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Senate

The Senate met at 9:30 a.m. and was called to order by the Honorable RAND PAUL, a Senator from the Commonwealth of Kentucky.

PRAYER

The Chaplain, Dr. Barry C. Black, offered the following prayer:

Let us pray.

Beautiful Savior, You have been our dwelling place in all generations, and we are sustained by Your steadfast love. Today, surround our Senators with the shield of Your favor, as they labor to keep our Nation strong.

Lord, teach them to be obedient to Your commands, doing Your good will as Your presence fills them with joy. May they be quick to listen, slow to speak, and slow to anger. Manifest Your power throughout their labors, so that this Nation will be exalted by righteousness.

May Your angels guard us in all our ways.

We pray in Your mighty Name. Amen.

PLEDGE OF ALLEGIANCE

The Presiding Officer led the Pledge of Allegiance, as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore (Mr. HATCH).

The legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, July 26, 2017.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable RAND PAUL, a Senator from the Commonwealth of Kentucky, to perform the duties of the Chair.

ORRIN G. HATCH,
President pro tempore.

Mr. PAUL thereupon assumed the Chair as Acting President pro tempore.

RECOGNITION OF THE MAJORITY LEADER

The ACTING PRESIDENT pro tempore. The majority leader is recognized.

HEALTHCARE

Mr. MCCONNELL. Mr. President, the Senate took a critical step yesterday afternoon to finally leave the failed experiment of ObamaCare in the past. It marks an important moment for our country. It signals a positive development for the countless Americans who continue to suffer under ObamaCare's skyrocketing costs and diminishing options.

I thank every colleague who voted to begin the debate. I thank the President, his administration, and our friends in the House for the roles they have played.

Now we have to keep working hard. We are determined to do everything we can to succeed. We know our constituents are counting on us. We will work through an open amendment process. I know Members in both parties have healthcare ideas they would like to offer. If you have one, bring it to the floor.

Last night the Senate considered a comprehensive ObamaCare repeal-and-replace substitute. That amendment was subject to a 60-vote threshold because the Congressional Budget Office had not provided a score for that provision as yet, but it represented a number of important healthcare reform ideas developed by our Members.

Later today, the Senate will vote on another alternative that is based on the ObamaCare repeal legislation that passed Congress in 2015 and was vetoed by President Obama.

We will consider many different proposals throughout this process from Senators on both sides of the aisle. Ultimately, we want to get legislation to finally end the failed ObamaCare status quo through Congress and to the President's desk for his signature.

This certainly will not be easy. Hardly anything in this process has been. We know that moving beyond the failures of ObamaCare is the right thing to do. We have put a lot of hard work already into this. We have had important successes, as we saw with the vote to proceed yesterday. We have to keep up the work now so we can get this done.

RESERVATION OF LEADER TIME

The ACTING PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

CONCLUSION OF MORNING BUSINESS

The ACTING PRESIDENT pro tempore. Morning business is closed.

AMERICAN HEALTH CARE ACT OF 2017

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate will resume consideration of H.R. 1628, which the clerk will report.

The legislative clerk read as follows:

A bill (H.R. 1628) to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017.

Pending:

McConnell amendment No. 267, of a perfecting nature.

Enzi (for PAUL) amendment No. 271 (to amendment No. 267), of a perfecting nature.

Donnelly motion to commit the bill to the Committee on Finance with instructions to report back with instructions.

The ACTING PRESIDENT pro tempore. Under the previous order, the

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

time until 11:30 a.m. will be equally divided between the leaders or their designees.

Who yields time?

If no one yields time, time will be charged equally to both sides.

RECOGNITION OF THE MINORITY LEADER

The Democratic leader is recognized.

Mr. SCHUMER. Mr. President, I ask unanimous consent that my speaking time be taken from leader time, not the debate time.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. SCHUMER. Mr. President, as the Senate continues the debate on the Republican healthcare bill, it seems the Republican majority is no clearer on what the endgame is because there is no good way out of this.

Last night, the Senate Republican TrumpCare bill—after months of backroom negotiating and provisions aimed at all kinds of individual States and Members—died, with nine Republicans voting against the measure and many others who voted for it gritting their teeth unhappily.

Later today, we will vote on a bill to repeal the Affordable Care Act without replacing it. I know that you, Mr. President, have championed that bill. Based on public comments and public criticism from the other side of the aisle, repeal without replace will fail as well. It is becoming clearer that in the end, the majority leader might push a much scaled-back version of repeal in the hopes of passing something—a so-called skinny repeal—just to get to conference. My colleagues, make no mistake about it, skinny repeal is equal to full repeal. It is a Trojan horse, designed to get the House and Senate into conference where a hard-right flank of the House Republicans, the Freedom Caucus, will demand full repeal or something very close to it. They will demand all the things—deep cuts to Medicaid, generous tax breaks for the wealthy, elimination of preexisting conditions, slashing the kinds of things people need for nursing homes and opioid treatment and disabled kids—that many of my Republican colleagues in the Senate have very sincerely tried to undo.

There is no such thing as skinny repeal. It is a ruse to get to full repeal, with all the concomitant cuts to Medicaid and tax breaks which are so unpopular and which so many of my Republican colleagues here on the other side have opposed. It is clear House and Senate Republicans are miles apart. They are divided on major issues—on Medicaid, tax breaks, and preexisting conditions. The differences between House Republicans and Senate Republicans are virtually irreconcilable. So what is the point of a conference?

You can imagine a conference that turns into an endless game of hot potato; the Republican leader and the Senate passing the potato to the House; the Republican leader of the House passing the potato back to the Senate because neither wants to be responsible for what is inevitable: the demise of TrumpCare. Of course, it is likely a conference could probably produce no agreement at all, keeping the incredibly toxic and unpopular TrumpCare bill the topic of conversation for another 3 months, stalling the legislative agenda for another 3 months, and in the end getting nothing done.

My Republican colleagues should consider that. Many of them want to work with us on so many issues. Above all, NDAA, which my dear friend JOHN MCCAIN, who we pray for every day, wants to get to right away, and the Energy bill, which my colleague from Washington and her chair, the senior Member from Alaska, could bring to the floor and get moving in a bipartisan way. Leader MCCONNELL has made it clear he wants to move nominations.

If we stop playing this game with TrumpCare and send it back to committee and do regular order, as JOHN MCCAIN preached so well yesterday, we could move on to all these other things in a good, strong bipartisan way and start to get things done. My Republican colleagues should consider that carefully.

We Democrats want to start working with our Republican colleagues on the issues I mentioned. We also want to work on improving ACA. No one has ever said ObamaCare was perfect. I have called five or six of my Republican colleagues on the other side and said if we stop this effort with TrumpCare—with repeal or repeal and replace with something far worse than the present—we can go back to committee and improve the present healthcare system and get premiums lower, make healthcare better, and stabilize the system so there is more competition. We will do that.

My good friend the Senator from Wyoming, not the Senator sitting here but his colleague—I heard he was saying to some Members: Oh, the Democrats will never negotiate. SCHUMER will never negotiate. I saw him last night on the floor, and I assured him we will. That is our goal. He accepted that in good faith, which I very much respect.

So the bottom line is simple. I say to my Republican colleagues, when you find yourself in a hole, the first rule is stop digging. By continuing this process—trying to send something, anything, to conference with the House—Republicans are just digging a deeper and deeper hole for themselves and for this body. I implore my Republican colleagues to stop digging and come work with Democrats. We can work to improve our Nation's healthcare system, but Republicans have to turn back soon, and they are running out of chances.

One more thing I would add. I heard my friend the Republican leader say we are going to have a full amendment process. He is trying to convince the folks on the other side that, oh, we will do a bunch of amendments, and then we will have no choice, we will have to send something to conference because we couldn't get anything major done. That is a lot of bunk. We have had no hearings, we had no amendments, we had no bipartisan discussions, and we will not even be able to have debate on many amendments on one of the most major bills affecting us, that affects tens of millions of people's health, and affects one-sixth of the economy. Don't fall for this, oh, we are having a full process. I like my friend the Republican leader. We get along well, but sometimes he says things that when I hear them, I get a little twinge in the stomach. We have a full and open amendment process, he said three or four times. Everyone in this Chamber knows that is not the case. Don't be deluded into thinking, well, we tried. We haven't tried until we go back to regular order.

COMMENTS OF THE PRESIDENT ON ATTORNEY GENERAL SESSIONS

Mr. President, on another matter, President Trump continues to find new ways to humiliate his own Attorney General, Jeff Sessions, a man who stuck his neck out for the President before any other Senator would. I heard President Trump say: I was already popular. As I remember it, when Jeff Sessions supported him, he was an underdog, and everyone said: Wow, Jeff Sessions is doing that out of loyalty and friendship with Donald Trump, not because he was jumping on a train that was headed down the track. Maybe he saw that, but no one else did, and now the President humiliates him.

I would say to my fellow Americans—Democratic, Republican, liberal, conservative—every American should be troubled by the character of this person who humiliates and turns his back on a close friend after only 6 months. We are already far beyond the dangers of a chilling effect at the Department of Justice. The President is taking almost every opportunity in public to demonstrate an open hostility toward the Attorney General. It seems clear the President's intention is to make life unbearable for the Attorney General, hoping to prompt his resignation. All Americans should be wondering why the President is publicly demeaning and humiliating such a close friend and supporter—a member of his own Cabinet. They should wonder if the President is trying to pry open the office of Attorney General to appoint someone during the August recess who will fire Special Counsel Mueller and shut down the Republican investigation. Let me say, if such a situation arises, Democrats will use every tool in our toolbox to stymie such a recess appointment.

Second, I can't imagine my friends on the Republican side, particularly my friends in the Republican leadership, the majority leader and Speaker RYAN—I can't imagine they would be complicit in creating a constitutional crisis. They must work with us and not

open the door to a constitutional crisis during the August recess.

SANCTIONS BILL

Mr. President, one final point because I know my colleagues are waiting: sanctions—finally, a word on them. Yesterday, the House of Representatives passed nearly unanimously, 419 to 3, a sanctions bill that was a product of bicameral, bipartisan negotiations and includes strong sanctions against Russia, Iran, and North Korea. The Senate must act quickly on the legislation from the House.

I understand that earlier today the chairman of the Foreign Relations Committee indicated he plans to strip out a section of this package that relates to North Korea. This is yet another delay generated by Republicans to prevent this bill from landing on the President's desk before we leave for the recess. Even as we debate other items here on the floor, we shouldn't delay this legislation any longer.

I will work with the majority leader to schedule another vote on the sanctions bill so that we can send the legislation to the President's desk before the recess, and I expect the vote will constitute a veto-proof majority, just like the vote in the House.

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

The PRESIDING OFFICER (Mr. COTTON). The Senator from Washington.

EXPORT-IMPORT BANK

Ms. CANTWELL. Mr. President, I saw the remarks of the President of the United States in Youngstown, OH, and it has brought me to the floor this morning because the focus of some of his speech was on the economy and job creation. Well, I can tell the President right now that we need his urgent attention to making sure that we create jobs right now. It is not about something in the future; it is about right now.

There are over 40 projects worth $30 billion being held up because the Export-Import Bank does not have a quorum. It is incredibly important to get a functioning bank and to get a board that supports having the support of a credit agency to work with the private sector to finance the sale of U.S.-made products.

The President seems to embrace the notion that we should make things in America. I think we should make things in America, but I don't think that we sell them only in America. I actually want to sell the great manufactured products of the United States of America to overseas markets, to the 95 percent of consumers who are outside the United States. But because this administration has not shown the leadership to get a functioning Export-Import Bank, we continue to struggle. Those $30 billion in projects are being held up because we don't have a functioning quorum.

GE Aviation in Ohio—I wish he would have visited them because they decided to move part of their operations to Canada and Brazil, instead of expanding in Ohio, to take advantage of countries that actually have a credit agency. GE Aircraft Engines decided to open a turbine prop engine facility in Europe for the same reason. We are losing jobs simply because we don't have a tool to work with private-sector banking to make sure that the sale of U.S.-manufactured products actually gets done to countries and organizations in those countries that don't have the proper financing. GE supposedly said that they weren't going to move their corporate headquarters to Ohio because they did not support the reauthorization of the Export-Import Bank.

Between 2012 and 2016, the Export-Import Bank supported more than 255 export deals in Ohio from all sizes of companies, such as Haltec, which exports auto parts, and Anglo American Hardwoods, which exports wood products to the GE Aviation that I mentioned and GE Aircraft Engines. These deals were worth more than $2 billion.

What I am so frustrated about is that this administration has not kept its word in support of the Export-Import Bank. We continue today with the folly of having our Trade Ambassador show up before the Finance Committee and say that the Export-Import Bank is controversial. I reminded him that it was actually supported by a majority of Democrats and a majority of Republicans in the U.S. Senate. It was also supported by a majority of Republicans in the House of Representatives and the Democrats in the House of Representatives. So how could it be so controversial if we reauthorized it?

But the White House has continued to have a double-edged strategy, pretend that they support the Export-Import Bank, and yet send up the name of a nominee to chair the bank who wants to destroy the bank and has made that intention clear.

If we want jobs in Ohio, we need to get the Export-Import Bank approving deals from manufacturers that are ready to close sales and create more jobs, so let's focus on the task at hand. I hope the President will stand up and clearly articulate the need and support for an Export-Import Bank and stop sending us the name of someone who just wants to destroy it.

I thank the Presiding Officer.

I yield the floor.

The PRESIDING OFFICER. The Senator from Wyoming.

REQUESTS FOR AUTHORITY FOR COMMITTEES TO MEET

Mr. ENZI. Mr. President, I have 12 requests for committees to meet during today's session of the Senate. They do not have the approval of the Democratic leader; therefore, they will not be permitted to meet past 11:30 this morning, but I ask unanimous consent that a list of committees requesting authority to meet be printed in the RECORD.

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

Committee on Commerce, Science, and Transportation,
Committee on Environment and Public Works,
Committee on Foreign Relations,
Committee on Homeland Security and Governmental Affairs,
Committee on Indian Affairs,
Committee on the Judiciary,
Committee on Veterans' Affairs,
Committee on Aging,
Subcommittee on Public Lands, Forests, and Mining,
Subcommittee on Africa and Global Healthy Policy,
Subcommittee on Investigations.

Mr. ENZI. Mr. President, I listened with a lot of interest to the Democratic leader's comments this morning and his proposal that there would be cooperation if we went to a system of putting it back through committees and doing that, but I have to say that we would have a lot more confidence in getting a solution if there were a single positive suggestion from the other side for a change. Until that happens, there isn't much confidence on our side that the promise of bipartisanship is going to happen.

They keep saying that it isn't perfect, but they don't put forward ideas for any of the changes. We have been suggesting changes for several years, and we have been told each time that it just needed a little more time, that it was a perfect bill.

Soon we will be trying to do a budget. It would be nice if we had some suggestions on budget items that were positive things. I put out that offer as well.

The reason we are having this is that more than 7 years ago, President Obama and congressional Democrats imposed a risky, partisan healthcare experiment on America that ultimately led to skyrocketing healthcare costs and collapsing insurance markets for millions of Americans across the country. This riverboat gamble has caused a stark and dramatic outcome. Currently, there are projected to be 50 counties across the Nation that will not have a single insurer participating in the ObamaCare exchange.

To add further insult, Americans seeking affordable coverage in these almost 50 counties will still be fined under the ObamaCare mandate for not having health insurance. In other words, many Americans will either be forced to pay for insurance they cannot afford or pay a penalty for not having health insurance under this so-called Affordable Care Act, which they can't even access. Where are these people supposed to go? What can we do to help? Again, we are looking for some positive suggestions.

My colleagues on both sides of the aisle know that this healthcare experiment has failed and that we must work together to free Americans from these mandates and put healthcare decisions back in people's control.

Today, Senate Republicans are taking an important step to rescue the millions of hard-working families trapped by ObamaCare's taxes and

mandates. We are trying to repair the Nation's broken healthcare system because we now have a President in the White House who shares our commitment to improve America's healthcare system and make better care available to all Americans.

One of our top priorities in Congress has been to provide relief for hard-working Americans from ObamaCare, which has pushed insurance markets to the brink of collapse. In Wyoming and across the country, premiums for hard-working families are soaring while choices for patients have dwindled. As I travel across Wyoming, I have a lot of people who tell me that their health insurance costs more than their mortgage and, if they ever need healthcare, they have a deductible that is bigger than that.

Simply put, ObamaCare stumbled out of the starting gate on the very first date the healthcare.gov website launched. You might remember how you couldn't get on the website or how you got kicked off after you had done a lot to put in information. Yes, ObamaCare stumbled out of the starting gate on the very first day that the healthcare.gov website was launched, and it has consistently failed to deliver on its core promises while hurting far more Americans than it is helping.

One thing both parties should agree on is that an accessible and affordable healthcare system should be available to each and every American family, and I truly hope my colleagues on both sides of the aisle will work with us to find common ground on healthcare that truly delivers better care.

Millions of Americans have been suffering under President Obama's healthcare law, and this past fall our Nation voted for a change. These hard-working Americans made it clear that fixing our healthcare must be a top priority for Congress and the President. This week, we are delivering on that promise of relief from ObamaCare.

Making America's healthcare system more efficient and effective has always been an important and challenging endeavor for the public and private sector alike. President Obama and his congressional Democrats pushed Washington into the healthcare market, inflicting far greater uncertainty, cost, and disruption into the healthcare landscape than anyone ever imagined. By taking the important steps necessary to untangle Americans from this unworkable, unpopular, and unaffordable law, hard-working families can expect to see stability in the skyrocketing healthcare costs and egregious penalties imposed on them by the ill-named ObamaCare concept of ''affordable care.''

If you are young and healthy, ObamaCare has made it an easy choice to opt out of health coverage. But for those not so fortunate, for those who must have coverage, soaring healthcare costs are becoming a stunning reality. I have constituents in Wyoming who have written to me with worry and concern about their surging health insurance premiums.

I assume that my 99 other colleagues have received many letters like one I received from a family in Gillette, WY. They recently wrote me that under ObamaCare they are paying more than $2,400 a month—essentially taking on more than another mortgage.

In their letter to me, they write:

> Mike, we are small business owners in Gillette, WY. Between Obama trying to kill the coal, oil and gas industries and his insurance fraud, we are stuck between a rock and a hard place. I just paid a $2400 Blue Cross Blue Shield of Wyoming Health insurance bill. I can't keep doing that. I am a real person with real problems created by my own government. HELP MIKE HELP.

That last line of this letter is especially moving: ''HELP MIKE HELP.'' This is why Republicans in Congress and the President have focused on doing just that—helping hard-working Americans like this family in Wyoming. They are looking to us to provide real leadership and rescue them from the failed ObamaCare law.

The previous administration seemed to focus only on protecting their self-described signature legislative achievement. Our focus must be to address ObamaCare's tangled and expensive web of regulations. For families like my constituents, the situation is grim and only getting worse by the day.

One of the most disturbing parts of this law is that Americans are now essentially double-charged by having to pay more in taxes to fund the very healthcare law that is driving up the cost of their insurance premiums. Let me explain further. ObamaCare taxes have increased insurance premiums and limited options for patients and healthcare providers, including taxes on prescription drugs, over-the-counter medications, health insurance premiums, and medical devices.

Unless Congress acts, American households will be forced to pay nearly $1 trillion in new taxes and penalties over the next 10 years. Individual and employer mandate penalties forced millions of hard-working families into expensive and terribly inadequate ObamaCare plans that they did not want and could not afford. ObamaCare's crushing regulations mean smaller paychecks for families and prevent small businesses from expanding and hiring new workers.

For every American, ObamaCare has meant more government, more bureaucracy, and more rules and regulations, along with soaring healthcare costs and few choices. Working together, we can begin to lift these burdens and higher costs this law has imposed on all Americans. The bill we are debating this week will begin to provide relief from ObamaCare that millions of hard-working Americans have long demanded.

Fortunately, America now has a Congress and a President committed to helping stabilize the collapsing insurance markets that have left millions of Americans with no options.

The goal of the Republican healthcare bill will be to improve the affordability of health insurance, preserve access to care for Americans with preexisting conditions—yes, to preserve access to care for Americans with preexisting conditions—and to safeguard and strengthen Medicaid for those who truly need it. This will be accomplished by giving States more flexibility and ensuring that those who rely on this program won't have the rug pulled out from under them. Most importantly, we will free the American people from the onerous ObamaCare mandates to purchase insurance that they don't want and can't afford.

The American people have endured a lot under ObamaCare—including every broken promise. We all remember President Obama's promise to each and every American that if they liked their health plan, they could keep it. Well, Americans soon learned they couldn't keep their plan or their doctor or any extra money in their wallet. The main reason for this is because ObamaCare invaded the insurance marketplace and drastically reduced Americans' choice of healthcare plans and with it the competition necessary to contain the costs of health insurance. It was no surprise that the President's promise—if you like your plan, you can keep it—became the ultimate example of the unfulfilled and unattainable promises of ObamaCare.

For many Senators, especially from rural States like mine, the real impact of ObamaCare on our health insurance market is much more disturbing. Wyoming currently only has one health insurer in the individual market, both on and off the ObamaCare exchange. Let me say that again so there is no mistake. There is only one health insurer either on or off the ObamaCare exchange for all of Wyoming. One health insurer for all of Wyoming. Many States are experiencing a similar crisis, with only one insurer left standing since others have entirely abandoned the exchanges.

For residents of Wyoming and millions of other Americans, the Obama administration's public relations campaign—on which it spent millions of taxpayer dollars—touted choice that ultimately became false advertising. This is the actual ''choice'' for millions of Americans: one and none—but the ''none'' will cost you because of the mandate penalty. You can't afford it, so you don't get it, and then it costs you because of the mandate penalty.

What about the promise of lower healthcare costs that provided the foundation for my colleagues on the other side of the aisle to pass this flawed bill? Even President Obama's administration admitted that ObamaCare is failing to address costs, with average premiums rising by 25 percent for silver-level plans on the Federal exchange. That means families have to decide whether to purchase unaffordable insurance or pay a fine. In most cases, they are literally paying

more money for less control of their healthcare.

Last October's dramatic premium increase was clearly on the minds of voters when they cast their ballots in the November election. Let me say that again. Last October's dramatic premium increase was clearly on the minds of voters when they cast their ballots in the November election. There is trying to be some blame put on us for those increases, but that was before last November's election.

This is a crucial time for healthcare in America. We do not have the luxury of ignoring the crisis in health insurance markets and the crushing premiums faced by families across the country. Healthcare costs for my constituents in Wyoming continue to be among the highest in the Nation, with other States not far behind.

We must act now to rescue the millions of Americans who are suffering under ObamaCare in order to provide relief to those who have been harmed by this law. Unwinding this failed law to make meaningful changes has not been easy, but Americans are relying on us to accomplish this task and keep the promise to rescue them from ObamaCare. Our goal is to create a healthcare system where Washington gets out of the way and families are again empowered to control their own healthcare, with more choices and lower costs.

So this is where we find ourselves today. Congress and the President are fulfilling their promise to provide relief for millions of hard-working Americans trapped by Obamacare's taxes and mandates. We are not tied to any single idea. We hope our Democratic colleagues will ultimately join us in this worthy endeavor. The American people are expecting us to act. We must not let them down.

I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

Ms. WARREN. Mr. President, since the Republicans have announced that their top legislative priority in this Congress would be to rip away healthcare from millions of Americans, I have come down to the floor many times to beg them to reconsider. I shared stories about families in Massachusetts who gained quality healthcare coverage for the first time after the passage of the Affordable Care Act. I shared statements and letters from hospitals and doctors in Massachusetts talking about the incredible difference healthcare coverage makes for the patients who walk through their doors. I have also shared many, many stories from parents with children who have complex medical needs—all of those children depending on Medicaid.

I know that families, doctors, hospitals, nursing homes, and patients lying in their hospital beds haven't just been sharing their stories with me; they have been begging every Republican in the Senate to listen to them as well. People share their stories because they want to make a difference. These are the stories of families we represent. They are the reason we are here in the Senate. They are supposed to be our guiding light for the choices we make and the way we vote.

Senate Republicans who voted yesterday to move forward with their effort to rip away Americans' healthcare are not listening to the people they represent. Their vote was irresponsible. It was reckless. It was cruel. It was immoral. But more than that, this was a vote that is not who we are as a country.

Let's be very clear about what is happening on the floor of the Senate right now. Fifty Republicans have voted to open debate on a series of bills, each of which would have devastating effects for healthcare in this country. Now the Republicans don't know which of these bills will actually be the ones they will be asked to vote on. Only some of the bills have been analyzed by the number crunchers over at the Congressional Budget Office, the CBO, to estimate exactly how many people would be kicked off insurance and how high premiums would go, but every version that the CBO did examine over the last few weeks was very ugly, with tens of millions of people losing their coverage and costs skyrocketing for millions more.

The latest plan Senator MCCONNELL has been floating behind the scenes would have Republicans ultimately vote on what is called a skinny repeal bill. This bill would make a limited set of changes to the Affordable Care Act—just the important stuff. What is important to Senator MCCONNELL? It seems to be the part of the Affordable Care Act that makes the health insurance system actually work, because the skinny bill would repeal the parts of the ACA that say everyone needs health insurance coverage. This is the individual mandate.

Republican leadership is telling their Members that if they vote for this skinny bill, they can hammer out the rest of the details in conference with the House of Representatives. But make no mistake—this isn't a more moderate version of the Republicans' ugly plan to repeal the Affordable Care Act. This isn't compromise. In fact, this may be the worst idea they have had yet because if Senate Republicans vote to repeal the individual mandate, they are getting rid of the linchpin of the insurance markets in this country. That is because this provision—the one the Republicans want to junk—is what keeps the price of insurance affordable for people with preexisting conditions.

Don't just take my word for it. Independent experts have looked at what would happen if the Republicans repeal the individual mandate. Boy, it is not pretty. Just yesterday, the American Academy of Actuaries—these are the experts who study how insurance works. They do that for a living. These are their numbers. They wrote to Senate leadership begging them not to go forward with this reckless plan. They wrote that eliminating this part of the health law ''would likely have significant implications for health care coverage and costs both to consumers and the federal government.'' They said that it would ''lead to premium increases.'' It would ''weaken insurer solvency.''

Let me do the translation on this. The actuaries—those who study insurance for a living—are saying that what the Republicans are thinking of voting on is a provision to jack up insurance costs through the roof and rip away coverage from those who can't afford to pay those higher costs.

We should be very clear about the consequences. If the Republicans go through with that vote, they will be responsible for every dollar of premium increases that occur over the weeks and months that follow as this bill sits in a conference with the House and insurance companies jack up prices because they don't know what they might be required to cover. Senate Republicans will be responsible for every single person who has to drop coverage because they can't afford those price increases. The Senate Republicans will be responsible for every single person who didn't go to the doctor when they needed to or didn't schedule surgery when they needed to because they no longer have health insurance. Senate Republicans will be responsible for every family in this country who misses a mortgage payment or can't pay their electricity bill or is forced into bankruptcy because their medical debts have become too big to ever pay off.

Every time I have come to the floor to talk about this terrible Republican bill, I have said that I am ready to work on bipartisan proposals that will actually improve healthcare in this country, and I say it again. I am still ready to do that, but we cannot move forward while Senate Republicans are still trying to take healthcare coverage away from millions of Americans and drive up costs for millions more.

Republicans seem to think they can wear us down, that they can keep us here until we get too tired or we give up or we just give in, but, boy, that is where they are wrong. They do not have a clue what they are up against because we are fighting for families. We are fighting for little kids. We are fighting for our neighbors. We are fighting for parents and brothers and sisters and loved ones. We are fighting for the American people. When you fight for the American people, the wind is always at your back, and your heart is always strong.

So Democrats will be here, fighting for as long as it takes to beat back these shameful healthcare bills. We hear the American people. We hear you. We are on your side, and we will never give up.

Thank you, Mr. President.

I yield the floor.

The PRESIDING OFFICER. The Senator from Virginia.

Mr. WARNER. Mr. President, first of all, I thank my friend, the Senator from Massachusetts, for her comments today and for her relentless willingness to take on this fight and so many other fights that are so important to our country.

I come to join her call to point out some of the challenges in this legislation but also to make an appeal to my friends on the other side that this does not have to be the way we go. I have been one who has acknowledged for many years that there are challenges in the Affordable Care Act and that there are areas in which there could be common interests in finding solutions, but what we have before us now is a series of ''bad, badder, and baddest'' choices. In effect, we have a series of options that ask: Do we want to pass legislation that would take 16 million Americans off healthcare? Do we want to pass legislation that would take 22 million people off healthcare? Do we want to pass legislation that would take 32 million Americans off health insurance?

What parts of these choices do my Republican colleagues really embrace?

I think that in the 8 years I have been here, I have never seen a series of pieces of legislation that have been so unpopular, even before they are passed, than this litany of options from full repeal to skinny repeal and all of the variations in between.

As has been said by the Senator from Massachusetts and I know by the Senator from Washington State as well, the American people know this. That is why our phones are ringing in our offices and I know in our Senate Republican colleagues' offices. People are saying do not pass this kind of legislation.

I think about the fact that in the last couple of weeks, the parents of a number of children and young adults who have enormous disabilities have come to my office. In Virginia, we run a very skinny Medicaid Program. Frankly, it has not been very generous. Some of the individuals who have come to my office have waited 5, 6 years—one person has waited 10 years—to get a Medicaid waiver. These families, these children, in any of the proposals that have been put forward, would be the first to lose their coverage.

Family after family talked about the fact that, right now, both parents can work because they have a little bit of relief to take care of their disabled young adults in certain cases. In many cases, it is because the young adults can at least find someplace to do some productive work themselves. Yet, if they were to lose the Medicaid waiver, one of the parents would have to stop working, and the child would have to stop his form of employment. Net-net, it would be a loss not only to that family, but it would be a loss to our economy.

I mentioned that I used to be the Governor of Virginia. In 2016, Virginia received about $4 billion in Federal Medicaid funds—51 percent of the State's funding for people covered by Medicaid. As I mentioned, we are ranked one of the skinniest programs in the country. Unfortunately, we rank about 47th, I believe, in terms of our payments. Yet, under any of these proposals that decimate Medicaid, Virginia would be penalized for running an efficient program.

Again, one of the ironies of this is that the States that are the least penalized in the Republican proposals, in terms of the $700 billion-plus of Medicaid cuts, are actually the States that have more generous programs. They are often States that are represented by Democratic Governors. In what way do these proposals help our Republican colleagues or, for that matter, their constituents?

We have heard, as well, that the American Cancer Society, the American Medical Association, the American Academy of Pediatrics, the American Hospital Association, and AARP—a who's who of groups affiliated with healthcare—have come in and pleaded: Please, do not do this, this way—any one of these litany of proposals that we will be dealing with over the next few days.

From what I have heard on an individual basis—and I take enormous pride in the fact that in my time here—and sometimes it has even gotten me crosswise with the ranking member of the HELP Committee—I have tried to reach out on virtually every piece of legislation I have worked on to find a Republican partner. I actually got put in a timeout by a previous leader for doing too much of that.

What I hear from my Republican colleagues is, they do not want to own this. They know, in many ways, that this is walking the plank on what is both bad policy, bad politics, bad for their constituents, but the notion that somehow they have to provide a win for a President who has provided zero leadership before they can take some kind of August recess is literally the worst reasoning I have heard in my 8 years in the Senate as to why to pass a piece of legislation, particularly a piece of legislation that affects one-sixth of our economy. In many ways, it is almost one-third of the people who will be affected by some of these changes.

I think many of us were touched yesterday when we saw Senator MCCAIN, who is an American hero and who himself is having to grapple with enormous healthcare challenges, come back to the floor and, frankly, admonish us appropriately but also say that while he was going to vote to start debate on this bill, the real way we ought to go about doing this is to roll up our sleeves, in a bipartisan fashion, and take this legislation back to where it should start, which is in the HELP Committee, where the Senator from Washington serves, in the Budget Committee, whose chairman is on the floor, and in the Finance Committee. Two of those three committees I have the honor of serving on.

I commit to my Republican colleagues that I will work with them. I have laid out a series of ideas, some of which they have endorsed in terms of there potentially being cheaper options, in terms of selections; the idea, as long as we protect consumers, of allowing insurance policies to be sold across State lines and other ideas in terms of reinsurance that other colleagues have worked on. There are a host of ideas we all agree on. Let's start with that premise, in terms of coming to a solution, not coming up with legislation that is cooked up behind closed doors that even my strongest Republican colleagues have acknowledged they cannot vote on when they only get an hour to look at it.

Think about all of the same criticisms—some of them valid—that were made against the Democrats when we passed the ACA; although I would continue to remind my friends that we had, literally, hundreds of amendments which were Republican amendments that were accepted into that legislation. It was not a perfect process, but let's learn from that and take this advantage right now. Listen to the American public, and let's work together to get this right.

The other item that will come about from any of this Republican legislation put forward, even from the skinniest of their proposals, would dramatically affect those individuals with preexisting conditions. I have three daughters. One of my daughters has juvenile diabetes. She has had it for 18 years. Another daughter has asthma and a very strange set of allergic reactions that have actually caused her to have been hospitalized 38 times in the last 40 months.

I am an extraordinarily lucky individual. I know that both through health insurance and because I had the resources, every time my two children got sick, I could make sure they got the medical attention they deserved. I cannot imagine talking to any Virginia family or Washington family or Wyoming family or Arkansas family who has a child with those same afflictions and trying to explain to them that my kids who have juvenile diabetes, asthma, and allergic reactions—through no fault of their own and that have caused this number of hospitalizations—have a right to healthcare and that their kids who have preexisting conditions do not have that right.

Our country is much better than this. We can figure out a way to get this right, but we are not going to get it right if we continue to have this ploy of one closed-door, cooked-up deal after another that is put forward, with no review and no real attempt to find a common solution.

I do not come to the floor that often, and I do not often talk about the medical needs of my family. This is for the sake of not only my kids who get the coverage they need and deserve but for

all the kids who now get the coverage they did not have prior to the ACA and who have it now. It is the idea that insurance companies cannot discriminate against you because you have preexisting conditions.

Let's see if we can make sure we maintain that commitment. In the greatest country in the world, as Senator MCCAIN so eloquently put it yesterday, let's see if we can work through to a way that makes this body, once again, the greatest deliberative body in the world. Let's see if we can find that common ground that would allow us to put forward legislation that at the end of the day, we would all be proud of. That is a goal worth working on.

My hope is, over the coming days, we will find that common group of Senators who will say we are going to take that path rather than the path we are on right now.

I yield the floor.

The PRESIDING OFFICER. The Senator from Washington.

Mrs. MURRAY. Mr. President, I hope all Senators in this Chamber took the time to listen to the very wise words from the Senator from Virginia as to the fact that we are facing real issues in this country and that when we work together and go through the regular process of having committee hearings and no secret negotiations or backroom deals, we can lead this country in the way it should be led.

I thank the Senator for coming to the floor and reminding us that is how we get things done in a way that America accepts it.

Yet we are not here after having had committee hearings or process or anything. We are here because of backroom deals that have brought us to this floor at a time when no one can accept the fact that all of the proposals are as a result, so far, of how many millions of people will lose insurance—22 million, 15 million, 24 million. That is what we are debating here, and that is a terrible debate. That is not what we should be talking about, but those are the proposals we are being offered.

Again, the Democrats are here. We are not giving up, and we are going to fight any effort to pass TrumpCare until the last possible moment because that will be the result. We are going to speak out for families nationwide—children, parents, patients, people with disabilities, seniors, and people who have called and tweeted and marched and filled our office halls. So many people are worried and, frankly, scared right now. These are families who are being kept in the dark by our Republican colleagues and who are being left to wonder what might happen to their healthcare, their financial security, and even their lives.

It is appalling the majority of Republicans who are willing to go along with this plan and move to begin debate without even knowing what bill they will be debating. Yet, last night, the vast majority of the Senate did something unusual. It showed just how much agreement there actually can be among us, when 57 Republicans and Democrats agreed to reject a full TrumpCare replacement bill and sent a message that we agreed with Senator MCCAIN in that we should stop letting the ''bombastic loudmouths'' drive our work and instead return to regular order and get back to work on policies that actually help the people we are here to represent.

There are responsible Republicans who disagree with the way the Republican leaders have hidden their legislation from Democrats and the public throughout this process, who think there should be an open, transparent process, with both sides at the table, and who want hearings and public debate rather than backroom deals and secret negotiations. I do as well, and I know many of my Democratic colleagues agree.

Now that it is clear that there is absolutely no path to full TrumpCare in the Senate, what is the reason for continuing this damaging, rushed, deeply partisan effort on the floor to jam just any bill through the Senate? Together we can do a lot better than the lowest common denominator bill that simply sends TrumpCare to conference with the House and then gives the Freedom Caucus a blank check to gut Medicaid and put insurance companies back in charge of people's healthcare, and more. Let's be clear. The only reason to pass a cobbled-together, last-minute bill on the floor is to keep the extreme conservative dream of repealing ObamaCare alive, no matter what that means for patients and families.

I truly believe there is a better way to get this done right, and it is to stop what Senate Republican leaders are doing right now and start over.

So, once again, I ask my Republican colleagues to drop this partisan effort and join us at the table. Let's work together to improve families' healthcare, as so many of us truly want to do. My door is open, and I am ready to get started.

Thank you, Mr. President.

I yield the floor.

The PRESIDING OFFICER. The Senator from Connecticut.

Mr. MURPHY. Mr. President, no one should normalize what is happening on this Senate floor right now. We are all waiting for the white smoke to come out of Republican leadership offices so that the millions and millions of very scared people in my State will be able to see what is about to happen to their lives.

This isn't a game. People's lives are at stake. People's health is at stake. Yet, because this debate is now devoid of policy and substance and seemingly just about delivering a political victory to Republicans, we wait and we wait and we wait.

People are scared. All over the Capitol today there are parents of children with disabilities, many of whom rely on Medicaid in order to keep their children alive. I have spent a lot of time with them over the course of the last 6 months because, to them, the measure of a civilization is how it treats the most vulnerable, and their kids, with these deep disabilities, are among the most vulnerable. For much of the last 6 months I have seen anger in their eyes—anger that Congress would choose to hurt their kids or to force their family to go bankrupt.

Yesterday, I saw something new in their eyes. I saw fear. I saw deep, debilitating fear because they sense that we are on the precipice of doing something that they didn't think was possible—a piece of legislation passing the Senate and the House that would deliberately and intentionally hurt their children.

There is no way around it. It is not hyperbole. The House bill that we are debating right now guts Medicaid to the point where 15 million people—the most vulnerable Americans—would lose access to healthcare.

I know it is very hard for people in this Chamber to understand because we all have really good healthcare. But when you have an expensive disease or your child has an expensive disease and you lose insurance, you can't pay for it. You can sell your house, you can sell your car, and you can exhaust your savings. For some families, that will cover 6 months' worth of expenses for their sick child. At some point, the patient dies if they don't have access to healthcare.

So people are scared. They are really scared. They are scared not just at the consequences of the House bill eventually passing, but they are also scared at the casualness with which this debate seems to treat their plight.

There are rumors now that, at the end of this process, we are going to vote on what has been described as a stripped-down, gutted version of the original Republican healthcare bill. It might have one or two provisions in it—maybe the elimination of the individual mandate, maybe the elimination of a few taxes. The intent would be to essentially punt the more comprehensive debate about what our healthcare system is going to look like to a conference committee.

I want to talk about that for a few moments and what the consequences of that are. First, I want to talk about what the consequences are, if that end result is achieved, for the Senate. Why do my colleagues choose to run for the Senate if they are prepared to surrender the biggest policy decision they will likely face to the House of Representatives? Why go through all the trouble of running, of raising all the money, of getting all the votes to become a Senator if you aren't prepared to actually render an opinion and pass a bill on the biggest priority issue facing this country right now—the future of the American healthcare system?

Republicans have been unable to come up with a bill that can get 50 votes. Why? Because they refuse to engage with Democrats. Now the solution

is to punt by passing a stripped-down version of the bill, handing all power to the House of Representatives, surrendering to the House of Representatives. What is the point of being a U.S. Senator if you aren't actually going to make policy, if you are just going to hand over the keys of policymaking to the House of Representatives? This is the U.S. Senate.

I disagreed with Senator MCCAIN's vote yesterday, but I heard the speech he gave to us that this should be the place in which we make the big, tough decisions about the future of the American economy. The Senate will put an ''out of business'' sign on the outside of this Chamber if we pass a scaled-down version of this bill that admits we can't come to a conclusion.

What is the point of being a Senator if you just hand this debate over to the House of Representatives? By the way, that is what will happen. If the Senate goes to conference with the House of Representatives and there is only one bill in that conference—and that is what will happen if a stripped-down version of this bill goes into conference and the House has a comprehensive reform bill—the House bill will be the only one in the conference committee, and the House bill will become law. The House bill will survive. It may have some small cosmetic amendments to it, but all of the power will be given to the House of Representatives in those negotiations because there is only one idea that will be present.

Let's go back for a moment and remember what was in that House bill that so many of my Republican colleagues told me was deeply objectionable to them and would never get a vote on the Senate floor. Twenty-three million people will lose insurance. Rates will go up by 15 to 20 percent. People with preexisting conditions in most States likely will lose all protections available to them. Insurance plans will not have to cover maternity care, mental illness, or addiction any longer. Medicaid will be gone as we know it. My small State, with an $8 billion Medicaid Program, will have a $3 billion cut. Children will lose their ability to stay alive because they lose their healthcare insurance. Seniors in nursing homes will be put out on the street. That is not hyperbole. That is real. That is what happens when you kick 23 million people off of insurance.

That bill or some version of it would emerge from the conference committee because the Senate would have defaulted to it by going to conference with nothing. But that is just the long-term consequence. The short-term consequence is that this scaled-down bill reportedly will include an elimination of the individual mandate. Insurance markets will fall apart.

Everybody here knows, whether you are a Republican or a Democrat, that the only way you guarantee that people get priced the same if they are sick or not sick is to require people to buy insurance when they are not sick. In fact, the Republicans know that because in their bill that they wrote behind closed doors, they included an individual mandate. They did. It was designed in a different way. They said that if you don't buy insurance, you will be penalized by being locked out of the insurance market for 6 months. But they had a penalty for people who don't buy insurance, just like the Affordable Care Act has a penalty. Republicans and Democrats understand that in order for the insurance markets to work as they are regulated today, you need to encourage people to buy insurance when they are healthy and penalize them if they don't. The Republican bill does that, just like the Affordable Care Act does that.

If you pass a bill that removes that mandate, then every insurance adjuster, every actuary who works for a major healthcare insurance company, will tell you that the markets will crater because individuals won't buy insurance until they get sick, knowing that they can't be charged any more. Healthy people will not buy insurance. Rates will go up. Insurers will flee the markets. The entire thing collapses.

That is the short-term consequence of telegraphing to the insurance companies that you are getting rid of the individual mandate. Even if that is not the final result, that telegraph signal, at a point where insurers are already rethinking the markets because of the sabotage campaign that President Trump has undertaken, would be catastrophic.

This is not a game. These stakes are big. The casualness with which people are approaching this debate is scaring the life out of people in my State, out of parents of kids with disabilities and folks who are dealing with sickness and illness all across this country.

It is not too late. We don't have a communicable disease. We aren't going to physically harm Republicans if they come talk to us. It is time to abandon this Republican-only approach and come work with Democrats. Let's jointly own the problems that still exist in the healthcare system and jointly own the solution. People are scared of what is happening in the Senate today, and there is a different way.

I yield the floor.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. ENZI. What is the time situation?

The PRESIDING OFFICER (Mr. SULLIVAN). The Senator from Wyoming controls 24 minutes. The Senator from Washington controls 1 minute.

The Senator from Connecticut.

Mr. BLUMENTHAL. Mr. President, I want to say that the field hearings I had have shown me that people not only fear but will be justifiably hurt forever by this sabotage of our exchanges and by the repeal of the Affordable Care Act. Whether it is called a skinny repeal or any other name, it will fundamentally decimate Medicaid, it will put Americans who are in nursing homes out on the streets, and it will mean that people who need treatment for opioids—the consequences to them and many others whom I have seen in Connecticut and around the country will be absolutely devastating.

This shameful and senseless step toward gutting the Affordable Care Act has left millions not only in fear but in potential real jeopardy. We can do better, and the people of Connecticut and around the country know we can do better.

We owe it to our democracy to go through the regular order, as Senator MCCAIN urged us to do, and to make sure that we fulfill our promise, our oath that we will uphold the Constitution and do what is right for the American people.

The PRESIDING OFFICER. The Senator's time has expired.

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

Mr. ENZI. Mr. President, I yield such time as the Senator from Kentucky needs.

The PRESIDING OFFICER. The Senator from Kentucky.

Mr. PAUL. Mr. President, as a physician and an eye surgeon, I have seen ObamaCare up close, and it is not working for Americans.

If you look across the country and say ''Is it working?'' you find that ObamaCare premiums have doubled for those in the individual marketplace in just a few short years. You find that the ObamaCare insurance mandates have caused 4.7 million people to lose the insurance they chose. If you like your doctor, you can keep him or her—that was the promise, and it was a lie. Some 4.7 million people were told that they couldn't choose the insurance they want and couldn't choose their doctor.

It is estimated that there are 800,000 fewer jobs because of ObamaCare. How does that happen? Well, if you work 32 hours a week and your employer has to provide insurance at 30 hours, guess what happens. Some people get moved to 28 hours. You add up all those hours, and millions of people are working fewer hours.

Who are the people who got shafted by ObamaCare? Often, working-class people. In my State, there are 25,000 people who pay a fine because they can't afford ObamaCare. These 25,000 people make less than $25,000 a year. They are our working class.

ObamaCare punishes them and says: You have to pay a fine.

They say: I wish I had insurance, but ObamaCare added all these mandates, things that I can't afford.

Sure, everybody wants to have everything under the Sun covered by their insurance, but when you mandate that, you elevate the price of insurance. So what has happened? Young, healthy people have lost their insurance and don't buy insurance in droves.

ObamaCare says: You can come back any time after you are sick and buy your insurance.

That sounds good, but what it leads to is the death spiral of ObamaCare. ObamaCare premiums have doubled because the young, healthy people are saying it costs too much and the sicker people are the only ones left in insurance.

This is what happens when you let the government get involved in the marketplace. If you allow the marketplace to work—what is the one universal feature of capitalism? You get the lowest amount of cost and the most amount of goods distributed to the most amount of people.

Right now under ObamaCare, 50 percent of America has one choice. What does that mean? A monopoly. Who wants the insurance company to have a monopoly? When the insurance companies have monopolies, the prices get doubled.

There are now some parts of our country that have no choice in the individual market. If you are a plumber or a welder or a carpenter, you have to buy insurance in the individual market. In many places in America, you have no choice. In half of America, if you buy insurance by yourself, if you are not part of a large group, in half of America, there is one choice—a monopoly and monopoly prices.

In my State alone, 50,000 Kentuckians have to pay a tax. They have to pay a fine because they can't afford ObamaCare. They are regular working people, and they do work and they do pay taxes. They pay a fine. We pay $16 million in fines in just my State. Across America, this is happening.

How did it become an American sort of legislation or plan to force people to buy stuff they don't want and then to extract money out of their paycheck if they don't do what you tell them?

Ultimately, Americans should remember that ObamaCare is predicated on force and coercion. ObamaCare dictates what kind of insurance you can get and makes you pay a fine if you don't get what the politicians tell you you must get.

President Obama basically told you that you were too stupid to make your own choices. These people who want to dictate to you are elitists. They think they know better than you what kind of insurance you should get. If you don't buy the insurance they dictate, they will fine you. If you don't pay the fine, they will jail you. How is that consistent with the American ideal of freedom?

This debate is about more than actuarial tables. We get dragged down into this debate, and we think it is all this healthcare wonkiness, this and that. It is about freedom of choice. It is about whether you as an American can make the choice whether you want insurance or don't want insurance, whether you want insurance that is really expensive or not.

They put a special tax in there if you have good insurance. First they tell you what kind of insurance to buy, and then they tell you that your insurance is too good. If you are in a union or you are an executive and you have great insurance, ObamaCare tells you they are going to tax you because your insurance is too good. These busybodies think they know everything about what you want. They are going to dictate what kind of insurance you can get, and then when you buy it, they are going to tell you that you have too much, so you have to pay a tax. That isn't the American way.

Today we will vote on a bill we have voted on many times. The Senate itself voted on this 2 years ago. It is the identical bill. We are going to vote on a bill we voted on 2 years ago. I hope everybody who voted for it before will vote for it again. It is what we call a clean repeal. It is not cluttered with insurance company bailouts. It is not cluttered with this and that, new Federal regulations. It is just trying to peel back ObamaCare.

While it is a clean repeal, it is only a partial repeal. Why? It is only a partial repeal because we have these arcane Senate rules that say we can't repeal the whole thing. Because we are only repealing part of it, ObamaCare will remain. Even if we are successful with this bill, at least half or more of ObamaCare remains. Bad things remain. All of the mandates on what you have to purchase on your insurance will remain. That doesn't mean we shouldn't do this.

The other side does not want to help. The other side has never met a regulation they want to repeal and has never met a tax they want to lower. So if you want to get rid of the taxes, it has to be done today.

People say: Well, this doesn't have the replacement.

Well, sure we should replace ObamaCare. I have been advocating that from the beginning. But we have to figure out what that replacement is. And the only way we are going to be forced into a bipartisan compromise is if we repeal it. If we do not repeal it today, there is no impetus from either side to work on replacing it. If you repeal it, even the other side will say: Oh, my goodness, we have to do something because they repealed these subsidies in this Medicaid expansion. They will say: We will work with you now. But everything else is false.

They will not work on repealing one regulation or one tax. That heavy lift is left to Republicans, and my hope is that Republicans would band together and say: Sure, this isn't everything I wanted. It is not everything I want. It is a partial repeal. It leaves in place a lot of ObamaCare that we should get rid of, and we should continue to try to get rid of these Federal mandates on insurance.

This is a beginning, and it is all we are being offered up as a beginning, but it is a victory for those of us in America who have said: Enough is enough. My government shouldn't be telling me what I can buy and what I cannot buy. My government should not tell me which doctor I can choose and which doctor I have to leave behind. The government should not be involved in my healthcare business. I want to be left alone. The right to privacy, the right to be left alone is a fundamental right of Americans. That is what this is about.

It is about freedom of choice. It is not about actuarial tables. It is not about the Federal Government designing a perfect healthcare system. The Federal Government cannot deliver the mail. They lose a billion dollars a quarter delivering your mail. Do you want them in charge of your doctor? Do you want them in charge of your insurance? This is the one chance we get today. We will have a chance to repeal ObamaCare. We will have a chance to fulfill our promise to the American voters.

There is a partisan divide. Democrats are for keeping it; Republicans are for repealing it. But Republicans made a promise. We made a promise to the American people to repeal it. There may be some Republicans today who say: I am not voting to repeal any longer; things have changed. The problem is that we are not going to get toward a solution if we don't begin to repeal. The other thing about this repeal is that there is a 2-year window in which part of the repeal doesn't take place for 2 years. Over those 2 years, my guess is that we will have impetus from the other side to actually begin to negotiate. Currently, there are 27 million people in America without insurance. From all the talk, you would think that ObamaCare has covered everyone, and somehow Republicans are against that.

Count me as one Republican who wants to figure out how we insure the 27 million who don't have insurance. Of the 27 million people who don't have insurance under ObamaCare, half of them don't buy insurance because it is too expensive. Why is it too expensive? Because ObamaCare dictates about 15 different things that every insurance policy has to have: Vision, hearing, pregnancy—you name it; it is all on there. Everyone wants it. If you put it on every insurance policy, not everyone is going to be able to afford it. You force people out of the market. So 27 million people don't have insurance, and half say they can't get it because it is too expensive.

Where is the problem in insurance? If you are here today visiting in Washington, and you work for Toyota or Ford or General Motors or any big American company—any big corporation in our country—if you work for them, my guess is that you are not worried about your wife getting sick and they fire you from your job or raise your rates. What happens when you have group insurance is, if your family member gets sick, you don't lose your job. Your insurance rates really don't change, and you continue on with your life. You still have the tragedy to deal with of someone in

your family being sick. But if you have group insurance, it seems to work in our country.

What we are talking about is the individual insurance market. We are talking about the plumber, the pest control guy, the carpenter, the welder, the farmer—people who are in a small business. Either they have a few employees or it is just them. That is what we are talking about. It is horribly broken. I don't wish it on any American. I wish no American had to buy any insurance in the individual market. In fact, what I am proposing would so disrupt the individual market that maybe everyone would leave. I am trying to give an exit ramp to everyone in the individual market to get out of the individual market because the individual market is a terrible place to be.

If you are a farmer in America and you buy insurance for you and your wife, and your wife gets breast cancer, you are not only deathly afraid for her health, you are deathly afraid your insurance rates will be doubled, tripled, or you will be dropped. I don't care if you are a Republican, Independent, or a Democrat. People in the individual market do worry. We have had people here worried that people are going to lose their health insurance. The individual market is a terrible place to be.

So what should we do? Should we give hundreds of billions of dollars to the insurance company and say: Please insure these people and make sure their rates aren't too high. I don't like that because I am not for crony capitalism. These companies make billions of dollars a year in profit. I am not for giving them one penny of your money.

Do you know what I want? I want something that doesn't cost anything, that doesn't cost one penny and would completely transform healthcare and insurance in this country. I want to legalize—I want to make it open to every American that you can go out with an association across State lines and buy your insurance as part of a group. What would that mean? In my State, the Farm Bureau has 33,000 people. But when you go to the Farm Bureau to buy your insurance, you get an individual policy. A farmer, his wife, and their family get a policy. It is just them. They are not really protected by the group. They don't get the leverage of price, and they are not protected. If they get sick, their rates are based on them and their family. Why don't we let them join together? There are probably a million farmers in the Farm Bureau throughout the American Farm Bureau. What if the American Farm Bureau had an association and one person negotiated for them? I don't think we can overstate the negotiating value of a group.

In China recently, they negotiated for patented medicines, and they reduced the price by 67 percent. Groups can negotiate prices down. This is a free market reform. This is collective bargaining for consumers. I can't see why either side—I am still hopeful, no matter where this goes, that at some point in time, when partisan fervor dies down, we can go to the other side and say: What's so wrong with collective bargaining? I thought you were for collective bargaining for labor. Why not be for collective bargaining for consumers? Let the consumers band together. AARP has 33 million people. What if one person negotiated the rate for their insurance and their drugs? My guess is that they would have the lowest drug prices in the world, and more people would want to join AARP. What if the credit unions—there are about 20 million people in credit unions, maybe more, across the United States. What if you could join your credit union and became part of a national association to buy your insurance? The leverage of 20 million people would be maybe 40, 50 times bigger than America's biggest corporation.

Right now, if you are General Motors and you are a big corporation, you have leverage to bring prices down. What if you were in a corporation 20 times bigger than General Motors—an association that negotiated your prices? This is freedom, though; this isn't a government plan. This is the Federal Government saying that you are allowed to do what you want. You are allowed to collectively bargain as consumers.

I think there is every chance that we could fix a lot of the market. Would there be anybody left behind? Yes. I mean, we have terrible tragedies. I spent my adult career in medicine. I have seen the terrible tragedies, the terrible disabilities, the terrible neurologic disorders people are born with and have to live their lives with. Those exceptions will be treated and are treated.

Frankly, one of the misunderstandings of this debate is that any Republican is up here talking about trying to take away stuff from those who are disabled, can't work, and do have to have care. That is traditional Medicaid. They will continue to be cared for. Under this, we are talking only about able-bodied people. Should able-bodied people—people who walk around, hop out of their truck—should they be working? Should they be providing for their health insurance? Yes. Can there be a transition zone? Yes. We have transition programs between unemployment back to employment. We shouldn't have people permanently unemployed—people permanently on benefits who don't work or won't work. There should be work requirements. I am not afraid to say that every able-bodied person on Medicaid ought to work. There should be a work requirement. I meet many people on both sides of the aisle who are for that.

I don't say they should work as punishment. I think everyone in America should work as a reward. I think work is a reward. I don't care whether you are from the lowest job on the totem pole to the top, to the chief executive. Work is where you get self-esteem. No one can give you self-esteem. Your self-esteem comes from work. I think we are wrong. In fact, I think what we have done—in some cases, we now have multigenerational dependency on government, and they are so distraught and so lacking in self-esteem that it also compounds the drug problem that we have.

Some say that we need more Medicaid money to fight the drug problem. I worry that more Medicaid trips to the doctor may actually be part of the drug problem—that much of the dependency is coming from OxyContin, which the drug company says was not addictive, but everyone got put on OxyContin because it supposedly wasn't addictive. A lot of our heroin and OxyContin problem came out of going to the doctor.

If we were to get everyone out of the individual market into group insurance, there would be some people left behind. My hope is it would be a small number of people, and we would know after a year or two. Let's see what it is. We already have a safety net. The other side is acting as if there is no safety net. We have had a safety net for decade after decade. The safety net is Medicaid. If your child has a disability, no one is trying to take that away from him.

The thing is, we have to try to fix what we have. We need to understand that what we are looking at—what we are trying to fix isn't just some kind of policy that nobody can understand. Healthcare policy is very technical and detailed. This is about freedom.

Do you think that every American should get to choose whether they have insurance and what kind of insurance they have? This is what it is about. It is freedom of choice. It isn't about whether we want people to be insured. When you hear these hyperbolic statements saying that all these people are going to die—Republicans want people to die—those hyperbolic statements aren't really helpful to the debate.

I do not question the motives of any of the Democrats as far as wanting to provide care. I never questioned President Obama's desire to help people get insurance. To me, it is more of a question of what will work. What distributes goods better: socialism or capitalism? Look at the Soviet Union. We defeated the Soviet Union because capitalism defeated socialism. Socialism doesn't work.

When the government fixes the prices, it doesn't work. Are we going to have some government involvement? Yes. But because Government is so pitiful at anything they do, we should minimize government's involvement in any industry. If we say that government has to be involved to take care of the poor, let's do it at the State level, not the Federal level.

People ask me: Are the people in government inherently stupid? I say no, but it is a debatable question. The reason is this: Government doesn't get the proper incentives, and they are too distant from the people, and we have a printing press.

What is the fundamental deceit of ObamaCare? This is the fundamental problem of all government, but the fundamental deceit of ObamaCare is this: They said that everyone is going to get free healthcare. Everyone is going to have Medicaid, and you don't have to pay for it, and the States don't have to pay for it. We are going to have the Federal Government pay for it. But the problem is the Federal Government can't pay for most of the things we already have. We already had Medicaid we can't pay for—Medicare we were short of money for. We already have Social Security that we are short of money for. What do we do? We borrow the money. Our deficit this year will be $500 billion. Our deficit is projected next year to be $1 trillion. That is the real question. It isn't, do you want to help people? It is, how are you going to pay for it? If this were done at the State level, what would happen? If the State of Kentucky wants to keep the expansion—we have expanded Medicare to 450,000 people. The question should be, should we double the State income tax in Kentucky? If that went to the State legislature, they have to balance competing concerns. If we double the State tax to pay for it—we live right next to Tennessee, which has no State income tax—would we possibly lose existing businesses or existing jobs or would we encourage new businesses not to come to Kentucky? That would be a valid debate. We want to help people, but what are the ramifications of it?

In Washington, it is said that there are no ramifications because everything goes to the debt. Everything just piles up. We have $20 trillion in debt. Whose fault is it? Both parties. Under George Bush, the debt went from $5 trillion to $10 trillion. Under President Obama, it went from $10 trillion to $20 trillion. Both parties are at fault, but the entitlements are consuming us.

How would we possibly move forward with a bill that sets up a new insurance entitlement, as some of the Republican plans wanted to do? We can't pay for the current entitlements. As we look forward today to the solution, what I would say is that there are alternatives. We really shouldn't question the motives of those across the aisle, and they shouldn't question ours.

I want more people to have insurance at a lower cost. We should have a disagreement on how it works. I think capitalism works better than socialism. I think we should minimize government's involvement because government is not very good at distributing anything. Just look at the mail.

I also think there are exciting opportunities for saying how we could insure the 27 million who are not insured currently. Twenty-seven million people under ObamaCare are without insurance. The question shouldn't be about debating over the past. It should be over debating the future. The future should be about trying to figure out how we insure those 27 million. I think there are a lot of opportunities that involve more freedom of choice, more freedom to choose your doctor, more freedom to choose what insurance works for you. My goodness, that is what this debate is about. It is not about healthcare policy. It is about freedom of choice, and I hope every Senator today will vote for freedom of choice.

Thank you.

The PRESIDING OFFICER. The Senator from Wyoming.

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

The PRESIDING OFFICER. Is there objection?

Mr. ENZI. I object.

The PRESIDING OFFICER. Objection is heard.

The clerk will continue to call the roll.

The legislative clerk continued with the call of the roll.

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

The PRESIDING OFFICER (Mrs. ERNST). Without objection, it is so ordered.

Mr. ENZI. Madam President, I ask unanimous consent that the actions scheduled to take place at 11:30 this morning occur at 3:30 p.m. today and that all other provisions of the previous unanimous consent agreement remain in place.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The time until 3:30 p.m. is now equally divided.

The Senator from Oregon.

Mr. WYDEN. Madam President, on this matter of repealing the Affordable Care Act, soon the Senate is going to vote on just whether or not to repeal the Affordable Care Act. I think it is important to note that this would walk back months and months of Republican promises to directly link repealing the Affordable Care Act with a replacement—a replacement that would improve coverage, lower premiums, and be better for the American people. In fact, the President of the United States said repeatedly over the last few months that these would be inextricably linked, that repeal and replace would go hand-in-hand. That is not what is on offer right now. What is on offer are specific changes that would actually harm Americans.

For example, no more middle-class tax credits for healthcare—that is something that is critically important to the millions of middle-class folks who are walking on an economic tightrope every month, balancing their food costs against their fuel costs, their fuel costs against their medical costs.

I was struck this morning when I heard that, under this repeal approach, there is not going to be any real pain, that everything is just put off. Make no mistake about it. The pain for our families under this repeal measure is going to start right away. Nobody says they are going to be part of a marketplace if they believe it is not going to exist in a few years. Seventeen million fewer Americans are going to have healthcare 1 year from now. An analysis from the Congressional Budget Office—and this is only a week old—said that half of the country will have zero insurance choices in the private marketplace under this scheme.

I would like to repeat that so people understand that, as to this idea that there is really no pain here and that nothing starts for a long time, the Congressional Budget Office—our nonpartisan, impartial umpire—doesn't agree with that. They said just last week that half of the country will have zero insurance choices in the private marketplace under this scheme. That goes up to 75 percent of Americans with no options in later years.

So my view is that this is just legislative malpractice, first because of the pain and harm it is going to cause so many Americans. The Congressional Budget Office says that kind of misery is going to kick in quickly.

Second—and I don't think this has been discussed on the floor—this walks back months and months of Republican promises. The American people were told again and again that repeal and replace were going to be directly linked. The President said it multiple times. Then he went over the top and told people that they were going to have lower costs and better coverage.

Mr. SANDERS. Madam President, will my friend from Oregon yield for a question?

Mr. WYDEN. I am happy to yield to my friend.

Mr. SANDERS. Madam President, our friend from Oregon is pointing out that this legislation would impact virtually every American because, in one way or another, we all interface with the healthcare system.

I would ask my friend to confirm: This legislation would impact what percentage of the U.S. economy?

Mr. WYDEN. I would say to my colleague, the ranking member of the Budget Committee, that we are talking about one-sixth of the American economy.

Mr. SANDERS. One-sixth of the American economy is over $3 trillion every single year.

Now, when we are dealing with legislation that impacts virtually every American, over $3 trillion every year, would my friend from Oregon please tell me this—and I know that he is the ranking member of the Finance Committee, and I am on the Health, Education, Labor, and Pensions Committee: How many hearings have been held in the Finance Committee to discuss the economic implications of this legislation? Were there five, ten? How many hearings on this enormously

complicated and important issue have there been?

Mr. WYDEN. My colleague is being logical, and heaven forbid that logic should be introduced into this, because we would automatically assume that on a matter like this—we are talking about one-sixth of the American economy—the Senate Finance Committee would have hearings. There have been no hearings.

Mr. SANDERS. No hearings?

Mr. WYDEN. None.

Mr. SANDERS. There have been no hearings on a bill that impacts one-sixth of the American economy and every single American.

Now, let me ask my friend from Oregon this. Obviously, before my Republican colleagues would go forward on radical legislation like this that would throw some 32 million Americans off of the health insurance they have, they have obviously consulted with doctors and hospitals to get their views as to the impact this legislation would have on patients and hospitals all over America.

What kind of testimony did the doctors make on this bill or the hospital administrators make?

Mr. WYDEN. I can tell my colleagues that Senator MURRAY and I, the two of us—the ranking member on the Budget Committee and I—have actually made public the overwhelming opposition from providers on this. So, in effect, providers and patients are standing together in opposition to this.

Mr. SANDERS. Right, so if my understanding is correct—and I am quite sure it is—the American Medical Association, which is not one of the great progressive groups in America but the group that represents the physicians in this country, A, they have not been able to make testimony. But, B, what is their view on this legislation? What do the doctors of America feel about this important legislation?

Mr. WYDEN. They are opposed, as I have indicated. I think it is particularly important to see this provider-patient partnership that this time is saying the patients come first and this bill hurts patients.

Mr. SANDERS. But we have not heard yet from one doctor making public testimony at a hearing.

Mr. WYDEN. That is correct.

Mr. SANDERS. In other words, this bill is not saying to doctors: What will this mean to your patients? What happens if 32 million people are thrown off of medication? How many of them will get sick? How many of them will die?

No testimony.

How about hospitals? What kind of testimony have we heard from hospital administrators, those in rural America, about the impact of this legislation on rural hospitals in Vermont and rural hospitals in Oregon?

Mr. WYDEN. What I can tell my colleagues is that, again, those hospitals have not been in front of the Finance Committee.

One of the things I appreciate about so many colleagues on this side of the aisle is that they said: Well, if we are not going to hear from these providers, like the hospitals, in the committee, we are going to go out to the country and listen to them. I have had townhall meetings throughout rural Oregon, as my colleague Senator MERKLEY has had. The rural hospitals, which are the economic engines of so many rural communities, are opposed to this legislation.

Mr. SANDERS. Let me ask my friend from Oregon: What kind of testimony have we heard as to the impact of this legislation on older working people, in terms of what it might mean in increased premiums? Have we heard much discussion? Has the AARP, which is strongly opposed to this legislation, been able to come forward at a public hearing and express their point of view?

Mr. WYDEN. The AARP has also not been in front of the Senate Finance Committee. I want to say again that Senators have said: If they are not going to be in front of the Senate Finance Committee, where we ought to actually hear testimony in line with the regular order, we are going to go out to the country and listen to AARP members and organizations. They are overwhelmingly opposed to this because people between 55 and 64 would pay five times as much as younger people, and they would get fewer tax credits.

Mr. SANDERS. Madam President, would my colleague please repeat that. I think it is important for older Americans to hear this.

We had a candidate running for President of the United States by the name of Donald Trump, and he ran all over this country and said he was going to stand up for working families and he was going to stand up for the working class of this country.

Please repeat what this legislation would mean if somebody were a 62-year-old worker in Vermont or in Oregon. What kind of premium increases might he or she see?

Mr. WYDEN. It is hundreds and hundreds of dollars and, in a number of instances, more. The reality is that I think they are going to have a lot of trouble getting coverage at all. The reality is, when you pour gasoline on the fires of uncertainty—and this is particularly important right now as plans are thinking about signing up—that makes it more likely you aren't going to have plans at all. The Congressional Budget Office has also found that the Paul legislation makes that worse.

Mr. SANDERS. Now, while the AARP and other senior groups have not been able to testify, would my friend from Oregon tell me what their views are on this particular legislation because of its impact on older workers and seniors in general?

Mr. WYDEN. While the senior groups have not been able to come before the Finance Committee to discuss this issue, I can say—and I have been working with a number of these organizations since my days with the Gray Panthers—that they are overwhelmingly opposed to this. I think, in particular, this idea that we heard from the Congressional Budget Office last week—that half of the country will have zero insurance choices in the private marketplace under this repeal scheme, and that it goes up—will just cause even more seniors to be against it.

Mr. SANDERS. But it is not only older workers because we have as an aging population more and more people in nursing homes. Would my friend from Oregon describe what happens under this legislation if somebody has a mom or a dad in a nursing home, struggling with Alzheimer's or some other terrible illness?

Mr. WYDEN. Under this legislation, you would have a massive rollback of the Medicaid Program. So for all of those older people who scrimped and saved all of their lives—they didn't take that vacation; they tried to make sure they could educate their kids—Medicaid picks up the costs of two out of three nursing home beds in America. This legislation would produce a massive rollback of the Medicaid Program, and I believe so many older people are going to find long-term care unaffordable—millions.

Mr. SANDERS. I think it is important to repeat that because this is not something that I think most Americans are aware of. Medicaid now pays, as I understand it, for two out of three nursing home beds in this country; is that correct?

Mr. WYDEN. That is correct.

Mr. SANDERS. And a massive cut in Medicaid would be devastating to those families who have loved ones in nursing homes?

Mr. WYDEN. That is correct. It would be accompanied with further misery because it would leave the millions suffering from opioid addiction with nowhere to turn for coverage as a result of this massive rollback in Medicaid coverage under this amendment.

Mr. SANDERS. I have asked my colleague from Oregon a little bit about some of the cruel and devastating impacts this legislation would have, but we have to be honest and acknowledge that there are some beneficiaries in this legislation as well.

Would my friend describe the beneficiaries in the House bill, in particular? While millions were thrown off of Medicaid, while 23 million people lost their health insurance, some people actually did gain from this bill, and we have to acknowledge that; is that true?

Mr. WYDEN. Yes, the fortunate few would benefit under the House bill. There is no question about it.

To give my colleagues an idea of how regressive those efforts are, they would actually be retroactive. So this idea that these tax cuts for the well-to-do were in some way going to create jobs is just absurd. They are made retroactive. So they aren't going to be creating jobs going forward.

Mr. SANDERS. Correct me if I am wrong, but my recollection is that in the House bill there were $300 billion in tax breaks going to the top 1 percent at exactly the same time that 23 million Americans were thrown off of their health insurance; is that correct?

Mr. WYDEN. A few hundred families benefit so greatly that it could actually cover Medicaid expansion in several States.

Ms. STABENOW. Will the distinguished Senator from Oregon allow me a question?

This is a very, very important debate. On the point that my colleague just made, isn't it correct that there is nothing in any of these versions that lowers the cost of prescription drugs, which is the No. 1 issue for people in this country, as it relates to healthcare, or for businesses? I hear it all the time. There is nothing in here to lower the cost of prescription drugs, but there are tax cuts in here for the prescription drug companies. Is that correct?

Mr. WYDEN. That is correct. The special interests get very, very substantial tax breaks. Those working-class people lose tax credits, so they actually lose, and, in effect, those dollars can be used for the tax cuts for the fortunate.

Ms. STABENOW. There is nothing to go further to use the buying power with Medicare to negotiate prescription drugs or to allow, with safe FDA approval, for people in Michigan to be able to drive across a bridge to Windsor and be able to get the very same prescription drugs for 40 percent less. There is nothing in there about that, is that correct?

Mr. WYDEN. There is nothing that would give Medicare bargaining power to make sure seniors get a better deal. There is nothing for the kind of effort our colleague from Vermont and Senator KLOBUCHAR have pursued, which would allow, under circumstances where there were safety precautions, for pharmaceuticals to come from other countries. There is nothing to go after pharmaceutical middlemen. So, yes, there is nothing in these bills to hold down the cost of pharmaceuticals.

Mr. SANDERS. If I could, let me ask my colleagues from Oregon or Michigan maybe to speculate here.

If the House bill were to be successful—and we are going to do everything in our ability to make sure it is not successful—and Medicaid were severely cut back, what do my colleagues think will eventually happen in the near future—not eventually, but in the short term, to programs like Medicare and Social Security? Would it be a reasonable assumption that this is the beginning of the effort on the part of the Koch brothers and Republicans in the Congress to begin dismantling virtually every Federal program that helps working people? Is it not true that the House Budget Committee has already passed legislation that would move toward voucherizing Medicare and privatizing it?

Mr. WYDEN. My colleague is right. There is a very regressive effort going forward in the House, the House Budget Committee, and, clearly, this is to try to set up tax cuts for the fortunate few.

I was struck by the fact that the President has talked about a 15-percent corporate rate. You lose $100 billion for every point you lower the corporate rate. The corporate rate is now 35 percent. If you move it to 15, that is $2 trillion that goes out the door.

Yes, I am very troubled that the House effort plus this legislation is really an effort to begin the unraveling of America's social safety net, and the funds that provide for those very vulnerable people would be used for these additional tax breaks.

Ms. STABENOW. I wonder if the Senators are aware that in Michigan—and I share in the deep concerns of the Senator from Vermont about those opportunities that people have paid into, by the way. This is not free. This is not an entitlement. People pay into Medicare, pay into Social Security, which has lifted a generation of seniors out of poverty and allowed seniors and people with disabilities to live longer because of Medicare, and it has created a better quality of life—Medicaid, as well.

There is a great success story in Michigan that I would share on the Medicaid front. Of course, three out of five Michigan seniors in nursing homes with Alzheimer's or other kinds of challenges get their healthcare from Medicaid. In addition to Medicare, Medicaid is there for middle-class seniors, for low-income seniors, and so on.

When our distinguished Senator from Oregon talks about dollars—saving dollars or costing dollars—an interesting thing has happened by setting up Healthy Michigan and expanding Medicaid healthcare to minimum-wage working people. We are actually saving money.

Ninety-seven percent of our children can now see a doctor in Michigan. That is great. They have cut in half the number of people who walk into the emergency room who can't pay. We all pay if somebody walks in and gets the most expensive treatment through the emergency room.

The State of Michigan will save $432 million in taxpayer money next year because they are focusing on children going to a doctor, people getting preventive care, not using the emergency room. It saves money.

Instead of doing these tax-cut provisions for the wealthiest and for the pharmaceutical companies that take dollars away, actually doing the right thing on healthcare in Michigan is a great success story for saving taxpayer dollars.

Mr. WYDEN. I think my colleague is making an important point, as well as my friend from Vermont.

Part of the reason that many Republicans want these tax cuts for the fortunate few is arcane to people, pretty complicated. What they really want to do is get them now, to put them in the budget baseline in order to open up the opportunity when tax reform comes along to have even more tax breaks for the fortunate few. So, yes, Medicare and Medicaid are going to face real challenges.

In fact, as my colleagues know, the Affordable Care Act had a modest additional tax on people who earn over $250,000 a year, and it was to go just to Medicare. You see your paycheck—everyone gets a paycheck—and the Medicare tax is right on it. The only people under these Republican plans who would get the Medicare tax cut would be couples who make over $250,000 a year.

When my colleague from Vermont asks ''What does this mean for Medicare?'' it isn't necessarily about some bill far off in the future. It is about right now. By the way, taking that money away—the money that comes just from the modest additional tax on couples over $250,000—reduces Medicare solvency by several years. It actually reduces Medicare solvency, which breaks yet another Trump promise not to in any way injure Medicare.

Mr. SANDERS. I have a meeting that I have to get to. I want to summarize this. My friends from Oregon and Michigan can correct me if I am wrong.

We are looking at a bill that came from the House and various proposals being introduced in the Senate, which essentially says that we are going to throw over 20 million Americans off of the health insurance they currently have. What I haven't heard much discussion about is what happens to someone who today has health insurance and is struggling with cancer, maybe getting chemotherapy or radiation therapy right now. What happens to someone who is in treatment for diabetes? What happens to someone with a serious heart condition, who had a stroke and is on Medicaid? What happens to those people when their health insurance is simply cut?

Mr. WYDEN. Two points are raised by my colleague—very good points. First, in the immediate, those people will go to the hospital emergency room, which means that, once again, we are turning back the clock toward approaches that don't provide better care at lower costs.

I wish to also mention, when we are listening to folks at home—because they don't get to testify here in the Senate—people appreciate the part of the Affordable Care Act that ensures their lifetime limits on what they can be charged by insurers. Almost all of these Republican bills create an arrangement where a State could waive that protection. Not only would people who are facing cancer and serious illnesses and probably have to go to the hospital emergency room a fair amount be hurt now, but people who have employer-based coverage are going to be hurt in the future. So 160 million people don't even know what is coming out.

Ms. STABENOW. If I might ask one final question, would my colleague agree that rather than this approach, in which we don't even know, moment to moment, what we are voting on here—unlike what we did in the Finance Committee in 2009, where there were 100 hearings in the Finance Committee and the HELP Committee before we even voted on anything on the Affordable Care Act. Rather than that process, we are looking at a situation where everything coming before us will take away healthcare for tens of millions of people and raise costs on everyone. Would my colleague agree that it would be better to stop this process and go back to a bipartisan effort to lower costs and increase healthcare coverage? Would my colleague agree, as well, that we know that there are people paying too much for copays and premiums, and that needs to be addressed?

In the private marketplace, there is not enough competition among insurance companies. In some places, there are none in the individual market. We need to work together to lower costs, starting with prescription drugs, and to also continue to increase the opportunity for people to get healthcare coverage. That is what we ought to be doing together and doing it in a thoughtful way and getting input and actually solving the real problems.

Mr. WYDEN. My colleague has described how the Senate works best when she says: Look, bipartisanship is not about taking each other's lousy ideas. Bipartisanship is about both sides getting together, having hearings, listening to all alternatives and ideas, and often coming up with something no one has thought of.

My colleague knows a lot about bipartisanship in healthcare because my colleague was part of our effort in 2008 when we put together the first bipartisan universal coverage bill in the history of the Senate—seven Democrats, seven Republicans. By the way, a number of those Republicans are still serving in the Senate today. We know that is a better path.

To wrap up this portion of the debate, I wish to say to my colleagues that the best way to proceed is with a kind of two-part effort. The first is to say that we all agree the Affordable Care Act is not perfect. We are going to take steps immediately to stabilize the private insurance market.

We have a number of our colleagues—Senator SHAHEEN, with her effort to make sure people can get some help when they have deductibles and copayments; our colleague from Virginia, Senator KAINE, with reinsurance; Senator MCCASKILL with a fine idea to help areas that are bare in terms of no coverage. We have to move to stabilize the private market quickly because at the end of August, the plans are essentially signing contracts for premiums for 2018.

My colleague is absolutely right. We ought to knock off this partisan our-way-or-the-highway approach, move on a bipartisan basis to take steps to improve the Affordable Care Act now after we have hearings, input, and the opportunity to have people in front of the committees of jurisdiction. After that, we then move to the broader array of issues, starting with the immediate challenge my colleague has led on, which is clamping down on the cost of pharmaceuticals. You take steps to stabilize the market immediately, and then you move again in a bipartisan way on what our constituents are talking about at every community meeting, which is that their Social Security checks, the benefits they get, aren't coming close to keeping up with the rise in the cost of prescriptions.

I thank my colleague for her very helpful questions and our colleague from Vermont, Senator SANDERS.

I yield the floor.

The PRESIDING OFFICER. The Senator from South Dakota.

Mr. THUNE. Madam President, I don't need to tell anyone why we are here. We are here because ObamaCare is fundamentally broken. That is clear. It is evident. Everybody knows that.

A combination of soaring premiums and rapidly decreasing insurer participation has left the law's centerpiece—the healthcare exchanges—literally on the brink of collapse. Insurers are fleeing. Nationwide, 141 insurers have registered to offer plans on the exchanges in 2018, which represents a 38-percent drop from 2017, and that is on top of a nearly 30-percent drop in insurer participation from 2016 to 2017.

If the trend of the past 2 years continues, the final number of insurers offering plans on the exchanges in 2018 is likely to be roughly half the number that offered plans in 2016—a year ago. At least 40 counties around the country are likely to have no ObamaCare insurer in 2018 and another 1,300-plus counties are likely to have just one choice of insurer.

