shown time and time again they are willing to force needless procedural votes on nominees they actually support in order to waste the Senate's time—and presumably with the simultaneous goal of impeding the President's ability to make almost any appointments at all. If this trend continues, it will take us more than 11 years to confirm the remaining Presidential appointments. Let me repeat that. More than 11 years. A Presidential term lasts 4 years.

The level of obstruction exhibited by Senate Democrats on these nominees is simply breathtaking. It is often leaving key Departments without the senior leadership needed to guide our country through the various challenges we face. It needs to stop.

The Senate needs to confirm Mr. Shanahan quickly, and we need to do that for the sake of our national security. And our colleagues need to stop this immediately, for the sake of the country.

HEALTHCARE LEGISLATION

Mr. MCCONNELL. Mr. President, ObamaCare has been hurting the people we represent for many years now. That is why the Senate has been working hard to move beyond its failures. Costs were supposed to go down under ObamaCare, but they skyrocketed. Premiums have already increased by an average of more than 100 percent on the Federal exchange. Next year, they could rise by as much as 50 percent or more in States as diverse as Georgia, New Mexico, and Maryland.

Look, we need to tackle this problem. The revised discussion draft we released last week contains many different reforms designed to make insurance more affordable and more flexible so it is something Americans actually want to buy. It gives Americans more choices for managing their care. It also takes aim at ObamaCare's taxes that target the middle class and drive up premiums—taxes on everything from health insurance to over-the-counter medication.

Choice was supposed to go up under ObamaCare, but of course it plummeted. Americans living in 70 percent of counties have little to no options for ObamaCare insurance today. Next year, nearly 40 percent fewer insurers have filed to offer plans. Many Americans face the real possibility of having no options at all and could find themselves trapped, forced by law to purchase ObamaCare insurance but left by ObamaCare without any means to do so.

We need to tackle this problem. The revised discussion draft is designed to stabilize the collapsing insurance markets and encourage more insurers to participate. It will transfer many healthcare decisions away from Washington bureaucrats and politicians and put them back with Americans and their doctors. It will also give Americans the freedom to decide their own healthcare, allowing them to purchase the insurance they actually want, rather than just forcing Americans to buy what ObamaCare is selling.

There are other healthcare problems that need to be tackled as well. We need to strengthen Medicaid, for instance, so it can deliver better care at a better cost today and remain available to future generations tomorrow.

Our legislation contains important reforms to move our country forward in all of these areas. These are the kinds of reforms Americans deserve—not the status quo of ObamaCare, not a multibillion-dollar bandaid, not a piling on of even more ObamaCare, but real, patient-centered reforms that can finally move us beyond the pain of this law. The only way we will get there is with continued hard work. That is just what we intend to do.

MEASURE PLACED ON THE CALENDAR—H.R. 2430

Mr. MCCONNELL. Mr. President, I understand there is a bill at the desk due for a second reading.

The PRESIDING OFFICER. The clerk will read the bill by title for the second time.

The legislative clerk read as follows:

A bill (H.R. 2430) to amend the Federal Food, Drug, and Cosmetic Act to revise and extend the user-fee programs for prescription drugs, medical devices, generic drugs, and biosimilar biological products, and for other purposes.

Mr. MCCONNELL. In order to place the bill on the calendar under the provisions of rule XIV, I object to further proceedings.

The PRESIDING OFFICER. Objection is heard.

The bill will be placed on the calendar.

RESERVATION OF LEADER TIME

The PRESIDING OFFICER. Under the previous order, the leadership time is reserved.

CONCLUSION OF MORNING BUSINESS

The PRESIDING OFFICER. Morning business is closed.

EXECUTIVE SESSION

EXECUTIVE CALENDAR

The PRESIDING OFFICER. Under the previous order, the Senate will proceed to executive session to resume consideration of the Shanahan nomination, which the clerk will report.

The legislative clerk read the nomination of Patrick M. Shanahan, of Washington, to be Deputy Secretary of Defense.

The PRESIDING OFFICER. The Senator from Texas.

HEALTHCARE LEGISLATION

Mr. CORNYN. Mr. President, on Thursday, after two additional weeks of consultation and input from Senators, we released an improved version of the bill we call the Better Care Reconciliation Act, which represents our efforts to address the failing status quo of ObamaCare.

We have said all along that even if Hillary Clinton were elected President, we would have to revisit ObamaCare because we have seen in a number of States that insurance companies are fleeing, leaving people with few, if any, options. People in the individual and small group market are seeing their premiums skyrocket 105 percent, nationwide, since 2013 alone—a 105-percent increase in premiums.

