In addition to propping up Assad's reign of terror, Iran also provides support to the Houthi rebels in Yemen. Secretary of Defense James Mattis recently noted: ''We see Iranian-supplied missiles being fired by the Houthis into Saudi Arabia.''

Well, providing these missiles puts Iran in violation of at least two U.N. Security Council resolutions—not that Iran appears to care. In fact, violating U.N. Security Council resolutions and international law is common practice for the Iranian Government, whether it involves supplying missiles to the Houthis or increasing Iran's own stockpiles.

When it is not violating the letter of the law, Iran is also happy to violate the spirit of international agreements. After the misguided Iran deal went into effect, Iran resumed ballistic missile testing, even though the U.N. Security Council resolution endorsing the nuclear deal called upon Iran not to engage in these activities.

Most recently, Iran unsuccessfully tested a submarine missile in the Strait of Hormuz in May, following ground-based missile testing in January and March. Many of those missiles have a range to reach targets, not only throughout the Middle East but outside it.

Under the last administration, Iranian belligerence was too often ignored or even rewarded. That needs to end now. We cannot afford to let Iran continue to destabilize the Middle East. We need to make it clear that the United States and its new leadership will not tolerate Iranian aggression and the terrible human suffering that has resulted.

We need to assure our allies—especially Israel, our closest and most reliable ally in the Middle East—that we are committed to standing with them against Iranian threats. The Countering Iran's Destabilizing Activities Act will send a clear signal to Iran that the United States and its new leadership are serious about cracking down on Iranian misconduct.

This bill will sanction individuals involved in Iran's ballistic missile program or any other program designed to deliver weapons of mass destruction. It will sanction individuals who contribute to Iranian violations of arms embargoes. It will allow the President to impose sanctions on individuals who have perpetrated human rights violations against human rights crusaders in Iran. Perhaps most importantly, this legislation identifies and will hold accountable the entire Iranian Islamic Revolutionary Guard Corps, not just the Quds Force, for its role in implementing Iran's destabilizing agenda.

There is no easy solution to the unrest and violence in the Middle East, but this bill offers one commonsense step forward.

Yesterday the Senate passed an amendment to this bill imposing additional sanctions against another country stirring up unrest in the Middle East, and that is Russia. Russia's increasing boldness on the international stage is a natural consequence of the Obama administration's passive foreign policy. From annexing Crimea to supporting the murderous Assad regime in Syria, to meddling in elections, we cannot allow this level of Russian aggression to go unchallenged.

The Russia sanctions amendment codifies and strengthens existing Russia sanctions and imposes a number of new ones. Human rights abusers, individuals supplying weapons to Assad's regime, hackers acting on behalf of the Russian Government, and Russians involved in corruption are all sanctioned in this amendment.

I am grateful to Senators CORKER and CRAPO, the chairman of the Foreign Relations Committee and the chairman of the Banking Committee, for all the work they have done on this bill and on the Russia sanctions amendment. It was a bipartisan bill. Our colleagues on the other side, the Senator from Maryland and others, were involved in crafting this legislation, and it is a demonstration that this body can come together and do consequential things. These are two big national security and foreign policy measures that we have moved today.

There have to be consequences for Iranian and Russian aggression, and this legislation makes sure there will be. I am pleased that it moved today with largely bipartisan support in the U.S. Senate because it will send a clear message.

I yield the floor.

The PRESIDING OFFICER. The Senator from Maryland.

MINORITY HEALTH

Mr. CARDIN. Mr. President, April was National Minority Health Month. I point that out because I have worked with many of my colleagues in order to advance minority health.

We have done some very important things in recent years that I am very proud of, and many of those are included in the Affordable Care Act. I know that Senator CARPER and Senator BLUMENTHAL will be on the floor; Senator CARPER is here now. They have been instrumental in advancing quality healthcare for all Americans, but we do recognize that we have a special role in regard to historic discrimination on minority health. I was pleased that the Affordable Care Act included the National Institute on Minority Health and Health Disparities so that we could have a focal point at NIH to deal with the historic problems and have a game plan to advance that.

I was also pleased that the Affordable Care Act provided coverage for minorities in greater numbers because when we looked at the number of uninsured, the number of minorities were a much higher percentage than the general population of uninsured. When we looked at inadequate coverage, we saw the same numbers. So we have made advancements.

In April, historically, I had filed a resolution in order to acknowledge the progress we made and to continue our commitment to make sure that all Americans have access to affordable, quality healthcare and that we do not discriminate. That resolution had always cleared without any difficulty until 2017. For reasons I cannot explain, there were Republican objections, and we were not able to adopt the resolution commemorating minority health month.

Mr. President, I ask unanimous consent that the text of that resolution be printed in the RECORD.

