The plain text of the Affordable Care Act authorizes subsidies only through State exchanges, not the Federal exchange. This decision will allow the administration to continue to ignore the law in order to implement its own preferred policies.

(Mrs. FISCHER assumed the Chair.)

As Justice Scalia said in his dissent, ''We should start calling this law SCOTUScare.'' Only Justice Scalia would come up with something like that, which I find extremely humorous.

Justice Scalia continued, saying:

Perhaps the Patient Protection and Affordable Care Act will attain the enduring status of the Social Security Act or the Taft-Hartley Act; perhaps not. But this Court's two decisions on the Act will surely be remembered through the years. The somersaults of statutory interpretation . . . they have performed will be cited by litigants endlessly, to the confusion of honest jurisprudence. And the cases publish forever the discouraging truth that the Supreme Court of the United States favors some laws over others, and is prepared to do whatever it takes to assist its favorites.

I couldn't have said it any better myself.

Needless to say, I am disappointed at this decision, as I know many throughout the country are, but at the same time I am undeterred.

As I said on the floor last week, ObamaCare has been nothing but a long series of broken promises that include skyrocketing costs, reduced access to care, and more government mandates hanging over our health care system.

Today's ruling changes none of that. Just because the Court decided to misinterpret, in my opinion, the statute doesn't mean that the law suddenly works and that all is now right with the world. For the good of our health care system and hardworking taxpayers throughout our country, we still need to chart a new course on health care policy. Unfortunately, with the current occupant of the White House, those kinds of reforms are not currently possible.

But make no mistake, Republicans in Congress have a plan to help the American people by repealing ObamaCare and replacing it with reforms that will put patients—not Washington bureaucrats—in charge of their own health care decisions.

I am coauthor of the Patient CARE Act, a legislative proposal that would replace ObamaCare with real reforms that would actually reduce health costs without all the burdensome mandates that have come part and parcel with the so-called Affordable Care Act—which is anything but affordable. Moving forward, I, along with the coauthors of this proposal, Senator BURR and Chairman UPTON over in the House, will continue to seek input from experts and stakeholders and use every opportunity to give States more freedom and flexibility.

Once again, any workable reform must lower costs and put patients first. That is the only way we will end the negative consequences of ObamaCare and help the American people move past this misguided attempt at health care reform.

The American people deserve better, and Republicans in Congress are united in our commitment to make sure we do better on health care reform in the future.

Now, I had suspected that this is the way the court would decide and it is a big enough bill that extremely clever judges could find a way to rule how they did today. And there are few justices as clever as the Chief Justice. I have tremendous respect for him.

And though he used his talents to uphold this law, he did it with aplomb and unparalleled legal skill. I have had colleagues bad-mouth the Chief Justice for this case and especially the Sebelius case.

What few of my colleagues remember, however, is that in the Sebelius decision, the Chief Justice led the way to preserve for States the right to make their own decisions with regard to whether to undertake a Medicaid expansion or not.

Under Obamacare, the Democrats wanted to force the hands of the States—either expand the program, or you would lose all access to Medicaid funds.

That was coercion, pure and simple, and the Court ruled accordingly. And Justice Roberts wrote the opinion, which was joined, at least with regard to the Medicaid expansion, by all conservative justices on the Court.

The Court's decision preserved a real and meaningful choice for the States, and States have used that ability to choose in different ways. Some have expanded Medicaid. Some have not. Some have tried to use waiver authority to craft solutions that work for them. This flexibility is how it should work.

All I can say is that the Chief Justice is a remarkable judge. He is a tremendous human being. I have a tremendous confidence in him and I believe in him. I differ with him on this opinion though. This ruling will not solve any of the problems inherent in Obamacare, as we can see from the continually skyrocketing costs of health care and insurance coverage.

As I have said, clever judges can find ambiguities where none exist. Clever judges can find ambiguities that others may not be able to find. And despite the Chief Justice's brilliance and integrity of character, we need to repeal Obamacare and replace it with something better.

I believe, with Chairman UPTON in the House, and Senator BURR, that the Patient CARE Act is one of the best solutions out there. I urge all of my colleagues to read through our proposal and offer constructive criticism. We need an off-ramp from Obamacare to an actually affordable, and privatized, health care system. Only then can we give every day Americans the economic growth and prosperity they deserve.

