HEALS ACT

Mr. CORNYN. Mr. President, as I said, the number of COVID–19 cases has surged in recent weeks in the Rio Grande Valley, South Texas, and throughout the State as well. Just a couple of weeks ago, Texas reported more than 10,000 new cases in a single day, and that happened 5 days in a row.

It certainly was a wake-up call for many who had not had taken the most effective precautions seriously—things like social distancing, good personal hygiene, the wearing of masks if you can't socially distance, and staying home if you are sick. It is amazing what we can do as individuals to stop the spread of this virus by doing those simple things. Unfortunately, some people let their guard down and didn't follow those protocols, so we saw a huge uptick in the number of cases. Thankfully, though, I think the message has been received and understood, and we have recently seen a gradual and encouraging decline in cases.

Yet, as the war against COVID–19 wages on, we can't afford to lose any additional ground whether from a public health perspective or from an economic recovery perspective. So I believe it is time for Congress to pass additional legislation to strengthen our fight. That is why my colleagues and I introduced the HEALS Act yesterday. This legislation builds on the significant progress we have made already in four bipartisan bills that have already passed the Congress and have been signed into law by President Trump that will sustain our effort to defeat this virus and recover economically.

This legislation will ensure that workers who had the rug pulled out from under them earlier this year will continue to receive enhanced unemployment benefits.

It will provide funding to help K–12 schools, colleges, and universities safely and effectively educate their students this fall whether that means there being a combination of online or in-person instruction.

It will send additional and needed assistance to our farmers, ranchers, and producers who are keeping our families fed in the midst of the pandemic, and it will give States and local governments the flexibility they have requested and that they need to use CARES Act funding where it is needed the most.

In the coming days, I will talk more about how this legislation supports the workers and institutions that have been hit the hardest by this virus, but, today, I would like to focus on the ways it bolsters our fight against the virus itself.

One of the most important ways we can do that is through testing. The ability to identify positive cases as early as possible is the key to stopping the spread of the virus. Yet, as we have learned, there are massive numbers of people who have the virus who don't even know it and don't experience any symptoms. In short, they don't even feel sick. What we have seen, whether it be in multigenerational households or with the people who are most vulnerable to this virus—mainly, the elderly and the people with underlying health problems—is that they cannot be properly isolated unless we can identify the people who are carrying the virus even though they themselves may not be suffering any symptoms.

The first coronavirus package we passed made testing free. It removed the cost barrier that could prevent those who needed a test from receiving one. At the time, if you were asymptomatic, the CDC—Centers for Disease Control and Prevention—didn't recommend your getting a test. Some of that was because of the constraints on the numbers of tests that were available. The fact is, if you are not suffering from any symptoms, you are probably not highly motivated to go get a test because you may not even know you have the virus, and you may not know you need one.

We are testing a lot more now than we were back then. Congress has provided another $26 billion to scale up testing, and we have gone from conducting an average of 145,000 tests a day nationwide in early April to more than 780,000 per day in mid-July. So that has been a dramatic improvement. What we know is there is more we need to do.

The HEALS Act, which we introduced yesterday, will provide an additional $16 billion to support testing efforts. When combined with the approximately $9 billion that still exists from the previous bills, it will make another $25 billion available to strengthen our testing nationwide. This will help to improve our testing strategy and capacity and reduce the backlog that has left some Texans waiting more than 2 weeks for test results. These tests are not very useful if it takes 2 weeks to get the results.

Because we ramped up the number of people who were tested, the lab companies that were analyzing the tests ended up getting backlogged. Now we have taken corrective measures in cities like Dallas to make other testing available and bring that number down, but this has been a constant challenge. It needs to be as quick and easy as possible for folks not only to get tests but to get the results, and this funding helps to make sure there will be serious strides in support of that goal.

I know there are testing protocols that are being analyzed right now that may make this easier and may even make the results quicker. I know, for example, in the Texas A&M University System, Chancellor Sharp said he has contracted for 15,000 tests a month for students who will return on campus. Now, in his view, he said those students will probably be safer on campus than they will be back home, especially if they end up going to bars or other social venues and do not properly social distance or wear masks.

Beyond testing, we need additional support for the healthcare providers who have been on the frontlines. In my State, I know the Governor has asked a number of hospitals in the hardest hit areas to defer elective surgeries. As I have come to learn and as the Presiding Officer, no doubt, knows, that is how hospitals pay the bills. Many of the people who show up either get charity care or the payment through Medicaid or Medicare is less than that from private health insurance, so hospitals need a mix of elective surgeries and other treatments so they will have full insurance coverage in order to balance their books overall.