President Obama once said that shopping on the exchanges would be like buying a TV on Amazon. For a lot of people next year, it is going to be like shopping for a TV on Amazon, if Amazon only offered one brand of TV. Of course, for some people it is going to be like shopping for a TV on Amazon only to discover that Amazon has no TVs at all.

Another thing ObamaCare was supposed to do was make health insurance more affordable. That hasn't worked too well. Premiums on the exchanges have soared and soared again. Between 2013 and 2017, the average individual market monthly premium in the healthcare.gov States increased by 105 percent. How many families in this country can afford to have their health insurance premium more than double in just 5 years—and there is no end in sight.

Here are some of the premium hikes insurers are proposing for 2018:

In Maryland, one insurer has proposed an average premium increase of 52 percent; an Iowa insurer is seeking an average 43.5-percent premium increase; a North Carolina insurer is pursuing an average 22.9-percent hike; a Virginia insurer is looking for an average rate increase of 38 percent; a Delaware insurer is looking for an average rate hike of 33.6 percent; a Maine insurer is seeking an average rate hike of 40 percent; and in New Mexico, one insurer is seeking a rate increase of nearly 80 percent.

Again, those are rate hikes for just 1 year. That is after years of dramatic premium increases on the exchanges. Suffering under ObamaCare isn't limited to high premiums and decreasing choices. There are the Americans who have lost their healthcare plans, and the Americans who have lost access to the doctors they liked, the huge deductibles that left some Americans unable to use their insurance, and the ObamaCare tax hikes that have hurt small businesses and driven up the cost of health insurance.

ObamaCare has failed. Americans are suffering. Doing nothing is not an option. Yesterday we moved forward to debate legislation to provide relief to the millions of Americans who have been hurt by ObamaCare. We are going to have a full debate and give people a chance to help shape the final bill.

I hope that at the end of the week, we will be able to pass a strong bill to start undoing the harm ObamaCare has caused. We owe the American people nothing less. We made a commitment to the American people; that if they elected us, we would do everything we could to give them relief from ObamaCare. It is time to make good on that promise.

Chances to do away with damaging government programs don't come around every day. Once you give the government power, it can be pretty hard to wrest it away. This week, we have the chance to start repealing a really bad government program. We need to take it. If we don't act to help the American people, no one will. Democrats have made it clear that if they were in power, they would be doubling down on ObamaCare's failures.

The head of the Democratic Party in the U.S. Senate openly stated single-payer healthcare is on the table for Democrats. A number of colleagues on the Democratic side have proposed that legislation. An analysis of one of our Democratic colleague's single-payer plan estimated that it would cost $32 trillion over 10 years. Well, that would require a tax hike so staggering the Washington Post pointed out that even the Senator who proposed it—an avowed Socialist—didn't offer anything close to what would be needed to pay for it.

We are the only hope Americans have of getting out from under ObamaCare's burdens. This week, we have a chance to pass legislation to finally provide them with relief. I heard my colleagues get up and talk about the impact the proposed legislation that is before us

would have on people across this country and American workers. I have to say, I talked to a lot of rank-and-file, hard-working South Dakotans and South Dakota families who have been hit so hard by these premium increases. I talked to families—a mom and dad with two kids who are paying more than $2,000 a month in premiums to get insurance in the individual marketplace.

In my State of South Dakota, premiums since 2013—the last 5 years—have gone up 124 percent. They have literally doubled. Do you know what that means in South Dakota? That is almost a $3,600 increase in just the last 5 years. What average family who is trying to raise kids, trying to pay the bills, trying to save for retirement, trying to put something aside for college education, trying to pay the mortgage and the utility bill—how many families can put up with a healthcare bill that has gone up in the last 5 years by almost $3,600? That is a crisis. That is why we are here.

Our colleagues on the other side want to turn a deaf ear and blind eye to what is happening out there. We can't afford to do that because the status quo is unsustainable. There is absolutely no way the American people who are suffering under the harms caused by ObamaCare can continue to abide the status quo.

It is up to us to take the steps that are necessary to move us in a different direction, a better path that brings stability to the marketplace, that gives people more choices, more options, greater competition, and brings down premiums and deductibles and the costs that are driving family budgets through the roof.

What we have seen since ObamaCare has been implemented are higher costs, higher taxes, and fewer options. It is as simple as that. That is what we are up against, and that is why it is time for us to act. I hope when we conclude this process at the end of this week—and we have an opportunity for everybody to offer their amendments—we will move forward with the bill and fulfill our promise to the American people.

I yield the floor.

The PRESIDING OFFICER. The Senator from Rhode Island.

Mr. WHITEHOUSE. Madam President, I appreciate the remarks of my friend.

I would simply note that nothing he has said explains why you would want to strip hundreds of millions of dollars out of Medicaid or why you want to deny coverage to elderly folks who get Medicaid support for their nursing homes, people who are in the throes of addiction getting medical support for opioid treatment, children are often born on Medicaid—why you want to do all that. Nor does it explain why you would want to give big tax breaks to the most well-off people in the country.

Fine, let's fix the markets, if that is the problem, but this isn't really about that. This is stripping money out of Medicaid to give it to very wealthy people who are doing quite well already, in my view.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. DAINES. Madam President, Karen from Missoula County wrote to me about how her daughter can't afford to buy insurance. ObamaCare imposes a tax penalty on Americans who don't buy insurance. In fact, in 2014 and 2015 alone, they collected over $5 billion in fines.

It turns out, this tax has hurt poor and middle-income Americans the worst. That is why I refer to this as ObamaCare's ''poverty'' tax. For Karen from Missoula, paying ObamaCare's poverty tax is cheaper for her so she pays the IRS a fine because she can't afford healthcare insurance.

Take Debbie from Roundup, MT. She lost her own healthcare insurance. She couldn't afford the $1,700 per month premiums so she, too, was subject to ObamaCare's poverty tax and was forced to pay the IRS.

Take Mike from Kalispell, MT. He is concerned for his son who can't afford a health insurance plan either. The poverty tax he is forced to pay to the IRS is expensive. It is hard to come up with money to pay it. There are American families who can't afford health insurance because of ObamaCare, and what does ObamaCare do? It fines them. This is adding insult to injury.

These are just a few of the stories I have received from my constituents back home in Montana, where ObamaCare is doing more harm than good. Yes, it is doing some good, but it is doing more harm than good. In fact, 40 percent of the 34,250 Montanans who paid ObamaCare's poverty tax made less than $25,000 a year; 80 percent made less than $50,000 a year. This is not a tax on the rich. In fact, just 3.4 percent make more than $100,000. This is a tax on the poor.

Instead of helping these vulnerable Montanans to make ends meet, ObamaCare puts a poverty tax on them for being too poor to afford health insurance. In fact, in Montana alone, they paid nearly $7.8 million to the IRS. This individual mandate—this poverty tax—is immoral. It is unfair. It is a tax on freedom. It needs to be repealed immediately, and these poverty taxes must be paid back to the poor who have paid them.

Our friends across the aisle will say we want to get rid of taxes on the rich, but the rich aren't paying this tax. The poor are paying this tax. I think the right thing to do—the handshake agreement we have back in Montana as Montanans, where a man or woman's word is worth something—the right thing to do is, they should be paid back.

That is why I will be offering an amendment on the floor when we debate. We should pay back this poverty tax to the poor who have paid it. The poverty tax is just one of the many problems of ObamaCare, and I look forward to continued debate.

By the way, if you take this to the higher level here nationwide, nearly 8 million Americans have paid this poverty tax. As we looked at every State's numbers, it all is about the same: Somewhere between 40 percent and 50 percent of those Americans make less than $25,000 a year. In Indiana, it is 176,000 Indianans.

We have them for every State. Look at West Virginia. West Virginians, 45,000 have paid the poverty tax; 49 percent make less than $25,000 a year.

Take North Dakota. We share, in Montana, the same fence line with North Dakota. They are our neighbor. Over 20,000 North Dakotans paid the poverty tax. North Dakotans paid $4.6 million, and 40 percent of them make less than $25,000 a year.

Missouri: 143,000 Missourians paid the poverty tax, and nearly 48 percent of those Missourians make less than $25,000 a year.

Wisconsin: 115,000 paid the poverty tax, and 45 percent make less than $25,000.

I have a lot of other States. I would urge my colleagues to take a look at their respective States, and I ask: Can you look in the mirror and say we should be charging this poverty tax on those who make less than $25,000 a year?

Madam President, I yield the floor.

The PRESIDING OFFICER. The Senator from Washington.

Ms. CANTWELL. Thank you, Madam President.

I come to the floor—I know my colleague from Indiana, Senator DONNELLY, is going to be down here to talk a little bit about his motion, and I want to support him in that, along with the Senator from Pennsylvania, Mr. CASEY, because we are here to say we need to stop this war on Medicaid.

Throughout this healthcare process, it has been very clear that there are many on the other side of the aisle who just want to cut or gut Medicaid. What we are saying is, if you are serious about protecting Medicaid and stopping the war on Medicaid, then you should support the Donnelly-Cantwell-Casey amendment, which would recommit the bill to the Finance Committee with instructions to strike the language about Medicaid. It would make sure a state can expand Medicaid Program, and it would say: Don't cost-shift to the States.

With this motion, we are saying to our Republican colleagues: We don't want to cut people off of Medicaid. We want the committee to do exactly what the Republican Governors are saying, which is, quit beating up on Medicaid and focus instead on fixing the individual market. The individual market is 7 percent of the overall market for health insurance.

What we have found with the expansion of Medicaid that has been done by both Democratic and Republican Governors is great success.

I hope my Republican colleagues will heed the warnings of our Nation's Republican Governors and Democratic Governors. In June, a letter from seven bipartisan Governors was sent to Senate leaders. This is a letter by the Governors of Ohio, Montana, Nevada, Louisiana, Colorado, Massachusetts, and Pennsylvania. It shows the diversity of both our Nation and political parties. It says:

> We believe that, first and foremost, Congress should focus on improving our nation's private health insurance system.

Then they say:

> Medicaid provisions included in this bill [that has been proposed by the House] are particularly problematic. Instead, we recommend Congress address factors we can all agree need fixing.

So the message was clear from these Governors, including Republican Governors, and I hope my colleagues will listen to them. The Nation's Governors know because they have had to provide and be a partner on Medicaid for their citizens. They know how it affects their economy, and they know what it does when families in their States get access to healthcare. It reduces the bankruptcy rate. It helps people stay employed. It boosts GDP. All of these things are benefits of Medicaid expansion that we have seen in Washington State. It cut the uncompensated care cost in half. It also resulted in the creation of new jobs.

A nonpartisan study found that if the current bill we are debating, the House bill, is passed, state economies will shrink by $93 billion. So pulling the rug out from under Medicaid recipients would hurt jobs and hurt economies in Nevada, Alaska, and West Virginia. West Virginia would lose more than 10,000 jobs, more than $1 billion in gross State product, and more than $1.7 billion in business output. Nevada would lose 3,300 healthcare jobs and Alaska would lose 2,600.

So all of these things are ways for us to say: If you are serious now—before you go home for the August recess—about protecting Medicaid and stopping this ridiculous war on Medicaid, vote for our motion. Stand up and say you understand that we may have challenges in the individual market, but it doesn't mean that we should cut people off of access to healthcare through Medicaid.

I thank the Presiding Officer.

I yield the floor.

The PRESIDING OFFICER (Mr. PERDUE). Who yields time?

If no one yields time, time will be charged equally to both sides.

The Senator from Indiana.

Mr. DONNELLY. Mr. President, I rise today to offer a motion that would protect Medicaid, the Medicaid expansion, and the Healthy Indiana Plan—known as HIP 2.0—in my home State of Indiana.

I first want to thank my colleagues for their support of this motion. I am proud to have Senators CASEY, CANTWELL, BLUMENTHAL, LEAHY, BROWN, HARRIS, HASSAN, FRANKEN, FEINSTEIN, UDALL, SHAHEEN, CARPER, COONS, WHITEHOUSE, KAINE, VAN HOLLEN, CORTEZ MASTO, BALDWIN, MENENDEZ, REED, DUCKWORTH, MANCHIN, MARKEY, STABENOW, DURBIN, WYDEN, MURPHY, WARREN, GILLIBRAND, CARDIN, KLOBUCHAR, HEINRICH, HIRONO, BOOKER, PETERS, WARNER, and NELSON as supporters of this effort.

I also want to extend a special thank-you to my friend Senator BOB CASEY of Pennsylvania. Senator CASEY has been a tireless advocate for protecting the Medicaid Program and the critical services it provides, not just to the people of Pennsylvania but to millions of Americans across our beloved country. Senator CASEY has done incredible work to remind all Americans of the important role Medicaid plays in our communities and the millions of children, families, students, and seniors who have coverage through Medicaid.

My motion is simple. It would send this bill back to the Finance Committee to get the consideration it never received, and it would require the committee to strike provisions that reduce or eliminate benefits for those currently eligible for Medicaid, prevent States from expanding Medicaid, or shift costs to States to cover that care.

In my State of Indiana, we have seen the success of a bipartisan approach to expanding the Medicaid Program and helping our fellow citizen access health insurance. I was proud to work with then-Indiana Governor and now-Vice President MIKE PENCE when he used the Affordable Care Act to establish HIP 2.0. More than 400,000 Hoosiers have been able to access coverage through HIP 2.0, many for the first time in their lives. HIP 2.0 has helped reduce the uninsured rate in Indiana by 30 percent. Our Vice President called HIP 2.0—that is the Medicaid expansion in Indiana—a national model.

Then-Governor PENCE is hardly the only Republican Governor to praise the Medicaid expansion as a way to cover more of our citizens. Governor Sandoval of Nevada said just yesterday that he ''will continue to do all I can to protect the thousands of Nevadans whose lives are healthier and happier as a result of the expansion of Medicaid.'' Governor Kasich of Ohio has offered similar sentiments as he has fought to protect the Medicaid coverage for his State.

Nationwide, 31 States and Washington, DC, expanded coverage to more than 14 million Americans, many of whom have health insurance for the first time in their lives. All of that progress is at risk with the current bill.

Many of our States, including Indiana, have been devastated by the opioid abuse and heroin use epidemics. This public health crisis hasn't been confined to simply one neighborhood or one economic bracket; it has been felt in communities across my State and all communities across our country.

Vice President PENCE said in his farewell address as Governor: ''With HIP 2.0, we have also made great strides expanding treatment for those who struggle in the grip of drug addiction.'' I agree with the Vice President. HIP 2.0 and the Medicaid expansion have made treatment and recovery services more accessible for thousands of Americans struggling with addiction as they work to get back on their feet.

I don't think there is a single Member of this entire body—the U.S. Senate—who hasn't heard from the relative of someone who is battling addiction or from someone who has lost a loved one due to this epidemic. Gutting Medicaid and ending programs like HIP 2.0 as we know them would not make life better for Hoosiers or for the other 14 million Americans who have gained coverage through the Medicaid expansion. It would actually do the opposite.

Too often, this debate has been about statistics and not about the people who would be harmed. But healthcare, at the end of the day, is inherently personal. It is about the health and the economic well-being of our loved ones. It is about not having to go to the ER just to visit a doctor. It is about our financial security so our families and our friends aren't one illness away from bankruptcy.

The proposal before us wouldn't just impact Medicaid expansion; it would harm millions of working Americans who count on Medicaid for basic healthcare. It would affect more families than that, including those families who have insurance through their jobs but also use Medicaid to access care for chronic or complex conditions.

In 2015, 63 percent of Medicaid households had at least one full-time worker, and another 14 percent had part-time workers. That is almost 80 percent. For these hard-working Americans, Medicaid provides their families with financial security and stability and the healthcare they need so they can keep working.

Last month I stood on this floor and shared the stories of Hoosiers, including those who have Medicaid for themselves or to ensure that their children have the care they need. I have met with these families and heard their struggles, their fears, and their pain. I have listened as they pleaded with all of us here to protect their ability to access Medicaid. Many of these Hoosiers or their children are struggling with very complex medical needs that made it impossible for them to get coverage in the past. They would be priced out of the market under this current legislation. I cannot support a bill that takes care away from these families or from their children.

My faith teaches me that we are all God's children, and every man, woman, and child should have the chance to live up to their God-given potential. There is nothing we wouldn't do to take care of our kids. These aren't just Indiana values. These are values in every town in every corner of our country.

My faith also teaches me that we all deserve to live, work, and retire with dignity. In Indiana, 62 percent of Hoosier nursing home residents use Medicaid to help pay for their care. According to the Kaiser Family Foundation, Medicaid supports more than 1.4 million Americans in nursing homes across our country. Their care would be threatened by this bill, which is part of why seniors' groups have been so vocal in their opposition to the proposed Medicaid cuts in this bill.

I have also heard from a number of school superintendents all across my State opposing the Medicaid cuts because of the harm it would cause to the thousands of students across the Hoosier State. Schools use Medicaid funding for certain health-related services they provide, including individualized education plans, special transportation for children with disabilities, social workers, physical and occupational therapists, and medical equipment at the schools.

Some school districts use Medicaid to help pay for health professionals or for full-time registered nurses at schools across the country, where they assist students with complex medical needs and treat students with everything from illnesses to asthma attacks.

As school districts and local governments across the country continue to make even more difficult budget choices, cutting off this critically important source of funding creates just one more huge challenge. In addition to trying to make up the lost funding, our communities and States could be impacted in other areas as well, including infrastructure, other education spending, police and fire, and other local priorities.

The plan from my friends across the aisle undermines coverage for millions, but we haven't even had a hearing on their proposal. Committees haven't been able to go through regular order to examine the merits of Medicaid and the Medicaid expansion and how gutting them would harm millions of people—children with really complex medical conditions, those struggling with substance abuse disorders, and seniors in nursing homes trying to live with dignity and peace.

My motion sends this bill back to the Finance Committee to ensure that we are protecting those Americans who are the most vulnerable among our society. It would allow us to move toward strengthening healthcare for our country.

If you believe we should support children and families with complex medical conditions, then you should support this motion. If you want to protect the 1.4 million seniors using Medicaid for nursing home care, then you should vote for this motion. If you want to continue the progress we have made fighting the opioid abuse and heroin use epidemics, then I ask for your vote in this effort.

I firmly believe we can improve healthcare and build upon the gains we have made if we work together—not as Democrats or as Republicans but as Senators and Americans—in a bipartisan manner. This is not a political game. The consequences are as serious as it gets, and the American people are counting on us.

I urge my colleagues to support this motion.

Thank you, Mr. President.

The PRESIDING OFFICER. The Senator from Maryland.

Mr. VAN HOLLEN. I thank the Presiding Officer, and I want to start by thanking my friend and our colleague, Senator JOE DONNELLY, for standing up for Hoosiers and, in standing up for Hoosiers, standing up for all Americans whose healthcare is threatened if we continue to proceed down this very dangerous road in the Senate.

He talked about the opioid epidemic. Just last week I met with a dad by the name of Rick Warner and the brother and sister of a young man by the name of Jamie Warner who had recently graduated from the University of Maryland. He was a Terp.

Jamie died of an opioid overdose. He was part of the opioid epidemic that is sweeping the country. Rick Warner and his family were here in the Senate asking Senators—in fact, pleading with Senators, Republicans and Democrats alike—not to pass this healthcare bill.

He had lost his son Jamie, and he is determined that other moms and dads not lose their children to opioid overdose. This bill—make no mistake—will make those tragedies much more likely by taking away access to care in the way Senator DONNELLY just mentioned.

Yesterday, with the tie-breaking vote of Vice President PENCE, the Senate began down a very dangerous path, but we can get off that path. We can make sure we do not reach the end of that very dangerous journey. It was as if yesterday we lit the fuse and the fire is traveling down that fuse and at the end of the fuse is the plan to totally blow up the Affordable Care Act, which will wreak havoc on our healthcare system. That is why we have to put out the fire on that fuse right here in the Senate. We have the power to do that. We have the power to prevent the chaos and harm that will be created in our healthcare system if we continue down this path.

The reality, we know, is that all the healthcare plans that we have seen emerge to date—whether it was House plan 1 or House plan 2, or Senate plan 1 or Senate plan 2, or the proposal to repeal entirely the Affordable Care Act, which would cause great harm—have the same rotten core. All of them have the same nasty DNA, and that is this: They would deny access to affordable care for tens of millions of our fellow Americans in order to give tax breaks to the very powerful and very rich and to big corporations. In fact, the proposal we are voting on very soon, which is entirely repealing the Affordable Care Act with no replacement, will result, according to the nonpartisan Congressional Budget Office—these are the nonpartisan referees who look at these proposals and tell the American people what the impact will be—in 32 million fewer of our fellow Americans having access to affordable care than today. They also tell us that we will double the health insurance premiums compared to today. And for what? They give a gigantic tax break to the wealthiest Americans.

Warren Buffett, a name most Americans know, said about a month ago: For goodness' sake, I don't need a $670,000 a year tax cut in order to throw tens of millions of Americans off of affordable care. Don't do that. I don't need it.

Make no mistake. This has never been about healthcare. It has been about wealth care. I want people to think about this. If this were really about healthcare, why is it that all of the folks involved in providing healthcare to the American people are against it—the nurses, doctors, and hospitals?

People hear a lot of facts and figures from Senators and from the House. Some people may dismiss those numbers, but why don't we ask the people whose daily business it is to take care of the American people? What the doctors say is that all of these Republican plans violate their Hypocratic oath. What is the Hypocratic oath? It is the oath that every doctor in the country takes and the first principle is to first, do no harm.

Doctors, nurses, and hospitals all want to make people better. They all want to cure us. They all want to improve our health situation, but their No. 1 rule is not to make things worse, and all of these bills make things worse. That is what the numbers show us, and that is what the doctors, hospitals, and nurses show us. I think it is worse to have 32 million fewer Americans have access to affordable care.

What about our colleagues? Don't they think that is worse? I think it is worse when you double health insurance premiums and raise the cost of healthcare to Americans. That sounds like it is worse to me, not better.

It is not just all the folks who provide healthcare. Why don't we ask all of the patient advocacy groups across America about this so-called healthcare bill? What do they say?

The American Cancer Society: Bad bill—don't pass it. It will create harm. It will be a setback in our fight against cancer.

The American Diabetes Association says the same thing: Bad news for patients with diabetes.

The American Heart Association tells us that this will be bad and harmful to people with heart disease.

There is the Alzheimer's association, and we can go down the list. Every single patient advocacy group in America that has taken a position on this bill says it is a bad bill, it is dangerous to our health, and it will do harm.

So I don't know how our Republican colleagues can bring Senate bill 1, Senate bill 2, or Senate bill 3 before this

House and call it a healthcare bill when all the people who provide healthcare to our constituents say it is harmful to their health and when every patient advocacy group that has weighed in says that it is bad for their health. How is that a healthcare bill?

It is good for one group of Americans—those who will get a windfall tax break, but many of them, like Warren Buffett, are saying: Hey, I don't want this.

Now there are some very big corporations that are wanting their tax breaks, and, yes, as corporations, they are going to get this windfall benefit at the expense of everybody else in America and at the expense of our healthcare system.

So let's not go down this path. The way to avoid going down this path is to vote down all of these amendments and make sure that we don't put this bill into the House of Representatives, where they have already passed a bill that is harmful to Americans' health.

In fact, I think people will remember that President Trump had this big celebration in the Rose Garden of the White House after the House passed that bill. They were slapping each other on their backs before the cameras.

Yet, behind closed doors, what did President Trump have to say about the House bill? Behind closed doors, he called it a mean bill, and it is a mean bill. These Senate bills, when it comes to cuts in Medicaid that our colleague Senator DONNELLY was talking about, are even meaner than the House bill, with deeper long-term cuts. This is not according to me. It is according to the nonpartisan Congressional Budget Office.

Those cuts get translated into stories of people like Rick Warner, the dad I talked about at the beginning of my comments who lost his son Jamie. Those numbers get translated into harm to people throughout this country who have been crying out. We heard some of them in the Gallery just yesterday. What did they say? ''Kill the bill. Don't kill us.''

The reality is, when you deny access to affordable care to millions of Americans, you are putting their lives at risk, and when you raise premiums and costs, you are putting people's livelihoods at risk. So let's not go down this path.

The motion by Senator DONNELLY and others will do what Senator JOHN MCCAIN asked us to do yesterday—to go back to regular order, to go back to the committee process, to go back to the way this democratic institution is supposed to work, which is when we hear from our constituents, we hear from the doctors, we hear from the nurses. We do not cover our eyes and ears to the facts and the truth.

That open process is designed to protect the American people. It is designed to protect the American people from bills just like this one for which this Senate took that dangerous first step down the road on proposals that only 11 percent of the American people think is a good idea—11 percent. I cannot even find that 11 percent myself. I have gone all over the State of Maryland, to those parts of our State that voted for Donald Trump for President and to those that did not. I cannot find 11 percent in Maryland who are for this bill. That is why what we call the regular order around here is supposed to protect the public interest—because when you have a committee hearing on a bill like this and the doctors and the nurses and the hospitals all come out and testify against it, they let people know how bad it is. Instead, we have had this process in secret, behind closed doors. In many cases, we do not even know what the next amendments after this one that is coming up are going to be. We do not know what the Republican leader is cooking up behind closed doors.

Let's do what Senator MCCAIN urged us all to do. Let's get back to regular order. Let's get back to a process that is designed to provide transparency because with transparency comes accountability. It lets the American public know exactly what we are doing and how we are going to impact their lives.

Here is what I do know. Everybody across this country who knows about this bill—everyone I have spoken to and from the phone calls we are getting and the emails we are getting and at the rallies and the townhalls—is catching on. Why would we just steamroll over all of that important public sentiment coming from all political views? The American Cancer Society is not a Republican or a Democratic organization. The American Diabetes Association is not partisan. These groups are crying out and saying: Stop.

So let's get off this path, this very dangerous path. Let's get back to regular order. We all know our healthcare system is not perfect. We all know the Affordable Care Act is not perfect. Senator DONNELLY and I and others and many of our Republican colleagues have put forward much more narrow plans that focus on improving our healthcare system, not on blowing it up entirely. That is the path we should take.

I hope all of our Senators will agree not to continue to let that fire burn on the fuse until it gets to the end and blows up our healthcare system. Let's stop now. Let's get together, and let's have a committee process. Let's do something that really improves our healthcare system and not something that destroys it.

Thank you, Mr. President.

The PRESIDING OFFICER. Who yields time?

If no one yields time, time will be divided equally between both sides.

The majority whip.

Mr. CORNYN. Mr. President, I am advised we are not in a quorum call. Is that correct?

The PRESIDING OFFICER. The Senator is correct.

Mr. CORNYN. Mr. President, yesterday we took a giant step toward delivering on our promise to the American people to provide relief from the failures of the Affordable Care Act, otherwise known as ObamaCare.

Over the last 7 years, we have discussed what our solution would look like, and everybody who has been willing to participate in that conversation—sadly, not our Democratic colleagues, who simply refuse to do so, but every Member of our conference—has engaged in discussions and has had input on how best to accomplish the goal of providing people affordable coverage, increased access, market stability, and better care.

We can talk about all of the details, but basically what this boils down to is how to provide people with access to quality, affordable health care. I know some of our friends across the aisle thought the Affordable Care Act was it, but it failed. It started with the promises that were made by President Obama when he sold this to the American people, saying: If you like your policy, you can keep your policy; if you like your doctor, you can keep your doctor. He said that premiums would go down $2,500 for a family of four, none of which have proved to be true—none of which have proved to be true.

Now we find that in many parts of the country, insurance companies are pulling out, limiting if not denying altogether people's access to coverage within the exchanges. We know what has happened to premiums. Since 2013, they have gone up 105 percent nationally—a 105-percent increase in premiums.

People find that their deductibles are so high that they effectively are self-insured. They have been denied the benefit of their own insurance. Nominally, they may have insurance, but the fact is, if you go to the hospital, you are going to be responsible personally for what is not covered by that deductible.

Even our colleagues across the aisle admit that ObamaCare has failed to provide stable access to insurance markets, but their solution has been to pay more money to insurance companies. I would call that an insurance company bailout without any reform, without any changes in the basic structure of ObamaCare, which has caused this failure.

What we have tried to do on this side of the aisle—and we have repeatedly invited our Democratic colleagues to join us because optimally this would be a bipartisan effort, but so far they have refused to participate whatsoever and really are focused solely on trying to blow up the current process.

What we have said we want to accomplish are four things. We want to stabilize the insurance markets. We want to bring premiums down so they are more affordable. We want to protect people with preexisting conditions. We want to put Medicaid—the safety net for low-income Americans—on a sustainable path.

Of course, as you might imagine with something as complex as healthcare, we have had a number of opinions on how best to achieve these goals. Even as approaches and ideas have differed, one thing has remained constant: the belief that the status quo is simply unacceptable. It is unacceptable.

Take, for example, one of my constituents in Texas, who wrote me recently to say that his monthly insurance premium under the Affordable Care Act had nearly tripled, to $690, and his deductible, to my earlier point, went from $1,500 to $6,000.

I don't know many people—unless they happen to be well-to-do—who can afford to absorb those sorts of increases in premiums and deductibles. Because his coverage went from a PPO, a preferred provider organization, to an HMO, a health maintenance organization, some of his doctors are no longer in the network, forcing him to switch healthcare providers entirely.

This story is certainly not unique. It is typical. This is the norm under the Affordable Care Act. I often hear from Texans who would rather drop their coverage and pay the costly fine rather than have to pay for insurance that will cost them more and more each month, which they can't afford.

Here is a telling statistic. More than 400,000 Texans who earn less than $25,000 a year have decided to pay the penalty rather than to be forced to buy the insurance they can't afford, so many of them pay the penalty because of the individual mandate in the Affordable Care Act. They are left with nothing, other than having to pay the penalty as required by the law. That is not a solution. That is why I hope that someday we can get out of this rut and off of the talking points on each side and say: What can we do to try to provide people access to affordable health care? That is the key.

People are going to make their own decisions based on their own economic self-interest. If you are a young person, you might decide: What I would like to do is to buy a policy that will cover me in emergency circumstances if I have to go to the hospital, but I don't want to have to pay for all the bells and whistles that raise the price. You can't do that under the Affordable Care Act and take advantage of the tax subsidies that everybody else can. It is basically a false promise.

I also heard from another small business owner in Donna, TX, who was forced to fire four employees just to comply with the employer mandate or otherwise owe the government more than $100,000 in fines that he said could bankrupt his business. Those are the kinds of decisions that ObamaCare is forcing. Rather than hire enough people—or if you have more than 50—you decide you need to fire people in order to avoid these penalties that come from the employer mandate. That is not good for the economy. That is not good for the job prospects of hard-working Texans.

I shared the story of a constituent in Needville, TX, who, after a 50-percent increase in his monthly premiums, still lost his doctor because the doctor wouldn't accept his ObamaCare plan.

Then there is the emergency room employee in North Texas, who wrote me to say that she has seen a significant increase in the Medicare and Medicaid patients in the emergency room because fewer and fewer doctors would accept these patients.

In my State, only about one-third of doctors will accept a new Medicaid patient because it pays at such a low rate. We have a better idea that will make people up to 350 percent of the Federal poverty level eligible for a tax credit they can use to buy private insurance, which will increase their access to care and make it more affordable. We have coupled that with something called the innovation and stability fund, in which we have taken the authority out of Washington and sent it back to the States to let Governors and State legislators and regulators at the local level design policies that meet the needs of the people in the States.

The basic structural failure of ObamaCare was to assume that you could write a one-size-fits-all plan for 320 million-plus people that would work. It hasn't. We know that. That is not speculation; this is based on experience.

I know my colleagues across the aisle have heard similar stories from their constituents, as well, but apparently they don't seem to care very much about that. Otherwise, they would join with us in trying to improve the status quo, which they have refused so far to do.

One thing about the procedure that we are undertaking here is that any Senator who wants to offer an amendment to improve the bill or even offer a complete substitute to the bill is entitled to do so, and they will get a vote on that. Our colleagues on the Democratic side, despite hearing from their own constituents that they are hurting as a result of the status quo, appear not willing to lift a finger to help them.

Indeed, the only proposal I have heard from the other side—I have heard two. One is an insurance company bailout, which does nothing to effect reforms that would ultimately address the structural problems with ObamaCare or else they say: We want to have a single-payer system, which will bankrupt the country. Those are their solutions.

On Monday, I noted that in an effort to try to unite their deeply divided party after last year's elections, our Democratic colleagues unveiled an economic agenda aimed at, they say, lifting up lower and middle-class Americans. That is an admirable goal.

If Democrats are really serious about helping lower and middle-income Americans, one glaring and immediate action they could take is to join us in alleviating the burdens placed on these very same folks by ObamaCare—the types of people I have been talking about back in Texas, whom I know exist in their States as well.

If the Democratic leader refuses to help get rid of one of the biggest economic burdens on lower and middle-income Americans, then his plan is not worth the paper it is printed on. What they are offering is false hope. Unless you are willing to deal concretely with the problem here and now, that is just another campaign promise—one they will not be able to keep until they address what the failures of the Affordable Care Act have imposed on low- and middle-income Americans.

Simply stated, ObamaCare is a failed experiment. It has failed because Washington has tried to do too much at the expense of individual choices, individual liberties, and family control over what are deeply personal decisions.

With each day that passes, ObamaCare keeps getting worse. The premiums for 2018 will soon be announced by the insurance companies, and we are going to see double-digit increases again, over and above what ObamaCare has seen so far—105-percent increases since 2013 alone—on top of that.

After yesterday's vote, we now have the opportunity to provide relief from this failed law. I know Members have a lot of ideas about how to fix the mess that ObamaCare has left us, but that was precisely why it was so important for us to get on the bill yesterday, so Members on both sides of the aisle can offer amendments and share their ideas.

Do you know how many Democrats voted to get on the bill and begin the debate and offer amendments? Zero, zip, nada. Their protestations that they somehow want to do things on a bipartisan basis really have fallen flat, as demonstrated by their own failure to act.

If they were really interested in working with us to do something on a bipartisan basis, why wouldn't they take advantage of this opportunity to do so?

Last night we began the process of considering amendments, including one from my colleague in Texas, Senator CRUZ, who has a plan to provide people who choose a lower cost premium insurance product the opportunity to do so, as long as the State also requires a comprehensive plan as well. This is something that is ideal for many people who want an insurance safety net but don't necessarily want their health insurance to pay for their regular medical expenses or doctor visits. They can handle those through a health savings account or some other way.

Later today we will continue to work toward bringing relief to millions of Americans suffering from the failure of ObamaCare. Yesterday was a big step toward ending ObamaCare and the first step toward ending the mandates, the

penalties on low- and middle-class Texans who are having to choose between buying unaffordable insurance or paying a penalty that their government is forcing them to pay. We are going to end that.

We are going to end the job-killing employer mandate, which is forcing employers either to lay people off or not hire additional people because they don't want to run into the additional costs required by the employer mandate.

Then there is the single mom, whom I met in Tyler, TX, a few years back. She said: I want to work full time. I want to work at least 40 hours a week, but the restaurant where I work figured out that if they put me on part time, 29 hours a week, then they wouldn't be required to meet the mandates of the Affordable Care Act.

What this single mother, who wanted to work full time, was forced to do because of ObamaCare was to work part time. Do you know what? She can't make it on 29 hours a week, so she has to get two jobs. Effectively, she had to go from 40 hours a week doing a job she enjoyed, which helped her pay the bills, to working two jobs in order to make ends meet.

We can and we should do better, and we invite our colleagues across the aisle to join us, if they will.

People keep talking about a secret process. Well, this is about as open and transparent as it gets. Everybody will have an opportunity to offer an amendment, to discuss what is in the amendment, and to vote on it. To the extent that the Senate's work product differs from what the House of Representatives provides us, we can go to a conference and work out those differences. That is how the legislative process is supposed to work. Sitting on your hands and complaining about something while offering no effort to try to help solve the problem simply boils down to hollow words. Unfortunately, that is all we have been hearing so far.

We hope our colleagues will change their minds and join us. Insurance bailouts with reform are not the answer, a single-payer system is not the answer because it will bankrupt the country, but we are more than happy to entertain any reasonable proposal from our colleagues across the aisle. We will guarantee they get a chance to debate it and to have a vote on their amendment. I don't think they could ask for anything more.

The PRESIDING OFFICER (Mr. COTTON). The Senator from New Hampshire.

Mrs. SHAHEEN. Mr. President, as we all know, we are continuing to debate what amounts to repealing the Affordable Care Act without any indication of what is going to replace it—what is actually in the Republican leader's bill. I think this is worth repeating because we are talking about changing one-sixth of the U.S. economy, impacting every American family, and yet we still have no idea what the bill actually is.

We do know this. A partisan bill to take away health insurance from tens of millions of Americans, written behind closed doors, opposed by every healthcare stakeholder group and by an overwhelming majority of the American people should not pass the Senate.

As I have repeatedly said, the only constructive way forward is for Democrats and Republicans to come together in a good-faith, bipartisan effort to repair and strengthen the current law. Bipartisanship should not be our last resort, as Senator MCCONNELL has suggested. It should be a starting point. It should be the foundation of what we do in this body. This is how the great majority of the American people want us to conduct the Senate's business. This is what I hear from my constituents in New Hampshire, and this is especially true with healthcare legislation which affects families all across this country.

Make no mistake, every bill proposed by the Republican leadership has been designed as a bullet to the heart of the Affordable Care Act. Republican proposals will collapse the individual marketplaces, make it impossible to provide affordable coverage for people with preexisting conditions, and take healthcare coverage away from up to 32 million Americans, including the most vulnerable.

I hope nobody is fooled by this latest partisan measure to roll back the Affordable Care Act and take healthcare coverage away from tens of millions of Americans. I hope every Senator will, at long last, heed Senator MCCAIN's call for bipartisanship—as we have been hearing at townhalls and in countless messages from our constituents. The American people want us to make commonsense, bipartisan changes to the current law. We need to work together to build on the strengths of the Affordable Care Act, which has dramatically reduced the number of uninsured Americans and has given us valuable tools for fighting the opioid epidemic which is ravaging so many communities in America. This is the best way forward for both the Senate and our country.

Republican leaders have spent the last 7 months pushing deeply unpopular bills to repeal the Affordable Care Act, including their effort to dramatically cut Medicaid—not just the expansion of Medicaid under the Affordable Care Act but the Medicaid Program that has done so much to protect and provide healthcare for children across this country, for pregnant women, for those with disabilities and older Americans, so many of whom are in nursing homes who would lose that care if we dramatically cut the Medicaid Program as the Republican proposals have tried to do.

At the recent National Governors Association meeting, Democratic and Republican Governors alike urged Congress to reject the Republican leaders' healthcare bill—in particular, its harsh and unsustainable cuts to Medicaid. The Republican Governor, John Kasich, was especially forceful in urging Members of Congress to work together to find bipartisan solutions. He urged Congress to give first priority to stabilizing the healthcare marketplaces.

We should listen to the Governors, but most importantly we should listen to our constituents—to the great majority of our constituents who want to preserve what is working in the Affordable Care Act and see us change what is not working. Instead of legislation to take healthcare away from people, it is time now for an inclusive, bipartisan approach to provide quality, affordable healthcare for every American.

Thank you.

I yield the floor.

The PRESIDING OFFICER. The assistant Democratic leader.

Mr. DURBIN. Mr. President, yesterday, on the floor of the Senate, there was a speech which will be remembered for a long time. Our friend and colleague Senator JOHN MCCAIN came to the floor just days after he had been diagnosed with a serious cancer challenge. He made the trip from Arizona to Washington to vote on the floor on this healthcare debate, then asked for 15 minutes of time afterward to speak to the Senate. Of course, he was given that opportunity.

During the time that we learned about his diagnosis and he was home, virtually every one of us sent our personal best wishes to him and his family. Our love and respect for JOHN MCCAIN is deeply felt in the U.S. Senate, and virtually everyone stayed on the floor to hear his speech. Look around the floor now. There aren't many people, right? As good as my speech may be, it is not going to touch the quality of what John delivered yesterday. I wanted to be here for it and so did my colleagues on the Democratic side and on the Republican side.

JOHN said a lot about who we are and what we are in the U.S. Senate. Fewer than 2,000 individuals, in the history of the United States of America, have had the honor to stand here and speak on the floor of the Senate. This is a rare opportunity. For many of us, it is a dream come true and one we couldn't imagine, but what JOHN said yesterday, to summarize part of his statement, is that we ought to understand our responsibilities, as well, as Senators.

We ought to be honest about what we now face in America when it comes to the political discourse, the political debate. What we face now is a divided country, a divided Senate, divided House, and yet a yearning by all Americans for us to step up and do something; make America a better nation; help America's families, the workers, the businesses; step forward and solve a problem. JOHN reminded us yesterday that to do that, we needed to move to what he called the regular order.

It may not mean much to those who are just watching this debate and don't follow the Senate closely, but the regular order is to introduce a bill into

the Senate, send it to a committee, have the committee staff review it, experts take a look at it, call for a committee hearing so the American people can see what is in the bill, debate the back-and-forth at the hearing, then have members offer amendments—changes. Some will win, some will lose. Then the bill can come to the floor of the Senate for a similar process. It is an open, public process. That is what regular order is, and that is what JOHN MCCAIN spoke to.

Let me, at this point, quote what he said verbatim. I like this paragraph a lot so I am going to add it here. Here is what JOHN MCCAIN said yesterday on the floor of the Senate:

> I hope we can again rely on humility, our need to cooperate, on our dependence on each other to learn how to trust each other again and, by so doing, better serve the people who elected us.

I like this part:

> Stop listening to the bombastic loudmouths on the radio and television and the internet.

JOHN MCCAIN said:

> To hell with them. They don't want anything done for the public good. Our incapacity is their livelihood.
>
> Let's trust each other. Let's return to regular order. We have been spinning our wheels on too many important issues because we keep trying to find a way to win without help from across the aisle. That is an approach that has been employed by both sides; mandating legislation from the top down, without any support from the other side, with all the parliamentary maneuvers it requires. We are getting nothing done, my friends. We are getting nothing done.

JOHN said it yesterday and it still applies and he is right. I say that as a Democrat with respect for him as a Republican, but if we are not going to do more than just listen and be warmed by his words and applaud his speech, what should we do at this moment?

What is pending before us on the floor of the U.S. Senate is legislation that will change healthcare for every single American—every one of them. It will change it for us in the Senate, but it will change it for the 12.5 million people I represent in Illinois too. Every one of them will be changed by this bill. What is in this bill that will change it? We honestly can't tell you. The bill has not been written. We aren't able to see it. We are being told before the end of the week we will actually get a copy of the bill. I am not making that up.

We have tried several amendments on the floor, and they failed—one has failed. Several are likely to fail this afternoon, but there is no bill before us. We can't explain to the American people what this is ultimately going to be, except in the most general terms of what is being debated. That is embarrassing. It is embarrassing on the floor of the Senate.

What we should do is take this critical matter that affects every American and every American's healthcare and send it to a committee—the HELP Committee, chaired by Senator LAMAR ALEXANDER, Republican of Tennessee; Ranking Member PATTY MURRAY, who is a Senator from Washington; the Finance Committee, Senator HATCH of Utah, Republican; Senator WYDEN of Oregon, Democrat. They need to sit down and look at these bills carefully.

Let's not make a mistake at the expense of the people who sent us here. Let's stand up for sound, thoughtful judgment. Let's stand up for a Senate that works, as JOHN MCCAIN challenged us. Is that what the American people wish? I think it is at the heart of all of it. I think JOHN MCCAIN really set a standard we ought to live up to. Let's stop this waste of time over a debate over a bill that cannot even be printed. Let's take this to the regular order. Let's do it the right way, to the credit of the Senate and to the credit of our country.

We took an oath, each and every one of us, to swear to uphold the Constitution. That Constitution, that document we revere, spells out exactly what we should do at this moment, which is stop what we are doing on this floor, stop wasting the time of the American people and endangering their healthcare and take this to a debate that is befitting a great Constitution and a great nation and a great Senate.

I yield the floor.

I do it with the hopes that those who speak after me, of both political parties, will first sit down and read what JOHN MCCAIN said yesterday and let their applause for his remarks be reflected in what they do on the floor of the Senate today.

I yield the floor.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. WYDEN. Mr. President, I thank my colleague for an excellent statement and for appealing to the better angels.

Mr. President, I am rising to speak about the Donnelly amendment, which is very much needed because the President—and now Republicans—are walking back a clear commitment.

The President said in the campaign that he would not cut Medicaid, he wouldn't touch it, but even before the inauguration, the Trump team eagerly signed on to a Republican plan to slash it by more than $700 billion. They stared into television cameras, looked American voters in the eyes, and said that somehow these massive cuts to Medicaid wouldn't in any way harm the seniors. Medicaid picks up 2 out of 3 dollars with respect to seniors in nursing home beds and special needs kids and disabled youngsters.

When we hear that Medicaid picks up the cost of two out of three nursing home beds and compare that to the President's statement that he wouldn't cut Medicaid—wouldn't cut it—when we are now faced with a plan to cut it by more than $700 billion, one, that is walking back the President's solemn pledge in the campaign, and, two, it is going to make it harder for older people in this country to be able to afford long-term care.

The majority has brought the TrumpCare debate and the extreme Medicaid cuts that I just described directly to the floor of this Senate without a single committee hearing to justify this ill-advised policy.

Our colleague from Indiana, Senator DONNELLY, has put forward an important amendment to stop this ideological crusade to unravel the Medicaid safety net. Senator DONNELLY's proposal would send this partisan attack on Medicaid back to the Senate Finance Committee, where it should have been raised and struck down in the first place.

Mr. President, I am the ranking Democrat on the Senate Finance Committee. My focus in public life has always been to try to find common ground with people of common sense. And I wrote with colleagues—many of whom still serve on the Republican side and on the Democratic side—a universal coverage bill that pulled together both sides of the political spectrum.

So unless you provide an opportunity to have a discussion about the Medicaid safety net in the Senate Finance Committee, you are not going to be able to have policies that get to common ground on this vital issue. What you are going to have is what is really on offer now—an anti-Medicaid crusade that is a grave threat to the health and well-being of tens of millions of Americans.

Over the last few months, I have heard Republican colleagues say that Medicaid is a disincentive to work and that there are too many able-bodied adults enrolled. If you look at the facts, that is not what the program is all about. Medicaid is a vital source of coverage for our neighbors and friends who live in poverty. It tells those families that healthcare is covered while they work to climb the economic ladder in the private sector.

In addition to that, for the older people I have mentioned—these are the folks who have done everything right in life. They went to school, they found jobs, they worked hard in their careers, they raised families, and they scrimped and saved all through their lives. Growing old in America is pretty costly. So what happens is that millions of seniors who have done everything right spend down their savings, and that is when Medicaid steps in to help. It covers two out of three seniors living in nursing homes. It is a major source of funding for community-based care, and people generally don't know that. Now they may have heard about nursing homes, but it also picks up the costs for community-based care, where older people are more comfortable, and it often costs less than institutional care.

Seniors who lose those benefits due to TrumpCare Medicaid cuts are going to have to find somewhere else to live. A lot of families want to be able to help elderly parents and grandparents. It is going to be pretty hard because a lot of them are walking on an economic tightrope, and if they go looking

for nursing home care, it is going to cost on average more than $90,000.

So it is seniors, and it is disabled folks who count on Medicaid to have a chance to be productive. With the Medicaid benefits under threat, people with disabilities are going to find it hard to be able to attain the productive role in our society that they so fervently want to have. Our communities are so much better off when folks with disabilities can contribute, and Medicaid makes that possible. It covers services that many private insurers don't. It helps people make it out of bed and provides safe transportation to jobs. It helps them avoid unnecessary illnesses. It is not a disincentive for people with disabilities to work; having the support of Medicaid is what makes it possible for disabled folks to work.

Across the country, there are millions of kids with special needs who rely on Medicaid every day for services—behavioral care services, mental health services. Mom or dad might have good insurance through work, but private plans don't always cover the care those vulnerable kids need.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. WYDEN. Mr. President, I ask unanimous consent for 1 additional minute.

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

Mr. WYDEN. Mr. President, I have commented on the secret process that went on in this discussion, but I will close with this: One version of TrumpCare has already been voted down here in the last day. Nobody knows where this debate will wind up, but what is important now is that Senators support the Donnelly motion. The Donnelly motion is going to ensure that the Finance Committee, where Senator ENZI serves so admirably, and all of our colleagues, Democrats and Republicans, is going to be able to look at this issue in a way that is going to bring the Senate together, not divide it, as we would be without the Donnelly motion.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Connecticut.

Mr. BLUMENTHAL. Mr. President, I appreciate my colleagues across the aisle accommodating me for 3 minutes, and I ask that—

The PRESIDING OFFICER. There is no Democratic time remaining.

The Senator from Wyoming.

Mr. ENZI. Mr. President, Senator BLUMENTHAL, the Senator from Connecticut—I ask for 3 minutes from our time, and we will allot that as long as we preserve the full time for the Senator from Wisconsin.

The PRESIDING OFFICER. The Senator from Connecticut is recognized.

Mr. BLUMENTHAL. Mr. President, we have seen in the course of this debate some very high points and some points that I think in some ways we regretted. One of the high points for me was the return of Senator MCCAIN, and I want to join all of my colleagues in saying how heartfelt our gratitude is for his return and his eloquence here about the need for us to work together.

Yet yesterday we also saw, in my view, a shameful and disgraceful mockery of our democracy when Senators proceeded, in effect, to a slogan, a shell of a bill, not a really substantive measure. Yet that shell itself will undermine the exchanges and insurance coverage for millions and millions of Americans by creating uncertainty, and this process itself will aggravate that fear.

I have now held five field hearings in Connecticut, and at each one I have heard from countless people with tears in their eyes telling me what the Affordable Care Act and Medicaid have meant to them, what repeal of it will mean to them, and how devastating and cataclysmic the damage will be.

Thousands of constituents have written, have called, and have also contacted others of my colleagues, as I have urged them to do, and I want to say how grateful I am to them for their continued activism and advocacy. We need to maintain this fight. I have heard from moms and dads about what would happen to their children. One said to me: We can't thrive as a nation or as individuals if we can't afford to be healthy.

So I ask my colleagues to listen to their constituents, to the people in their States, people like Conner and Mackenzie and Amelie and Evan and Amanda and Michelle and Jennifer and Gay. I described them on the floor in my previous talks. These voices and faces need to be brought here because there have been no hearings, no regular order, no democratic process, as we have an obligation to do.

If at some point my colleagues abandon this effort to repeal and decimate the Affordable Care Act, I stand ready to come across the aisle to work together to drive down the costs of healthcare—particularly pharmaceutical drugs—and to open the exchanges to more competition and create more choices for consumers among insurance companies. There are steps we can take together to improve this process. As Senator MCCAIN urged us so powerfully, we need to go back to regular order, come together, and work across the aisle. There is no panacea. There is no instant solution. But we need to work together.

Thank you, Mr. President.

I yield the floor.

The PRESIDING OFFICER. The Senator from Wisconsin.

Mr. JOHNSON. Mr. President, I come to the floor today to speak to three amendments that I have either submitted or plan to submit on the matter before the Senate here today, the repeal and hopefully complete replacement of ObamaCare.

There are two issues that concern me the most and that I have fought for and debated.

In this process, how can we bring down gross premium levels that have skyrocketed under ObamaCare? According to HHS, on a national average, premiums have increased 105 percent. They have more than doubled. And of course it is far worse than that in many places.

Janice Fenniman was a 62-year-old woman when I met her a couple of years ago. Prior to ObamaCare, she was paying $276 per month. In 2016, just 2 years into the implementation of ObamaCare, she was paying $786 per month. Last time I talked to her, she would be paying over $900 a month, but the problem is, she can't afford it, so she is just taking a risk and going uninsured until she reaches the age of 65 and is qualified for Medicare.

The other issue I want to speak about is literally the unsustainable nature of Medicaid. The other thing I fought for is reducing the disparity between States that have expanded Medicaid and those that haven't, like Wisconsin, that have done a great job managing Medicaid. My concern is that Medicaid expansion, which is directed toward able-bodied, working-age, childless adults, is funded by the Federal Government 90 to 100 percent, depending on which year you are looking at, versus traditional Medicaid targeted toward—40 percent of Medicaid spending is targeted toward children, the disabled, and the elderly. Medicaid expansion is putting at risk the sustainability of traditional Medicaid. So my three amendments deal with those issues, and let me first take up the first two amendments dealing with premiums.

I have a few charts. Unfortunately, in Washington, DC, there is not a whole lot of people who understand the problem-solving process. Let me describe it briefly.

It starts with information. It starts with defining the problem, doing a root cause analysis, having the courage to recognize and acknowledge the truth in reality. Based on that reality, you try to set achievable goals. From my standpoint, the achievable goals should be to bring down gross premium levels back to a reasonable level where they were prior to the implementation of this completely faulty architecture of ObamaCare and preserving and sustaining traditional Medicaid.

This chart, I realize, is a little busy, but let me walk you through it. This shows the trend line of ObamaCare, in terms of what we have experienced from 2010 to 2017, plus the estimates of the Congressional Budget Office as it relates to the Senate bill we voted on yesterday.

Let's take a look at this. Back in 2010 to 2013, you see the trend line here. In 2013, on the national average, an individual is paying about $232 per month for healthcare. Now had that trend line just continued, had we not passed this faulty architecture of ObamaCare, we could reasonably expect that in about 10 years, premiums for an individual being about $303 per month.

What has happened—again, according to HHS—those premiums have gone

from $232 per month to this year $476 per month on a nationwide average. That is a 105-percent increase.

One of the problems with CBO scoring is it is difficult to interpret. What I tried to do for my colleagues is put in chart form exactly what CBO is saying. In their scoring of the Senate bill, they said next year premiums would be 20 percent above the current baseline. Of course, they don't give you the baseline, and they don't really give you the premiums so I had to try to cobble those together. This is pretty accurate. That would put premiums next year at about $546 versus $232 about 4 years ago. The following year it would be 10 percent above the baseline. So it would start decreasing with the Senate bill, and the third year would be 30 percent below baseline. You would see a dramatic drop. You would be at $441 per month. Then the trend over the next 7 or 8 years would be 20 percent below the baseline, $574.

Take a look at this. Had we never passed ObamaCare, premiums should be in the $300-a-month level versus $574. This is the damage done by ObamaCare, and this, I am very sad to report, is not what we are adequately addressing because we do not have the courage to do the root cause analysis and be honest with the American public about what is happening.

Let me read you a dictation from the family I just heard from yesterday. Sheri and Vern Kolby, whom we heard about from one of our State legislators who contacted one of my regional directors. He sent me an email telling me their story.

I called Sheri last night. She didn't have time. She was just off her shift. Her husband is working way more than 40 hours a week—basically, that is 60 hours a week. The people whom President Clinton was talking about, people busting it, working 60 hours a week, their premiums have doubled and their coverage has been cut in half. So my staff reached out, and we basically dictated her story, her and her husband Vern's story.

This is not her letter to me but her voice based on what was told to me by my staff. This is Sheri Kolby from River Falls, WI.

My husband and I have preexisting conditions. We need affordable healthcare through ObamaCare or whatever works. Vern is a milkman now, driving a tank to farms to pick up milk, and there are only seven employees at his company which doesn't provide coverage. I am a florist. Now, I am the only full-time employee so they don't have health coverage at my work either. We signed up for ObamaCare in 2014 for the entire 12-month period.

We went on healthcare.gov, but the site crashed, so we had to call a phone number which was jammed. Finally, I got hold of someone and got through an hour and a half of questionnaires. Then you get information in the mail about what your premium will be and your subsidy, and you make your monthly payment.

We were getting monthly letters telling us we had to fax in our pay stubs to make sure we were still qualifying for the subsidized premiums. We did that every month, but then next March, when we filed our taxes, that is when my tax preparer said, ''You better sit down. Not only did you pay your premium, but they want your subsidy back.'' That was about $15,000.

We were earning too much to qualify for the subsidies, even though we held blue-collar jobs. If we stayed on ObamaCare, we would have to pay the entire premium unsubsidized. In 2015, we made $59,000 and ended paying almost $30,000 for premiums and deductibles. That was 51 percent of our income.

In covering our deductibles and our out-of-pocket costs, we used up almost all of our 401(k)s. It just multiplied and multiplied. When a huge amount of money was due the IRS, we decided we had to sell our house.

Sheri and Vern Kolby had to sell their house so it wouldn't be taken away in foreclosure because of Obama's skyrocketing premiums.

Now we can only get a 3-month plan. That is all that is available. Private catastrophic plans are few and far between.

And I will add, parenthetically, also way overpriced because of the faulty architecture of ObamaCare.

There aren't a lot of companies that offer plans in Pierce County. We are kind of in a funnel and that funnel keeps narrowing. In May, I went back to healthcare.gov, but coverage would have cost $1,200 per month, about $14,400 per year in premiums for a policy with a $14,000 deductible. If you made $200,000, you could pay that, but we are not even close to that. We usually fluctuate between $50,000 and $60,000. We are blue collar. We pay our bills on time, we respect people, and we want to live a good life, and we have just been dumped on. It has got to stop.

It may come to a point where we might not have insurance, but we will just end up owing the hospital if something else happens. My husband works 60 to 70 hours a week, and I work 30. We drive a '98 Wrangler. We are not running around in a Ferrari. We don't spend money beyond our means. We don't take trips to Tahiti, and we are not trying to swindle the system, but it has been a very stressful experience.

We have been married 28 years, and we have stayed together through so much, but we are not old enough to even think about retirement for a long time so I don't know what we will do.

These are the forgotten men and women of this healthcare debate—the people who are busting it, who don't get subsidized, who can't afford insurance coverage because of the faulty architecture of ObamaCare, and we are not courageous or honest enough to really address it.

We did get from HHS a study that they commissioned and they had the results in May.

I would like to put up my next chart here.

Basically, what they did is they studied the cause, and I have the study right here. Basically this is the question they are asking: What portion of the increase in premiums is attributable to the effects of guaranteed issue and community rating?

Now I realize those are very popular elements of ObamaCare. The problem is, they cause premiums to skyrocket. That last graph—way above what they would have been without that architecture—pricing people out of the market, forcing American taxpayers to pay far more in subsidies than we otherwise would have to do or would be necessary had we never passed ObamaCare.

Well, here is the result of their study. They studied four States: Georgia, Ohio, Tennessee, and I can't remember the last one, but I am going to focus on Tennessee.

What this graph shows—I realize it is kind of hard to see—but in Tennessee, between 2013 and 2017, premiums increased $327 per month, from $104 per month to $431 a month for a 41-year-old male. That is a threefold increase, 314 percent. What caused it, 73 to 76 percent was increased risk. Again, increased risk is basically defined as the guaranteed issue covering preexisting conditions and community rating—things that are popular but again that cause premiums to double and in Janice Fenniman's case, more than tripled.

One thing I want to point out about that, when you hear that talking point, premiums that double and triple, look at the inverse of that. If we could roll back the clock, go back 4 years, premiums would be one-half to one-third of what they are today. People would be able to afford coverage, and the American taxpayer would be supporting those whom we want to support with a whole lot less dollars.

Now, the good news, if we were honest, if we were courageous, and if we actually addressed the root cause analysis, which has been done, which we have largely ignored, the good news is, you can actually cover people with high costs and preexisting conditions without collapsing insurance markets. They are called high-risk pools or, in the case of Maine, invisible high-risk pools. The people in it don't even realize they are in it, but it has worked phenomenally well.

Maine passed guaranteed issues, and just like they did under ObamaCare, guaranteed issues caused premiums to skyrocket. You can see the premium rate from their old Anthem HealthChoice plan back in 2011. Once they supplanted—they didn't even repeal the guaranteed issue, but they just supplanted this with an invisible high-risk pool—their premiums were cut in half. This is doable. It is possible, but it is only possible if we take a look at best practice, if we are willing to have the courage to admit exactly what is causing the problem.

I have two amendments designed to address the increase in premiums. First—and I realize this will probably not even be voted on—would be a simple one-sentence amendment that would repeal all of ObamaCare, not partial repeal, not just two-thirds repeal but repeal that would concentrate on removing all of those market reforms. I would call them market distortions that cause premiums to skyrocket, that cause people like Sheri and Vern Kolby to lose their house. That is my first amendment.

The second amendment really relates to exactly what ObamaCare was originally designed to do, which was put Members of Congress in the exact same position of people like Sheri and Vern Kolby.

Back in July of 2009, November 18, as this was being debated in the HELP and the Finance Committee, Senators Coburn and GRASSLEY introduced language to those bills that would make Members of Congress have to purchase their health insurance plans on any kind of program or the State-based exchanges, whatever was passed under the Democrats' healthcare plan.

On December 24, 2009, the Senate passed the Patient Protection and Affordable Care Act, an Orwellian-named bill that did neither, that had Senator Coburn's basic language from the HELP Committee that was going to require Members of Congress to purchase their coverage through the exchanges. What was interesting is, it did not include an employer contribution. Those were barred.

On March 24, after the House had passed their version of the Patient Protection and Affordable Care Act and the Healthcare Education Reconciliation Act, Senator GRASSLEY again offered an amendment to allow an employer contribution to Members of Congress and their staffs' healthcare plans. That amendment was defeated with 56 Democratic Senators defeating it. Three Democratic Senators voted for it, and every Republican Senator voted for it, allowing the Federal contribution. So Congress specifically said in the Patient Protection and Affordable Care Act, Members of Congress and their staffs must purchase their healthcare through the State exchanges, and they cannot obtain an employer contribution for those plans.

Let's fast forward to October 2, 2013. Members of Congress and their staff panicked. They went running to the Obama White House and said: You have to fix this. We know what we passed. We know what the law says, but we have to weasel our way around this—and they did. So the Office of Personnel Management issued a rule, first of all, that Congress was a small business that could purchase their insurance on a shop exchange which required a small business, which is defined in the law as less than 100 employees—I just want you to know that Congress has about 11,000 employees. There is no way this Congress is a small employer, but that was the technique that they were able to work their way around this law. So right now Members of Congress and staffs are the only Americans who get the special treatment of being able to purchase insurance on ObamaCare exchanges and get an employer contribution.

Millions of Americans did lose their insurance because of ObamaCare. They had to purchase the overpriced insurance policies out of the exchanges, but they have no access to employer contributions. So my second amendment would put only Members of Congress—I don't think we should penalize our staff—but I want to put Members of Congress in the exact same position as Sheri and Vern and thousands and maybe tens of thousands, maybe hundreds of thousands, maybe millions of Americans who are making too much, busting it, working 60 hours a week. Their premiums have doubled, sometimes tripled. Coverage is cut in half, and they can't afford it. They are taking a risk. Congress is still advantaged because we are making more than $59,000. We are making $174,000.

The reason I am offering this amendment—I know it will not be popular—is that the only way Congress will have the courage to act is if they are affected every bit as much as the American public. I urge all of my colleagues to be honest, to be courageous, and to make sure they do not exempt themselves from the pain, from the harm, from the damage of ObamaCare, so that they will commit themselves to actually fixing this problem.

Those are my first two amendments that have to do with premiums. I urge my colleagues to support them. I think that they are good amendments and are worthy of support.

Mr. President, how much time do I have remaining?

The PRESIDING OFFICER. There are 30 minutes remaining.

Mr. JOHNSON. Mr. President, let me move on to my second point.

Again, I come from a State whose Governor showed real courage in recognizing that traditional Medicaid was unsustainable and was in trouble. The last thing we really should be doing to an unsustainable entitlement program is to throw more promises on top of that and make it even more unsustainable. I think it is extremely important that we recognize that Medicaid expansion is directed toward able-bodied, childless, working-age adults. That is, again, funded at a much higher level by the Federal Government, at 90 to 100 percent, versus traditional Medicaid, which is really targeted to those we want to help—children. Forty percent of traditional Medicaid goes toward children, the disabled, and the elderly.

My next amendment is designed to try and make traditional Medicaid more sustainable, not by pulling the rug out from anyone but simply by limiting further enrollment and allowing Medicaid expansion to phase out based on attrition. Let me show you a couple of facts, because we hear an awful lot of demagoguery. We hear an awful lot of scaremongering. I hear it in Wisconsin, as people who are on traditional Medicaid and who are largely unaffected by this bill other than in the out years are scared that their traditional Medicaid is going to be taken away from them.

Here are the facts. Back in 2008, the Federal Government spent about $200 billion on traditional Medicaid. With the implementation of ObamaCare, we began increasing that pretty dramatically with Medicaid expansion. Over the next decade or so, we will spend close to $90 billion per year, on average, on Medicaid expansion—again, targeted toward able-bodied, working-age, childless adults. This was the former trend line, and this is the current trend line for traditional Medicaid.

Now, you hear about all of this slashing of Medicaid. Here is the current baseline. This is what the Senate bill would have done to traditional Medicaid and to Medicaid expansion. Yes, you can see some relatively significant cuts to Medicaid expansion, but to traditional Medicaid, you see, really, not all that much—about $164 billion over 10 years.

My amendment would say, without pulling the rug out from anyone: Let's end further enrollment in Medicaid expansion, and as that program phases out through attrition, let's devote the money that we save to traditional Medicaid—supporting and sustaining the elderly, children, and the disabled.

This is what happens to traditional Medicaid under my amendment. First of all, this is what happens under the Senate bill. You do not see any year in which Medicaid is actually cut. It is always rising. We boost it a little bit further and do not increase the deficit by any more, under the Senate bill, by doing that.

My last point is this, and then I will move on and yield the floor. This is what I am talking about in terms of dollars. Under current law, traditional Medicaid will spend $4 trillion over the next decade and Medicaid expansion almost $1 trillion, for a total of $5 trillion spending. Under the Senate bill that was originally proposed, original Medicaid would have been cut by about $164 billion, which is still close to $4 trillion, and Medicaid expansion, obviously, would have been reduced by a fair amount.

Under what I call my sustainability amendment, traditional Medicaid would actually increase in spending slightly and not harm anybody—not children, not the disabled, not the elderly. Obviously, with Medicaid expansion, just by allowing it to phase out through attrition—not pulling the rug out from anyone—in the end, you would be spending the same amount on the Senate bill. From my standpoint, I think that we preserve and sustain Medicaid.

Again, I urge my colleagues to support all three of my amendments. I hope to get a vote. If not a vote, I hope that they are considered if this thing goes to a House-Senate conference.

I yield the floor.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. ENZI. Mr. President, I thank my colleague from Wisconsin, my fellow accountant, for doing a good job of accounting there and providing some charts that very explicitly show what he has been working on, what he has been encouraging people to do, and

some solutions. That is what we keep looking for within the criticism that we are getting from the other side of the aisle—some solutions.

Earlier this year, Congress took an important first step in fulfilling the promise of repealing ObamaCare by passing a budget resolution that paved the way for this debate that we are having right now and paved the way for some real healthcare reforms that we are currently debating. These reforms are focused on rescuing the millions of hardworking families who are trapped by ObamaCare's taxes and mandates.

You heard one example from the Senator from Wisconsin of a family who is paying excruciatingly high prices for their healthcare only to find out that they have $16,000 in deductibles, which makes it very difficult to utilize it at all. Is that insurance, if you have to pay $16,000 before the rest kicks in?

What we are doing here is working to stabilize collapsing insurance markets that have left millions of Americans with no options. We improve the affordability of health insurance. We preserve access to care for Americans who have preexisting conditions while we safeguard Medicaid for those who need it the most by giving States more flexibility. We ensure that those who rely on this program will not have the rug pulled out from under them. Most importantly, we liberate the American people from the onerous ObamaCare mandates of purchasing insurance they do not want and/or cannot afford.

Additionally, these bills can reduce the Federal deficit, the amount the Federal Government overspends each year, by billions of dollars. They can also end up saving taxpayers billions more by improving and reforming the way Medicaid operates. These aspects of the bill are enormously important. This will be the first time in a generation that we will have even attempted to rein in any of these programs and put them on a sustainable path—the ones that are threatening to bankrupt our country—without pulling the rug out from under people, as you saw from the charts by the Senator from Wisconsin.

By reducing spending, lowering the tax burden on hard-working families, and curbing our national debt, which now stands at almost $20 trillion and is on its way rapidly to $29 trillion, we will be ensuring a brighter and stable fiscal future for our children and our grandchildren. Actually, with that kind of debt, we are almost ensuring a brighter and stable future for ourselves. We are in trouble.

While my colleagues complain about using the reconciliation process to untangle the country from this unworkable, unpopular, and unaffordable law, they should remember that they actually employed the exact same procedure to secure the passage of ObamaCare, without having any input or assistance from Republicans, and rushed it through both Houses of Congress in less than a week. Senate Republicans are responsibly utilizing this reconciliation process to address the healthcare crisis that has been thrust upon America by former President Obama and congressional Democrats.

There is also the common misconception that some of my friends across the aisle have promoted—the idea that ObamaCare is a runaway success and that repeal will be tearing down a functioning program. This is, simply, not true. My Democratic colleagues know it is not true. Former President Obama knows that it is not true, and the American people, certainly, know it is not true.

Here is the reality. ObamaCare has put our health insurance markets on the brink of collapse in many parts of the country. As I pointed out in an earlier speech, that began in October of last year, which was before the elections. It has nothing to do with what has transpired since the elections. ObamaCare put our health insurance markets on the brink of collapse in many parts of the country, and what the Republicans are tackling now is what President Obama and congressional Democrats simply could not bring themselves to do when they had control, which was to fix the problems they had created. This may be because ObamaCare has enshrined their idea that bigger government is better and that any changes, unless done by Executive action under the President, were out of the question.

In their zeal to protect this flawed program, they may have missed it when President Obama himself admitted last year that the law had real problems.

He said:

> There are going to be people who are hurt by premium increases or lack of competition and choice.

He went on to say that these problems are simply called ''growing pains.''

Now, these growing pains have forced millions of Americans across the country to grapple with impossibly high health insurance premiums for plans they do not want, out-of-reach deductibles to help with common prescriptions, and disappearing insurance providers to even be allowed to shop for better coverage.

As I noted earlier, for more and more Americans, there is only a single insurer from which they can select health plans, and they may soon not have a single ObamaCare insurer, as 50 counties already do not have one, and others are threatened. Thousands only have one choice. In fact, on the Federal exchanges, one in five consumers will only be able to select plans from a single insurer. Many residents across the country will have only one choice of health insurer. This includes my home State of Wyoming, as well as the entire State of Alaska.

What does this lack of competition mean? Premiums are surging for hard-working families, who now have to choose between unreasonable insurance rates or an unreasonable fine. If my colleagues wanted yet further evidence that competition lowers prices, they need look no further than their constituent mail.

In Wyoming, some families will be forced to pay more than 30 percent of their total income on premiums in order to obtain healthcare coverage, which often includes deductibles of over $1,000. One family faced premiums of more than $1,600 a month. As an alternative, their tax penalty for not carrying coverage was only $1,700 for the year. That is a $1,600-a-month premium charge or a $1,700 penalty for not covering it for the whole year.

So guess what they did? They paid the fine because they could not afford the insurance premium, let alone the deductible. I think $5.3 million in fines were collected in Wyoming from the people who could not afford the insurance. They took the lesser alternative of paying a tax penalty, which gave them nothing.

For those who are lucky enough to be able to afford insurance, particularly in the individual market, under the new health law, premiums are expected to increase faster in 2017 than in previous years. Some States will see insurance premiums rise by as much as 53 percent. That is in 1 year. We are talking about a 4-year doubling of cost. This will be a 50-percent cost increase in 1 year. That is truly a healthcare emergency. Not doing anything and accepting the status quo is simply unacceptable to millions of Americans suffering under this law.

Now that we have discussed why we are doing this, it is important to also ask how we hope to help these suffering Americans. It is vital that we stabilize collapsing insurance markets that have left millions of Americans with no options, while reestablishing the affordability of health insurance.

Our bill will also preserve access to care for Americans with preexisting conditions, and it will safeguard Medicaid for those who need it most by giving States more flexibility, yet ensuring that those who rely on this program will not have the rug pulled out from under them—contrary to the scare tactics being put forth by ObamaCare's defenders.

Most importantly, Congress is working to free the American people from the onerous mandates to purchase insurance they don't want or can't afford.

Congressional Republicans and our President are focused on securing the future of Americans' healthcare system and truly understand the importance of restoring the trust of hard-working taxpayers.

What we are doing here under reconciliation, which is a budget process, will not solve all the problems. There will be an opportunity for bipartisan investigation, support, and changes if the other side is willing to do that. There are some things that need to be

done immediately to protect the American taxpayers and the people who want to have healthcare.

So I ask everyone to focus on securing the future of America's healthcare system and to try to understand the importance of restoring the trust of hard-working taxpayers.

Thank you, Mr. President.

I yield the floor.

The PRESIDING OFFICER (Mr. TOOMEY). The Senator from Alabama.

Mr. STRANGE. Mr. President, I ask unanimous consent to speak for up to 5 minutes.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. STRANGE. Mr. President, I rise today in defense of those who cannot defend themselves. After 8 years of policies that have undermined the sanctity of life, we have an opportunity today to extend the protections of the Hyde amendment wider than ever before.

After 8 years of a failed social experiment that subverted the will of a majority of Americans and denied rights of conscience and religious freedom, we have an opportunity to ensure that taxpayer dollars will not contribute to the scourge of abortion under any circumstance.

As we consider options to fix our nation's failing healthcare system, partisan lines cut deeper on abortion than on any other issue. However, we should all be able to agree that taxpayer funds have no place in funding abortions.

I also hope we can agree that our society cannot be truly prosperous until it respects the rights of the most vulnerable among us. If we fail to stand for those who cannot stand for themselves, then the words of our founding documents, the words inscribed in the halls of this building, and the truths we each hold in our hearts mean nothing.

To that end, I will be offering a motion to waive the point of order on Hyde amendment protections as we work to solve our healthcare crisis. Today, and every day, I stand for life. I am joined by colleagues who understand what is at stake, and I thank Senator ENZI for his leadership.

I yield the floor.

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

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

VOTE ON AMENDMENT NO. 271

The question is on agreeing to the amendment.

Mr. CORNYN. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The clerk will call the roll.

The legislative clerk called the roll.

The result was announced—yeas 45, nays 55, as follows:

[Rollcall Vote No. 169 Leg.]

YEAS—45

Barrasso	Flake	Perdue
Blunt	Gardner	Risch
Boozman	Graham	Roberts
Burr	Grassley	Rounds
Cassidy	Hatch	Rubio
Cochran	Hoeven	Sasse
Corker	Inhofe	Scott
Cornyn	Isakson	Shelby
Cotton	Johnson	Strange
Crapo	Kennedy	Sullivan
Cruz	Lankford	Thune
Daines	Lee	Tillis
Enzi	McConnell	Toomey
Ernst	Moran	Wicker
Fischer	Paul	Young

NAYS—55

Alexander	Gillibrand	Murray
Baldwin	Harris	Nelson
Bennet	Hassan	Peters
Blumenthal	Heinrich	Portman
Booker	Heitkamp	Reed
Brown	Heller	Sanders
Cantwell	Hirono	Schatz
Capito	Kaine	Schumer
Cardin	King	Shaheen
Carper	Klobuchar	Stabenow
Casey	Leahy	Tester
Collins	Manchin	Udall
Coons	Markey	Van Hollen
Cortez Masto	McCain	Warner
Donnelly	McCaskill	Warren
Duckworth	Menendez	Whitehouse
Durbin	Merkley	Wyden
Feinstein	Murkowski	
Franken	Murphy	

The amendment (No. 271) was rejected.

VOTE ON MOTION TO COMMIT

The PRESIDING OFFICER (Mr. GARDNER). The question is on agreeing to the Donnelly motion to commit.

Mr. ENZI. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a second sufficient?

There appears to be a sufficient second.

The clerk will call the roll.

The legislative clerk called the roll.

The result was announced—yeas 48, nays 52, as follows:

[Rollcall Vote No. 170 Leg.]

YEAS—48

Baldwin	Gillibrand	Murray
Bennet	Harris	Nelson
Blumenthal	Hassan	Peters
Booker	Heinrich	Reed
Brown	Heitkamp	Sanders
Cantwell	Hirono	Schatz
Cardin	Kaine	Schumer
Carper	King	Shaheen
Casey	Klobuchar	Stabenow
Coons	Leahy	Tester
Cortez Masto	Manchin	Udall
Donnelly	Markey	Van Hollen
Duckworth	McCaskill	Warner
Durbin	Menendez	Warren
Feinstein	Merkley	Whitehouse
Franken	Murphy	Wyden

NAYS—52

Alexander	Crapo	Hoeven
Barrasso	Cruz	Inhofe
Blunt	Daines	Isakson
Boozman	Enzi	Johnson
Burr	Ernst	Kennedy
Capito	Fischer	Lankford
Cassidy	Flake	Lee
Cochran	Gardner	McCain
Collins	Graham	McConnell
Corker	Grassley	Moran
Cornyn	Hatch	Murkowski
Cotton	Heller	Paul
Perdue	Sasse	Tillis
Portman	Scott	Toomey
Risch	Shelby	Wicker
Roberts	Strange	Young
Rounds	Sullivan	
Rubio	Thune	

The motion was rejected.

The PRESIDING OFFICER. The Senator from Pennsylvania.

MOTION TO COMMIT

Mr. CASEY. Mr. President, I have a motion to commit at the desk.

The PRESIDING OFFICER. The clerk will report the motion.

The legislative clerk read as follows:

The Senator from Pennsylvania

Mr. CASEY moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the American Health Care Act of 2017 that would harm individuals with disabilities as defined in the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.) by reducing their access to affordable health care or limiting coverage or benefits under Medicaid or in the private health insurance market.

Mr. CASEY. Mr. President, first, I thank my friend from Indiana, Senator DONNELLY, for his remarks this afternoon and also for his efforts to help to protect and preserve Medicaid so that hundreds of thousands of people in our States and across the country can continue to live in the community.

I want to point out that today is the 27th anniversary of the signing of the Americans with Disabilities Act. This legislation, known as the Americans with Disabilities Act, is 27 years old. It is a piece of legislation that both recognizes and guarantees the rights of people with disabilities. It is, at its heart, a civil rights bill, one that promotes and promises liberty and freedom for people with disabilities—the liberty and freedom that all Americans are promised, that our founding documents guarantee, and that we in the Senate are charged with protecting for all citizens.

We should be celebrating the liberty and freedom of people with disabilities, but instead of having a celebration of the Americans with Disabilities Act on this anniversary day, the Senate Republican bill—which, I guess, is basically the House bill that we are on right now—threatens that freedom and threatens that liberty that was accorded in the Americans with Disabilities Act with regard to those with disabilities.

Now, I have heard a lot of speeches on this floor by my Republican colleagues about freedom and liberty in the context of healthcare—lots of speeches about both of those words. I would argue that, if you consider this legislation and the Senate versions of it that came after the House bill, all of these Republican healthcare bills were really, simply, about decimating Medicaid, limiting community-based care, and cutting long-term services and support, which will rob people with disabilities of their rights that the Americans with Disabilities Act advanced.

I think everyone here knows the disabilities story. I will just do a quick summary.

For centuries, people with disabilities have been placed against their will in institutions like this one. This is a building in Pennsylvania. When it was open and operating, it was known as Pennhurst. There were lots of places like this across the country, not just in one or two States. These institutions were, in fact, over time, warehouses, in which people had few, if any, rights. They were told what time to wake up, what time to go to bed, and when to eat. They were told they could never leave. That was the basic set of rules they lived by when they lived in institutions like that. These were places where choice was unknown and where freedom, liberty, and self-determination were also unknown.

Over the past 50 years, we have made some improvements—slow improvements—with the voices of people with disabilities leading the way. Throughout those 50 years, individuals and families have fought for their freedom and have worked to create laws that protect their freedom.

For example, the 1973 Rehabilitation Act Amendments and the Americans with Disabilities Act affirmed and protected the rights of people with disabilities to have access to all of society. The 1999 Olmstead Supreme Court decision reaffirmed the right of people with disabilities to live where they want to live and to be free of the confines of an institution.