With that, I yield the floor.

The PRESIDING OFFICER. The Senator from Colorado.

REACH ACT

Mr. GARDNER. Madam President, today I wish to discuss the REACH Act, legislation that I have introduced with my colleague, the senior Senator from Iowa, Mr. GRASSLEY, to establish a new category for critical access hospitals in financial distress.

Rural hospitals are an essential yet vulnerable part of our health care system. Rural residents face a unique set of challenges in relation to their urban counterparts. According to the American Hospital Association, rural residents are typically older, poorer, and more likely to have chronic diseases than those living in more developed cities. The unique challenges of caring for patients in underserved areas are not the only hurdles that face rural hospitals today. They have a hard time simply keeping their doors open.

Since January of 2010, approximately 55 rural hospitals nationwide have closed because they could not generate the kind of support or the volume necessary to continue operation. In Colorado, nearly 60 percent of care for patients in underserved areas is provided by hospitals dependent on rural payment mechanisms, and many hospitals are in danger of closing their doors.

I would like to share with you a story about the impact of a rural hospital in my hometown of Yuma, CO, as shared by the CEO of the hospital. Now, I will also tell you that the name of the CEO of the hospital is John Gardner. John Gardner also happens to be the name of my father. They are two different people. My father sells farm equipment. This John Gardner runs a hospital. I think I can tell you that both of them have gotten complaints.

My dad has gotten complaints about the emergency room bill, and John Gardner, this CEO of the hospital, has gotten complaints about a tractor overhaul bill. But they are two different people. But this John Gardner, the CEO of the hospital, does live right next to me in this small town of right around 3,000 people. This is what he said, the CEO of the hospital:

Because we are located in a rural farming community, we see many farming accidents and motor vehicle accidents. Gravel roads are not the driver's friend. In partnership with the city ambulance service, we have invested a lot of time and training and equipment to be prepared to respond to these accidents. We have two young adults in our community who were involved in serious automobile accidents on gravel roads. Both had severe head trauma which without immediate stabilization would have had terminal outcomes.

Because of our hospital we were able to treat and transport both to level 1 trauma centers for complete treatment and following extensive rehabilitation are now back with their families.

Stories like this and the invaluable lifesaving services provided by rural

hospitals are why we need a new system, a new system that recognizes the financial challenges and obstacles that rural hospitals face today. Without an adjustment, there may be more facilities closing. A 2014 report by the National Rural Health Association identified 283 additional hospitals at risk of closing.

Now, we saw 55 nationwide hospitals already close. An additional 283 rural hospitals around the country are at risk of closing. Ensuring that rural communities have access to the lifesaving care they need is why I am introducing—and joining Senator GRASSLEY—the Rural Emergency Acute Care Hospital Act or the REACH Act.

The REACH Act aims to allow rural hospitals which are in financial distress to become a new category of hospital, called a rural emergency hospital. Here is the problem and why we need to pass the REACH Act. Under current law, critical access hospitals are classified as hospitals maintaining no more than 25 acute care beds. These hospitals rely on rural payment mechanism for Medicare reimbursements for outpatient, inpatient, laboratory, therapy services, and post-acute swing-bed services.

As the medical service industry has evolved, patients find it more and more attractive to have services requiring rural hospital admission performed in large city hospitals because inpatient services are delivered there on a more routine basis. We see more people leaving rural hospitals to go to the city hospitals because they perform these inpatient services more regularly.

The problem, of course, is that leaves rural hospitals without enough inpatient volume to cover their costs, oftentimes resulting in hospital closures. So when a critical access hospital—again, these are hospitals defined under the law as 25 acute care beds. When a critical access hospital has to shut its doors for inpatient services, it has to stop providing inpatient services, it also means the emergency care closes with it.

So now you have a hospital no longer providing inpatient services and no longer offering emergency care. But as highlighted by my hometown story—the story I just shared from the CEO of the hospital, timely access to emergency services is truly the difference between life and death. Those two young men who would have faced a terminal outcome were saved because of the availability of a rural hospital emergency room.