Congress has already provided $175 billion for a healthcare provider relief fund, which has given hospitals, clinics, and physicians the resources they need to continue treating COVID–19 patients and stay afloat financially. So far, more than 20,000 hospitals and healthcare providers in my State alone have benefited from that funding, with over $4.1 billion coming to Texas.

The HEALS Act will supplement that fund with an additional $25 billion to help these providers navigate the surge in cases and maintain critical supplies like masks, gloves, and ventilators. If our hospitals don't have the personal protective equipment to protect the frontline staff, the resources to treat patients, or the funding to keep their doors open, we will be in bad, bad shape. This legislation will go a long way to making sure we don't ever reach that point.

In addition to supplementing the healthcare provider relief fund, this legislation will also support some of our most critical health resources. We know our community health centers are an important part of the safety net when it comes to accessing healthcare. This bill will provide $7.6 billion to our community health centers, which usually serve people on a sliding scale based on their ability to pay. Some people have full insurance coverage; others are covered by Medicare or Medicaid; and some simply don't have the means to pay at all, but all are welcome and are treated at our community health centers.

We also send $4.5 billion to mental health, suicide prevention, and substance use disorder services. We all know that the mitigation efforts we have all been engaged in by staying in our homes and not leaving for a period of time, as instructed by public health and other government officials, has exacted a very difficult toll on families, particularly on people who have had nowhere to go to escape somebody who has been abusing them in domestic violence scenarios or on people who are simply feeling a sense of isolation and a challenge to their mental health as they wonder how they are going to pay the bills and take care of their families. Maybe they have loved ones who are in nursing homes—the elderly are particularly vulnerable—whom they haven't been able to see because of the isolation efforts.

And then we know people will self-medicate with alcohol or drugs. So this

$4.5 billion is important to help provide the mental health, suicide prevention, and substance use disorder services that are going to be needed not only right now but in the indefinite future.

We also provide an additional $15 billion to the National Institutes of Health for research and an additional $26 billion for vaccine research.

We know our frontline healthcare providers have gotten much, much better and saved many more lives by coming up with treatments that actually have been effective. Some of these are common prescription drugs that are used for other purposes that have been repurposed for treatment of COVID–19 symptoms.

We know that convalescent plasma, taken from people who have had the virus, who have developed immunities, when they donate blood, that plasma can actually be used to help treat patients with serious COVID–19 symptoms.

And we know that there are other treatments in progress, along with the race to get a vaccine. Ultimately, we know that the vaccine is going to be important to our ability to defeat and live with this virus.

But in the meantime, we know we need to learn to live with this virus in a way that protects our public health and allows us to safely reopen our economy.

So the last thing I want to mention is liability protection. Why is this so important?

Well, as many nonprofits or businesses think about reopening, thinking about kids going back to school safely—whether online and then transitioning to in person, or colleges and universities—we know that there are going to be a lot of lawsuits filed, second guessing why people didn't do something different, when, in fact, this pandemic has surprised all of us in so many ways.

And what this does is provide a safe harbor from legal liability for those individuals who followed government guidance in good faith. It can't be the fact that you would subject a frontline healthcare worker who had no choice but to put on personal protective equipment and go to work to treat patients—it would be a cruel joke to say: Now we are going to come back and file lawsuits against you and sue you for money damages because you didn't somehow know exactly what you were dealing with.

We know that frontline healthcare workers are performing a physically and mentally taxing job, made only more difficult by the fact we didn't understand exactly what we were dealing with, with this novel virus, and we are still learning more.

Well, I learned, for example, about a rural hospital where test kits are in short supply. In fact, it was especially true in the early days as testing infrastructure was being stood up, and I mentioned that a moment ago.

I learned about a hospital in a rural community outside Wichita Falls that only had 12 tests available. Because of limited resources, a physician made the difficult decision not to test an ER patient for COVID–19 because the patient didn't meet the criteria set out by the Centers for Disease Control. The following day, that same patient went to Wichita Falls and received a test, and several days later found out that they tested positive.

Now, imagine you are that physician. You followed the CDC guidelines for testing; you tried to conserve the limited resources available in your community; but there is nothing stopping the patient from heading to the nearest lawyer's office and filing a lawsuit against you for somehow refusing them a test.

All of a sudden, you are scrambling to defend yourself in a lawsuit that, quite frankly, should not have been filed in the first place.

But I have spent enough time in courtrooms to know that many times lawsuits are not filed with the goal of actually prevailing on the merits; they are filed in order to gain a settlement because the cost of defending yourself can be large, indeed. And, in fact, if you are a business that has been hanging on by a thread, just the threat of that kind of litigation and the expense and energy it takes to defend that case, even though it lacks merit, could well cause you to throw in the towel or put you out of business.