Let's take it from the institution down to the individual—to individuals like Jensen, who is pictured right here. People like Jensen, who were once forced to live in nursing homes, now live where they want to live and pursue their dreams. Yet we know that rights alone do not equal freedom and liberty for people with disabilities.

Medicaid provides the supports that are necessary to live in the community and to have that full measure of freedom and that full measure of choice. Medicaid protects the hard-won rights of people with disabilities to have real choices. Medicaid home-based and community-based supports mean that people with disabilities can live in their own apartments, hold jobs, and contribute to their communities. Medicaid makes it possible to use the talents, skills, and knowledge of people with disabilities. Medicaid makes their rights a reality.

Do not take my word for it. Just ask the people who were here today in the Gallery, the people who are outside this Chamber and are walking the halls of the Senate, walking throughout the buildings, marching, demonstrating, and greeting people on the streets, with some of them staying overnight at one place to make their voices heard. Ask the members of ADAPT. Ask the members of the National Council on Independent Living. Ask The Arc's 700 affiliates around the country. Ask the folks from Easterseals, the Association of University Centers on Disabilities, the Autistic Self Advocacy Network, and on and on and on—groups across the country that are telling us with one voice: Do not move forward with cuts to Medicaid as have been proposed in each of these bills.

These Americans will tell you that their rights are not real without community supports. This bill will drive people back into those institutions that I just showed you a picture of.

In the midst of voting on my amendment—which would basically say: Let's go back to the committee of jurisdiction—in this case, the Finance Committee—and spend some time to have some hearings, have some regular order, which some have called for here, and really consider this issue seriously—I know there will be talk that some will reject my amendment and will introduce and maybe have a vote on a sense of the Senate.

There is a time and a place for that kind of measure when the Senate speaks with one voice on a matter. This is not one of those times. This is a time when we have to do more than just have a sense of the Senate. We have to be serious about a particular matter of public policy—in this case, of making sure that we protect people with disabilities so that they have all of the rights and all of the promises fulfilled in the Americans with Disabilities Act and other legislation.

So we are hearing that there might be a sense of the Senate offered as a side-by-side to the amendment that I will offer. This is totally inadequate in terms of the serious issue that we are here to talk about—in this case, protecting people with disabilities. It is a totally inadequate response to that. The people with disabilities who are in the Gallery, who are in the reception area, or who are back at home in congressional districts and States—those folks in each and every community around the country—want to ensure that the promise that we made to them in the ADA and in other measures will be kept—that we will keep our promise. If Medicaid community-based services are slashed, statements by the Senate will not help very much.

What will we likely have in front of us in the next couple of hours or between today and tomorrow?

I know it has been described in a lot of ways, if the Republicans want to get there. Here is the way I describe it. It is a congressional Republican scheme that they are working on to get to repeal—not repeal and replace. In this case, it would be repeal and decimate—decimating Medicaid, repealing the entire Patient Protection and Affordable Care Act.

Some here will argue that they can support this because this next version—this scheme—will not include Medicaid and will likely not even include tax cuts for the very wealthy. Cuts to Medicaid have been the core part of every House version of healthcare and every Senate bill that we have seen so far. They will get to those cuts one way or another, and they will also get to the tax cuts for the superrich.

The bill that we are debating, H.R. 1628, as you know, creates block grants in the context of Medicaid. Block-granting, in a sense, may be sending to the States a limited amount of money and saying: Good luck when you have to balance your budget and pay for Medicaid services. It will have per capita caps, which would, again, limit what States can do in terms of the dollars they have, or it would just continue to have cuts to Medicaid, as every bill has had, the likes of which we have never seen—sometimes over $800 billion, sometimes over $700 billion, but it is in that neighborhood of hundreds and hundreds of billions of dollars of cuts to Medicaid. This next version of the Senate bill will do the same.

When you consider the cuts to Medicaid juxtaposed with the tax breaks given to the superrich—really giveaways—there is no other word that I can come up with other than ''obscene.'' There are probably other words, but that is, I think, a good description of what that is. That is one of the reasons that these measures have been so unpopular across the board with every income group. Those folks who would get those big giveaways—I think most of them would not want them if they knew the price of that tax giveaway to someone with a lot of money would be to decimate Medicaid.

So passing this version of the bill—passing a scaled-down scheme—means that Republicans have not abandoned their Medicaid cuts. They are going to get to that as soon as they can. This is simply what we are going to see over the next couple of hours—a back door to cutting and capping Medicaid—and anyone who believes otherwise is probably deceiving themselves.

What we need are serious policies crafted to ensure long-term supports and services that provide and guarantee community-based services that promote choice and freedom for people with disabilities. This bill doesn't promise freedom or liberty. It doesn't promise the choice to live in a community and to be part of a family, like this family, where one member of that family has a disability and gets to live in a house with other members of the family. That is not possible for many Americans without Medicaid.

For people with disabilities, this bill is anything but a bill that would enhance freedom or enhance choice. This bill would, in fact, be an anti-freedom bill when it comes to people with disabilities. It is not a key to liberty. It is really just a pathway to institutional care, where we were years ago and where we have come from, from whence we have made progress. It is a return to limited choices, a lack of rights, and a place where freedom is not possible.

In conclusion, let me thank the Members of the Senate who have supported

this motion: Senators STABENOW, DUCKWORTH, HASSAN, VAN HOLLEN, MURRAY, BROWN, BLUMENTHAL, CARPER, DURBIN, KAINE, BALDWIN, WYDEN, MARKEY, MURPHY, HARRIS, CARDIN, WARREN, HIRONO, REED, NELSON, KLOBUCHAR, WARNER, SHAHEEN, COONS, BENNET, KING, MENENDEZ, WHITEHOUSE, LEAHY, and BOOKER. I want to thank them for joining me in this effort.

Mr. President, I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The senior assistant legislative clerk proceeded to call the roll.

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

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

The Senator from Louisiana.

Mr. CASSIDY. Mr. President, we are struggling right now to find a replacement for the Affordable Care Act. The American people have voted in four successive elections for such a replacement, culminating in the election of Donald Trump to be President of the United States.

Now, one can ask oneself, if the Affordable Care Act is so great, why would the American people continue to want to have a different program? I think the wisdom of the American people is that they do not want the government so intrusive in their lives, and secondly, there is a sense that somehow the Affordable Care Act is not entirely fair, that perhaps there are some who do better under the Affordable Care Act than others. Our country is about equity.

By the way, I am a physician, and for 25 years I have worked in the public hospital system of Louisiana trying to get healthcare for those who otherwise did not have it. I am all about those who do not have insurance or those who are fully insured getting better care. Ultimately, to have better care, there has to be adequate financing for that care. So we begin to look at the numbers that underlie how the Affordable Care Act—ObamaCare, if you will—finances healthcare across the Nation. It is very interesting.

If you look at the numbers from Health and Human Services, three States—Massachusetts, California, and New York—get 37 percent of the money that ObamaCare spends on Medicaid expansion and health insurance access. Three States get 37 percent. And although I don't have an accurate depiction of what the demography is, I estimate their population to be roughly 18 percent, if that much, of our Nation's total population. So they get twice as much, if you will, on a per-beneficiary basis than the rest of the Nation put together. That is not fair. And if we are going to provide access for patients—our fellow Americans—to healthcare, ultimately we have to have adequate financial resources to do so.

My colleague Senator GRAHAM will speak in more detail about the inequities between the States, but let me just say as a guideline, how do we create equity? How do we create fairness so it is not just three States that benefit, but wherever you live, if the Federal taxpayers are contributing to your access to insurance, you get about the same amount whether you are in Louisiana, Colorado, South Carolina, Mississippi, or in California, Massachusetts, or New York? That is about equity.

What we attempt to do—and we are going to submit this as part of the Graham-Cassidy amendment—is we attempt to establish fairness for all Americans in terms of the support they receive from the Federal taxpayer. What we will do, beginning in 2020, is begin to equalize the payments between those States receiving very little, those States receiving a lot more, and those States that are kind of right where they should be. We do this by beginning with a formula that acknowledges that the poorer the people, the more support they need; the older the person, the higher their medical expenses. So between poverty and age, it is a good starting point about how to divide those dollars. Between 2020 and 2026, we will actually gradually move those high-cost States down, those lower cost States up, and keep those just-about-right States just about right, until at the end, wherever that American lives, she or he is getting about the same amount as every other patient receiving support across the country.

When we say this—I am a physician. I know that if you have more disease burden in one State, that is a costlier population. If your average age is greater in one State, that is another aspect of a costlier population. We can go through those sorts of factors. So we do put wiggle room at the end, so that if a State is higher cost because they have more disease, they would get a little bit more money. But on the whole, if you net it out, wherever that American lives, she or he would get about the same amount of money.

Senator GRAHAM will go over this in more detail, but it turns out that the average American receiving benefits under the Affordable Care Act—if you combine Medicaid expansion and the tax credits people receive, the average credit is somewhere in the mid-$6,000 range; call it $6,400, $6,500. But if you look at what some States receive, in Massachusetts, it is about $18,000 per person. Now, that is a lot of money. So if the average is $6,600 and in one State it is $18,000, that is not fair.

Now, I would submit that if we equalize that treatment; if we just treat people fairly; if no matter where you live, the amount you get is not dependent upon the State in which you live but upon your need, then we can actually provide access. We can fulfill President Trump's campaign pledges of continuing coverage, caring for those with preexisting conditions, lowering premiums—lowering premiums—and eliminating mandates.

By the way, it isn't just Republican-represented States that would benefit. We can look at West Virginia. These are some preliminary numbers. West Virginia would receive in 2020 about 43 percent more than they would based upon current trajectories. Indiana would receive about 48 percent more. Let's look at Montana. Montana would receive about—my gosh—Montana would receive over 100 percent more than they are currently scheduled to receive.

This takes the money that has already been allocated, and instead of focusing it on three States—there are a few more; call it seven, but those are the States that really bring it home—if, instead of all of this Federal largess going to three States, we distribute it fairly, all Americans can do better. All Americans can do better.

Ultimately, we should be about fairness in this Chamber, not about partisan politics.

I thank the Chair for the privilege of addressing this issue, and I now defer to my colleague from South Carolina.

The PRESIDING OFFICER. The Senator from South Carolina.

Mr. GRAHAM. Mr. President, let me just tell my colleagues where I am coming from.

Under the current system—ObamaCare as we know it—the money to help people buy insurance and the money for Medicaid expansion, those two pools of money—here is what happens under ObamaCare: California is 21.39 percent of all the money, and they are 12.15 percent of the population. Maryland gets 2.35 percent of the money, and they are 1.86 percent of the population. Massachusetts gets 6.67 percent of all the money, and they are 2.11 percent. New York gets 8.62 percent, and they are 6.11 percent. That is a lot of math for a guy who didn't do well in math. So 39 percent of all the money goes to four States that represent 22 percent of the population. I like these people. They are all good Americans. I just don't like them that much. The bottom line is, the rest of us—46 States—get 60 percent to divide up among ourselves. How can that be?

Senator CASSIDY explained that the current system is weighted to the benefit of four States at the expense of the rest of us. I would like to fix that, and if you don't live in one of those States, you will want to fix it too.

What I want to do is take the money that we are spending under ObamaCare and block grant it back to the States so that we can level out the disparity in funding but go even further and allow people in each State to develop healthcare systems that meet the needs of that State.

If you are for single-payer healthcare, you will hate this idea because that will be the end of single-payer healthcare because the money and the power will leave Washington and it will go back to people where they live. It will be healthcare closest to the patient. So if you believe that

government is better—closer to the voter, closer to the people—if the idea of government close to the people is a good idea, I would argue that healthcare closer to the patient is a good idea.

I regret we didn't think of this sooner.

What Senator CASSIDY said is that our goal is to make sure that no matter in what State you live, you are going to get X amount of dollars, and it is going to be fairly equal no matter where you live. If you live in a State with a unique disease problem or an aged State, you will get a little bit more because you will need a little bit more.

The model we have today is really disproportionate. It doesn't work. It is driving up healthcare costs all over the country. People are dropping coverage because the ObamaCare mandates are too expensive.

So what we are doing is we are leaving the taxes on the wealthy in place. To my conservative friends, I am sorry, but that is what we are going to have to do to make this work. We eliminate the medical device tax because that hurts innovation. We eliminate the individual employer mandate because that stifles the whole idea of having creativity at the State level. We leave the taxes on the wealthier Americans in place. We are able to take that money, plus money we would give to insurance companies to stabilize the national market, and block grant it back to the States with a formula that is fairer.

Let me tell my colleagues what that would look like. Let me drill down to what two States do, by the way. California and Massachusetts by themselves are 28 percent of all ObamaCare money and 14 percent of the population.

Let's look at Alabama. Beginning in 2020, you are going to get 200 percent more. How can that be? It is where you start from. The people in Alabama are going to get a lot more money because when you look at the money coming through the ObamaCare system to the good people of Alabama and how we spend per patient, you are way behind. You are going to get a lot of money to catch up with what should be the national average.

Our friends in California are going to get a 38-percent reduction, but we are going to give you time to adjust for that. There is going to be a wind-down period. It is not going to happen overnight. There will be a fund that can help you if you can prove you have a unique population of people who are sicker and older.

To my good friend from Colorado, you get 42 percent more. How can that be? Under ObamaCare, the money that was going to these four States gets a little higher percentage if you block grant. Not only will you get 42 percent more money than ObamaCare would give the good people of Colorado, you actually get a chance to spend the money unique to the needs of Colorado.

Let's go to Oklahoma, since we have a guy from Oklahoma here whom we like a lot. You get 200 percent. Congratulations. Why do you get 200 percent? You are starting way behind everybody else. The bottom line is, we want to catch you up beginning in 2020. We are going to have to take away from some other people because they are hoggish.

New York, California, we want to help you transition, but the rest of us are not going to sit on the sidelines anymore and watch you take most of the money. We are going to begin to level this out.

Where is South Carolina? I have a unique interest in that State. How did we do? We get 123 percent. That shows you where we start from.

In about 6 years, we are all going to meet. It is going to take 6 or 7 years to level this all out, and we are going to get more. Other States are going to get a little bit less. The ones that are about where they need to be will get about the same.

The big benefit for all of us is, the people in your backyard get to make decisions about healthcare rather than a Washington bureaucrat whom you will never meet. The big thing about this to me is, you have a voice now as a consumer.

Right now, if you don't like your healthcare under ObamaCare, whom do you complain to? Do you complain to your Congressman? I guess your Senator. At the end of the day, most of ObamaCare is administered by the Federal Government through a bureaucracy. We don't manage healthcare in the Senate.

Under this construct, the same amount of money is going to go back to your backyard, and you will get a better deal if you are starting on the tail end of this now. If you don't like what is going on in your State, you can actually complain to somebody whom you vote for in the statehouse. You can go to your State capital and complain to your Governor.

The likelihood that the person you are complaining to goes to the same hospital as you and your family goes up. Wouldn't it be nice to be able to complain to somebody who is in the same boat you are who goes to the same healthcare network because they live in your neighborhood?

To me, the most innovative thing we could do in healthcare in America is allow people in their own backyard to design healthcare systems that meet the unique needs of that State and give consumers a voice that really can be heard because, under this model, your statehouse and your Governor are going to have a lot of flexibility. They can't spend it on roads and bridges. They have to spend it on healthcare.

If they get really efficient, the savings they will accrue stays in that State to even do more for healthcare so you will have a race for efficiency rather than just a race to write bigger and bigger checks.

The big benefit to me is, if you are a healthcare consumer, you will finally have somebody you know you can talk to about what works and what doesn't.

We are about to talk about how we end this debate. I hope this idea will be looked at by not just Republicans but Democrats. If you are from West Virginia—our good friend JOE MANCHIN—West Virginia gets 43 percent more dollars under the block grant than they would ObamaCare. West Virginia gets to determine how to spend that money more under the block grant than they would under ObamaCare. You can't spend it on roads and bridges, but you have to spend it on healthcare.

There are three things we are trying to achieve. We are not going to let four States take most of the money, a disproportionate share of the money. Over time, we are going to create a system—no matter where you live—you are going to get roughly the same amount of money from the Federal Government, but the money comes in a bock grant so the people in that State can use it without being dictated to by a Washington bureaucrat as long as it is on healthcare. The biggest thing we give you is a chance to have a voice about your healthcare because the people in charge of your healthcare will be in your own backyard, not in Washington, somebody who doesn't know you, you will never get to meet, and quite frankly doesn't understand your world.

I hope we can rally around this. These are not 100 percent done numbers. Generally speaking, this is pretty accurate. It came from the Labor-HHS people. It may change a little bit, but when you start the debate with four States getting 40 percent of the money, clearly most of us are going to get more. When you see these big numbers like our friends in Oklahoma and Montana, the reason you are getting so much more now is that the current system leaves you behind in an unfair way.

My goal is, if you live in Oklahoma, New York, and California, the Federal Government is going to provide healthcare resources as equal as possible, but those resources will be managed by people in the State, not bureaucrats in Washington.

I hope over the coming day and a half that maybe we can rally around an idea that we should have started with to begin with. I don't mind being generous when it comes to putting money on the table to make sure people can afford healthcare. The tradeoff is as follows. We leave most of the ObamaCare taxes in place because we need a funding stream to level out the inequities. We are going to have a tax cut bill later. I want a flatter tax, a smaller corporate tax, and lower individual taxes, but this revenue stream coming from wealthy Americans is going to be used in a different fashion. It is going to provide resources to States that they can manage, unlike ObamaCare where one-size-fits-all.

To me, this is a tradeoff. To the people in West Virginia, I am not asking you to take less and have a tax cut for rich people. We are going to keep the wealthy taxes in place. I am asking the people of West Virginia to take 43 percent more money. It is not a trick. Use it wisely.

Thank you all. I hope over the next day we can inform you about how your State benefits. To those States who are going to have to ramp down, the only reason you are ramping down is you are taking so much more from the rest of us. Quite frankly, that is not fair. We want to be fair to you and give you a chance to adjust, but the rest of us should stand up and say it is not fair that an American in California or New York or Massachusetts—all fine States—gets 40 percent of the money. That is not right.

It is not right to have a one-size-fits-all healthcare system because you will not get the best product. The best product will come from innovation. Your strongest voice will come from having a say to people who live in your same community, talking to a politician who sends their kids to the same hospital you do. That is what this is all about.

With that, I yield the floor.

The PRESIDING OFFICER (Mr. LEE). Time will be equally charged to both sides.

The Senator from Oklahoma.

Mr. INHOFE. Mr. President, I ask unanimous consent that I be recognized in morning business for as much time as I shall consume.

The PRESIDING OFFICER. Is there objection?

Mr. INHOFE. Mr. President, there seems to be some confusion. I will take whatever time you designate is left. I wanted to talk longer.

The things the Senator from South Carolina was talking about are pretty amazing. I look at my State of Oklahoma. Did you know our premiums in the State of Oklahoma under ObamaCare have tripled? They have gone up 201 percent.

When you look and you see the options that are out there, what really disturbs me—I understand one big difference between Democrats and Republicans is Democrats are disciplined, Republicans aren't, so they are all voting against any kind of a change. I guess they all love ObamaCare.

I can assure you, though, if you look at the charts the Senator from South Carolina was showing, you would wonder why in the world they would all be gathering around when they would dramatically benefit by taking one of the alternatives to ObamaCare.

I didn't come down to talk about that, but I have to say, from a State where our premiums have gone up—tripled—you stop and you ask: What is this going to look like when we get the new bill done?

We don't know exactly what it is going to look like. It is going to have the individual mandates done away with. It is going to have the taxes reduced. It is going to have block grants going to the States.

Look at my State of Oklahoma. That will increase the amount of money that will be coming in, with less taxes, by 200 percent. I dare say, there are a lot of Democrats who would find that in the same situation.

One last note about that, as I go back and I work around the State, I find there are a lot of people who are saying: I don't like this alternative.

I would only say, not just in Oklahoma but anywhere in the Nation, if you oppose what is going to be the alternative, what you are saying is, you would rather have ObamaCare.

COMMENDING ATTORNEY GENERAL SESSIONS

Mr. President, actually, I came to the floor for a different reason. It is probably the most awkward situation I have been in before. Since they cut me down to 8½ minutes, I will have to come back to the floor and embellish a little bit more. I am in an awkward situation. First of all, I believe that we have a President in President Trump who is doing a great job.

I look around and I see what is happening to us. We are now a leader in the free world again. All kinds of things have happened that are very good. Yet I have to say the Attorney General, Jeff Sessions, if I could single out three people in the U.S. Senate whom I respect more, he would be among those.

I am fortunate enough to have known him since the middle eighties, back during the Reagan administration. I knew him very well when he was elected the first time in 1996. Here is a guy who is an outstanding guy, who does things, gets things done. Look at his accomplishments as Attorney General. In that short period of time, what he has done is, he has been working to crack down on immigration. He has performed some real miracles there, and he has worked on protecting law enforcement. In fact, a law enforcement group came out and singled him out as the most prominent and most popular Attorney General we have had.

Look what he has done in his time, what he has introduced. Child abuse—he did the Child Abuse Act. He did it himself. Nobody else helped him. His quote was: ''There is no higher duty than protecting our Nation's children.'' The Prison Rape Elimination Act, the first Federal law dealing with sexual assault on prisoners. A lot of those are young prisoners. We all know the stories. He is the guy who passed that, and nobody else was in on that deal—just him. Forensic sciences, he has been able to be a champion there.

I would have to say that the major thing he did during the time in his early years was that he was the one who was standing up against segregation. He was the one who singlehandedly put himself in a situation where he was taking on the bad guys, and he was desegregating the schools in Alabama. He was key to the prosecution of the Klansmen for abducting and killing a Black teenager. We all remember that. Who was that? Who did that? That was Jeff Sessions. So he gets things done. He was the one who was responsible for bankrupting the Klan in his State of Alabama. Here is a guy who has the sensitivity. I have never known a person I could respect more. That is what bothers me.

I think we have a President who is doing a good job, and the only area where I disagree with him—he has this fight going with Jeff Sessions.

Let me just say this: There is no one I hold in higher regard. He is about the most knowledgeable person, compassionate person, and honorable person we could have in that job.

When there is more time on the schedule, I will come back and elaborate a little bit more on my hero Jeff Sessions and how he ought to remain in that office and do a great job for the United States.

With that, I will comply with the request and yield my time.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. ENZI. Mr. President, I ask unanimous consent that Senator ENZI or his designee be recognized to offer the Heller amendment No. 288 and that the time until 6:10 p.m. be equally divided in the usual form on the Casey motion to commit and the Heller amendment. I further ask that at 6:10 p.m., the Senate vote in relation to the Casey motion, followed by a vote in relation to the Heller amendment, with 2 minutes of debate equally divided in the usual form between the votes.

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

The Senator from Delaware.

Mr. ENZI addressed the Chair.

Mr. CARPER. I am happy to yield.

The PRESIDING OFFICER. The Senator from Wyoming.

AMENDMENT NO. 288 TO AMENDMENT NO. 267

Mr. ENZI. Mr. President, I call up the Heller amendment No. 288.

The PRESIDING OFFICER. The clerk will report.

The senior assistant legislative clerk read as follows:

The Senator from Wyoming [Mr. ENZI], for Mr. HELLER, proposes an amendment numbered 288 to amendment No. 267.

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

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

The amendment is as follows:

(Purpose: To express the sense of the Senate that Medicaid expansion is a priority and that Obamacare must be improved)

At the appropriate place, insert the following:

SEC. _____. SENSE OF THE SENATE.

It is the Sense of the Senate that—

(1) the committee of jurisdiction of the Senate—

(A) should review the issue of Medicaid expansion and coverage for low-income Americans, and the incentives such expansion provides States for certain services;

(B) should consider legislation that provides incentives for States to prioritize Medicaid services for individuals who have the greatest medical need, including individuals with disabilities;

(C) should not consider legislation that reduces or eliminates benefits or coverage for individuals who are currently eligible for Medicaid;

(D) should not consider legislation that prevents or discourages a State from expanding its Medicaid program to include groups or individuals or types of services that are operational under current law; and

(E) should not consider legislation that shifts costs to States to cover such care;

(2) Obamacare should be repealed because it increases health care costs, limits patient choice of health plans and doctors, forces Americans to buy insurance that they do not want, cannot afford, or may not be able to access, and increases taxes on middle class families, which is evidenced by the facts that—

(A) premiums for health plans offered on the Federal Exchange have doubled on average over the last 4 years, and those increases are projected to continue;

(B) 70 percent of counties have only a few options for Obamacare insurance in 2017, and at least 40 counties are expected to have zero insurers planning on their Exchange for 2018;

(C) 2,300,000 Americans on the Exchange are projected to have only one insurer to choose from for plan year 2018; and

(D) the Joint Committee on Taxation has identified significant and widespread tax increases on individuals earning less than $200,000; and

(3) Obamacare should be replaced with patient-centered legislation that—

(A) provides access to quality, affordable private health care coverage for Americans and their families by increasing competition, State flexibility, and individual choice; and

(B) strengthens Medicaid and empowers States through increased flexibility to best meet the needs of each State's population.

Mr. ENZI. I thank the Senator for yielding.

The PRESIDING OFFICER. The Senator from Delaware.

Mr. CARPER. I was happy to yield. Good to see you.

Mr. President, I want to say a few words about ObamaCare. If you ask most people in this country ''What is ObamaCare?'' my guess is, they probably wouldn't know. Those who do might think it has something to do with the exchanges that would allow people to have coverage who don't have coverage on their own. They are not in a large group plan and they are not insured by their employer. They are not covered by Medicaid. They are not covered by Medicare. Maybe they are not a veteran. And 5 or 6 or 7 percent of the people today get their coverage from something called the exchanges.

We have large purchasing pools in each State that are insured by private health insurance. That was not invented by Barack Obama. People call it ObamaCare, but its roots go back well before he was a U.S. Senator, much less before he was President of the United States. The idea of these large purchasing pools in each State—called exchanges—goes back to, as far as I can tell, 1993, when the new First Lady, Hillary Clinton, was offering to begin work to find a way to do what I think every President since Harry Truman has tried to do, and that is three things: provide better coverage for people in this country, do so at less cost, and cover everybody. I believe that has been the goal of every President since Harry Truman.

When Lyndon Johnson was President, some notable progress was made with the introduction of Medicare and Medicaid. But there were still a lot of people who, in 1993—in fact, in 2003 and 2008 and 2009—who didn't have healthcare coverage in this country, tens of millions of people.

In 1993, when Hillary Clinton worked on what was called—in some cases derisively—HillaryCare, she and others said to Republicans: Well, where is your idea? What is your idea? At least we have an idea. The Republicans apparently turned to the Heritage Foundation and said: Help us come up with an alternative. And Heritage did. The alternative they came up with was a market-based approach to providing coverage for people. The idea was that in every State across the country, something called an exchange or marketplace would be created, which is really a large purchasing pool for people who don't have coverage.

So the idea of the exchanges originally suggested by Hillary were introduced in the U.S. Senate by a Republican Senator from Rhode Island named John Chafee, who was a very good man, a marine veteran, a former Governor, and a greatly admired U.S. Senator. He offered legislation to do five things. As far as I can tell, all ideas were suggested by the Heritage Foundation.

No. 1, create purchasing pools in every State. People who didn't have coverage could buy their coverage as a member of a much larger purchasing pool, and by doing that, bring down the cost of coverage.

The second thing in the Chafee legislation in 1993 was to allow folks who bought their coverage through the exchanges to be eligible for a slight tax credit—the lower their income, the bigger the tax credit. When their income reached a certain level, the tax credit would go away.

The third component of the Chafee proposal—again, going back to Heritage—was the idea of individual mandates. You can't make people get coverage, but in the case of the Chafee legislation, provide for a monetary fine for people who failed to get coverage. Over time, the amount of that fine would go up. The idea was to make sure that younger, healthier people would get healthcare coverage, and they would sign up for coverage in the exchanges. That way, the insurance companies would have a healthy mix of people to insure. Otherwise, people would wait until they were really sick—they need to go see a doctor, go to the hospital, or have an operation—to get their coverage, and then the health insurance companies would be left with a tough mix of people to insure. Financially, that would be very challenging for health insurance companies. They said: We need something to ensure that young, healthy people get their coverage through the exchanges.

The fourth piece of the 1993 legislation offered by Senator Chafee said that employers of a certain size, with a certain number of employees, have to cover their employees. You don't have to cover them 100 percent for their insurance and their family's insurance, but they have to be covered with insurance and have access to health insurance through their employer.

The fifth and last piece of ObamaCare, which is really the Heritage Foundation's idea, was a prohibition against health insurance companies saying to people who have a preexisting condition—they had to cover people with preexisting conditions in these exchanges.

That is what people think of and call ObamaCare.

Barack Obama is a bright guy. I knew him before he was a U.S. Senator. I knew him when he was a State senator. He didn't invent it. It was not made up in his head. The source of those ideas was originally the Heritage Foundation. I actually think they are good ideas. I thought they were good ideas then, and I think they are good ideas now.

Somewhere between 1993 and 2009, when we debated on this floor the Affordable Care Act—including exchanges, tax credits, the individual mandate, the employer mandate, a prohibition against insurance companies not covering people with preexisting conditions—somewhere between 1993 and the debate here in 2009 on the Affordable Care Act, a Governor of Massachusetts said: Why don't we try to be the first State to provide healthcare coverage for everybody? And they took that Chafee legislation—the Heritage Foundation idea—dusted it off, and turned it into RomneyCare. It actually worked pretty well. They sure covered a whole lot of people in that State who hadn't been covered before. They covered a lot of people who were not eligible for Medicaid, not eligible for Medicare, maybe not a veteran. They were not receiving coverage from a large group plan, so they now had an option to get coverage in the exchanges.

For those who chose not to in Massachusetts, they had to pay a fine. As it turns out, it was not a very big fine, and it went up over time but not quickly and not very high. So did some people who were young and healthy get coverage in the exchanges in Massachusetts? Yes. If you asked some of the people who were involved with Governor Romney at that time, they would say that if they had to do it over again, the fine would have started a little bigger and gone up a little faster in order to make sure healthier, insurable people got into the exchanges for their coverage.

Well, in 2009, we were here on this floor and debating what some people

still call ObamaCare, but it is something else. It is really RomneyCare. It is really ChafeeCare. It is really HeritageCare. But it ain't ObamaCare. It is a market-based idea to get coverage for people. I think it happens to be a good idea.

Right now, this administration has done their dead level best to destabilize the exchanges. They made it a question of whether the individual mandates will be enforced. If young, healthy people decline to sign up for coverage, will there be a fine they would have to pay? Will it go up over time? This administration has thrown big doubt on that. As a result, a lot of young people haven't signed up. They are not sure they really need to.

We had something in place for a couple of years called CRAs, cost-sharing arrangements. Think, if you will, about people who are buying their healthcare coverage on the exchanges. Their income is under 250 percent of poverty. For several years now, they have been able to get help paying down their copays and their deductibles when they get their coverage on the exchanges.

What this administration has sought to do is throw doubt on whether those cost-sharing arrangements will continue. What has happened as a result is the health insurance companies, which lost their shirts in 2014, raised premiums, deductibles, and copays. They lost money again in 2015, but less. They raised premiums, deductibles, and copays, and lost money in 2016, but less. Some of them even actually made some money. They were not in a death spiral. According to Standard and Poor's, they were actually coming to a stronger financial position.

Enter into that this administration throwing doubt on whether the exchange are going to be around, the individual mandate is going to be enforced, these cost-sharing reductions are going to continue to be offered. That is why a lot of the health insurance companies in this country decided they are going to get out in different States. They are not going to offer coverage in a number of States, a number of counties. That is why. Businesses need certainty and they need predictability, and that includes health insurance costs. Frankly, they didn't have that certainty and predictability.

If we are smart about it, we will hit the ''pause'' button and maybe, before we do anything else, provide the certainty and the stability in the exchanges that are needed. And for the health insurance companies, make sure they will offer coverage without having to fear that they will be back in 2014 and lose their shirts again. That is not why they are in business.

There are three things that need to be done in order to stabilize the exchanges.

The first thing that needs to be done is the individual mandate, which we have by law. It says: If you don't have healthcare coverage, get your coverage on the exchange. If you choose not to, you have to pay a fine. Over time, that fine goes up.

We need to preserve something that works like the individual mandate—maybe, ideally, the individual mandate as it is, and if we can't get the votes for that, then something that works at least as well as the individual mandate in making sure people—healthy people too—get their coverage on the exchanges if they are eligible.

The second thing we ought to do is reinsurance. Senator KAINE, myself, and others, including some recovering Governors who serve here in the Senate, have cosponsored legislation that we have described as reinsurance. I am told it has been around forever in the insurance business, and it is one of the reasons the Medicare Part D drug program is successful and works.

The way it works, quite simply, is this: Say an individual who has serious medical problems gets their coverage in the exchanges. They first start in 2018. In 2018, 2019, and 2020, for a person who has significant health challenges and is expensive to insure, the first $50,000 of their cost to the insurer in a year would be borne by the insurer. Between $50,000 and $500,000 for one individual for one year, the Federal Government would pay 80 percent of that. It is reinsurance.

For anything over that in those 3 years, 2018 through 2020, the first 3 years, anything between $50 and $500,000, the Federal Government would pay 80 percent.

Starting in 2021 and beyond, the reinsurance program would continue, but it would be a little bit different. In 2021 and beyond, the first $100,000 of costs incurred by an individual covered by a policy in the exchange—the first $100,000 would be on the insurance company. They would have the liability. Anything between $100,000 and $500,000 in one year for that individual, 80 percent of that cost would be borne by the Federal Government. Anything above $500,000 from 2021 and beyond would be borne, again, by the insurance company. It is called reinsurance.

The last piece of the three is to make it clear that these cost-sharing reductions are reduced and make sure that the copays and the deductibles will continue to be subsidized by the Federal Government. It will reduce the out-of-pocket costs for people whose income is below 250 percent of poverty.

If we do those three things, the insurance companies tell us we will stabilize the exchanges. They will have a healthy group of people to insure. More insurance companies will come in to provide coverage in States and in counties. More insurance companies providing policies and coverage leads to competition. The competition leads to better quality coverage, and the competition leads to lower prices—lower prices for individuals who are getting their coverage in the exchanges and lower prices, we are told, for Uncle Sam. The Federal Government, the costs to the Treasury, will be reduced, as well, if we do these three things.

Again, we are told by the health insurance companies that have been reluctant to stay in the exchanges, if we do those three things, we would reduce the cost of premiums in the exchanges by 25 to 35 percent. That helps individuals get their coverage, and it helps the government, too, in reducing our exposure. I think that makes a lot of sense.

Unfortunately, what our colleagues here on the floor are talking about doing—and the rumors we hear about some kind of skinny repeal—certainly, it doesn't stabilize the exchanges. It does more to destabilize the exchanges. That isn't where we need to go.

We need to hit the pause button and say: Let's stabilize the exchanges, and then let's revert to regular order. People have ideas on health insurance. Let's introduce bills. Let's have hearings with witnesses who come in and say what is good or what is bad. The witnesses could include Governors, health insurance folks, providers, normal people.

Let's have a debate. Let Members offer amendments in committee, have votes, report the bills out, and eventually bring them here and go through the same thing. We call that regular order. JOHN MCCAIN, in his return speech yesterday—thank God he is back—called again and again for return to regular order. We need to do that, and if we do, we will end up not with a Democratic victory or a Republican victory or a Trump victory, we might win a victory for democracy and actually doing what is right and what needs to be done. That, most of all, is what we need to do.

I yield the floor.

The PRESIDING OFFICER. The Senator from New Hampshire.

Ms. HASSAN. Mr. President, I rise today in support of Senator CASEY's motion to strike provisions from TrumpCare that would harm individuals with disabilities by reducing their access to affordable healthcare or limiting coverage or benefits under Medicaid or in the private health insurance market.

Today, as Senator CASEY noted, we celebrate the 27th anniversary of the Americans with Disabilities Act, recognizing the enormous contributions that Americans who experience disabilities have made in communities in New Hampshire and across our Nation.

Unfortunately, Senate Republicans are proposing massive cuts to traditional Medicaid, which threaten the support that individuals who experience disabilities need to thrive in their homes, their schools, and their communities.

A few weeks ago, I visited an organization called Granite State Independent Living in Concord, NH. It is a nonprofit that helps individuals with disabilities of all ages to try to have an independent life for themselves. What struck me the most was the consistent theme that I heard over and over from

different people who experience different disabilities. They said that because of services like personal care attendants, transportation help, and other medical supports, they were able to work and live more independent lives.

Many shared their biggest fears about what would happen if they didn't receive the support—a real possibility if plans to decimate Medicaid go into effect. Their biggest fear is that independence would go away. There were fears of becoming a burden for their families or having family members have to give up their jobs or having to be put in a nursing home because that would be the only way they could survive.

Person after person talked about how much they wanted to contribute to American life—to their communities, to their States, and to our economy. I kept thinking that all of these people were expressing such an American value with their desires to roll up their sleeves, do everything they could to make a difference, to be self-sufficient, to be independent.

The ability for Americans who experience disabilities to reach their full potential is truly put at risk with some of these TrumpCare proposals, and just a little while ago on the floor, I heard a discussion that perhaps there might be a proposal put forward on the floor—maybe this evening—that would record a sense of the Senate that the Senate wants to make sure that whatever action it takes will not hurt people with disabilities. It will support people with disabilities.

There is no doubt that a kind word can go a long way on a difficult day, but as someone who has raised a child who has experienced severe disabilities, as someone who has spent a lot of time talking to people with disabilities and their families, I can tell you that sympathy and empathy only go so far.

The people I know who experience disabilities want to do everything they can to support themselves, to be independent, to be able to reach their full potential. There is a difference between charity and justice, and while none of us would ever reject the kindness that so many people demonstrate to people with disabilities, what we really should be working toward is making sure people with disabilities have the same access to healthcare, to education, to the workforce that will allow them to have what every American wants, which is an independent life where they are free to chart their own course, support themselves, move forward.

We celebrate the 27th anniversary of the Americans with Disabilities Act today—one of our great moments in this country, as we have reminded ourselves of our Founders' vision. Our Founders said that every single person counts, and while they didn't honor that principle perfectly at our founding, while they did not count everyone at first, they have had the confidence that every generation of Americans would move forward, bringing in more and more people from the margins into the heart and soul of our democracy, our communities, our economy, and, in doing that, we would unleash the talent and energy of more and more Americans. It is that talent and energy that has been the secret of our country's success. It is our vision that continues to drive us forward.

On this day of all days, when we celebrate the progress we have made to honor the freedom, strength, and productivity of Americans who experience disabilities, the last thing we should do is pull the rug out from under those very people by decimating the Medicaid Program that provides them the kind of support that actually allows them to be free, to work hard, to be with their families, to make a difference, to be treated like every other American, to have the rights of every other American, and to feel like every other American.

We can't afford to go back to the days when we marginalized or didn't assist some of our most vulnerable people—people who want to participate and contribute to their communities and to the country they love. So I urge my colleagues to vote in favor of Senator CASEY's motion and make clear that individuals with disabilities deserve the right to receive the support they need at home, at school, and in their communities, so they can be free and thrive.

Thank you.

I yield the floor.

The PRESIDING OFFICER. The Senator from Maryland.

Mr. CARDIN. Mr. President, I have listened very carefully to the majority leader and his requests that we come forward and bring amendments to the floor—all of our ideas about how we can improve our healthcare system so that this would be an opportunity through budget reconciliation for us to deal with those issues.

I asked my staff to prepare amendments in order to protect the Medicaid system from cuts. I asked my staff to prepare amendments to protect the essential health benefits that are in the Affordable Care Act because it is important that we preserve those benefits, whether it is mental health and addiction services or one that is particularly important to Maryland; that is, pediatric dental. In Maryland, we all recall the loss of a 12-year-old not too many years ago because he couldn't get dental care—Deamonte Driver.

I asked my staff to take a look at preparing amendments to protect minority health and health disparities because the Affordable Care Act made tremendous advancements in trying to close that gap on the disparities in minority health and health disparities. I asked my staff to take a look at the tax provisions because we want to make sure that we are not giving tax cuts to wealthy people at the expense of cutting the Medicaid system. I asked them to look at this in a lot of different ways.

Listening to the majority leader, I also have introduced legislation that I will talk about that could build on the Affordable Care Act, and I was wondering what bill I should amend? What is the bill that we are considering? It is not the bill that Senator MCCONNELL brought forward because that bill was defeated. It is not the repeal—and we are starting with a blank slate—because that was defeated. I don't believe it is the House bill because that has been discredited, called a mean bill by the President, as well as by Members of this body, who said it has no chance of passing. So my dilemma is that I don't know what I should be amending.

I expect we will get to see another bill somewhere along the process with virtually no notice and no opportunity to read and no opportunity to amend, but the majority leader says I am going to have that opportunity. Yet we don't know what the bill is that I am supposed to be addressing my amendments to.

We know that all the bills we have seen today—every single one from the Republicans—have been scored by the Congressional Budget Office as to tens of millions of Americans losing their insurance coverage—tens of millions. I understand it is about 33 million if we just repeal the Affordable Care Act, 22 million if we use the type of replacement that the majority leader was suggesting. All of those move in the wrong direction.

We also know that in every one of these proposals to date, insurance premiums are going to go up, not down.

That is one thing I have heard from my constituents. They would like to see us bring down the growth rate of health insurance costs and healthcare, not increase it. So, yes, I would like to be able to offer amendments, but I don't know what to offer amendments to.

I also am concerned when I see that every one of the bills that have been suggested by the Republicans would reverse the protections that we put in law against the wrong practices—the discriminatory practices—of insurance companies. I have talked to many of my constituents who tell me that if we reimpose caps, either yearly or lifetime—they have the circumstance where their child was born with a disability and that cap would have been expended within a matter of months—they would be left without insurance coverage. They tell me about how preexisting conditions could be jeopardized. All of us have some form of preexisting condition, and, on a lot of these plans that are being suggested where you could choose the type of coverage you want, insurance companies are not going to offer the benefits you need. People who have challenges are going to be most discriminated against. So I don't quite understand how I can offer amendments and we could have a vote on the floor when we don't know what we are trying to amend.

I must state that there is a common theme here, and we know it. We know that there is now talk that the majority leader might bring up, sometime during this process, what has been called in the press a ''skinny'' bill. I call it a slow death of the Affordable Care Act, and, in fact, I am afraid it might be a fast death of the Affordable Care Act because, if the reports are accurate, one of the provisions that the majority leader is looking to bring in as the final bill that we would vote on would eliminate the requirement that companies have to provide insurance coverage to their employees and individuals must have coverage.

Now that seems innocent enough, except for the tens of millions who are going to lose their insurance coverage—people who are working for companies that decide to terminate their policies, healthy people who decide not to buy insurance policies. I believe you are going to find that there still will be tens of millions of people losing their insurance coverage, and that is unacceptable. But it goes beyond that. That proposal will also increase premium costs by a very large percent. Why?

Think about this for a moment. If you don't have to buy insurance and you are young and healthy, are you going to buy insurance or not? Many will say no until they need the insurance, and then they will buy the insurance. Actuaries tell us that without the requirement to have insurance, the insurance pools will contain a very high percentage of adverse risks—people at higher risk—and when that happens, the purpose of insurance to spread the risk is no longer done. It means premiums will go up dramatically. That doesn't help the people who are going to need it.

What you also find when you eliminate this requirement is that people get what we call job locked. They may have a company that provides health benefits, but now they may have to leave that company. But if they want to leave that company and start a job or go to another job that doesn't have insurance, they are locked into where they work. All of that adds to anxiety, adds to lack of coverage, adds to people who don't have health insurance, adds to people not getting adequate healthcare, adds to bankruptcies, adds to the problems that we addressed with the Affordable Care Act.

But there is another explanation here. Maybe this is just a shell bill that is going to go back—hopefully, as the Republicans believe, but I hope it does not happen—to the House, and then we will put in the Medicaid cuts and the tax relief and all the other things that are not in the bill. This is just a shell to get us back to one of the bills that couldn't get the votes here on the floor, where tens of millions of people will lose their insurance coverage, premiums will go up, and insurance company arbitrary and discriminatory practices will return.

Every one of these proposals—every single one—moves us in the wrong direction in healthcare. We recognize that we can improve our healthcare system. I am for improving our healthcare system. I think we can work together—Democrats and Republicans—to improve our healthcare system.

So here is my request: Vote for the Casey motion. Why? For two reasons. One, I would hope that on this anniversary of the ADA, or the Americans with Disabilities Act, we would want to do no harm to those with disabilities in our healthcare system and they would have adequate coverage. I was in a celebration over the weekend in Baltimore City with the disabilities community. We celebrated one of the great victories in America, the Americans with Disabilities Act—a bipartisan bill, with Democrats and Republicans coming together in a proud moment, in the best traditions of the Senate, to say that people with disabilities will be treated fairly in America. On this day we should adopt the Casey motion on the issue of protecting people with disabilities.

But there is a second issue here.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. CARDIN. Mr. President, I ask unanimous consent to speak for 2 additional minutes.

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

Mr. CARDIN. I will try to conclude my remarks. On this day that we are celebrating the anniversary of the Americans with Disabilities Act, let's do right by that. There is a second part to the Casey motion that sends it back to committee so we can use the regular process, as Senator MCCAIN talked about yesterday. Let's have the committee hearings, as Senator ALEXANDER talked about. Let's have the committee markups and work together. I introduced legislation that would bring down the cost of healthcare and lower the rate of increase of individual premiums. I do that by suggesting more competition in the individual marketplace, by having a public option, by providing stronger subsidies to lower income families, by making sure that cost-sharing is in fact paid for so we don't have that uncertainty, with the reinsurance that Senator CARPER was talking about to deal with the overall cost of healthcare, by dealing with prescription drug costs, and by dealing with coordinated care so that we can deal with the whole patient rather than their individual disease.

All of those issues would improve the Affordable Care Act, but before we get there, we have to get off of this train. We have to stop this disastrous course. I am going to do everything in my power to make sure that, as to the bill we have, whenever it comes forward, we stop it right here, and then work together, Democrats and Republicans, to improve our healthcare system, not to take away insurance coverage and increase costs for so many Americans.

With that, I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

Ms. DUCKWORTH. Mr. President, I rise in support of Senator CASEY's motion protecting people with disabilities.

The PRESIDING OFFICER. I am sorry. There is no Democratic time remaining.

The Senator from Nevada.

Mr. HELLER. Mr. President, I rise today to talk about my amendment, Heller amendment No. 288.

My amendment reinforces the important role Medicaid has played in my home State and in the States of many of my colleagues here today.

Let me explain the impact Medicaid has had on the State of Nevada. As many of you know, the State of Nevada was the first to expand Medicaid. Before Nevada made that decision, the State's uninsured rate was at 23 percent, and it was one of the highest in the country. So think about that for a minute. One in four Nevadans did not have healthcare coverage. Under expanded Medicaid today, Nevadans' uninsured rate is between 11 percent and 12 percent. I have also seen the number of uninsured people living in Nevada's rural communities cut in half, and I have seen major gains with the number of children in our State with healthcare coverage.

In fact, Nevada has seen one of the most significant decreases in uninsured children in the country. In 2013, our State had the highest rate of uninsured children in the country. We were ranked 50th in the nation. Now I can proudly say that Nevada is the most improved State when it comes to addressing our rates of uninsured children. Our State has made significant progress since the State's decision to expand Medicaid, and that has made a big impression on me.

Over the past few months, I have had the privilege of meeting with Nevadans here in Washington, DC, as well as back home, to discuss healthcare. The resounding message I continue to hear is that, because of Medicaid expansion, more than 200,000 Nevadans have health insurance today who otherwise wouldn't. The other resounding message I hear is that drastic cuts to the Medicaid Program threaten the critical services that Nevadans rely on.

Let me read you a letter I received from a woman in Las Vegas. She said:

> My oldest child has Down Syndrome and has depended on Medicaid since the day she was born, and was denied healthcare because of preexisting conditions that she was born with. My husband and I are hardworking Americans. We started our own business 5 years ago and have seen that business grow more and more each year. We do not rely on the government for assistance, other than Medicaid coverage. Without it, we would be unable to afford the numerous appointments with specialists and surgeries that keep our daughter happy, healthy, and progressing in life.

This is one example of the real stories behind the numbers, and I want to do everything I can to make sure they are protected and their coverage is not threatened. I want to make sure their daughter has healthcare coverage today and tomorrow.

Medicaid also plays a crucial role in Nevada when it comes to covering the elderly and people with disabilities. More than 30,000 of Nevada's seniors receive healthcare through Medicaid, including nursing home care and services that help them live at home. In fact, more than half of Nevada's nursing home residents are covered by Medicaid. Nearly 50,000 people with disabilities in Nevada now have access to care that helps them live independently, thanks to Medicaid.

Karen from Henderson recently contacted me and said that her adult son has MS and depends on Medicaid to help cover the cost of his medication, which costs $300 per month. Without Medicaid, he can't afford it.

One Nevadan traveled all the way from Las Vegas to talk with me about her two sons with cystic fibrosis. She is worried about any legislation that would jeopardize access to care for people with serious, chronic illnesses, such as the ones her sons are struggling with.

In total, over 631,000 people in Nevada are covered by the Medicaid Program. That is low-income children, pregnant women, seniors, and people with disabilities. It is why I have said since the beginning of the healthcare debate, that I will only support a solution that protects Nevada's most vulnerable. The House bill didn't go far enough to do that, and neither did the Senate's bill, and that is why I voted against it last night.

Nevada faces unique challenges when it comes to healthcare. I have spent the past few months trying to find ways to protect Nevadans who depend on Medicaid and provide coverage for those with preexisting conditions, all the while bringing down costs and improving quality and access to care. I have also been having discussions with Nevadans in Washington and back home to hear from them how potential changes could impact their care.

Whether it is a mom in Reno who has a son with a heart condition and is terrified about the future of his treatments or the nurses from Las Vegas who came all the way to DC because they are worried that their patients could lose coverage, I have been listening and I do understand.

Make no mistake, ObamaCare needs fixing. It has led to higher costs and fewer choices in my State. For the past 7 years, I have said that we need more competition to drive down costs and increase competition for Nevadans. My discussions with Nevadans in Washington and back home have also allowed me the opportunity to hear from them how potential changes could impact their care. I believe we can achieve these goals while recognizing the role that Medicaid plays in our States and ensuring that those who have coverage today are protected.

My role as a Senator is doing the very best I can for my State, and that means standing up for Nevadans who depend on Medicaid. We are having this debate because I do believe there are commonsense solutions that can improve our healthcare system, and I voted to give us the opportunity to have that discussion and to fight for them. But, as I have said all along, healthcare reform cannot be balanced on the backs of Nevada's low-income families and sickest individuals. That is something I cannot and I will not stand for.

We can work to find a way to lower costs, increase choices, and improve the quality of care for Nevadans everywhere, but we can do it in a way that also protects our most vulnerable. That is why for the past few months I have been working with my colleagues in the Senate who also understand the unique challenges expansion States face, and we have been fighting for solutions that will protect those who currently rely on the Medicaid Program. It hasn't been easy, but that is the way it is supposed to be, and that is OK.

I am here to roll up my sleeves, get to work, and fight for policies that will be in the best interests of all Nevadans. So I encourage my colleagues to support this amendment, Heller No. 288, today to reiterate the value of Medicaid in our States. We have much work ahead of us to do to improve the healthcare system for Nevadans and Americans across this country.

I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

Ms. DUCKWORTH. Mr. President, I speak in support of Senator CASEY's motion protecting people with disabilities.

It is appalling that the Republican Party is working to strip healthcare from the disability community on the very anniversary of the day when we passed monumental legislation that improved the lives of Americans with disabilities.

It was 27 years ago that the Americans with Disabilities Act—one of the most important pieces of legislation of our time—was signed into law, and it is a shame that as we celebrate our great achievement for equality, we are moving backward rather than building on the progress our community has worked so hard on to make it so Americans with disabilities can live healthy, productive, independent lives. We cannot afford to move backward, and I will not sit quietly by and let that happen and neither will my constituents.

I have heard from thousands of Illinoisans who are struggling to understand why lawmakers are considering ripping away the care that is keeping them alive and allowing them to be independent and productive members of our community. I want to share just one of their stories with you.

It is about a woman by the name of Jessica Baker, from Mascoutah, IL. Nearly 10 years ago, when she was a healthy and young 19-year-old, her entire life changed. Jessica was driving on the highway on a foggy morning. Because of the lack of visibility on the road, a truckdriver ahead of her ran through two cars. Jessica, just feet behind the truck, never saw the brake light go off. She struck that semitruck and became part of a 20-car pileup. This young, healthy woman's life completely changed in an instant.

Jessica is now 29 years old and is a quadriplegic. She depends on Medicaid for her healthcare needs. She is living an independent life and has done well under the ACA. Now she fears she will lose her care that the law has helped her to receive. Jessica was a healthy, vital person whose life changed in an instant.

I understand how that feels. I went from being a soldier—one of the most physically fit people among my peers—to becoming wheelchair bound. So many of our brave men and women take that risk every single day, and we must be completely honest with ourselves as any American's life can change in the blink of an eye. The healthy can become sick, and the able-bodied can become disabled in a single moment. Any one of us can end up at the mercy of our healthcare system.

After her accident, Jessica had to fight for her life and relearn how to live as a thriving young person. Now Senate Republicans and President Trump are threatening her life by eliminating her access to care. As proud as I am to be a part of the Senate Chamber, which passed the monumental ADA, I am also appalled by what the Republicans in this body are doing today.

Yesterday's vote to proceed on a debate on a bill that would rob tens of millions of their health insurance is utterly shameful. It would jeopardize a program that 1 in 10 veterans, 2 out of 3 nursing home residents, and children with autism, Down syndrome, and special needs depend on. That is simply unacceptable. Senate Republicans have done everything they can to hide their legislation from the American people, crafting it in secret, behind closed doors. However, one thing remains clear; that the fight to protect healthcare is not over.

This is the time for the American people to keep speaking up, to make their voices heard, and Senate Republicans must listen. They must listen to their constituents and to the most vulnerable among us, like the members of the disability community who have been here day after day, literally, fighting for their lives. Day after day, I see people who come into my office who say: Save me. Save my child. Save our lives.

That is why I am working every single day to not only push back against these Republican efforts to strip away care from those who need it the most

but also to bring people together on commonsense improvements to our current healthcare system. We cannot be a nation that says: If you are sick or ill, we are going to leave you behind. That is simply not who we are. We are the greatest democracy on the face of the Earth, and we do not leave our most vulnerable behind.

Thank you.

The PRESIDING OFFICER (Mr. TILLIS). The Senator from Pennsylvania.

Mr. CASEY. Mr. President, I know the Chair said I may speak for a few minutes before the vote. I spoke earlier so I will not reiterate every argument.

Really, what we are doing with this particular amendment is sending this legislation to the Finance Committee so as to focus it as the motion itself says: When this bill would be recommitted to the Finance Committee, the Finance Committee could examine it from the perspective, in this case, of people with disabilities and to focus on changes that could be made in order to prevent harm to individuals with disabilities as defined in the Americans with Disabilities Act of 1990.

The reason we mention that particularly is that is the seminal piece of legislation to protect people with disabilities who would be harmed by this legislation because you cannot just have rights that are guaranteed without the support for those rights. Medicaid provides that support so folks, if they want to live at home or if they want to live in a community-based setting, can do that, but they can only do that with the help of Medicaid. It is a pretty simple amendment to make sure there is some adequate review of the impact on Americans with disabilities.

We have, in Pennsylvania, for example, over 720,000 people who have a disability and depend upon Medicaid. I want to make sure every one of those Pennsylvanians has all of the protections we say we are guaranteeing with disability legislation—with laws like the Americans with Disabilities Act and with the protections Medicaid provides.

This is critically important. At a time when we are talking about freedom and liberty in the context of healthcare, I would hope we would take steps to guarantee that freedom and liberty apply to those with disabilities so that as the Americans with Disabilities Act has enshrined in our law, they may be able to choose the kind of places they want to live and choose the settings within which they want to live their lives, to be able to have the freedom to choose that by way of the support they can get from Medicaid. I hope that is something that is reasonable enough so as to get support from both sides of the aisle.

I know my friend from Nevada is offering a sense of the Senate in the next vote. I just do not think that a sense of the Senate, in any way, is commensurate with the gravity of this problem. There is a time and a place for a sense of the Senate—when we are expressing a sentiment that is bipartisan—but we need more than sentimentality here. We need more than good wishes. We need to make sure we get this policy right as it relates to people with disabilities.

Mr. President, I yield the floor.

The PRESIDING OFFICER. All time has expired.

VOTE ON MOTION TO COMMIT

The question occurs on agreeing to the Casey motion to commit.

The Senator from Wyoming.

Mr. ENZI. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The clerk will call the roll.

The bill clerk called the roll.

Mr. CORNYN. The following Senator is necessarily absent: the Senator from Wisconsin (Mr. JOHNSON).

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

The result was announced—yeas 48, nays 51, as follows:

[Rollcall Vote No. 171 Leg.]

YEAS—48

Baldwin	Gillibrand	Murray
Bennet	Harris	Nelson
Blumenthal	Hassan	Peters
Booker	Heinrich	Reed
Brown	Heitkamp	Sanders
Cantwell	Hirono	Schatz
Cardin	Kaine	Schumer
Carper	King	Shaheen
Casey	Klobuchar	Stabenow
Coons	Leahy	Tester
Cortez Masto	Manchin	Udall
Donnelly	Markey	Van Hollen
Duckworth	McCaskill	Warner
Durbin	Menendez	Warren
Feinstein	Merkley	Whitehouse
Franken	Murphy	Wyden

NAYS—51

Alexander	Fischer	Paul
Barrasso	Flake	Perdue
Blunt	Gardner	Portman
Boozman	Graham	Risch
Burr	Grassley	Roberts
Capito	Hatch	Rounds
Cassidy	Heller	Rubio
Cochran	Hoeven	Sasse
Collins	Inhofe	Scott
Corker	Isakson	Shelby
Cornyn	Kennedy	Strange
Cotton	Lankford	Sullivan
Crapo	Lee	Thune
Cruz	McCain	Tillis
Daines	McConnell	Toomey
Enzi	Moran	Wicker
Ernst	Murkowski	Young

NOT VOTING—1

Johnson

The motion was rejected.

AMENDMENT NO. 288

The PRESIDING OFFICER. There is now 2 minutes equally divided before the vote on the Heller amendment.

The Senator from Nevada.

Mr. HELLER. Mr. President, I have an amendment at the desk that would express the importance of Medicaid in our individual States. I would like to read from it two provisions that I think are important to this whole body; that is, the Senate prioritizes ''Medicaid services for individuals who have the greatest medical need, including individuals with disabilities;'' also, that we ''should not consider legislation that reduces or eliminates benefits or coverage for individuals who are currently eligible for Medicaid.''

That is the amendment. I want everyone to express for their own States how important the Medicaid Program is for their States, and I would urge a ''yes'' vote from my colleagues.

The PRESIDING OFFICER. The Senator from Vermont.

Mr. SANDERS. Mr. President, I raise a point of order that the pending amendment violates section 313(b)1(A) of the Congressional Budget Act of 1974.

I am glad that the Senator from Nevada is concerned about Medicaid, but I would remind the Senate that yesterday the vast majority of Republicans voted to throw 15 million people off of Medicaid on their way to end health insurance for 22 million Americans.

Our job as a nation is to guarantee healthcare to every man, woman, and child and join the rest of the industrialized world, not throw disabled children off of the healthcare they currently have.

I urge a ''no'' vote.

Mr. President, I raise a point of order that the pending amendment violates section 313(b)1(A) of the Congressional Budget Act of 1974.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. HELLER. Mr. President, pursuant to section 904 of the Congressional Budget Act of 1974 and the waiver provisions of applicable budget resolutions, I move to waive all applicable sections of that act and applicable budget resolutions for purposes of amendment No. 288 and, if adopted, for the provisions of the adopted amendment included in any subsequent amendment to H.R. 1628 and any amendment between Houses or conference report thereon, 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 senior assistant legislative clerk called the roll.

The yeas and nays resulted—yeas 10, nays 90, as follows:

[Rollcall Vote No. 172 Leg.]

YEAS—10

Capito	Gardner	Portman
Cassidy	Heller	Sullivan
Collins	McCain	
Enzi	Murkowski	

NAYS—90

Alexander	Cantwell	Crapo
Baldwin	Cardin	Cruz
Barrasso	Carper	Daines
Bennet	Casey	Donnelly
Blumenthal	Cochran	Duckworth
Blunt	Coons	Durbin
Booker	Corker	Ernst
Boozman	Cornyn	Feinstein
Brown	Cortez Masto	Fischer
Burr	Cotton	Flake

Franken	Lee	Sasse
Gillibrand	Manchin	Schatz
Graham	Markey	Schumer
Grassley	McCaskill	Scott
Harris	McConnell	Shaheen
Hassan	Menendez	Shelby
Hatch	Merkley	Stabenow
Heinrich	Moran	Strange
Heitkamp	Murphy	Tester
Hirono	Murray	Thune
Hoeven	Nelson	Tillis
Inhofe	Paul	Toomey
Isakson	Perdue	Udall
Johnson	Peters	Van Hollen
Kaine	Reed	Warner
Kennedy	Risch	Warren
King	Roberts	Whitehouse
Klobuchar	Rounds	Wicker
Lankford	Rubio	Wyden
Leahy	Sanders	Young

The PRESIDING OFFICER (Mrs. ERNST). On this vote, the yeas are 10, the nays are 90.

Three-fifths of the Senators duly chosen and sworn not having voted in the affirmative, the motion is rejected.

The point of order is sustained and the amendment falls.

The PRESIDING OFFICER. The majority leader.

AMENDMENT NO. 340, AS MODIFIED, TO AMENDMENT NO. 267

Mr. MCCONNELL. Madam President, I call up amendment No. 340, as modified.

The PRESIDING OFFICER. The clerk will report.

The senior assistant legislative clerk read as follows:

The Senator from Kentucky [Mr. MCCONNELL], for Mr. DAINES, proposes an amendment numbered 340, as modified, to amendment No. 267.

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

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

The amendment, as modified, is as follows:

(Purpose: To provide for comprehensive health insurance coverage for all United States residents, improved health care delivery, and for other purposes)

Strike all after the first word and, insert the following:

SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Expanded & Improved Medicare For All Act''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. DEFINITIONS AND TERMS.

In this Act:

(1) MEDICARE FOR ALL PROGRAM; PROGRAM.—The terms ''Medicare For All Program'' and ''Program'' mean the program of benefits provided under this Act and, unless the context otherwise requires, the Secretary with respect to functions relating to carrying out such program.

(2) NATIONAL BOARD OF UNIVERSAL QUALITY AND ACCESS.—The term ''National Board of Universal Quality and Access'' means such Board established under section 305.

(3) REGIONAL OFFICE.—The term ''regional office'' means a regional office established under section 303.

(4) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(5) DIRECTOR.—The term ''Director'' means, in relation to the Program, the Director appointed under section 301.

TITLE I—ELIGIBILITY AND BENEFITS

SEC. 101. ELIGIBILITY AND REGISTRATION.

(a) IN GENERAL.—All individuals residing in the United States (including any territory of the United States) are covered under the Medicare For All Program entitling them to a universal, best quality standard of care. Each such individual shall receive a card with a unique number in the mail. An individual's Social Security number shall not be used for purposes of registration under this section.

(b) REGISTRATION.—Individuals and families shall receive a Medicare For All Program Card in the mail, after filling out a Medicare For All Program application form at a health care provider. Such application form shall be no more than 2 pages long.

(c) PRESUMPTION.—Individuals who present themselves for covered services from a participating provider shall be presumed to be eligible for benefits under this Act, but shall complete an application for benefits in order to receive a Medicare For All Program Card and have payment made for such benefits.

(d) RESIDENCY CRITERIA.—The Secretary shall promulgate a rule that provides criteria for determining residency for eligibility purposes under the Medicare For All Program.

(e) COVERAGE FOR VISITORS.—The Secretary shall promulgate a rule regarding visitors from other countries who seek premeditated non-emergency surgical procedures. Such a rule should facilitate the establishment of country-to-country reimbursement arrangements or self pay arrangements between the visitor and the provider of care.

SEC. 102. BENEFITS AND PORTABILITY.

(a) IN GENERAL.—The health care benefits under this Act cover all medically necessary services, including at least the following:

(1) Primary care and prevention.

(2) Approved dietary and nutritional therapies.

(3) Inpatient care.

(4) Outpatient care.

(5) Emergency care.

(6) Prescription drugs.

(7) Durable medical equipment.

(8) Long-term care.

(9) Palliative care.

(10) Mental health services.

(11) The full scope of dental services, services, including periodontics, oral surgery, and endodontics, but not including cosmetic dentistry.

(12) Substance abuse treatment services.

(13) Chiropractic services, not including electrical stimulation.

(14) Basic vision care and vision correction (other than laser vision correction for cosmetic purposes).

(15) Hearing services, including coverage of hearing aids.

(16) Podiatric care.

(b) PORTABILITY.—Such benefits are available through any licensed health care clinician anywhere in the United States that is legally qualified to provide the benefits.

(c) NO COST-SHARING.—No deductibles, copayments, coinsurance, or other cost-sharing shall be imposed with respect to covered benefits.

SEC. 103. QUALIFICATION OF PARTICIPATING PROVIDERS.

(a) REQUIREMENT TO BE PUBLIC OR NON-PROFIT.—

(1) IN GENERAL.—No institution may be a participating provider unless it is a public or not-for-profit institution. Private physicians, private clinics, and private health care providers shall continue to operate as private entities, but are prohibited from being investor owned.

(2) CONVERSION OF INVESTOR-OWNED PROVIDERS.—For-profit providers of care opting to participate shall be required to convert to not-for-profit status.

(3) PRIVATE DELIVERY OF CARE REQUIREMENT.—For-profit providers of care that convert to non-profit status shall remain privately owned and operated entities.

(4) COMPENSATION FOR CONVERSION.—The owners of such for-profit providers shall be compensated for reasonable financial losses incurred as a result of the conversion from for-profit to non-profit status.

(5) FUNDING.—There are authorized to be appropriated from the Treasury such sums as are necessary to compensate investor-owned providers as provided for under paragraph (3).

(6) REQUIREMENTS.—The payments to owners of converting for-profit providers shall occur during a 15-year period, through the sale of U.S. Treasury Bonds. Payment for conversions under paragraph (3) shall not be made for loss of business profits.

(7) MECHANISM FOR CONVERSION PROCESS.—The Secretary shall promulgate a rule to provide a mechanism to further the timely, efficient, and feasible conversion of for-profit providers of care.

(b) QUALITY STANDARDS.—

(1) IN GENERAL.—Health care delivery facilities must meet State quality and licensing guidelines as a condition of participation under such program, including guidelines regarding safe staffing and quality of care.

(2) LICENSURE REQUIREMENTS.—Participating clinicians must be licensed in their State of practice and meet the quality standards for their area of care. No clinician whose license is under suspension or who is

under disciplinary action in any State may be a participating provider.

(c) PARTICIPATION OF HEALTH MAINTENANCE ORGANIZATIONS.—

(1) IN GENERAL.—Non-profit health maintenance organizations that deliver care in their own facilities and employ clinicians on a salaried basis may participate in the program and receive global budgets or capitation payments as specified in section 202.

(2) EXCLUSION OF CERTAIN HEALTH MAINTENANCE ORGANIZATIONS.—Other health maintenance organizations which principally contract to pay for services delivered by non-employees shall be classified as insurance plans. Such organizations shall not be participating providers, and are subject to the regulations promulgated by reason of section 104(a) (relating to prohibition against duplicating coverage).

(d) FREEDOM OF CHOICE.—Patients shall have free choice of participating physicians and other clinicians, hospitals, and inpatient care facilities.

SEC. 104. PROHIBITION AGAINST DUPLICATING COVERAGE.

(a) IN GENERAL.—It is unlawful for a private health insurer to sell health insurance coverage that duplicates the benefits provided under this Act.

(b) CONSTRUCTION.—Nothing in this Act shall be construed as prohibiting the sale of health insurance coverage for any additional benefits not covered by this Act, such as for cosmetic surgery or other services and items that are not medically necessary.

TITLE II—FINANCES

Subtitle A—Budgeting and Payments

SEC. 201. BUDGETING PROCESS.

(a) ESTABLISHMENT OF OPERATING BUDGET AND CAPITAL EXPENDITURES BUDGET.—

(1) IN GENERAL.—To carry out this Act there are established on an annual basis consistent with this title—

(A) an operating budget, including amounts for optimal physician, nurse, and other health care professional staffing;

(B) a capital expenditures budget;

(C) reimbursement levels for providers consistent with subtitle B; and

(D) a health professional education budget, including amounts for the continued funding of resident physician training programs.

(2) REGIONAL ALLOCATION.—After Congress appropriates amounts for the annual budget for the Medicare For All Program, the Director shall provide the regional offices with an annual funding allotment to cover the costs of each region's expenditures. Such allotment shall cover global budgets, reimbursements to clinicians, health professional education, and capital expenditures. Regional offices may receive additional funds from the national program at the discretion of the Director.

(b) OPERATING BUDGET.—The operating budget shall be used for—

(1) payment for services rendered by physicians and other clinicians;

(2) global budgets for institutional providers;

(3) capitation payments for capitated groups; and

(4) administration of the Program.

(c) CAPITAL EXPENDITURES BUDGET.—The capital expenditures budget shall be used for funds needed for—

(1) the construction or renovation of health facilities; and

(2) for major equipment purchases.

(d) PROHIBITION AGAINST CO-MINGLING OPERATIONS AND CAPITAL IMPROVEMENT FUNDS.—It is prohibited to use funds under this Act that are earmarked—

(1) for operations for capital expenditures; or

(2) for capital expenditures for operations.

SEC. 202. PAYMENT OF PROVIDERS AND HEALTH CARE CLINICIANS.

(a) ESTABLISHING GLOBAL BUDGETS; MONTHLY LUMP SUM.—

(1) IN GENERAL.—The Medicare For All Program, through its regional offices, shall pay each institutional provider of care, including hospitals, nursing homes, community or migrant health centers, home care agencies, or other institutional providers or pre-paid group practices, a monthly lump sum to cover all operating expenses under a global budget.

(2) ESTABLISHMENT OF GLOBAL BUDGETS.—The global budget of a provider shall be set through negotiations between providers, State directors, and regional directors, but are subject to the approval of the Director. The budget shall be negotiated annually, based on past expenditures, projected changes in levels of services, wages and input, costs, a provider's maximum capacity to provide care, and proposed new and innovative programs.

(b) THREE PAYMENT OPTIONS FOR PHYSICIANS AND CERTAIN OTHER HEALTH PROFESSIONALS.—

(1) IN GENERAL.—The Program shall pay physicians, dentists, doctors of osteopathy, pharmacists, psychologists, chiropractors, doctors of optometry, nurse practitioners, nurse midwives, physicians' assistants, and other advanced practice clinicians as licensed and regulated by the States by the following payment methods:

(A) Fee for service payment under paragraph (2).

(B) Salaried positions in institutions receiving global budgets under paragraph (3).

(C) Salaried positions within group practices or non-profit health maintenance organizations receiving capitation payments under paragraph (4).

(2) FEE FOR SERVICE.—

(A) IN GENERAL.—The Program shall negotiate a simplified fee schedule that is fair and optimal with representatives of physicians and other clinicians, after close consultation with the National Board of Universal Quality and Access and regional and State directors. Initially, the current prevailing fees or reimbursement would be the basis for the fee negotiation for all professional services covered under this Act.

(B) CONSIDERATIONS.—In establishing such schedule, the Director shall take into consideration the following:

(i) The need for a uniform national standard.

(ii) The goal of ensuring that physicians, clinicians, pharmacists, and other medical professionals be compensated at a rate which reflects their expertise and the value of their services, regardless of geographic region and past fee schedules.

(C) STATE PHYSICIAN PRACTICE REVIEW BOARDS.—The State director for each State, in consultation with representatives of the physician community of that State, shall establish and appoint a physician practice review board to assure quality, cost effectiveness, and fair reimbursements for physician delivered services.

(D) FINAL GUIDELINES.—The Director shall be responsible for promulgating final guidelines to all providers.

(E) BILLING.—Under this Act physicians shall submit bills to the regional director on a simple form, or via computer. Interest shall be paid to providers who are not reimbursed within 30 days of submission.

(F) NO BALANCE BILLING.—Licensed health care clinicians who accept any payment from the Medicare For All Program may not bill any patient for any covered service.

(G) UNIFORM COMPUTER ELECTRONIC BILLING SYSTEM.—The Director shall create a uniform computerized electronic billing system, including those areas of the United States where electronic billing is not yet established.

(3) SALARIES WITHIN INSTITUTIONS RECEIVING GLOBAL BUDGETS.—

(A) IN GENERAL.—In the case of an institution, such as a hospital, health center, group practice, community and migrant health center, or a home care agency that elects to be paid a monthly global budget for the delivery of health care as well as for education and prevention programs, physicians and other clinicians employed by such institutions shall be reimbursed through a salary included as part of such a budget.

(B) SALARY RANGES.—Salary ranges for health care providers shall be determined in the same way as fee schedules under paragraph (2).

(4) SALARIES WITHIN CAPITATED GROUPS.—

(A) IN GENERAL.—Health maintenance organizations, group practices, and other institutions may elect to be paid capitation payments to cover all outpatient, physician, and medical home care provided to individuals enrolled to receive benefits through the organization or entity.

(B) SCOPE.—Such capitation may include the costs of services of licensed physicians and other licensed, independent practitioners provided to inpatients. Other costs of inpatient and institutional care shall be excluded from capitation payments, and shall be covered under institutions' global budgets.

(C) PROHIBITION OF SELECTIVE ENROLLMENT.—Patients shall be permitted to enroll or disenroll from such organizations or entities without discrimination and with appropriate notice.

(D) HEALTH MAINTENANCE ORGANIZATIONS.—Under this Act—

(i) health maintenance organizations shall be required to reimburse physicians based on a salary; and

(ii) financial incentives between such organizations and physicians based on utilization are prohibited.

SEC. 203. PAYMENT FOR LONG-TERM CARE.

(a) ALLOTMENT FOR REGIONS.—The Program shall provide for each region a single budgetary allotment to cover a full array of long-term care services under this Act.

(b) REGIONAL BUDGETS.—Each region shall provide a global budget to local long-term care providers for the full range of needed services, including in-home, nursing home, and community based care.

(c) BASIS FOR BUDGETS.—Budgets for long-term care services under this section shall be based on past expenditures, financial and clinical performance, utilization, and projected changes in service, wages, and other related factors.

(d) FAVORING NON-INSTITUTIONAL CARE.—All efforts shall be made under this Act to provide long-term care in a home- or community-based setting, as opposed to institutional care.

SEC. 204. MENTAL HEALTH SERVICES.

(a) IN GENERAL.—The Program shall provide coverage for all medically necessary mental health care on the same basis as the coverage for other conditions. Licensed mental health clinicians shall be paid in the same manner as specified for other health professionals, as provided for in section 202(b).

(b) FAVORING COMMUNITY-BASED CARE.—The Medicare For All Program shall cover supportive residences, occupational therapy, and ongoing mental health and counseling services outside the hospital for patients with serious mental illness. In all cases the highest quality and most effective care shall be delivered, and, for some individuals, this may mean institutional care.

SEC. 205. PAYMENT FOR PRESCRIPTION MEDICATIONS, MEDICAL SUPPLIES, AND MEDICALLY NECESSARY ASSISTIVE EQUIPMENT.

(a) NEGOTIATED PRICES.—The prices to be paid each year under this Act for covered pharmaceuticals, medical supplies, and medically necessary assistive equipment shall be negotiated annually by the Program.

(b) PRESCRIPTION DRUG FORMULARY.—

(1) IN GENERAL.—The Program shall establish a prescription drug formulary system, which shall encourage best-practices in prescribing and discourage the use of ineffective, dangerous, or excessively costly medications when better alternatives are available.

(2) PROMOTION OF USE OF GENERICS.—The formulary shall promote the use of generic medications but allow the use of brand-name and off-formulary medications.

(3) FORMULARY UPDATES AND PETITION RIGHTS.—The formulary shall be updated frequently and clinicians and patients may petition their region or the Director to add new pharmaceuticals or to remove ineffective or dangerous medications from the formulary.

SEC. 206. CONSULTATION IN ESTABLISHING REIMBURSEMENT LEVELS.

Reimbursement levels under this subtitle shall be set after close consultation with regional and State Directors and after the annual meeting of National Board of Universal Quality and Access.

Subtitle B—Funding

SEC. 211. OVERVIEW: FUNDING THE MEDICARE FOR ALL PROGRAM.

(a) IN GENERAL.—The Medicare For All Program is to be funded as provided in subsection (c)(1).

(b) MEDICARE FOR ALL TRUST FUND.—There shall be established a Medicare For All Trust Fund in which funds provided under this section are deposited and from which expenditures under this Act are made.

(c) FUNDING.—

(1) IN GENERAL.—There are appropriated to the Medicare For All Trust Fund amounts sufficient to carry out this Act from the following sources:

(A) Existing sources of Federal Government revenues for health care.

(B) Increasing personal income taxes on the top 5 percent income earners.

(C) Instituting a modest and progressive excise tax on payroll and self-employment income.

(D) Instituting a modest tax on unearned income.

(E) Instituting a small tax on stock and bond transactions.

(2) SYSTEM SAVINGS AS A SOURCE OF FINANCING.—Funding otherwise required for the Program is reduced as a result of—

(A) vastly reducing paperwork;

(B) requiring a rational bulk procurement of medications under section 205(a); and

(C) improved access to preventive health care.

(3) ADDITIONAL ANNUAL APPROPRIATIONS TO MEDICARE FOR ALL PROGRAM.—Additional sums are authorized to be appropriated annually as needed to maintain maximum quality, efficiency, and access under the Program.

SEC. 212. APPROPRIATIONS FOR EXISTING PROGRAMS.

Notwithstanding any other provision of law, there are hereby transferred and appropriated to carry out this Act, amounts from the Treasury equivalent to the amounts the Secretary estimates would have been appropriated and expended for Federal public health care programs, including funds that would have been appropriated under the Medicare program under title XVIII of the Social Security Act, under the Medicaid program under title XIX of such Act, and under the Children's Health Insurance Program under title XXI of such Act.

TITLE III—ADMINISTRATION

SEC. 301. PUBLIC ADMINISTRATION; APPOINTMENT OF DIRECTOR.

(a) IN GENERAL.—Except as otherwise specifically provided, this Act shall be administered by the Secretary through a Director appointed by the Secretary.

(b) LONG-TERM CARE.—The Director shall appoint a director for long-term care who shall be responsible for administration of this Act and ensuring the availability and accessibility of high quality long-term care services.

(c) MENTAL HEALTH.—The Director shall appoint a director for mental health who shall be responsible for administration of this Act and ensuring the availability and accessibility of high quality mental health services.

SEC. 302. OFFICE OF QUALITY CONTROL.

The Director shall appoint a director for an Office of Quality Control. Such director shall, after consultation with State and regional directors, provide annual recommendations to Congress, the President, the Secretary, and other Program officials on how to ensure the highest quality health care service delivery. The director of the Office of Quality Control shall conduct an annual review on the adequacy of medically necessary services, and shall make recommendations of any proposed changes to the Congress, the President, the Secretary, and other Medicare For All Program officials.

SEC. 303. REGIONAL AND STATE ADMINISTRATION; EMPLOYMENT OF DISPLACED CLERICAL WORKERS.

(a) ESTABLISHMENT OF MEDICARE FOR ALL PROGRAM REGIONAL OFFICES.—The Secretary shall establish and maintain Medicare For All regional offices for the purpose of distributing funds to providers of care. Whenever possible, the Secretary should incorporate pre-existing Medicare infrastructure for this purpose.

(b) APPOINTMENT OF REGIONAL AND STATE DIRECTORS.—In each such regional office there shall be—

(1) one regional director appointed by the Director; and

(2) for each State in the region, a deputy director (in this Act referred to as a ''State Director'') appointed by the governor of that State.