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

Promoting minority health awareness and supporting the goals and ideals of National Minority Health Month in April 2017, which include bringing attention to the health disparities faced by minority populations of the United States such as American Indians, Alaskan Natives, Asian Americans, African Americans, Latino Americans, and Native Hawaiians or other Pacific Islanders.

Whereas the origin of National Minority Health Month is National Negro Health Week, established in 1915 by Dr. Booker T. Washington;

Whereas the theme for National Minority Health Month in 2017 is ''Bridging Health Equity Across Communities'';

Whereas, through the National Stakeholder Strategy for Achieving Health Equity and the HHS Action Plan to Reduce Racial and Ethnic Health Disparities, the Department of Health and Human Services has set goals and strategies to advance the safety, health, and well-being of the people of the United States;

Whereas a study by the Joint Center for Political and Economic Studies, entitled ''The Economic Burden of Health Inequalities in the United States'', concludes that, between 2003 and 2006, the combined cost of health inequalities and premature death in the United States was $1,240,000,000,000;

Whereas the Department of Health and Human Services has identified 6 main categories in which racial and ethnic minorities experience the most disparate access to health care and health outcomes, including infant mortality, cancer screening and management, cardiovascular disease, diabetes, HIV/AIDS, and immunizations;

Whereas, in 2012, African American women were as likely to have been diagnosed with breast cancer as non-Latina White women, but African American women were almost 40 percent more likely to die from breast cancer than non-Latina White women;

Whereas African American women are twice as likely to lose their lives to cervical cancer as non-Latina White women;

Whereas African American men are 60 percent more likely to die from a stroke than non-Latino White men;

Whereas Latinos are 1.7 times more likely to be diagnosed with diabetes by a physician, and are 40 percent more likely to die of diabetes, than non-Latino Whites;

Whereas Latino men are 3 times more likely to have HIV infections or AIDS than non-Latino White men;

Whereas Latina women are 4 times more likely to have AIDS than non-Latina White women;

Whereas, in 2014, although African Americans represented only 13 percent of the population of the United States, African Americans accounted for 43 percent of HIV infections;

Whereas, in 2010, African American youth accounted for an estimated 57 percent, and

Latino youth accounted for an estimated 20 percent, of all new HIV infections among youth in the United States;

Whereas, between 2005 and 2014, the number of Asian Americans diagnosed with HIV increased by nearly 70 percent;

Whereas, in 2014, Native Hawaiians and Pacific Islanders were 1.7 times more likely to be diagnosed with HIV than non-Latino whites;

Whereas Native Hawaiians living in the State of Hawaii are 5.7 times more likely to die of diabetes than non-Latino Whites living in Hawaii;

Whereas Native Hawaiians and Pacific Islanders are 30 percent more likely to be diagnosed with cancer than non-Latino whites;

Whereas, although the prevalence of obesity is high among all population groups in the United States, 42 percent of American Indian and Alaskan Natives, 41 percent of Native Hawaiian and Pacific Islanders, 40 percent of African Americans, 31 percent of Latinos, 24 percent of non-Latino whites, and 11 percent of Asian Americans are obese;

Whereas, in 2013, Asian Americans were 1.2 times more likely than non-Latino Whites to contract Hepatitis A;

Whereas, among all ethnic groups in 2013, Asian Americans and Pacific Islanders had the highest incidence of Hepatitis A;

Whereas Asian American women are 1.3 times more likely than non-Latina Whites to die from viral hepatitis;

Whereas Asian Americans are 3 times more likely than non-Latino Whites to develop chronic Hepatitis B;

Whereas of the children living with diagnosed perinatal HIV in 2014, 65 percent were African American, 15 percent were Latino Americans, and 11 percent were non-Latino whites;

Whereas the Department of Health and Human Services has identified heart disease, stroke, cancer, and diabetes as some of the leading causes of death among American Indians and Alaskan Natives;

Whereas American Indians and Alaskan Natives die from diabetes, alcoholism, unintentional injuries, homicide, and suicide at higher rates than other people in the United States;

Whereas American Indians and Alaskan Natives have a life expectancy that is 4.4 years shorter than the life expectancy of the overall population of the United States;

Whereas African American babies are 3.5 times more likely than non-Latino White babies to die due to complications related to low birth weight;

Whereas American Indian and Alaskan Native babies are twice as likely as non-Latino White babies to die from sudden infant death syndrome;

Whereas American Indian and Alaskan Natives have 1.5 times the infant mortality rate as that of non-Latino whites;

Whereas American Indian and Alaskan Native babies are 70 percent more likely to die from accidental deaths before their first birthday than non-Latino White babies;

Whereas only 5 percent of Native Hawaiian and Pacific Islanders, 6 percent of Asian Americans, 8 percent of Latinos, 9 percent of African Americans, and 14 percent of American Indians and Alaska Natives received mental health treatment or counseling in the past year, compared to 18 percent of non-Latino whites;