So we have introduced, as part of this HEALS Act, legislation that will provide that safe harbor. It will not provide blanket immunity; it will not protect against intentional or reckless misconduct; but it would establish clear guardrails like those in a number of States. As a matter of fact, 30 different States have passed similar protections for their healthcare workers. Other States have done it in other categories, but it is important, I believe, for us to provide clear authority so people know what they are dealing with.

I would note, for example, that some of these same guardrails are very similar to those enacted by Executive order in the minority leader's home State of New York. I know the legislature has now sent Governor Cuomo another bill, basically, with the same framework, and he has not yet made a decision to sign that.

But overall the HEALS Act will help provide the resources Texas hospitals, clinics, and healthcare providers need to sustain and win this fight, while protecting our heroic healthcare workers from a second epidemic in the courtroom.

So I hope both sides of the aisle will work together, as we have in the past on COVID–19 response legislation, and make sure we can get a bill to the President's desk on a timely basis that delivers these and other necessary changes at a critical time for our country.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

The PRESIDING OFFICER (Ms. MCSALLY). Without objection, it is so ordered.

Mr. LANKFORD. Madam President, Senator DURBIN and I have worked for months on an issue on rural healthcare. Whether it is in rural Illinois or it is in rural Oklahoma, there is a challenge dealing with rural hospitals and sustaining their viability.

So Senator DURBIN and I partnered together to determine what is the best way to get a solution that is a long-term solution to what they are currently facing with COVID–19.

While COVID–19 has impacted all types of businesses, rural hospitals have uniquely dealt with some very difficult challenges. Getting PPE early on in the process was much more challenging for rural hospitals than it was for urban—keeping doctors, managing separation, getting airflow areas in hospitals to manage the flow of the virus through areas, and also managing just patient count, where, for many rural hospitals, they just shut down because all elective surgery was stopped and such, and so they lost all of that income, though they still had all the employees. It was an exceptionally challenging thing, but it is challenging on top of the challenge that they have already faced for decades in just surviving in rural America.

So what Senator DURBIN and I have brought is a reasonable, nonpartisan solution to how we can deal with not only COVID–19 but to help rural hospitals long term.

Decades ago, Congress established something called the critical access hospital and made sure that those hospitals that were designated ''critical access hospitals'' would receive proper reimbursement from the Federal Government for healthcare services.

Many individuals in rural areas—in fact, the dominant proportion in many rural areas receiving healthcare are receiving it through Medicaid or Medicare. We want to make sure that those providers providing those high-need areas are reimbursed appropriately.

But, in 2006, Congress shifted the designation for critical access hospitals and took away something called the necessary provider, giving the flexibility to the States.

As a result of that action in 2006, we have seen the closure of 118 rural hospitals nationwide since that time period. The ''critical access hospital'' designation was created because of a string of hospital closures in the 1980s and early 1990s. Yet we have not responded in the way that we should from the change in statute in 2006.

Simply what we are trying to do is to give that flexibility back to States again. If they have a hospital in a rural area that is the only provider in that community that is a Medicare-dependent hospital or is a very small hospital

with fewer than 50 beds, that area has to be an area that is designated as a rural area. It can't just be any suburban area or any other type of hospital. It has to be a rural hospital in particular. It has to have a high percentage relative to the national average of individuals with income below the poverty line. Those hospitals in those locations could be designated by their States as a necessary provider and be treated as if they are a critical access hospital. What would that do? That would be a lifeline for reimbursement because now we have some rural hospitals designated as critical access and some hospitals that meet all the other criteria, but they may be 34 miles away from another hospital, so that hospital in that county dies while the other hospital survives. In my State, we have a critical access hospital 34 miles away from a hospital across the border in Texas, so the hospital in Oklahoma can't get the critical access designation and can't survive because 34 miles away there is a hospital in another State that has the critical access.

We need the flexibility in our States to be able to do this kind of designation. Senator DURBIN and I have run this through a lot of places and a lot of people, and we have gotten a lot of technical input in it to make sure this actually works for our rural hospitals and provides not just a short-term survival through COVID–19 but also provides long-term stability for them. This is the kind of work we should do together to make sure we stabilize those rural hospitals. They are a lifeline to people in rural America. They are a lifeline of employment, and they are a stable feature in every community. Without them, those communities dry up because people need access to healthcare, and this is the way that they can get it.

I am glad to partner with Senator DURBIN on this issue, and it is our hope to get this into the next bill dealing with COVID–19 in the days ahead. Quite frankly, it was our hope to get it into the last one—we didn't get it—and into the one before that. Surprisingly enough, everyone seems to be nodding their heads on both sides of the aisle saying: That is a good idea. That will be effective. We want to move it from ''that is a good idea'' to ''done'' for the sake of rural hospitals across the Nation.

With that, I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. I thank my colleague from Oklahoma. I could not have said it any better or more effectively than he just did.