(c) REGIONAL OFFICE DUTIES.—Regional offices of the Program shall be responsible for—

(1) coordinating funding to health care providers and physicians; and

(2) coordinating billing and reimbursements with physicians and health care providers through a State-based reimbursement system.

(d) STATE DIRECTOR'S DUTIES.—Each State Director shall be responsible for the following duties:

(1) Providing an annual State health care needs assessment report to the National Board of Universal Quality and Access, and the regional board, after a thorough examination of health needs, in consultation with public health officials, clinicians, patients, and patient advocates.

(2) Health planning, including oversight of the placement of new hospitals, clinics, and other health care delivery facilities.

(3) Health planning, including oversight of the purchase and placement of new health equipment to ensure timely access to care and to avoid duplication.

(4) Submitting global budgets to the regional director.

(5) Recommending changes in provider reimbursement or payment for delivery of health services in the State.

(6) Establishing a quality assurance mechanism in the State in order to minimize both under utilization and over utilization and to assure that all providers meet high quality standards.

(7) Reviewing program disbursements on a quarterly basis and recommending needed adjustments in fee schedules needed to achieve budgetary targets and assure adequate access to needed care.

(e) FIRST PRIORITY IN RETRAINING AND JOB PLACEMENT; 2 YEARS OF SALARY PARITY BENEFITS.—The Program shall provide that clerical, administrative, and billing personnel in insurance companies, doctors offices, hospitals, nursing facilities, and other facilities whose jobs are eliminated due to reduced administration—

(1) should have first priority in retraining and job placement in the new system; and

(2) shall be eligible to receive two years of Medicare For All employment transition benefits with each year's benefit equal to salary earned during the last 12 months of employment, but shall not exceed $100,000 per year.

(f) ESTABLISHMENT OF MEDICARE FOR ALL EMPLOYMENT TRANSITION FUND.—The Secretary shall establish a trust fund from which expenditures shall be made to recipients of the benefits allocated in subsection (e).

(g) ANNUAL APPROPRIATIONS TO MEDICARE FOR ALL EMPLOYMENT TRANSITION FUND.—Sums are authorized to be appropriated annually as needed to fund the Medicare For All Employment Transition Benefits.

(h) RETENTION OF RIGHT TO UNEMPLOYMENT BENEFITS.—Nothing in this section shall be interpreted as a waiver of Medicare For All Employment Transition benefit recipients' right to receive Federal and State unemployment benefits.

SEC. 304. CONFIDENTIAL ELECTRONIC PATIENT RECORD SYSTEM.

(a) IN GENERAL.—The Secretary shall create a standardized, confidential electronic patient record system in accordance with laws and regulations to maintain accurate patient records and to simplify the billing process, thereby reducing medical errors and bureaucracy.

(b) PATIENT OPTION.—Notwithstanding that all billing shall be preformed electronically, patients shall have the option of keeping any portion of their medical records separate from their electronic medical record.

SEC. 305. NATIONAL BOARD OF UNIVERSAL QUALITY AND ACCESS.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—There is established a National Board of Universal Quality and Access (in this section referred to as the ''Board'') consisting of 15 members appointed by the President, by and with the advice and consent of the Senate.

(2) QUALIFICATIONS.—The appointed members of the Board shall include at least one of each of the following:

(A) Health care professionals.

(B) Representatives of institutional providers of health care.

(C) Representatives of health care advocacy groups.

(D) Representatives of labor unions.

(E) Citizen patient advocates.

(3) TERMS.—Each member shall be appointed for a term of 6 years, except that the President shall stagger the terms of members initially appointed so that the term of no more than 3 members expires in any year.

(4) PROHIBITION ON CONFLICTS OF INTEREST.—No member of the Board shall have a financial conflict of interest with the duties before the Board.

(b) DUTIES.—

(1) IN GENERAL.—The Board shall meet at least twice per year and shall advise the Secretary and the Director on a regular basis to ensure quality, access, and affordability.

(2) SPECIFIC ISSUES.—The Board shall specifically address the following issues:

(A) Access to care.

(B) Quality improvement.

(C) Efficiency of administration.

(D) Adequacy of budget and funding.

(E) Appropriateness of reimbursement levels of physicians and other providers.

(F) Capital expenditure needs.

(G) Long-term care.

(H) Mental health and substance abuse services.

(I) Staffing levels and working conditions in health care delivery facilities.

(3) ESTABLISHMENT OF UNIVERSAL, BEST QUALITY STANDARD OF CARE.—The Board shall specifically establish a universal, best quality of standard of care with respect to—

(A) appropriate staffing levels;

(B) appropriate medical technology;

(C) design and scope of work in the health workplace;

(D) best practices; and

(E) salary level and working conditions of physicians, clinicians, nurses, other medical professionals, and appropriate support staff.

(4) TWICE-A-YEAR REPORT.—The Board shall report its recommendations twice each year to the Secretary, the Director, Congress, and the President.

(c) COMPENSATION, ETC.—The following provisions of section 1805 of the Social Security Act shall apply to the Board in the same manner as they apply to the Medicare Payment Assessment Commission (except that any reference to the Commission or the Comptroller General shall be treated as references to the Board and the Secretary, respectively):

(1) Subsection (c)(4) (relating to compensation of Board members).

(2) Subsection (c)(5) (relating to chairman and vice chairman).

(3) Subsection (c)(6) (relating to meetings).

(4) Subsection (d) (relating to director and staff; experts and consultants).

(5) Subsection (e) (relating to powers).

TITLE IV—ADDITIONAL PROVISIONS

SEC. 401. TREATMENT OF VA AND IHS HEALTH PROGRAMS.

(a) VA HEALTH PROGRAMS.—This Act provides for health programs of the Department of Veterans' Affairs to initially remain independent for the 10-year period that begins on the date of the establishment of the Medicare For All Program. After such 10-year period, the Congress shall reevaluate whether such programs shall remain independent or be integrated into the Medicare For All Program.

(b) INDIAN HEALTH SERVICE PROGRAMS.—This Act provides for health programs of the Indian Health Service to initially remain independent for the 5-year period that begins on the date of the establishment of the Medicare For All Program, after which such programs shall be integrated into the Medicare For All Program.

SEC. 402. PUBLIC HEALTH AND PREVENTION.

It is the intent of this Act that the Program at all times stress the importance of good public health through the prevention of diseases.

SEC. 403. REDUCTION IN HEALTH DISPARITIES.

It is the intent of this Act to reduce health disparities by race, ethnicity, income and geographic region, and to provide high quality, cost-effective, culturally appropriate care to all individuals regardless of race, ethnicity, sexual orientation, or language.

TITLE V—EFFECTIVE DATE

SEC. 501. EFFECTIVE DATE.

Except as otherwise specifically provided, this Act shall take effect on the first day of the first year that begins more than 1 year after the date of the enactment of this Act, and shall apply to items and services furnished on or after such date.

The PRESIDING OFFICER. The Democratic leader.

Mr. SCHUMER. Madam President, I rise this evening to announce the Democrats will offer no further amendments to the pending legislation until the Republican leader shows us what the final legislation will be.

Clearly, the Senate bill—repeal and replace—has failed. Senator PAUL's bill—repeal without replace—has also failed. We know the Republicans are not going to take a final vote on the underlying House bill, which is still the pending legislation.

Now the Republican leadership team has been telling the press about a yet-to-be-disclosed final bill. If the reports are true, the Republicans will offer a skinny repeal plan.

We just heard from the nonpartisan Congressional Budget Office that under such a plan as reported in the press, 16 million Americans would lose their health insurance and millions more would pay a 20-percent—20-percent—increase in their premiums—at least 20 percent.

I thank Senator MURRAY and Senator WYDEN for working with CBO so that we could figure out what exactly is going on, if this skinny bill is the bill that is brought to the floor.

My Republican friends come to the floor every day to assail the problem of high premiums. If the reporting is accurate and skinny repeal is their plan, it makes premiums far higher than they are today. We don't know if skinny repeal is going to be their final bill, but if it is, the CBO says that it would cause costs to go up and millions to lose insurance.

In the meantime, Democrats are not going to continue to try and amend the House plan that is already dead. Certainly, we are not going to do that while there is some secret legislation—skinny repeal it is reported—waiting to emerge from the leader's office.

The Republican leader has said that this is a robust amendment process. No, it isn't—far from it. We don't even know what bill to direct our amendments to. Certainly, a process that bypassed the committees and public hearings was never an open and transparent process. There was never a robust amendment process to this bill, but now it has gotten even worse. Since the beginning of this debate, we have just been taking votes on amendments to a piece of dead legislation.

What kind of process is this? Anyone who listened, as we all did, so intently to Senator MCCAIN's wonderful speech yesterday and applauded the sentiment that he mentioned—getting back to regular order and proper procedure—anyone who listened to that speech would blush at this sham of an amendment process thus far. We don't even have a final bill to amend. The idea that this is a robust amendment process, I would say to my dear friend the leader, defies credulity. No one believes it. I bet not a single person on either side of the aisle believes it. So Democrats are not going to participate in this one-sided and broken process.

Once the majority leader shows his hand, reveals what his bill will actually be, Democrats will use the opportunity to try to amend the bill. But we have to see it first, and we ought to see it soon in broad daylight, not at the eleventh hour.

Until we see the real bill, Democrats will offer no further amendments.

Thank you, and I yield the floor.

The PRESIDING OFFICER. The Senator from Rhode Island.

Mr. REED. Madam President, let me join the Democratic leader in expressing my dismay in what has been going on on the Senate floor with respect to healthcare.

For over 7 years, my colleagues on the other side of the aisle have been talking about how they intended to repeal the Affordable Care Act in order to replace it with something better and improve our healthcare system. President Trump has said time and again that he would provide better healthcare at a lower cost. He said that everyone would be covered. Yet we have seen no solutions from the other side that would accomplish these goals. We have been trying to work with Republicans, not just this year but for the last several years to improve our healthcare system. In fact, we worked with them to craft the Affordable Care Act in the first place, holding public hearings and meetings with both Democrats and Republicans around the table. The Affordable Care Act included well over 150 Republican amendments. Yet they refused to work with us on our final passage of the law and refused to work with us on the current law and healthcare ever since.

However, today we have seen a couple of glimpses of bipartisanship. First, the Senate voted last night, both Democrats and Republicans, to reject the TrumpCare bill that would have provided tax breaks to special interests while decimating Medicaid. I am glad the Senate has spoken on that issue and said that we do not support this effort. This afternoon, Democrats and Republicans voted to reject a bill that would have repealed the Affordable Care Act with no replacement. A majority of Senators voted to say that effort was unacceptable.

Now that we have taken those votes, Senators have had their say on what they think is the best path forward, and to me, these votes show that most Senators want to work in a bipartisan fashion to improve our healthcare system. I have heard many of my colleagues on the other side of the aisle say just that, as Senator MCCAIN said so eloquently yesterday.

I think, if my colleagues are willing to sit down and negotiate in good faith

on legislation to improve our healthcare system and bring down costs, we could come up with a bill that would get the support of the majority of this body. My colleague Senator SHAHEEN, for example, introduced legislation to help stabilize the individual market, something I think most of us would agree is an important step forward in improving the Affordable Care Act. However, we are now hurdling toward a vote with absolutely no plan to improve the healthcare system. My Republican colleagues are scrambling to get enough votes just to pass anything at all.

Right now we are debating the bill, but what does that mean when we have not yet seen the bill we are eventually going to vote on? This is not a meaningful exercise with opportunities to amend and improve legislation. We are simply killing time so that the Republican leadership can unveil a new bill, if they are able to come up with one, that they can convince enough of their Members to support. Hours or minutes before final passage this could be sprung upon us, and we would then be forced to take a vote. That is not the way the legislative process should work.

What kind of message does this send to our constituents? This is an example of legislating at its worst.

This is why many Americans don't trust Washington to have their backs. We don't know what Republicans intend to pass at the end of this debate, but we do know that they intend to pass something that is harmful. The CBO score, which the Democratic leader suggested, based upon the reports of what is pending, suggests significant losses in coverage across the country and significant increases in the cost of healthcare insurance for Americans. Based on what we have seen so far, each proposal would send the healthcare market into a death spiral, impacting all of our constituents—not just the Medicaid recipients, not just those who are in the exchanges—and even private employers who provide insurance coverage for their workers would see increases.

As I mentioned earlier, the bill we voted on this afternoon would repeal the Affordable Care Act with no replacement. In that case, the nonpartisan Congressional Budget Office said this would cause 32 million Americans to lose health insurance over the next decade, including 17 million next year alone, and health insurance markets would collapse.

As I indicated, fortunately, that failed, with both Democrats and Republicans voting against it, but it looks like Senate Republican leadership is still trying to cobble together yet another version, taking some of the worst elements of the repeal act. What is worse, there will be no opportunity to review the bill, no chance for CBO to analyze the bill and provide feedback, no opportunities for stakeholders, patients, and States to weigh in.

It is telling that the only path forward they have for their repeal effort is to pass a bill no one has literally read. The only chance they have to get support for their effort is to hide, essentially, the impact of the bill because on the merits it appears devastating to our constituents.

Nevertheless, as much as they try to hide this bill, the American people will find out. They will find out when they get the bill for their health insurance. They will find out when they go to their doctor and discover the treatment they had last year that was covered under the Affordable Care Act is no longer covered. They will find out when the only insurance company in their State decides to leave. They will find out when their employer says: We are no longer providing healthcare to our employees. They will find out when they start a family and discover that maternity care is no longer covered and, if the child needs medical care early in life, the insurance company can say: No, thank you; we don't have to cover the child. There is a preexisting condition.

Just last night I got a call from a woman in Charlestown, RI—Amy. She urged me to continue fighting to preserve the Affordable Care Act. She is a hairdresser and her husband is a commercial fisherman. Because they are both self-employed, they are not able to get coverage through work. They have been able to access care through our State's health insurance marketplace, HealthSource RI. As Amy said, she and her husband are hard-working, middle-income taxpayers, but they never have been able to afford coverage without the help of the Affordable Care Act. They would not have been able to do that. Amy recently got sick and had to be hospitalized. She has coverage because of ObamaCare. She was able to get the treatment she needed. Without coverage, she would have been left to pay a bill of $78,000. Amy told me that she and her husband would have had to sell their house to afford that, and, probably even with that, they would have been left impoverished.

Is that really what my colleagues want for their constituents?

My constituents know what is at stake. I have heard from thousands and thousands of them throughout the year, urging me to keep fighting for healthcare, asking me to put an end to this repeal effort. However, Democrats cannot do this alone. We need more Republicans like some of my colleagues, Senator COLLINS and Senator MURKOWSKI, to come forward and say: Enough is enough. Even if you have problems with the current system, let's try to work together to solve the problems. We might not always agree, but we will try our best to come to a consensus. There is no harm in trying to come up with a bipartisan solution. It is not too late to reverse course and return to regular order, to start again, to start right, and to do it, as my colleague on the Armed Services Committee, Chairman MCCAIN, said, the good old fashioned way, with Senator ALEXANDER and Senator MURRAY on the HELP Committee and my colleagues on the Finance Committee working their way through, carefully and deliberately, listening, amending, moving forward legislation so that we can come to this body not with a few minutes' notice but fully prepared to vote on something that is critical to every family in the country.

With that, Madam President, I yield the floor.

The PRESIDING OFFICER. The Senator from Minnesota.

Mr. FRANKEN. Thank you, Madam President.

Madam President, I rise this evening to speak in opposition to the Republican plan to dismantle our healthcare system. Their effort to repeal the Affordable Care Act and gut Medicaid would put the health, as well as the financial security of millions of Americans, at risk.

Let me tell you how this would affect Minnesotans such as Annie and her 5-year-old son Carter. Carter has autism spectrum disorder and relies on Medicaid to help cover necessary therapy services. When Carter was 2, he did not talk, make eye contact, or interact with anyone. But now, because of the treatment he receives under Medicaid, Carter speaks full sentences and is entering kindergarten. Annie explains how none of that would be possible without Medicaid. If Republicans succeed in imposing drastic cuts to Medicaid, which is what they want to do, and States are forced to cut back services, Annie and her family would not be able to afford the therapy that Carter needs to thrive.

Think about that. Think about what that does to one life. Think about the other millions that would be affected in such a negative, tragic way.

There is also Mari and Chrysann, both from Moorhead, MN. Moorhead is in northwestern Minnesota, right across the river from Fargo. Mari took care of her aging mother in her home as long as she could, but when Chrysann's health began to decline, Mari helped her mom move to a nursing home where she could access the higher level of care she needed.

Mari and her husband work full time and still have children at home. I visited the nursing home where Mari spoke, and she got emotional when she told me that if it were not for Medicaid, her family would not have any other way to pay for her mother's care. She does not know how she would care for her mom or what would happen to her.

Chrysann, Mari's mom, is worried too. She spoke at this roundtable at the nursing home. She is worried about how the Republican plan will affect her own future and those of others who are in similar situations in nursing homes. Sixty-four percent of Americans in nursing homes have their care paid for by Medicaid. Chrysann told me this

plan is not about taking care of people but simply about ''survival of the fittest.''

Is that really the healthcare system we support in the United States of America—the survival of the fittest?

How about Chuck? Chuck is the CEO of Perham Health. It is a rural hospital that is doing really innovative work in Northwest Minnesota. It is kind of central, north. It is in rural Minnesota, not unlike the rural areas in the Presiding Officer's State.

Chuck told me: ''Cutting Medicaid as drastically as they are proposing will force us to cut staff in areas that are actually saving the system money today.''

These cuts would affect nurses who run the hospital's medical homes, community paramedics, and other staff who are helping to keep people out of the Emergency Department, reduce readmissions, and keep people healthy overall. This is part of the innovation they are doing there. This is part of the innovation that Minnesota leads the Nation in.

Perham Health is one of the largest employers in town so taking away jobs does not just impact the patients and the hospital, it affects the community and rural economy. Cutting jobs and getting rid of successful reforms just does not make sense, and this would be repeated over and over and over again in rural America.

Again, the question is, Why are Republicans pursuing such a reckless and irresponsible strategy?

All of the bills they have proposed thus far will increase patient costs, including premiums and out-of-pocket costs, will increase the number of uninsured Americans, and will rip apart our healthcare safety net. These are not the changes Americans want. In fact, this is the opposite of what Americans want and are asking for.

Now, over the last day, we have heard a lot more about another path Republicans may pursue—a scaled-back plan that eliminates a handful of the ACA provisions, including the employer mandate and individual mandate. While these two changes may be politically expedient, they would, according to the Congressional Budget Office, drive up premiums and cause millions of Americans to become uninsured.

What is more, as the New York Times points out, this plan does nothing to address the criticisms Leader MCCONNELL, President Trump, and their allies continue to lodge against the Affordable Care Act. For example, this approach does nothing to improve competition and choice in the individual market and, in fact, injects far more uncertainty into individual health insurance markets, which are already rattled by the administration's deliberate efforts to sabotage them.

Should this plan pass the Senate, it will surely get much worse when the differences between the plan and the House bill are reconciled in the conference committee. According to news reports, a number of my Republican colleagues are arguing that passing this scaled-back version of repeal is really just a means to get to conference, where Members can further negotiate the House and Senate repeal and replace bills. In fact, some are even suggesting that the provisions in the House-passed bill would be a guidepost for negotiations.

I think all of us remember how awful, far-reaching, and—according to President Trump—mean the House-passed bill is. What is more, we can see the worst provisions of the Better Care Reconciliation Act resurface in the conference committee, which is the Senate repeal and replace bill that was defeated on a bipartisan basis.

Overall, pursuing this path is dangerous, given the tremendous number of unknowns. Not only would this half-baked—that is being generous—quarter-baked, scaled-back version of the ACA repeal destabilize health insurance markets, but it would also serve as a vehicle for Republicans to take up the most controversial measures included in the defeated BCRA and the House-passed bill.

Why on Earth would we support that?

Frankly, it is also delusional to believe that a small group of House and Senate leaders can craft a workable solution in a matter of days or weeks. They have had 7 years to come up with an alternative. They do not have one so how can we expect them to, all of a sudden, come up with a viable plan that affects one-sixth of our economy?

Look, this whole process has been and continues to be irresponsible. In fact, this is one of the most irresponsible policymaking processes I have seen in my time in the U.S. Senate. What we should do is just what Senator MCCAIN called for in his speech yesterday, which is to pursue regular order, work together—Republicans and Democrats—and seek out compromise. If we reject this wrongheaded effort, then I and many of my colleagues are ready and committed to work in a bipartisan way on reforms that will expand coverage, lower costs, and improve care.

Let's have bipartisan hearings on the individual market, on drug prices, and more. Let's call in nonpartisan expert witnesses. Let's have meaningful committee and floor debates. Let's fix what needs fixing in the Affordable Care Act. Annie, Carter, Mari, Chrysann, Chuck, and millions of other Americans need us to do just that.

To my colleagues on the other side of the aisle, please, stand up to the bullying, stand up to the lies, and work with us to improve people's lives, not make them worse. Paul Wellstone said that politics is not about winning, that it is not about power, that it is not about money. Politics is about working to improve people's lives, and that is what we should be doing. You owe it to your constituents. You owe it to yourselves.

Thank you.

I yield the floor.

The PRESIDING OFFICER. The Senator from Rhode Island.

CLIMATE CHANGE

Mr. WHITEHOUSE. Madam President, something else happened this afternoon in Washington that I wish to relate today on the floor, which is that the American Enterprise Institute hosted the launch of Senator SCHATZ's and my American Opportunity Carbon Fee Act. I am delighted the American Enterprise Institute did that. Their conservative credentials are rock solid, but they do not fear debate, and they were extraordinarily helpful and open-minded in allowing us to make the announcement and in hosting a discussion on the bill that followed.

Virtually every person on the Republican side who has thought the climate change problem through to a solution has come to the same place—a revenue-neutral, border-adjustable price on carbon. That means that all of the revenues are returned to the American people.

Former Treasury Secretaries Baker, Shultz, and Paulson—all Republicans—former EPA Administrators Ruckelshaus, Thomas, Reilly, and Whitman—all Republicans—and leading economists and former Presidential economic advisers Arthur Laffer, Gregory Mankiw, and Douglas Holtz-Eakin—all Republicans—along with many others, support a revenue-neutral, border-adjustable carbon fee. Well, that is what we do.

You all know the phrase ''offering an olive branch.'' Former Republican Congressman Bob Inglis described our proposal as an olive limb, not a branch, when pairing a carbon tax with corporate tax reduction. He said it provides what he called ''an opportunity for conservatives to show how free enterprise can solve climate change.''

When I first came to the Senate in 2007, this place was humming with bipartisan action on climate change for years—but, in 2010, a dead stop. The Republican Party disappeared from the field after the fossil fuel industry secured from five Justices on the Supreme Court the infamous Citizens United decision. The fossil fuel industry, as if it saw the decision coming, immediately launched a veritable Soviet May Day parade of political artillery and rocketry. No special interest had that kind of political muscle before Citizens United. The combination of this industry political weaponry, plus the proliferation of dark money, plus the shady science simulacrum of climate denial has been formidable.

Despite this, there is room for optimism. There are Republicans who are willing to work with us. They just need some prospect of safe passage through the political kill zone that the fossil fuel industry has created.

Over 1,000 American companies have voiced their support for the Paris climate agreement, including corporate powerhouses like Walmart, Goldman Sachs, PepsiCo, and Google. If American companies were to mobilize in

Congress just like they did for the Paris Agreement, that would be a game-changer.

But notwithstanding all of that corporate support, the big business trade associations and lobbying groups have lined up against action on climate change. The so-called U.S. Chamber of Commerce—probably more accurately described as the U.S. chamber of carbon—is one of climate action's most implacable enemies, despite the good climate policies of so many of its member companies. How is it representing its members? It is incredible.

The American Petroleum Institute represents Shell, BP, Total, and Exxon—companies that claim to support the Paris Agreement and the Climate Leadership Council's carbon fee proposal—but API opposes anything getting done.

We all know here that corporate America commands extraordinary attention in our political system. If American corporations aligned their political engagement on climate change with their actual position on climate change, which should not be asking too much of them, we could get going.

So, in a spirit of hopefulness, Senator SCHATZ and I reintroduced at the American Enterprise Institute our American Opportunity Carbon Fee Act, a framework that I hope both Republicans and Democrats can embrace. The bill would establish an economy-wide carbon fee on carbon dioxide and other greenhouse gas emissions. The fee would be assessed where it is easiest to administer, minimizing the compliance burden. Other greenhouse gases would be tied to their carbon dioxide equivalency with a bumper for fluorocarbons to account for their high greenhouse gas potency. Sequestering, utilizing, or encapsulating carbon dioxide emissions would earn you a credit. The market would begin to work in this space.

Our bill sets the 2018 fee per ton of carbon emitted at $49—the central range of the social cost of carbon last estimated by the Office of Management and Budget. That fee would increase each year at a real 2 percent until emissions fall 80 percent below 2005 levels, and then it would follow inflation.

Border adjustments for energy-intensive goods traded with countries that have weaker or no carbon pricing will make sure that we protect our industries at home. We took care to design the border adjustments in harmony with World Trade Organization rules.

This carbon fee would produce meaningful reductions in carbon emissions. The nonpartisan Resources for the Future projects a 36-percent drop by 2025, compared to the benchmark year of 2005, exceeding the U.S.-Paris Agreement commitment significantly.

In addition to the environmental value, of course, a carbon fee also generates revenue—in this case, nearly $2.1 trillion in revenue over 10 years. Our plan would return every dime of that to the American people. Here is how.

First, the bill lowers the top corporate income tax rate from 35 percent to 29 percent—a longstanding goal of Republicans. This would cut American corporate taxes by almost $600 billion over the first decade.

Second, it provides workers with a $550 refundable tax credit—$1,100 for a couple—against payroll taxes. The tax credits, which would grow with inflation, would return almost $900 billion to the pocketbooks of American households over the first 10 years.

Third, it would provide a matching benefit to Social Security beneficiaries, veterans program beneficiaries, and certain other retirees. These benefits would total nearly $500 billion over 10 years.

Finally, the bill would establish a block grant program, delivering the remaining funds to our States—over $100 billion to help workers in coal country, for instance, or provide coastal protection for seaside States facing terrible threats of sea level rise, at the discretion of the State, to meet local needs and concerns.

I understand the suffering in coal country. Coal country will continue to decline as natural gas drives coal out of the energy market. There is now no mechanism to remedy that inevitability.

Remember Huey Long's old slogan, ''Every Man a King''? With a carbon fee, we could make every miner a king—a solid pension, retirement at any time, full health benefits for life, a cash bonus based on years worked, a voucher for a new vehicle, a college plan for their kids. These things become doable with carbon fee revenues.

It is not the miners' fault that the coal industry has collapsed. They worked hard. They did dangerous work. It is a rigorous occupation to be a coal miner, and they are entitled to respect. Give them their dignity. Make them kings. With a small fraction of the revenue from a carbon fee, we could assure every single coal miner a lifetime of comfort, security, and financial stability.

Senator SCHATZ and I extend an open hand, an olive branch. Give Senator SCHATZ and me a Republican to negotiate with. That shouldn't be too much to ask. Then let's talk about the economics. Let's talk about where the revenue should go. And because I know it is a part of the Baker-Schultz-Paulson proposal, let's talk about where we can get fact-based, scientifically rigorous analytics of which regulations might become unnecessary or duplicative of a carbon fee's emission reductions.

Let's restart the bipartisan conversation we had going until 2010.

Let me close with an appeal to our patriotic sense. America holds herself out as an exemplary nation, a ''City on a Hill.'' The tactics of climate denial and political menace the fossil fuel industry has deployed around here have degraded our city.

There is a remorseless functioning of the laws of physics, of chemistry, and of biology. Deny them all you want, but time will tell. And even now, everyone, from our Secretary of Defense to every single Senator's home State, State university, understands that climate change is real and urgent, is teaching the science of climate change in those universities, and is warning of the dire consequences.

When the Presiding Officer left the Environment and Public Works Committee the other day, I was talking about the Leopold Center at Iowa State University and the powerful language in which they describe the present effects on agriculture of climate change and the danger of disruption to the fundamental systems of the planet. That is the home State universities telling us what the facts are.

So one day there will be a reckoning, and the longer our American democracy lies incapacitated at the hands of the fossil fuel industry, the worse the outcome will be, and the worse the outcome, the greater the harm to the country we love that holds its example up to the world.

We are all extremely fond of JOHN MCCAIN. JOHN MCCAIN returned to the Senate yesterday and called our country ''the strong, inspiring, inspirational beacon of liberty and defender of dignity of all human beings.'' Some beacon, if we continue to get this wrong because of what one industry did to our politics, using political menace, dark money, and fake science.

America deserves better than what we are doing in this Chamber on this issue.

I thank the Presiding Officer.

I yield the floor.

Mr. TESTER. Madam President, I intend to offer the following motion to H.R. 1628 and I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senators KING, HEINRICH, BALDWIN, BENNET, BROWN, CANTWELL, CARPER, COONS, DONNELLY, FEINSTEIN, FRANKEN, HARRIS, HEITKAMP, KLOBUCHAR, LEAHY, MANCHIN, MCCASKILL, SHAHEEN, STABENOW, UDALL, VAN HOLLEN, and WARREN.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Tester moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that would force the closure of rural hospitals or otherwise reduce access to affordable health care in rural areas.

Ms. KLOBUCHAR. Madam President, I ask unanimous consent that the text of my motion to commit be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Klobuchar moves to commit the bill H.R. 1628 to the Committee on Finance of the

Senate with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) provide a tax credit equal to 25 percent of the premiums for health insurance paid during the taxable year for individuals who—

(A) do not qualify for the credit under section 36B of the Internal Revenue Code of 1986;

(B) are not enrolled in or eligible for Medicaid coverage; and

(C) in the case of individuals residing in a State that has not expanded Medicaid as provided under the Patient Protection and Affordable Care Act, would not be eligible for Medicaid coverage even if the State did so expand Medicaid.

Mr. KING. Madam President, I intend to move, with the support of Senator BLUMENTHAL, that H.R. 1628 be committed to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days with changes that will direct the Secretary of Health and Human Services to establish 10 pilot projects in 10 States that have experienced high rates of opioid substance use disorder and neonatal abstinence syndrome to further research the efficacy of early intervention and case management model of care for mothers and babies. Success to be evaluated by determining the rate of child protective services intervention, foster care for minor children and successful long term recovery. At least five projects are required to be granted for projects focused primarily on rural populations.

I ask unanimous consent that the text of my motion to commit be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. King moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) direct the Secretary of Health and Human Services to establish 10 pilot projects in 10 States that have experienced high rates of opioid substance use disorder and neonatal abstinence syndrome (including 5 such projects focused primarily on rural populations) to further research the efficacy of early intervention and case management model of care for mothers and babies, and provide that the success of such projects shall be evaluated by determining the rate of foster care for minor children and successful long term recovery.

Ms. DUCKWORTH. Madam President, I ask unanimous consent that the text of my motions to commit be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Duckworth moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) would eliminate any provision that would result in a reduction in funding for the Ryan White HIV/AIDS Program of the Health Resources and Services Administration.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Duckworth moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) would eliminate any provision that would result in a decrease in health care for patients who receive employer-sponsored health insurance coverage.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Duckworth moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) strike provisions in the bill that would result in a decrease in care for any veteran who depends on orthotics, prosthetics, and complex rehabilitation technology.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Duckworth moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) strike provisions in the bill that would result in a decrease in care for any individual who depends on orthotics, prosthetics, and complex rehabilitation technology.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Duckworth moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) would eliminate any provision that would result in increased epinephrine prices for patients.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Duckworth moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) would eliminate any provision that would result in increased insulin prices for patients.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Duckworth moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) would eliminate any provision that would result in an increase in the price of naloxone, a medication designed to rapidly reverse opioid overdose.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Duckworth moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that no veteran or former service member of the United States Armed forces will lose access to mental health care services currently funded in any part through Medicaid.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Duckworth moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) revise the bill in a manner that prevents any veteran or former member of the Armed Forces from losing access to nursing home care funded through Medicaid.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Duckworth moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) revise the bill in a manner that prevents any veteran or former member of the Armed Forces from losing access to spinal cord injury services, prosthetics or sensory aid services, or other specialty services due to changes in Medicaid or other programs.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Duckworth moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) maintain all lactation standards that were established under the Patient Protection and Affordable Care Act (Public Law 111–148).

Mr. DONNELLY. Madam President, I intend to offer the following motion to H.R. 1628 and I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senators CASEY, CANTWELL, BLUMENTHAL, LEAHY, BROWN, HARRIS, HASSAN, FRANKEN, FEINSTEIN, UDALL, SHAHEEN, CARPER, COONS, WHITEHOUSE, KAINE, VAN HOLLEN, CORTEZ MASTO, BALDWIN, MENENDEZ, REED, DUCKWORTH, MANCHIN, MARKEY, STABENOW, DURBIN, WYDEN, MURPHY, WARREN, GILLIBRAND, CARDIN, KLOBUCHAR, HEINRICH, HIRONO, BOOKER, PETERS, and NELSON.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Donnelly moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) strike provisions that will—

(A) reduce or eliminate benefits or coverage for individuals who are currently eligible for Medicaid;

(B) prevent or discourage a State from expanding its Medicaid program to include groups of individuals or types of services that are optional under current law; or

(C) shift costs to States to cover this care.

Mr. WARNER. Madam President, I intend to offer the following motion to H.R. 1628 and I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senators STABENOW, BALDWIN, KAINE, COONS, KING, CARPER, NELSON, and PETERS.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Warner moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee;

(2) eliminates the harm that would be caused by the termination of the Medicaid expansion; and

(3) ensures that every State that expands Medicaid coverage can receive the full enhanced Federal medical assistance percentage available as if they expanded in 2014, regardless of when they expand Medicaid.

Mr. WARNER. Madam President, I intend to offer the following motions to H.R. 1628 and I ask unanimous consent that they be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Warner moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee;

(2) eliminates the harm that would be caused by the Medicaid per capita caps; and

(3) ensure that any changes to Medicaid made in the bill do not adversely impact the ability of school districts to comply with the Individuals with Disabilities Education Act, the Rehabilitation Act of 1973, or the Americans with Disabilities Act.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Warner moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that nothing in the bill impacts the ability of local educational agencies with an urban-centric district locale code of 32, 33, 41, 42, or 43 to meet the health care needs of their students and staff.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Warner moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that individuals with employer-sponsored health insurance coverage will not lose comprehensive coverage on account of the amendments to the waiver program under section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C. 18052).

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Warner moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee;

(2) strike subsection (c)(1) of section 102 (relating to affordability of employer-sponsored coverage); and

(3) offsets any increased spending that results from such changes.

Mr. NELSON. Madam President, I intend to offer the following motion to commit on older Americans to H.R. 1628 and I ask that it be printed in the RECORD. The motion is supported by Senators CASEY, LEAHY, BROWN, HARRIS, FEINSTEIN, HIRONO, BLUMENTHAL, WHITEHOUSE, BALDWIN, FRANKEN, CARPER, VAN HOLLEN, MENENDEZ, COONS, UDALL, REED, MANCHIN, WARREN, STABENOW, DURBIN, CARDIN, KING, KLOBUCHAR, and WARNER.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Nelson moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that harm older Americans by increasing their premiums, cutting Federal Medicaid funding that supports those in nursing homes, or weakening Medicare.

Mr. UDALL. Madam President, I intend to offer the following motions to H.R. 1628 and I ask unanimous consent that they be printed in the RECORD.

I ask that the RECORD reflect the support of Senator HEINRICH.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Udall moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days, not counting any day on which the Senate is not in session, with changes to ensure that the bill does not limit the ability of State Medicaid programs to continue to make medical assistance available to low-income adults under the eligibility options under clause (i)(VIII) or clause (ii)(XX) of section 1902(a)(10)(A) of the Social Security Act, and does not reduce Federal payments to States for providing such assistance.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Udall moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that no provision of the bill reduces access to substance abuse and mental health services.

Mr. UDALL. Madam President, I intend to offer the following motions to H.R. 1628 and I ask unanimous consent that they be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Udall moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days, not counting any day on which the Senate is not in session, with changes to exempt any State with an unemployment rate of 4 percent or higher from any provision that would reduce or limit Federal payments to the State for spending on the State Medicaid program, including any provision that would impose a per capita cap on such payments.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Udall moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, after having held a hearing to assess the impact of the bill on Medicaid, as the Congressional Budget Office has not prepared a statement of the costs which would be incurred in carrying out the bill and the effect on revenue of the bill.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Udall moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that States that have a 4 percent or higher unemployment rate cannot implement work requirements to determine Medicaid eligibility.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Udall moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days, not counting any day on which the Senate is not in session, with changes to ensure that qualified health plans offered through the Consumer Operated and Oriented Plan (CO–OP) program are treated in the same manner as other qualified health plans under the State waiver program under section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C. 18052).

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Udall moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that no provision adversely impacts Medicaid coverage or services for children age 18 or younger.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Udall moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such Committee; and

(2) would ensure that no provision eliminates or reduces funding for public health programs.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Udall moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that no provision of the bill eliminates or reduces access to pediatric dental coverage.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Udall moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that medically underserved areas with limited providers are not subject to any reductions in Federal Medicaid funding.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Udall moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that no State may use funds described in section 1332(a)(3) of the Patient Protection and Affordable Care Act for purposes unrelated to the public health.

Mr. CASEY. Madam President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senators STABENOW, DUCKWORTH, HASSAN, VAN HOLLEN, MURRAY, BROWN, BLUMENTHAL, CARPER, DURBIN, KAINE, BALDWIN, WYDEN, MARKEY, MURPHY, HARRIS, CARDIN, WARREN, HIRONO, REED, and NELSON.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Casey moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the American Health Care Act of 2017 that would harm individuals with disabilities as defined in the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.) by reducing their access to affordable health care or limiting coverage or benefits under Medicaid or in the private health insurance market.

Ms. Duckworth. Madam President, I ask unanimous consent that the text of this motion to commit be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Duckworth moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) strike any provision in the bill that results in a decrease in maternal care for new mothers, including pre-natal care, delivery, and post-natal care.

Ms. WARREN. Madam President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senators MARKEY, CARPER, DURBIN, STABENOW, HIRANO, VAN HOLLEN, and BROWN.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that no provision of the bill would increase costs for community health centers, including by increasing the number of uninsured individuals or by reducing Federal funding of the Medicaid program that helps provide coverage for many patients receiving care at community health centers.

Mr. KING. Madam President, I intend to move, with the support of Senator BLUMENTHAL, that H.R. 1628 be committed to the Committee on Finance with instructions to report the same back to the Senate in 3 days with changes that will require tax rebates to individuals who, through no fault of their own, received lump-sum Social Security disability insurance settlements which resulted in loss of advance premium tax credits for that year and not include as income retirement and savings drawdowns used to pay medical bills.

I ask unanimous consent that this statement be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. King moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) require—

(A) tax rebates to individuals who, through no fault of their own, received lump sum social security disability insurance settlements which were calculated in the year they were received and disqualified the individuals from receiving advanced premium tax credits in that year; and

(B) that income drawn from retirement and savings accounts utilized to pay medical bills not be counted as income for purposes of the premium tax credit.

Mr. WHITEHOUSE. Madam President, I intend to file the following motion to H.R. 1628 and I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senators BROWN, FRANKEN, VAN HOLLEN, CARDIN, and FEINSTEIN.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Whitehouse moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) establish a public health insurance option.

Ms. WARREN. Madam President, I intend to offer the following motions to H.R. 1628, and I ask unanimous consent that they be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that will lead to an increased likelihood of bankruptcies for American families, including provisions that would allow insurers to impose annual or lifetime limits on insurance benefits or that would eliminate insurance coverage.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that reduce funding for special education programs, including provisions that break President Trump's promise not to cut Medicaid.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that harm individuals with Alzheimer's disease by increasing their premiums or cutting Federal Medicaid funding that supports those in nursing homes.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that harm babies born prematurely by cutting Federal Medicaid funding that supports medications, special equipment, and therapies to help these babies thrive and protect their family from bankruptcy.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that reduce coverage for prescription drug benefits, lead to increased out-of-pocket prescription drug costs, or allow States to apply for waivers to drop prescription drug coverage from the list of essential health benefits.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that make it harder for a person with breast cancer to access health care.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that make it harder for a person with cervical cancer to access health care.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that make it harder for a victim of human trafficking to access health care.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that make it harder for a pregnant woman to access health care.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that make it harder for a victim of sexual violence to access health care.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for children with a rare disease.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for foster children.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for people with a disability.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for people living in a nursing home.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for people receiving home and community based services.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for people receiving long term services and supports.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for people seeking treatment for opioid addiction.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for people with any substance use disorder.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for people seeking mental health care.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for people with brain cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for people receiving chemotherapy or radiation treatment.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for people living in a rural area.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for veterans.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for people over the age of 50.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for people with ALS.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days,

not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for people with multiple sclerosis.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for people with diabetes.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for people receiving Social Security benefits, including SSI and SSDI.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for people with heart disease.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for people with prostate cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for children with a rare disease.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for foster children.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for people with a disability.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for people living in a nursing home.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for people receiving home and community based services.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for people receiving long term services and supports.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for people seeking treatment for opioid addiction.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for people with any substance use disorder.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for people seeking mental health care.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for people with brain cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for people receiving chemotherapy or radiation treatment.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for people living in a rural area.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for veterans.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for people over the age of 50.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for people with ALS.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for people with multiple sclerosis.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the

Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for people with diabetes.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for people receiving Social Security benefits, including SSI and SSDI.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for people with heart disease.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Warren moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health insurance unaffordable for people with prostate cancer.

Mr. HEINRICH. Madam President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Heinrich moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that would ensure that the bill would not result in a decrease in the number of children enrolled in Medicaid, or the Children's Health Insurance Program.

Mr. HEINRICH. Madam President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Heinrich moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that would ensure that the bill would not result in an increase in the rate of uninsured individuals in rural areas, a decrease in Medicaid enrollment or a reduction in the scope of Medicaid benefits offered in rural areas, reduced wages or a shortage of employment opportunities in the health care profession for prospective employees and previously insured individuals living in rural areas, or a decrease in revenue or Federal funds available to rural health care providers, including hospitals, clinics, and community health centers.

Mr. CARDIN. Madam President, I intend to offer a motion to commit the reconciliation bill to the Finance Committee with instructions to report the bill back to the Senate within 3 days, not counting any day on which the Senate is not in session, with changes eliminating provisions that would weaken access to essential health benefits, reduce access to affordable preventive services, and undermine the prohibition of annual and lifetime limits and caps on out-of-pocket expenditures for health insurance plans.

I am offering this motion because the reconciliation bill affects tens of millions of Americans who gained health coverage under the Patient Protection and Affordable Care Act, ACA. The reconciliation bill allows insurers to eliminate coverage of essential health benefits. Insurance companies could exclude essential benefits like maternity care, substance use disorder treatment, mental healthcare, prescription drugs, and hospitalization—the very services people buy insurance to obtain. Before the ACA, one-third of individual market health plans did not cover substance use disorder services, nearly one-fifth of those plans did not cover mental health, and only nine States required all insurers on the individual market to cover maternity care.

Allowing States to waive essential health benefits would also allow insurance companies to reinstate annual and lifetime caps. This means that a premature baby could exceed its lifetime limit within its first few months of life or that a cancer patient could hit an annual cap just a couple of months into treatment.

Before the ACA, too many people and families were hurt physically and financially because they could not afford access to healthcare. They didn't get the tests they needed. Perhaps they did not catch a preventable disease early enough—so the treatment costs skyrocketed. We saw too many families go through bankruptcy because they could not afford the healthcare that they needed. We saw too many people literally cutting their prescription pills in half, hoping to stretch out their medicine because they could not afford more, even though they knew they were compromising their health. We cannot go back to this cruel, dreadful situation.

The following Senators support my motion to commit: Senators CARPER, BROWN, BLUMENTHAL, WARREN, NELSON, VAN HOLLEN, DUCKWORTH, and STABENOW. I ask unanimous consent that the full text of my motion to commit be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Cardin moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions in the bill that would weaken access to essential health benefits, reduce access to affordable preventive services, and undermine the prohibition of annual and lifetime limits and caps on out-of-pocket expenditures for health insurance plans.

Mr. CARDIN. Madam President, I intend to offer a motion to commit the reconciliation bill to the Senate Health, Education, Labor & Pensions, HELP, Committee with instructions to report the bill back to the Senate within 3 days, not counting any day on which the Senate is not in session, with changes that would eliminate provisions in the bill that would increase health disparities among certain populations, including disparities on the basis of race and ethnicity, socioeconomic status, gender, religion, disability status, geographic location, and sexual identity and orientation.

I am offering this motion because communities of color and disenfranchised communities have faced significant barriers to accessing affordable health coverage, and these barriers have contributed to health disparities, which are evident in higher rates of diabetes, heart disease, hepatitis B, HIV/AIDS and infant mortality, among other conditions. The Patient Protection and Affordable Care Act's vital coverage reforms, which include Medicaid expansion, cost sharing reductions, eliminating annual and lifetime limits, and creating coverage options for individuals with preexisting conditions, has led to sharp declines in the uninsured rates for minorities and low-income populations. With the implementation of the major ACA coverage provisions in 2014, the uninsured rate dropped dramatically and continued to fall in 2015. In 2015, the nonelderly uninsured rate was 10.5 percent, the lowest rate in decades, with the most dramatic changes seen among low-income Latino Americans, African Americans, and Asian Americans.

Minorities now make up more than 35 percent of the American population, and that number is expected to rise in the future. Every community across this great Nation deserves optimal health. A person's ethnic or racial background should never determine the length or quality of his or her life. We must work to bridge health equity across communities, ensure that all Americans have access to affordable, high-quality healthcare, and continue our efforts to eliminate health disparities.

The following Senators support my motion to commit: Senators BOOKER, HIRONO, BROWN, CARPER, STABENOW, MARKEY, BLUMENTHAL, VAN HOLLEN, and NELSON. I ask unanimous consent that the full text of my motion to commit be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Cardin moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminates provisions of the bill that would increase health disparities among certain populations, including disparities on the basis of race and ethnicity, socioeconomic status, gender, religion, disability status, geographic location, and sexual identity and orientation.

Ms. BALDWIN. Madam President, I intend to offer the following motion to commit H.R. 1628 with instructions, on behalf of myself and Senator HIRONO, to the Committee on Health, Education, Labor, and Pensions to eliminate provisions that threaten to make healthcare unaffordable for those with preexisting conditions. I ask unanimous consent that it be printed in the RECORD.

The motion is supported by Senators BLUMENTHAL, DURBIN, STABENOW, FEINSTEIN, LEAHY, BROWN, HARRIS, FRANKEN, CARPER, COONS, UDALL, SHAHEEN, VAN HOLLEN, MENENDEZ, REED, MANCHIN, CARDIN, MURPHY, DUCKWORTH, WARREN, WYDEN, WHITEHOUSE, HEINRICH, WARNER, KLOBUCHAR, NELSON, BENNET, MARKEY, BOOKER, and KING.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Baldwin moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make health care unaffordable for those with pre-existing conditions.

Mrs. MCCASKILL. Madam President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senator DONNELLY.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mrs. McCaskill moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with—

(1) changes that are within the jurisdiction of such committee and are comparable to the amendment described in paragraph (2); or

(2) the following amendment: At the appropriate place, insert the following:

SEC. ___. ACCESS TO COVERAGE FOR INDIVIDUALS IN AREAS WITHOUT ANY AVAILABLE EXCHANGE PLANS.

Part 2 of subtitle D of title I of the Patient Protection and Affordable Care Act (42 U.S.C. 18031 et seq.) is amended by adding at the end the following:

''SEC. 1314. ACCESS TO COVERAGE FOR INDIVIDUALS IN AREAS WITHOUT ANY AVAILABLE EXCHANGE PLANS.

''(a) IN GENERAL.—

''(1) COVERAGE THROUGH DC SHOP EXCHANGE.—Not later than 3 months after the date of enactment of this section, the Secretary, in consultation with the Secretary of the Treasury and the Director of the Office of Personnel Management, shall establish a mechanism to ensure that, for any plan year beginning on or after the date described in subsection (c), any individual described in paragraph (2) may enroll in health insurance coverage in the small group market through the Exchange operating in the District of Columbia, including the health insurance coverage that is available to Members of Congress and congressional staff (as defined in section 1312(d)(3)(D)).

''(2) INDIVIDUAL DESCRIBED.—An individual described in this paragraph is any individual who—

''(A) is eligible to purchase health insurance coverage through the Exchange operating in the State of residence of the individual; and

''(B) resides in a rating area or county in which the Secretary certifies that no qualified health plan is offered through an Exchange established under this title.

''(b) PREMIUM ASSISTANCE TAX CREDITS AND COST-SHARING.—Any individual described in subsection (a)(2) who enrolls in health insurance coverage through the Exchange operating in the District of Columbia pursuant to subsection (a)(1) shall be eligible for any premium tax credit under section 36B of the Internal Revenue Code of 1986, or reduced cost-sharing under section 1402, that the individual would otherwise be eligible for if enrolling in health insurance coverage in the individual market through the Exchange operating in the State of the individual.

''(c) DATE DESCRIBED.—The date described in this subsection is the date on which the Secretary establishes the mechanism under subsection (a)(1).''.

Mr. NELSON. Madam President, I intend to offer the following motion to commit about children with a Zika-related condition to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Nelson moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee;

(2) ensure that no children who are born with or develop a Zika-related condition will lose their existing health insurance coverage whether obtained through an Exchange or Medicaid.

Mr. CARDIN. Madam President, I intend to offer a motion to commit the reconciliation bill to the Finance Committee with instructions to report the bill back to the Senate within 3 days, not counting any day on which the Senate is not in session, with changes that would eliminate provisions that hand out tax breaks to large corporations and the most affluent Americans while the bill makes cuts to Medicaid, which serves millions of our most needy Americans, including the elderly poor and poor children.

I am offering this motion because the Finance Committee should review the implications of depriving millions of Americans, including children, veterans, individuals with disabilities, and older people, of their health insurance while at the same time providing large tax breaks to the richest Americans and biggest corporations. H.R. 1628 offsets those tax breaks by voraciously cutting the Medicaid Program. Republicans are using the Medicaid Program as a pay-for for these large tax breaks. As a result, the Republican bill harms far more people than it will help. Former President John F. Kennedy said, ''To govern is to choose.'' The Republicans have made a cruel choice, and I object to it.

The following Senators support my motion to commit: Senators HARRIS, VAN HOLLEN, CASEY, UDALL, COONS, MARKEY, BOOKER, and LEAHY. I ask unanimous consent that the full text of my motion to commit be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Cardin moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that hand out tax breaks to large corporations and high-income taxpayers in connection with a bill that makes cuts to Medicaid.

Mr. KING. Madam President, I intend to move, with the support of Mr. BLUMENTHAL and Mrs. SHAHEEN, that H.R. 1628 be committed to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that preserve, maintain, sustain, and expand the Prevention and Public Health Fund established under section 4002 of the Patient Protection and Affordable Care Act, 42 USC 300u–11.

I request unanimous consent that this motion to commit be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. King moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) preserve, maintain, sustain, and expand the Prevention and Public Health Fund established under section 4002 of the Patient Protection and Affordable Care Act (42 U.S.C. 300u–11).

Mr. KING. Madam President, I intend to move, with the support of Mr. BLUMENTHAL and Mrs. SHAHEEN, that H.R. 1628 be committed to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3

days, not counting any day on which the Senate is not in session, with changes that will support the preservation, maintenance, sustenance. and expansion of the National Health Service Corps and public health nursing programs by preserving such programs and their funding.

I request unanimous consent that this motion to commit be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. King moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) support the preservation, maintenance, sustenance, and expansion of the National Health Service Corps programs and public health nursing programs by preserving such programs and their funding.

Mr. KING. Madam President, I intend to move, with the support of Mr. BLUMENTHAL and Mrs. SHAHEEN, that H.R. 1628 be committed to the Committee on Health, Education, Labor and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that will protect, preserve, maintain, sustain, and expand all programs related to addressing, identifying the causes of, and reducing infant mortality.

I request unanimous consent that this motion to commit be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. King moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) will protect, preserve, maintain, sustain, and expand all programs related to addressing, identifying causes of, and reducing infant mortality.

Mr. KING. Madam President, I intend to move, with the support of Mr. BLUMENTHAL, Mr. CASEY, Mrs. SHAHEEN, and Mr. COONS, that H.R. 1628 be committed to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that will support the promotion of maternal and child health, including the reduction of infant, child, and maternal mortality, through the use of home-visiting services by extending funding for maternal, infant, and early childhood home-visiting programs under section 511 of the Social Security Act, 42 USC 711, through the 10-year budget window.

I request unanimous consent that this motion to commit be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. King moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) supports the promotion of maternal and child health, including the reduction of infant, child, and maternal mortality, through the use of home visiting services by extending funding for maternal, infant, and early childhood home visiting programs under section 511 of the Social Security Act (42 U.S.C. 711) through the 10-year budget window.

Mr. MERKLEY. Madam President, I intend to offer the following motions to H.R. 1628, and I ask unanimous consent that they be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for people with diabetes.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for people wih diabetes.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for pregnant women.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for parents of children ages 3-10.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for parents of infants.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for Korean War veterans.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for Vietnam War veterans.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for veterans of the wars in Afghanistan.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for veterans of the War in Iraq.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for World War II veterans.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for Social Security recipients.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for Medicare beneficiaries.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for individuals with pre-existing conditions.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are

within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for people with cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for children with cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for people with brain cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for people with leukemia.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for people with cervical cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for people with colorectal cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for people with lymphoma.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for people with lung cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for people with melanoma.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for people with ovarian cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for people with pancreatic cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for people with prostate cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for people with breast cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for people with asthma.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for people with autism.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for people with Alzheimer's Disease.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for people with cerebral palsy.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for people with cystic fibrosis.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for people with crohn's disease.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for people with ulcerative colitis.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for people with lupus.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for people with rheumatoid arthritis.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for people with AIDs.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for people with HIV.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for people with multiple sclerosis.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the

effect of increasing health insurance premiums for people with muscular dystrophy.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for people with Parkinson's Disease.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for people with Lou Gehrig's disease (ALS).

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing health insurance premiums for people with autism.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for pregnant women.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for children ages 3 to 10 years old.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for parents of infants.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for Korean War veterans.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for Vietnam War veterans.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for veterans of the Wars in Afghanistan.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for veterans of the War in Iraq.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for World War II veterans.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for Social Security recipients.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for Medicare beneficiaries.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for individuals with pre-existing conditions.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for people with cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for children with cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for people with brain cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for people with leukemia.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for people with cervical cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for people with colorectal cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for people with lymphoma.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for people with lung cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for people with melanoma.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for people with ovarian cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for people with pancreatic cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for people with prostate cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for people with breast cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for people with asthma.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for people with Alzheimer's Disease.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for people with cerebral palsy.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for people with cystic fibrosis.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for people with Crohn's disease.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for people with ulcerative colitis.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for people with lupus.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for people with rheumatoid arthritis.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for people with AIDs.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for people with HIV.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for people with multiple sclerosis.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for people with muscular dystrophy.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for people with Parkinson's Disease.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for people with Lou Gehrig's disease (ALS).

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of increasing out of pocket health care costs for people with autism.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for pregnant women.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for children ages 3-10 years olf.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for parents of infants.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for Korean War veterans.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for Vietnam veterans.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for veterans of the Wars in Afghanistan.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for veterans of the War in Iraq.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for World War II veterans.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for Social Security recipients.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for Medicare beneficiaries.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for individuals with pre-existing conditions.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for people with cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for children with cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for people with brain cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for people with leukemia.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for people with cervical cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for people with colorectal cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for people with lymphoma.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for people with lung cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for people with melanoma.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for people with Ovarian cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for people with pancreatic cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for people with prostate cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for people with breast cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for people with diabetes.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for people with asthma.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for people with asthma.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for people with Alzheimer's Disease.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for people with cerebral palsy.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for people with cystic fibrosis.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for people with Crohn's Disease.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for people with ulcerative colitis.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for people with lupus.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for people with rheumatoid arthritis.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for people with AIDs.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for people with HIV.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for people with multiple sclerosis.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for people with muscular dystrophy.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for people with Parkinson's Disease.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Merkley moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days with changes that are within the jurisdiction of such Committee to strike provisions in the Better Care Reconciliation Act of 2017 that could have the effect of eliminating Medicaid coverage for people with Lou Gehrig's Disease (ALS).

Mr. VAN HOLLEN. Madam President, I ask unanimous consent that the text of my motions to commit be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to charge individuals with childhood cancer more for preventative health care.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to charge individuals with metastatic cancer more for preventative health care.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to charge individuals with Amyotrophic lateral sclerosis (ALS) more for preventative health care.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to charge individuals with asthma more for preventative health care.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to charge individuals with autism more for preventative health care.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to charge individuals with blast injuries more for preventative health care.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to charge individuals with congenital heart defects more for preventative health care.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that would weaken coverage provided by Medicaid to individuals with a mental health illness.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that would weaken coverage provided by Medicaid to individuals with Alzheimer's disease.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that would weaken coverage provided by Medicaid to individuals with any rare disease.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that would weaken coverage provided by Medicaid to individuals with lupus.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that would weaken coverage provided by Medicaid to individuals with Down syndrome.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make prescription drugs unaffordable for individuals with breast cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make prescription drugs unaffordable for individuals with blast injuries.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make prescription drugs unaffordable for individuals with autism.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to charge individuals with opioid addiction more for preventative health care.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to charge individuals with a mental health illness more for preventative health care.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to charge individuals with Alzheimer's disease more for preventative health care.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to charge individuals with any rare disease more for preventative health care.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to charge individuals with Down syndrome more for preventative health care.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to charge individuals with any lupus more for preventative health care.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make prescription drugs unaffordable for individuals with metastatic cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make prescription drugs unaffordable for individuals with Down syndrome.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make prescription drugs unaffordable for individuals with childhood cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance of the Senate with instructions to report the same back to the Senate within 3 days, not counting any day on which the Senate is not in session, with changes that would ensure that no individual with income of more than $750,000,000 annually would benefit from any of the TrumpCare tax cuts.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that would weaken coverage provided by Medicaid to individuals with congenital heart defects.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that would weaken coverage provided by Medicaid to individuals with diabetes.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that would weaken coverage provided by Medicaid to individuals with opioid addiction.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that would threaten to make prescription drugs unaffordable for individuals with asthma.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make prescription drugs unaffordable for individuals with Amyotrophic Lateral Sclerosis (ALS).

Mr. VAN HOLLEN. Mr. President, I intend to file a motion to commit the reconciliation bill to the Finance Committee with instructions to report the same back to the Senate within 3 days, not counting any day on which the Senate is not in Session, with changes that would eliminate provisions that threaten to make prescription drugs unaffordable for those with childhood cancer. I am offering this motion because the Finance Committee should review the implications of depriving millions of Americans of health insurance while at the same time providing tax breaks to the wealthiest Americans. I ask unanimous consent that the full text of my motion to commit be printed in the RECORD following my remarks.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make prescription drugs unaffordable for individuals with Multiple Sclerosis.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make prescription drugs unaffordable for individuals with Parkinson's disease.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to charge individuals with diabetes more for preventative health care.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance of the Senate with instructions to report the same back to the Senate within 3 days, not counting any day on which the Senate is not in session, with changes that would ensure that no individual with income of more than $1,000,000 annually would benefit from any of the TrumpCare tax cuts.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance of the Senate with instructions to report the same back to the Senate within 3 days, not counting any day on which the Senate is not in session, with changes that would ensure that billionaires would not benefit from any of the TrumpCare tax cuts.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance of the Senate with instructions to report the same back to the Senate within 3 days, not counting any day on which the Senate is not in session, with changes that would ensure that no individual with income of more than $500,000,000 annually would benefit from any of the TrumpCare tax cuts.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that would weaken coverage provided by Medicaid to individuals with blast injuries.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that would weaken coverage provided by Medicaid to individuals with autism.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that would weaken coverage provided by Medicaid to individuals with asthma.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that would weaken coverage provided by Medicaid to individuals with Amyotrophic Lateral Sclerosis (ALS).

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that would weaken coverage provided by Medicaid to individuals with metastatic cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that would weaken coverage provided by Medicaid to individuals with childhood cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that would weaken coverage provided by Medicaid to individuals with Multiple Sclerosis.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that would weaken coverage provided by Medicaid to individuals with Parkinson's disease.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that would weaken coverage provided by Medicaid to individuals with breast cancer.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make prescription drugs unaffordable for individuals with congenital heart defects.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make prescription drugs unaffordable for individuals with diabetes.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make prescription drugs unaffordable for individuals with opioid addiction.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make prescription drugs unaffordable for individuals with a mental health illness.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make prescription drugs unaffordable for individuals with Alzheimer's disease.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make prescription drugs unaffordable for individuals with any rare disease.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to make prescription drugs unaffordable for individuals with lupus.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that would reduce financial assistance, such as tax credits, for low- and moderate-income Americans.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to charge individuals with breast cancer more for preventative health care.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to charge individuals with Parkinson's disease more for preventative health care.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Van Hollen moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate

in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that threaten to charge individuals with Multiple Sclerosis more for preventative health care.

Ms. HEITKAMP. Madam President, I intend to offer the following motions to H.R. 1628, and I ask unanimous consent that they be printed in the RECORD. Both motions are supported by Senators FRANKEN and UDALL.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Heitkamp moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that all Native children with family incomes that do not exceed 133 percent of the Federal poverty line (as determined under section 1902(e)(14) of the Social Security Act (42 U.S.C. 1396a(e)(14))) continue to receive the same level of Medicaid benefits and protections that they are eligible for under current law, such as early and periodic screening, diagnostic, and treatment services, and cost-sharing protections.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Heitkamp moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that would limit access to health care for Native American youth, including members of Indian tribes and Native Hawaiians, with respect to services related to—

(A) mental and behavioral health care;

(B) trauma-informed and trauma-specific interventions; and

(C) suicide prevention.

Mr. FRANKEN. Madam President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senators SHAHEEN and BLUMENTHAL.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Franken moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that are within the jurisdiction of the Committee and that strike provisions that would unravel the rural health safety net by further reducing revenue to rural providers, put health care and other community jobs at risk, or otherwise force rural providers to cut back on services.

Mr. FRANKEN. Madam President, I intend to offer the following motion to H.R. 1628, and I ask that it be printed in the RECORD. The motion is supported by Senator BLUMENTHAL.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Franken moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that are within the jurisdiction of the Committee and that strike provisions that would increase premiums and other health care costs for farmers or other individuals and families living in rural areas.

Mr. FRANKEN. Madam President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senator UDALL.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Franken moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that no provision of the bill would—

(A) exacerbate the state of emergency regarding opioids in Indian country;

(B) reduce funding for the Indian Health Service or Medicaid such that Indians or Alaskan Natives would experience a decrease in access or services; or

(C) cause any cost or shift to the Indian Health Service for services that are currently paid for by Medicaid.

Mr. FRANKEN. Madam President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Franken moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that are within the jurisdiction of the Committee and that strike provisions that would further limit the amount of revenues that States could collect through provider tax arrangements to fund the State share of Medicaid spending.

Mr. FRANKEN. Madam President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senators BALDWIN, CASEY, COONS, and BLUMENTHAL.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Franken moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that are within the jurisdiction of the Committee and that strike provisions that threaten the affordability of health plans offered by employers to their employees, or otherwise fail to address plan affordability for employees and their dependents.

Mr. FRANKEN. Madam President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senators BALDWIN, DUCKWORTH, REED, CARPER, BLUMENTHAL, BROWN, WARREN, STABENOW, BOOKER, UDALL, FEINSTEIN, SHAHEEN, COONS, NELSON, and VAN HOLLEN.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Franken moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that are within the jurisdiction of the Committee and that strike provisions that result in increased prescription drug costs for patients and families.

Mr. FRANKEN. Madam President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senators CANTWELL and KLOBUCHAR.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Franken moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that are within the jurisdiction of the Committee and that strike provisions that would jeopardize funding for State basic health programs, or otherwise force States to pay more for providing health coverage under a State basic health program.

Mrs. MCCASKILL. Madam President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senators DONNELLY and STABENOW.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mrs. MCCASKILL moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with—

(1) changes that are within the jurisdiction of such committee and are comparable to the amendment described in paragraph (2); or

(2) the following amendment: At the appropriate place, insert the following:

SEC. ____. ACCESS TO COVERAGE FOR INDIVIDUALS IN AREAS WITHOUT ANY AVAILABLE EXCHANGE PLANS.

Part 2 of subtitle D of title I of the Patient Protection and Affordable Care Act (42 U.S.C. 18031 et seq.) is amended by adding at the end the following:

"SEC. 1314. ACCESS TO COVERAGE FOR INDIVIDUALS IN AREAS WITHOUT ANY AVAILABLE EXCHANGE PLANS.

''(a) IN GENERAL.—

''(1) COVERAGE THROUGH DC SHOP EXCHANGE.—Not later than 3 months after the date of enactment of this section, the Secretary, in consultation with the Secretary of

the Treasury and the Director of the Office of Personnel Management, shall establish a mechanism to ensure that, for any plan year beginning on or after the date described in subsection (c), any individual described in paragraph (2) may enroll in health insurance coverage in the small group market through the Exchange operating in the District of Columbia, including the health insurance coverage that is available to Members of Congress and congressional staff (as defined in section 1312(d)(3)(D)).

''(2) INDIVIDUAL DESCRIBED.—An individual described in this paragraph is any individual who—

''(A) is eligible to purchase health insurance coverage through the Exchange operating in the State of residence of the individual; and

''(B) resides in a rating area or county in which the Secretary certifies that no qualified health plan is offered through an Exchange established under this title.

''(b) PREMIUM ASSISTANCE TAX CREDITS AND COST-SHARING.—Any individual described in subsection (a)(2) who enrolls in health insurance coverage through the Exchange operating in the District of Columbia pursuant to subsection (a)(1) shall be eligible for any premium tax credit under section 36B of the Internal Revenue Code of 1986, or reduced cost-sharing under section 1402, that the individual would otherwise be eligible for if enrolling in health insurance coverage in the individual market through the Exchange operating in the State of the individual.

''(c) DATE DESCRIBED.—The date described in this subsection is the date on which the Secretary establishes the mechanism under subsection (a)(1).''.

Mr. MURPHY. Madam President, I intend to offer the following motions to H.R. 1628, and I ask unanimous consent that they be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Murphy moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate all tax cuts in the bill for the pharmaceutical industry.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Murphy moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate all tax cuts in the bill for—

(A) the health insurance and pharmaceutical industries; and

(B) the wealthiest 1 percent of Americans.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Murphy moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate all tax cuts in the bill for the health insurance industry.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Murphy moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate all tax cuts in the bill for insurance companies for the purposes of executive compensation.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Murphy moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate all tax cuts in the bill for the tanning bed industry.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Murphy moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that would reduce access to mental health treatment.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Murphy moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that would reduce access to health care for cancer patients.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Murphy moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that would reduce access to health care for Medicaid beneficiaries receiving home and community-based services.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Murphy moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate all tax cuts in the bill that would negatively impact the solvency of the Medicare Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i).

Mrs. SHAHEEN. Madam President, I intend to offer the following five motions to commit to H.R. 1628, and I ask unanimous consent that they be printed in the RECORD.

The first motion would send the reconciliation bill to the Health, Education, Labor and Pensions Committee with instructions to strike repeal of cost sharing reductions, CSRs, and advanced premium tax credits and replace this section with my legislation, the Marketplace Certainty Act, which would make CSRs permanent and extend them to those making up to 400 percent of the Federal poverty line. I want to reiterate what I previously said for the RECORD, that the Affordable Care Act, ACA, already prescribes that such payments are to be made from such a permanent appropriation pursuant to 31 U.S.C. 1324.

The first motion is supported by Senators CARPER, REED, MURPHY, BALDWIN, HIRONO, KLOBUCHAR, BLUMENTHAL, HEINRICH, COONS, HEITKAMP, STABENOW, CARDIN, MARKEY, WARNER, and VAN HOLLEN.

The second motion would send the reconciliation bill to the Finance Committee with instructions to strike repeal of cost sharing reductions, CSRs, and advanced premium tax credits and replace this section with my legislation, the Marketplace Certainty Act, which would make CSRs permanent and extend them to those making up to 400 percent of the Federal poverty line. Similar to the first motion, I want to reiterate what I previously said for the RECORD, that the ACA already prescribes that such payments are to be made from such a permanent appropriation pursuant to 31 U.S.C. 1324.

The second motion is supported by Senators CARPER, REED, MURPHY, BALDWIN, HIRONO, KLOBUCHAR, BLUMENTHAL, HEINRICH, COONS, HEITKAMP, STABENOW, CARDIN, MARKEY, WARNER, and VAN HOLLEN.

The third motion would send the reconciliation bill to the Finance Committee with instructions to strike provisions that would weaken or eliminate the small employer health insurance credit, prohibit the ability of entrepreneurs to purchase affordable health coverage through the individual marketplace, or allow discriminatory rating rules that prohibit small businesses from providing affordable, comprehensive benefits to their employees.

The third motion is supported by Senators BLUMENTHAL, CARPER, UDALL, BALDWIN, BROWN, PETERS, and STABENOW.

The fourth motion would send the reconciliation bill to the Health, Education, Labor and Pensions Committee with instructions to strike provisions that would allow insurers to establish diabetes as a preexisting condition or reduce funding for diabetes research, treatment, prevention and education.

The fourth motion is supported by Senators HIRONO, KLOBUCHAR, BLUMENTHAL, MENENDEZ, and VAN HOLLEN.

The fifth motion would send the reconciliation bill to the Finance Committee with instructions to strike language that would remove mental healthcare services from the list of essential health benefits or prohibit States from providing Medicaid coverage for more than 30 consecutive days of inpatient psychiatric services.

The fifth motion is supported by Senators HIRONO and BLUMENTHAL.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mrs. Shaheen moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that nothing in the bill would—

(A) establish diabetes as a pre-existing condition such that insurers could charge higher premiums for diabetes patients; or

(B) reduce funding allocated to diabetes research, treatment, prevention, and education.

MOTION TO COMMIT WITH INSTRUCTIONS

Mrs. Shaheen moves to commit the bill H.R. 1628 to the Committee on Finance of the Senate with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) strike any language that would repeal advanced premium tax credits under the Patient Protection and Affordable Care Act to insurance companies.

MOTION TO COMMIT WITH INSTRUCTIONS

Mrs. Shaheen moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions of the Senate with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee;

(2) strike any language that would repeal or prevent the Federal government from paying cost sharing reductions under the Patient Protection and Affordable Care Act to insurance companies; and

(3) increase cost sharing reductions under such Act such that the plan's share of the allowed cost of benefits provided under a plan is 95 percent, 90 percent, and 85 percent respectively, rather than 94 percent, 87 percent, and 73 percent as under current law.

MOTION TO COMMIT WITH INSTRUCTIONS

Mrs. Shaheen moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that—

(A) mental health care services are not removed from the list of essential health benefits; and

(B) States are permitted to provide Medicaid coverage for more than 30 consecutive days of inpatient psychiatric services.

MOTION TO COMMIT WITH INSTRUCTIONS

Mrs. Shaheen move to commit the bill H.R. 1628 to the Committee on Finance of the Senate with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee;

(2) strike any language that—

(A) weakens or eliminates the tax credit to help small businesses purchase health insurance under section 45R of the Internal Revenue Code of 1986;

(B) inhibits the ability of entrepreneurs to purchase affordable health coverage through the individual marketplace; or

(C) employs discriminatory rating rules that prohibit small businesses from providing affordable, comprehensive benefits to their employees;

(3) expand the tax credit for employee health insurance expenses of small employers to include employers with a greater number of employees, to extend the credit period, and to raise the level of other limitations under the credit; and

(4) offset such amendments with modifications to the rules relating to inverted corporations.

Mr. UDALL. Madam President, I intend to offer a motion to commit H.R. 1628 to the Finance Committee to review the impacts of this bill on the Indian Health Service, Tribal Health Programs, Urban Indian Health Programs, or Indian Tribes or other Tribal organizations, or with respect to services provided to individuals who are American Indian or Alaska Native.

I ask unanimous consent that it be printed in the RECORD, and it is supported by Senators CANTWELL, CORTEZ MASTO, HEINRICH, HEITKAMP, FRANKEN, MURRAY, MERKLEY, SCHATZ, STABENOW, and TESTER.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Udall moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee;

(2) provide that any reduction or limitation of Federal payments to help cover the cost of private health insurance not apply with respect to private health insurance purchased by American Indians or Alaska Natives; and

(3) provide that any reduction or limitation of Federal payments for spending under the Medicaid program shall not apply with respect to services provided by the Indian Health Service, an Indian Health Program, an Urban Indian Organization, or Indian tribes or other tribal organizations, or with respect to services provided to individuals who are American Indians or Alaska Natives.

Mr. MENENDEZ. Madam President, I intend to offer a motion to commit the reconciliation bill to the Committe on Health, Education, Labor and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that prohibit eliminating or reducing funding to States unless the Congressional Budget Office certifies that such changes will not increase the number of uninsured Americans, decrease Medicaid enrollment in Medicaid expansion States, reduce the likelihood non-expansion States will expand, or increase the State share of Medicaid spending.

I am offering this motion to ensure individuals who gained coverage due to the Affordable Care Act's Medicaid expansion do not lose their coverage and States that expanded Medicaid are not penalized by this bill.

The following Senators support my motion to commit: DURBIN, HEINRICH, UDALL, BOOKER, SHAHEEN, and BLUMENTHAL.

I ask unanimous consent that the full text of my motion to commit be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Menendez moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) prohibit eliminating or reducing funding available to States to provide comprehensive, affordable health care to low-income Americans by eliminating or reducing the availability of Federal financial assistance to States available under section 1905(y)(1) or 1905(z)(2) of the Social Security Act (42 U.S.C. 1396d(y)(1), 1396d(z)(2)) or other means, unless the Director of the Congressional Budget Office certifies any such changes will not—

(A) increase the number of uninsured Americans;

(B) decrease Medicaid enrollment in States that have opted to expand eligibility for medical assistance under that program for low-income, non-elderly individuals under the eligibility option established by the Affordable Care Act under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(VIII));

(C) reduce the likelihood that any State that has not opted to expand Medicaid under the eligibility option established by the Affordable Care Act under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(VIII)) would opt to use that eligibility option to expand eligibility for medical assistance under that program for low-income, non-elderly individuals; or

(D) increase the State share of Medicaid spending under that eligibility option.

Mr. MENENDEZ. Madam President, I intend to offer a motion to commit the reconciliation bill to the Committee on Health, Education, Labor and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that No. 1, are within the jurisdiction of such committee; and No. 2, ensure that the bill shall not take effect until the Secretary of Health and Human Services certifies under oath, with standing given to each State attorney general for any charges of perjury, that no individual with a preexisting condition will be unable to receive the necessary medications to sustain their life, limbs, eyesight, or other necessary healthcare and medications for the preexisting condition due to a State cutting essential health benefits, minimum services, or necessary medication from the insurance plans offered through their exchanges. I am offering this motion because individuals with preexisting condition must not lose access to the medications they need to manage their conditions and live full, productive lives.

The following Senators support my motion to commit: SHAHEEN and BLUMENTHAL.

I ask unanimous consent that the full text of my motion to commit be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Menendez moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that the bill shall not take effect until the Secretary of Health and Human Services certifies under oath, with standing given to each State Attorney General for any charges of perjury, that no individual with a preexisting condition will be unable to receive the necessary medications to sustain their life, limbs, eyesight, or other necessary healthcare and medications for the preexisting condition due to a State cutting essential health benefits, minimum services, or necessary medication from the insurance plans offered through their Exchanges.

Mr. MENENDEZ. Madam President, I intend to offer a motion to commit the reconciliation bill to the Committee on Finance with Instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that No. 1, are within the jurisdiction of such committee; and No. 2, add automatic sunset to the bill and reinstate the Affordable Care Act if the uninsured rate increases 10 percent as compared to the rate at the beginning of fiscal year 2017. I am offering this motion because any bill that increases the uninsured rate is a giant step backward.

I ask unanimous consent that the full text of my motion to commit be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Menendez moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) add an automatic sunset to the bill and reinstate the Affordable Care Act if the uninsured rate increases 10 percent as compared to the rate at the beginning of fiscal year 2017.

Mr. MENENDEZ. Madam President, I intend to offer a motion to commit the reconciliation bill to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that No. 1, are within the jurisdiction of such committee; and No. 2, add an automatic sunset to the bill and reinstate the Affordable Care Act if the uninsured rate increases 20 percent as compared to the rate at the beginning of fiscal year 2017. I am offering this motion because any bill that increases the uninsured rate is a giant step backward.

I ask unanimous consent that the full text of my motion to commit be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Menendez moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) add an automatic sunset to the bill and reinstate the Affordable Care Act if the uninsured rate increases 20 percent as compared to the rate at the beginning of fiscal year 2017.

Mr. MENENDEZ. Madam President, I intend to offer a motion to commit the reconciliation bill to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that No. 1, are within the jurisdiction of such committee; and No. 2, ensure that the bill shall not take effect until the Secretary of Health and Human Services certifies under oath, with standing given to each State attorney general for any charges of perjury, that no domestic violence victim will have less coverage for any condition arising from the abuse than they have under current law. I am offering this motion because survivors of domestic or sexual abuse must receive the care they need to deal with their past trauma.

The following Senator supports my motion to commit: BLUMENTHAL.

I ask unanimous consent that the full text of my motion to commit be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Menendez moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that the bill shall not take effect until the Secretary of Health and Human Services certifies under oath, with standing given to each State Attorney General for any charges of perjury, that no domestic or sexual violence victim will have less coverage for any condition arising from the abuse than they have under current law.

Mr. MENENDEZ. Madam President, I intend to offer a motion to commit the reconciliation bill to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that No. 1, are within the jurisdiction of such committee; and No. 2, add an automatic sunset to the bill and reinstate the Affordable Care Act if, (A), premiums increase by more than 10 percent for the average senior aged 50 to 64 within any 365-day period in the next 10 years; or, B, out-of-pocket costs increase by more than 10 percent for the average senior aged 50 to 64 within any 365-day period in the next 10 years. I am offering this motion to provide relief for older Americans who will be harmed by harmful provisions in this bill.

The following Senator supports my motion to commit: SHAHEEN.

I ask unanimous consent that the full text of my motion to commit be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Menendez moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) add an automatic sunset to the bill and reinstate the Affordable Care Act if—

(A) premiums increase by more than 10 percent for the average senior aged 50 to 64 within any 365 day period in the next 10 years; or

(B) out-of-pocket costs increase by more than 10 percent for the average senior aged 50 to 64 within any 365 day period in the next 10 years.

Mr. MENENDEZ. Madam President, I intend to offer a motion to commit the reconciliation bill to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that No. 1, are within the jurisdiction of such committee; and No. 2, ensure that the procedure for distribution of funds from the State Stability and Innovation Program also factor in the number of uninsured in the State when reviewing the cost of premiums in the State as compared to the national average and prioritize States with a larger number of uninsured.

I am offering this motion to ensure States with higher populations receive their fair share of the funds.

I ask unanimous consent that the full text of my motion to commit be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Menendez moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that the procedure for distribution of funds from the State Stability and Innovation Program also factor in the number of uninsured in the State when reviewing the cost of premiums in the State as compared to the national average and prioritize States with a larger number of uninsured.

Mr. MENENDEZ. Madam President, I intend to offer a motion to commit the reconciliation bill to the Committee on Finance with instructions to report the

same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that No. 1, are within the jurisdiction of such committee; and No. 2, ensure that no State can deny a woman who becomes pregnant Medicaid coverage regardless of income. I am offering this motion because all women deserve access to maternity care and we know a healthy pregnancy will help ensure a healthy baby.