So when dealing with life-threatening injuries, it is critical for patients to receive the kind of health care they need, that lifesaving care to prevent the terminal outcome within the golden hour. That is something doctors and hospitals use—a term for medical professionals—meaning that hour after injury where it is absolutely critical that they receive treatment, that can make the difference between survival—if they do not receive their care during this critical golden hour, their condition could rapidly deteriorate.

Recent statistics from the National Conference of State Legislatures found that 60 percent of trauma deaths in the United States occur in rural areas but only represent 15 percent of the overall population. So if we are talking about why we need access to rural emergency hospitals, the statistic is very clear: 60 percent of rural trauma deaths in this country occur amongst a population that only represents 15 percent of the overall population. That is a pretty dramatic number.

It is critical that we provide rural hospitals that are under financial distress the necessary tools to prevent closures for those living in isolated areas, to make sure they have the same access to emergency services. The solution is the REACH Act, a solution Senator GRASSLEY and I are working on together, to allow rural hospitals in financial distress to switch from being a critical access hospital to this new category called a rural emergency hospital.

This new category would offer reimbursement rates that are consistent with the care, needs, and capabilities of rural hospitals, but more importantly allowing them to remain open, keeping that critical emergency room service open. Now, the emergency hospital must provide emergency medical care and observation 24 hours a day, 7 days a week by onsite staff.

So we are still providing quality care, but we are allowing them to overcome the fact that they have seen their inpatient services decline, enabling them to keep their emergency services open 24 hours a day, 7 days a week, to make sure trauma patients can see the doctor and be provided the necessary medical care they need during that all-important golden hour.

The bill would also establish protocols for the timely transfer of patients in need of a higher level of care and patient admittance. The Presiding Officer and I both came from rural States, where we know—there are hospitals in our States that are facing financial challenges. There have been stories in newspapers in Colorado about the struggles some communities are having maintaining their services, keeping their doors open. But there are stories in each and every one of these communities like the story John Gardner told about those two young people in my hometown who otherwise would have had a terminal outcome but for the availability of the emergency care in rural Colorado.

So to avoid missing out on the services necessary to keep people alive, to make sure rural patients have access to care during that critical golden hour, the REACH Act provides our hospitals with an opportunity to keep health services and hospitals available across rural America—available, open with emergency care, giving troubled hospitals an avenue to keep their doors open and to keep providing the lifesaving care we all so desperately want in each of our communities, rural or urban.

I thank the Presiding Officer for the time on the floor today. I urge my colleagues to support the REACH Act. We are always reaching out for more cosponsors in a bipartisan fashion to make sure we can do the best job possible providing health care to rural America, to urban America, and to make sure we keep these hospitals open.

I yield the floor.

The PRESIDING OFFICER. The Senator from Maryland.

TRAGEDY IN CHARLESTON, SOUTH CAROLINA

Mr. CARDIN. Madam President, I rise today to discuss my hometown of Baltimore and the city's recovery after the civil unrest related to the Freddie Gray case. But first let me say a few words about the heartbreaking events in South Carolina. Words are inadequate to express the heartache of yet another mass shooting. Gun violence regularly takes far too many victims in Baltimore and other cities across the country, but to have a place of worship violated in such a hateful way is inexplicable.

My prayers are with the Mother Emanuel AME Church, its congregants, and the people of Charleston, SC, at this difficult time. I appreciate the Department of Justice's swiftness in opening a hate crimes investigation of this tragedy. Despite the alarming frequency of such shootings, we as a nation cannot become complacent and immune to the pain and anguish caused by these instances.

Every time a senseless shooting takes place, there should be more and more of us who shout to the Heavens in protest as loudly as we can. As parents, we have a responsibility to teach our children to focus on things that unite all people and to view differences as strengths, rather than seeds for hatred and resentment. As lawmakers, we need to move from a place of political inertia to stop guns from getting into the hands of people who use them for the wrong reasons. We have mourned too many good people—men, women, and children—to stand idly by.

I am pleased State leaders have come together for the removal of the Confederate flag from the grounds of South Carolina's statehouse. I urge the State legislature to move quickly to permanently remove this symbol of intolerance from government facilities.

BALTIMORE ACT

Mr. CARDIN. Now, as I travel around Baltimore, and particularly the neighborhoods that are trying to recover, I hear a recurring theme from constituents: They don't feel their government truly represents them and their interests. They don't feel government has fully invested in recovery efforts in