have been killed in Iraq since July 28. This brings to 882 the number of servicemembers either from California or based in California that have been killed while serving our country in Iraq. This represents 20 percent of all U.S. deaths in Iraq.

SPC Lukas C. Hopper, 20, of Merced, CA, died October 30, southeast of Karadah, Iraq, of injuries sustained during a vehicle roll-over. Private First Class Hopper was assigned to the 1st Battalion, 505th Parachute Infantry Regiment, 3rd Brigade Combat Team, 82nd Airborne Division, Fort Bragg, NC.

SPC Christopher M. Cooper, 28, of Oceanside, CA, died October 30 in Babil province, Iraq, of injuries sustained from a noncombat related incident. Specialist Cooper was assigned to the 2nd Battalion, 28th Infantry, 172nd Infantry Brigade, Schweinfurt, Germany.

PVT Jhanner A. Tello, 29, of Los Angeles, CA, died December 10 in Baghdad, Iraq, of injuries sustained from a noncombat related incident. Private Tello was assigned to the 3rd Aviation Support Battalion, 227th Aviation Regiment, 1st Air Cavalry Brigade, 1st Cavalry Division, Fort Hood, TX.

I would also like to pay tribute to the 27 soldiers from California or based in California who have died while serving our country in Operation Enduring Freedom since July 28.

SPC Matthew K.S. Swanson, 20, of Lake Forest, CA, died August 8 at the National Naval Medical Center in Bethesda, MD, of injuries sustained during a vehicle roll-over July 19 in Logar province, Afghanistan. Specialist Swanson was assigned to the 3rd Brigade Special Troops Battalion, 3rd Brigade Combat Team, 10th Mountain Division, Light Infantry, Fort Drum, NY.

LCpl Javier Olvera, 20, of Palmdale, CA, died August 8 while supporting combat operations in Helmand province, Afghanistan. Lance Corporal Olvera was assigned to 2nd Battalion, 8th Marine Regiment, 2nd Marine Division, II Marine Expeditionary Force, Camp Lejeune, NC.

PFC Brian M. Wolverton, 21, of Oak Park, CA, died August 20 in Kunar province, Afghanistan, of wounds suffered when insurgents attacked his unit with indirect fire. Private First Class Wolverton was assigned to the 1st Battalion, 32nd Infantry Regiment, 3rd Brigade Combat Team, 10th Mountain Division, Light Infantry, Fort Drum, NY.

LCpl Donald J. Hogan, 20, of San Clemente, CA, died August 26 while supporting combat operations in Helmand province, Afghanistan. Lance Corporal Hogan was assigned to 1st Battalion, 5th Marine Regiment, 1st Marine Division, I Marine Expeditionary Force, Camp Pendleton, CA.

CPT John L. Hallett III, 30, of Concord, CA, died August 25 in southern Afghanistan, of wounds suffered when enemy forces attacked his vehicle with an improvised explosive device. Captain Hallett was assigned to the 1st Battalion, 17th Infantry Regiment, 5th Stryker Brigade, 2nd Infantry Division, Fort Lewis, WA.

SPC Tyler R. Walshe, 21, of Shasta, CA, died August 31 in southern Afghanistan, of wounds suffered when enemy forces attacked his unit with an improvised explosive device. Specialist Walshe was assigned to the 1st Battalion, 17th Infantry Regiment, 5th Stryker Brigade, 2nd Infantry Division, Fort Lewis, WA.

SPC Jonathan D. Welch, 19, of Yorba Linda, CA, died August 31 in Shuyene Sufia, Afghanistan, of wounds suffered when enemy forces attacked his unit with an improvised explosive device. Specialist Welch was assigned to the 1st Battalion, 17th Infantry Regiment, 5th Stryker Brigade, 2nd Infantry Division, Fort Lewis, WA.

PO3 James R. Layton, 22, of Riverbank, CA, died September 8 in Kunar province, Afghanistan, while supporting combat operations. Petty Officer 3rd Class Layton was assigned to an embedded training team with Combined Security Transition Command in Afghanistan.

Capt Joshua S. Meadows, 30, of Bastrop, TX, died September 5 while supporting combat operations in Farah province, Afghanistan. Captain Meadows was assigned to 1st Marine Special Operations Battalion, Marine Corps Forces Special Operations Command, Camp Pendleton, CA.

TSgt James R. Hornbarger, 33, of Castle Rock, WA, died September 12 as a result of a non-hostile incident in the Mediterranean. Technical Sergeant Hornbarger was assigned to the 9th Aircraft Maintenance Squadron, Beale Air Force Base, CA.

SGT Joshua M. Hardt, 24, of Applegate, CA, died October 3 in Kamdesh, Afghanistan, of wounds suffered when enemy forces attacked his contingency outpost with small arms, rocket-propelled grenade and indirect fires. Sergeant Hardt was assigned to the 3rd Squadron, 61st Cavalry Regiment, 4th Brigade Combat Team, 4th Infantry Division, Fort Carson, CO.

SSgt Aaron J. Taylor, 27, of Bovey, MN, died October 9 while supporting combat operations in Helmand province, Afghanistan. Staff Sergeant Taylor was assigned to Marine Wing Support Squadron 372, Marine Wing Support Group 37, 3rd Marine Aircraft Wing, I Marine Expeditionary Force, Camp Pendleton, CA.

LCpl Alfonso Ochoa, Jr., 20, of Armona, CA, died October 10 while supporting combat operations in Farah province, Afghanistan. Lance Corporal Ochoa was assigned to 2nd Battalion, 3rd Marine Regiment, 3rd Marine Division, III Marine Expeditionary Force,