The following Senators support my motion to commit: SHAHEEN and BLUMENTHAL.

I ask unanimous consent that the full text of my motion to commit be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Menendez moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that no State can deny a woman who becomes pregnant Medicaid coverage regardless of income.

Mr. MENENDEZ. Madam President, I intend to offer a motion to commit the reconciliation bill to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that No. 1, are within the jurisdiction of such committee; and No. 2, ensure that there is not a disproportionate impact on women and minorities from reductions in Medicaid funding.

I am offering this motion because these healthcare repeal bills have one thing in common: the changes proposed will disproportionately harm women and minorities.

The following Senators support my motion to commit: SHAHEEN and BLUMENTHAL.

I ask unanimous consent that the full text of my motion to commit be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Menendez moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that there is not a disproportionate impact on women and minorities from reductions in Medicaid funding.

Mr. MENENDEZ. Madam President, I intend to offer a motion to commit the reconciliation bill to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that No. 1, are within the jurisdiction of such committee; No. 2, strike section provision amending Section 2701(a)(1)(a)(iii) of the Public Health Service Act; and No. 3, preserve the existing permissible age variation in health insurance premium rates under the Affordable Care Act. I am offering this motion this change in permissible age variation will harm older Americans.

The following Senator supports my motion to commit: SHAHEEN.

I ask unanimous consent that the full text of my motion to commit be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Menendez moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee;

(2) strike the provision that amends section 2701(a)(1)(A)(iii) of the Public Health Service Act (42 U.S.C. 300gg(a)(1)(A)(iii)); and

(3) preserve the existing permissible age variation in health insurance premium rates under such section 2701(a)(1)(A)(iii), as added by the Patient Protection and Affordable Care Act.

Mr. MENENDEZ. Madam President, I intend to offer a motion to commit the reconciliation bill to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that No. 1, are within the jurisdiction of such committee; and No. 2, ensure that the bill will not take effect until the Secretary of Health and Human Services certifies under oath—with standing given to each State attorney general to bring perjury charges—that no individual with autism or any caretaker of an individual with autism will have higher out-of-pocket costs as compared to average costs for similarly situated individuals in fiscal year 2017. I am offering this motion because individuals with autism and their caretakers face high costs of medical care and any legislation increasing those costs will prove burdensome for American families.

The following Senator supports my motion to commit: BOOKER.

I ask unanimous consent that the full text of my motion to commit be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Menendez moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that the bill will not take effect until the Secretary of Health and Human Services certifies under oath (with standing given to each State Attorney General to bring perjury charges) that no individual with autism or any caretaker of an individual with autism will have higher out of pocket costs as compared to average costs for similarly situated individuals in fiscal year 2017.

Mr. MENENDEZ. Madam President, I intend to offer a motion to commit the reconciliation bill to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that No. 1, are within the jurisdiction of such committee; and No. 2, eliminate provision that would harm children by reducing their access to affordable healthcare or limiting coverage or benefits under Medicaid.

The following Senators support my motion to commit: BOOKER, BALDWIN, BLUMENTHAL, WHITEHOUSE, LEAHY, BROWN, PETERS, VAN HOLLEN, HARRIS, FRANKEN, FEINSTEIN, UDALL, COONS, CARPER, REED, DUCKWORTH, DURBIN, GILLIBRAND, STABENOW, WYDEN, HIRONO, CARDIN, CASEY, BENNET, WARREN, HEINRICH, NELSON, and SHAHEEN.

I am offering the motion to protect American children from being harmed by the upheaval that will result in insurance markets from this bill becoming law.

I ask unanimous consent that the full text of my motion to commit be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Menendez moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that would harm children by reducing their access to affordable health care or limiting coverage or benefits under Medicaid or in the private insurance market.

Mr. MENENDEZ. Madam President, I intend to offer a motion to commit the reconciliation bill to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that No. 1, are within the jurisdiction of such committee; and No. 2, ensure that States cannot waive essential health benefits for individuals with autism.

I am offering this motion because individuals with autism should not lose access to these critical health insurance benefits.

The following Senator supports my motion to commit: BOOKER.

I ask unanimous consent that the full text of my motion to commit be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Menendez moves to commit the bill H.R. 1628 to the Committee on Finance with

instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that States cannot waive essential health benefits for individuals with autism.

Mr. BLUMENTHAL. Madam President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Blumenthal moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days, not counting any day on which the Senate is not in session, with changes that ensure that no tax cuts in the bill go to individuals making over $200,000 per year and married people filing joint tax returns making over $250,000 per year at the expense of funding for Medicaid.

Mr. BLUMENTHAL. Madam President, I intend to offer the following motion, Conner's amendment, to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Blumenthal moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that States would not be able to submit waivers asking for the imposition of lifetime or annual out-of-pocket limits on insurance coverage, or the removal of any essential health benefits.

Mr. BLUMENTHAL. Madam President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senator SHAHEEN.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Blumenthal moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that there will be no Medicaid cuts in services provided to veterans.

Mr. BLUMENTHAL. Madam President, I intend to offer the following motion, Sean and Frank's amendment, to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Blumenthal moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that no individual who is enrolled in Medicaid and has or is recovering from a substance use disorder will lose coverage or services.

Mr. BLUMENTHAL. Madam President, I intend to offer the following motion, Justice's amendment, to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Blumenthal moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that mental health and substance use disorder treatments and services are guaranteed as an essential health benefit.

Mr. BLUMENTHAL. Madam President, I intend to offer the following motion, Gay's amendment, to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Blumenthal moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that the bill will not increase the percentage of individuals in our Nation who do not have health insurance.

Mr. BLUMENTHAL. Madam President, I intend off the following motion, Amelie, Amanda, and Evan's amendment, to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senator SHAHEEN.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Blumenthal moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that no Medicaid beneficiary will lose coverage or health services due to provisions or cuts in this bill.

Mr. BLUMENTHAL. Madam President, I intend to offer the following motion, Michelle's amendment, to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Blumenthall moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that no State may ask for a waiver allowing for the imposition of pre-existing condition coverage limitations.

Mr. BLUMENTHAL. Madam President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senators CARPER, BROWN, REED, KING, COONS, WARREN, STABENOW, FEINSTEIN, KLOBUCHAR, MARKEY, DURBIN, CASEY, FRANKEN, SHAHEEN, CARDIN, UDALL, VAN HOLLEN, HIRONO, and MURRAY.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Blumenthal moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that there will be no funding reductions for disease prevention efforts of public health, including funding for the Prevention and Public Health Fund established under section 4002 of the Patient Protection and Affordable Care Act (42 U.S.C. 300u–11).

Mr. BOOKER. Madam President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senators BLUMENTHAL, DUCKWORTH, and VAN HOLLEN.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Booker moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that consumers' deductibles in the private health insurance market will not increase as a result of the enactment of the bill.

Mr. BOOKER. Mr. President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senators BLUMENTHAL, CASEY, MENENDEZ, SHAHEEN, and VAN HOLLEN.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Booker moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) would ensure that the bill does not disrupt access to long term services and supports.

Mr. BOOKER. Madam President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senators BLUMENTHAL and VAN HOLLEN.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Booker moves to commit the bill H.R. 1628 to the Committee on Finance of the Senate with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that individuals with household income between 350 percent and 400 percent of the poverty line do not lose Federal financial assistance with the cost of health care.

Mr. BOOKER. Madam President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senators BLUMENTHAL, DUCKWORTH, MARKEY, SHAHEEN, and VAN HOLLEN.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Booker moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that there would be no reduction in access to the essential health benefits required under the Patient Protection and Affordable Care Act, including for people with employer-sponsored health plans, as a result of the enactment of the bill.

Mr. BOOKER. Madam President, I intend to offer the following motion to H.R. 1628, and I ask that it be printed in the RECORD. The motion is supported by Senators STABENOW, BLUMENTHAL, MENENDEZ, SHAHEEN, and VAN HOLLEN.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Booker moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that our Nation's maternal morbidity and mortality rates do not increase, and that disparities in maternal morbidity and mortality do not increase, as a result of the enactment of the bill.

Mr. BOOKER. Madam President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Booker moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminates provisions of the bill that would increase health disparities among certain populations, including disparities on the basis of race and ethnicity, socioeconomic status, gender, religion, disability status, geographic location, and sexual identity and orientation.

Mr. DURBIN. Madam President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senators BLUMENTHAL, COONS, and CARPER.

For years, Republicans painted a drastic, dire picture of the Affordable Care Act. Just this week, President Trump talked about the so-called forgotten victims of the ACA.

The ACA isn't perfect—no law is—but to say it hasn't been a landmark achievement for our Nation and for my State would be absolutely wrong.

Our country's uninsured rate is at the lowest level in our Nation's history. In Illinois, our uninsured rate has been cut in half. These insurance gains are thanks to the Affordable Care Act.

Insurance companies can no longer deny someone coverage or charge them sky-high premiums because of a preexisting condition, benefitting roughly 5 million Illinoisans.

Insurance companies can no longer charge women more than men, drop someone from coverage when they get sick, charge seniors exorbitantly more than younger people for insurance, or refuse to cover important and essential health benefits.

I think these consumer protections represent a step forward in healthcare for people nationwide, and I don't believe we should get rid of them.

So my motion would instruct the Finance Committee to report out a bill—within 3 days—that would let any State keep the ACA if they want.

These Republican repeal proposals are cruel and dangerous. States ought to be able to keep the ACA if they want, including all the record coverage gains, consumer protections and benefits, and Federal funding for the Medicaid expansion and tax credits.

If Senator CRUZ wants to rip away health insurance ''root and branch'' from his constituents, that is fine.

But this motion protects any State who thinks we have made too much progress to turn back.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Durbin moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pension with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such Committee; and

(2) permit a State to continue to implement the provisions of the Patient Protection and Affordable Care Act (Public Law 111-148), as in effect on the date of enactment of this Act, if the Governor of that State elects to continue such implementation, including provisions relating to health insurance coverage gains, consumer protections and benefits (including protections related to coverage of pre-existing conditions, essential health benefits, and the premium levels that older enrollees may be charged relative to younger enrollees), and Federal funding provided under that Act (including levels of Medicaid funding for the Medicaid expansion population, Federal funding for tax credits, and cost sharing reduction subsidies).

Mr. DURBIN. Madam President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senators BLUMENTHAL and CARPER.

Some of the strongest opponents to the secretive and devastating Republican repeal effort are our hospitals, especially our rural hospitals, critical access hospitals, and safety net hospitals in underserved urban communities.

In particular, they warn us that the devastating cuts in Medicaid will dramatically increase uncompensated care costs.

The Illinois Hospital Association tells us that slashing Medicaid like these Republican repeal bills do will cost Illinois between 60,000 and 95,000 healthcare jobs.

You see, not only are our rural hospitals critical lifelines for healthcare in their communities, they are often the best jobs in town; yet these drastic Medicaid cuts will increase uncompensated care costs by billions, forcing cutbacks in services, staff, and expansion.

So my motion would instruct the Finance Committee to report out a bill—within 3 days—that would protect funding for these hospitals and prohibit increases in uncompensated care costs for these critical facilities.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Durbin moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pension with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such Committee; and

(2) would prohibit increases in uncompensated costs or reductions in funding for rural hospitals, hospitals in underserved areas, or critical access hospitals.

Mr. DURBIN. Madam President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senators BLUMENTHAL and CARPER.

Medicaid covers one in two births in Illinois. It helps pay for two out of every three seniors in nursing homes, and it is the largest payor of opioid and substance abuse treatment.

But guess what else Medicaid does? It helps 45 percent of school districts provide medical and therapy services for

lower-income kids and those with special needs.

That is right, Illinois schools currently receive about $144 million in Medicaid funding each year.

They use this money to provide dental screenings, therapy services for kids with disabilities, to purchase handicap equipment, and employing trained staff.

What would happen to kids nationwide if the $4 billion in Medicaid funding for schools went away?

My motion would to commit would instruct the Finance Committee to report out a bill—within 3 days—that would protect funding for schools and students and says, if you want to slash Medicaid, it won't be on the backs of our kids.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. DURBIN moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensures no reduction in Medicaid funding for items or services provided in, or under arrangements with, any kindergarten through grade 12 elementary school in the Nation.

Mr. DURBIN. Madam President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senators BLUMENTHAL and CARPER.

When thinking about Medicaid, we often talk about low-income children or pregnant women. But do you know the most expensive part of Medicaid?

It is providing long-term care for your grandmother, your grandfather—at home or in the nursing home.

When Social Security and Medicare aren't enough, Medicaid steps in to care for millions of seniors over age 65.

Medicaid helps pay for two out of three seniors currently in nursing homes.

These Republican proposals to slash Medicaid are so devastating that the American Association of Retired Persons, AARP, has come out in loud opposition to all the repeal bills.

My motion to commit would instruct the Finance Committee to report out a bill—within 3 days—that protects the millions of seniors who rely on Medicaid for their care and says, if you want to slash Medicaid, it will not be on the backs of our vulnerable seniors.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Durbin moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensures no seniors on Medicaid lose benefits, have reduced provider payments for services furnished to them, or have any increase in out-of-pocket costs.

Mr. DURBIN. Madam President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senator BLUMENTHAL.

Over the past few months, I have met with many heroes in the disability community, including a woman in Illinois who has a 23-year-old son with autism. She told me that Medicaid allows her son to be at home and function independently.

She told me that, without Medicaid, her son would have to be in a facility she couldn't afford.

You know what else all of these advocates and fighters tell me? They tell me that the Republican healthcare repeal proposals—all of which decimate the Medicaid Program in order to give tax breaks to the wealthy—would be devastating for people with disabilities.

Medicaid is a lifeline for 11 million people with disabilities. It is the core of our commitment to care for them, and it helps us meet our basic obligations as a society.

That is why my motion to commit would instruct the Finance Committee to report out a bill—within 3 days—that protects children and adults on Medicaid with disabilities from increased costs and fewer benefits.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Durbin moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensures no individuals with disabilities on Medicaid lose benefits, have reduced provider payments for services furnished to them, or have any increase in out-of-pocket costs.

Mr. DURBIN. Madam President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senator BLUMENTHAL.

Under the ACA, our Nation has seen the largest decline in the child uninsured rate, and in Illinois, we have seen a 40 percent drop. Today more than 95 percent of kids in our country are insured.

Half of all children born in Illinois are covered by Medicaid.

That means they are guaranteed quality, comprehensive health coverage, from vaccinations and vision checks, to dental health, mental health, and lead poisoning screenings.

Medicaid serves low-income children in schools, and I have visited many school-based health clinics that provide critical access and services for our kids.

But every single Republican healthcare repeal proposal would slash Medicaid for our most vulnerable kids, jeopardizing the services they receive and their ability to access care.

That is why my motion to commit would instruct the Finance Committee to report out a bill—within 3 days—that protects our kids and tells Republicans they will not be a bargaining chip in this cruel repeal effort.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Durbin moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensures no children on Medicaid lose benefits, have reduced provider payments for services furnished to them, or have any increase in out-of-pocket costs.

Mr. DURBIN. Madam President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senators BLUMENTHAL and CARPER.

Thanks to the Affordable Care Act, Medicare is now financially stable for an additional 11 years.

Because of the healthcare reforms that improve the delivery of healthcare, seniors are now paying $700 less annually in premiums and cost-sharing.

The ACA is also closing the dreaded Medicare ''donut hole''—the gap where seniors were faced with high costs for their drugs—saving 11 million seniors an average for $2,127 each year on their medications.

But Republicans want to jeopardize this progress.

Instead of strengthening Medicare for the long run, many of the Republican repeal bills would give a huge tax giveaway to wealthy Americans—cutting years off Medicare's solvency.

That is why my motion to commit would instruct the Finance Committee to report out a bill—within 3 days—that does not shorten Medicare's solvency.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Durbin moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that the bill will not shorten the solvency of the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i).

Mr. DURBIN. Madam President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed the RECORD.

When Republicans talk about the challenges facing Obamacare, they

tend to be a bit misleading. Let's set the record straight.

What they are really talking about is within the individual market, where 6 percent of Americans get their coverage and more than 70 percent of those people get subsidies to help cover their costs.

One problem Republicans like to cite is lack of competition, that private, for-profit insurers are pulling out, leaving few choices.

We call these ''bare counties,'' and they are more common in rural areas and in States that did not expand Medicaid.

I agree that we need more competition in the individual market.

As a solution, my motion to commit instructs the Finance Committee—within 3 days—to report out a bill that requires insurers offering Medicare Advantage plans in a particular county, to also offer an individual market plan in that county.

Medicare Advantage insurance plans make huge profits off the Federal Government, yet many of those same insurers are refusing to participate in the individual exchange.

To address bare counties, my motion says that, if you have a provider network and you are making money off the Federal Government, then you should also help improve choice by offering a plan in the exchange.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Durbin moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) require each insurer who offers a Medicare Advantage plan under part C of the Medicare program in a specific county to also offer health insurance coverage through the individual market in that county.

Mr. DURBIN. Madam President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senator BLUMENTHAL.

All of these Republican repeal bills shift costs onto consumers, patients, hospitals, and State budgets.

None of them do anything to actually address what is driving the increase in healthcare costs. And one of those biggest drivers? Pharmaceutical costs—Blue Cross of Illinois tells me they spend more on prescription drugs than inpatient hospital care.

So what can we do to address prescription drugs? Listen to the American Medical Association, which called for a ban on direct-to-consumer pharmaceutical advertising.

According to the AMA, these ads are, ''driving demand for expensive treatments despite the clinical effectiveness of less costly alternatives.'' In short, pharma advertises their drugs because they know you will tell your doctor you need it—driving up the cost—regardless of whether it's right for you. That is why they spend billions on it.

But the moment of truth on when patients find out about the cost is when they are checking out at the pharmacy. That is wrong.

So my motion to commit would instruct the Finance Committee—within 3 days—to report out a bill that helps lower the cost of healthcare by tackling the driving cost of prescription drugs, requiring pharmaceutical companies to disclose the price of their drug in their ads.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Durbin moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pension with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such Committee; and

(2) would require pharmaceutical companies to disclose the price of their drug to doctors as part of their educational outreach, or to patients through direct-to-consumer advertising.

Mr. DURBIN. Madam President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senator BLUMENTHAL.

All of these Republican repeal bills shift costs onto consumers, patients, hospitals, and state budgets.

None of them do anything to actually address what is driving the increase in healthcare costs. And one of those biggest drivers? Pharmaceutical costs—Blue Cross of Illinois tells me they spend more on prescription drugs than inpatient hospital care.

So what can we do to address prescription drugs? Have Medicare negotiate drug prices on behalf of seniors. Even the President says he supports this policy.

Medicaid can negotiate drug costs, the Veterans Administration can negotiate drug costs, why shouldn't Medicare be able to leverage its 50 million beneficiaries to get a better deal?

This motion is simple; it is something the President has talked about, something the American people support.

This motion to commit would instruct the Finance Committee—within 3 days—to report out a bill that would require the Secretary of Health and Human Services to begin negotiating drug prices on behalf of seniors in Medicare.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Durbin moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) require the Secretary of Health and Human Services to, beginning not later than one year after the date of enactment of this Act, negotiate the price of drugs covered by the Medicare program on behalf of Medicare beneficiaries.

Mr. DURBIN. Madam President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senator DUCKWORTH.

The process Republicans have undertaken to repeal our healthcare law has been secretive, wrong, and undemocratic.

At first, it was 13 chosen apostles—all men—meeting in secret to craft their repeal measure.

At this moment, I don't know who is hiding in the shadows writing their repeal measure.

But what I do know is that there have been no hearings, no opportunity for public input, and no opportunity for myself and Senator DUCKWORTH—as representatives of Illinois—to offer input.

If myself and Senator DUCKWORTH have been locked out of the process from the beginning, why then should our constituents have to pay the price for this partisan Republican effort?

So our motion is simple. It says that this Republican repeal bill cannot unfairly impose hardships on our Illinois constituents. It cannot increase costs on my constituents, cut services or benefits or eligibility for my constituents, eliminate essential health benefits for my constituents, or impose lifetime limits or discriminate against my constituents with preexisting conditions.

If Senator CRUZ who has been allowed to have input on this repeal bill—wants to rip away health insurance ''root and branch''from his constituents, that is fine.

But this motion protects my constituents in Illinois.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Durbin moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pension with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such Committee;

(2) prohibit increases in health insurance premiums or out-of-pocket health care costs for residents of Illinois;

(3) prohibit reductions in eligibility or services, or any increases in cost-sharing (including premiums and co-payments) related to the eligibility of residents of Illinois to participate in the Medicaid program;

(4) prohibit health insurance issuers from imposing annual or lifetime limits on residents of Illinois;

(5) prohibit health insurance issuers from charging residents of Illinois who have preexisting conditions more than the amount charged to healthy residents; or

(6) prohibit health insurance issuers from stopping coverage of any essential health

benefits provided under section 1302 of the Patient Protection and Affordable Care Act (42 U.S.C. 18022).

Mr. DURBIN. Madam President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD.

The Commonwealth of Kentucky has benefitted immensely from the Affordable Care Act.

Its uninsured rate has fallen 61 percent, one of the sharpest declines of any State.

Kentucky chose to expand Medicaid, allowing 150,000 people to gain coverage.

More than 1.4 million Kentuckians are no longer subjected to lifetime or annual caps on their benefits.

Kentucky, sadly, has been one of the States hardest hit by the opioid epidemic. Thanks to the ACA, substance abuse treatment has increased 740 percent among Kentucky residents on Medicaid.

Today, 881,000 Kentuckians—33 percent of adults—have a preexisting condition that, before Obamacare, could have left them uninsurable.

So to ensure the health cand well-being of the residents of my neighboring State, Kentucky, this amendment says you cannot increase costs; cut services, benefits, or eligibility; eliminate essential health benefits; or impose lifetime limits or discriminate against Kentuckians with preexisting conditions.

If the Senators representing the Commonwealth want to rip away health insurance from their constituents, undermine protections for Kentuckians with preexisting conditions, and raise costs on older Kentuckians, well, count this neighboring Senator in to fight on their behalf.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Durbin moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pension with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such Committee;

(2) prohibit increases in health insurance premiums or out-of-pocket health care costs for residents of Kentucky;

(3) prohibit reductions in eligibility or services, or any increases in cost-sharing (including premiums and co-payments) related to the eligibility of residents of Kentucky to participate in the Medicaid program;

(4) prohibit health insurance issuers from imposing annual or lifetime limits on residents of Kentucky;

(5) prohibit health insurance issuers from charging residents of Kentucky who have pre-existing conditions more than the amount charged to healthy residents; or

(6) prohibit health insurance issuers from stopping coverage of any essential health benefits provided under section 1302 of the Patient Protection and Affordable Care Act (42 U.S.C. 18022).

Ms. STABENOW. Madam President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senators CARDIN, MURPHY, DURBIN, BALDWIN, BLUMENTHAL, BROWN, COONS, DUCKWORTH, FEINSTEIN, FRANKEN, HEINRICH, KLOBUCHAR, MARKEY, MENENDEZ, NELSON, PETERS, SHAHEEN, VAN HOLLEN, and WARREN.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Stabenow moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that no American will face reduced access to mental health care and services, and that the bill will not reduce the number of individuals with mental illness enrolled in health insurance coverage.

Ms. STABENOW. Madam President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senators BOOKER, BALDWIN, BLUMENTHAL, BROWN, CARPER, CASEY, COONS, FEINSTEIN, GILLIBRAND, HASSAN, HIRONO, MARKEY, MENENDEZ, PETERS, SHAHEEN, VAN HOLLEN, and WARREN.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Stabenow moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that the bill would not reduce the percentage or number of health plans that cover pregnancy, maternity, and newborn care, and would not increase out-of-pocket costs for such care.

Ms. STABENOW. Madam President, I intend to offer the following motions to H.R. 1628, and I ask unanimous consent that they be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Stabenow moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) lower the cost of prescription drugs, including costs for families with private health insurance coverage and seniors enrolled in the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Stabenow moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) establishes a refundable tax credit for out-of-pocket health care costs for which a deduction is otherwise allowed under current law.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Stabenow moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate within 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) reinstates, increases, and simplifies the small employer health insurance tax credit.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Stabenow moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) increase competition in the individual health insurance market in order to reduce premium costs and out-of-pocket expenses.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Stabenow moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that no American loses coverage of the essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(b)), including ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive and wellness services and chronic disease management, and pediatric services.

Ms. HASSAN. Madam President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senators CASEY, BALDWIN, BROWN, BOOKER, FRANKEN, KAINE, STABENOW, DUCKWORTH, LEAHY, COONS, BLUMENTHAL, DURBIN, WARREN, WYDEN, PETERS, WARNER, KING, MARKEY, CARDIN, MENENDEZ, NELSON, REED, UDALL, CARPER, BENNET, HIRONO, CANTWELL, HEINRICH, and VAN HOLLEN.

I would like to take a moment to thank my colleagues for their support.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Hassan moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that no provision in the bill would reduce or eliminate the amount, duration, or scope of Medicaid services available in schools under current law.

Mr. MARKEY. Madam President, I intend to offer the following motion to

H.R. 1628, and I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senators WARNER, BROWN, CARPER, REED, BLUMENTHAL, WARREN, KING, KLOBUCHAR, MENENDEZ, and VAN HOLLEN.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Markey moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that nothing in the bill would increase costs or decrease benefits for any individual with Alzheimer's disease or another dementia, including provisions that would reduce long term care coverage under the Medicaid program for Americans with Alzheimer's disease.

Mr. MARKEY. Madam President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senators MANCHIN, WHITEHOUSE, BROWN, BLUMENTHAL, WARREN, KING, NELSON, WARNER, and VAN HOLLEN.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Markey moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that nothing in the bill would increase out-of-pocket costs or reduce access to treatment, including medication-assisted treatment for Americans suffering from substance use disorders, including those with an opioid use disorder.

Mr. MARKEY. Madam President, I intend to offer the following motion to H.R. 1628, and I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senators CARPER, WARREN, CASEY, BROWN, HIRONO, STABENOW, MENENDEZ, and VAN HOLLEN.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Markey moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that nothing in the bill would increase the amount of uncompensated care provided by hospitals.

Mr. BENNET. Madam President, I intend to offer the following motions to H.R. 1628, and I ask unanimous consent that they be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Bennet moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that the health insurance coverage made available to Members of Congress shall not be more generous than the coverage available to Medicaid enrollees who are subject to the per capita cap under section 1903A of the Social Security Act, as added by the bill.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Bennet moves to commit the bill H.R. 1628 to the Committee on Finance of the Senate with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) strike the repeal of the tax on excessive remuneration of health insurers, and direct the savings from not repealing such tax to funding for treatment of opioid addiction.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Bennet moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) would ensure that, if the annual number of deaths due to opioid overdoses increases in any one of the 50 States or the District of Columbia in any year after the date of enactment, sections 126 (relating to the repeal of the Medicaid expansion) and 133 (relating to the per capita caps on Federal Medicaid spending) shall be repealed and the provisions of title XIX of the Social Security Act affected by such sections shall be restored as if such sections had not been enacted.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Bennet moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pension with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such Committee; and

(2) would reinstate funding for risk corridors in order to increase health plan choices and affordability and to prevent the further collapse of cooperatives.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Bennet moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that the bill will not result in increased uncompensated care payments to hospitals under the Medicare program in order to protect the solvency of such program.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Bennet moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such Committee; and

(2) provide that if the Secretary of Health and Human Services determines that uncompensated care at rural hospitals (defined as low-volume or critical access hospitals) has increased as a result of the implementation of this Act, then this Act shall be repealed and those provisions of law that were amended or repealed by this Act (including provisions of the Patient Protection and Affordable Care Act (Public Law 111-148), the Internal Revenue Code of 1986, and the Social Security Act) shall be restored or revived as if this Act had not been enacted.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Bennet moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pension with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such Committee; and

(2) provide that if the United States Census Bureau determines in its 2018 Health Insurance Coverage in the United States report that at least 2,000,000 individuals have lost their health insurance coverage, as compared to the 2016 Health Insurance Coverage in the United States report, as a result of the implementation of this Act, then this Act shall be repealed and those provisions of law that were amended or repealed by this Act (including provisions of the Patient Protection and Affordable Care Act (Public Law 111-148), the Internal Revenue Code of 1986, and the Social Security Act) shall be restored or revived as if this Act had not been enacted.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Bennet moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) would protect all children who are currently eligible for Medicaid.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Bennet moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee;

(2) would exempt any group of individuals that is eligible for Medicaid under current law, including children, adults with disabilities, pregnant women, seniors, those who need access to opioid addiction treatment, adults in school, and caretakers, from the Medicaid per capita caps; and

(3) would establish under title XIX of the Social Security Act a $10,000,000 fund to eliminate waste, fraud, and abuse in State Medicaid programs.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Bennet moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such Committee; and

(2) would strike section 207 of the bill and prohibit States from waiving essential health benefits.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Bennet moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days,

not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such Committee; and

(2) would strike section 205 of the bill and prohibit States from changing the medical loss ratio.

Mr. MANCHIN. Madam Pesident, I intend to offer the following motion to commit that would send H.R. 1628 to the Finance Committee with instructions to eliminate any provision that would hurt the clinics serving miners with Black Lung by increasing the number of uninsured individuals. I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senators MANCHIN, BROWN, WARNER, KAINE, and COONS.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Manchin moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) would eliminate any provision that would weaken the financial viability of the Black Lung Clinics serving coal miners with pneumoconiosis, including any provision that would cause an increase in the rate of uninsured individuals in the communities served by those clinics.

Mr. MANCHIN. Madam President, I intend to offer the following motion to commit that would send H.R. 1628 to the Finance Committee to include provisions of S. 523, as introduced in the Senate on March 2, 2017, the Budgeting for Opioid Addiction Treatment Act, commonly referred to as the LifeBOAT Act. This amendment would increase funding for substance use disorder treatment by establishing a 1-cent fee on every milligram of an opioid medication. It would exempt medication assisted treatment and include a rebate for cancer and hospice patients. I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senators MANCHIN, MURPHY, WHITEHOUSE, KING, KLOBUCHAR, NELSON, HEITKAMP, SHAHEEN, BALDWIN, and BLUMENTHAL.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Manchin moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee;

(2) include the provisions of S. 523, as introduced in the Senate on March 2, 2017, the Budgeting for Opioid Addiction Treatment Act (commonly referred to as the ''LifeBOAT Act''); and

(3) offsets any increased spending that results from such changes.

Mr. MANCHIN. Madam President, I intend to offer the following motion to commit that would send H.R. 1628 to the Finance Committee with instructions to include provisions that would improve health literacy and access to wellness programs and provisions to encourage State and local governments to educate their constituents about healthy choices. I ask unanimous consent that it be printed in the RECORD. The motion is supported by Senator BLUMENTHAL.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Manchin moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) would—

(A) improve health literacy and access to wellness programs, including through Medicaid managed care and health insurance plans that offer education and wellness incentives; and

(B) encourage State and local health officials to expand health literacy and wellness programs, particularly among the newly insured.

Mr. REED. Madam President, I intend to offer the following motion to H.R. 1628 and ask unanimous consent that it be printed in the RECORD.

I move to commit the bill, H.R. 1628, to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that, No. 1, are within the jurisdiction of such committee; and No. 2, ensure that no senior will lose access to long-term care service including nursing home care and home and community-based care under the Medicaid Program. Medicaid is the largest payer of nursing home care, with 900,000 individuals across the country and 4,756 individuals in Rhode Island who reside in nursing homes having their care paid for by Medicaid. This bill would decimate Medicaid, harming seniors and their families. This motion is supported by Senators BLUMENTHAL and SHAHEEN.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Reed moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that no senior will lose access to long term care services (including nursing home care and home and community-based care) under the Medicaid program.

Mr. REED. Madam President, I have a motion to commit the bill, H.R. 1628, to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that, No. 1, are within the jurisdiction of such committee; and No. 2, ensure that any cuts to Medicaid shall cease to apply in States with fewer than 26 weeks of unemployment insurance under State law and shall be reversed in States with increased unemployment in a quarter and include a study on available job opportunities for those most likely to lose health insurance coverage in the next 10 years as a result of the bill. Like most of the country, Rhode Island was hit hard by the recession, and Medicaid provided a critical safety net. Medicaid can adapt to cover those who have lost their jobs or are facing other economic hardships, saving families from having to choose whether to take their kids to the doctor or put food on the table. Under this bill, States will be unable to expand coverage during a recession to those in need and will likely be forced to make devastating across the board cuts.

I ask unanimous consent that the motion be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. Reed moves to commit the bill H.R. 1628 to the Committee on Finance of the Senate with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) ensure that any cuts to Medicaid shall cease to apply in States with fewer than 26 weeks of unemployment insurance under State law and shall be reversed in States with increased unemployment in a quarter, and include a study on available job opportunities for those most likely to lose health insurance coverage in the next ten years as a result of the bill.

Mrs. MURRAY. Madam President, with the support of Senators GILLIBRAND, BLUMENTHAL, SHAHEEN, STABENOW, HIRONO, BALDWIN, CORTEZ MASTO, HASSAN, VAN HOLLEN, LEAHY, WHITEHOUSE, BROWN, HARRIS, FRANKEN, FEINSTEIN, UDALL, KAINE, COONS, CANTWELL, MENENDEZ, REED, DUCKWORTH, DURBIN, WARREN, BOOKER, BALDWIN, CARPER, NELSON, HEINRICH, and KLOBUCHAR, I intend to make a motion to commit H.R. 1628, the American Health Care Act, to the Senate Committee on Health, Education, Labor, and Pensions for further consideration to ensure that it does not endanger the health of women. This closed-door, fast-track process is no way to make decisions that affect the health of every single woman in this country. It is imperative that we fix this legislation in an open, regular-order committee process.

I ask unanimous consent that the motion be printed in the RECORD.

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

MOTION TO COMMIT WITH INSTRUCTIONS

Mrs. Murray moves to commit the bill H.R. 1628 to the Committee on Health, Education, Labor, and Pensions with instructions to report the same back to the Senate in 3 days,

not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) eliminate provisions that make it harder for women to access health care, by—

(A) preventing women from accessing care through trusted health care providers;

(B) allowing or requiring insurance companies to offer plans that do not fully cover women's health care needs;

(C) charging women more for coverage; or

(D) ripping away women's access to the coverage they receive today.

The PRESIDING OFFICER. The Senator from Wyoming.

MORNING BUSINESS

Mr. ENZI. Madam President, I ask unanimous consent that the Senate be in a period of morning business, with Senators permitted to speak therein for up to 10 minutes each.

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

BUDGETARY REVISIONS

Mr. ENZI. Madam President, section 3001 of S. Con. Res. 3, the concurrent resolution on the budget for fiscal year 2017, allows the chairman of the Senate Budget Committee to revise the allocations, aggregates and levels in the budget resolution for legislation related to healthcare reform. The authority to adjust is contingent on the legislation not increasing the deficit over the period of the total of fiscal years 2017 to 2026.

I find that amendment No. 271 fulfills the conditions of deficit neutrality found in sec. 3001 of S. Con. Res. 3. Accordingly, I am revising the allocations to the Committee on Finance, the Committee on Health, Education, Labor, and Pensions, HELP and the budgetary aggregates to account for the budget effects of the amendment. I am also adjusting the unassigned to committee savings levels in the budget resolution to reflect that while there are savings in the amendment attributable to both the HELP and Finance committees, the Congressional Budget Office and Joint Committee on Taxation are unable to produce unique estimates for each provision due to interactions and other effects that are estimated simultaneously.

This adjustment supersedes the adjustment I previously made for the processing of S. Amdt. 267. This adjustment applies while this amendment is under consideration. Should the amendment be withdrawn, fail, or lose its pending status, this adjustment will be null and void and the adjustment for amendment No. 267 shall remain active.

I ask unanimous consent that the accompanying tables, which provide details about the adjustment, be printed in the RECORD.

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

BUDGET AGGREGATES BUDGET AUTHORITY AND OUTLAYS

(Pursuant to Section 311 of the Congressional Budget Act of 1974 and Section 3001 of S. Con. Res. 3, the Concurrent Resolution on the Budget for Fiscal Year 2017)

$ in millions	2017
Current Aggregates:	
Spending:	
Budget Authority	3,329,289
Outlays	3,268,171
Adjustments:	
Spending:	
Budget Authority	−4,100
Outlays	−4,500
Revised Aggregates:	
Spending:	
Budget Authority	3,325,189
Outlays	3,263,671

BUDGET AGGREGATE REVENUES

(Pursuant to Section 311 of the Congressional Budget Act of 1974 and Section 3001 of S. Con. Res. 3, the Concurrent Resolution on the Budget for Fiscal Year 2017)

$ in millions	2017	2017–2021	2017–2026
Current Aggregates:			
Revenue	2,682,088	14,498,573	32,351,660
Adjustments:			
Revenue	−6,200	−305,300	−891,500
Revised Aggregates:			
Revenue	2,675,888	14,193,273	31,460,160

REVISION TO ALLOCATION TO THE COMMITTEE ON FINANCE

(Pursuant to Section 302 of the Congressional Budget Act of 1974 and Section 3001 of S. Con. Res. 3, the Concurrent Resolution on the Budget for Fiscal Year 2017)

$ in millions	2017	2017–2021	2017–2026
Current Allocation:			
Budget Authority	2,277,203	13,101,022	31,274,627
Outlays	2,262,047	13,073,093	31,233,186
Adjustments:			
Budget Authority	−200	−1,000	13,600
Outlays	−200	−1,000	13,600
Revised Allocation:			
Budget Authority	2,277,003	13,100,022	31,288,227
Outlays	2,261,847	13,072,093	31,246,786

REVISION TO ALLOCATION TO THE COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

(Pursuant to Section 302 of the Congressional Budget Act of 1974 and Section 3001 of S. Con. Res. 3, the Concurrent Resolution on the Budget for Fiscal Year 2017)

$ in millions	2017	2017–2021	2017–2026
Current Allocation:			
Budget Authority	17,204	90,282	176,893
Outlays	15,841	89,820	183,421
Adjustments:			
Budget Authority	400	−1,000	−9,200
Outlays	0	500	−6,000
Revised Allocation:			
Budget Authority	17,604	89,282	167,693
Outlays	15,841	90,320	177,421

REVISION TO ALLOCATION TO THE UNASSIGNED COMMITTEE

(Pursuant to Section 302 of the Congressional Budget Act of 1974 and Section 3001 of S. Con. Res. 3, the Concurrent Resolution on the Budget for Fiscal Year 2017)

$ in millions	2017	2017–2021	2017–2026
Current Allocation:			
Budget Authority	−844,671	−4,649,869	−10,724,965
Outlays	−835,437	−4,608,689	−10,648,885
Adjustments:			
Budget Authority	−4,300	−364,900	−1,432,100
Outlays	−4,300	−364,900	−1,432,100
Revised Allocation:			
Budget Authority	−848,971	−5,014,769	−12,157,065
Outlays	−839,737	−4,973,589	−12,080,985

HONORING CHIEF EDWARD SWITALSKI

Mr. PETERS. Madam President, today, I wish to honor the 38-year public service career of Comstock, MI, fire chief Edward Switalski. Known for his bravery and devotion to his family and community, Chief Switalski was killed in the line of duty on June 14, 2017, having been struck and killed by a motorist on Interstate 94 in Kalamazoo County, as he was responding to a previous car crash at that site. He is survived by his wife, Holly, and two daughters, Alison and Emily.

Chief Switalski's dream of becoming a firefighter arrived early. As a child, he volunteered to clean equipment and perform other tasks for his local fire department. His career began as a part-time paramedic at Pleasantview Fire District in Illinois in 1982; while there, he rose to become battalion chief before retiring after 32 years of service and moving to Michigan to be closer to his daughters.

While in Illinois, Chief Switalski won numerous awards and citations, including one for running into the basement of a burning building in an attempt to rescue one of his colleagues. The chief was also a compassionate volunteer who traveled to New Orleans to help rebuild the community in the wake of the devastating Hurricane Katrina.

After his relocation to Michigan, Switalski became the chief of the Comstock, MI, fire department in 2013. Chief Switalski quickly became known as a visionary leader who would often pick up open firefighting shifts in his small department. Active in the community, the chief was involved in numerous organizations and was a member of Zion Lutheran Church in Kalamazoo.

Colleagues have paid numerous tributes to Chief Switalski. A former chief of his remarked he ''did not know anyone who enjoyed being a firefighter more than he did.'' The public safety chaplain of a neighboring fire department said that, on June 14, ''we lost a great man on Earth that day, but we gained one in heaven.'' The leader of a local ambulance service called Chief Switalski ''an extraordinary man who had a deep compassion for his family and the communities that he served. He was a man of integrity, who believed in doing the right thing.''

It was entirely appropriate that United States and State of Michigan flags flew at half-staff on all State buildings on the day of the chief's funeral.

Chief Switalski was a brave and selfless public servant who was taken from our world much too soon. The tremendous outpouring of support demonstrated at his funeral service is a reminder of the risks undertaken every day by our first responders and the gratitude the public has for their vital work.

TRIBUTE TO LOU D'ALLESANDRO

Ms. HASSAN. Madam President, today I wish to recognize Senator Lou D'Allesandro and congratulate him on his 20 years of service in the New Hampshire Senate and to honor his extraordinary career of public service to the State of New Hampshire.

Senator D'Allesandro is serving his 10th term in the New Hampshire Senate representing Manchester and previously served three terms on the New Hampshire Executive Council and two terms in the New Hampshire House of Representatives. Serving with distinction, he has always sought to best represent his constituents and is well known in New Hampshire for his leadership, his willingness to work constructively to better the Granite State, and for the responsiveness and care he has shown throughout his years in public service.

In addition to his many legislative achievements, Senator D'Allesandro served our country honorably in uniform in the U.S. Marine Corps and is an accomplished educator. Senator D'Allesandro was instrumental in getting NCAA status for SNHU and has remained extremely involved in New Hampshire education, having served as chairman of the New England Board of Higher Education. Appointed the first basketball coach in Southern New Hampshire University history in 1963, Senator D'Allesandro led the SNHU Penmen to three straight titles and compiled a record of 114–40 in 7 years of coaching collegiate athletics. He holds honorary doctorates from Franklin Pierce University, Daniel Webster College, and the New Hampshire Institute of Art, as well as degrees from the University of New Hampshire, Rivier University, New England College, and the New Hampshire Institute of Art. He is a member of the National Football Foundation and College Hall of Fame, Inc., and is a director of the New Hampshire Hockey Hall of Fame.

As one may gather, Senator D'Allesandro is passionate about bettering the lives of New Hampshire's young people through education, and I sincerely thank him for his years supporting, in so many ways, our colleges and universities. I also thank his wonderful wife, Pat, who has stood by Lou's side and, in doing so, has also served the people of New Hampshire. I am honored to call Lou D'Allesandro a friend, and as Senator for New Hampshire, I join my voice with the voices of so many other Granite Staters to express gratitude to Senator D'Allesandro for his extraordinary commitment to public service, his selfless contributions to higher education, and the positive impact he has made on the State of New Hampshire. Of course, I join all Granite Staters in wishing Lou a great American day.

TRIBUTE TO JOHN MICHELS

Mr. WYDEN. Madam President, Team Wyden will shortly lose one of its stalwarts, but before John Michels of my Portland office takes his well-deserved retirement after two decades of service to the people of Oregon, I want to take just a few minutes to recognize his many, many contributions.

John joined my office in the late 1990s through a work-study program run by the Department of Veterans Affairs. He had previously worked in construction, and he served as a jet engine mechanic in the U.S. Navy before coming to my office, so suffice it to say that he was no stranger to long hours and tough assignments.

As a member of Team Wyden, John put his shoulder to the wheel to help other veterans when backlogs, bureaucracy, or red tape held up the care or the recognition they had earned. In his years of service, John has managed thousands of cases for Oregon constituents struggling with one Federal agency or another.

John has also always been a practical soul and has a passion for tinkering and fixing things. He brought these skills to bear as our resident IT expert and computer whisperer in Oregon.

Anybody who has worked in the government can tell you it can be tough. The pace can be grueling, the cynicism can be frustrating, and the bureaucracy can be maddening, but as John will attest, there are few more rewarding experiences than helping a veteran receive overdue recognition or bringing a new VA facility to a rural community or ensuring seniors and people with disabilities receive the Social Security benefits they so richly deserve.

John is not the type of person to trumpet his service from the rooftops, but he has an enormous heart and a passion for public service. The bottom line is that John has found ways to help me help countless people across Oregon.

Now, as John knows, we never really let anybody leave Team Wyden, so I am sure we will still call upon his wealth of knowledge and experience. In the meantime, I want to thank him for all the help he has provided over these past two decades. I have been fortunate to have him on my team, and we will all miss him greatly.

ADDITIONAL STATEMENTS

SESQUICENTENNIAL CELEBRATION OF CHEYENNE, WYOMING

• Mr. BARRASSO. Madam President, I want to take a moment to commemorate the sesquicentennial of the city of Cheyenne, WY.

The city of Cheyenne is an irreplaceable catalyst in Wyoming's birth and development. Christened on July 4, 1867, Cheyenne was named after the Cheyenne Tribe found in the Dakota territory. As the population jumped from 400 to 3,000 and beyond, Cheyenne earned nickname ''The Magic City of the Plains'' in reference to how it seemingly sprouted overnight and kept

on growing. This unfettered momentum showed enough potential that in 1886, 4 years before Wyoming became the 44th State, the construction of a State capitol was approved in Cheyenne. Among these barren plains, a wellspring of prosperity and opportunity was found for the independent, brave folks who were willing to work hard to build it. In that, Cheyenne's legacy perfectly captures Wyoming's spirit.

Cheyenne, WY, is a railroad town through and through. General Grenville Dodge, chief engineer for the Union Pacific Railroad, selected this dusty spot as a connecting point in the Nation's first transcontinental railroad. Thousands of men and their families came here to lay track up the Gangplank, the unique geography that allows a gradual grading from the plains to the Laramie Mountains. Supply stores, banks, and dentists all sprang up in their wake to accommodate the booming town. Now, Interstate 80 runs alongside the Gangplank from Cheyenne to Laramie, where the climb from the plains to the mountains continues today. On March 3, 2006, the Cheyenne Train Depot become a national historic landmark, solidifying the railroads irremovable stitching in the fabric of Cheyenne, WY, and the rest of the Nation.

During Cheyenne's first fragile years, soldiers were stationed at Fort D.A. Russell to protect the railroad. The base was established on the same day as the city, and construction began in October 1867. It later became the F.E. Warren Air Force base that continues to be crucial to Cheyenne today. The base was expected to last 6 months, then to dry up along with the town itself as folks followed the train tracks to find more work. However, Cheyenne endured—and the base along with it. It became a permanent Army installation in 1884, and soon ramshackle wood housings were replaced with brick buildings. In 1930, it was renamed F.E. Warren Base by President Herbert Hoover to honor Wyoming's first Governor, Francis Emroy Warren. It was officially renamed F.E. Warren Air Force Base in 1949, making it the oldest continually active base in the Air Force system. The base is currently responsible for 15 missile alert facilities and 150 Minute Man III missiles and is known throughout Wyoming as a fixture in the Cheyenne community. The F.E. Warren Base and some 4,000 personnel on site continue to be a massively positive presence in the Cheyenne neighborhood, especially at Cheyenne Frontier Days.

As with the F.E. Warren Air Force Base, there would be no Cheyenne without Cheyenne Frontier Days. The first frontier day took place on September 13, 1897, kicked off with a parade led by Buffalo Bill Cody. This event started as the brainchild of passenger agent Frank Angier, hired by railroad officials to increase the number of passengers. This was following the devastation of the prosperous cattle trade by the blizzards of 1886 to 1887, which killed thousands of cattle and the businesses of their barons. Cheyenne needed a boost, and the Cheyenne Frontier Days became the perfect solution. The first rodeo was attended by 400 folks, and more and more have been coming back ever since. Today Frontier Days is the world's largest outdoor rodeo, while also boasting world famous musical acts. In 2016, 259,193 people attended the event to watch professional cowboys compete for over $1 million while enjoying the festive celebration of cowboy culture. This event symbolizes the western spirit that beats from within Cheyenne throughout the rest of Wyoming.

In honor of the 150th anniversary of Cheyenne, WY, I urge my esteemed colleagues to visit this ''Magic City'' themselves. I congratulate all the folks who work to preserve Cheyenne's rich history and continue its valuable legacy. I stand proudly with them in celebrating this historical achievement.●

TRIBUTE TO ELLEN SCHLECHTER

● Mr. ROUNDS. Madam President, today I recognize the distinguished accomplishment of a young South Dakotan, Ellen Schlechter, a 2017 recipient of the National Federation of Independent Businesses NFIB Young Entrepreneur Award. Ellen is a recent high school graduate from Orient, SD, and the founder and owner of The Calving Book App, a convenient and simple way to keep calf records on a user's smartphone, tablet, or computer.

Growing up raising cattle, Ellen recognized a need in the agricultural sector for an application that would allow producers to document all of their cattle records in one place. Two years after the launch of The Calving Book App, Ellen has introduced an advanced version of the app and been featured in numerous ag publications and on local media in our State.

I extend my congratulations to Ellen for being recognized by the NFIB for her accomplishments and entrepreneurial spirit, and I thank her for the work she has done to help our producers become more efficient. I wish her continued success in the years to come.●

TRIBUTE TO ABIGAIL KOSIAK

● Mr. THUNE. Madam President, today I recognize the hard work of my Commerce, Science, and Transportation Committee intern Abigail Kosiak. Abigail hails from Sioux Falls, SD, and is a rising junior at Utah State University.

While interning on the Commerce Committee, Abigail worked in the committee's front office, assisted the Communications, Technology, Innovation, and the Internet Subcommittee and gave tours of the Capitol. She is a dedicated worker who was committed to getting the most out of her internship. I extend my sincere thanks and appreciation to Abigail for all of the fine work she did for the Commerce Committee and wish her continued success in the years to come.●

MESSAGE FROM THE HOUSE

At 10:06 a.m., a message from the House of Representatives, delivered by Mrs. Cole, one of its reading clerks, announced that the House has passed the following bills, in which it requests the concurrence of the Senate:

H.R. 2182. An act to require the Comptroller General of the United States to submit a report to Congress on the alternatives for the final disposition of Plum Island, including preservation of the island for conservation, education, and research, and for other purposes.

H.R. 3178. An act to amend title XVIII of the Social Security Act to improve the delivery of home infusion therapy and dialysis and the application of the Stark rule under the Medicare program, and for other purposes.

H.R. 3364. An act to provide congressional review and to counter aggression by the Governments of Iran, the Russian Federation, and North Korea, and for other purposes,

The message also announced that pursuant to section 4003(e) of the 21st Century Cures Act (Public Law 114–255), and the order of the House of January 3, 2017, the Speaker appoints the following individual on the part of the House of Representatives to the Health Information Technology Advisory Committee: Ms. Cynthia A. Fisher of Newton, Massachusetts.

MEASURES REFERRED

The following bill was read the first and the second times by unanimous consent, and referred as indicated:

H.R. 3178. An act to amend title XVIII of the Social Security Act to improve the delivery of home infusion therapy and dialysis and the application of the Stark rule under the Medicare program, and for other purposes; to the Committee on Finance.

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. MORAN (for himself, Mr. SCHATZ, Mr. INHOFE, Mr. BLUMENTHAL, Mr. YOUNG, and Mr. UDALL):

S. 1632. A bill to establish an additional fund in the Treasury to meet existing statutory obligations to reimburse costs reasonably incurred as a result of the reorganization of broadcast television spectrum, and for other purposes; to the Committee on Commerce, Science, and Transportation.

By Mr. WYDEN:

S. 1633. A bill to promote innovative approaches to outdoor recreation on Federal land and to open up opportunities for collaboration with non-Federal partners, and for other purposes; to the Committee on Energy and Natural Resources.

By Mr. BLUMENTHAL (for himself and Mr. MARKEY):

S. 1634. A bill to require auto dealers to fix outstanding safety recalls before selling or leasing a used passenger motor vehicle; to the Committee on Commerce, Science, and Transportation.

By Ms. HIRONO:

S. 1635. A bill to amend title 38, United States Code, to extend authority for operation of the Department of Veterans Affairs Regional Office in Manila, the Republic of the Philippines; to the Committee on Veterans' Affairs.

By Mr. DURBIN (for himself, Mr. REED, Mr. BROWN, Mr. FRANKEN, Mrs. FEINSTEIN, Mr. WHITEHOUSE, Mr. MERKLEY, Mr. VAN HOLLEN, Ms. DUCKWORTH, Ms. HIRONO, and Ms. WARREN):

S. 1636. A bill to amend the Internal Revenue Code of 1986 to modify the rules relating to inverted corporations; to the Committee on Finance.

By Mr. DURBIN (for himself, Mr. REED, Mr. FRANKEN, Ms. DUCKWORTH, and Mr. WHITEHOUSE):

S. 1637. A bill to prohibit the award of Federal Government contracts to inverted domestic corporations, and for other purposes; to the Committee on Homeland Security and Governmental Affairs.

By Mr. GRASSLEY (for himself, Ms. STABENOW, Mr. FRANKEN, Mr. KAINE, Mr. KING, and Mr. SCOTT):

S. 1638. A bill to provide priority under certain federally assisted housing programs to assist youths who are aging out of foster care, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

By Mr. WHITEHOUSE (for himself and Mr. SCHATZ):

S. 1639. A bill to amend the Internal Revenue Code of 1986 to provide for carbon dioxide and other greenhouse gas emission fees, reduce the rate of the corporate income tax, provide tax credits to workers, deliver additional benefits to retired and disabled Americans, and for other purposes; to the Committee on Finance.

By Mr. DURBIN (for himself, Ms. BALDWIN, Mr. BENNET, Mr. BLUMENTHAL, Mr. BOOKER, Mr. COONS, Ms. DUCKWORTH, Mr. FRANKEN, Mrs. GILLIBRAND, Mr. HEINRICH, Ms. HIRONO, Ms. KLOBUCHAR, Mr. LEAHY, Mr. MARKEY, Mr. MENENDEZ, Mr. MERKLEY, Mr. MURPHY, Mrs. MURRAY, Mr. PETERS, Mr. SANDERS, Mr. SCHATZ, Mrs. SHAHEEN, Mr. UDALL, Mr. VAN HOLLEN, and Ms. WARREN):

S. 1640. A bill to reform the financing of Senate elections, and for other purposes; to the Committee on Finance.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. BENNET (for himself, Mr. HELLER, Mr. MENENDEZ, Mr. UDALL, Mr. COONS, Mrs. FEINSTEIN, Mr. CARDIN, Mr. PETERS, Mr. VAN HOLLEN, Ms. HARRIS, Mr. HEINRICH, Mr. MERKLEY, Mr. FRANKEN, Mr. CARPER, Ms. STABENOW, Ms. CANTWELL, Mrs. MURRAY, and Ms. CORTEZ MASTO):

S. Res. 232. A resolution supporting the inclusion and meaningful engagement of Latinos in environmental protection and conservation efforts; to the Committee on Energy and Natural Resources.

By Mr. REED (for himself, Ms. MURKOWSKI, Mr. BLUMENTHAL, Mr. VAN HOLLEN, Mrs. SHAHEEN, Mr. PETERS, and Mr. TESTER):

S. Res. 233. A resolution designating August 16, 2017, as ''National Airborne Day''; to the Committee on the Judiciary.

ADDITIONAL COSPONSORS

S. 223

At the request of Ms. COLLINS, the name of the Senator from South Carolina (Mr. SCOTT) was added as a cosponsor of S. 223, a bill to provide immunity from suit for certain individuals who disclose potential examples of financial exploitation of senior citizens, and for other purposes.

S. 298

At the request of Mr. TESTER, the name of the Senator from Ohio (Mr. BROWN) was added as a cosponsor of S. 298, a bill to require Senate candidates to file designations, statements, and reports in electronic form.

S. 339

At the request of Mr. NELSON, the name of the Senator from Minnesota (Mr. FRANKEN) was added as a cosponsor of S. 339, a bill to amend title 10, United States Code, to repeal the requirement for reduction of survivor annuities under the Survivor Benefit Plan by veterans' dependency and indemnity compensation, and for other purposes.

S. 364

At the request of Ms. KLOBUCHAR, the name of the Senator from Vermont (Mr. LEAHY) was added as a cosponsor of S. 364, a bill to amend the Food Security Act of 1985 to exempt certain recipients of Department of Agriculture conservation assistance from certain reporting requirements, and for other purposes.

S. 540

At the request of Mr. THUNE, the name of the Senator from Hawaii (Ms. HIRONO) was added as a cosponsor of S. 540, a bill to limit the authority of States to tax certain income of employees for employment duties performed in other States.

S. 671

At the request of Mr. MORAN, the name of the Senator from Maine (Mr. KING) was added as a cosponsor of S. 671, a bill to amend the Internal Revenue Code of 1986 to exclude from gross income certain amounts realized on the disposition of property raised or produced by a student farmer, and for other purposes.

S. 711

At the request of Mr. THUNE, the name of the Senator from Wisconsin (Ms. BALDWIN) was added as a cosponsor of S. 711, a bill to amend the Internal Revenue Code of 1986 to provide for S corporation reform, and for other purposes.

S. 859

At the request of Mr. PETERS, the name of the Senator from Illinois (Ms. DUCKWORTH) was added as a cosponsor of S. 859, a bill to authorize the Director of the United States Geological Survey to conduct monitoring, assessment, science, and research, in support of the binational fisheries within the Great Lakes Basin, and for other purposes.

S. 910

At the request of Mr. SCHUMER, the name of the Senator from New Jersey (Mr. BOOKER) was added as a cosponsor of S. 910, a bill to prohibit discrimination against individuals with disabilities who need long-term services and supports, and for other purposes.

S. 1172

At the request of Mrs. SHAHEEN, the name of the Senator from California (Mrs. FEINSTEIN) was added as a cosponsor of S. 1172, a bill to impose sanctions with respect to foreign persons responsible for gross violations of internationally recognized human rights against lesbian, gay, bisexual, and transgender (LGBT) individuals, and for other purposes.

S. 1182

At the request of Mr. YOUNG, the names of the Senator from Oregon (Mr. MERKLEY) and the Senator from Ohio (Mr. BROWN) were added as cosponsors of S. 1182, a bill to require the Secretary of the Treasury to mint commemorative coins in recognition of the 100th anniversary of The American Legion.

S. 1326

At the request of Mr. MURPHY, the name of the Senator from Rhode Island (Mr. REED) was added as a cosponsor of S. 1326, a bill to require the Secretary of the Treasury to mint coins in recognition of American innovation and significant innovation and pioneering efforts of individuals or groups from each of the 50 States, the District of Columbia, and the United States territories, to promote the importance of innovation in the United States, the District of Columbia, and the United States territories, and for other purposes.

S. 1332

At the request of Ms. STABENOW, the name of the Senator from Illinois (Ms. DUCKWORTH) was added as a cosponsor of S. 1332, a bill to establish the Great Lakes Aquatic Connectivity and Infrastructure Program, and for other purposes.

S. 1354

At the request of Mr. CARPER, the name of the Senator from New Mexico (Mr. HEINRICH) was added as a cosponsor of S. 1354, a bill to establish an Individual Market Reinsurance fund to provide funding for State individual market stabilization reinsurance programs.

S. 1425

At the request of Mr. WICKER, the name of the Senator from New Hampshire (Ms. HASSAN) was added as a cosponsor of S. 1425, a bill to reauthorize the Integrated Coastal and Ocean Observation System Act of 2009, and for other purposes.

S. 1498

At the request of Ms. COLLINS, the name of the Senator from Delaware

(Mr. COONS) was added as a cosponsor of S. 1498, a bill to establish in the Smithsonian Institution a comprehensive American women's history museum, and for other purposes.

S. 1591

At the request of Mr. VAN HOLLEN, the name of the Senator from Texas (Mr. CRUZ) was added as a cosponsor of S. 1591, a bill to impose sanctions with respect to the Democratic People's Republic of Korea, and for other purposes.

S. 1595

At the request of Mr. RUBIO, the names of the Senator from Texas (Mr. CORNYN) and the Senator from Mississippi (Mr. WICKER) were added as cosponsors of S. 1595, a bill to amend the Hizballah International Financing Prevention Act of 2015 to impose additional sanctions with respect to Hizballah, and for other purposes.

S. 1598

At the request of Mr. TESTER, the names of the Senator from Massachusetts (Mr. MARKEY), the Senator from Maryland (Mr. VAN HOLLEN), the Senator from Wisconsin (Ms. BALDWIN), the Senator from California (Mrs. FEINSTEIN), the Senator from Delaware (Mr. COONS) and the Senator from Washington (Ms. CANTWELL) were added as cosponsors of S. 1598, a bill to amend title 38, United States Code, to make certain improvements in the laws administered by the Secretary of Veterans Affairs, and for other purposes.

At the request of Mr. ISAKSON, the names of the Senator from Arizona (Mr. MCCAIN) and the Senator from Mississippi (Mr. COCHRAN) were added as cosponsors of S. 1598, supra.

S. 1608

At the request of Mr. FLAKE, the names of the Senator from Texas (Mr. CORNYN), the Senator from Arkansas (Mr. BOOZMAN), the Senator from Louisiana (Mr. KENNEDY) and the Senator from Massachusetts (Mr. MARKEY) were added as cosponsors of S. 1608, a bill to authorize the Capitol Police Board to make payments from the United States Capitol Police Memorial Fund to employees of the United States Capitol Police who have sustained serious line-of-duty injuries, and for other purposes.

S. 1615

At the request of Ms. CORTEZ MASTO, her name was added as a cosponsor of S. 1615, a bill to authorize the cancellation of removal and adjustment of status of certain individuals who are long-term United States residents and who entered the United States as children and for other purposes.

S.J. RES. 47

At the request of Mr. CRAPO, the name of the Senator from Utah (Mr. LEE) was added as a cosponsor of S.J. Res. 47, a joint resolution providing for congressional disapproval under chapter 8 of title 5, United States Code, of the rule submitted by Bureau of Consumer Financial Protection relating to ''Arbitration Agreements''.

S. RES. 162

At the request of Mr. LANKFORD, the name of the Senator from South Carolina (Mr. SCOTT) was added as a cosponsor of S. Res. 162, a resolution reaffirming the commitment of the United States to promoting religious freedom, and for other purposes.

AMENDMENT NO. 268

At the request of Mr. WHITEHOUSE, the name of the Senator from Massachusetts (Ms. WARREN) was added as a cosponsor of amendment No. 268 intended to be proposed to H.R. 1628, a bill to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017.

AMENDMENT NO. 276

At the request of Mr. KAINE, the names of the Senator from New Mexico (Mr. HEINRICH), the Senator from Maine (Mr. KING) and the Senator from Connecticut (Mr. BLUMENTHAL) were added as cosponsors of amendment No. 276 intended to be proposed to H.R. 1628, a bill to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. DURBIN (for himself, Mr. REED, Mr. BROWN, Mr. FRANKEN, Mrs. FEINSTEIN, Mr. WHITEHOUSE, Mr. MERKLEY, Mr. VAN HOLLEN, Ms. DUCKWORTH, Ms. HIRONO, and Ms. WARREN):

S. 1636. A bill to amend the Internal Revenue Code of 1986 to modify the rules relating to inverted corporations; to the Committee on Finance.

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

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

S. 1636

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Stop Corporate Inversions Act of 2017''.

SEC. 2. MODIFICATIONS TO RULES RELATING TO INVERTED CORPORATIONS.

(a) IN GENERAL.—Subsection (b) of section 7874 of the Internal Revenue Code of 1986 is amended to read as follows:

''(b) INVERTED CORPORATIONS TREATED AS DOMESTIC CORPORATIONS.—

''(1) IN GENERAL.—Notwithstanding section 7701(a)(4), a foreign corporation shall be treated for purposes of this title as a domestic corporation if—

''(A) such corporation would be a surrogate foreign corporation if subsection (a)(2) were applied by substituting '80 percent' for '60 percent', or

''(B) such corporation is an inverted domestic corporation.

''(2) INVERTED DOMESTIC CORPORATION.—For purposes of this subsection, a foreign corporation shall be treated as an inverted domestic corporation if, pursuant to a plan (or a series of related transactions)—

''(A) the entity completes after May 8, 2014, the direct or indirect acquisition of—

''(i) substantially all of the properties held directly or indirectly by a domestic corporation, or

''(ii) substantially all of the assets of, or substantially all of the properties constituting a trade or business of, a domestic partnership, and

''(B) after the acquisition, either—

''(i) more than 50 percent of the stock (by vote or value) of the entity is held—

''(I) in the case of an acquisition with respect to a domestic corporation, by former shareholders of the domestic corporation by reason of holding stock in the domestic corporation, or

''(II) in the case of an acquisition with respect to a domestic partnership, by former partners of the domestic partnership by reason of holding a capital or profits interest in the domestic partnership, or

''(ii) the management and control of the expanded affiliated group which includes the entity occurs, directly or indirectly, primarily within the United States, and such expanded affiliated group has significant domestic business activities.

''(3) EXCEPTION FOR CORPORATIONS WITH SUBSTANTIAL BUSINESS ACTIVITIES IN FOREIGN COUNTRY OF ORGANIZATION.—A foreign corporation described in paragraph (2) shall not be treated as an inverted domestic corporation if after the acquisition the expanded affiliated group which includes the entity has substantial business activities in the foreign country in which or under the law of which the entity is created or organized when compared to the total business activities of such expanded affiliated group. For purposes of subsection (a)(2)(B)(iii) and the preceding sentence, the term 'substantial business activities' shall have the meaning given such term under regulations in effect on January 18, 2017, except that the Secretary may issue regulations increasing the threshold percent in any of the tests under such regulations for determining if business activities constitute substantial business activities for purposes of this paragraph.

''(4) MANAGEMENT AND CONTROL.—For purposes of paragraph (2)(B)(ii)—

''(A) IN GENERAL.—The Secretary shall prescribe regulations for purposes of determining cases in which the management and control of an expanded affiliated group is to be treated as occurring, directly or indirectly, primarily within the United States. The regulations prescribed under the preceding sentence shall apply to periods after May 8, 2014.

''(B) EXECUTIVE OFFICERS AND SENIOR MANAGEMENT.—Such regulations shall provide that the management and control of an expanded affiliated group shall be treated as occurring, directly or indirectly, primarily within the United States if substantially all of the executive officers and senior management of the expanded affiliated group who exercise day-to-day responsibility for making decisions involving strategic, financial, and operational policies of the expanded affiliated group are based or primarily located within the United States. Individuals who in fact exercise such day-to-day responsibilities shall be treated as executive officers and senior management regardless of their title.

''(5) SIGNIFICANT DOMESTIC BUSINESS ACTIVITIES.—For purposes of paragraph (2)(B)(ii), an expanded affiliated group has significant domestic business activities if at least 25 percent of—

''(A) the employees of the group are based in the United States,

''(B) the employee compensation incurred by the group is incurred with respect to employees based in the United States,

''(C) the assets of the group are located in the United States, or

''(D) the income of the group is derived in the United States,

determined in the same manner as such determinations are made for purposes of determining substantial business activities under regulations referred to in paragraph (3) as in effect on January 18, 2017, but applied by treating all references in such regulations to 'foreign country' and 'relevant foreign country' as references to 'the United States'. The Secretary may issue regulations decreasing the threshold percent in any of the tests under such regulations for determining if business activities constitute significant domestic business activities for purposes of this paragraph.''.

(b) CONFORMING AMENDMENTS.—

(1) Clause (i) of section 7874(a)(2)(B) of such Code is amended by striking ''after March 4, 2003,'' and inserting ''after March 4, 2003, and before May 8, 2014,''.

(2) Subsection (c) of section 7874 of such Code is amended—

(A) in paragraph (2)—

(i) by striking ''subsection (a)(2)(B)(ii)'' and inserting ''subsections (a)(2)(B)(ii) and (b)(2)(B)(i)'', and

(ii) by inserting ''or (b)(2)(A)'' after ''(a)(2)(B)(i)'' in subparagraph (B),

(B) in paragraph (3), by inserting ''or (b)(2)(B)(i), as the case may be,'' after ''(a)(2)(B)(ii)'',

(C) in paragraph (5), by striking ''subsection (a)(2)(B)(ii)'' and inserting ''subsections (a)(2)(B)(ii) and (b)(2)(B)(i)'', and

(D) in paragraph (6), by inserting ''or inverted domestic corporation, as the case may be,'' after ''surrogate foreign corporation''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after May 8, 2014.

By Mr. DURBIN (for himself, Mr. REED, Mr. FRANKEN, Ms. DUCKWORTH, and Mr. WHITEHOUSE):

S. 1637. A bill to prohibit the award of Federal Government contracts to inverted domestic corporations, and for other purposes; to the Committee on Homeland Security and Governmental Affairs.

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

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

S. 1637

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''American Business for American Companies Act of 2017''.

SEC. 2. PROHIBITION ON AWARDING CONTRACTS TO INVERTED DOMESTIC CORPORATIONS.

(a) CIVILIAN CONTRACTS.—

(1) IN GENERAL.—Chapter 47 of title 41, United States Code, is amended by adding at the end the following new section:

''§ 4713. Prohibition on awarding contracts to inverted domestic corporations

''(a) PROHIBITION.—

''(1) IN GENERAL.—The head of an executive agency may not award a contract for the procurement of property or services to—

''(A) any foreign incorporated entity that such head has determined is an inverted domestic corporation or any subsidiary of such entity; or

''(B) any joint venture if more than 10 percent of the joint venture (by vote or value) is held by a foreign incorporated entity that such head has determined is an inverted domestic corporation or any subsidiary of such entity.

''(2) SUBCONTRACTS.—

''(A) IN GENERAL.—The head of an executive agency shall include in each contract for the procurement of property or services awarded by the executive agency with a value in excess of $10,000,000, other than a contract for exclusively commercial items, a clause that prohibits the prime contractor on such contract from—

''(i) awarding a first-tier subcontract with a value greater than 10 percent of the total value of the prime contract to an entity or joint venture described in paragraph (1); or

''(ii) structuring subcontract tiers in a manner designed to avoid the limitation in paragraph (1) by enabling an entity or joint venture described in paragraph (1) to perform more than 10 percent of the total value of the prime contract as a lower-tier subcontractor.

''(B) PENALTIES.—The contract clause included in contracts pursuant to subparagraph (A) shall provide that, in the event that the prime contractor violates the contract clause—

''(i) the prime contract may be terminated for default; and

''(ii) the matter may be referred to the suspension or debarment official for the appropriate agency and may be a basis for suspension or debarment of the prime contractor.

''(b) INVERTED DOMESTIC CORPORATION.—

''(1) IN GENERAL.—For purposes of this section, a foreign incorporated entity shall be treated as an inverted domestic corporation if, pursuant to a plan (or a series of related transactions)—

''(A) the entity completes on or after May 8, 2014, the direct or indirect acquisition of—

''(i) substantially all of the properties held directly or indirectly by a domestic corporation; or

''(ii) substantially all of the assets of, or substantially all of the properties constituting a trade or business of, a domestic partnership; and

''(B) after the acquisition, either—

''(i) more than 50 percent of the stock (by vote or value) of the entity is held—

''(I) in the case of an acquisition with respect to a domestic corporation, by former shareholders of the domestic corporation by reason of holding stock in the domestic corporation; or

''(II) in the case of an acquisition with respect to a domestic partnership, by former partners of the domestic partnership by reason of holding a capital or profits interest in the domestic partnership; or

''(ii) the management and control of the expanded affiliated group which includes the entity occurs, directly or indirectly, primarily within the United States, as determined pursuant to regulations prescribed by the Secretary of the Treasury, and such expanded affiliated group has significant domestic business activities.

''(2) EXCEPTION FOR CORPORATIONS WITH SUBSTANTIAL BUSINESS ACTIVITIES IN FOREIGN COUNTRY OF ORGANIZATION.—

''(A) IN GENERAL.—A foreign incorporated entity described in paragraph (1) shall not be treated as an inverted domestic corporation if after the acquisition the expanded affiliated group which includes the entity has substantial business activities in the foreign country in which or under the law of which the entity is created or organized when compared to the total business activities of such expanded affiliated group.

''(B) SUBSTANTIAL BUSINESS ACTIVITIES.—The Secretary of the Treasury (or the Secretary's delegate) shall establish regulations for determining whether an affiliated group has substantial business activities for purposes of subparagraph (A), except that such regulations may not treat any group as having substantial business activities if such group would not be considered to have substantial business activities under the regulations prescribed under section 7874 of the Internal Revenue Code of 1986, as in effect on January 18, 2017.

''(3) SIGNIFICANT DOMESTIC BUSINESS ACTIVITIES.—

''(A) IN GENERAL.—For purposes of paragraph (1)(B)(ii), an expanded affiliated group has significant domestic business activities if at least 25 percent of—

''(i) the employees of the group are based in the United States;

''(ii) the employee compensation incurred by the group is incurred with respect to employees based in the United States;

''(iii) the assets of the group are located in the United States; or

''(iv) the income of the group is derived in the United States.

''(B) DETERMINATION.—Determinations pursuant to subparagraph (A) shall be made in the same manner as such determinations are made for purposes of determining substantial business activities under regulations referred to in paragraph (2) as in effect on January 18, 2017, but applied by treating all references in such regulations to 'foreign country' and 'relevant foreign country' as references to 'the United States'. The Secretary of the Treasury (or the Secretary's delegate) may issue regulations decreasing the threshold percent in any of the tests under such regulations for determining if business activities constitute significant domestic business activities for purposes of this paragraph.

''(c) WAIVER.—

''(1) IN GENERAL.—The head of an executive agency may waive subsection (a) with respect to any Federal Government contract under the authority of such head if the head determines that the waiver is—

''(A) required in the interest of national security; or

''(B) necessary for the efficient or effective administration of Federal or federally funded—

''(i) programs that provide health benefits to individuals; or

''(ii) public health programs.

''(2) REPORT TO CONGRESS.—The head of an executive agency issuing a waiver under paragraph (1) shall, not later than 14 days after issuing such waiver, submit a written notification of the waiver to the relevant authorizing committees of Congress and the Committees on Appropriations of the Senate and the House of Representatives.

''(d) APPLICABILITY.—

''(1) IN GENERAL.—Except as provided in paragraph (2), this section shall not apply to any contract entered into before the date of the enactment of this section.

''(2) TASK AND DELIVERY ORDERS.—This section shall apply to any task or delivery order issued after the date of the enactment of this section pursuant to a contract entered into before, on, or after such date of enactment.

''(3) SCOPE.—This section applies only to contracts subject to regulation under the Federal Acquisition Regulation.

''(e) DEFINITIONS AND SPECIAL RULES.—

''(1) DEFINITIONS.—In this section, the terms 'expanded affiliated group', 'foreign incorporated entity', 'person', 'domestic', and 'foreign' have the meaning given those terms in section 835(c) of the Homeland Security Act of 2002 (6 U.S.C. 395(c)).

''(2) SPECIAL RULES.—In applying subsection (b) of this section for purposes of subsection (a) of this section, the rules described under 835(c)(1) of the Homeland Security Act of 2002 (6 U.S.C. 395(c)(1)) shall apply.''.

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 47 of title 41, United States Code, is amended by inserting after the item relating to section 4712 the following new item:

''4713. Prohibition on awarding contracts to inverted domestic corporations.''.

(b) DEFENSE CONTRACTS.—

(1) IN GENERAL.—Chapter 137 of title 10, United States Code, is amended by adding at the end the following new section:

''§ 2340. Prohibition on awarding contracts to inverted domestic corporations

''(a) PROHIBITION.—

''(1) IN GENERAL.—The head of an agency may not award a contract for the procurement of property or services to—

''(A) any foreign incorporated entity that such head has determined is an inverted domestic corporation or any subsidiary of such entity; or

''(B) any joint venture if more than 10 percent of the joint venture (by vote or value) is owned by a foreign incorporated entity that such head has determined is an inverted domestic corporation or any subsidiary of such entity.

''(2) SUBCONTRACTS.—

''(A) IN GENERAL.—The head of an executive agency shall include in each contract for the procurement of property or services awarded by the executive agency with a value in excess of $10,000,000, other than a contract for exclusively commercial items, a clause that prohibits the prime contractor on such contract from—

''(i) awarding a first-tier subcontract with a value greater than 10 percent of the total value of the prime contract to an entity or joint venture described in paragraph (1); or

''(ii) structuring subcontract tiers in a manner designed to avoid the limitation in paragraph (1) by enabling an entity or joint venture described in paragraph (1) to perform more than 10 percent of the total value of the prime contract as a lower-tier subcontractor.

''(B) PENALTIES.—The contract clause included in contracts pursuant to subparagraph (A) shall provide that, in the event that the prime contractor violates the contract clause—

''(i) the prime contract may be terminated for default; and

''(ii) the matter may be referred to the suspension or debarment official for the appropriate agency and may be a basis for suspension or debarment of the prime contractor.

''(b) INVERTED DOMESTIC CORPORATION.—

''(1) IN GENERAL.—For purposes of this section, a foreign incorporated entity shall be treated as an inverted domestic corporation if, pursuant to a plan (or a series of related transactions)—

''(A) the entity completes on or after May 8, 2014, the direct or indirect acquisition of—

''(i) substantially all of the properties held directly or indirectly by a domestic corporation; or

''(ii) substantially all of the assets of, or substantially all of the properties constituting a trade or business of, a domestic partnership; and

''(B) after the acquisition, either—

''(i) more than 50 percent of the stock (by vote or value) of the entity is held—

''(I) in the case of an acquisition with respect to a domestic corporation, by former shareholders of the domestic corporation by reason of holding stock in the domestic corporation; or

''(II) in the case of an acquisition with respect to a domestic partnership, by former partners of the domestic partnership by reason of holding a capital or profits interest in the domestic partnership; or

''(ii) the management and control of the expanded affiliated group which includes the entity occurs, directly or indirectly, primarily within the United States, as determined pursuant to regulations prescribed by the Secretary of the Treasury, and such expanded affiliated group has significant domestic business activities.

''(2) EXCEPTION FOR CORPORATIONS WITH SUBSTANTIAL BUSINESS ACTIVITIES IN FOREIGN COUNTRY OF ORGANIZATION.—

''(A) IN GENERAL.—A foreign incorporated entity described in paragraph (1) shall not be treated as an inverted domestic corporation if after the acquisition the expanded affiliated group which includes the entity has substantial business activities in the foreign country in which or under the law of which the entity is created or organized when compared to the total business activities of such expanded affiliated group.

''(B) SUBSTANTIAL BUSINESS ACTIVITIES.—The Secretary of the Treasury (or the Secretary's delegate) shall establish regulations for determining whether an affiliated group has substantial business activities for purposes of subparagraph (A), except that such regulations may not treat any group as having substantial business activities if such group would not be considered to have substantial business activities under the regulations prescribed under section 7874 of the Internal Revenue Code of 1986, as in effect on January 18, 2017.

''(3) SIGNIFICANT DOMESTIC BUSINESS ACTIVITIES.—

''(A) IN GENERAL.—For purposes of paragraph (1)(B)(ii), an expanded affiliated group has significant domestic business activities if at least 25 percent of—

''(i) the employees of the group are based in the United States;

''(ii) the employee compensation incurred by the group is incurred with respect to employees based in the United States;

''(iii) the assets of the group are located in the United States; or

''(iv) the income of the group is derived in the United States.

''(B) DETERMINATION.—Determinations pursuant to subparagraph (A) shall be made in the same manner as such determinations are made for purposes of determining substantial business activities under regulations referred to in paragraph (2) as in effect on January 18, 2017, but applied by treating all references in such regulations to 'foreign country' and 'relevant foreign country' as references to 'the United States'. The Secretary of the Treasury (or the Secretary's delegate) may issue regulations decreasing the threshold percent in any of the tests under such regulations for determining if business activities constitute significant domestic business activities for purposes of this paragraph.