Whereas marked differences in the social determinants of health, described by the World Health Organization as ''the high burden of illness responsible for appalling premature loss of life'' that ''arises in large part because of the conditions in which people are born, grow, live, work, and age'', lead to poor health outcomes and declines in longevity;

Whereas the Patient Protection and Affordable Care Act (Public Law 111–148; 124 Stat. 119)—

(1) has reduced the uninsured rate for minority communities by at least 35 percent;

(2) has helped further combat health disparities for low-income individuals through coverage expansions in the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) and the individual health insurance marketplaces; and

(3) provides specific protections and rights for American Indians and Alaskan Natives, 21.4 percent of whom lack health insurance;

Whereas, despite the substantial improvements in health insurance coverage among women overall, women of color are more likely to be uninsured;

Whereas, in 2012, 36 percent of Latina women, 29 percent of American Indian women, 23 percent of African American women, 19 percent of Asian and Pacific Islander women, and 14 percent of non-Latina White women were uninsured;

Whereas community-based health care initiatives, such as prevention-focused programs, present a unique opportunity to use innovative approaches to improve health practices across the United States and to sharply reduce disparities among racial and ethnic minority populations: Now, therefore, be it

Resolved, That the Senate supports the goals and ideals of National Minority Health Month in April 2017, which include bringing attention to the severe health disparities faced by minority populations in the United States, such as American Indians, Alaskan Natives, Asian Americans, African Americans, Latino Americans, and Native Hawaiians or other Pacific Islanders.

Mr. CARDIN. I thank Senators Menendez, Blumenthal, Brown, Hirono, Markey, Klobuchar, Van Hollen, Booker, Peters, Duckworth, and Carper for their help in regard to minority health and the resolution.

HEALTHCARE LEGISLATION

So we couldn't do that, which is a pretty easy thing to do, but now the Republicans are looking to bring out in the next 2 weeks a rewriting of our entire healthcare law, one-sixth of our economy, and they are talking about bringing this out for perhaps passage in the U.S. Senate during the next 2 weeks.

I don't know of anyone who has seen a copy of this bill. I certainly have not seen it, and I am a member of the Senate Finance Committee. Senator CARPER is a member of the Senate Finance Committee. We have not seen a copy of the bill, even though we are the committee of jurisdiction, along with the HELP Committee. I certainly want to be able to look at this bill, make sure that there are public hearings and an opportunity for input from all Members of the U.S. Senate—first those who serve on the relevant committees through the committee markups and then on the floor of the U.S. Senate. But what I understand from the majority leader is that may not be the case. That would be an affront to our Democratic institution. That would be insulting the Members of the Senate and the committee that I serve on, the Senate Finance Committee.

I need to mention that because we do know what the House of Representatives sent over to us. We don't know if that is going to be the bill that is going to be brought out, but there hasn't been any hearing on the bill that the House of Representatives sent over to us.

Compare that to the passage of the Affordable Care Act. We had numerous, dozens of hearings on the Affordable Care Act. We had months of negotiations on the Affordable Care Act back and forth—bipartisan negotiations. We had committee markups in two of our committees, and hundreds of amendments were considered. Many Republican-sponsored amendments were adopted on the Affordable Care Act. We went through a regular legislative process.

Yet the Republican leadership is telling us that we are going to totally change the Affordable Care Act, totally change the healthcare system, and not offer the American people an opportunity to see what we are doing—or their elected Representatives to be able to offer comments or amendments to that? That is outrageous. That is not a democratic institution. We need to speak out about it.

Now we are all vulnerable to that, all Americans. I have thought about the people in my State, the 400,000 who have coverage under the Affordable Care Act, who didn't have coverage prior to the Affordable Care Act. They are very much at risk because, according to the Congressional Budget Office, if we have on the floor of the Senate anything similar to what the House passed, most of those 400,000 are going to lose their insurance coverage. What are they going to do?

Then we are talking about putting a cap on Medicaid. Well, have you talked to the Governor of your State? Have you talked to your State legislature as to how they are doing with their budgets? Do you really believe the States can pick up what we cut? The answer is obviously no.

We offered an expansion of Medicaid so more working families, more veterans, more people who are vulnerable could get coverage. That is gone under the caps that the Republicans are talking about, putting our most vulnerable at risk.

I started talking about minority health. Let me just underscore that with Medicaid. In my State and in every State, when you look at the percentage of people who are covered under Medicaid, it is much higher for the minority community because they historically have been discriminated against. They do not have the coverage going into the Affordable Care Act. That is going to affect our most vulnerable. It is also interesting to note that a higher percentage of veterans is under the Medicaid system. That will affect our veterans. Of course, our seniors depend upon Medicaid for longer long-term care. They are going to be adversely affected by these caps under the Medicaid Program.

Then we have the impact on all of us who have insurance and may be able to