Like Oklahoma, downstate Illinois has an area of smaller cities and rural towns and smalltown communities. Many of them are lucky enough to have great hospitals, and they love their hospitals. They are not only important sources of medical care; they are a major part of the local economy and really are a rallying point for communities. Auxiliaries, volunteers, and so many people make these hospitals the focal point when you visit these communities. They are so proud of them.

Of course, we are worried about what this current pandemic is going to do. I have had conference calls with leaders from almost 120 hospitals across Illinois. I invited Members of Congress in, so we had bipartisan exchanges about the current state of affairs. One hospital CEO from Crawford County, downstate along the Indiana border, told me that he used to pay 22 cents for a surgical gown, and now he pays between $11 and $20 for each one. Hospitals are facing limited access to reagents, swabs, and supplies that they need. The Heroes Act would direct the administration to utilize the Defense Production Act to help solve that problem, and I commend Senators MURPHY and BALDWIN for their legislation, which I am joining, to do the same.

One of the most profound consequences of the pandemic is the impact on the solvency of these hospitals. Across Illinois, rural hospitals are the heart and soul of the community; otherwise, people drive literally for hours to get medical care, sometimes in emergency situations. They are important parts of the local economy. We think downstate hospitals generate $5 billion into our State economy each year, and I don't doubt that.

This pandemic has pushed them to the brink. Even prior to this crisis, they were facing financial uncertainty. Half of rural hospitals were operating in the red. One in four were at risk of closure. As the Senator from Oklahoma mentioned, 120 have closed across the Nation in the past decade.

We have fared a little better in Illinois, but we are worried about the future. When a rural hospital closes, not only do doctors disappear, but jobs disappear, and businesses struggle to stay.

The coronavirus pandemic has accelerated and compounded the strains we face. We believe our Illinois hospitals are losing $1.4 billion each month. Many, like those near nursing homes and meat processing plants, have had to expand surge staffing to deal with COVID patients. All have been forced to cancel outpatient and elective services. In Illinois, 70 percent of rural hospital revenues are from outpatient services. The same is true in neighboring States like Kentucky.

Nationwide, rural hospitals have on average only 33 days of cash on hand. There is an immediate need to stabilize, and that is why we have come up with this bipartisan plan. Senator JAMES LANKFORD and I have introduced a bill called the Rural Hospital Closure Relief Act. It is supported by the American Hospital Association and the National Rural Health Association. It would update Medicare's ''critical access hospital'' designation to provide flexibility around the 35-mile distance requirement, so more rural hospitals would qualify for additional payments from the Federal Government.

We project that six hospitals in Iowa and scores more in Illinois, New York, and Kentucky would qualify for this financial lifeline, securing their stability. We do it in a restrained, cost-effective manner by focusing on the hospitals that have faced financial losses and are located in areas with a shortage of healthcare providers. It is common sense.

This bipartisan bill is a priority for us. We want to make it a priority for the Senate, and we hope to do so. We know that we have come to this discussion with a good, encouraging conversation with Senator GRASSLEY today in support of the Iowa Rural Health Association. The CEO and leader of the Kentucky Rural Health Association projects that more than 18 rural hospitals in that State are at high risk of closure. We hope to make that point very clear to the majority leader. Several of them would be helped by our legislation.

With a spike in COVID–19 cases across rural America, we have seen hospitals reaching capacity, and we need to make sure that our hospitals—the ones we are talking about in rural areas—survive. The health and economic toll of this crises demands it. I hope that Democrats and Republicans in the Senate include this in any bipartisan package. The cost of inaction will be disastrous.

Senator LANKFORD and I were prepared to seek passage of this bill by unanimous consent today, but we have been encouraged to continue negotiating with our colleagues to see if we can make it part of the package—a timely part of the package—in the near future. I hope that is the case, and we will hold off from any unanimous consent request because of that hope.

UNANIMOUS CONSENT REQUEST—H.R. 6

Mr. DURBIN. Madam President, last month, in a landmark decision, the Supreme Court rejected President Trump's effort to repeal deportation protections for Dreamers. Those are the young immigrants who came to the United States as children.

In an opinion by Chief Justice John Roberts, the Court held that President Trump's attempt to rescind DACA, Deferred Action for Childhood Arrivals, was ''arbitrary and capricious.''

Those were the words of the Court.

More than a month later, the Trump administration has refused to restore the DACA Program despite the decision written by the Chief Justice. The administration is now in open defiance of the Supreme Court when it comes to the DACA Program. The stakes are too high, both for the rule of law and the lives of these young Dreamers, for us to ignore it. Republicans and Democrats in Congress need to come together to compel the President to immediately comply with the Supreme Court mandate.

On June 4, 2019, the House of Representatives passed H.R. 6. In 2019, they