''(c) WAIVER.—

''(1) IN GENERAL.—The head of an agency may waive subsection (a) with respect to any Federal Government contract under the authority of such head if the head determines that the waiver is required in the interest of national security or is necessary for the efficient or effective administration of Federal or federally funded programs that provide health benefits to individuals.

''(2) REPORT TO CONGRESS.—The head of an agency issuing a waiver under paragraph (1) shall, not later than 14 days after issuing such waiver, submit a written notification of the waiver to the Committees on Armed Services and Appropriations of the Senate and the House of Representatives.

''(d) APPLICABILITY.—

''(1) IN GENERAL.—Except as provided in paragraph (2), this section shall not apply to any contract entered into before the date of the enactment of this section.

''(2) TASK AND DELIVERY ORDERS.—This section shall apply to any task or delivery order issued after the date of the enactment of this section pursuant to a contract entered into before, on, or after such date of enactment.

''(3) SCOPE.—This section applies only to contracts subject to regulation under the Federal Acquisition Regulation and the Defense Supplement to the Federal Acquisition Regulation.

''(e) DEFINITIONS AND SPECIAL RULES.—

''(1) DEFINITIONS.—In this section, the terms 'expanded affiliated group', 'foreign incorporated entity', 'person', 'domestic', and 'foreign' have the meaning given those terms in section 835(c) of the Homeland Security Act of 2002 (6 U.S.C. 395(c)).

''(2) SPECIAL RULES.—In applying subsection (b) of this section for purposes of subsection (a) of this section, the rules described under 835(c)(1) of the Homeland Security Act of 2002 (6 U.S.C. 395(c)(1)) shall apply.''.

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 137 of title 10, United States Code, is amended by inserting after the item relating to section 2339 the following new item:

''2340. Prohibition on awarding contracts to inverted domestic corporations.''.

(c) REGULATIONS REGARDING MANAGEMENT AND CONTROL.—

(1) IN GENERAL.—The Secretary of the Treasury (or the Secretary's delegate) shall, for purposes of section 4713(b)(1)(B)(ii) of title 41, United States Code, and section 2340(b)(1)(B)(ii) of title 10, United States Code, as added by subsections (a) and (b), respectively, prescribe regulations for purposes of determining cases in which the management and control of an expanded affiliated group is to be treated as occurring, directly or indirectly, primarily within the United States. The regulations prescribed under the preceding sentence shall apply to periods after May 8, 2014.

(2) EXECUTIVE OFFICERS AND SENIOR MANAGEMENT.—The regulations prescribed under paragraph (1) shall provide that the management and control of an expanded affiliated group shall be treated as occurring, directly or indirectly, primarily within the United States if substantially all of the executive officers and senior management of the expanded affiliated group who exercise day-to-day responsibility for making decisions involving strategic, financial, and operational policies of the expanded affiliated group are based or primarily located within the United States. Individuals who in fact exercise such day-to-day responsibilities shall be treated as executive officers and senior management regardless of their title.

By Mr. DURBIN (for himself, Ms. BALDWIN, Mr. BENNET, Mr. BLUMENTHAL, Mr. BOOKER, Mr. COONS, Ms. DUCKWORTH, Mr. FRANKEN, Mrs. GILLIBRAND, Mr. HEINRICH, Ms. HIRONO, Ms. KLOBUCHAR, Mr. LEAHY, Mr. MARKEY, Mr. MENENDEZ, Mr. MERKLEY, Mr. MURPHY, Mrs. MURRAY, Mr. PETERS, Mr. SANDERS, Mr. SCHATZ, Mrs. SHAHEEN, Mr. UDALL, Mr. VAN HOLLEN, and Ms. WARREN):

S. 1640. A bill to reform the financing of Senate elections, and for other purposes; to the Committee on Finance.

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

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

S. 1640

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Fair Elections Now Act''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—FAIR ELECTIONS FINANCING OF SENATE ELECTION CAMPAIGNS

Subtitle A—Fair Elections Financing Program

SEC. 101. FINDINGS AND DECLARATIONS.

(a) UNDERMINING OF DEMOCRACY BY CAMPAIGN CONTRIBUTIONS FROM PRIVATE SOURCES.—The Senate finds and declares that the current system of privately financed campaigns for election to the United States Senate has the capacity, and is often perceived by the public, to undermine democracy in the United States by—

(1) creating a culture that fosters actual or perceived conflicts of interest by encouraging Senators to accept large campaign contributions from private interests that are directly affected by Federal legislation;

(2) diminishing or appearing to diminish Senators' accountability to constituents by compelling legislators to be accountable to the major contributors who finance their election campaigns;

(3) undermining the meaning of the right to vote by allowing monied interests to have a disproportionate and unfair influence within the political process;

(4) imposing large, unwarranted costs on taxpayers through legislative and regulatory distortions caused by unequal access to lawmakers for campaign contributors;

(5) making it difficult for some qualified candidates to mount competitive Senate election campaigns;

(6) disadvantaging challengers and discouraging competitive elections; and

(7) burdening incumbents with a preoccupation with fundraising and thus decreasing the time available to carry out their public responsibilities.

(b) ENHANCEMENT OF DEMOCRACY BY PROVIDING ALLOCATIONS FROM THE FAIR ELECTIONS FUND.—The Senate finds and declares that providing the option of the replacement of large private campaign contributions with allocations from the Fair Elections Fund for all primary, runoff, and general elections to the Senate would enhance American democracy by—

(1) reducing the actual or perceived conflicts of interest created by fully private financing of the election campaigns of public officials and restoring public confidence in the integrity and fairness of the electoral and legislative processes through a program which allows participating candidates to adhere to substantially lower contribution limits for contributors with an assurance that there will be sufficient funds for such candidates to run viable electoral campaigns;

(2) increasing the public's confidence in the accountability of Senators to the constituents who elect them, which derives from the program's qualifying criteria to participate in the voluntary program and the conclusions that constituents may draw regarding candidates who qualify and participate in the program;

(3) helping to reduce the ability to make large campaign contributions as a determinant of a citizen's influence within the political process by facilitating the expression of support by voters at every level of wealth, encouraging political participation, and incentivizing participation on the part of Senators through the matching of small dollar contributions;

(4) potentially saving taxpayers billions of dollars that may be (or that are perceived to be) currently allocated based upon legislative and regulatory agendas skewed by the influence of campaign contributions;

(5) creating genuine opportunities for all Americans to run for the Senate and encouraging more competitive elections;

(6) encouraging participation in the electoral process by citizens of every level of wealth; and

(7) freeing Senators from the incessant preoccupation with raising money, and allowing them more time to carry out their public responsibilities.

SEC. 102. ELIGIBILITY REQUIREMENTS AND BENEFITS OF FAIR ELECTIONS FINANCING OF SENATE ELECTION CAMPAIGNS.

The Federal Election Campaign Act of 1971 (52 U.S.C. 30101 et seq.) is amended by adding at the end the following:

''TITLE V—FAIR ELECTIONS FINANCING OF SENATE ELECTION CAMPAIGNS

''Subtitle A—General Provisions

''SEC. 501. DEFINITIONS.

''In this title:

''(1) ALLOCATION FROM THE FUND.—The term 'allocation from the Fund' means an allocation of money from the Fair Elections Fund to a participating candidate pursuant to section 522.

''(2) BOARD.—The term 'Board' means the Fair Elections Oversight Board established under section 531.

''(3) FAIR ELECTIONS QUALIFYING PERIOD.—The term 'Fair Elections qualifying period' means, with respect to any candidate for Senator, the period—

''(A) beginning on the date on which the candidate files a statement of intent under section 511(a)(1); and

''(B) ending on the date that is 30 days before—

''(i) the date of the primary election; or

''(ii) in the case of a State that does not hold a primary election, the date prescribed by State law as the last day to qualify for a position on the general election ballot.

''(4) FAIR ELECTIONS START DATE.—The term 'Fair Elections start date' means, with respect to any candidate, the date that is 180 days before—

''(A) the date of the primary election; or

''(B) in the case of a State that does not hold a primary election, the date prescribed by State law as the last day to qualify for a position on the general election ballot.

''(5) FUND.—The term 'Fund' means the Fair Elections Fund established by section 502.

''(6) IMMEDIATE FAMILY.—The term 'immediate family' means, with respect to any candidate—

''(A) the candidate's spouse;

''(B) a child, stepchild, parent, grandparent, brother, half-brother, sister, or half-sister of the candidate or the candidate's spouse; and

''(C) the spouse of any person described in subparagraph (B).

''(7) MATCHING CONTRIBUTION.—The term 'matching contribution' means a matching payment provided to a participating candidate for qualified small dollar contributions, as provided under section 523.

''(8) NONPARTICIPATING CANDIDATE.—The term 'nonparticipating candidate' means a candidate for Senator who is not a participating candidate.

''(9) PARTICIPATING CANDIDATE.—The term 'participating candidate' means a candidate for Senator who is certified under section 515 as being eligible to receive an allocation from the Fund.

''(10) QUALIFYING CONTRIBUTION.—The term 'qualifying contribution' means, with respect to a candidate, a contribution that—

''(A) is in an amount that is—

''(i) not less than the greater of $5 or the amount determined by the Commission under section 531; and

''(ii) not more than the greater of $150 or the amount determined by the Commission under section 531;

''(B) is made by an individual—

''(i) who is a resident of the State in which such candidate is seeking election; and

''(ii) who is not otherwise prohibited from making a contribution under this Act;

''(C) is made during the Fair Elections qualifying period; and

''(D) meets the requirements of section 512(b).

''(11) QUALIFIED SMALL DOLLAR CONTRIBUTION.—The term 'qualified small dollar contribution' means, with respect to a candidate, any contribution (or series of contributions)—

''(A) which is not a qualifying contribution (or does not include a qualifying contribution);

''(B) which is made by an individual who is not prohibited from making a contribution under this Act; and

''(C) the aggregate amount of which does not exceed the greater of—

''(i) $150 per election; or

''(ii) the amount per election determined by the Commission under section 531.

''(12) QUALIFYING MULTICANDIDATE POLITICAL COMMITTEE CONTRIBUTION.—

''(A) IN GENERAL.—The term 'qualifying multicandidate political committee contribution' means any contribution to a candidate that is made from a qualified account of a multicandidate political committee (within the meaning of section 315(a)(2)).

''(B) QUALIFIED ACCOUNT.—For purposes of subparagraph (A), the term 'qualified account' means, with respect to a multicandidate political committee, a separate, segregated account of the committee that consists solely of contributions which meet the following requirements:

''(i) All contributions to such account are made by individuals who are not prohibited from making contributions under this Act.

''(ii) The aggregate amount of contributions from each individual to such account and all other accounts of the political committee do not exceed the amount described in paragraph (11)(C).

''SEC. 502. FAIR ELECTIONS FUND.

''(a) ESTABLISHMENT.—There is established in the Treasury a fund to be known as the 'Fair Elections Fund'.

''(b) AMOUNTS HELD BY FUND.—The Fund shall consist of the following amounts:

''(1) APPROPRIATED AMOUNTS.—

''(A) IN GENERAL.—Amounts appropriated to the Fund.

''(B) SENSE OF THE SENATE REGARDING APPROPRIATIONS.—It is the sense of the Senate that—

''(i) there should be imposed on any payment made to any person (other than a State or local government or a foreign nation) who has a contract with the Government of the United States in excess of $10,000,000 a tax equal to 0.50 percent of amount paid pursuant to each contract, except that the aggregate tax on each contract for any taxable year shall not exceed $500,000; and

''(ii) the revenue from such tax should be appropriated to the Fund.

''(2) VOLUNTARY CONTRIBUTIONS.—Voluntary contributions to the Fund.

''(3) OTHER DEPOSITS.—Amounts deposited into the Fund under—

''(A) section 513(c) (relating to exceptions to contribution requirements);

''(B) section 521(c) (relating to remittance of allocations from the Fund);

''(C) section 533 (relating to violations); and

''(D) any other section of this Act.

''(4) INVESTMENT RETURNS.—Interest on, and the proceeds from, the sale or redemption of, any obligations held by the Fund under subsection (c).

''(c) INVESTMENT.—The Commission shall invest portions of the Fund in obligations of the United States in the same manner as provided under section 9602(b) of the Internal Revenue Code of 1986.

''(d) USE OF FUND.—

''(1) IN GENERAL.—The sums in the Fund shall be used to provide benefits to participating candidates as provided in subtitle C.

''(2) INSUFFICIENT AMOUNTS.—Under regulations established by the Commission, rules similar to the rules of section 9006(c) of the Internal Revenue Code shall apply.

''Subtitle B—Eligibility and Certification

''SEC. 511. ELIGIBILITY.

''(a) IN GENERAL.—A candidate for Senator is eligible to receive an allocation from the Fund for any election if the candidate meets the following requirements:

''(1) The candidate files with the Commission a statement of intent to seek certification as a participating candidate under this title during the period beginning on the Fair Elections start date and ending on the last day of the Fair Elections qualifying period.

''(2) The candidate meets the qualifying contribution requirements of section 512.

''(3) Not later than the last day of the Fair Elections qualifying period, the candidate files with the Commission an affidavit signed by the candidate and the treasurer of the candidate's principal campaign committee declaring that the candidate—

''(A) has complied and, if certified, will comply with the contribution and expenditure requirements of section 513;

''(B) if certified, will comply with the debate requirements of section 514;

''(C) if certified, will not run as a nonparticipating candidate during such year in any election for the office that such candidate is seeking; and

''(D) has either qualified or will take steps to qualify under State law to be on the ballot.

''(b) GENERAL ELECTION.—Notwithstanding subsection (a), a candidate shall not be eligible to receive an allocation from the Fund for a general election or a general runoff election unless the candidate's party nominated the candidate to be placed on the ballot for the general election or the candidate otherwise qualified to be on the ballot under State law.

''SEC. 512. QUALIFYING CONTRIBUTION REQUIREMENT.

''(a) IN GENERAL.—A candidate for Senator meets the requirement of this section if, during the Fair Elections qualifying period, the candidate obtains—

''(1) a number of qualifying contributions equal to the greater of—

''(A) the sum of—

''(i) 2,000; plus

''(ii) 500 for each congressional district in the State with respect to which the candidate is seeking election; or

''(B) the amount determined by the Commission under section 531; and

''(2) a total dollar amount of qualifying contributions equal to the greater of—

''(A) 10 percent of the amount of the allocation such candidate would be entitled to receive for the primary election under section 522(c)(1) (determined without regard to paragraph (5) thereof) if such candidate were a participating candidate; or

''(B) the amount determined by the Commission under section 531.

''(b) REQUIREMENTS RELATING TO RECEIPT OF QUALIFYING CONTRIBUTION.—Each qualifying contribution—

''(1) may be made by means of a personal check, money order, debit card, credit card, or electronic payment account;

''(2) shall be accompanied by a signed statement containing—

''(A) the contributor's name and the contributor's address in the State in which the contributor is registered to vote; and

''(B) an oath declaring that the contributor—

''(i) understands that the purpose of the qualifying contribution is to show support for the candidate so that the candidate may qualify for Fair Elections financing;

''(ii) is making the contribution in his or her own name and from his or her own funds;

''(iii) has made the contribution willingly; and

''(iv) has not received anything of value in return for the contribution; and

''(3) shall be acknowledged by a receipt that is sent to the contributor with a copy kept by the candidate for the Commission and a copy kept by the candidate for the election authorities in the State with respect to which the candidate is seeking election.

''(c) VERIFICATION OF QUALIFYING CONTRIBUTIONS.—The Commission shall establish procedures for the auditing and verification of qualifying contributions to ensure that such contributions meet the requirements of this section.

''SEC. 513. CONTRIBUTION AND EXPENDITURE REQUIREMENTS.

''(a) GENERAL RULE.—A candidate for Senator meets the requirements of this section if, during the election cycle of the candidate, the candidate—

''(1) except as provided in subsection (b), accepts no contributions other than—

''(A) qualifying contributions;

''(B) qualified small dollar contributions;

''(C) qualifying multicandidate political committee contributions;

''(D) allocations from the Fund under section 522;

''(E) matching contributions under section 523; and

''(F) vouchers provided to the candidate under section 524;

''(2) makes no expenditures from any amounts other than from—

''(A) qualifying contributions;

''(B) qualified small dollar contributions;

''(C) qualifying multicandidate political committee contributions;

''(D) allocations from the Fund under section 522;

''(E) matching contributions under section 523; and

''(F) vouchers provided to the candidate under section 524; and

''(3) makes no expenditures from personal funds or the funds of any immediate family member (other than funds received through qualified small dollar contributions and qualifying contributions).

For purposes of this subsection, a payment made by a political party in coordination with a participating candidate shall not be treated as a contribution to or as an expenditure made by the participating candidate.

''(b) CONTRIBUTIONS FOR LEADERSHIP PACS, ETC.—A political committee of a participating candidate which is not an authorized committee of such candidate may accept contributions other than contributions described in subsection (a)(1) from any person if—

''(1) the aggregate contributions from such person for any calendar year do not exceed $150; and

''(2) no portion of such contributions is disbursed in connection with the campaign of the participating candidate.

''(c) EXCEPTION.—Notwithstanding subsection (a), a candidate shall not be treated as having failed to meet the requirements of this section if any contributions that are not qualified small dollar contributions, qualifying contributions, qualifying multicandidate political committee contributions, or contributions that meet the requirements of subsection (b) and that are accepted before the date the candidate files a statement of intent under section 511(a)(1) are—

''(1) returned to the contributor; or

''(2) submitted to the Commission for deposit in the Fund.

''SEC. 514. DEBATE REQUIREMENT.

''A candidate for Senator meets the requirements of this section if the candidate participates in at least—

''(1) 1 public debate before the primary election with other participating candidates and other willing candidates from the same party and seeking the same nomination as such candidate; and

''(2) 2 public debates before the general election with other participating candidates and other willing candidates seeking the same office as such candidate.

''SEC. 515. CERTIFICATION.

''(a) IN GENERAL.—Not later than 5 days after a candidate for Senator files an affidavit under section 511(a)(3), the Commission shall—

''(1) certify whether or not the candidate is a participating candidate; and

''(2) notify the candidate of the Commission's determination.

''(b) REVOCATION OF CERTIFICATION.—

''(1) IN GENERAL.—The Commission may revoke a certification under subsection (a) if—

''(A) a candidate fails to qualify to appear on the ballot at any time after the date of certification; or

''(B) a candidate otherwise fails to comply with the requirements of this title, including any regulatory requirements prescribed by the Commission.

''(2) REPAYMENT OF BENEFITS.—If certification is revoked under paragraph (1), the candidate shall repay to the Fund an amount equal to the value of benefits received under this title plus interest (at a rate determined by the Commission) on any such amount received.

"Subtitle C—Benefits

"SEC. 521. BENEFITS FOR PARTICIPATING CANDIDATES.

''(a) IN GENERAL.—For each election with respect to which a candidate is certified as a participating candidate, such candidate shall be entitled to—

''(1) an allocation from the Fund to make or obligate to make expenditures with respect to such election, as provided in section 522;

''(2) matching contributions, as provided in section 523; and

''(3) for the general election, vouchers for broadcasts of political advertisements, as provided in section 524.

''(b) RESTRICTION ON USES OF ALLOCATIONS FROM THE FUND.—Allocations from the Fund received by a participating candidate under section 522 and matching contributions under section 523 may only be used for campaign-related costs.

''(c) REMITTING ALLOCATIONS FROM THE FUND.—

''(1) IN GENERAL.—Not later than the date that is 45 days after an election in which the participating candidate appeared on the ballot, such participating candidate shall remit to the Commission for deposit in the Fund an amount equal to the lesser of—

''(A) the amount of money in the candidate's campaign account; or

''(B) the sum of the allocations from the Fund received by the candidate under section 522 and the matching contributions received by the candidate under section 523.

''(2) EXCEPTION.—In the case of a candidate who qualifies to be on the ballot for a primary runoff election, a general election, or a general runoff election, the amounts described in paragraph (1) may be retained by the candidate and used in such subsequent election.

"SEC. 522. ALLOCATIONS FROM THE FUND.

''(a) IN GENERAL.—The Commission shall make allocations from the Fund under section 521(a)(1) to a participating candidate—

''(1) in the case of amounts provided under subsection (c)(1), not later than 48 hours after the date on which such candidate is certified as a participating candidate under section 515;

''(2) in the case of a general election, not later than 48 hours after—

''(A) the date of the certification of the results of the primary election or the primary runoff election; or

''(B) in any case in which there is no primary election, the date the candidate qualifies to be placed on the ballot; and

''(3) in the case of a primary runoff election or a general runoff election, not later than 48 hours after the certification of the results of the primary election or the general election, as the case may be.

''(b) METHOD OF PAYMENT.—The Commission shall distribute funds available to participating candidates under this section through the use of an electronic funds exchange or a debit card.

''(c) AMOUNTS.—

''(1) PRIMARY ELECTION ALLOCATION; INITIAL ALLOCATION.—Except as provided in paragraph (5), the Commission shall make an allocation from the Fund for a primary election to a participating candidate in an amount equal to 67 percent of the base amount with respect to such participating candidate.

''(2) PRIMARY RUNOFF ELECTION ALLOCATION.—The Commission shall make an allocation from the Fund for a primary runoff election to a participating candidate in an amount equal to 25 percent of the amount the participating candidate was eligible to receive under this section for the primary election.

''(3) GENERAL ELECTION ALLOCATION.—Except as provided in paragraph (5), the Commission shall make an allocation from the Fund for a general election to a participating candidate in an amount equal to the base amount with respect to such candidate.

''(4) GENERAL RUNOFF ELECTION ALLOCATION.—The Commission shall make an allocation from the Fund for a general runoff election to a participating candidate in an amount equal to 25 percent of the base amount with respect to such candidate.

''(5) UNCONTESTED ELECTIONS.—

''(A) IN GENERAL.—In the case of a primary or general election that is an uncontested election, the Commission shall make an allocation from the Fund to a participating candidate for such election in an amount equal to 25 percent of the allocation which such candidate would be entitled to under this section for such election if this paragraph did not apply.

''(B) UNCONTESTED ELECTION DEFINED.—For purposes of this subparagraph, an election is uncontested if not more than 1 candidate has campaign funds (including payments from the Fund) in an amount equal to or greater than 10 percent of the allocation a participating candidate would be entitled to receive under this section for such election if this paragraph did not apply.

''(d) BASE AMOUNT.—

''(1) IN GENERAL.—Except as otherwise provided in this subsection, the base amount for any candidate is an amount equal to the greater of—

''(A) the sum of—

''(i) $750,000; plus

''(ii) $150,000 for each congressional district in the State with respect to which the candidate is seeking election; or

''(B) the amount determined by the Commission under section 531.

''(2) INDEXING.—In each even-numbered year after 2021—

''(A) each dollar amount under paragraph (1)(A) shall be increased by the percent difference between the price index (as defined in section 315(c)(2)(A)) for the 12 months preceding the beginning of such calendar year and the price index for calendar year 2020;

''(B) each dollar amount so increased shall remain in effect for the 2-year period beginning on the first day following the date of the last general election in the year preceding the year in which the amount is increased and ending on the date of the next general election; and

''(C) if any amount after adjustment under subparagraph (A) is not a multiple of $100, such amount shall be rounded to the nearest multiple of $100.

"SEC. 523. MATCHING PAYMENTS FOR QUALIFIED SMALL DOLLAR CONTRIBUTIONS.

''(a) IN GENERAL.—The Commission shall pay to each participating candidate an amount equal to 600 percent of the amount of qualified small dollar contributions received by the candidate from individuals who are residents of the State in which such participating candidate is seeking election after the date on which such candidate is certified under section 515.

''(b) LIMITATION.—The aggregate payments under subsection (a) with respect to any candidate shall not exceed the greater of—

''(1) 400 percent of the allocation such candidate is entitled to receive for such election under section 522 (determined without regard to subsection (c)(5) thereof); or

''(2) the percentage of such allocation determined by the Commission under section 531.

''(c) TIME OF PAYMENT.—The Commission shall make payments under this section not later than 2 business days after the receipt of a report made under subsection (d).

''(d) REPORTS.—

''(1) IN GENERAL.—Each participating candidate shall file reports of receipts of qualified small dollar contributions at such times and in such manner as the Commission may by regulations prescribe.

''(2) CONTENTS OF REPORTS.—Each report under this subsection shall disclose—

''(A) the amount of each qualified small dollar contribution received by the candidate;

''(B) the amount of each qualified small dollar contribution received by the candidate from a resident of the State in which the candidate is seeking election; and

''(C) the name, address, and occupation of each individual who made a qualified small dollar contribution to the candidate.

''(3) FREQUENCY OF REPORTS.—Reports under this subsection shall be made no more frequently than—

''(A) once every month until the date that is 90 days before the date of the election;

''(B) once every week after the period described in subparagraph (A) and until the date that is 21 days before the election; and

''(C) once every day after the period described in subparagraph (B).

''(4) LIMITATION ON REGULATIONS.—The Commission may not prescribe any regulations with respect to reporting under this subsection with respect to any election after the date that is 180 days before the date of such election.

''(e) APPEALS.—The Commission shall provide a written explanation with respect to any denial of any payment under this section and shall provide the opportunity for review and reconsideration within 5 business days of such denial.

"SEC. 524. POLITICAL ADVERTISING VOUCHERS.

''(a) IN GENERAL.—The Commission shall establish and administer a voucher program for the purchase of airtime on broadcasting stations for political advertisements in accordance with the provisions of this section.

''(b) CANDIDATES.—The Commission shall only disburse vouchers under the program established under subsection (a) to participants certified pursuant to section 515 who have agreed in writing to keep and furnish to the Commission such records, books, and other information as it may require.

''(c) AMOUNTS.—The Commission shall disburse vouchers to each candidate certified under subsection (b) in an aggregate amount equal to the greater of—

''(1) $100,000 multiplied by the number of congressional districts in the State with respect to which such candidate is running for office; or

''(2) the amount determined by the Commission under section 531.

''(d) USE.—

''(1) EXCLUSIVE USE.—Vouchers disbursed by the Commission under this section may be used only for the purchase of broadcast airtime for political advertisements relating to a general election for the office of Senate by the participating candidate to which the vouchers were disbursed, except that—

''(A) a candidate may exchange vouchers with a political party under paragraph (2); and

''(B) a political party may use vouchers only to purchase broadcast airtime for political advertisements for generic party advertising (as defined by the Commission in regulations), to support candidates for State or local office in a general election, or to support participating candidates of the party in

a general election for Federal office, but only if it discloses the value of the voucher used as an expenditure under section 315(d).

''(2) EXCHANGE WITH POLITICAL PARTY COMMITTEE.—

''(A) IN GENERAL.—A participating candidate who receives a voucher under this section may transfer the right to use all or a portion of the value of the voucher to a committee of the political party of which the individual is a candidate (or, in the case of a participating candidate who is not a member of any political party, to a committee of the political party of that candidate's choice) in exchange for money in an amount equal to the cash value of the voucher or portion exchanged.

''(B) CONTINUATION OF CANDIDATE OBLIGATIONS.—The transfer of a voucher, in whole or in part, to a political party committee under this paragraph does not release the candidate from any obligation under the agreement made under subsection (b) or otherwise modify that agreement or its application to that candidate.

''(C) PARTY COMMITTEE OBLIGATIONS.—Any political party committee to which a voucher or portion thereof is transferred under subparagraph (A)—

''(i) shall account fully, in accordance with such requirements as the Commission may establish, for the receipt of the voucher; and

''(ii) may not use the transferred voucher or portion thereof for any purpose other than a purpose described in paragraph (1)(B).

''(D) VOUCHER AS A CONTRIBUTION UNDER FECA.—If a candidate transfers a voucher or any portion thereof to a political party committee under subparagraph (A)—

''(i) the value of the voucher or portion thereof transferred shall be treated as a contribution from the candidate to the committee, and from the committee to the candidate, for purposes of sections 302 and 304;

''(ii) the committee may, in exchange, provide to the candidate only funds subject to the prohibitions, limitations, and reporting requirements of title III of this Act; and

''(iii) the amount, if identified as a 'voucher exchange', shall not be considered a contribution for the purposes of sections 315 and 513.

''(e) VALUE; ACCEPTANCE; REDEMPTION.—

''(1) VOUCHER.—Each voucher disbursed by the Commission under this section shall have a value in dollars, redeemable upon presentation to the Commission, together with such documentation and other information as the Commission may require, for the purchase of broadcast airtime for political advertisements in accordance with this section.

''(2) ACCEPTANCE.—A broadcasting station shall accept vouchers in payment for the purchase of broadcast airtime for political advertisements in accordance with this section.

''(3) REDEMPTION.—The Commission shall redeem vouchers accepted by broadcasting stations under paragraph (2) upon presentation, subject to such documentation, verification, accounting, and application requirements as the Commission may impose to ensure the accuracy and integrity of the voucher redemption system.

''(4) EXPIRATION.—

''(A) CANDIDATES.—A voucher may only be used to pay for broadcast airtime for political advertisements to be broadcast before midnight on the day before the date of the Federal election in connection with which it was issued and shall be null and void for any other use or purpose.

''(B) EXCEPTION FOR POLITICAL PARTY COMMITTEES.—A voucher held by a political party committee may be used to pay for broadcast airtime for political advertisements to be broadcast before midnight on December 31st of the odd-numbered year following the year in which the voucher was issued by the Commission.

''(5) VOUCHER AS EXPENDITURE UNDER FECA.—The use of a voucher to purchase broadcast airtime constitutes an expenditure as defined in section 301(9)(A).

''(f) DEFINITIONS.—In this section:

''(1) BROADCASTING STATION.—The term 'broadcasting station' has the meaning given that term by section 315(f)(1) of the Communications Act of 1934.

''(2) POLITICAL PARTY.—The term 'political party' means a major party or a minor party as defined in section 9002 (3) or (4) of the Internal Revenue Code of 1986 (26 U.S.C. 9002 (3) or (4)).

''Subtitle D—Administrative Provisions

''SEC. 531. FAIR ELECTIONS OVERSIGHT BOARD.

''(a) ESTABLISHMENT.—There is established within the Federal Election Commission an entity to be known as the 'Fair Elections Oversight Board'.

''(b) STRUCTURE AND MEMBERSHIP.—

''(1) IN GENERAL.—The Board shall be composed of 5 members appointed by the President by and with the advice and consent of the Senate, of whom—

''(A) 2 shall be appointed after consultation with the majority leader of the Senate;

''(B) 2 shall be appointed after consultation with the minority leader of the Senate; and

''(C) 1 shall be appointed upon the recommendation of the members appointed under subparagraphs (A) and (B).

''(2) QUALIFICATIONS.—

''(A) IN GENERAL.—The members shall be individuals who are nonpartisan and, by reason of their education, experience, and attainments, exceptionally qualified to perform the duties of members of the Board.

''(B) PROHIBITION.—No member of the Board may be—

''(i) an employee of the Federal Government;

''(ii) a registered lobbyist; or

''(iii) an officer or employee of a political party or political campaign.

''(3) DATE.—Members of the Board shall be appointed not later than 60 days after the date of the enactment of this Act.

''(4) TERMS.—A member of the Board shall be appointed for a term of 5 years.

''(5) VACANCIES.—A vacancy on the Board shall be filled not later than 30 calendar days after the date on which the Board is given notice of the vacancy, in the same manner as the original appointment. The individual appointed to fill the vacancy shall serve only for the unexpired portion of the term for which the individual's predecessor was appointed.

''(6) CHAIRPERSON.—The Board shall designate a Chairperson from among the members of the Board.

''(c) DUTIES AND POWERS.—

''(1) ADMINISTRATION.—

''(A) IN GENERAL.—The Board shall have such duties and powers as the Commission may prescribe, including the power to administer the provisions of this title.

''(2) REVIEW OF FAIR ELECTIONS FINANCING.—

''(A) IN GENERAL.—After each general election for Federal office, the Board shall conduct a comprehensive review of the Fair Elections financing program under this title, including—

''(i) the maximum dollar amount of qualified small dollar contributions under section 501(11);

''(ii) the maximum and minimum dollar amounts for qualifying contributions under section 501(10);

''(iii) the number and value of qualifying contributions a candidate is required to obtain under section 512 to qualify for allocations from the Fund;

''(iv) the amount of allocations from the Fund that candidates may receive under section 522;

''(v) the maximum amount of matching contributions a candidate may receive under section 523;

''(vi) the amount and usage of vouchers under section 524;

''(vii) the overall satisfaction of participating candidates and the American public with the program; and

''(viii) such other matters relating to financing of Senate campaigns as the Board determines are appropriate.

''(B) CRITERIA FOR REVIEW.—In conducting the review under subparagraph (A), the Board shall consider the following:

''(i) QUALIFYING CONTRIBUTIONS AND QUALIFIED SMALL DOLLAR CONTRIBUTIONS.—The Board shall consider whether the number and dollar amount of qualifying contributions required and maximum dollar amount for such qualifying contributions and qualified small dollar contributions strikes a balance regarding the importance of voter involvement, the need to assure adequate incentives for participating, and fiscal responsibility, taking into consideration the number of primary and general election participating candidates, the electoral performance of those candidates, program cost, and any other information the Board determines is appropriate.

''(ii) REVIEW OF PROGRAM BENEFITS.—The Board shall consider whether the totality of the amount of funds allowed to be raised by participating candidates (including through qualifying contributions and small dollar contributions), allocations from the Fund under section 522, matching contributions under section 523, and vouchers under section 524 are sufficient for voters in each State to learn about the candidates to cast an informed vote, taking into account the historic amount of spending by winning candidates, media costs, primary election dates, and any other information the Board determines is appropriate.

''(C) ADJUSTMENT OF AMOUNTS.—

''(i) IN GENERAL.—Based on the review conducted under subparagraph (A), the Board shall provide for the adjustments of the following amounts:

''(I) the maximum dollar amount of qualified small dollar contributions under section 501(11)(C);

''(II) the maximum and minimum dollar amounts for qualifying contributions under section 501(10)(A);

''(III) the number and value of qualifying contributions a candidate is required to obtain under section 512(a)(1);

''(IV) the base amount for candidates under section 522(d);

''(V) the maximum amount of matching contributions a candidate may receive under section 523(b); and

''(VI) the dollar amount for vouchers under section 524(c).

''(ii) REGULATIONS.—The Commission shall promulgate regulations providing for the adjustments made by the Board under clause (i).

''(D) REPORT.—Not later than March 30 following any general election for Federal office, the Board shall submit a report to Congress on the review conducted under paragraph (1). Such report shall contain a detailed statement of the findings, conclusions, and recommendations of the Board based on such review.

''(d) MEETINGS AND HEARINGS.—

''(1) MEETINGS.—The Board may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Board considers advisable to carry out the purposes of this Act.

''(2) QUORUM.—Three members of the Board shall constitute a quorum for purposes of voting, but a quorum is not required for members to meet and hold hearings.

''(e) REPORTS.—Not later than March 30, 2019, and every 2 years thereafter, the Board shall submit to the Senate Committee on Rules and Administration a report documenting, evaluating, and making recommendations relating to the administrative implementation and enforcement of the provisions of this title.

''(f) ADMINISTRATION.—

''(1) COMPENSATION OF MEMBERS.—

''(A) IN GENERAL.—Each member, other than the Chairperson, shall be paid at a rate equal to the daily equivalent of the minimum annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(B) CHAIRPERSON.—The Chairperson shall be paid at a rate equal to the daily equivalent of the minimum annual rate of basic pay prescribed for level III of the Executive Schedule under section 5314 of title 5, United States Code.

''(2) PERSONNEL.—

''(A) DIRECTOR.—The Board shall have a staff headed by an Executive Director. The Executive Director shall be paid at a rate equivalent to a rate established for the Senior Executive Service under section 5382 of title 5, United States Code.

''(B) STAFF APPOINTMENT.—With the approval of the Chairperson, the Executive Director may appoint such personnel as the Executive Director and the Board determines to be appropriate.

''(C) ACTUARIAL EXPERTS AND CONSULTANTS.—With the approval of the Chairperson, the Executive Director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

''(D) DETAIL OF GOVERNMENT EMPLOYEES.—Upon the request of the Chairperson, the head of any Federal agency may detail, without reimbursement, any of the personnel of such agency to the Board to assist in carrying out the duties of the Board. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the Federal employee.

''(E) OTHER RESOURCES.—The Board shall have reasonable access to materials, resources, statistical data, and other information from the Library of Congress and other agencies of the executive and legislative branches of the Federal Government. The Chairperson of the Board shall make requests for such access in writing when necessary.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out the purposes of this subtitle.

''SEC. 532. ADMINISTRATION PROVISIONS.

''The Commission shall prescribe regulations to carry out the purposes of this title, including regulations—

''(1) to establish procedures for—

''(A) verifying the amount of valid qualifying contributions with respect to a candidate;

''(B) effectively and efficiently monitoring and enforcing the limits on the raising of qualified small dollar contributions;

''(C) monitoring the raising of qualifying multicandidate political committee contributions through effectively and efficiently monitoring and enforcing the limits on individual contributions to qualified accounts of multicandidate political committees;

''(D) effectively and efficiently monitoring and enforcing the limits on the use of personal funds by participating candidates;

''(E) monitoring the use of allocations from the Fund and matching contributions under this title through audits or other mechanisms; and

''(F) the administration of the voucher program under section 524; and

''(2) regarding the conduct of debates in a manner consistent with the best practices of States that provide public financing for elections.

''SEC. 533. VIOLATIONS AND PENALTIES.

''(a) CIVIL PENALTY FOR VIOLATION OF CONTRIBUTION AND EXPENDITURE REQUIREMENTS.—If a candidate who has been certified as a participating candidate under section 515(a) accepts a contribution or makes an expenditure that is prohibited under section 513, the Commission shall assess a civil penalty against the candidate in an amount that is not more than 3 times the amount of the contribution or expenditure. Any amounts collected under this subsection shall be deposited into the Fund.

''(b) REPAYMENT FOR IMPROPER USE OF FAIR ELECTIONS FUND.—

''(1) IN GENERAL.—If the Commission determines that any benefit made available to a participating candidate under this title was not used as provided for in this title or that a participating candidate has violated any of the dates for remission of funds contained in this title, the Commission shall so notify the candidate and the candidate shall pay to the Fund an amount equal to—

''(A) the amount of benefits so used or not remitted, as appropriate; and

''(B) interest on any such amounts (at a rate determined by the Commission).

''(2) OTHER ACTION NOT PRECLUDED.—Any action by the Commission in accordance with this subsection shall not preclude enforcement proceedings by the Commission in accordance with section 309(a), including a referral by the Commission to the Attorney General in the case of an apparent knowing and willful violation of this title.''.

SEC. 103. PROHIBITION ON JOINT FUNDRAISING COMMITTEES.

Section 302(e) of the Federal Election Campaign Act of 1971 (52 U.S.C. 30102(e)) is amended by adding at the end the following new paragraph:

''(6) No authorized committee of a participating candidate (as defined in section 501) may establish a joint fundraising committee with a political committee other than an authorized committee of a candidate.''.

SEC. 104. EXCEPTION TO LIMITATION ON COORDINATED EXPENDITURES BY POLITICAL PARTY COMMITTEES WITH PARTICIPATING CANDIDATES.

Section 315(d) of the Federal Election Campaign Act of 1971 (52 U.S.C. 30116(d)) is amended—

(1) in paragraph (3)(A), by striking ''in the case of'' and inserting ''except as provided in paragraph (5), in the case of''; and

(2) by adding at the end the following new paragraph:

''(6)(A) The limitation under paragraph (3)(A) shall not apply with respect to any expenditure from a qualified political party-participating candidate coordinated expenditure fund.

''(B) In this paragraph, the term 'qualified political party-participating candidate coordinated expenditure fund' means a fund established by the national committee of a political party, or a State committee of a political party, including any subordinate committee of a State committee, for purposes of making expenditures in connection with the general election campaign of a candidate for election to the office of Senator who is a participating candidate (as defined in section 501), that only accepts qualified coordinated expenditure contributions.

''(C) In this paragraph, the term 'qualified coordinated expenditure contribution' means, with respect to the general election campaign of a candidate for election to the office of Senator who is a participating candidate (as defined in section 501), any contribution (or series of contributions)—

''(i) which is made by an individual who is not prohibited from making a contribution under this Act; and

''(ii) the aggregate amount of which does not exceed $500 per election.''.

TITLE II—IMPROVING VOTER INFORMATION

SEC. 201. BROADCASTS RELATING TO ALL SENATE CANDIDATES.

(a) LOWEST UNIT CHARGE; NATIONAL COMMITTEES.—Section 315(b)(1) of the Communications Act of 1934 (47 U.S.C. 315(b)(1)) is amended—

(1) in the matter preceding subparagraph (A), by striking ''to such office'' and inserting the following: ''to such office, or by a national committee of a political party on behalf of such candidate in connection with such campaign,''; and

(2) in subparagraph (A), by inserting ''for preemptible use thereof'' after ''station''.

(b) PREEMPTION; AUDITS.—Section 315 of the Communications Act of 1934 (47 U.S.C. 315) is amended—

(1) by redesignating subsections (c) and (d) as subsections (f) and (g), respectively and moving them to follow the existing subsection (e);

(2) by redesignating the existing subsection (e) as subsection (c); and

(3) by inserting after subsection (c) (as redesignated by paragraph (2)) the following:

''(d) PREEMPTION.—

''(1) IN GENERAL.—Except as provided in paragraph (2), and notwithstanding the requirements of subsection (b)(1)(A), a licensee shall not preempt the use of a broadcasting station by a legally qualified candidate for Senate who has purchased and paid for such use.

''(2) CIRCUMSTANCES BEYOND CONTROL OF LICENSEE.—If a program to be broadcast by a broadcasting station is preempted because of circumstances beyond the control of the station, any candidate or party advertising spot scheduled to be broadcast during that program shall be treated in the same fashion as a comparable commercial advertising spot.

''(e) AUDITS.—During the 30-day period preceding a primary or primary runoff election and the 60-day period preceding a general or special election, the Commission shall conduct such audits as it deems necessary to ensure that each licensee to which this section applies is allocating television broadcast advertising time in accordance with this section and section 312.''.

(c) REVOCATION OF LICENSE FOR FAILURE TO PERMIT ACCESS.—Section 312(a)(7) of the Communications Act of 1934 (47 U.S.C. 312(a)(7)) is amended—

(1) by striking ''or repeated'';

(2) by inserting ''or cable system'' after ''broadcasting station''; and

(3) by striking ''his candidacy'' and inserting ''the candidacy of the candidate, under the same terms, conditions, and business practices as apply to the most favored advertiser of the licensee''.

(d) TECHNICAL AND CONFORMING AMENDMENTS.—Section 315 of the Communications Act of 1934 (47 U.S.C. 315) is amended—

(1) in subsection (f), as redesignated by subsection (b)(1)—

(A) in the matter preceding paragraph (1), by striking ''For purposes of this section—'' and inserting the following: ''DEFINITIONS.—For purposes of this section:'';

(B) in paragraph (1)—

(i) by striking ''the term'' and inserting ''BROADCASTING STATION.—The term''; and

(ii) by striking ''; and'' and inserting a period; and

(C) in paragraph (2), by striking ''the terms'' and inserting ''LICENSEE; STATION LICENSEE.—The terms''; and

(2) in subsection (g), as redesignated by subsection (b)(1), by striking ''The Commission'' and inserting ''REGULATIONS.—The Commission''.

SEC. 202. BROADCAST RATES FOR PARTICIPATING CANDIDATES.

Section 315(b) of the Communications Act of 1934 (47 U.S.C. 315(b)), as amended by section 201, is amended—

(1) in paragraph (1)(A), by striking ''paragraph (2)'' and inserting ''paragraphs (2) and (3)''; and

(2) by adding at the end the following:

''(3) PARTICIPATING CANDIDATES.—In the case of a participating candidate (as defined in section 501(9) of the Federal Election Campaign Act of 1971), the charges made for the use of any broadcasting station for a television broadcast shall not exceed 80 percent of the lowest charge described in paragraph (1)(A) during—

''(A) the 45 days preceding the date of a primary or primary runoff election in which the candidate is opposed; and

''(B) the 60 days preceding the date of a general or special election in which the candidate is opposed.

''(4) RATE CARDS.—A licensee shall provide to a candidate for Senate a rate card that discloses—

''(A) the rate charged under this subsection; and

''(B) the method that the licensee uses to determine the rate charged under this subsection.''.

SEC. 203. FCC TO PRESCRIBE STANDARDIZED FORM FOR REPORTING CANDIDATE CAMPAIGN ADS.

(a) IN GENERAL.—Not later than 90 days after the date of enactment of this Act, the Federal Communications Commission shall initiate a rulemaking proceeding to establish a standardized form to be used by each broadcasting station, as defined in section 315(f) of the Communications Act of 1934 (47 U.S.C. 315(f)) (as redesignated by section 201(b)(1)), to record and report the purchase of advertising time by or on behalf of a candidate for nomination for election, or for election, to Federal elective office.

(b) CONTENTS.—The form prescribed by the Federal Communications Commission under subsection (a) shall require a broadcasting station to report to the Federal Communications Commission and to the Federal Election Commission, at a minimum—

(1) the station call letters and mailing address;

(2) the name and telephone number of the station's sales manager (or individual with responsibility for advertising sales);

(3) the name of the candidate who purchased the advertising time, or on whose behalf the advertising time was purchased, and the Federal elective office for which he or she is a candidate;

(4) the name, mailing address, and telephone number of the person responsible for purchasing broadcast political advertising for the candidate;

(5) notation as to whether the purchase agreement for which the information is being reported is a draft or final version; and

(6) with respect to the advertisement—

(A) the date and time of the broadcast;

(B) the program in which the advertisement was broadcast; and

(C) the length of the broadcast airtime.

(c) INTERNET ACCESS.—In its rulemaking under subsection (a), the Federal Communications Commission shall require any broadcasting station required to file a report under this section that maintains an Internet website to make available a link to each such report on that website.

TITLE III—RESPONSIBILITIES OF THE FEDERAL ELECTION COMMISSION

SEC. 301. PETITION FOR CERTIORARI.

Section 307(a)(6) of the Federal Election Campaign Act of 1971 (52 U.S.C. 30107(a)(6)) is amended by inserting ''(including a proceeding before the Supreme Court on certiorari)'' after ''appeal''.

SEC. 302. FILING BY SENATE CANDIDATES WITH COMMISSION.

Section 302(g) of the Federal Election Campaign Act of 1971 (52 U.S.C. 30102(g)) is amended to read as follows:

''(g) FILING WITH THE COMMISSION.—All designations, statements, and reports required to be filed under this Act shall be filed with the Commission.''.

SEC. 303. ELECTRONIC FILING OF FEC REPORTS.

Section 304(a)(11) of the Federal Election Campaign Act of 1971 (52 U.S.C. 30104(a)(11)) is amended—

(1) in subparagraph (A), by striking ''under this Act—'' and all that follows and inserting ''under this Act shall be required to maintain and file such designation, statement, or report in electronic form accessible by computers.'';

(2) in subparagraph (B), by striking ''48 hours'' and all that follows through ''filed electronically)'' and inserting ''24 hours''; and

(3) by striking subparagraph (D).

TITLE IV—PARTICIPATION IN FUNDING OF ELECTIONS

SEC. 401. REFUNDABLE TAX CREDIT FOR SENATE CAMPAIGN CONTRIBUTIONS.

(a) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by inserting after section 36B the following new section:

''SEC. 36C. CREDIT FOR SENATE CAMPAIGN CONTRIBUTIONS.

''(a) IN GENERAL.—In the case of an individual, there shall be allowed as a credit against the tax imposed by this subtitle an amount equal to 50 percent of the qualified My Voice Federal Senate campaign contributions paid or incurred by the taxpayer during the taxable year.

''(b) LIMITATIONS.—

''(1) DOLLAR LIMITATION.—The amount of qualified My Voice Federal Senate campaign contributions taken into account under subsection (a) for the taxable year shall not exceed $50 (twice such amount in the case of a joint return).

''(2) LIMITATION ON CONTRIBUTIONS TO FEDERAL SENATE CANDIDATES.—No credit shall be allowed under this section to any taxpayer for any taxable year if such taxpayer made aggregate contributions in excess of $300 during the taxable year to—

''(A) any single Federal Senate candidate, or

''(B) any political committee established and maintained by a national political party.

''(3) PROVISION OF INFORMATION.—No credit shall be allowed under this section to any taxpayer unless the taxpayer provides the Secretary with such information as the Secretary may require to verify the taxpayer's eligibility for the credit and the amount of the credit for the taxpayer.

''(c) QUALIFIED MY VOICE FEDERAL SENATE CONTRIBUTIONS.—For purposes of this section, the term 'My Voice Federal Senate campaign contribution' means any contribution of cash by an individual to a Federal Senate candidate or to a political committee established and maintained by a national political party if such contribution is not prohibited under the Federal Election Campaign Act of 1971.

''(d) FEDERAL SENATE CANDIDATE.—For purposes of this section—

''(1) IN GENERAL.—The term 'Federal Senate candidate' means any candidate for election to the office of Senator.

''(2) TREATMENT OF AUTHORIZED COMMITTEES.—Any contribution made to an authorized committee of a Federal Senate candidate shall be treated as made to such candidate.

''(e) INFLATION ADJUSTMENT.—

''(1) IN GENERAL.—In the case of a taxable year beginning after 2019, the $50 amount under subsection (b)(1) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2018' for 'calendar year 1992' in subparagraph (B) thereof.

''(2) ROUNDING.—If any amount as adjusted under subparagraph (A) is not a multiple of $5, such amount shall be rounded to the nearest multiple of $5.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 6211(b)(4)(A) of such Code is amended by inserting ''36C,'' after ''36B,''.

(2) Section 1324(b)(2) of title 31, United States Code, is amended by inserting ''36C,'' after ''36B,''.

(3) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 36B the following new item:

''Sec. 36C. Credit for Senate campaign contributions.''.

(c) FORMS.—The Secretary of the Treasury, or his designee, shall ensure that the credit for contributions to Federal Senate candidates allowed under section 36C of the Internal Revenue Code of 1986, as added by this section, may be claimed on Forms 1040EZ and 1040A.

(d) ADMINISTRATION.—At the request of the Secretary of the Treasury, the Federal Election Commission shall provide the Secretary of the Treasury with such information and other assistance as the Secretary may reasonably require to administer the credit allowed under section 36C of the Internal Revenue Code of 1986, as added by this section.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2018.

TITLE V—REVENUE PROVISIONS

SEC. 501. FAIR ELECTIONS FUND REVENUE.

(a) IN GENERAL.—The Internal Revenue Code of 1986 is amended by inserting after chapter 36 the following new chapter:

''CHAPTER 37—TAX ON PAYMENTS PURSUANT TO CERTAIN GOVERNMENT CONTRACTS

''Sec. 4501. Imposition of tax.

''SEC. 4501. IMPOSITION OF TAX.

''(a) TAX IMPOSED.—There is hereby imposed on any payment made to a qualified person pursuant to a contract with the Government of the United States a tax equal to 0.50 percent of the amount paid.

''(b) LIMITATION.—The aggregate amount of tax imposed per contract under subsection (a) for any calendar year shall not exceed $500,000.

''(c) QUALIFIED PERSON.—For purposes of this section, the term 'qualified person' means any person which—

''(1) is not a State or local government, a foreign nation, or an organization described in section 501(c)(3) which is exempt from taxation under section 501(a), and

''(2) has a contract with the Government of the United States with a value in excess of $10,000,000.

''(d) PAYMENT OF TAX.—The tax imposed by this section shall be paid by the person receiving such payment.

''(e) USE OF REVENUE GENERATED BY TAX.—It is the sense of the Senate that amounts equivalent to the revenue generated by the tax imposed under this chapter should be appropriated for the financing of a Fair Elections Fund and used for the public financing of Senate elections.''.

(b) CONFORMING AMENDMENT.—The table of chapters of the Internal Revenue Code of 1986 is amended by inserting after the item relating to chapter 36 the following:

''CHAPTER 37—TAX ON PAYMENTS PURSUANT TO CERTAIN GOVERNMENT CONTRACTS''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to contracts entered into after the date of the enactment of this Act.

TITLE VI—MISCELLANEOUS PROVISIONS

SEC. 601. SEVERABILITY.

If any provision of this Act or amendment made by this Act, or the application of a provision or amendment to any person or circumstance, is held to be unconstitutional, the remainder of this Act and amendments made by this Act, and the application of the provisions and amendment to any person or circumstance, shall not be affected by the holding.

SEC. 602. EFFECTIVE DATE.

Except as otherwise provided for in this Act, this Act and the amendments made by this Act shall take effect on January 1, 2019.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 232—SUPPORTING THE INCLUSION AND MEANINGFUL ENGAGEMENT OF LATINOS IN ENVIRONMENTAL PROTECTION AND CONSERVATION EFFORTS

Mr. BENNET (for himself, Mr. HELLER, Mr. MENENDEZ, Mr. UDALL, Mr. COONS, Mrs. FEINSTEIN, Mr. CARDIN, Mr. PETERS, Mr. VAN HOLLEN, Ms. HARRIS, Mr. HEINRICH, Mr. MERKLEY, Mr. FRANKEN, Mr. CARPER, Ms. STABENOW, Ms. CANTWELL, Mrs. MURRAY, and Ms. CORTEZ MASTO) submitted the following resolution; which was referred to the Committee on Energy and Natural Resources:

S. RES. 232

Whereas Latinos are the largest ethnic group in the United States, with more than 56,600,000 Latinos making up 17.6 percent of the population of the United States;

Whereas the Latino community is projected to grow to nearly ¼ of the population of the United States by 2050;

Whereas Latinos should have greater representation in the decisionmaking process relating to, and management of, public land;

Whereas Latino conservation initiatives break down barriers, improve access to public land, and encourage outreach to, and new opportunities for, the Latino community to use public land;

Whereas Latino conservation efforts can range from outdoor activities, such as hiking and kayaking, to educational activities and community gatherings;

Whereas increased access to outdoor recreation opportunities encourages Latino families and youth to engage with the outdoors and demonstrate the commitment of the Latino families and youth to conservation;

Whereas each person should have the opportunity to discover his or her history, culture, and heritage by exploring and experiencing the public land of the United States;

Whereas access to green spaces provides for healthier and more active lifestyles, which helps address numerous health disparity issues facing the Latino community, such as diabetes, obesity, and cardiovascular disease;

Whereas the participation of Latinos in conservation efforts can encourage the interest and involvement of Latinos in careers in conservation;

Whereas the people of the United States must ensure that the public land and natural surroundings of the United States are protected for future generations; and

Whereas the members of the largest ethnic group in the United States, as the environmental stewards of tomorrow, will play a significant role in securing the future success and preservation of the public land of the United States, especially as that group continues to grow: Now, therefore, be it

Resolved, That the Senate—

(1) recognizes the role of Latinos in protecting and preserving the land, water, and wildlife of the United States;

(2) supports the inclusion and meaningful engagement of Latinos in environmental protection and conservation efforts; and

(3) encourages Latinos in the United States to participate in ceremonies, activities, and programs that engage the community in the outdoors and bring awareness to the importance of conservation.

SENATE RESOLUTION 233—DESIGNATING AUGUST 16, 2017, AS ''NATIONAL AIRBORNE DAY''

Mr. REED (for himself, Ms. MURKOWSKI, Mr. BLUMENTHAL, Mr. VAN HOLLEN, Mrs. SHAHEEN, Mr. PETERS, and Mr. TESTER) submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 233

Whereas the members of the airborne forces of the Armed Forces of the United States have a long and honorable history as bold and fierce warriors who, for the national security of the United States and the defense of freedom and peace, project the ground combat power of the United States by air transport to the far reaches of the battle area and to the far corners of the world;

Whereas, on June 25, 1940, experiments with airborne operations by the United States began when the Army Parachute Test Platoon was first authorized by the Department of War;

Whereas, in July 1940, 48 volunteers began training for the Army Parachute Test Platoon;

Whereas August 16 marks the anniversary of the first official Army parachute jump, which took place on August 16, 1940, to test the innovative concept of inserting United States ground combat forces behind a battle line by means of a parachute;

Whereas the success of the Army Parachute Test Platoon in the days immediately before the entry of the United States into World War II validated the airborne operational concept and led to the creation of a formidable force of airborne formations that included the 11th, 13th, 17th, 82nd, and 101st Airborne Divisions;

Whereas, included in those divisions, and among other separate formations, were many airborne combat, combat support, and combat service support units that served with distinction and achieved repeated success in armed hostilities during World War II;

Whereas the achievements of the airborne units during World War II prompted the evolution of those units into a diversified force of parachute and air-assault units that, over the years, have fought in Korea, Vietnam, Grenada, Panama, the Persian Gulf region, and Somalia, and have engaged in peacekeeping operations in Lebanon, the Sinai Peninsula, the Dominican Republic, Haiti, Bosnia, and Kosovo;

Whereas, since the terrorist attacks of September 11, 2001, the members of the United States airborne forces, including members of the XVIII Airborne Corps, the 82nd Airborne Division, the 101st Airborne Division, the 173rd Airborne Brigade Combat Team, the 4th Brigade Combat Team (Airborne) of the 25th Infantry Division, the 75th Ranger Regiment, special operations forces of the Army, Marine Corps, Navy, and Air Force, and other units of the Armed Forces, have demonstrated bravery and honor in combat, stability, and training operations in Afghanistan and Iraq;

Whereas the modern-day airborne forces also include other elite forces composed of airborne trained and qualified special operations warriors, including Army Special Forces, Marine Corps Reconnaissance units, Navy SEALs, and Air Force combat control and pararescue teams;

Whereas, of the members and former members of the United States airborne forces, thousands have achieved the distinction of making combat jumps, dozens have earned the Medal of Honor, and hundreds have earned the Distinguished Service Cross, the Silver Star, or other decorations and awards for displays of heroism, gallantry, intrepidity, and valor;

Whereas the members and former members of the United States airborne forces are all members of a proud and honorable tradition that, together with the special skills and achievements of those members, distinguishes the members as intrepid combat parachutists, air assault forces, special operation forces, and, in the past, glider troops;

Whereas individuals from every State of the United States have served gallantly in the airborne forces, and each State is proud of the contributions of its paratrooper veterans during the many conflicts faced by the United States;

Whereas the history and achievements of the members and former members of the United States airborne forces warrant special expressions of the gratitude of the people of the United States; and

Whereas, since the airborne forces, past and present, celebrate August 16 as the anniversary of the first official jump by the Army Parachute Test Platoon, August 16 is an appropriate day to recognize as National Airborne Day: Now, therefore, be it

Resolved, That the Senate—

(1) designates August 16, 2017, as ''National Airborne Day''; and

(2) calls on the people of the United States to observe National Airborne Day with appropriate programs, ceremonies, and activities.

AMENDMENTS SUBMITTED AND PROPOSED

SA 281. Mr. PAUL submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table.

SA 282. Mr. ROUNDS submitted an amendment intended to be proposed by him to the bill H.R. 2810, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and

for other purposes; which was ordered to lie on the table.

SA 283. Mr. ROUNDS submitted an amendment intended to be proposed by him to the bill H.R. 2810, supra; which was ordered to lie on the table.

SA 284. Mr. KENNEDY submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table.

SA 285. Mr. KENNEDY submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 286. Mr. KENNEDY submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 287. Mr. KENNEDY submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 288. Mr. ENZI (for Mr. HELLER) proposed an amendment to amendment SA 267 by Mr. MCCONNELL to the bill H.R. 1628, supra.

SA 289. Mr. DAINES submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 290. Ms. WARREN (for herself, Mr. MARKEY, Mr. CARPER, Mr. DURBIN, Ms. STABENOW, Ms. HIRONO, Mr. VAN HOLLEN, and Mr. BROWN) submitted an amendment intended to be proposed by her to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 291. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 292. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 293. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 294. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 295. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 296. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 297. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 298. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 299. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 300. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 301. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 302. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 303. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 304. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 305. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 306. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 307. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 308. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 309. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 310. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 311. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 312. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 313. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 314. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 315. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 316. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 317. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 318. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 319. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 320. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 321. Mr. NELSON submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 322. Mr. HEINRICH (for himself, Mr. UDALL, and Mr. BLUMENTHAL) submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 323. Mr. HEINRICH (for himself and Mr. UDALL) submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 324. Mr. HEINRICH (for himself and Mr. UDALL) submitted an amendment intended to be proposed by him to the bill H.R. 2810, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table.

SA 325. Mr. HEINRICH (for himself and Mr. UDALL) submitted an amendment intended to be proposed by him to the bill H.R. 2810, supra; which was ordered to lie on the table.

SA 326. Mr. LANKFORD (for himself, Mr. CRUZ, Mrs. FISCHER, and Mr. INHOFE) submitted an amendment intended to be proposed by him to the bill H.R. 2810, supra; which was ordered to lie on the table.

SA 327. Mrs. SHAHEEN (for herself and Mr. SASSE) submitted an amendment intended to be proposed by her to the bill H.R. 2810, supra; which was ordered to lie on the table.

SA 328. Mrs. SHAHEEN submitted an amendment intended to be proposed by her to the bill H.R. 2810, supra; which was ordered to lie on the table.

SA 329. Ms. BALDWIN (for herself, Mr. REED, Mr. KAINE, and Ms. WARREN) submitted an amendment intended to be proposed by her to the bill H.R. 2810, supra; which was ordered to lie on the table.

SA 330. Mr. TILLIS submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table.

SA 331. Mr. COONS (for himself and Mr. BLUMENTHAL) submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 332. Mr. COONS (for himself and Mr. BLUMENTHAL) submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 333. Mr. COONS (for himself, Mr. DURBIN, and Mr. BLUMENTHAL) submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 334. Mr. COONS (for himself and Mr. BLUMENTHAL) submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 335. Mr. KING (for himself, Mr. BLUMENTHAL, Mr. CASEY, Mrs. SHAHEEN, and Mr. COONS) submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 336. Mr. KING (for himself, Mr. BLUMENTHAL, and Mrs. SHAHEEN) submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 337. Mr. KING (for himself, Mr. BLUMENTHAL, and Mrs. SHAHEEN) submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 338. Mr. KING (for himself, Mr. BLUMENTHAL, and Mrs. SHAHEEN) submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 339. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 340. Mr. MCCONNELL (for Mr. DAINES) proposed an amendment to amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, supra.

SA 341. Mr. UDALL (for himself, Ms. CANTWELL, Ms. CORTEZ MASTO, Ms. HEITKAMP, Mr. FRANKEN, Mrs. MURRAY, Mr. SCHATZ, Ms. STABENOW, Mr. TESTER, and Mr. MERKLEY) submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 342. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 343. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 344. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 345. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 346. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 347. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 348. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 349. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 350. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 351. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 352. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 353. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 354. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 355. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 356. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 357. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 358. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 359. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 360. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 361. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 362. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 363. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 364. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 365. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 366. Mr. KAINE (for himself, Mr. BLUMENTHAL, Mr. CARPER, and Mrs. SHAHEEN) submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 367. Ms. DUCKWORTH submitted an amendment intended to be proposed by her to the bill H.R. 2810, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table.

SA 368. Ms. DUCKWORTH submitted an amendment intended to be proposed by her to the bill H.R. 2810, supra; which was ordered to lie on the table.

SA 369. Ms. DUCKWORTH submitted an amendment intended to be proposed by her to the bill H.R. 2810, supra; which was ordered to lie on the table.

SA 370. Ms. DUCKWORTH submitted an amendment intended to be proposed by her to the bill H.R. 2810, supra; which was ordered to lie on the table.

SA 371. Ms. DUCKWORTH submitted an amendment intended to be proposed by her to the bill H.R. 2810, supra; which was ordered to lie on the table.

SA 372. Ms. DUCKWORTH submitted an amendment intended to be proposed by her to the bill H.R. 2810, supra; which was ordered to lie on the table.

SA 373. Ms. DUCKWORTH submitted an amendment intended to be proposed by her to the bill H.R. 2810, supra; which was ordered to lie on the table.

SA 374. Ms. DUCKWORTH submitted an amendment intended to be proposed by her to the bill H.R. 2810, supra; which was ordered to lie on the table.

SA 375. Ms. DUCKWORTH submitted an amendment intended to be proposed by her to the bill H.R. 2810, supra; which was ordered to lie on the table.

SA 376. Ms. DUCKWORTH (for herself, Mr. DURBIN, Mrs. ERNST, and Mr. GRASSLEY) submitted an amendment intended to be proposed by her to the bill H.R. 2810, supra; which was ordered to lie on the table.

SA 377. Mr. MENENDEZ (for himself, Mr. DURBIN, Mr. BLUMENTHAL, Mr. BOOKER, and Mr. HEINRICH) submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table.

SA 378. Mr. MARKEY submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 379. Mr. MARKEY (for himself, Ms. WARREN, Mr. CARPER, Mr. CASEY, Mr. BROWN, Ms. HIRONO, Ms. STABENOW, Mr. MENENDEZ, and Mr. VAN HOLLEN) submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 380. Mr. MARKEY submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 381. Mr. MARKEY submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 382. Mr. MARKEY submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 383. Mr. FRANKEN (for himself, Mr. CORNYN, Ms. HEITKAMP, and Ms. BALDWIN) submitted an amendment intended to be proposed by him to the bill H.R. 2810, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table.

SA 384. Mr. MANCHIN (for himself, Mr. MURPHY, Mr. WHITEHOUSE, Mr. KING, Ms. KLOBUCHAR, Mr. NELSON, Ms. HEITKAMP, Mrs. SHAHEEN, Ms. BALDWIN, Mr. BLUMENTHAL, and Ms. WARREN) submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table.

SA 385. Mr. MANCHIN (for himself and Mr. BLUMENTHAL) submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 386. Mr. MANCHIN (for himself, Mr. BROWN, Mr. WARNER, Mr. KAINE, Mr. COONS, and Mr. CASEY) submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 387. Mr. CARDIN (for himself, Mr. CARPER, Mr. NELSON, Ms. WARREN, Mr. BLUMENTHAL, Mr. BROWN, Mr. VAN HOLLEN, Ms. STABENOW, Ms. DUCKWORTH, and Mr. MARKEY) submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 388. Mr. CRAPO (for himself and Mr. RISCH) submitted an amendment intended to be proposed by him to the bill H.R. 2810, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table.

SA 389. Mr. STRANGE submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table.

SA 390. Mr. BLUNT submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 391. Mr. GRAHAM (for himself and Mr. CASSIDY) submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 281. Mr. PAUL submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on

the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the end of title I, insert the following:

SEC. 122. SMALL BUSINESS HEALTH PLANS.

(a) TAX TREATMENT OF SMALL BUSINESS HEALTH PLANS.—A small business health plan (as defined in section 801(a) of the Employee Retirement Income Security Act of 1974) shall be treated—

(1) as a group health plan (as defined in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91)) for purposes of applying title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) and title XXII of such Act (42 U.S.C. 300bb–1);

(2) as a group health plan (as defined in section 5000(b)(1) of the Internal Revenue Code of 1986), for purposes of applying sections 4980B and 5000 and chapter 100 of the Internal Revenue Code of 1986; and

(3) as a group health plan (as defined in section 733(a)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(a)(1))) for purposes of applying parts 6 and 7 of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.)

(b) RULES.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1021 et seq.) is amended by adding at the end the following new part:

"PART 8—RULES GOVERNING SMALL BUSINESS RISK SHARING POOLS

"SEC. 801. SMALL BUSINESS HEALTH PLANS.

''(a) IN GENERAL.—For purposes of this part, the term 'small business health plan' means—

''(1) a fully insured group health plan, offered by a health insurance issuer in the large group market; or

''(2) a self-insured group health plan,

whose sponsor is described in subsection (b).

''(b) SPONSOR.—The sponsor of a group health plan is described in this subsection if such sponsor—

''(1) is a qualified sponsor and receives certification by the Secretary;

''(2) is organized and maintained in good faith, with a constitution or bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis;

''(3) is established as a permanent entity; and

''(4) does not condition membership on the basis of a minimum group size.

"SEC. 802. FILING FEE AND CERTIFICATION OF SMALL BUSINESS HEALTH PLANS.

''(a) FILING FEE.—A small business health plan shall pay to the Secretary at the time of filing an application for certification under subsection (b) a filing fee in the amount of $5,000, which shall be available to the Secretary for the sole purpose of administering the certification procedures applicable with respect to small business health plans.

''(b) CERTIFICATION.—

''(1) IN GENERAL.—Not later than 6 months after the date of enactment of this part, the Secretary shall prescribe by interim final rule a procedure under which the Secretary—

''(A) will certify a qualified sponsor of a small business health plan, upon receipt of an application that includes the information described in paragraph (2);

''(B) may provide for continued certification of small business health plans under this part;

''(C) shall provide for the revocation of a certification if the applicable authority finds that the small business health plan involved fails to comply with the requirements of this part;

''(D) shall conduct oversight of certified plan sponsors, including periodic review, and consistent with section 504, applying the requirements of sections 518, 519, and 520; and

''(E) will consult with a State with respect to a small business health plan domiciled in such State regarding the Secretary's authority under this part and other enforcement authority under sections 502 and 504.

''(2) INFORMATION TO BE INCLUDED IN APPLICATION FOR CERTIFICATION.—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form which shall be prescribed by the applicable authority by regulation, at least the following information:

''(A) Identifying information.

''(B) States in which the plan intends to do business.

''(C) Bonding requirements.

''(D) Plan documents.

''(E) Agreements with service providers.

''(3) REQUIREMENTS FOR CERTIFIED PLAN SPONSORS.—Not later than 6 months after the date of enactment of this part, the Secretary shall prescribe by interim final rule requirements for certified plan sponsors that include requirements regarding—

''(A) structure and requirements for boards of trustees or plan administrators;

''(B) notification of material changes; and

''(C) notification for voluntary termination.

''(c) FILING NOTICE OF CERTIFICATION WITH STATES.—A certification granted under this part to a small business health plan offered by a health insurance issuer, as described in section 801(a)(1), shall not be effective unless written notice of such certification is filed by the plan sponsor with the applicable authority of each State in which the small business health plan operates.

''(d) EXPEDITED AND DEEMED CERTIFICATION.—

''(1) IN GENERAL.—If the Secretary fails to act on a complete application for certification under this section within 90 days of receipt of such complete application, the applying small business health plan sponsor shall be deemed certified until such time as the Secretary may deny for cause the application for certification.

''(2) PENALTY.—The Secretary may assess a penalty against the board of trustees, plan administrator, and plan sponsor (jointly and severally) of a small business health plan sponsor that is deemed certified under paragraph (1) of up to $500,000 in the event the Secretary determines that the application for certification of such small business health plan sponsor was willfully or with gross negligence incomplete or inaccurate.

"SEC. 803. PARTICIPATION AND COVERAGE REQUIREMENTS.

''(a) COVERED EMPLOYERS AND INDIVIDUALS.—The requirements of this subsection are met with respect to a small business health plan if, under the terms of the plan—

''(1) each participating employer must be—

''(A) a member of the sponsor;

''(B) the sponsor; or

''(C) an affiliated member of the sponsor, except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or such an affiliated member of the sponsor, participating employers may also include such employer;

''(2) a participating employer is not deemed to be a plan sponsor in applying requirements relating to coverage renewal; and

''(3) all individuals commencing coverage under the plan after certification under this part must be—

''(A) an active or retired owner (including a self-employed individual with or without employees), officer, director, or employee of, or partner in, a participating employer;

''(B) an eligible individual; or

''(C) a dependent of an individual described in subparagraph (A) or (B).

''(b) PROHIBITION OF DISCRIMINATION AGAINST EMPLOYERS AND EMPLOYEES ELIGIBLE TO PARTICIPATE.—The requirements of this subsection are met with respect to a small business health plan if—

''(1) under the terms of the plan, no participating employer may provide health insurance coverage in the individual market for any employee not covered under the plan, if such exclusion of the employee from coverage under the plan is based on a health status-related factor with respect to the employee and such employee would, but for such exclusion on such basis, be eligible for coverage under the plan; and

''(2) information regarding all coverage options available under the plan is made readily available to any employer eligible to participate.

"SEC. 804. DEFINITIONS; RENEWAL.

''For purposes of this part:

''(1) AFFILIATED MEMBER.—The term 'affiliated member' means, in connection with a sponsor—

''(A) a person who is otherwise eligible to be a member of the sponsor but who elects an affiliated status with the sponsor, or

''(B) in the case of a sponsor with members which consist of associations, a person who is a member or employee of any such association and elects an affiliated status with the sponsor.

''(2) APPLICABLE AUTHORITY.—The term 'applicable authority' means—

''(A) with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of title XXVII of the Public Health Service Act for the State involved with respect to such issuer; and

''(B) with respect to a group health plan, the Secretary of Labor.

''(3) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' means any individual who—

''(A) is a member of a sponsor; and

''(B)(i) is not employed or self-employed; or

''(ii) is employed by an employer who does not offer the individual the option to enroll in a group health plan.

''(4) FRANCHISOR; FRANCHISEE.—The terms 'franchisor' and 'franchisee' have the meanings given such terms for purposes of sections 436.2(a) through 436.2(c) of title 16, Code of Federal Regulations (including any such amendments to such regulation after the date of enactment of this part) and, for purposes of this part, franchisor or franchisee employers participating in such a group health plan shall not be treated as the employer, co-employer, or joint employer of the employees of another participating franchisor or franchisee employer for any purpose.

''(5) HEALTH PLAN TERMS.—The terms 'group health plan', 'health insurance coverage', and 'health insurance issuer' have the meanings given such terms in section 733.

''(6) INDIVIDUAL MARKET.—

''(A) IN GENERAL.—The term 'individual market' means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

''(B) TREATMENT OF VERY SMALL GROUPS.—

''(i) IN GENERAL.—Subject to clause (ii), such term includes coverage offered in connection with a group health plan that has fewer than 2 participants as current employees or participants described in section 732(d)(3) on the first day of the plan year.

''(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of health insurance coverage offered in a State if such State regulates the coverage described in such clause in the same manner and to the same extent as coverage in the small group market (as defined in section 2791(e)(5) of the Public Health Service Act) is regulated by such State.

''(7) PARTICIPATING EMPLOYER.—The term 'participating employer' means, in connection with a small business health plan, any employer, if any individual who is an employee of such employer, a partner in such employer, or a self-employed individual who is such employer, including a self-employed individual with no additional employees (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employee, partner, or self-employed individual in relation to the plan.''.

(c) PREEMPTION RULES.—Section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) is amended by adding at the end the following:

''(f)(1) Except as provided in subsection (b)(4), the provisions of this title shall supersede any and all State laws insofar as they may now or hereafter preclude a health insurance issuer from offering health insurance coverage in connection with a small business health plan which is certified under part 8 or preclude a self-insured small business health plan which is certified under part 8 from operating.

''(2) Nothing in subparagraph (1) shall be construed to limit the authority of a State to otherwise regulate health plans offered by a health insurance issuer in such State.''.

(d) PLAN SPONSOR.—Section 3(16)(B) of such Act (29 U.S.C. 102(16)(B)) is amended by adding at the end the following new sentence: ''Such term also includes a person serving as the sponsor of a small business health plan under part 8.''.

(e) SAVINGS CLAUSE.—Section 731(c) of such Act is amended by inserting ''or part 8'' after ''this part''.

(f) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this section within 6 months after the date of the enactment of this Act.

SA 282. Mr. ROUNDS submitted an amendment intended to be proposed by him to the bill H.R. 2810, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle A of title VII, add the following:

SEC. 710. EXCEPTION TO INCREASE IN COST-SHARING REQUIREMENTS FOR TRICARE PHARMACY BENEFITS PROGRAM FOR BENEFICIARIES WHO LIVE MORE THAN 40 MILES FROM A MILITARY TREATMENT FACILITY.

(a) IN GENERAL.—Notwithstanding paragraph (6) of section 1074g(a) of title 10, United States Code, as amended by section 706(a), the Secretary of Defense may not increase after the date of the enactment of this Act any cost-sharing amounts under such paragraph with respect to covered beneficiaries described in subsection (b).

(b) COVERED BENEFICIARIES DESCRIBED.—Covered beneficiaries described in this subsection are eligible covered beneficiaries (as defined in section 1074g(g) of title 10, United States Code) who live more than 40 miles driving distance from the closest military treatment facility to the residence of the beneficiary.

(c) REPORT ON EFFECT OF INCREASE.—

(1) IN GENERAL.—Not later than 60 days after the date of the enactment of this Act, the Secretary of Defense shall submit to the Committees on Armed Services of the Senate and the House of Representatives a report on the potential effect, without regard to subsection (a), of the increase in cost-sharing amounts under section 1074g(a)(6) of title 10, United States Code, on covered beneficiaries described in subsection (b).

(2) ELEMENTS.—The report required by paragraph (1) shall include an assessment of how much additional costs would be required of covered beneficiaries described in subsection (b) per year as a result of increases in cost-sharing amounts described in such paragraph, including the average amount per individual and the aggregate amount.

SA 283. Mr. ROUNDS submitted an amendment intended to be proposed by him to the bill H.R. 2810, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle C of title XVI, add the following:

SEC. 1630C. SENSE OF CONGRESS ON USE OF INTERGOVERNMENTAL PERSONNEL ACT MOBILITY PROGRAM AND DEPARTMENT OF DEFENSE INFORMATION TECHNOLOGY EXCHANGE PROGRAM TO OBTAIN PERSONNEL WITH CYBER SKILLS AND ABILITIES FOR THE DEPARTMENT OF DEFENSE.

It is the sense of Congress that—

(1) the Department of Defense should fully use the Intergovernmental Personnel Act Mobility Program (IPAMP) and the Department of Defense Information Technology Exchange Program (ITEP) to obtain cyber personnel across the Government by leveraging cyber capabilities found at the State and local government level and in the private sector in order to meet the needs of the Department for cybersecurity professionals; and

(2) the Department should implement at the earliest practicable date a strategy that includes policies and plans to fully use such programs to obtain such personnel for the Department.

SA 284. Mr. KENNEDY submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. REDUCING MEDICAID FRAUD, WASTE, ABUSE, AND OTHER IMPROPER PAYMENTS.

Not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services, in consultation with the Comptroller General of the United States and representatives of State auditors, shall issue guidance establishing a national strategy for reducing fraud, waste, abuse, and other improper payments in Medicaid.

SA 285. Mr. KENNEDY submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. EXPLANATION OF BENEFITS.

Subpart I of part A of title XXVII of the Public Health Service Act (42 U.S.C.300gg et seq.) is amended by adding at the end the following:

''SEC. 2710. EXPLANATION OF BENEFITS.

''Each health insurance issuer offering health insurance coverage in the individual market or group market shall include the Current Procedural Terminology ('CPT') code with each explanation of benefits.''.

SA 286. Mr. KENNEDY submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. EMERGENCY ROOM PHYSICIANS.

The Secretary of Health and Human Services shall promulgate regulations requiring hospitals to employ only emergency room physicians who have a contract with the same health insurance issuers with which the hospital has a contract.

SA 287. Mr. KENNEDY submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. WORK REQUIREMENT FOR NON-DISABLED, NONELDERLY, NONPREGNANT INDIVIDUALS.

Section 1902 of the Social Security Act (42 U.S.C. 1396a), as previously amended, is further amended by adding at the end the following new subsection:

''(oo) WORK REQUIREMENT FOR NON-DISABLED, NONELDERLY, NONPREGNANT INDIVIDUALS.—

''(1) IN GENERAL.—Beginning October 1, 2017, subject to paragraph (3), States shall condition medical assistance to a non-disabled, nonelderly, nonpregnant individual under this title upon such an individual's satisfaction of a work requirement (as defined in paragraph (2)).

''(2) WORK REQUIREMENT DEFINED.—In this section, the term 'work requirement' means, with respect to an individual, the individual's participation in work activities (as defined in section 407(d)) for such period of time as determined by the State, and as directed and administered by the State.