For many of these folks, even though they paid the higher additional premium, their deductibles are so high that, effectively, they are being denied the benefit of any insurance whatsoever. I guess, perhaps, it is no surprise that 28 million Americans would simply be willing to pay the fine that goes along with the individual mandate for not buying government-approved health insurance or claim some sort of hardship exemption.

ObamaCare was sold under the premise that, if you like your policy, you can keep your policy, and, if you like your doctor, you can keep your doctor and, oh, by the way, your premiums are going to go down $2,500, but what people have experienced has been the opposite of that, with premiums going up on average $3,000.

We simply believe that we have to act to save the millions of people who are being hurt by the status quo. That would be true whether Hillary Clinton were President or Donald Trump were President.

Our first goal in the Better Care Reconciliation Act is to stabilize the insurance markets, to make sure that people actually have an insurance company they can buy from.

Our second goal is to get premiums down. The reasons premiums are not down are mainly twofold. One is that you have younger, healthier people simply forgoing insurance, leaving only sicker, older people in the risk pools. Under adverse selection, that means everybody pays higher premiums when younger, healthier people simply don't purchase the product because they can't be part of that risk pool. The second reason why premiums are so high is the mandates. People are simply being ordered by their own government to buy coverage they don't want or need, which drives up premiums, not to mention the fact that young people are subsidizing older people's health insurance premiums the way that ObamaCare was constructed.

We are going to do everything we can to get the premiums down. The first Congressional Budget Office report said that long term you would see premiums go down by as much as 30 percent by the year 2020, but we want to do even better than that if we can.

The third thing we said we wanted to do was that we wanted to protect people with preexisting conditions. When

people are forced to keep a job they really don't want because they don't want to lose their employer-provided health coverage due to preexisting conditions, we don't want people to be stuck at a job they don't want or be unable to quit their job and look for something else because they are worried about not being covered due to preexisting condition exclusions. We maintain the current status of the law with regard to protecting people with preexisting conditions.

The fourth thing that we try to do in this bill is that we try to take one of the large entitlement programs, Medicaid, which is an important safety net for low-income Americans, and we put it on a sustainable path. There are some people who think you can spend hundreds of billions of dollars more for Medicaid over time and we can continue to deliver those services to the poor people in our country, and we don't need to worry about crowding out defense spending or education or some other priority. We simply cannot do it. What we have done is put it on a responsible growth rate and delegate more of that authority to the States to come up with innovative programs.

Our plan will remove costly mandates and will help provide more options and drive down some of the exorbitant costs. We will soon have a chance to rescue the American people from the failures of the ObamaCare experiment. This is a critical moment for the Senate.

I want to go over a few updates to the discussion draft, perhaps in the hopes that some of my colleagues on both sides of the aisle will realize that, when faced with the choice of our reform plan or the status quo, the choice is clear.

After listening to a number of Senators, we made some important updates. For example, to combat the opioid epidemic that is ravaging the country, our new draft includes an additional $45 billion for substance abuse and recovery.

As this chart indicates, the number of people with HIV has gone down to 6,400, thanks to innovations and drug therapy, principally. As to car accidents, 37,000 people a year die in the United States as a result of car accidents, but 52,000 people—and growing—lose their lives due to opioid and other drug overdoses.

This is an epidemic that has to be dealt with. The abuse of heroin and prescription painkillers is devastating families and communities all across the country, but, particularly, we hear from our colleagues in Ohio, West Virginia, and Kentucky that this is an urgent and unmet need.

These additional resources will be critical for providers, for advocates, and for families on the front lines of this crisis. As I said, our colleagues from Ohio, West Virginia, New Hampshire, and other places advocated for something called the Comprehensive Addiction and Recovery Act last year, which we were able to pass to address this crisis, and we passed additional legislation called the 21st Century Cures Act in December, which, again, added additional resources. But this represents the single largest allocation or appropriation of Federal dollars to deal with this crisis than has ever occurred before. I think it is because it is necessary, and I thank our colleagues for bringing this to our attention. This is a shocking statistic, when you think about it—that more people die of drug overdoses in America today than die in car accidents—and we are going to do something about that in this legislation.

We are also introducing a provision that, for the first time, would allow people to use pretax dollars to pay for their insurance premiums. Let's say you paid 25 percent of your income to taxes. If you can use pretax dollars, then, basically, that effectively lowers your out-of-pocket cost if you can use pretax dollars rather than the net of tax.

We expand the use of health savings accounts to give people that ability, which effectively lowers the cost of their premiums, again, and provides them more flexibility in terms of determining how to provide for their healthcare. Some people may decide—and we want to give them the freedom to do so—to say: Maybe, all I need is a hospitalization policy in addition to a health savings account, where I will put pretax dollars in there and save them and use those to pay for doctors' visits.