''(3) REQUIRED EXCEPTIONS.—States may not apply a work requirement under this subsection to—

''(A) a woman during pregnancy through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends;

''(B) an individual who is under 19 years of age;

''(C) an individual who is a regular participant in a drug addiction or alcoholic treatment and rehabilitation program;

''(D) an individual who is the only parent or caretaker relative in the family of a child who has not attained 6 years of age or who is the only parent or caretaker of a child with disabilities; or

''(E) an individual who is married or a head of household and has not attained 20 years of age and who—

''(i) maintains satisfactory attendance at secondary school or the equivalent; or

''(ii) participates in education directly related to employment.''.

SA 288. Mr. HELLER submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. SENSE OF THE SENATE.

It is the Sense of the Senate that—

(1) the committee of jurisdiction of the Senate—

(A) should review the issue of Medicaid expansion and coverage for low-income Americans, and the incentives such expansion provides States for certain services;

(B) should consider legislation that provides incentives for States to prioritize Medicaid services for individuals who have the greatest medical need, including individuals with disabilities;

(C) should not consider legislation that reduces or eliminates benefits or coverage for individuals who are currently eligible for Medicaid;

(D) should not consider legislation that prevents or discourages a State from expanding its Medicaid program to include groups or individuals or types of services that are operational under current law; and

(E) should not consider legislation that shifts costs to States to cover such care;

(2) Obamacare should be repealed because it increases health care costs, limits patient choice of health plans and doctors, forces Americans to buy insurance that they do not want, cannot afford, or may not be able to access, and increases taxes on middle class families, which is evidenced by the facts that—

(A) premiums for health plans offered on the Federal Exchange have doubled on average over the last 4 years, and those increases are projected to continue;

(B) 70 percent of counties have only a few options for Obamacare insurance in 2017, and at least 40 counties are expected to have zero insurers planning on their Exchange for 2018;

(C) 2,300,000 Americans on the Exchange are projected to have only one insurer to choose from for plan year 2018; and

(D) the Joint Committee on Taxation has identified significant and widespread tax increases on individuals earning less than$200,000; and

(3) Obamacare should be replaced with patient-centered legislation that—

(A) provides access to quality, affordable private health care coverage for Americans and their families by increasing competition, State flexibility, and individual choice; and

(B) strengthens Medicaid and empowers States through increased flexibility to best meet the needs of each State's population.

SA 289. Mr. DAINES submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

On page 5, strike lines 20 through 22 and insert the following:

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to months beginning after December 31, 2013.

(c) TAXPAYER REFUND PROGRAM.—

(1) IN GENERAL.—The Secretary of the Treasury shall implement a program under which taxpayers who have paid a penalty under section 5000A of the Internal Revenue Code of 1986 for any taxable year receive 1 payment in refund of all such penalties paid, without regard to whether or not an amended return is filed. Such payment shall be made not later than April 15, 2018.

(2) WAIVER OF STATUTE OF LIMITATIONS.—Solely for purposes of claiming the refund under paragraph (1), the period prescribed by section 6511(a) of the Internal Revenue Code of 1986 with respect to any payment of a penalty under section 5000A shall be extended until the date prescribed by law (including extensions) for filing the return of tax for the taxable year that includes December 31, 2017.

SA 290. Ms. WARREN (for herself, Mr. MARKEY, Mr. CARPER, Mr. DURBIN, Ms. STABENOW, Ms. HIRONO, Mr. VAN HOLLEN, and Mr. BROWN) submitted an amendment intended to be proposed by her to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. NULLIFICATION OF CERTAIN PROVISIONS.

The provisions of, and the amendments made by, this Act that would increase costs for community health centers, including by increasing the number of uninsured individuals or by reducing Federal funding of the Medicaid program that helps provide coverage for many patients receiving care at community health centers, shall be null and void and this Act shall be applied and administered as if such provisions and amendments had never been enacted.

SA 291. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. NULLIFICATION OF CERTAIN PROVISIONS.

The provisions of, and the amendments made by, this Act that would lead to an increased likelihood of bankruptcies for American families, including provisions that would allow insurers to impose annual or lifetime limits on insurance benefits or that would eliminate insurance coverage, shall be null and void and this Act shall be applied and administered as if such provisions and amendments had never been enacted.

SA 292. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. NULLIFICATION OF CERTAIN PROVISIONS.

The provisions of, and the amendments made by, this Act that would reduce funding for special education programs, including provisions that break President Trump's promise not to cut Medicaid, shall be null and void and this Act shall be applied and administered as if such provisions and amendments had never been enacted.

SA 293. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. NULLIFICATION OF CERTAIN PROVISIONS.

The provisions of, and the amendments made by, this Act that would harm individuals with Alzheimer's disease by increasing their premiums or cutting Federal Medicaid funding that supports those in nursing homes, shall be null and void and this Act shall be applied and administered as if such provisions and amendments had never been enacted.

SA 294. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. NULLIFICATION OF CERTAIN PROVISIONS.

The provisions of, and the amendments made by, this Act that would harm babies born prematurely by cutting Federal Medicaid funding that supports medications, special equipment, and therapies to help these babies thrive and protect their family from bankruptcy, shall be null and void and this Act shall be applied and administered as if such provisions and amendments had never been enacted.

SA 295. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. NULLIFICATION OF CERTAIN PROVISIONS.

The provisions of, and the amendments made by, this Act that would reduce coverage for prescription drug benefits, lead to increased out-of-pocket prescription drug costs, or allow States to apply for waivers to drop prescription drug coverage from the list of essential health benefits, shall be null and void and this Act shall be applied and administered as if such provisions and amendments had never been enacted.

SA 296. Ms. WARREN submitted an amendment intended to be proposed by

her to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. NULLIFICATION OF CERTAIN PROVISIONS.

The provisions of, and the amendments made by, this Act that would make it harder for a person with breast cancer to access health care, shall be null and void and this Act shall be applied and administered as if such provisions and amendments had never been enacted.

SA 297. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. NULLIFICATION OF CERTAIN PROVISIONS.

The provisions of, and the amendments made by, this Act that would make it harder for a person with cervical cancer to access health care, shall be null and void and this Act shall be applied and administered as if such provisions and amendments had never been enacted.

SA 298. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. NULLIFICATION OF CERTAIN PROVISIONS.

The provisions of, and the amendments made by, this Act that would make it harder for a victim of human trafficking to access health care, shall be null and void and this Act shall be applied and administered as if such provisions and amendments had never been enacted.

SA 299. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. NULLIFICATION OF CERTAIN PROVISIONS.

The provisions of, and the amendments made by, this Actt hat would make it harder for a pregnant woman to access health care, shall be null and void and this Act shall be applied and administered as if such provisions and amendments had never been enacted.

SA 300. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. NULLIFICATION OF CERTAIN PROVISIONS.

The provisions of, and the amendments made by, this Act that would make it harder for a victim of sexual violence to access health care, shall be null and void and this Act shall be applied and administered as if such provisions and amendments had never been enacted.

SA 301. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. NULLIFICATION OF CERTAIN PROVISIONS.

The provisions of, and the amendments made by, this Act that would threaten to make health insurance unaffordable for children with a rare disease shall be null and void and this Act shall be applied and administered as if such provisions and amendments had never been enacted.

SA 302. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. NULLIFICATION OF CERTAIN PROVISIONS.

The provisions of, and the amendments made by, this Act that would threaten to make health insurance unaffordable for foster children shall be null and void and this Act shall be applied and administered as if such provisions and amendments had never been enacted.

SA 303. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. NULLIFICATION OF CERTAIN PROVISIONS.

The provisions of, and the amendments made by, this Act that would threaten to make health insurance unaffordable for people with a disability shall be null and void and this Act shall be applied and administered as if such provisions and amendments had never been enacted.

SA 304. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. NULLIFICATION OF CERTAIN PROVISIONS.

The provisions of, and the amendments made by, this Act that would threaten to make health insurance unaffordable for people living in a nursing home shall be null and void and this Act shall be applied and administered as if such provisions and amendments had never been enacted.

SA 305. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. NULLIFICATION OF CERTAIN PROVISIONS.

The provisions of, and the amendments made by, this Act that would threaten to make health insurance unaffordable for people receiving home and community based services shall be null and void and this Act shall be applied and administered as if such provisions and amendments had never been enacted.

SA 306. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. NULLIFICATION OF CERTAIN PROVISIONS.

The provisions of, and the amendments made by, this Act that would threaten to make health insurance unaffordable for people receiving long term services and supports shall be null and void and this Act shall be applied and administered as if such provisions and amendments had never been enacted.

SA 307. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. NULLIFICATION OF CERTAIN PROVISIONS.

The provisions of, and the amendments made by, this Act that would threaten to make health insurance unaffordable for people seeking treatment for opioid addiction shall be null and void and this Act shall be applied and administered as if such provisions and amendments had never been enacted.

SA 308. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. NULLIFICATION OF CERTAIN PROVISIONS.

The provisions of, and the amendments made by, this Act that would threaten to make health insurance unaffordable for people with any substance use disorder shall be null and void and this Act shall be applied and administered as if such provisions and amendments had never been enacted.

SA 309. Ms. WARREN submitted an amendment intended to be proposed by

her to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. NULLIFICATION OF CERTAIN PROVISIONS.

The provisions of, and the amendments made by, this Act that would threaten to make health insurance unaffordable for people seeking mental health care shall be null and void and this Act shall be applied and administered as if such provisions and amendments had never been enacted.

SA 310. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. NULLIFICATION OF CERTAIN PROVISIONS.

The provisions of, and the amendments made by, this Act that would threaten to make health insurance unaffordable for people with brain cancer shall be null and void and this Act shall be applied and administered as if such provisions and amendments had never been enacted.

SA 311. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. NULLIFICATION OF CERTAIN PROVISIONS.

The provisions of, and the amendments made by, this Act that would threaten to make health insurance unaffordable for people receiving chemotherapy or radiation treatment shall be null and void and this Act shall be applied and administered as if such provisions and amendments had never been enacted.

SA 312. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. NULLIFICATION OF CERTAIN PROVISIONS.

The provisions of, and the amendments made by, this Act that would threaten to make health insurance unaffordable for people living in a rural area shall be null and void and this Act shall be applied and administered as if such provisions and amendments had never been enacted.

SA 313. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. NULLIFICATION OF CERTAIN PROVISIONS.

The provisions of, and the amendments made by, this Act that would threaten to make health insurance unaffordable for veterans shall be null and void and this Act shall be applied and administered as if such provisions and amendments had never been enacted.

SA 314. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. NULLIFICATION OF CERTAIN PROVISIONS.

The provisions of, and the amendments made by, this Act that would threaten to make health insurance unaffordable for people over the age of 50 shall be null and void and this Act shall be applied and administered as if such provisions and amendments had never been enacted.

SA 315. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. NULLIFICATION OF CERTAIN PROVISIONS.

The provisions of, and the amendments made by, this Act that would threaten to make health insurance unaffordable for people with ALS shall be null and void and this Act shall be applied and administered as if such provisions and amendments had never been enacted.

SA 316. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. NULLIFICATION OF CERTAIN PROVISIONS.

The provisions of, and the amendments made by, this Act that would threaten to make health insurance unaffordable for people with multiple sclerosis shall be null and void and this Act shall be applied and administered as if such provisions and amendments had never been enacted.

SA 317. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. NULLIFICATION OF CERTAIN PROVISIONS.

The provisions of, and the amendments made by, this Act that would threaten to make health insurance unaffordable for people with diabetes shall be null and void and this Act shall be applied and administered as if such provisions and amendments had never been enacted.

SA 318. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. NULLIFICATION OF CERTAIN PROVISIONS.

The provisions of, and the amendments made by, this Act that would threaten to make health insurance unaffordable for people receiving Social Security benefits, including SSI and SSDI shall be null and void and this Act shall be applied and administered as if such provisions and amendments had never been enacted.

SA 319. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. NULLIFICATION OF CERTAIN PROVISIONS.

The provisions of, and the amendments made by, this Act that would threaten to make health insurance unaffordable for people with heart disease shall be null and void and this Act shall be applied and administered as if such provisions and amendments had never been enacted.

SA 320. Ms. WARREN submitted an amendment intended to be proposed by her to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. NULLIFICATION OF CERTAIN PROVISIONS.

The provisions of, and the amendments made by, this Act that would threaten to make health insurance unaffordable for people with prostate cancer shall be null and void and this Act shall be applied and administered as if such provisions and amendments had never been enacted.

SA 321. Mr. NELSON submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. HEALTHCARE FRAUD REMOVAL.

(a) 10-YEAR PROHIBITION ON DEDUCTION OF TRADE OR BUSINESS EXPENSES FOR BUSINESSES ENGAGED IN FRAUD OR ILLEGAL TRANSACTIONS.—Subsection (c) of section 162 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

''(4) 10-YEAR PROHIBITION ON DEDUCTION OF TRADE OR BUSINESS EXPENSES.—In the case of a taxpayer subject to a criminal penalty for

engaging in fraud, an illegal bribe or kickback, or any other illegal transaction (as such term is defined by the Secretary) under any law of the United States, or under any law of a State (but only if such State law is generally enforced), no deduction shall be allowed under subsection (a) for any taxable year during the 10-year period subsequent to the date on which such criminal penalty was imposed.''.

(b) HEALTH CARE FRAUD PENALTIES.—Section 1347(a) of title 18, United States Code, is amended, in the undesignated matter following paragraph (2)—

(1) by striking ''10 years'' and inserting ''15 years''; and

(2) by striking ''20 years'' and inserting ''25 years''.

(c) ESTABLISHMENT OF HEALTH CARE FRAUD EXCISE TAX.—

(1) HEALTH CARE FRAUD EXCISE TAX.—

(A) IN GENERAL.—Subchapter C of chapter 100 of subtitle K of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

''SEC. 9835. HEALTH CARE FRAUD EXCISE TAX.

''(a) IN GENERAL.—In the case of any payment relating to health care benefits, items, or services which is made by health insurance issuer (as defined in section 9832(c)(2)) to a person engaged in a violation of section 1347(a) of title 18, United States Code, there is hereby imposed a tax equal to 20 percent of such payment.

''(b) NO KNOWLEDGE REQUIREMENT.—With respect the tax imposed under subsection (a), the health insurance issuer shall not be required to have knowledge of the violation under section 1347(a) of title 18, United States Code.''.

(B) CLERICAL AMENDMENT.—The table of sections for such subchapter is amended by adding at the end the following new item:

''Sec. 9835. Health care fraud excise tax.''.

(C) EFFECTIVE DATE.—The amendments made by this paragraph shall apply to payments made after the date of the enactment of this Act.

(2) HEALTH CARE FRAUD TRUST FUND.—

(A) IN GENERAL.—Subchapter A of chapter 98 of the Internal Revenue Code of 1986 is amended by adding at the end the following section:

''SEC. 9512. HEALTH CARE FRAUD TRUST FUND.

''(a) CREATION OF TRUST FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'Health Care Fraud Trust Fund', consisting of any amount appropriated or credited to the Trust Fund as provided in this section or section 9602(b).

''(b) TRANSFERS TO TRUST FUND.—There is hereby appropriated to the Health Care Fraud Trust Fund amounts equivalent to the revenues received in the Treasury from the tax imposed by section 9835.

''(c) EXPENDITURES.—Amounts in the Health Care Fraud Trust Fund shall be available, without further appropriation, to the Secretary of Health and Human Services for providing grants to—

''(1) local law enforcement authorities for health care fraud prevention efforts, with priority given to authorities operating in areas experiencing high rates of health care fraud or drug abuse, and

''(2) qualified drug addiction treatment centers.

''(d) DEFINITIONS.—

''(1) LOCAL LAW ENFORCEMENT AUTHORITY.—The term 'local law enforcement authority' means any officially recognized law enforcement agency legally organized under a political subdivision of a state or possession of the United States.

SA 322. Mr. HEINRICH submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. POINT OF ORDER AGAINST LEGISLATION THAT WOULD DECREASE MEDICAID OR CHIP ENROLLMENT OF CHILDREN.

(a) POINT OF ORDER.—It shall not be in order in the Senate to consider any bill, joint resolution, motion, amendment, amendment between the Houses, or conference report that, as determined by the Director of the Congressional Budget Office, would result in a decrease in the number of children enrolled in Medicaid under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) or the Children's Health Insurance Program under title XXI of such Act (42 U.S.C. 1397aa et seq.).

(b) WAIVER AND APPEAL.—Subsection (a) may be waived or suspended in the Senate only by an affirmative vote of three-fifths of the Members, duly chosen and sworn. An affirmative vote of three-fifths of the Members of the Senate, duly chosen and sworn, shall be required to sustain an appeal of the ruling of the Chair on a point of order raised under subsection (a).

SA 323. Mr. HEINRICH submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. POINT OF ORDER AGAINST LEGISLATION THAT WOULD AFFECT ADVERSELY IMPACT UNINSURED INDIVIDUALS IN RURAL AREAS,.

(a) POINT OF ORDER.—It shall not be in order in the Senate to consider any bill, joint resolution, motion, amendment, amendment between the Houses, or conference report that would result in an increase in the rate of uninsured individuals in rural areas, a decrease in Medicaid enrollment or a reduction in the scope of Medicaid benefits offered in rural areas, reduced wages or a shortage of employment opportunities in the health care profession for prospective employees and previously insured individuals living in rural areas, or a decrease in revenue or Federal funds available to rural health care providers, including hospitals, clinics, and community health centers.

(b) WAIVER AND APPEAL.—Subsection (a) may be waived or suspended in the Senate only by an affirmative vote of three-fifths of the Members, duly chosen and sworn. An affirmative vote of three-fifths of the Members of the Senate, duly chosen and sworn, shall be required to sustain an appeal of the ruling of the Chair on a point of order raised under subsection (a).

SA 324. Mr. HEINRICH (for himself and Mr. UDALL) submitted an amendment intended to be proposed by him to the bill H.R. 2810, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title XXXI, add the following:

SEC. 3116. PLUTONIUM CAPABILITIES.

(a) REPORT.—Not later than 30 days after the date of the enactment of this Act, the Administrator for Nuclear Security shall submit to the congressional defense committees, the Secretary of Defense, and the Director of Cost Assessment and Program Evaluation of the Department of Defense a report on the recommended alternative endorsed by the Administrator for recapitalization of plutonium science and production capabilities of the nuclear security enterprise. The report shall identify the recommended alternative endorsed by the Administrator and contain the analysis of alternatives, including costs, upon which the Administrator relied in making such endorsement.

(b) CERTIFICATION.—Not later than 60 days after the date on which the Secretary of Defense receives the notification under subsection (a), the Chairman of the Nuclear Weapons Council shall submit to the congressional defense committees the written certification of the Chairman regarding whether the recommended alternative endorsed by the Administrator—

(1) is acceptable to the Secretary of Defense and the Nuclear Weapons Council and meets the requirements of the Secretary for plutonium pit production capacity and capability;

(2) is likely to meet the pit production timelines and milestones required by section 4219 of the Atomic Energy Defense Act (50 U.S.C. 2538a);

(3) is likely to meet pit production timelines and requirements responsive to military requirements;

(4) is cost effective and has reasonable near-term and lifecycle costs that are minimized, to the extent practicable, as compared to other alternatives, and has tested and documented the sensitivity of the cost estimates for each alternative to risks and changes in key assumptions;

(5) contains minimized and manageable risks as compared to other alternatives;

(6) can be acceptably reconciled with any differences in the conclusions made by the Office of Cost Assessment and Program Evaluation of the Department of Defense in the business case analysis of plutonium pit production capability issued in 2013; and

(7) has documented the assumptions and constraints used in the analysis of alternatives.

(c) FAILURE TO CERTIFY.—If the Chairman is unable to submit the certification under subsection (b), the Chairman shall submit to the congressional defense committees and the Administrator written notification describing why the Chairman is unable to make such certification.

(d) ASSESSMENT.—Not later than 120 days after the date on which the Director of Cost Assessment and Program Evaluation receives the notification under subsection (a), the Director shall provide to the congressional defense committees a briefing containing the assessment of the Director of the analysis of alternatives conducted by the Administrator to select a preferred alternative for recapitalizing plutonium science and production capabilities.

SA 325. Mr. HEINRICH (for himself and Mr. UDALL) submitted an amendment intended to be proposed by him to the bill H.R. 2810, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle E of title X, add the following:

SEC. _____. AIR FORCE PILOT PROGRAM ON EDUCATION AND TRAINING AND CERTIFICATION OF SECONDARY AND POST-SECONDARY STUDENTS AS AIRCRAFT TECHNICIANS.

(a) PILOT PROGRAM REQUIRED.—

(1) IN GENERAL.—The Secretary of the Air Force shall carry out a pilot program to assess the feasability and advisability of—

(A) providing education and training to secondary and post-secondary students in the skills and qualifications required to lead to certification as an aircraft technician for the Air Force with skills levels 3-5; and

(B) certifying individuals who successfully complete education and training under the pilot program as aircraft technicians for the Air Force at the applicable skill level.

(2) DESIGNATION.—The pilot program carried out pursuant to this section may be known as the ''Air Force Dual Credit Maintainers Program'' (in this section, referred to as the ''pilot program'').

(b) ELIGIBLE PARTICIPANTS.—Individuals eligible to participate in the pilot program are individuals in secondary or post-secondary school who—

(1) have education, skills, or both appropriate for further education and training leading to certification as an aircraft technician of the Air Force; and

(2) seek to pursue education and training under the pilot program in order to become certified as aircraft technicians of the Air Force.

(c) SECONDARY SCHOOLS AND INSTITUTIONS OF HIGHER EDUCATION.—

(1) IN GENERAL.—The Secretary shall carry out the pilot program through secondary schools and institutions of higher education selected by the Secretary for purposes of the pilot program.

(2) LOCATIONS.—The secondary schools and institutions of higher education selected pursuant to paragraph (1) shall, to the extent practicable, be located in the vicinity of installations of the Air Force at which there is, or is anticipated to be, a shortfall in aircraft technicians with skill levels 3-5.

(3) COORDINATION.—The pilot program may be carried out at a secondary school only with the approval of the local educational agency concerned. The pilot program may be carried out at an institution of higher education only with the approval of the board of trustees or other appropriate leadership of the institution.

(4) GRANTS.—In carrying out the pilot program, the Secretary may award a grant to any secondary school or institution of higher education participating in the pilot program for purposes of providing education and training under the pilot program.

(d) CURRICULUM AND ASSOCIATED EQUIPMENT.—In carrying out the pilot program, the Secretary shall support curriculum development by secondary and post-secondary educational institutions, and any associated training equipment, to be used in providing education and training under the pilot program.

(e) EMPLOYMENT AS AIR FORCE AIRCRAFT TECHNICIANS.—As part of the pilot program, the Secretary may employ, and may afford an emphasis on employment, in the Department of the Air Force as aircraft technicians of the Air Force any individuals who obtain certification under the pilot program as aircraft technicians of the Air Force.

(f) SUNSET.—The authority of the Secretary to carry out the pilot program shall expire on the date that is five years after the date of the enactment of this Act. Expiration of the authority to carry out the pilot program shall not be construed to require the termination of any education or training, or the provision of any certifications, for individuals participating in education or training under the pilot program on the date of the expiration of authority to carry out the pilot program

(g) FUNDING.—

(1) IN GENERAL.—The amount authorized to be appropriated for fiscal year 2018 for the Department of Defense by this division is hereby increased by $5,000,000, with the amount of the increase to be available for the pilot program, including for the award of grants pursuant to subsection (c)(4) and for support of the development of curriculum and training equipment pursuant to subsection (d)

(2) OFFSET.—The amount authorized to be appropriated for fiscal year 2018 by section 301 is hereby reduced by $5,000,000, with the amount of the reduction to be applied against amounts available for operation and maintenance, Defense-wide, for SAG 4GTV Office of the Inspector General.

SA 326. Mr. LANKFORD (for himself, Mr. CRUZ, Mrs. FISCHER, and Mr. INHOFE) submitted an amendment intended to be proposed by him to the bill H.R. 2810, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. JUDGMENT FUND TRANSPARENCY.

(a) TRANSPARENCY REQUIREMENT.—Section 1304 of title 31, United States Code, is amended by adding at the end the following:

''(d)(1) Unless the disclosure of such information is otherwise prohibited by law (other than section 552a of title 5) or court order, the Secretary of the Treasury shall make available to the public on a website, as soon as practicable, but not later than 30 days after the date on which the Secretary makes a payment under this section, the following information with regard to that payment:

''(A) The name of the specific agency or entity whose actions gave rise to the claim or judgment.

''(B) The name of the plaintiff or claimant who is 18 years or older.

''(C) The name of counsel for the plaintiff or claimant.

''(D) The amount paid representing principal liability, and any amounts paid representing any ancillary liability, including attorney fees, costs, and interest.

''(E) A brief description of the facts that gave rise to the claim.

''(F) The name of the agency that submitted the claim.

''(2) In addition to the information described in paragraph (1), if a payment under this section is made to a foreign state, the Secretary of the Treasury shall make available to the public in accordance with paragraph (1), the following information with regard to that payment:

''(A) A description of the method of payment.

''(B) A description of the currency denominations used for the payment.

''(C) The name and location of each financial institution owned or controlled, directly or indirectly, by a foreign state or an agent of a foreign state to which the payment was disbursed, including any financial institution owned or controlled, directly or indirectly, by a foreign state or an agent of a foreign state that is holding the payment as of the date on which the information is made available.

''(3) In this subsection, the term 'foreign state' has the meaning given the term in section 1603 of title 28.

''(e) No payment may be made under this section to a state sponsor of terrorism, as defined in section 1605A(h) of title 28.''.

(b) IMPLEMENTATION.—The Secretary of the Treasury shall carry out the amendment made by this section not later than 90 days after the date of enactment of this Act.

SA 327. Mrs. SHAHEEN (for herself and Mr. SASSE) submitted an amendment intended to be proposed by her to the bill H.R. 2810, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle C of title XII, add the following:

SEC. _____. SYRIA STUDY GROUP.

(a) ESTABLISHMENT.—There is hereby established a working group to be known as the ''Syria Study Group'' (in this section referred to as the ''Group'').

(b) PURPOSE.—The purpose of the Group is to examine and make recommendations with respect to the military and diplomatic strategy of the United States with respect to the conflict in Syria.

(c) COMPOSITION.—

(1) MEMBERSHIP.—The Group shall be composed of 8 members appointed as follows:

(A) One member appointed by the chair of the Committee on Armed Services of the Senate.

(B) One member appointed by the ranking minority member of the Committee on Armed Services of the Senate.

(C) One member appointed by the chair of the Committee on Foreign Relations of the Senate.

(D) One member appointed by the ranking minority member of the Committee on Foreign Relations of the Senate.

(E) One member appointed by the chair of the Committee on Armed Services of the House of Representatives.

(F) One member appointed by the ranking minority member of the Committee on Armed Services of the House of Representatives.

(G) One member appointed by the chair of the Committee on Foreign Affairs of the House of Representatives.

(H) One member appointed by the ranking minority member of the Committee on Foreign Affairs of the House of Representatives.

(2) CO-CHAIRS.—

(A) The chair of the Committee on Armed Services of the Senate, the chair of the Committee on Armed Services of the House of Representatives, the chair of the Committee on Foreign Relations of the Senate, and the chair of the Committee on Foreign Affairs of the House of Representatives shall jointly designate one member of the Group to serve as co-chair of the Group.

(B) The ranking minority member of the Committee on Armed Services of the Senate, the ranking minority member of the Committee on Armed Services of the House of Representatives, the ranking minority member of the Committee on Foreign Relations of the Senate, and the ranking minority member of the Committee on Foreign Affairs of the House of Representatives shall jointly designate one member of the Group to serve as co-chair of the Group.

(3) PERIOD OF APPOINTMENT; VACANCIES.—Members shall be appointed for the life of the Group. Any vacancy in the Group shall be filled in the same manner as the original appointment.

(d) DUTIES.—

(1) REVIEW.—The Group shall review the current situation with respect to the United States military and diplomatic strategy in Syria, including a review of current United States objectives in Syria and the desired end state in Syria.

(2) ASSESSMENT AND RECOMMENDATIONS.—The Group shall—

(A) conduct a comprehensive assessment of the current situation in Syria, its impact on neighboring countries, resulting regional and geopolitical threats to the United States, and current military, diplomatic, and political efforts to achieve a stable Syria; and

(B) develop recommendations on a military and diplomatic strategy for the United States with respect to the conflict in Syria.

(e) COOPERATION FROM UNITED STATES GOVERNMENT.—

(1) IN GENERAL.—The Group shall receive the full and timely cooperation of the Secretary of Defense, the Secretary of State, and the Director of National Intelligence in providing the Group with analyses, briefings, and other information necessary for the discharge of the duties of the Group.

(2) LIAISON.—The Secretary of Defense, the Secretary of State, and the Director of National Intelligence shall each designate at least one officer or employee of their respective organizations to serve as a liaison officer to the Group.

(f) REPORT.—

(1) FINAL REPORT.—Not later than September 30, 2018, the Group shall submit to the President, the Secretary of Defense, the Committee on Armed Services of the Senate, the Committee on Armed Services of the House of Representatives, the Committee on Foreign Relations of the Senate, and the Committee on Foreign Affairs of the House of Representatives a report on the findings, conclusions, and recommendations of the Group under this section. The report shall do each of the following:

(A) Assess the current security, political, humanitarian, and economic situation in Syria.

(B) Assess the current participation and objectives of various external actors in Syria.

(C) Assess the consequences of continued conflict in Syria.

(D) Provide recommendations for a diplomatic resolution of the conflict in Syria, including options for a gradual political transition to a post-Assad Syria and actions necessary for reconciliation.

(E) Provide a roadmap for a United States and coalition strategy to reestablish security and governance in Syria, including recommendations for the synchronization of stabilization, development, counterterrorism, and reconstruction efforts.

(F) Address any other matters with respect to the conflict in Syria that the Group considers appropriate.

(2) INTERIM BRIEFING.—Not later than June 30, 2018, the Group shall provide to the Committees on Armed Services of the Senate and the House of Representatives a briefing on the status of its review and assessment under subsection (d), together with a discussion of any interim recommendations developed by the Group as of the date of the briefing.

(3) FORM OF REPORT.—The report submitted to Congress under paragraph (1) shall be submitted in unclassified form, but may include a classified annex.

(g) FACILITATION.—The United States Institute of Peace shall take appropriate actions to facilitate the Group in the discharge of its duties under this section.

(h) TERMINATION.—The Group shall terminate six months after the date on which it submits the report required by subsection (f)(1).

(i) FUNDING.—Of the amounts authorized to be appropriated for fiscal year 2018 for the Department of Defense by this Act, $1,500,000 is available to fund the activities of the Group.

SA 328. Mrs. SHAHEEN submitted an amendment intended to be proposed by her to the bill H.R. 2810, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. FOREIGN AGENTS REGISTRATION.

(a) SHORT TITLE.—This section may be cited as the ''Foreign Agents Registration Modernization and Enforcement Act''.

(b) CIVIL INVESTIGATIVE DEMAND AUTHORITY.—The Foreign Agents Registration Act of 1938 (22 U.S.C. 611 et seq.) is amended—

(1) by redesignating sections 8, 9, 10, 11, 12, 13, and 14 as sections 9, 10, 11, 12, 13, 14, and 16, respectively; and

(2) by inserting after section 7 (22 U.S.C. 617) the following:

''CIVIL INVESTIGATIVE DEMAND AUTHORITY

''SEC. 8. (a) Whenever the Attorney General has reason to believe that any person or enterprise may be in possession, custody, or control of any documentary material relevant to an investigation under this Act, the Attorney General, before initiating a civil or criminal proceeding with respect to the production of such material, may serve a written demand upon such person to produce such material for examination.

''(b) Each such demand under subsection (a) shall—

''(1) state the nature of the conduct constituting the alleged violation which is under investigation and the provision of law applicable to such violation;

''(2) describe the class or classes of documentary material required to be produced under such demand with such definiteness and certainty as to permit such material to be fairly identified;

''(3) state that the demand is immediately returnable or prescribe a return date which will provide a reasonable period within which the material may be assembled and made available for inspection and copying or reproduction; and

''(4) identify the custodian to whom such material shall be made available.

''(c) A demand under subsection (a) may not—

''(1) contain any requirement that would be considered unreasonable if contained in a subpoena duces tecum issued by a court of the United States in aid of grand jury investigation of such alleged violation; or

''(2) require the production of any documentary evidence that would be privileged from disclosure if demanded by a subpoena duces tecum issued by a court of the United States in aid of a grand jury investigation of such alleged violation.''.

(c) INFORMATIONAL MATERIALS.—

(1) DEFINITIONS.—Section 1 of the Foreign Agents Registration Act of 1938, as amended (22 U.S.C. 611) is amended—

(A) in subsection (c), by striking ''Expect as provided in subsection (d) hereof,'' and inserting ''Except as provided in subsection (d),''; and

(B) by inserting after subsection (i) the following:

''(j) The term 'informational materials' means any oral, visual, graphic, written, or pictorial information or matter of any kind, including matter published by means of advertising, books, periodicals, newspapers, lectures, broadcasts, motion pictures, or any means or instrumentality of interstate or foreign commerce or otherwise.''.

(2) INFORMATIONAL MATERIALS.—Section 4 of the such Act (22 U.S.C. 614) is amended—

(A) in subsection (a)—

(i) by inserting '', including electronic mail and social media,'' after ''United States mails''; and

(ii) by striking '', not later than forty-eight hours after the beginning of the transmittal thereof, file with the Attorney General two copies thereof'' and inserting ''file such materials with the Attorney General in conjunction with, and at the same intervals as, disclosures required under section 2(b).''; and

(B) in subsection (b)—

(i) by striking ''It shall'' and inserting ''(1) Except as provided in paragraph (2), it shall''; and

(ii) by inserting at the end the following:

''(2) Foreign agents described in paragraph (1) may omit disclosure required under that paragraph in individual messages, posts, or transmissions on social media on behalf of a foreign principal if the social media account or profile from which the information is sent includes a conspicuous statement that—

''(A) the account is operated by, and distributes information on behalf of, the foreign agent; and

''(B) additional information about the account is on file with the Department of Justice in Washington, District of Columbia.

''(3) Informational materials disseminated by an agent of a foreign principal as part of an activity that is exempt from registration, or an activity which by itself would not require registration, need not be filed under this subsection.''.

(d) FEES.—

(1) REPEAL.—The Department of Justice and Related Agencies Appropriations Act, 1993 (title I of Public Law 102–395) is amended, under the heading ''SALARIES AND EXPENSES, GENERAL LEGAL ACTIVITIES'', by striking ''In addition, notwithstanding 31 U.S.C. 3302, for fiscal year 1993 and thereafter, the Attorney General shall establish and collect fees to recover necessary expenses of the Registration Unit (to include salaries, supplies, equipment and training) pursuant to the Foreign Agents Registration Act, and shall credit such fees to this appropriation, to remain available until expended.''.

(2) REGISTRATION FEE.—The Foreign Agents Registration Act of 1938, as amended (22 U.S.C. 611 et seq.), as amended by this Act, is further amended by adding after section 14, as redesignated by subsection (b)(1), the following:

''FEES

''SEC. 15. The Attorney General shall—

''(1) establish and collect a registration fee, as part of the initial filing requirement, to help defray the expenses of the FARA Registration Unit; and

''(2) credit such fees to the amount appropriated to carry out the activities of the National Security Division, which shall remain available until expended.''.

(e) REPORTS TO CONGRESS.—Section 12 of the Foreign Agents Registration Act of 1938, as amended, as redesignated by subsection (b)(1), is amended to read as follows:

''REPORTS TO CONGRESS

''SEC. 12. The Assistant Attorney General for National Security, through the FARA Registration Unit of the National Security Division, shall submit a semiannual report to Congress regarding the administration of this Act. Each report under this section shall include, for the applicable reporting period, the identification of—

''(1) registrations filed pursuant to this Act;

''(2) the nature, sources, and content of political propaganda disseminated and distributed by agents of foreign principal;

''(3) the number of investigations initiated based upon a perceived violation of section 8; and

''(4) the number of such investigations that were referred to the Attorney General for prosecution.''.

SA 329. Ms. BALDWIN (for herself, Mr. REED, Mr. KAINE, and Ms. WARREN) submitted an amendment intended to be proposed by her to the bill H.R. 2810, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle F of title VIII, add following:

SEC. _____. SUPPORT OF AMERICA'S DEFENSE WORKERS.

(a) SHORT TITLE.—This section may be cited as the ''Supporting America's Defense Workers Act''.

(b) INEFFECTIVENESS OF SECTION 863.—Section 863 shall have no force or effect, and the amendments specified in section 863 shall not be made.

SA 330. Mr. TILLIS submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

On page 104, line 15, strike ''mental health services'' and insert ''mental health services for conditions that are defined in the Diagnostic and Statistical Manual of Mental Disorders at the time of the enrollee's diagnosis, including Autism Spectrum Disorder,''.

SA 331. Mr. COONS (for himself and Mr. BLUMENTHAL) submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

Beginning on page 102, strike line 1 and all that follows through page 104, line 12, and insert the following:

SEC. 203. EXPANSION AND MODIFICATION OF CREDIT FOR EMPLOYEE HEALTH INSURANCE EXPENSES OF SMALL EMPLOYERS.

(a) EXPANSION OF DEFINITION OF ELIGIBLE SMALL EMPLOYER.—Subparagraph (A) of section 45R(d)(1) of the Internal Revenue Code of 1986 is amended by striking ''25'' and inserting ''50''.

(b) AMENDMENT TO PHASEOUT DETERMINATION.—Subsection (c) of section 45R of the Internal Revenue Code of 1986 is amended to read as follows:

''(c) PHASEOUT OF CREDIT AMOUNT BASED ON NUMBER OF EMPLOYEES AND AVERAGE WAGES.—The amount of the credit determined under subsection (b) (without regard to this subsection) shall be adjusted (but not below zero) by multiplying such amount by the product of—

''(1) the lesser of—

''(A) a fraction the numerator of which is the excess (if any) of 50 over the total number of full-time equivalent employees of the employer and the denominator of which is 30, and

''(B) 1, and

''(2) the lesser of—

''(A) a fraction—

''(i) the numerator of which is the excess (if any) of—

''(I) the dollar amount in effect under subsection (d)(3)(B) for the taxable year, multiplied by 3, over

''(II) the average annual wages of the employer for such taxable year, and

''(ii) the denominator of which is the dollar amount so in effect under subsection (d)(3)(B), multiplied by 2, and

''(B) 1.''.

(c) EXTENSION OF CREDIT PERIOD.—Paragraph (2) of section 45R(e) of the Internal Revenue Code of 1986 is amended by striking ''2-consecutive-taxable year period'' and all that follows and inserting ''3-consecutive-taxable year period beginning with the 1st taxable year beginning after 2016 in which—

''(A) the employer (or any predecessor) offers 1 or more qualified health plans to its employees through an Exchange, and

''(B) the employer (or any predecessor) claims the credit under this section.''.

(d) AVERAGE ANNUAL WAGE LIMITATION.—Subparagraph (B) of section 45R(d)(3) of the Internal Revenue Code of 1986 is amended to read as follows:

''(B) DOLLAR AMOUNT.—For purposes of paragraph (1)(B) and subsection (c)(2), the dollar amount in effect under this paragraph is the amount equal to 110 percent of the poverty line (within the meaning of section 36B(d)(3)) for a family of 4.''.

(e) ELIMINATION OF UNIFORM PERCENTAGE CONTRIBUTION REQUIREMENT.—Paragraph (4) of section 45R(d) of the Internal Revenue Code of 1986 is amended by striking ''a uniform percentage (not less than 50 percent)'' and inserting ''at least 50 percent''.

(f) ELIMINATION OF CAP RELATING TO AVERAGE LOCAL PREMIUMS.—Subsection (b) of section 45R of the Internal Revenue Code of 1986 is amended by striking ''the lesser of'' and all that follows and inserting ''the aggregate amount of nonelective contributions the employer made on behalf of its employees during the taxable year under the arrangement described in subsection (d)(4) for premiums for qualified health plans offered by the employer to its employees through an Exchange.''.

(g) AMENDMENT RELATING TO ANNUAL WAGE LIMITATION.—Subparagraph (B) of section 45R(d)(1) of the Internal Revenue Code of 1986 is amended by striking ''twice'' and inserting ''three times''.

(h) EFFECTIVE DATE.—The amendments made by this section shall apply to amounts paid or incurred in taxable years beginning after December 31, 2016.

SA 332. Mr. COONS (for himself and Mr. BLUMENTHAL) submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. ANNUAL AND LIFETIME LIMITS.

A State granted a waiver under section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C. 18052), as amended by this Act, shall ensure that the provisions of section 2711 of the Public Health Service Act (42 U.S.C. 300gg-11) shall continue to apply to health insurance issuers in the State with respect to any essential health benefit as defined by the Secretary of Health and Human Services under section 1302(b) of the Patient Protection and Affordable Care Act.

SA 333. Mr. COONS (for himself, Mr. DURBIN, and Mr. BLUMENTHAL) submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. LEVEL OF COVERAGE.

A State granted a waiver with respect to essential health benefits coverage under section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C. 18052), as amended by this Act, shall ensure that new essential health benefits provided under the waiver provide at least a level of coverage that is equal to the essential health benefits coverage provided to Members of Congress.

SA 334. Mr. COONS (for himself and Mr. BLUMENTHAL) submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. NOTICE REQUIREMENT.

The President shall notify in writing any individual who receives a cut in health care benefits, lower quality health insurance, or loses health insurance altogether that these changes are the result of this Act and the amendments made by this Act.

SA 335. Mr. KING (for himself, Mr. BLUMENTHAL, Mr. CASEY, Mrs. SHAHEEN, and Mr. COONS) submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAMS.

Section 511(j)(1) of the Social Security Act (42 U.S.C. 711(j)(1)) is amended—

(1) in subparagraph (G), by striking ''and'' after the semicolon;

(2) in subparagraph (H), by striking the period at the end and inserting ''; and'';and

(3) by adding at the end the following new subparagraph:

''(I) for each of fiscal years 2018 through 2027, $400,000,000.''.

SA 336. Mr. KING (for himself, Mr. BLUMENTHAL, and Mrs. SHAHEEN) submitted an amendment intended to be

proposed to amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ____. REDUCING INFANT MORTALITY.

The Secretary of Health and Human Services shall implement programs to protect, preserve, maintain, sustain, and expand all programs related to addressing, identifying the cause of, and reducing infant mortality.

SA 337. Mr. KING (for himself, Mr. BLUMENTHAL, and Mrs. SHAHEEN) submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. NATIONAL HEALTH SERVICE CORPS.

There are authorized to be appropriated, and there are appropriated, for each of fiscal years 2018 through 2026, $400,000,000 to carry out the National Health Service Corps program under subpart II of part D of title III of the Public Health Service Act (42 U.S.C. 254d et seq.) and the scholarship program and loan repayment program under subpart III of part D of title III of the Public Health Service Act (42 U.S.C. 254l et seq.).

SA 338. Mr. KING (for himself, Mr. BLUMENTHAL, and Mrs. SHAHEEN) submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

Strike section 201.

SA 339. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. PRESERVATION OF RIGHT TO MAINTAIN EXISTING COVERAGE.

(a) IN GENERAL.—Section 1251 of the Patient Protection and Affordable Care Act (42 U.S.C. 18011) is amended:

(1) in subsection (e), by inserting ''other than a plan or coverage described in subsection (f)'' before the period; and

(2) by adding at the end the following:

''(f) PRESERVATION OF EXISTING OPTIONS.—In the case of a group health plan or health insurance coverage (other than a qualified health plan offered on an exchange established pursuant to this Act) offered to the members of an agricultural organization exempt from Federal income tax under section 501(c)(5) of the Internal Revenue Code of 1986, in existence since 1918, that has been providing health coverage to members since 1970, to the extent permitted by applicable State law—

''(1) this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply, and

''(2) such plan or coverage shall not be subject to any requirement of this Act that does not apply to a grandfathered plan.

This subsection shall apply to such plan or coverage, including with respect to new enrollees.''.

(b) EFFECTIVE DATE.—This section shall be effective for plan and policy years beginning on or after January 1, 2018.

SA 340. Mr. MCCONNELL (for Mr. DAINES) proposed an amendment to amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; as follows:

In lieu of the matter proposed to be inserted, insert the following:

1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Expanded & Improved Medicare For All Act''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. DEFINITIONS AND TERMS.

In this Act:

(1) MEDICARE FOR ALL PROGRAM; PROGRAM.—The terms ''Medicare For All Program'' and ''Program'' mean the program of benefits provided under this Act and, unless the context otherwise requires, the Secretary with respect to functions relating to carrying out such program.

(2) NATIONAL BOARD OF UNIVERSAL QUALITY AND ACCESS.—The term ''National Board of Universal Quality and Access'' means such Board established under section 305.

(3) REGIONAL OFFICE.—The term ''regional office'' means a regional office established under section 303.

(4) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(5) DIRECTOR.—The term ''Director'' means, in relation to the Program, the Director appointed under section 301.

TITLE I—ELIGIBILITY AND BENEFITS

SEC. 101. ELIGIBILITY AND REGISTRATION.

(a) IN GENERAL.—All individuals residing in the United States (including any territory of the United States) are covered under the Medicare For All Program entitling them to a universal, best quality standard of care. Each such individual shall receive a card with a unique number in the mail. An individual's Social Security number shall not be used for purposes of registration under this section.

(b) REGISTRATION.—Individuals and families shall receive a Medicare For All Program Card in the mail, after filling out a Medicare For All Program application form at a health care provider. Such application form shall be no more than 2 pages long.

(c) PRESUMPTION.—Individuals who present themselves for covered services from a participating provider shall be presumed to be eligible for benefits under this Act, but shall complete an application for benefits in order to receive a Medicare For All Program Card and have payment made for such benefits.

(d) RESIDENCY CRITERIA.—The Secretary shall promulgate a rule that provides criteria for determining residency for eligibility purposes under the Medicare For All Program.

(e) COVERAGE FOR VISITORS.—The Secretary shall promulgate a rule regarding visitors from other countries who seek premeditated non-emergency surgical procedures. Such a rule should facilitate the establishment of country-to-country reimbursement arrangements or self pay arrangements between the visitor and the provider of care.

SEC. 102. BENEFITS AND PORTABILITY.

(a) IN GENERAL.—The health care benefits under this Act cover all medically necessary services, including at least the following:

(1) Primary care and prevention.

(2) Approved dietary and nutritional therapies.

(3) Inpatient care.

(4) Outpatient care.

(5) Emergency care.

(6) Prescription drugs.

(7) Durable medical equipment.

(8) Long-term care.

(9) Palliative care.

(10) Mental health services.

(11) The full scope of dental services, services, including periodontics, oral surgery, and endodontics, but not including cosmetic dentistry.

(12) Substance abuse treatment services.

(13) Chiropractic services, not including electrical stimulation.

(14) Basic vision care and vision correction (other than laser vision correction for cosmetic purposes).

(15) Hearing services, including coverage of hearing aids.

(16) Podiatric care.

(b) PORTABILITY.—Such benefits are available through any licensed health care clinician anywhere in the United States that is legally qualified to provide the benefits.

(c) NO COST-SHARING.—No deductibles, copayments, coinsurance, or other cost-sharing shall be imposed with respect to covered benefits.

SEC. 103. QUALIFICATION OF PARTICIPATING PROVIDERS.

(a) REQUIREMENT TO BE PUBLIC OR NON-PROFIT.—

(1) IN GENERAL.—No institution may be a participating provider unless it is a public or not-for-profit institution. Private physicians, private clinics, and private health care providers shall continue to operate as private entities, but are prohibited from being investor owned.

(2) CONVERSION OF INVESTOR-OWNED PROVIDERS.—For-profit providers of care opting to participate shall be required to convert to not-for-profit status.

(3) PRIVATE DELIVERY OF CARE REQUIREMENT.—For-profit providers of care that convert to non-profit status shall remain privately owned and operated entities.

(4) COMPENSATION FOR CONVERSION.—The owners of such for-profit providers shall be compensated for reasonable financial losses incurred as a result of the conversion from for-profit to non-profit status.

(5) FUNDING.—There are authorized to be appropriated from the Treasury such sums as are necessary to compensate investor-owned providers as provided for under paragraph (3).

(6) REQUIREMENTS.—The payments to owners of converting for-profit providers shall occur during a 15-year period, through the sale of U.S. Treasury Bonds. Payment for conversions under paragraph (3) shall not be made for loss of business profits.

(7) MECHANISM FOR CONVERSION PROCESS.—The Secretary shall promulgate a rule to provide a mechanism to further the timely, efficient, and feasible conversion of for-profit providers of care.

(b) QUALITY STANDARDS.—

(1) IN GENERAL.—Health care delivery facilities must meet State quality and licensing guidelines as a condition of participation under such program, including guidelines regarding safe staffing and quality of care.

(2) LICENSURE REQUIREMENTS.—Participating clinicians must be licensed in their State of practice and meet the quality standards for their area of care. No clinician whose license is under suspension or who is under disciplinary action in any State may be a participating provider.

(c) PARTICIPATION OF HEALTH MAINTENANCE ORGANIZATIONS.—

(1) IN GENERAL.—Non-profit health maintenance organizations that deliver care in their own facilities and employ clinicians on a salaried basis may participate in the program and receive global budgets or capitation payments as specified in section 202.

(2) EXCLUSION OF CERTAIN HEALTH MAINTENANCE ORGANIZATIONS.—Other health maintenance organizations which principally contract to pay for services delivered by non-employees shall be classified as insurance plans. Such organizations shall not be participating providers, and are subject to the regulations promulgated by reason of section 104(a) (relating to prohibition against duplicating coverage).

(d) FREEDOM OF CHOICE.—Patients shall have free choice of participating physicians and other clinicians, hospitals, and inpatient care facilities.

SEC. 104. PROHIBITION AGAINST DUPLICATING COVERAGE.

(a) IN GENERAL.—It is unlawful for a private health insurer to sell health insurance coverage that duplicates the benefits provided under this Act.

(b) CONSTRUCTION.—Nothing in this Act shall be construed as prohibiting the sale of health insurance coverage for any additional benefits not covered by this Act, such as for cosmetic surgery or other services and items that are not medically necessary.

TITLE II—FINANCES

Subtitle A—Budgeting and Payments

SEC. 201. BUDGETING PROCESS.

(a) ESTABLISHMENT OF OPERATING BUDGET AND CAPITAL EXPENDITURES BUDGET.—

(1) IN GENERAL.—To carry out this Act there are established on an annual basis consistent with this title—

(A) an operating budget, including amounts for optimal physician, nurse, and other health care professional staffing;

(B) a capital expenditures budget;

(C) reimbursement levels for providers consistent with subtitle B; and

(D) a health professional education budget, including amounts for the continued funding of resident physician training programs.

(2) REGIONAL ALLOCATION.—After Congress appropriates amounts for the annual budget for the Medicare For All Program, the Director shall provide the regional offices with an annual funding allotment to cover the costs of each region's expenditures. Such allotment shall cover global budgets, reimbursements to clinicians, health professional education, and capital expenditures. Regional offices may receive additional funds from the national program at the discretion of the Director.

(b) OPERATING BUDGET.—The operating budget shall be used for—

(1) payment for services rendered by physicians and other clinicians;

(2) global budgets for institutional providers;

(3) capitation payments for capitated groups; and

(4) administration of the Program.

(c) CAPITAL EXPENDITURES BUDGET.—The capital expenditures budget shall be used for funds needed for—

(1) the construction or renovation of health facilities; and

(2) for major equipment purchases.

(d) PROHIBITION AGAINST CO-MINGLING OPERATIONS AND CAPITAL IMPROVEMENT FUNDS.—It is prohibited to use funds under this Act that are earmarked—

(1) for operations for capital expenditures; or

(2) for capital expenditures for operations.

SEC. 202. PAYMENT OF PROVIDERS AND HEALTH CARE CLINICIANS.

(a) ESTABLISHING GLOBAL BUDGETS; MONTHLY LUMP SUM.—

(1) IN GENERAL.—The Medicare For All Program, through its regional offices, shall pay each institutional provider of care, including hospitals, nursing homes, community or migrant health centers, home care agencies, or other institutional providers or pre-paid group practices, a monthly lump sum to cover all operating expenses under a global budget.

(2) ESTABLISHMENT OF GLOBAL BUDGETS.—The global budget of a provider shall be set through negotiations between providers, State directors, and regional directors, but are subject to the approval of the Director. The budget shall be negotiated annually, based on past expenditures, projected changes in levels of services, wages and input, costs, a provider's maximum capacity to provide care, and proposed new and innovative programs.

(b) THREE PAYMENT OPTIONS FOR PHYSICIANS AND CERTAIN OTHER HEALTH PROFESSIONALS.—

(1) IN GENERAL.—The Program shall pay physicians, dentists, doctors of osteopathy, pharmacists, psychologists, chiropractors, doctors of optometry, nurse practitioners, nurse midwives, physicians' assistants, and other advanced practice clinicians as licensed and regulated by the States by the following payment methods:

(A) Fee for service payment under paragraph (2).

(B) Salaried positions in institutions receiving global budgets under paragraph (3).

(C) Salaried positions within group practices or non-profit health maintenance organizations receiving capitation payments under paragraph (4).

(2) FEE FOR SERVICE.—

(A) IN GENERAL.—The Program shall negotiate a simplified fee schedule that is fair and optimal with representatives of physicians and other clinicians, after close consultation with the National Board of Universal Quality and Access and regional and State directors. Initially, the current prevailing fees or reimbursement would be the basis for the fee negotiation for all professional services covered under this Act.

(B) CONSIDERATIONS.—In establishing such schedule, the Director shall take into consideration the following:

(i) The need for a uniform national standard.

(ii) The goal of ensuring that physicians, clinicians, pharmacists, and other medical professionals be compensated at a rate which reflects their expertise and the value of their services, regardless of geographic region and past fee schedules.

(C) STATE PHYSICIAN PRACTICE REVIEW BOARDS.—The State director for each State, in consultation with representatives of the physician community of that State, shall establish and appoint a physician practice review board to assure quality, cost effectiveness, and fair reimbursements for physician delivered services.

(D) FINAL GUIDELINES.—The Director shall be responsible for promulgating final guidelines to all providers.

(E) BILLING.—Under this Act physicians shall submit bills to the regional director on a simple form, or via computer. Interest shall be paid to providers who are not reimbursed within 30 days of submission.

(F) NO BALANCE BILLING.—Licensed health care clinicians who accept any payment from the Medicare For All Program may not bill any patient for any covered service.

(G) UNIFORM COMPUTER ELECTRONIC BILLING SYSTEM.—The Director shall create a uniform computerized electronic billing system, including those areas of the United States where electronic billing is not yet established.

(3) SALARIES WITHIN INSTITUTIONS RECEIVING GLOBAL BUDGETS.—

(A) IN GENERAL.—In the case of an institution, such as a hospital, health center, group practice, community and migrant health center, or a home care agency that elects to be paid a monthly global budget for the delivery of health care as well as for education and prevention programs, physicians and other clinicians employed by such institutions shall be reimbursed through a salary included as part of such a budget.

(B) SALARY RANGES.—Salary ranges for health care providers shall be determined in the same way as fee schedules under paragraph (2).

(4) SALARIES WITHIN CAPITATED GROUPS.—

(A) IN GENERAL.—Health maintenance organizations, group practices, and other institutions may elect to be paid capitation payments to cover all outpatient, physician, and medical home care provided to individuals enrolled to receive benefits through the organization or entity.

(B) SCOPE.—Such capitation may include the costs of services of licensed physicians and other licensed, independent practitioners provided to inpatients. Other costs of

inpatient and institutional care shall be excluded from capitation payments, and shall be covered under institutions' global budgets.

(C) PROHIBITION OF SELECTIVE ENROLLMENT.—Patients shall be permitted to enroll or disenroll from such organizations or entities without discrimination and with appropriate notice.

(D) HEALTH MAINTENANCE ORGANIZATIONS.—Under this Act—

(i) health maintenance organizations shall be required to reimburse physicians based on a salary; and

(ii) financial incentives between such organizations and physicians based on utilization are prohibited.

SEC. 203. PAYMENT FOR LONG-TERM CARE.

(a) ALLOTMENT FOR REGIONS.—The Program shall provide for each region a single budgetary allotment to cover a full array of long-term care services under this Act.

(b) REGIONAL BUDGETS.—Each region shall provide a global budget to local long-term care providers for the full range of needed services, including in-home, nursing home, and community based care.

(c) BASIS FOR BUDGETS.—Budgets for long-term care services under this section shall be based on past expenditures, financial and clinical performance, utilization, and projected changes in service, wages, and other related factors.

(d) FAVORING NON-INSTITUTIONAL CARE.—All efforts shall be made under this Act to provide long-term care in a home- or community-based setting, as opposed to institutional care.

SEC. 204. MENTAL HEALTH SERVICES.

(a) IN GENERAL.—The Program shall provide coverage for all medically necessary mental health care on the same basis as the coverage for other conditions. Licensed mental health clinicians shall be paid in the same manner as specified for other health professionals, as provided for in section 202(b).

(b) FAVORING COMMUNITY-BASED CARE.—The Medicare For All Program shall cover supportive residences, occupational therapy, and ongoing mental health and counseling services outside the hospital for patients with serious mental illness. In all cases the highest quality and most effective care shall be delivered, and, for some individuals, this may mean institutional care.

SEC. 205. PAYMENT FOR PRESCRIPTION MEDICATIONS, MEDICAL SUPPLIES, AND MEDICALLY NECESSARY ASSISTIVE EQUIPMENT.

(a) NEGOTIATED PRICES.—The prices to be paid each year under this Act for covered pharmaceuticals, medical supplies, and medically necessary assistive equipment shall be negotiated annually by the Program.

(b) PRESCRIPTION DRUG FORMULARY.—

(1) IN GENERAL.—The Program shall establish a prescription drug formulary system, which shall encourage best-practices in prescribing and discourage the use of ineffective, dangerous, or excessively costly medications when better alternatives are available.

(2) PROMOTION OF USE OF GENERICS.—The formulary shall promote the use of generic medications but allow the use of brand-name and off-formulary medications.

(3) FORMULARY UPDATES AND PETITION RIGHTS.—The formulary shall be updated frequently and clinicians and patients may petition their region or the Director to add new pharmaceuticals or to remove ineffective or dangerous medications from the formulary.

SEC. 206. CONSULTATION IN ESTABLISHING REIMBURSEMENT LEVELS.

Reimbursement levels under this subtitle shall be set after close consultation with regional and State Directors and after the annual meeting of National Board of Universal Quality and Access.

Subtitle B—Funding

SEC. 211. OVERVIEW: FUNDING THE MEDICARE FOR ALL PROGRAM.

(a) IN GENERAL.—The Medicare For All Program is to be funded as provided in subsection (c)(1).

(b) MEDICARE FOR ALL TRUST FUND.—There shall be established a Medicare For All Trust Fund in which funds provided under this section are deposited and from which expenditures under this Act are made.

(c) FUNDING.—

(1) IN GENERAL.—There are appropriated to the Medicare For All Trust Fund amounts sufficient to carry out this Act from the following sources:

(A) Existing sources of Federal Government revenues for health care.

(B) Increasing personal income taxes on the top 5 percent income earners.

(C) Instituting a modest and progressive excise tax on payroll and self-employment income.

(D) Instituting a modest tax on unearned income.

(E) Instituting a small tax on stock and bond transactions.

(2) SYSTEM SAVINGS AS A SOURCE OF FINANCING.—Funding otherwise required for the Program is reduced as a result of—

(A) vastly reducing paperwork;

(B) requiring a rational bulk procurement of medications under section 205(a); and

(C) improved access to preventive health care.

(3) ADDITIONAL ANNUAL APPROPRIATIONS TO MEDICARE FOR ALL PROGRAM.—Additional sums are authorized to be appropriated annually as needed to maintain maximum quality, efficiency, and access under the Program.

SEC. 212. APPROPRIATIONS FOR EXISTING PROGRAMS.

Notwithstanding any other provision of law, there are hereby transferred and appropriated to carry out this Act, amounts from the Treasury equivalent to the amounts the Secretary estimates would have been appropriated and expended for Federal public health care programs, including funds that would have been appropriated under the Medicare program under title XVIII of the Social Security Act, under the Medicaid program under title XIX of such Act, and under the Children's Health Insurance Program under title XXI of such Act.

TITLE III—ADMINISTRATION

SEC. 301. PUBLIC ADMINISTRATION; APPOINTMENT OF DIRECTOR.

(a) IN GENERAL.—Except as otherwise specifically provided, this Act shall be administered by the Secretary through a Director appointed by the Secretary.

(b) LONG-TERM CARE.—The Director shall appoint a director for long-term care who shall be responsible for administration of this Act and ensuring the availability and accessibility of high quality long-term care services.

(c) MENTAL HEALTH.—The Director shall appoint a director for mental health who shall be responsible for administration of this Act and ensuring the availability and accessibility of high quality mental health services.

SEC. 302. OFFICE OF QUALITY CONTROL.

The Director shall appoint a director for an Office of Quality Control. Such director shall, after consultation with State and regional directors, provide annual recommendations to Congress, the President, the Secretary, and other Program officials on how to ensure the highest quality health care service delivery. The director of the Office of Quality Control shall conduct an annual review on the adequacy of medically necessary services, and shall make recommendations of any proposed changes to the Congress, the President, the Secretary, and other Medicare For All Program officials.

SEC. 303. REGIONAL AND STATE ADMINISTRATION; EMPLOYMENT OF DISPLACED CLERICAL WORKERS.

(a) ESTABLISHMENT OF MEDICARE FOR ALL PROGRAM REGIONAL OFFICES.—The Secretary shall establish and maintain Medicare For All regional offices for the purpose of distributing funds to providers of care. Whenever possible, the Secretary should incorporate pre-existing Medicare infrastructure for this purpose.

(b) APPOINTMENT OF REGIONAL AND STATE DIRECTORS.—In each such regional office there shall be—

(1) one regional director appointed by the Director; and

(2) for each State in the region, a deputy director (in this Act referred to as a ''State Director'') appointed by the governor of that State.

(c) REGIONAL OFFICE DUTIES.—Regional offices of the Program shall be responsible for—

(1) coordinating funding to health care providers and physicians; and

(2) coordinating billing and reimbursements with physicians and health care providers through a State-based reimbursement system.

(d) STATE DIRECTOR'S DUTIES.—Each State Director shall be responsible for the following duties:

(1) Providing an annual State health care needs assessment report to the National Board of Universal Quality and Access, and the regional board, after a thorough examination of health needs, in consultation with public health officials, clinicians, patients, and patient advocates.

(2) Health planning, including oversight of the placement of new hospitals, clinics, and other health care delivery facilities.

(3) Health planning, including oversight of the purchase and placement of new health equipment to ensure timely access to care and to avoid duplication.

(4) Submitting global budgets to the regional director.

(5) Recommending changes in provider reimbursement or payment for delivery of health services in the State.

(6) Establishing a quality assurance mechanism in the State in order to minimize both under utilization and over utilization and to assure that all providers meet high quality standards.

(7) Reviewing program disbursements on a quarterly basis and recommending needed adjustments in fee schedules needed to achieve budgetary targets and assure adequate access to needed care.

(e) FIRST PRIORITY IN RETRAINING AND JOB PLACEMENT; 2 YEARS OF SALARY PARITY BENEFITS.—The Program shall provide that clerical, administrative, and billing personnel in insurance companies, doctors offices, hospitals, nursing facilities, and other facilities whose jobs are eliminated due to reduced administration—

(1) should have first priority in retraining and job placement in the new system; and

(2) shall be eligible to receive two years of Medicare For All employment transition benefits with each year's benefit equal to salary earned during the last 12 months of employment, but shall not exceed $100,000 per year.

(f) ESTABLISHMENT OF MEDICARE FOR ALL EMPLOYMENT TRANSITION FUND.—The Secretary shall establish a trust fund from

which expenditures shall be made to recipients of the benefits allocated in subsection (e).

(g) ANNUAL APPROPRIATIONS TO MEDICARE FOR ALL EMPLOYMENT TRANSITION FUND.—Sums are authorized to be appropriated annually as needed to fund the Medicare For All Employment Transition Benefits.

(h) RETENTION OF RIGHT TO UNEMPLOYMENT BENEFITS.—Nothing in this section shall be interpreted as a waiver of Medicare For All Employment Transition benefit recipients' right to receive Federal and State unemployment benefits.

SEC. 304. CONFIDENTIAL ELECTRONIC PATIENT RECORD SYSTEM.

(a) IN GENERAL.—The Secretary shall create a standardized, confidential electronic patient record system in accordance with laws and regulations to maintain accurate patient records and to simplify the billing process, thereby reducing medical errors and bureaucracy.

(b) PATIENT OPTION.—Notwithstanding that all billing shall be preformed electronically, patients shall have the option of keeping any portion of their medical records separate from their electronic medical record.

SEC. 305. NATIONAL BOARD OF UNIVERSAL QUALITY AND ACCESS.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—There is established a National Board of Universal Quality and Access (in this section referred to as the ''Board'') consisting of 15 members appointed by the President, by and with the advice and consent of the Senate.

(2) QUALIFICATIONS.—The appointed members of the Board shall include at least one of each of the following:

(A) Health care professionals.

(B) Representatives of institutional providers of health care.

(C) Representatives of health care advocacy groups.

(D) Representatives of labor unions.

(E) Citizen patient advocates.

(3) TERMS.—Each member shall be appointed for a term of 6 years, except that the President shall stagger the terms of members initially appointed so that the term of no more than 3 members expires in any year.

(4) PROHIBITION ON CONFLICTS OF INTEREST.—No member of the Board shall have a financial conflict of interest with the duties before the Board.

(b) DUTIES.—

(1) IN GENERAL.—The Board shall meet at least twice per year and shall advise the Secretary and the Director on a regular basis to ensure quality, access, and affordability.

(2) SPECIFIC ISSUES.—The Board shall specifically address the following issues:

(A) Access to care.

(B) Quality improvement.

(C) Efficiency of administration.

(D) Adequacy of budget and funding.

(E) Appropriateness of reimbursement levels of physicians and other providers.

(F) Capital expenditure needs.

(G) Long-term care.

(H) Mental health and substance abuse services.

(I) Staffing levels and working conditions in health care delivery facilities.

(3) ESTABLISHMENT OF UNIVERSAL, BEST QUALITY STANDARD OF CARE.—The Board shall specifically establish a universal, best quality of standard of care with respect to—

(A) appropriate staffing levels;

(B) appropriate medical technology;

(C) design and scope of work in the health workplace;

(D) best practices; and

(E) salary level and working conditions of physicians, clinicians, nurses, other medical professionals, and appropriate support staff.

(4) TWICE-A-YEAR REPORT.—The Board shall report its recommendations twice each year to the Secretary, the Director, Congress, and the President.

(c) COMPENSATION, ETC.—The following provisions of section 1805 of the Social Security Act shall apply to the Board in the same manner as they apply to the Medicare Payment Assessment Commission (except that any reference to the Commission or the Comptroller General shall be treated as references to the Board and the Secretary, respectively):

(1) Subsection (c)(4) (relating to compensation of Board members).

(2) Subsection (c)(5) (relating to chairman and vice chairman).

(3) Subsection (c)(6) (relating to meetings).

(4) Subsection (d) (relating to director and staff; experts and consultants).

(5) Subsection (e) (relating to powers).

TITLE IV—ADDITIONAL PROVISIONS

SEC. 401. TREATMENT OF VA AND IHS HEALTH PROGRAMS.

(a) VA HEALTH PROGRAMS.—This Act provides for health programs of the Department of Veterans' Affairs to initially remain independent for the 10-year period that begins on the date of the establishment of the Medicare For All Program. After such 10-year period, the Congress shall reevaluate whether such programs shall remain independent or be integrated into the Medicare For All Program.

(b) INDIAN HEALTH SERVICE PROGRAMS.—This Act provides for health programs of the Indian Health Service to initially remain independent for the 5-year period that begins on the date of the establishment of the Medicare For All Program, after which such programs shall be integrated into the Medicare For All Program.

SEC. 402. PUBLIC HEALTH AND PREVENTION.

It is the intent of this Act that the Program at all times stress the importance of good public health through the prevention of diseases.

SEC. 403. REDUCTION IN HEALTH DISPARITIES.

It is the intent of this Act to reduce health disparities by race, ethnicity, income and geographic region, and to provide high quality, cost-effective, culturally appropriate care to all individuals regardless of race, ethnicity, sexual orientation, or language.

TITLE V—EFFECTIVE DATE

SEC. 501. EFFECTIVE DATE.

Except as otherwise specifically provided, this Act shall take effect on the first day of the first year that begins more than 1 year after the date of the enactment of this Act, and shall apply to items and services furnished on or after such date.

SA 341. Mr. UDALL (for himself, Ms. CANTWELL, Ms. CORTEZ MASTO, Ms. HEITKAMP, Mr. FRANKEN, Mrs. MURRAY, Mr. SCHATZ, Ms. STABENOW, Mr. TESTER, and Mr. MERKLEY) submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. POINT OF ORDER AGAINST LEGISLATION THAT WOULD REDUCE OR LIMIT FEDERAL PAYMENTS FOR HEALTH INSURANCE OR HEALTH CARE FOR AMERICAN INDIANS OR ALASKA NATIVES.

(a) POINT OF ORDER.—It shall not be in order in the Senate to consider any bill, joint resolution, motion, amendment, amendment between the Houses, or conference report that would—

(1) reduce or limit Federal payments to help cover the cost of private health insurance with respect to private health insurance purchased by American Indians or Alaska Natives; or

(2) reduce or limit Federal payments for spending under the Medicaid program with respect to services provided by the Indian Health Service, an Indian Health Program, an Urban Indian Organization, or Indian tribes or other tribal organizations, or with respect to services provided to individuals who are American Indians or Alaska Natives.

(b) WAIVER AND APPEAL.—Subsection (a) may be waived or suspended in the Senate only by an affirmative vote of three-fifths of the Members, duly chosen and sworn. An affirmative vote of three-fifths of the Members of the Senate, duly chosen and sworn, shall be required to sustain an appeal of the ruling of the Chair on a point of order raised under subsection (a).

SA 342. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. PROTECTION OF INDIVIDUALS' HEALTH PLANS.

This Act (and the amendments made by this Act) shall not take effect until the Chief Actuary of the Centers for Medicare & Medicaid Services certifies to Congress that the implementation of this Act (and amendments) will not result in increased premiums under employer-sponsored insurance.

SA 343. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. PROTECTION OF INDIVIDUALS' HEALTH PLANS.

This Act (and the amendments made by this Act) shall not take effect until the Chief Actuary of the Centers for Medicare & Medicaid Services certifies to Congress that the implementation of this Act (and amendments) will not result in increased deductibles under employer-sponsored insurance.

SA 344. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. PROTECTION OF INDIVIDUALS' HEALTH PLANS.

This Act (and the amendments made by this Act) shall not take effect until the Chief Actuary of the Centers for Medicare & Medicaid Services certifies to Congress that the implementation of this Act (and amendments) will not result in the loss of pregnancy, maternity, and newborn care (both before and after birth) under qualified health plans.

SA 345. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. PROTECTION OF INDIVIDUALS' HEALTH PLANS.

This Act (and the amendments made by this Act) shall not take effect until the Chief Actuary of the Centers for Medicare & Medicaid Services certifies to Congress that the implementation of this Act (and amendments) will not result in the loss of mental health and substance use disorder services, including behavioral health treatment (including counseling and psychotherapy) under qualified health plans.

SA 346. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. NO INCREASES IN DEDUCTIBLES.

This Act (and the amendments made by this Act) shall not take effect until the Chief Actuary of the Centers for Medicare & Medicaid Services certifies to Congress that the implementation of this Act (and amendments) will not result in increased deductibles under qualified health plans.

SA 347. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. PROTECTION OF INDIVIDUALS' HEALTH PLANS.

This Act (and the amendments made by this Act) shall not take effect until the Chief Actuary of the Centers for Medicare & Medicaid Services certifies to Congress that the implementation of this Act (and amendments) will not result in the loss of coverage for people under qualified health plans.

SA 348. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. NO INCREASES IN UNCOMPENSATED CARE.

This Act (and the amendments made by this Act) shall not take effect until the Chief Actuary of the Centers for Medicare & Medicaid Services certifies to Congress that the implementation of this Act (and amendments) will not increase uncompensated care at nonprofit or hospitals operated by the Federal Government.

SA 349. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

On page 129, strike lines 3 through 10 and insert the following:

SEC. 221. SUPPORT FOR STATE RESPONSE TO OPIOID ADDICTION.

There is authorized to be appropriated, and is appropriated, out of monies in the Treasury not otherwise obligated, $10,000,000,000 for fiscal year 2018 to the Secretary of Health and Human Services to provide grants to States to support treatment for opioid addiction. Funds appropriated under this section shall remain available until expended.

SA 350. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. PROTECTION OF INDIVIDUALS' HEALTH PLANS.

This Act (and the amendments made by this Act) shall not take effect until the Chief Actuary of the Centers for Medicare & Medicaid Services certifies to Congress that the implementation of this Act (and amendments) will not result in individuals losing access to their current health plans, if such individuals wish to keep such plans.

SA 351. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

On page 129, strike lines 3 through 10 and insert the following:

SEC. 221. SUPPORT FOR STATE RESPONSE TO DOMESTIC VIOLENCE.

There is authorized to be appropriated, and is appropriated, out of monies in the Treasury not otherwise obligated, $10,000,000,000 for fiscal year 2018 to the Secretary of Health and Human Services to provide grants to States to support assistance for victims of domestic violence. Funds appropriated under this section shall remain available until expended.

SA 352. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

On page 129, strike lines 3 through 10 and insert the following:

SEC. 221. SUPPORT FOR STATE RESPONSE TO PEDIATRIC CANCERS.

There is authorized to be appropriated, and is appropriated, out of monies in the Treasury not otherwise obligated, $10,000,000,000 for fiscal year 2018 to the Secretary of Health and Human Services to provide grants to States to support treatment of pediatric cancers. Funds appropriated under this section shall remain available until expended.

SA 353. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

On page 129, strike lines 3 through 10 and insert the following:

SEC. 221. SUPPORT FOR STATE RESPONSE TO CANCER.

There is authorized to be appropriated, and is appropriated, out of monies in the Treasury not otherwise obligated, $10,000,000,000 for fiscal year 2018 to the Secretary of Health and Human Services to provide grants to States to support treatment of adults with cancer. Funds appropriated under this section shall remain available until expended.

SA 354. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

On page 129, strike lines 3 through 10 and insert the following:

SEC. 221. SUPPORT FOR STATE RESPONSE TO CHILDREN WITH PRE-EXISTING CONDITIONS.

There is authorized to be appropriated, and is appropriated, out of monies in the Treasury not otherwise obligated, $10,000,000,000 for fiscal year 2018 to the Secretary of Health and Human Services to provide grants to States to support treatment of children with pre-existing conditions. Funds appropriated under this section shall remain available until expended.

SA 355. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

On page 129, strike lines 3 through 10 and insert the following:

SEC. 221. SUPPORT FOR STATE RESPONSE TO ADULTS WITH PRE-EXISTING CONDITIONS.

There is authorized to be appropriated, and is appropriated, out of monies in the Treasury not otherwise obligated, $10,000,000,000 for fiscal year 2018 to the Secretary of Health and Human Services to provide grants to States to support treatment of adults with pre-existing conditions. Funds appropriated under this section shall remain available until expended.

SA 356. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

On page 129, strike lines 3 through 10 and insert the following:

SEC. 221. SUPPORT FOR STATE RESPONSE TO DEPRESSION.

There is authorized to be appropriated, and is appropriated, out of monies in the Treasury not otherwise obligated, $10,000,000,000 for fiscal year 2018 to the Secretary of Health and Human Services to provide grants to States to support treatment of individuals with depression. Funds appropriated under this section shall remain available until expended.

SA 357. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

On page 129, strike lines 3 through 10 and insert the following:

SEC. 221. SUPPORT FOR STATE RESPONSE TO MENTAL ILLNESS.

There is authorized to be appropriated, and is appropriated, out of monies in the Treasury not otherwise obligated, $10,000,000,000 for fiscal year 2018 to the Secretary of Health and Human Services to provide grants to States to support treatment of individuals with mental illness. Funds appropriated under this section shall remain available until expended.

SA 358. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

On page 129, strike lines 3 through 10 and insert the following:

SEC. 221. SUPPORT FOR STATE RESPONSE TO HEART DISEASE.

There is authorized to be appropriated, and is appropriated, out of monies in the Treasury not otherwise obligated, $10,000,000,000 for fiscal year 2018 to the Secretary of Health and Human Services to provide grants to States to support treatment of individuals with heart disease. Funds appropriated under this section shall remain available until expended.

SA 359. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

On page 129, strike lines 3 through 10 and insert the following:

SEC. 221. SUPPORT FOR STATE RESPONSE TO ALZHEIMER'S DISEASE.

There is authorized to be appropriated, and is appropriated, out of monies in the Treasury not otherwise obligated, $10,000,000,000 for fiscal year 2018 to the Secretary of Health and Human Services to provide grants to States to support treatment of individuals with Alzheimer's disease. Funds appropriated under this section shall remain available until expended.

SA 360. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

On page 129, strike lines 3 through 10 and insert the following:

SEC. 221. SUPPORT FOR STATE RESPONSE TO BREAST CANCER.

There is authorized to be appropriated, and is appropriated, out of monies in the Treasury not otherwise obligated, $10,000,000,000 for fiscal year 2018 to the Secretary of Health and Human Services to provide grants to States to support treatment of individuals with breast cancer. Funds appropriated under this section shall remain available until expended.

SA 361. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

On page 129, strike lines 3 through 10 and insert the following:

SEC. 221. SUPPORT FOR STATE RESPONSE TO PARKINSON'S DISEASE.

There is authorized to be appropriated, and is appropriated, out of monies in the Treasury not otherwise obligated, $10,000,000,000 for fiscal year 2018 to the Secretary of Health and Human Services to provide grants to States to support treatment of individuals with Parkinson's disease. Funds appropriated under this section shall remain available until expended.

SA 362. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

On page 129, strike lines 3 through 10 and insert the following:

SEC. 221. SUPPORT FOR STATE RESPONSE TO POST-TRAUMATIC STRESS DISORDER.

There is authorized to be appropriated, and is appropriated, out of monies in the Treasury not otherwise obligated, $10,000,000,000 for fiscal year 2018 to the Secretary of Health and Human Services to provide grants to States to support treatment of individuals with post-traumatic stress disorder. Funds appropriated under this section shall remain available until expended.

SA 363. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

On page 129, strike lines 3 through 10 and insert the following:

SEC. 221. SUPPORT FOR STATE RESPONSE TO DIABETES.

There is authorized to be appropriated, and is appropriated, out of monies in the Treasury not otherwise obligated, $10,000,000,000 for fiscal year 2018 to the Secretary of Health and Human Services to provide grants to States to support treatment of individuals with diabetes. Funds appropriated under this section shall remain available until expended.

SA 364. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ____. PROTECTION OF INDIVIDUALS' HEALTH CARE.

This Act (and the amendments made by this Act) shall not take effect until the Chief Actuary of the Centers for Medicare & Medicaid Services certifies to Congress that the implementation of this Act (and amendments) will not result in the loss of coverage under the Medicaid program.

SA 365. Mr. MURPHY submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ____. PROTECTION OF INDIVIDUALS' HEALTH CARE.

This Act (and the amendments made by this Act) shall not take effect until the Chief Actuary of the Centers for Medicare & Medicaid Services certifies to Congress that the implementation of this Act (and amendments) will not result in the loss of mental health and substance use disorder services, including behavioral health treatment (including counseling and psychotherapy) under the Medicaid program.