That is the kind of thing that we have seen in States like Indiana and elsewhere, which have been used very effectively to provide additional choices for consumers and their physicians on how they address their healthcare needs and their costs. As I say, allowing consumers to use pretax dollars to pay for their health insurance premiums will help bridge the coverage gap.

Both the Congressional Budget Office and the Joint Committee on Taxation have affirmed that this will help boost access to healthcare coverage.

Another improvement this latest discussion draft brings forward is more options to buy lower premium plans. Under the Better Care Act, anyone in the individual market is allowed to purchase a lower premium health insurance plan, like the one I mentioned.

While those plans have lower monthly costs with a higher deductible, they will still cover up to three primary care visits a year and, ultimately, limit an individual's out-of-pocket costs. Coupled together with the health savings account, this may well be the most affordable way for people to address their healthcare.

Not everybody is the same. That was part of the problem with ObamaCare. It treated us all like we were widgets and not human beings with unique needs, depending on our family circumstances or our health condition or what part of the country we lived in. This allows people to personalize and individualize their own healthcare plan.

I think this is great news for otherwise healthy adults previously barred from purchasing these plans under ObamaCare. Young people, whom we need in the insurance pool in order to bring down premiums for everybody else, don't want to have to subsidize older folks' health coverage. They want to pay the freight for their own costs, but this will allow them access to a lower cost plan that will allow them to be covered for an unexpected hospitalization or other catastrophic event.

In addition to this freedom of choice, these plans will now also be eligible for tax credits. In other words, what we provide is a refundable tax credit, which essentially is a check from the Federal Government to the insurance company to pay your health insurance premium.

Under ObamaCare, people enrolled in these sorts of catastrophic plans were prohibited from receiving tax credits like the ones we are offering, even when they met all other eligibility requirements. That doesn't make any sense, and our legislation fixes that.

We have also made several revisions to Medicaid. I might mention that there is a lot of discussion about whether we are cutting Medicaid. I have said before that only in Washington, DC, can you spend more money year after year and be accused of cutting.

Honestly, fairly, what we do is to reduce the rate of growth for Medicaid, this uncapped entitlement program that contributed more than $20 trillion to the national debt. We put it on a reasonable budget and a rate of growth. Actually, from the beginning until the end, we will see Medicaid spending go up by the Federal government by $71 billion.

Ultimately, for Medicaid to work more efficiently for the people it is intended to serve—primarily, the children, the blind, the disabled, and the elderly frail—we need to give the States more flexibility to implement Medicaid spending based upon the unique needs of people in their States.

One of the big problems with ObamaCare is that it expanded Medicaid to otherwise healthy adults. We have a better way to deal with that, using the tax credit, the State innovation and stability funds, and something called the 1332 waivers, where the Centers for Medicare and Medicaid Services essentially is giving the States the opportunity to innovate and use the money and the tax credit to come up with something that suits the needs of their population.

Really, what we need to do is to get Medicaid focused again on the most vulnerable populations, which are the disabled, the blind, the frail elderly, and children. To improve the management of vulnerable populations such as this, now States can apply for a waiver

to utilize existing funds as they see fit to improve community-based services that these folks rely on.

Our Medicaid provisions allow the States flexibility to route funds to regions impacted by public health emergencies, which include disastrous weather events like hurricanes. Instead of being applied as a block grant or based on per capita caps, under our legislation, emergency funding will be applied where and when it is needed.

Lastly, under our Medicaid revision, States can add expansion populations under existing block grants if they choose to do so. Medicaid will always be as it has been—a Federal-State shared expense. By allowing States to be flexible in their Medicaid application, we can help them fill the gaps that the mandates under ObamaCare chose to merely gloss over. For example, in Texas, we were not a Medicaid expansion State. So young adults between 100 percent of poverty and 138 percent of poverty will now get access to a tax credit with the innovation and stability funds and these waivers, which will allow them, for the first time, to get access to private health insurance. That is good for them, and I think represents a vast improvement on the status quo—about 600,000 in Texas alone.

Our new draft includes an additional $70 billion to encourage States and help them implement these new reforms. What I have come to learn is, people don't really trust Washington, DC. Certainly, based on the experience of ObamaCare—this failed experiment where people were promised certain things that ended up not being true and created the problems we now are having to fix—I think people will have a lot more confidence in a plan that lets the Governors and lets the State leaders manage this money and address the healthcare needs of their population by people who are closest to those people rather than out of Washington, DC.

Our bill does that in a dramatic way. It takes that authority and power grabbed by ObamaCare and gives it back to the Governors and the States to manage. Based on the polling I have seen, people certainly have greater confidence in the States and their leadership at the local level to deal with this than they do under ObamaCare. If Governors want to try to come up with unique healthcare products to drive down premiums, cost sharing, or increased funding for health savings accounts, this legislation gives them greater flexibility and gives them additional funding through the Innovation and Stability Fund to do just that.

Many of us have quoted Louis Brandeis, who served on the U.S. Supreme Court, who said: States are the ''laboratories of democracy.'' It is true. You don't see any innovation at the Federal level. It is more like dealing with the Politburo. It is all command and control—central planning, which we know doesn't work very well. The States are the laboratories of democracy. If we give them the freedom to innovate and the resources to do so, I think we can expect our healthcare system to move forward.

Soon we are going to have a critical vote, one that has been 7 years in the making. While our plan is not perfect, it is certainly better than the status quo, which is why we call it the Better Care Act. This is not the end, as Dr. Tom Price, of Health and Human Services, points out. This is just the next step. We know we are going to have other opportunities to address healthcare, most notably in September, when we reauthorize the Children's Health Insurance Program, but this, by any measure, represents an improvement over the status quo.

I think there are some very useful parts of this bill that people will like if they look at it objectively and consider it fairly, but if we don't take up the bill, well, it can't be changed, and millions of Americans will continue to be harmed by the status quo. That is a decision we all have to make when we move to the bill.

Do we have enough confidence that we can make it better or are we simply going to throw our hands up and say, ''Well, I give up,'' before we even start, leaving people with the failure of the status quo?

I would like to encourage our colleagues to work with us to make this legislation better. It is unfortunate that healthcare has become such a polarizing and partisan issue. It doesn't need to be that way, but it started off with ObamaCare, which was passed along purely party lines, creating a situation where there is not bipartisan support for healthcare, generally, which is a real tragedy, given the importance this has to all of us and all of our families. Given the hand we have been dealt, we are going to plow ahead and do the best we can.

I sat down at my computer this morning, and I started to write a list of things I liked about the Better Care Act that perhaps most people haven't heard much about. No. 1, it repeals the individual mandate. This is the fine that has been imposed on people for not buying government-approved health insurance. It repeals the job-killing employer mandate. This bill will lower premiums, repeal burdensome taxes, and restore choices. It will help stabilize insurance markets and protect people with preexisting conditions. It will allow people to use pretax dollars to pay for their healthcare costs, including insurance premiums. It provides substantial resources to fight opioid and other substance abuse. It provides better quality coverage to low-income Americans that will improve medical outcomes for low-income Americans, and it puts Medicaid on a sustainable path.

I would like to encourage all of our colleagues to work with us to help make this legislation even stronger. Everybody will be able to offer an amendment and get a vote on the amendment when this bill comes to the floor. I believe the alternative is a disaster for our country, and we simply can't afford to let it stand.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Florida.

Mr. NELSON. Mr. President, I came to speak on a different subject and will not speak at length about the healthcare bill because this Senator has spoken on a number of occasions about the healthcare bill. Suffice it to say, in light of what the majority whip has just said; that if we really did want to seek a bipartisan solution to the healthcare situation in expanding healthcare for as many people as we possibly can, then what we do, in a bipartisan way, is start saying: We have a current law. Let's fix what needs fixing.

This Senator can say there are a number of discussions going on between Democratic Senators and Republican Senators about doing just that—about such items as a reinsurance fund to ensure companies against catastrophe, the likes of which, in a proposal this Senator has filed, has been costed out. In my State of Florida, it would reduce insurance premiums for health insurance 13 percent. Ideas like that—in a bipartisan way—will solve and bring stability to the marketplace. That is why insurance companies, in fact, are being vigorous in their opposition to the Senator CRUZ part of the bill that basically destabilizes the market by taking all of the older and sicker people and putting them in one pot and putting the younger and healthier people in another pot, which is exactly the opposite of what the principle of insurance is. The principle of insurance is, you spread the risk over as many people as you can and thereby can bring down the per-unit cost.

If we really wanted to fix it in a bipartisan way, we would be able to, but still, as you can see, there is not the appetite for that in this highly polarized, highly ideological, and highly partisan atmosphere we find ourselves in on this particular topic.

PROTECTING THE SCIENTIFIC COMMUNITY

Mr. President, this Senator came here to talk about another thing that is equally disturbing because there is a blatant, coordinated effort by some elected officials to muzzle the scientific community. When you start muzzling scientists, you don't come up with the facts, and you don't come up with the truth. What is being presented as facts doesn't really match the truth, and certainly the rhetoric doesn't match what is happening.

For example, just last month in the State of Florida, the Florida Legislature passed, and the Governor signed into law, a bill that allows any resident of the State—regardless of whether they have a student in school—any resident can challenge what is being taught in the public schools. So if a single resident objects to a certain subject that students are being taught