SA 366. Mr. KAINE (for himself, Mr. BLUMENTHAL, Mr. CARPER, and Mrs. SHAHEEN) submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

Strike subtitles B through C of title I.

SA 367. Ms. DUCKWORTH submitted an amendment intended to be proposed by her to the bill H.R. 2810, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

On page 312, strike line 21 and all that follows through page 313, line 9.

SA 368. Ms. DUCKWORTH submitted an amendment intended to be proposed by her to the bill H.R. 2810, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 821.

SA 369. Ms. DUCKWORTH submitted an amendment intended to be proposed by her to the bill H.R. 2810, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle H of title V, add the following:

SEC. _____. REPORT ON POSSIBLE IMPROVEMENTS TO PROCESSING RETIREMENTS AND MEDICAL DISCHARGES.

(a) REPORT REQUIRED.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Defense shall, in consultation with the Secretary of Veterans Affairs, submit to the congressional defense committees and the Committees on Veterans' Affairs of the Senate and the House of Representatives a report on possible improvements to the transition of members of the Armed Forces to veteran status.

(b) ELEMENTS.—The report under subsection (a) shall address the following:

(1) Feasibility of requiring members of the Armed Forces to apply for benefits administered by the Secretary of Veterans Affairs before such members complete discharge from the Armed Forces.

(2) Feasibility of requiring members of the Armed Forces to undergo compensation and pension examinations (to be administered by the Secretary of Defense) for purposes of obtaining benefits described in paragraph (1) before such members complete discharge from the Armed Forces.

(3) Possible improvements to the timeliness of the process for transitioning members who undergo medical discharge to care provided by the Secretary of Veterans Affairs.

SA 370. Ms. DUCKWORTH submitted an amendment intended to be proposed by her to the bill H.R. 2810, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title VII, add the following:

SEC. _____. TRAINING REQUIREMENT FOR HEALTH CARE PROFESSIONALS OF THE DEPARTMENT OF DEFENSE PRESCRIBING OPIOIDS FOR TREATMENT OF PAIN.

(a) TRAINING.—

(1) IN GENERAL.—The Secretary of Defense shall ensure that health care professionals of the Department of Defense, other than pharmacists, who are authorized to prescribe or otherwise dispense opioids for the treatment of pain—

(A) complete the training described in paragraph (2) not less frequently than once every three years; or

(B) are licensed in a State that requires training that is equivalent to or greater than the training described in paragraph (2) with respect to the prescribing or dispensing of opioids for the treatment of pain.

(2) TRAINING DESCRIBED.—

(A) IN GENERAL.—The training described in this paragraph is not fewer than 12 hours of training (through classroom situations, seminars at professional society meetings, electronic communications, or otherwise) that is provided by organizations specified in subparagraph (B) with respect to—

(i) pain management treatment guidelines and best practices;

(ii) early detection of opioid addiction; and

(iii) the treatment and management of opioid-dependent patients.

(B) ORGANIZATIONS SPECIFIED.—The organizations specified in this subparagraph are the following:

(i) The American Society of Addiction Medicine.

(ii) The American Academy of Addiction Psychiatry.

(iii) The American Medical Association.

(iv) The American Osteopathic Association.

(v) The American Psychiatric Association.

(vi) The American Academy of Pain Management.

(vii) The American Pain Society.

(viii) The American Academy of Pain Medicine.

(ix) The American Board of Pain Medicine.

(x) The American Society of Interventional Pain Physicians.

(xi) Such other organizations as the Secretary of Defense determines appropriate for purposes of this subsection.

(b) ESTABLISHMENT OF TRAINING MODULES.—

(1) IN GENERAL.—The Secretary of Defense shall establish or support the establishment of one or more training modules to be used to provide the training required under subsection (a).

(2) SUPPORT FOR ORGANIZATIONS.—The Secretary may support the establishment of a training module under paragraph (1) by—

(A) an organization specified in paragraph (2)(B) of subsection (a); or

(B) any other organization that the Secretary determines is appropriate to provide the training required under such subsection.

SA 371. Ms. DUCKWORTH submitted an amendment intended to be proposed by her to the bill H.R. 2810, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle C of title VII, add the following:

SEC. _____. PROVISION OF SUPPORT BY DEPARTMENT OF DEFENSE TO DEPARTMENT OF VETERANS AFFAIRS REGARDING ELECTRONIC HEALTH RECORD SYSTEM.

(a) IN GENERAL.—The Secretary of Defense may support the Secretary of Veterans Affairs, to the extent the Secretary of Defense and the Secretary of Veterans Affairs jointly consider feasible and advisable, in the development and implementation of an electronic health record system that—

(1) is derivative of the Military Health System Genesis record being developed and implemented by the Secretary of Defense as of the date of the enactment of this Act; and

(2) achieves complete interoperability with the Military Health System Genesis.

(b) ANNUAL REVIEW.—The Secretary of Defense and the Secretary of Veterans Affairs shall jointly conduct an annual review of the efforts undertaken by the Secretary of Defense and the Secretary of Veterans Affairs to achieve complete interoperability between the electronic health record of the Department of Veterans Affairs and the Military Health System Genesis.

(c) ANNUAL REPORT.—

(1) REPORTS.—Not later than 60 days after completing each annual review under subsection (b), the Secretary of Defense and the Secretary of Veterans Affairs shall jointly submit to the Committee on Armed Services and the Committee on Veterans' Affairs of the Senate and the Committee on Armed Services and the Committee on Veterans' Affairs of the House of Representatives a report on the review.

(2) ELEMENTS.—Each report under paragraph (1) shall include an assessment of the following:

(A) Milestones reached as part of the schedule developed by the Department of Defense and the Department of Veterans Affairs of the development and implementation of an electronic health record system under subsection (a).

(B) Costs associated with such development and implementation.

(C) Actions, if any, of the Secretary of Defense in supporting the Secretary of Veterans Affairs pursuant to subsection (a) with respect to the development and implementation of an electronic health record system and in achieving complete interoperability with the Military Health System Genesis.

(D) Status of the adoption of the national standards and architectural requirements identified by the Interagency Program Office of the Department of Defense and the Department of Veterans Affairs in collaboration with the Office of the National Coordinator for Health Information Technology of the Department of Health and Human Services.

(d) TERMINATION.—The requirements under subsections (b) and (c) shall terminate on the date on which the Secretary of Defense and the Secretary of Veterans Affairs jointly certify to the Committee on Armed Services and the Committee on Veterans' Affairs of the Senate and the Committee on Armed Services and the Committee on Veterans' Affairs of the House of Representatives that the electronic health records of both the Department of Defense and the Department of Veterans Affairs are completely interoperable.

(e) INTEROPERABILITY DEFINED.—In this section, the term ''interoperability'' means the ability of different electronic health records systems or software to meaningfully exchange information in real time and provide useful results to one or more systems.

SA 372. Ms. DUCKWORTH submitted an amendment intended to be proposed by her to the bill H.R. 2810, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle A of title VII, add the following:

SEC. _____. COUNSELING AND TREATMENT FOR SUBSTANCE USE DISORDERS AND CHRONIC PAIN MANAGEMENT FOR MEMBERS WHO SEPARATE FROM THE ARMED FORCES.

Section 1145(a)(6)(B)(i) of title 10, United States Code, is amended—

(1) in subclause (I)—

(A) by inserting '', substance use disorder,'' after ''post-traumatic stress disorder''; and

(B) by striking ''and'' at the end;

(2) by redesignating subclause (II) as subclause (III); and

(3) by inserting after subclause (I) the following new subclause (II):

''(II) chronic pain management services, including counseling and treatment of co-occurring mental health disorders and alternatives to opioid analgesics; and''.

SA 373. Ms. DUCKWORTH submitted an amendment intended to be proposed by her to the bill H.R. 2810, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. RESPONSIBILITIES OF COMMERCIAL MARKET REPRESENTATIVES.

Section 4(h) of the Small Business Act (15 U.S.C. 633(h)) is amended to read as follows:

''(h) COMMERCIAL MARKET REPRESENTATIVES.—

''(1) DUTIES.—The principal duties of a commercial market representative employed by the Administrator and reporting to the senior official appointed by the Administrator with responsibilities under sections 8, 15, 31, and 36 (or the designee of the official) shall be to advance the policies established in section 8(d)(1) relating to subcontracting, including—

''(A) helping prime contractors to find small business concerns that are capable of performing subcontracts;

''(B) for contractors awarded contracts containing the clause described in section 8(d)(3), providing—

''(i) counseling on the responsibility of the contractor to maximize subcontracting opportunities for small business concerns;

''(ii) instruction on methods and tools to identify potential subcontractors that are small business concerns; and

''(iii) assistance to increase awards to subcontractors that are small business concerns through visits, training, and reviews of past performance;

''(C) providing counseling on how a small business concern may promote the capacity of the small business concern to contractors awarded contracts containing the clause described in section 8(d)(3); and

''(D) conducting periodic reviews of contractors awarded contracts containing the clause described in section 8(d)(3) to assess compliance with subcontracting plans required under section 8(d)(6).

''(2) CERTIFICATION REQUIREMENTS.—

''(A) IN GENERAL.—Consistent with the requirements of subparagraph (B), a commercial market representative referred to in section 15(q)(3) shall have a Level I Federal Acquisition Certification in Contracting (or any successor certification) or the equivalent Department of Defense certification.

''(B) DELAY OF CERTIFICATION REQUIREMENT.—The certification described in subparagraph (A) is not required—

''(i) for any person serving as a commercial market representative on the date of enactment of the National Defense Authorization Act for Fiscal Year 2018, until the date that is 1 calendar year after the date on which the person was appointed as a commercial market representative; or

''(ii) for any person serving as a commercial market representative on or before November 25, 2015, until November 25, 2020.

''(3) JOB POSTING REQUIREMENTS.—The duties and certification requirements described in this subsection shall be included in any initial job posting for the position of a commercial market representative.''.

SA 374. Ms. DUCKWORTH submitted an amendment intended to be proposed by her to the bill H.R. 2810, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle A of title IX, add the following:

SEC. _____. DESIGNATION OF OFFICE WITHIN OFFICE OF THE SECRETARY OF DEFENSE TO OVERSEE USE OF FOOD ASSISTANCE PROGRAMS BY MEMBERS OF THE ARMED FORCES ON ACTIVE DUTY.

Not later than 90 days after the date of the enactment of this Act, the Secretary of Defense shall designate an office or official within the Office of the Secretary of Defense for purposes as follows:

(1) To discharge responsibility for overseeing the efforts of the Department of Defense to collect, analyze, and monitor data on the use of food assistance programs by members of the Armed Forces on active duty.

(2) To establish and maintain relationships with other departments and agencies of the Federal Government to facilitate the discharge of the responsibility specified in paragraph (1).

SA 375. Ms. DUCKWORTH submitted an amendment intended to be proposed by her to the bill H.R. 2810, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title VIII, add the following:

SEC. 832. OPTIMIZATION OF MICRO-PURCHASE THRESHOLD TO INCREASE GOVERNMENT EFFICIENCY.

(a) INCREASE IN THRESHOLD.—Section 1902(a)(1) of title 41, United States Code, is amended—

(1) by striking ''sections 2338 and 2339'' and inserting ''section 2339''; and

(2) by striking ''$3,000'' and inserting ''$10,000''.

(b) CONFORMING AND CLERICAL AMENDMENTS.—

(1) Section 2338 of title 10, United States Code, is repealed.

(2) The table of sections at the beginning of chapter 137 of such title is amended by striking the item relating to section 2338.

(c) CONVENIENCE CHECKS.—A convenience check may not be used for an amount in excess of one half of the micro-purchase threshold under section 1902(a) of title 41, United States Code, or a lower amount set by the head of the agency. Use of convenience checks shall comply with controls prescribed in Office of Management and Budget Circular A–123, Appendix B.

SA 376. Ms. DUCKWORTH (for herself, Mr. DURBIN, Mrs. ERNST, and Mr. GRASSLEY) submitted an amendment intended to be proposed by her to the bill H.R. 2810, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title XXVIII, add the following:

SEC. _____. CERTIFICATION RELATED TO CERTAIN ACQUISITIONS OR LEASES OF REAL PROPERTY.

Section 2662(a) of title 10, United States Code, is amended—

(1) in paragraph (2), by striking the period at the end and inserting the following: '', as well as the certification described in paragraph (5).''; and

(2) by adding at the end the following:

''(5) For purposes of paragraph (2), the certification described in this paragraph with respect to an acquisition or lease of real property is a certification that the Secretary concerned—

''(A) evaluated the feasibility of using space in property under the jurisdiction of the Department of Defense to satisfy the purposes of the acquisition or lease; and

''(B) determined that—

''(i) space in property under the jurisdiction of the Department of Defense is not reasonably available to be used to satisfy the purposes of the acquisition or lease;

''(ii) acquiring the property or entering into the lease would be more cost-effective than the use of the Department of Defense property; or

''(iii) the use of the Department of Defense property would interfere with the ongoing military mission of the property.''.

SA 377. Mr. MENENDEZ (for himself, Mr. DURBIN, Mr. BLUMENTHAL, Mr. BOOKER, and Mr. HEINRICH) submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. POINT OF ORDER AGAINST ELIMINATING OR REDUCING FEDERAL FUNDING TO STATES UNDER THE MEDICAID EXPANSION.

(a) POINT OF ORDER.—It shall not be in order in the Senate to consider any bill, joint resolution, motion, amendment, amendment between the Houses, or conference report that would eliminate or reduce funding to States available under law in effect on the date of the adoption of this section to provide comprehensive, affordable health care to low-income Americans by eliminating or reducing the availability of Federal financial assistance to States available under section 1905(y)(1) or 1905(z)(2) of the Social Security Act (42 U.S.C. 1396d(y)(1), 1396d(z)(2)) or other means, unless the Director of the Congressional Budget Office certifies that the legislation would not—

(1) increase the number of uninsured Americans;

(2) decrease Medicaid enrollment in States that have opted to expand eligibility for medical assistance under that program for low-income, non-elderly individuals under the eligibility option established by the Affordable Care Act under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(VIII));

(3) reduce the likelihood that any State that, as of the date of the adoption of this section, has not opted to expand Medicaid under the eligibility option established by the Affordable Care Act under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(VIII)) would opt to use that eligibility option to expand eligibility for medical assistance under that program for low-income, non-elderly individuals; and

(4) increase the State share of Medicaid spending under that eligibility option.

(b) WAIVER AND APPEAL.—Subsection (a) may be waived or suspended in the Senate only by an affirmative vote of three-fifths of the Members, duly chosen and sworn. An affirmative vote of three-fifths of the Members of the Senate, duly chosen and sworn, shall be required to sustain an appeal of the ruling of the Chair on a point of order raised under subsection (a).

SA 378. Mr. MARKEY submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. NULLIFICATION OF CERTAIN PROVISIONS.

The provisions of, and the amendments made by, this Act that would reduce the Federal Government's financial commitment to currently active and successful Medicaid waivers under section 1115 of the Social Security Act that are promoting the objectives of title XIX of such Act shall be null and void and this Act shall be applied and administered as if such provisions and amendments had never been enacted.

SA 379. Mr. MARKEY (for himself, Ms. WARREN, Mr. CARPER, Mr. CASEY, Mr. BROWN, Ms. HIRONO, Ms. STABENOW, Mr. MENENDEZ, and Mr. VAN HOLLEN) submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. NULLIFICATION OF CERTAIN PROVISIONS.

If the Congressional Budget Office determines that the provisions of, or the amendments made by, this Act would increase the amount of uncompensated care provided by hospitals, such provisions or amendments shall be null and void and this Act shall be applied and administered as if such provisions and amendments had not been enacted.

SA 380. Mr. MARKEY submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. MEMBERS OF CONGRESS.

Notwithstanding any other provision of law, if, as a result of the enactment of this Act, the rate of uninsured individuals in the United States is higher on the date that is 1 year after the date of enactment of this Act than such rate was on the date of enactment of this Act, Members of Congress shall not be eligible for an employer contribution to their health plan premiums until the rate of uninsured individuals in the United States is equal to or lower than such rate on the date of enactment of this Act.

SA 381. Mr. MARKEY submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. NULLIFICATION OF CERTAIN PROVISIONS.

If the Congressional Budget Office determines that the provisions of, or the amendments made by, this Act would increase the average premium or out-of-pocket health care costs for individuals who have attained 50 years of age, such provisions or amendments shall be null and void and this Act shall be applied and administered as if such provisions and amendments had not been enacted.

SA 382. Mr. MARKEY submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. REPEAL OF CERTAIN PROVISIONS IF PERCENTAGE OF UNINSURED INCREASES.

Not later than 30 days after the date that is 1 year after the date of enactment of this Act, the Director of the Congressional Budget Office shall determine whether the percentage of uninsured individuals in America is higher than the percentage of such individuals as of such date of enactment. If the percentage of such individuals has increased during that 1-year period as a result of changes made by this Act, effective as of the date of such determination, the provisions of, and the amendments made by, this Act that terminate the Medicaid expansion and impose Medicaid per capita caps shall be null and void and this Act shall be applied and administered as if such provisions and amendments had never been enacted.

SA 383. Mr. FRANKEN (for himself, Mr. CORNYN, Ms. HEITKAMP, and Ms. BALDWIN) submitted an amendment intended to be proposed by him to the bill H.R. 2810, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title V, add the following:

PART II—RESERVE COMPONENT BENEFITS PARITY

SEC. _____. ELIGIBILITY OF RESERVE COMPONENT MEMBERS FOR PRE-MOBILIZATION HEALTH CARE.

Section 1074(d)(2) of title 10, United States Code, is amended by striking ''in support of a contingency operation under'' and inserting ''under section 12304b of this title or''.

SEC. _____. ELIGIBILITY OF RESERVE COMPONENT MEMBERS FOR TRANSITIONAL HEALTH CARE.

Section 1145(a)(2)(B) of title 10, United States Code, is amended by striking ''in support of a contingency operation'' and inserting ''under section 12304b of this title or a provision of law referred to in section 101(a)(13)(B) of this title''.

SEC. _____. CONSIDERATION OF SERVICE ON ACTIVE DUTY TO REDUCE AGE FOR ELIGIBILITY FOR RETIRED PAY FOR NON-REGULAR SERVICE.

Section 12731(f)(2)(B)(i) of title 10, United States Code, is amended by striking ''under a provision of law referred to in section 101(a)(13)(B) or under section 12301(d)'' and inserting ''under section 12301(d) or 12304b of this title or a provision of law referred to in section 101(a)(13)(B)''.

SEC. _____. ELIGIBILITY OF RESERVE COMPONENT MEMBERS FOR HIGH-DEPLOYMENT ALLOWANCE FOR LENGTHY OR NUMEROUS DEPLOYMENTS AND FREQUENT MOBILIZATIONS.

Section 436(a)(2)(C)(ii) of title 37, United States Code, is amended by inserting after ''under'' the first place it appears the following: ''section 12304b of title 10 or''.

SEC. _____. ELIGIBILITY OF RESERVE COMPONENT MEMBERS FOR POST-9/11 EDUCATIONAL ASSISTANCE.

Section 3301(1)(B) of title 38, United States Code, is amended by striking ''or 12304'' and inserting ''12304, 12304a, or 12304b''.

SEC. _____. ELIGIBILITY OF RESERVE COMPONENT MEMBERS FOR NONREDUCTION IN PAY WHILE SERVING IN THE UNIFORMED SERVICES OR NATIONAL GUARD.

Section 5538(a) of title 5, United States Code, is amended in the matter preceding paragraph (1) by inserting after ''under'' the following: ''section 12304b of title 10 or''.

SEC. _____. EFFECT OF ORDER TO SERVE ON ACTIVE DUTY ON ELIGIBILITY FOR OR USE OF CERTAIN MILITARY BENEFITS.

(a) EXCEPTION TO VOLUNTARY SEPARATION PAY REPAYMENT REQUIREMENT FOR MEMBERS WHO RETURN TO ACTIVE DUTY.—Section 1175a(j)(2) of title 10, United States Code, is amended by striking ''or 12304'' and inserting ''12304, 12304a, or 12304b''.

(b) TIME LIMITATION FOR TRAINING AND REHABILITATION FOR VETERANS WITH SERVICE-CONNECTED DISABILITIES.—Section 3103(f) of title 38, United States Code, is amended by striking ''or 12304'' and inserting ''12304, 12304a, or 12304b''.

SEC. _____. RETROACTIVE APPLICABILITY OF AMENDMENTS.

The amendments made by this part shall apply with respect to any order for a member of a reserve component to serve on active duty under section 12304a or 12304b of title 10, United States Code, issued on or after January 1, 2012.

SA 384. Mr. MANCHIN (for himself, Mr. MURPHY, Mr. WHITEHOUSE, Mr. KING, Ms. KLOBUCHAR, Mr. NELSON, Ms. HEITKAMP, Mrs. SHAHEEN, Ms. BALDWIN, Mr. BLUMENTHAL, and Ms. WARREN) submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___01. STEWARDSHIP FEE ON OPIOID PAIN RELIEVERS.

(a) IN GENERAL.—Subchapter E of chapter 32 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

''SEC. 4192. OPIOID PAIN RELIEVERS.

''(a) IN GENERAL.—There is hereby imposed on the sale of any active opioid by the manufacturer, producer, or importer a fee equal to 1 cent per milligram so sold.

''(b) ACTIVE OPIOID.—For purposes of this section—

''(1) IN GENERAL.—The term 'active opioid' means any controlled substance (as defined in section 102 of the Controlled Substances Act, as in effect on the date of the enactment of this section) which is opium, an opiate, or any derivative thereof.

''(2) EXCLUSION FOR CERTAIN PRESCRIPTION MEDICATIONS.—Such term shall not include any prescribed drug which is used exclusively for the treatment of opioid addiction as part of a medically assisted treatment effort.

''(3) EXCLUSION OF OTHER INGREDIENTS.—In the case of a product that includes an active opioid and another ingredient, subsection (a) shall apply only to the portion of such product that is an active opioid.''.

(b) CLERICAL AMENDMENTS.—

(1) The heading of subchapter E of chapter 32 of the Internal Revenue Code of 1986 is amended by striking ''**Medical Devices**'' and inserting ''**Other Medical Products**''.

(2) The table of subchapters for chapter 32 of such Code is amended by striking the item

relating to subchapter E and inserting the following new item:

''SUBCHAPTER E. OTHER MEDICAL PRODUCTS''.

(3) The table of sections for subchapter E of chapter 32 of such Code is amended by adding at the end the following new item:

''Sec. 4192. Opioid pain relievers.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to sales on or after the date that is 1 year after the date of the enactment of this Act.

(d) REBATE OR DISCOUNT PROGRAM FOR CERTAIN CANCER AND HOSPICE PATIENTS.—

(1) IN GENERAL.—The Secretary of Health and Human Services, in consultation with patient advocacy groups and other relevant stakeholders as determined by such Secretary, shall establish a mechanism by which—

(A) any amount paid by an eligible patient in connection with the stewardship fee under section 4192 of the Internal Revenue Code of 1986 (as added by this section) shall be rebated to such patient in as timely a manner as possible, or

(B) amounts paid by an eligible patient for active opioids (as defined in section 4192(b) of such Code) are discounted at time of payment or purchase to ensure that such patient does not pay any amount attributable to such fee,

with as little burden on the patient as possible. The Secretary shall choose whichever of the options described in subparagraph (A) or (B) is, in the Secretary's determination, most effective and efficient in ensuring eligible patients face no economic burden from such fee.

(2) ELIGIBLE PATIENT.—For purposes of this section, the term ''eligible patient'' means—

(A) a patient for whom any active opioid (as so defined) is prescribed to treat pain relating to cancer or cancer treatment;

(B) a patient participating in hospice care; and

(C) in the case of the death or incapacity of a patient described in subparagraph (A) or (B) or any similar situation as determined by the Secretary of Health and Human Services, the appropriate family member, medical proxy, or similar representative or the estate of such patient.

SEC. ___02. BLOCK GRANTS FOR PREVENTION AND TREATMENT OF SUBSTANCE ABUSE.

(a) GRANTS TO STATES.—Section 1921(b) of the Public Health Service Act (42 U.S.C. 300x–21(b)) is amended by inserting '', and, as applicable, for carrying out section 1923A'' before the period.

(b) NONAPPLICABILITY OF PREVENTION PROGRAM PROVISION.—Section 1922(a)(1) of the Public Health Service Act (42 U.S.C. 300x–22(a)(1)) is amended by inserting ''except with respect to amounts made available as described in section 1923A,'' before ''will expend''.

(c) OPIOID TREATMENT PROGRAMS.—Subpart II of part B of title XIX of the Public Health Service Act (42 U.S.C. 300x–21 et seq.) is amended by inserting after section 1923 the following:

''SEC. 1923A. ADDITIONAL SUBSTANCE ABUSE TREATMENT PROGRAMS.

''A funding agreement for a grant under section 1921 is that the State involved shall provide that any amounts made available by any increase in revenues to the Treasury in the previous fiscal year resulting from the enactment of section 4192 of the Internal Revenue Code of 1986, reduced by any amounts rebated or discounted under section __01(d) of the _____ Act (as described in section 1933(a)(1)(B)(i)) be used exclusively for substance abuse (including opioid abuse) treatment efforts in the State, including—

''(1) treatment programs—

''(A) establishing new addiction treatment facilities, residential and outpatient, including covering capital costs;

''(B) establishing sober living facilities;

''(C) recruiting and increasing reimbursement for certified mental health providers providing substance abuse treatment in medically underserved communities or communities with high rates of prescription drug abuse;

''(D) expanding access to long-term, residential treatment programs for opioid addicts (including 30-, 60-, and 90-day programs);

''(E) establishing or operating support programs that offer employment services, housing, and other support services to help recovering addicts transition back into society;

''(F) establishing or operating housing for children whose parents are participating in substance abuse treatment programs, including capital costs;

''(G) establishing or operating facilities to provide care for babies born with neonatal abstinence syndrome, including capital costs; and

''(H) other treatment programs, as the Secretary determines appropriate; and

''(2) recruitment and training of substance use disorder professionals to work in rural and medically underserved communities.''.

(d) ADDITIONAL FUNDING.—Section 1933(a)(1)(B)(i) of the Public Health Service Act (42 U.S.C. 300x–33(a)(1)(B)(i)) is amended by inserting '', plus any increase in revenues to the Treasury in the previous fiscal year resulting from the enactment of section 4192 of the Internal Revenue Code of 1986, reduced by any amounts rebated or discounted under section __01(d) of the _____ Act'' before the period.

SEC. ___03. REPORT.

Not later than 2 years after the date described in section ___01(c), the Secretary of Health and Human Services shall submit to Congress a report on the impact of the amendments made by sections __01 and __02 on—

(1) the retail cost of active opioids (as defined in section 4192 of the Internal Revenue Code of 1986, as added by section ___01);

(2) patient access to such opioids, particularly cancer and hospice patients, including the effect of the discount or rebate on such opioids for cancer and hospice patients under section __01(d);

(3) how the increase in revenue to the Treasury resulting from the enactment of section 4192 of the Internal Revenue Code of 1986 is used to improve substance abuse treatment efforts in accordance with section 1923A of the Public Health Service Act (as added by section __02); and

(4) suggestions for improving—

(A) access to opioids for cancer and hospice patients; and

(B) substance abuse treatment efforts under such section 1923A.

SA 385. Mr. MANCHIN (for himself and Mr. BLUMENTHAL) submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. HEALTH EDUCATION AND LITERACY FOR MEDICAID BENEFICIARIES.

(a) GUIDELINES.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall issue guidelines that require States to provide health education and literacy training to Medicaid enrollees. The guidelines shall include information on the following:

(1) Making healthy choices, including nutrition, exercise, and smoking cessation.

(2) How to manage chronic diseases.

(3) How to navigate the healthcare system, including finding a primary care physician and seeking care at the appropriate location.

(4) Helping Medicaid enrollees select a primary care physician and make appointments, when appropriate.

(b) STATE IMPLEMENTATION.—Not later than 2 years after the date of enactment of this Act, each State with a State Medicaid plan under title XIX of the Social Security Act shall implement the guidelines issued under subsection (a) and demonstrate to the Secretary that enrollees are receiving the health education and literacy training required under such guidelines. In implementing such guidelines, a State shall take into consideration barriers to enrollee participation, including transportation, health status, language barriers, and such other barriers as the Secretary may designate.

SA 386. Mr. MANCHIN (for himself, Mr. BROWN, Mr. WARNER, Mr. KAINE, Mr. COONS, and Mr. CASEY) submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. NULLIFICATION OF CERTAIN PROVISIONS.

The provisions of, and the amendments made by, this Act that would weaken the financial viability of the Black Lung Clinics serving coal miners with pneumoconiosis, including any provision that would cause an increase in the rate of uninsured individuals in the communities served by those clinics, shall be null and void and this Act shall be applied and administered as if such provisions and amendments had never been enacted.

SA 387. Mr. CARDIN (for himself, Mr. CARPER, Mr. NELSON, Ms. WARREN, Mr. BLUMENTHAL, Mr. BROWN, Mr. VAN HOLLEN, Ms. STABENOW, Ms. DUCKWORTH, and Mr. MARKEY) submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. STRIKING PROVISIONS THAT WEAKEN THE ACCESSIBILITY AND AFFORDABILITY OF HEALTH BENEFITS AND SERVICES.

Any provision of this Act that would weaken access to essential health benefits, reduce access to affordable preventive services, or undermine the prohibition of annual and lifetime limits and caps on out-of-pocket expenditures for health insurance plans shall be null and void and of no effect.

SA 388. Mr. CRAPO (for himself and Mr. RISCH) submitted an amendment intended to be proposed by him to the bill H.R. 2810, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and

for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle C of title XXVIII, add the following:

SEC. 2826. LAND CONVEYANCE, MOUNTAIN HOME AIR FORCE BASE, IDAHO.

(a) CONVEYANCE AUTHORIZED.—The Secretary of the Air Force may convey, without consideration, to the City of Mountain Home, Idaho (in this section referred to as the ''City''), all right, title, and interest of the United States in and to a parcel of real property, including improvements thereon, consisting of approximately 4.25 miles of railroad spur located near Mountain Home Air Force Base, Idaho, as further described in subsection (b), for the purpose of economic development.

(b) MAP AND LEGAL DESCRIPTION.—

(1) FINALIZING LEGAL DESCRIPTIONS.—As soon as practicable after the date of the enactment of this Act, the Secretary of the Air Force shall finalize a map and the legal description of the property to be conveyed under subsection (a).

(2) MINOR ERRORS.—The Secretary of the Air Force may correct any minor errors in the map or the legal description.

(3) AVAILABILITY.—The map and legal description shall be on file and available for public inspection.

(c) PAYMENT OF COSTS OF CONVEYANCE.—

(1) PAYMENT REQUIRED.—The Secretary may require the City to cover all costs (except costs for environmental remediation of the property) to be incurred by the Secretary, or to reimburse the Secretary for costs incurred by the Secretary, to carry out the conveyance under this section, including survey costs, costs for environmental documentation, and any other administrative costs related to the conveyance. If amounts are collected from the City in advance of the Secretary incurring the actual costs, and the amount collected exceeds the costs actually incurred by the Secretary to carry out the conveyance, the Secretary shall refund the excess amount to the City.

(2) TREATMENT OF AMOUNTS RECEIVED.—Amounts received under paragraph (1) as reimbursement for costs incurred by the Secretary to carry out the conveyance under subsection (a) shall be credited to the fund or account that was used to cover the costs incurred by the Secretary in carrying out the conveyance, or to an appropriate fund or account currently available to the Secretary for the purposes for which the costs were paid. Amounts so credited shall be merged with amounts in such fund or account and shall be available for the same purposes, and subject to the same conditions and limitations, as amounts in such fund or account.

(d) USE RESERVATION.—The Secretary may reserve a right to temporarily use, for urgent reasons of national defense and at no cost to the United States, all or a portion of the railroad spur conveyed under subsection (a).

(e) ADDITIONAL TERMS AND CONDITIONS.—The Secretary may require such additional terms and conditions in connection with the conveyance under subsection (a) as the Secretary considers appropriate to protect the interests of the United States.

SA 389. Mr. STRANGE submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. 1____. PREMIUM ASSISTANCE FOR LOW INCOME INDIVIDUALS.

(a) IN GENERAL.—Subsection (h) of section 2105 of the Social Security Act (42 U.S.C. 1397ee), as added by this Act, is amended to read as follows:

''(h) SHORT-TERM ASSISTANCE TO ADDRESS COVERAGE AND ACCESS DISRUPTION AND PROVIDE SUPPORT FOR STATES AND DIRECT PREMIUM ASSISTANCE.—

''(1) APPROPRIATION.—There are authorized to be appropriated, and are appropriated, out of monies in the Treasury not otherwise obligated—

''(A) $15,000,000,000 for each of calendar years 2018 and 2019, and $10,000,000,000 for each of calendar years 2020 and 2021, to remain available until expended, to the Administrator of the Centers for Medicare & Medicaid Services (in this subsection and subsection (i) referred to as the 'Administrator') to fund arrangements with health insurance issuers to assist in the purchase of health benefits coverage by addressing coverage and access disruption and responding to urgent health care needs within States; and

''(B) such sums as are necessary for calendar year 2019 and each calendar year thereafter to the Secretary of the Treasury for the purpose of making payments to the Administrator to allow the Administrator to make the premium assistance payments described in paragraph (2).

''(2) PREMIUM ASSISTANCE PAYMENTS.—For calendar year 2019 and each calendar year thereafter, with respect to each individual enrolled in a qualified health plan (as defined in section 1301(a) of the Patient Protection and Affordable Care Act) for whom an advance payment has been determined under section 1412 of such Act (as reported by the Secretary under subsection (c)(4)(B) of such section), the Administrator shall pay to the issuer of such plan the amount described in subsection (c)(4)(D) of such section.

''(3) PARTICIPATION REQUIREMENTS.—

''(A) GUIDANCE.—Not later than 30 days after the date of enactment of this subsection, the Administrator shall issue guidance to health insurance issuers regarding how to submit a notice of intent to participate in the program established under this subsection.

''(B) NOTICE OF INTENT TO PARTICIPATE.—To be eligible for funding under this subsection, a health insurance issuer shall submit to the Administrator a notice of intent to participate at such time (but, in the case of funding for calendar year 2018, not later than 35 days after the date of enactment of this subsection and, in the case of funding for any subsequent calendar year, not later than March 31 of the previous year) and in such form and manner as specified by the Administrator and containing—

''(i) a certification that the health insurance issuer will use the funds in accordance with the requirements of paragraph (6); and

''(ii) such information as the Administrator may require to carry out this subsection.

''(4) PROCEDURE FOR DISTRIBUTION OF FUNDS.—The Administrator shall determine an appropriate procedure for providing and distributing funds under this subsection that includes reserving an amount equal to 1 percent of the amount appropriated under paragraph (1)(A) for a calendar year for providing and distributing funds to health insurance issuers in States where the cost of insurance premiums are at least 75 percent higher than the national average.

''(5) NO MATCH.—Neither the State percentage applicable to payments to States under subsection (i)(5)(B) nor any other matching requirement shall apply to funds provided to health insurance issuers under this subsection.

''(6) USE OF FUNDS.—Funds provided to a health insurance issuer under paragraphs (1) and (2) shall be subject to the requirements of paragraphs (1)(D) and (7) of subsection (i) in the same manner as such requirements apply to States receiving payments under subsection (i) and shall be used only for the activities specified in paragraph (1)(A)(ii) of subsection (i) or, in the case of funds provided under paragraph (2), for reducing the amount of the premiums charged to individuals as required under section 1412(c)(4)(E) of the Patient Protection and Affordable Care Act.

''(7) MISUSE OF FUNDS.—If the Administrator determines that a health insurance issuer is not using funds provided under this subsection in a manner consistent with the requirements applicable to such funds, the Administrator may withhold payments, reduce payments, or recover previous payments to such health insurance issuer under this subsection as the Administrator deems appropriate.''.

(b) PASS-THROUGH OF FUNDING.—Subsection (i) of section 2105 of the Social Security Act (42 U.S.C. 1397ee), as added by this Act, is amended by adding at the end the following new paragraph:

''(8) PASS-THROUGH OF FUNDING.—Beginning in calendar year 2019, notwithstanding the other requirements of funds provided to States under this subsection, except for the requirements of paragraphs (1)(D) and (7), with respect to a State waiver under section 1332 of the Patient Protection and Affordable Care Act under which, due to the structure of the State plan, individuals would not qualify for advance payments under section 1412 of such Act (or under which the amount of such payments would be reduced), the Secretary shall provide for an alternative means by which the aggregate amount of such payments which would have been paid on behalf of participants in the Exchange established under such Act for or by the State if the State had not received such a waiver, shall be paid to the State for the purpose of assisting in the purchase of health benefits coverage by implementing the State plan under the waiver. Such amount shall be determined annually by the Secretary, taking into consideration the experience of other States with respect to participation in an Exchange and payments provided under such section to residents of the other States. A State may request that all of, or any portion of, the amount determined under this paragraph for the State for a year be paid to the State as described in subsection (h)(2).''.

(c) CONFORMING AMENDMENTS.—

(1) Section 2101(a) of the Social Security Act (42 U.S.C. 1397aa(a)), as previously amended by this Act, is amended in the matter preceding paragraph (1), by striking ''short-term assistance''.

(2) Section 2105(c)(1) of the Social Security Act (42 U.S.C. 1397ee(c)(1)), as previously amended by this Act, is amended by striking ''short-term assistance''.

(3) Section 1332(a) of the Patient Protection and Affordable Care Act (42 U.S.C. 18052(a)), as previously amended by this Act, is amended—

(A) in paragraph (2), by adding at the end the following new subparagraph:

''(E) Section 2105(h)(1)(B) of the Social Security Act.''; and

(B) in paragraph (3), by striking subparagraph (A) and redesignating subparagraphs (B) and (C) as subparagraphs (A) and (B), respectively.

(d) PHASEDOWN OF TAX CREDITS.—

(1) IN GENERAL.—Subsection (b) of section 36B of the Internal Revenue Code of 1986, as amended by section 102, is further amended

by adding at the end the following new paragraph:

''(4) PHASEDOWN OF PREMIUM ASSISTANCE CREDIT AMOUNT IN YEARS AFTER 2018.—In the case of any taxable year beginning after 2018, the premium assistance credit amount is 1/10 of the amount determined under paragraph (1) (without regard to this paragraph).''.

(2) COORDINATION WITH DIRECT PREMIUM ASSISTANCE.—

(A) IN GENERAL.—Subsection (c) of section 1412 of the Patient Protection and Affordable Care Act is amended by adding at the end the following new paragraph:

''(4) COORDINATION WITH DIRECT PREMIUM ASSISTANCE.—In the case of calendar, taxable, and plan years beginning after December 31, 2018—

''(A) solely for purposes of this section, the premium tax credit under section 36B of the Internal Revenue Code of 1986 shall be determined without regard to subsection (b)(4) thereof;

''(B) in addition to the persons described in paragraph (1), the Secretary shall notify the Administrator of the Centers for Medicare and Medicaid Services of the advance determination under this section;

''(C) notwithstanding subparagraph (A), only 1/10 of the advance payment determined under this section (but for this paragraph) shall be paid to the issuer of a qualified health plan as provided in paragraph (2);

''(D) the remaining 9/10 of the advance payment so determined shall be paid to the Administrator of the Centers for Medicare and Medicaid Services for the purposes described in section 2105(h)(2) of the Social Security Act; and

''(E) an issuer of a qualified health plan receiving a payment from the Administrator of the Centers for Medicare and Medicaid Services under section 2105(h)(2) of the Social Security Act shall treat such payment for purposes of paragraph (2)(B) in the same manner as an advance payment under paragraph (2).''.

(B) RECAPTURE OF EXCESS PAYMENTS AND INFORMATION REPORTING.—Subsection (f) of section 36B of the Internal Revenue Code of 1986 is amended—

(i) by striking ''advance payments to a taxpayer under section 1412 of the Patient Protection and Affordable Care Act for a taxable year exceed'' in paragraph (2)(A) and inserting ''aggregate sum of any advance payments to a taxpayer under section 1412 of the Patient Protection and Affordable Care Act and any premium assistance paid to a health insurance issuer with respect to such taxpayer under section 2105(h)(2) of the Social Security Act for a taxable year exceeds'',

(ii) by inserting ''or subsection (b)(4)'' after ''paragraph (1)'' in paragraph (2)(A),

(iii) by striking ''or cost-sharing reductions under section 1402 of such Act'' in paragraph (3)(B) and inserting '', premium assistance under section 2105(h)(2) of the Social Security Act, or cost-sharing reductions under section 1402 of the Patient Protection and Affordable Care Act'',

(iv) by striking ''such Act'' in paragraph (3)(C) and inserting ''the Patient Protection and Affordable Care Act, and any premium assistance under section 2105(h)(2) of the Social Security Act'', and

(v) by striking ''excess advance payments'' in paragraph (3)(F) and inserting ''an excess aggregate amount of advance payments and premium assistance payments for purposes of paragraph (2)''.

(C) REGULATIONS.—Subsection (g) of section 36B of such Code is amended by inserting ''and payments for premium assistance'' after ''the credit'' both places it appears.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to years beginning after December 31, 2018.

SA 390. Mr. BLUNT submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. SIMPLIFICATION OF SEASONAL RULES FOR PURPOSES OF EMPLOYER SHARED RESPONSIBILITY REQUIREMENT.

(a) FULL-TIME EMPLOYEE EXCEPTION FOR DETERMINING ASSESSABLE PAYMENT.—Paragraph (4) of section 4980H(c) of the Internal Revenue Code of 1986 is amended—

(1) by redesignating subparagraph (B) as subparagraph (C), and

(2) by inserting after subparagraph (A) the following new subparagraph:

''(B) EXCEPTION FOR SEASONAL EMPLOYEES.—Such term shall not include any seasonal employee.''.

(b) APPLICABLE LARGE EMPLOYER.—Subparagraph (B) of section 4980H(c)(2) of the Internal Revenue Code of 1986 is amended to read as follows:

''(B) EXCEPTION FOR SEASONAL EMPLOYEES.—For purposes of this paragraph, seasonal employees shall not be taken into account as employees.''.

(c) SEASONAL EMPLOYEE.—Subsection (c) of section 4980H of the Internal Revenue Code of 1986 is amended—

(1) by redesignating paragraphs (5), (6), and (7) as paragraphs (6), (7), and (8), respectively, and

(2) by inserting after paragraph (4) the following new paragraph:

''(5) SEASONAL EMPLOYEE.—The term 'seasonal employee' means an employee who is employed in a position for which the customary annual employment is not more than 6 months and which requires performing labor or services which are ordinarily performed at certain seasons or periods of the year.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in section 1513 of the Patient Protection and Affordable Care Act.

SA 391. Mr. GRAHAM (for himself and Mr. CASSIDY) submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

Strike all after the enacting clause and insert the following:

TITLE I

SEC. 101. ELIMINATION OF LIMITATION ON RECAPTURE OF EXCESS ADVANCE PAYMENTS OF PREMIUM TAX CREDITS.

Subparagraph (B) of section 36B(f)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following new clause:

''(iii) NONAPPLICABILITY OF LIMITATION.—This subparagraph shall not apply to taxable years ending after December 31, 2017.''.

SEC. 102. PREMIUM TAX CREDIT.

(a) PREMIUM TAX CREDIT.—

(1) MODIFICATION OF DEFINITION OF QUALIFIED HEALTH PLAN.—

(A) IN GENERAL.—Section 36B(c)(3)(A) of the Internal Revenue Code of 1986 is amended by inserting before the period at the end the following: ''or a plan that includes coverage for abortions (other than any abortion necessary to save the life of the mother or any abortion with respect to a pregnancy that is the result of an act of rape or incest)''.

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall apply to taxable years beginning after December 31, 2017.

(2) REPEAL.—

(A) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by striking section 36B.

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall apply to taxable years beginning after December 31, 2019.

(b) REPEAL OF ELIGIBILITY DETERMINATIONS.—

(1) IN GENERAL.—The following sections of the Patient Protection and Affordable Care Act are repealed:

(A) Section 1411 (other than subsection (i), the last sentence of subsection (e)(4)(A)(ii), and such provisions of such section solely to the extent related to the application of the last sentence of subsection (e)(4)(A)(ii)).

(B) Section 1412.

(2) EFFECTIVE DATE.—The repeals in paragraph (1) shall take effect on January 1, 2020.

(c) PROTECTING AMERICANS BY REPEAL OF DISCLOSURE AUTHORITY TO CARRY OUT ELIGIBILITY REQUIREMENTS FOR CERTAIN PROGRAMS.—

(1) IN GENERAL.—Paragraph (21) of section 6103(l) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

''(D) TERMINATION.—No disclosure may be made under this paragraph after December 31, 2019.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on January 1, 2020.

SEC. 103. MODIFICATIONS TO SMALL BUSINESS TAX CREDIT.

(a) SUNSET.—

(1) IN GENERAL.—Section 45R of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(j) SHALL NOT APPLY.—This section shall not apply with respect to amounts paid or incurred in taxable years beginning after December 31, 2019.''.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to taxable years beginning after December 31, 2019.

(b) DISALLOWANCE OF SMALL EMPLOYER HEALTH INSURANCE EXPENSE CREDIT FOR PLAN WHICH INCLUDES COVERAGE FOR ABORTION.—

(1) IN GENERAL.—Subsection (h) of section 45R of the Internal Revenue Code of 1986 is amended—

(A) by striking ''Any term'' and inserting the following:

''(1) IN GENERAL.—Any term'', and

(B) by adding at the end the following new paragraph:

''(2) EXCLUSION OF HEALTH PLANS INCLUDING COVERAGE FOR ABORTION.—The term 'qualified health plan' does not include any health plan that includes coverage for abortions (other than any abortion necessary to save the life of the mother or any abortion with respect to a pregnancy that is the result of an act of rape or incest).''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning after December 31, 2017.

SEC. 104. INDIVIDUAL MANDATE.

(a) IN GENERAL.—Section 5000A(c) of the Internal Revenue Code of 1986 is amended—

(1) in paragraph (2)(B)(iii), by striking ''2.5 percent'' and inserting ''Zero percent'', and

(2) in paragraph (3)—

(A) by striking ''$695'' in subparagraph (A) and inserting ''$0'', and

(B) by striking subparagraph (D).

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to months beginning after December 31, 2015.

SEC. 105. EMPLOYER MANDATE.

(a) IN GENERAL.—

(1) Paragraph (1) of section 4980H(c) of the Internal Revenue Code of 1986 is amended by inserting ''($0 in the case of months beginning after December 31, 2015)'' after ''$2,000''.

(2) Paragraph (1) of section 4980H(b) of the Internal Revenue Code of 1986 is amended by inserting ''($0 in the case of months beginning after December 31, 2015)'' after ''$3,000''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to months beginning after December 31, 2015.

SEC. 106. SHORT TERM ASSISTANCE FOR STATES AND MARKET-BASED HEALTH CARE GRANT PROGRAM.

(a) IN GENERAL.—Section 2105 of the Social Security Act (42 U.S.C. 1397ee) is amended by adding at the end the following new subsections:

''(h) SHORT-TERM ASSISTANCE TO ADDRESS COVERAGE AND ACCESS DISRUPTION AND PROVIDE SUPPORT FOR STATES.—

''(1) APPROPRIATION.—There are authorized to be appropriated, and are appropriated, out of monies in the Treasury not otherwise obligated, $20,000,000,000 for each of calendar years 2018 and 2019, and $15,000,000,000 for calendar year 2020, to the Administrator of the Centers for Medicare & Medicaid Services (in this subsection and subsection (i) referred to as the 'Administrator') to fund arrangements with health insurance issuers to assist in the purchase of health benefits coverage by addressing coverage and access disruption and responding to urgent health care needs within States. Funds appropriated under this paragraph shall remain available until expended.

''(2) PARTICIPATION REQUIREMENTS.—

''(A) GUIDANCE.—Not later than 30 days after the date of enactment of this subsection, the Administrator shall issue guidance to health insurance issuers regarding how to submit a notice of intent to participate in the program established under this subsection.

''(B) NOTICE OF INTENT TO PARTICIPATE.—To be eligible for funding under this subsection, a health insurance issuer shall submit to the Administrator a notice of intent to participate at such time (but, in the case of funding for calendar year 2018, not later than 35 days after the date of enactment of this subsection and, in the case of funding for calendar year 2019, 2020, or 2021, not later than March 31 of the previous year) and in such form and manner as specified by the Administrator and containing—

''(i) a certification that the health insurance issuer will use the funds in accordance with the requirements of paragraph (5); and

''(ii) such information as the Administrator may require to carry out this subsection.

''(3) PROCEDURE FOR DISTRIBUTION OF FUNDS.—The Administrator shall determine an appropriate procedure for providing and distributing funds under this subsection.

''(4) USE OF FUNDS.—Funds provided to a health insurance issuer under paragraph (1) shall be subject to the requirements of paragraphs (1)(D) and (7) of subsection (i) in the same manner as such requirements apply to States receiving payments under subsection (i) and shall be used only for the activities specified in paragraph (1)(A)(ii) of subsection (i).

''(i) MARKET-BASED HEALTH CARE GRANT PROGRAM.—

''(1) APPLICATION AND CERTIFICATION REQUIREMENTS.—To be eligible for an allotment of funds under this subsection, a State shall submit to the Administrator an application, not later than March 31, 2019, in the case of allotments for calendar year 2020, and not later than March 31 of the previous year, in the case of allotments for any subsequent calendar year) and in such form and manner as specified by the Administrator, that contains the following:

''(A) A description of how the funds will be used to do 1 or more of the following:

''(i) To establish or maintain a program or mechanism to help high-risk individuals in the purchase of health benefits coverage, including by reducing premium costs for such individuals, who have or are projected to have a high rate of utilization of health services, as measured by cost, and who do not have access to health insurance coverage offered through an employer, enroll in health insurance coverage under a plan offered in the individual market (within the meaning of section 5000A(f)(1)(C) of the Internal Revenue Code of 1986).

''(ii) To establish or maintain a program to enter into arrangements with health insurance issuers to assist in the purchase of health benefits coverage by stabilizing premiums and promoting State health insurance market participation and choice in plans offered in the individual market (within the meaning of section 5000A(f)(1)(C) of the Internal Revenue Code of 1986).

''(iii) To provide payments for health care providers for the provision of health care services, as specified by the Administrator.

''(iv) To provide health insurance coverage by funding assistance to reduce out-of-pocket costs, such as copayments, coinsurance, and deductibles, of individuals enrolled in plans offered in the individual market (within the meaning of section 5000A(f)(1)(C) of the Internal Revenue Code of 1986).

''(v) To establish or maintain a program or mechanism to help individuals purchase health benefits coverage, including by reducing premium costs for plans offered in the individual market (within the meaning of section 5000A(f)(1)(C) of the Internal Revenue Code of 1986) for individuals who do not have access to health insurance coverage offered through an employer.

''(vi) Subject to paragraph (4)(B)(iii), to provide wraparound, optional services to individuals enrolled in the State plan for medical assistance under title XIX who are not only eligible for such assistance on the basis of section 1902(a)(10)(A)(ii)(XXIII).

''(B) A certification that the State shall make, from non-Federal funds, expenditures for 1 or more of the activities specified in subparagraph (A) in an amount that is not less than the State percentage required for the year under paragraph (5)(B)(ii).

''(C) A certification that the funds provided under this subsection shall only be used for the activities specified in subparagraph (A).

''(D) A certification that none of the funds provided under this subsection shall be used by the State for an expenditure that is attributable to an intergovernmental transfer, certified public expenditure, or any other expenditure to finance the non-Federal share of expenditures required under any provision of law, including under the State plans established under this title and title XIX or under a waiver of such plans.

''(E) Such other information as necessary for the Administrator to carry out this subsection.

''(2) ELIGIBILITY.—Only the 50 States and the District of Columbia shall be eligible for an allotment and payments under this subsection and all references in this subsection to a State shall be treated as only referring to the 50 States and the District of Columbia.

''(3) ONE-TIME APPLICATION.—If an application of a State submitted under this subsection is approved by the Administrator for a year, the application shall be deemed to be approved by the Administrator for that year and each subsequent year through December 31, 2026.

''(4) MARKET-BASED HEALTH CARE GRANT ALLOTMENTS.—

''(A) APPROPRIATION.—For the purpose of providing allotments to States under this subsection, there is appropriated, out of any money in the Treasury not otherwise appropriated—

''(i) for calendar year 2020, [$140,000,000,000];

''(ii) for calendar year 2021, [$143,000,000,000];

''(iii) for calendar year 2022, [$146,000,000,000];

''(iv) for calendar year 2023, [$149,000,000,000];

''(v) for calendar year 2024, [$152,000,000,000];

''(vi) for calendar year 2025, [$155,000,000,000]; and

''(vii) for calendar year 2026, [$158,000,000,000].

''(B) ALLOTMENTS; AVAILABILITY OF ALLOTMENTS.—

''(i) IN GENERAL.—In the case of a State with an application approved under this subsection with respect to a year, the Administrator shall allot to the State for the year, from amounts appropriated for such year under subparagraph (A), the amount determined for the State and year under paragraph (5).

''(ii) AVAILABILITY OF ALLOTMENTS; UNUSED AMOUNTS.—

''(I) IN GENERAL.—Amounts allotted to a State for a calendar year under this subparagraph shall remain available for obligation by the State through March 31 of the second calendar year following the year for which the allotment is made.

''(II) UNUSED AMOUNTS TO BE USED FOR DEFICIT REDUCTION.—Amounts allotted to a State for a calendar year that remain unobligated on April 1 of the following year shall be deposited into the general fund of the Treasury and shall be used for deficit reduction.

''(iii) LIMITATION.—In no case may a State use more than 10 percent of the amount allotted to the State for a year under this subparagraph for the purpose described in clause (vi) of paragraph (1)(A).

''(5) DETERMINATION OF ALLOTMENT AMOUNTS.—

''(A) CALENDAR YEAR 2020.—Subject to subparagraph (B), the amount determined under this paragraph for a State for calendar year 2020 shall be equal to the sum of each of the following component amounts which is applicable to the State:

''(i) With respect to each State, an amount equal to 10 percent of the amount appropriated for calendar year 2020 under paragraph (4)(A) multiplied by the ratio of—

''(I) the number of individuals in the State whose income for calendar year 2019 was not less than 100 percent, and not greater than 138 percent, of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved; over

''(II) the number of individuals in all States whose income for calendar year 2019 was not less than 100 percent, and not greater than 138 percent, of the poverty line (as so defined) applicable to a family of the size involved.

''(ii) With respect to each State, an amount equal to 20 percent of the amount so appropriated multiplied by the ratio of—

''(I) the number of individuals in the State who are not less than 45 and not more than 64 years old; over

''(II) the number of individuals in all States who are not less than 45 and not more than 64 years old.

''(iii) With respect to each State that, for calendar year 2016, had a State average per capita income that did not exceed $52,500, an

amount equal to 25 percent of the amount so appropriated multiplied by the ratio of—

''(I) the number of individuals in the State whose income for calendar year 2019 was not less than 100 percent, and not greater than 138 percent, of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved; over

''(II) the number of individuals in all States that, for calendar year 2016, had a State average per capita income that did not exceed $52,500, whose income for calendar year 2019 was not less than 100 percent, and not greater than 138 percent, of the poverty line (as so defined) applicable to a family of the size involved.

''(iv) With respect to each State that, for calendar year 2016, had an average population density of fewer than 15 individuals per square mile, an amount equal to 1 percent of the amount so appropriated divided by the number of such States.

''(v) With respect to each State that, for calendar year 2016, had an average population density that was greater than 14 individuals per square mile but fewer than 80 individuals per square mile, an amount equal to 3.5 percent of the amount so appropriated, divided by the number of such States.

''(vi) With respect to each State that, for calendar year 2016, had an average population density that was greater than 79 individuals per square mile but fewer than 115 individuals per square mile, an amount equal to 5.5 percent of the amount so appropriated, divided by the number of such States.

''(vii) With respect to each State that was an expansion State for calendar year 2017, an amount equal to 35 percent of the amount so appropriated multiplied by the ratio of—

''(I) the number of individuals in the State whose income for calendar year 2016 was not less than 100 percent, and not greater than 138 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved; over

''(II) the number of individuals in all States that were expansion States for calendar year 2017 whose income for calendar year 2016 was not less than 100 percent, and not greater than 138 percent, of the poverty line (as so defined) applicable to a family of the size involved.

''(B) CALENDAR YEAR 2020 ALLOTMENT PARAMETERS.—The Secretary shall adjust the amounts of allotments determined under this paragraph for States for calendar year 2020 under subparagraph (A) as necessary to ensure that a State's allotment for calendar year 2026 (prior to any redistribution of unallotted funds under subparagraph (G)) shall in no case be—

''(i) greater than 3 times the sum of—

''(I) the amount of Federal payments made to the State for calendar year 2016 for medical assistance provided to individuals under clause (i)(VIII) or (ii)(XX) of section 1902(a)(10)(A) (including medical assistance provided to individuals who are not newly eligible (as defined in section 1905(y)(2)) individuals described in subclause (VIII) of section 1902(a)(10)(A)(i));

''(II) the amount of Federal payments made to the State for calendar year 2016 for operating a Basic Health Program under section 1331 of the Patient Protection and Affordable Care Act for such year;

''(III) the amount of advance payments of premium assistance credits allowable under section 36B of the Internal Revenue Code of 1986 made under section 1412(a) of the Patient Protection and Affordable Care Act in calendar year 2016 on behalf of individuals who purchased insurance through the Exchange established for or by the State pursuant to title I of such Act; and

''(IV) the amount of Federal payments for cost-sharing reductions provided for calendar year 2016 under section 1402 of such Act to individuals who purchased insurance through the Exchange established for or by the State pursuant to title I of such Act; or

''(ii) less than 75 percent of the sum of the amounts described in subclauses (I) through (IV) of clause (i).

''(C) CALENDAR YEARS AFTER 2020 AND BEFORE 2026.—Subject to subparagraph (F), For calendar years after 2020 and before 2026, the amount determined under this paragraph for a State and year shall be equal to—

''(i) for calendar years before 2025—

''(I) the amount determined for the State under subparagraph (A) (after adjustment under subparagraph (B), if applicable) or this subparagraph for the previous year; increased by

''(II) the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) from October 1 of the previous calendar year to October 1 of the calendar year involved;

''(ii) for calendar year 2025—

''(I) the amount determined for the State under this subparagraph for the previous year; increased by

''(II) the percentage increase in the consumer price index for all urban consumers (U.S. city average) from October 1 of the previous calendar year to October 1 of the calendar year involved.

''(D) CALENDAR YEAR 2026.—Subject to subparagraph (E), the amount determined under this paragraph for a State for calendar year 2026 shall be equal to the sum of each of the following component amounts which is applicable to the State:

''(i) With respect to each State, an amount equal to 15.5 percent of the amount appropriated for calendar year 2026 under paragraph (4)(A) multiplied by the ratio of—

''(I) the number of individuals in the State whose income for calendar year 2025 was not less than 100 percent, and not greater than 138 percent, of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved; over

''(II) the number of individuals in all States whose income for calendar year 2025 was not less than 100 percent, and not greater than 138 percent, of the poverty line (as so defined) applicable to a family of the size involved.

''(ii) With respect to each State, an amount equal to 30 percent of the amount so appropriated multiplied by the ratio of—

''(I) the number of individuals in the State who are not less than 45 and not more than 64 years old; over

''(II) the number of individuals in all States who are not less than 45 and not more than 64 years old.

''(iii) With respect to each State that, for calendar year 2025, had a State average per capita income that did not exceed $52,500, an amount equal to 39 percent of the amount so appropriated multiplied by the ratio of—

''(I) the number of individuals in the State whose income for calendar year 2025 was not less than 100 percent, and not greater than 138 percent, of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved; over

''(II) the number of individuals in all States that, for calendar year 2025, had a State average per capita income that did not exceed $52,500, whose income for calendar year 2019 was not less than 100 percent, and not greater than 138 percent, of the poverty line (as so defined) applicable to a family of the size involved.

''(iv) With respect to each State that, for calendar year 2025, had an average population density of fewer than 15 individuals per square mile, an amount equal to 1.5 percent of the amount so appropriated divided by the number of such States.

''(v) With respect to each State that, for calendar year 2025, had an average population density that was greater than 14 individuals per square mile but fewer than 80 individuals per square mile, an amount equal to 5.5 percent of the amount so appropriated, divided by the number of such States.

''(vi) With respect to each State that, for calendar year 2025, had an average population density that was greater than 79 individuals per square mile but fewer than 115 individuals per square mile, an amount equal to 8.5 percent of the amount so appropriated, divided by the number of such States.

''(E) CALENDAR YEAR 2026 ALLOTMENT PARAMETERS.—The Secretary shall adjust the amounts of allotments determined under this paragraph for States for calendar year 2026 as necessary to ensure that a State's allotment for calendar year 2026 (prior to any adjustment which may be applicable under subparagraph (F) or distribution under subparagraph (G)) shall in no case be—

''(i) greater than 3.5 times the sum of—

''(I) the amount of Federal payments made to the State for calendar year 2016 for medical assistance provided to individuals under clause (i)(VIII) or (ii)(XX) of section 1902(a)(10)(A) (including medical assistance provided to individuals who are not newly eligible (as defined in section 1905(y)(2)) individuals described in subclause (VIII) of section 1902(a)(10)(A)(i));

''(II) the amount of Federal payments made to the State for calendar year 2016 for operating a Basic Health Program under section 1331 of the Patient Protection and Affordable Care Act for such year;

''(III) the amount of advance payments of premium assistance credits allowable under section 36B of the Internal Revenue Code of 1986 made under section 1412(a) of the Patient Protection and Affordable Care Act in calendar year 2016 on behalf of individuals who purchased insurance through the Exchange established for or by the State pursuant to title I of such Act; and

''(IV) the amount of Federal payments for cost-sharing reductions provided for calendar year 2016 under section 1402 of such Act to individuals who purchased insurance through the Exchange established for or by the State pursuant to title I of such Act; or

''(ii) less than 75 percent of the sum of the amounts described in subclauses (I) through (IV) of clause (i).

''(F) LOW INCOME POPULATION ADJUSTMENT.—

''(i) FOR CALENDAR YEARS 2021 THROUGH 2025.—For each of calendar years 2021, 2022, 2023, 2024, and 2025 if a State's low income per capita allotment amount for the year (as defined in clause (iii))—

''(I) exceeds the mean low income per capita allotment amount for all States for the year by not less than 15 percent, the State's allotment for the year (as determined under subparagraph (C)) shall be reduced by a percentage that shall be determined by the Secretary but which shall not be less than 0.5 percent or greater than 5 percent; or

''(II) is not less than 15 percent below the mean low income per capita allotment amount for all States for the year, the State's allotment for the year (as so determined) shall be increased by a percentage that shall be determined by the Secretary but which shall not be less than 0.5 percent or greater than 5 percent.

''(ii) FOR CALENDAR YEAR 2026.—For calendar year 2026, Secretary shall adjust the allotment for the year for each State with a low income per capita allotment amount (as defined in clause (iii)) that exceeds the mean low income per capita allotment amount for

all States for the year by more than 10 percent or is below such mean amount by not less than 10 percent in such a manner that the low income per capita allotment for each such State (after the adjustment under this clause) is within 10 percent of such mean amount.

''(iii) LOW INCOME PER CAPITA ALLOTMENT AMOUNT.—The term 'low income per capita allotment amount' means, with respect to a State and year—

''(I) the State's allotment for the year, as determined under subparagraph (C); divided by

''(II) the number of individuals in the State—

''(aa) whose income for the previous calendar year did not exceed 138 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved; and

''(bb) who, during the previous calendar year, were not enrolled under the State plan under title XIX (except that, in the case of an individual who is enrolled under the State plan under clause (i)(VIII), (ii)(XX), or (ii)(XXIII) of section 1902(a)(10)(A) or is described in any such clause and is enrolled under a waiver of such plan, shall not be considered to be enrolled under such State plan for purposes of this clause).

''(iv) RULES OF APPLICATION.—

''(I) BUDGET NEUTRALITY REQUIREMENT.—In determining the appropriate percentages by which to adjust States' allotments for a calendar year under this subparagraph, the Secretary shall make such adjustments in a manner that does not result in a net increase in Federal payments under this section for such year, and if the Secretary cannot adjust such expenditures in such a manner there shall be no adjustment under this paragraph for such year.

''(II) NONAPPLICATION TO LOW-DENSITY STATES.—This paragraph shall not apply to any State that has a population density of less than 15 individuals per square mile, based on the most recent data available from the Bureau of the Census.

''(G) DISTRIBUTION OF UNALLOTTED FUNDS.—To the extent that any funds appropriated for a calendar year under paragraph (4)(A) remain unallotted after the determinations and adjustments made under the preceding subparagraphs of this paragraph, the Secretary shall increase the allotments so determined and adjusted for States that have a low income per capita allotment amount that is below the mean low income per capita allotment amount for all States in a manner to be determined by the Secretary.

''(H) EXPANSION STATE DEFINED.—In this paragraph, the term 'expansion State' means, with respect to a State and year, a State that provided for eligibility for medical assistance under the State plan established under title XIX on the basis of clause (i)(VIII) or (ii)(XX) of section 1902(a)(10)(A) (or provided eligibility for individuals described in either such clause under a waiver approved under section 1115) during calendar year 2017.

''(6) PAYMENTS.—

''(A) ANNUAL PAYMENT OF ALLOTMENTS.—Subject to subparagraph (B), the Administrator shall pay to each State that has an application approved under this subsection for a year, from the amount allotted to the State under paragraph (4)(B) for the year, an amount equal to the Federal percentage of the State's expenditures for the year.

''(B) STATE EXPENDITURES REQUIRED BEGINNING 2022.—For purposes of subparagraph (A), the Federal percentage is equal to 100 percent reduced by the State percentage for that year, and the State percentage is equal to—

''(i) in the case of calendar year 2020, 3 percent;

''(ii) in the case of calendar year 2021, 3 percent;

''(iii) in the case of calendar year 2022, 4 percent;

''(iv) in the case of calendar year 2023, 4 percent;

''(v) in the case of calendar year 2024, 5 percent;

''(vi) in the case of calendar year 2025, 5 percent; and

''(vii) in the case of calendar year 2026, 5 percent.

''(C) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—

''(i) IN GENERAL.—If the Administrator deems it appropriate, the Administrator shall make payments under this subsection for each year on the basis of advance estimates of expenditures submitted by the State and such other investigation as the Administrator shall find necessary, and shall reduce or increase the payments as necessary to adjust for any overpayment or underpayment for prior years.

''(ii) MISUSE OF FUNDS.—If the Administrator determines that a State is not using funds paid to the State under this subsection in a manner consistent with the description provided by the State in its application approved under paragraph (1), the Administrator may withhold payments, reduce payments, or recover previous payments to the State under this subsection as the Administrator deems appropriate.

''(D) FLEXIBILITY IN SUBMITTAL OF CLAIMS.—Nothing in this subsection shall be construed as preventing a State from claiming as expenditures in the year expenditures that were incurred in a previous year.

''(7) EXEMPTIONS.—Paragraphs (2), (3), (5), (6), (8), (10), and (11) of subsection (c) do not apply to payments under this subsection.''.

(b) OTHER TITLE XXI AMENDMENTS.—

(1) Section 2101 of such Act (42 U.S.C. 1397aa) is amended—

(A) in subsection (a), in the matter preceding paragraph (1), by striking ''The purpose'' and inserting ''Except with respect to short-term assistance activities under section 2105(h) and the Market-Based Health Care Grant Program established in section 2105(i), the purpose''; and

(B) in subsection (b), in the matter preceding paragraph (1), by inserting ''subsection (a) or (g) of'' before ''section 2105''.

(2) Section 2105(c)(1) of such Act (42 U.S.C. 1397ee(c)(1)) is amended by striking ''and may not include'' and inserting ''or to carry out short-term assistance activities under subsection (h) or the Market-Based Health Care Grant Program established in subsection (i) and, except in the case of funds made available under subsection (h) or (i), may not include''.

(3) Section 2106(a)(1) of such Act (42 U.S.C. 1397ff(a)(1)) is amended by inserting ''subsection (a) or (g) of'' before ''section 2105''.

SEC. 107. BETTER CARE RECONCILIATION IMPLEMENTATION FUND.

(a) IN GENERAL.—There is hereby established a Better Care Reconciliation Implementation Fund (referred to in this section as the ''Fund'') within the Department of Health and Human Services to provide for Federal administrative expenses in carrying out this Act.

(b) FUNDING.—There is appropriated to the Fund, out of any funds in the Treasury not otherwise appropriated, $2,000,000,000.

SEC. 108. REPEAL OF THE TAX ON EMPLOYEE HEALTH INSURANCE PREMIUMS AND HEALTH PLAN BENEFITS.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 is amended by striking section 4980I.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 2019.

(c) SUBSEQUENT EFFECTIVE DATE.—The amendment made by subsection (a) shall not apply to taxable years beginning after December 31, 2025, and chapter 43 of the Internal Revenue Code of 1986 is amended to read as such chapter would read if such subsection had never been enacted.

SEC. 109. REPEAL OF TAX ON OVER-THE-COUNTER MEDICATIONS.

(a) HSAs.—Subparagraph (A) of section 223(d)(2) of the Internal Revenue Code of 1986 is amended by striking ''Such term'' and all that follows through the period.

(b) ARCHER MSAs.—Subparagraph (A) of section 220(d)(2) of the Internal Revenue Code of 1986 is amended by striking ''Such term'' and all that follows through the period.

(c) HEALTH FLEXIBLE SPENDING ARRANGEMENTS AND HEALTH REIMBURSEMENT ARRANGEMENTS.—Section 106 of the Internal Revenue Code of 1986 is amended by striking subsection (f).

(d) EFFECTIVE DATES.—

(1) DISTRIBUTIONS FROM SAVINGS ACCOUNTS.—The amendments made by subsections (a) and (b) shall apply to amounts paid with respect to taxable years beginning after December 31, 2016.

(2) REIMBURSEMENTS.—The amendment made by subsection (c) shall apply to expenses incurred with respect to taxable years beginning after December 31, 2016.

SEC. 110. REPEAL OF TAX ON HEALTH SAVINGS ACCOUNTS.

(a) HSAs.—Section 223(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking ''20 percent'' and inserting ''10 percent''.

(b) ARCHER MSAs.—Section 220(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking ''20 percent'' and inserting ''15 percent''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to distributions made after December 31, 2016.

SEC. 111. REPEAL OF MEDICAL DEVICE EXCISE TAX.

Section 4191 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(d) APPLICABILITY.—The tax imposed under subsection (a) shall not apply to sales after December 31, 2017.''.

SEC. 112. REPEAL OF ELIMINATION OF DEDUCTION FOR EXPENSES ALLOCABLE TO MEDICARE PART D SUBSIDY.

(a) IN GENERAL.—Section 139A of the Internal Revenue Code of 1986 is amended by adding at the end the following new sentence: ''This section shall not be taken into account for purposes of determining whether any deduction is allowable with respect to any cost taken into account in determining such payment.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2016.

SEC. 113. REPEAL OF CHRONIC CARE TAX.

(a) IN GENERAL.—Subsection (a) of section 213 of the Internal Revenue Code of 1986 is amended by striking ''10 percent'' and inserting ''7.5 percent''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2016.

SEC. 114. PURCHASE OF INSURANCE FROM HEALTH SAVINGS ACCOUNT.

(a) IN GENERAL.—Paragraph (2) of section 223(d) of the Internal Revenue Code of 1986 is amended—

(1) by striking ''and any dependent (as defined in section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B)

thereof) of such individual'' in subparagraph (A) and inserting ''any dependent (as defined in section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof) of such individual, and any child (as defined in section 152(f)(1)) of such individual who has not attained the age of 27 before the end of such individual's taxable year'',

(2) by striking subparagraph (B) and inserting the following:

''(B) HEALTH INSURANCE MAY NOT BE PURCHASED FROM ACCOUNT.—Except as provided in subparagraph (C), subparagraph (A) shall not apply to any payment for insurance.'', and

(3) by striking ''or'' at the end of subparagraph (C)(iii), by striking the period at the end of subparagraph (C)(iv) and inserting '', or'', and by adding at the end the following:

''(v) a high deductible health plan but only to the extent of the portion of such expense in excess of—

''(I) any amount allowable as a credit under section 36B for the taxable year with respect to such coverage,

''(II) any amount allowable as a deduction under section 162(l) with respect to such coverage, or

''(III) any amount excludable from gross income with respect to such coverage under section 106 (including by reason of section 125) or 402(l).''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to amounts paid for expenses incurred for, and distributions made for, coverage under a high deductible health plan beginning after December 31, 2017.

SEC. 115. PRIMARY CARE ENHANCEMENT.

(a) TREATMENT OF DIRECT PRIMARY CARE SERVICE ARRANGEMENTS.—Section 223(c) of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

''(6) TREATMENT OF DIRECT PRIMARY CARE SERVICE ARRANGEMENTS.—An arrangement under which an individual is provided coverage restricted to primary care services in exchange for a fixed periodic fee or payment for such services—

''(A) shall not be treated as a health plan for purposes of paragraph (1)(A)(ii), and

''(B) shall not be treated as insurance for purposes of subsection (d)(2)(B).''.

(b) CERTAIN PROVIDER FEES TO BE TREATED AS MEDICAL CARE.—Section 213(d) of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

''(12) PERIODIC PROVIDER FEES.—The term 'medical care' shall include periodic fees paid for a defined set of primary care medical services provided on an as-needed basis.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2016.

SEC. 116. MAXIMUM CONTRIBUTION LIMIT TO HEALTH SAVINGS ACCOUNT INCREASED TO AMOUNT OF DEDUCTIBLE AND OUT-OF-POCKET LIMITATION.

(a) SELF-ONLY COVERAGE.—Section 223(b)(2)(A) of the Internal Revenue Code of 1986 is amended by striking ''$2,250'' and inserting ''the amount in effect under subsection (c)(2)(A)(ii)(I)''.

(b) FAMILY COVERAGE.—Section 223(b)(2)(B) of such Code is amended by striking ''$4,500'' and inserting ''the amount in effect under subsection (c)(2)(A)(ii)(II)''.

(c) COST-OF-LIVING ADJUSTMENT.—Section 223(g)(1) of such Code is amended—

(1) by striking ''subsections (b)(2) and'' both places it appears and inserting ''subsection'', and

(2) in subparagraph (B), by striking ''determined by'' and all that follows through '' 'calendar year 2003'.'' and inserting ''determined by substituting 'calendar year 2003' for 'calendar year 1992' in subparagraph (B) thereof.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2017.

SEC. 117. ALLOW BOTH SPOUSES TO MAKE CATCH-UP CONTRIBUTIONS TO THE SAME HEALTH SAVINGS ACCOUNT.

(a) IN GENERAL.—Section 223(b)(5) of the Internal Revenue Code of 1986 is amended to read as follows:

''(5) SPECIAL RULE FOR MARRIED INDIVIDUALS WITH FAMILY COVERAGE.—

''(A) IN GENERAL.—In the case of individuals who are married to each other, if both spouses are eligible individuals and either spouse has family coverage under a high deductible health plan as of the first day of any month—

''(i) the limitation under paragraph (1) shall be applied by not taking into account any other high deductible health plan coverage of either spouse (and if such spouses both have family coverage under separate high deductible health plans, only one such coverage shall be taken into account),

''(ii) such limitation (after application of clause (i)) shall be reduced by the aggregate amount paid to Archer MSAs of such spouses for the taxable year, and

''(iii) such limitation (after application of clauses (i) and (ii)) shall be divided equally between such spouses unless they agree on a different division.

''(B) TREATMENT OF ADDITIONAL CONTRIBUTION AMOUNTS.—If both spouses referred to in subparagraph (A) have attained age 55 before the close of the taxable year, the limitation referred to in subparagraph (A)(iii) which is subject to division between the spouses shall include the additional contribution amounts determined under paragraph (3) for both spouses. In any other case, any additional contribution amount determined under paragraph (3) shall not be taken into account under subparagraph (A)(iii) and shall not be subject to division between the spouses.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2017.

SEC. 118. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF HEALTH SAVINGS ACCOUNT.

(a) IN GENERAL.—Section 223(d)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

''(D) TREATMENT OF CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF ACCOUNT.—If a health savings account is established during the 60-day period beginning on the date that coverage of the account beneficiary under a high deductible health plan begins, then, solely for purposes of determining whether an amount paid is used for a qualified medical expense, such account shall be treated as having been established on the date that such coverage begins.''.

(b) EFFECTIVE DATE.—The amendment made by this subsection shall apply with respect to coverage under a high deductible health plan beginning after December 31, 2017.

SEC. 119. EXCLUSION FROM HSAS OF HIGH DEDUCTIBLE HEALTH PLANS INCLUDING COVERAGE FOR ABORTION.

(a) IN GENERAL.—Subparagraph (C) of section 223(d)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following flush sentence:

''A high deductible health plan shall not be treated as described in clause (v) if such plan includes coverage for abortions (other than any abortion necessary to save the life of the mother or any abortion with respect to a pregnancy that is the result of an act of rape or incest).''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply with respect to coverage under a high deductible health plan beginning after December 31, 2017.

SEC. 120. FEDERAL PAYMENTS TO STATES.

(a) IN GENERAL.—Notwithstanding section 504(a), 1902(a)(23), 1903(a), 2002, 2005(a)(4), 2102(a)(7), or 2105(a)(1) of the Social Security Act (42 U.S.C. 704(a), 1396a(a)(23), 1396b(a), 1397a, 1397d(a)(4), 1397bb(a)(7), 1397ee(a)(1)), or the terms of any Medicaid waiver in effect on the date of enactment of this Act that is approved under section 1115 or 1915 of the Social Security Act (42 U.S.C. 1315, 1396n), for the 1-year period beginning on the date of enactment of this Act, no Federal funds provided from a program referred to in this subsection that is considered direct spending for any year may be made available to a State for payments to a prohibited entity, whether made directly to the prohibited entity or through a managed care organization under contract with the State.

(b) DEFINITIONS.—In this section:

(1) PROHIBITED ENTITY.—The term ''prohibited entity'' means an entity, including its affiliates, subsidiaries, successors, and clinics—

(A) that, as of the date of enactment of this Act—

(i) is an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Code;

(ii) is an essential community provider described in section 156.235 of title 45, Code of Federal Regulations (as in effect on the date of enactment of this Act), that is primarily engaged in family planning services, reproductive health, and related medical care; and

(iii) provides for abortions, other than an abortion—

(I) if the pregnancy is the result of an act of rape or incest; or

(II) in the case where a woman suffers from a physical disorder, physical injury, or physical illness that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, including a life-endangering physical condition caused by or arising from the pregnancy itself; and

(B) for which the total amount of Federal and State expenditures under the Medicaid program under title XIX of the Social Security Act in fiscal year 2014 made directly to the entity and to any affiliates, subsidiaries, successors, or clinics of the entity, or made to the entity and to any affiliates, subsidiaries, successors, or clinics of the entity as part of a nationwide health care provider network, exceeded $1,000,000.

(2) DIRECT SPENDING.—The term ''direct spending'' has the meaning given that term under section 250(c) of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 900(c)).

SEC. 121. MEDICAID.

The Social Security Act (42 U.S.C. 301 et seq.) is amended—

(1) in section 1902—

(A) in subsection (a)(10)(A), in each of clauses (i)(VIII) and (ii)(XX), by inserting ''and ending December 31, 2019,'' after ''January 1, 2014,''; and

(B) in subsection (a)(47)(B), by inserting ''and provided that any such election shall cease to be effective on January 1, 2020, and no such election shall be made after that date'' before the semicolon at the end;

(2) in section 1905—

(A) in the first sentence of subsection (b), by inserting ''(50 percent on or after January 1, 2020)'' after ''55 percent'';

(B) in subsection (y)(1), by striking the semicolon at the end of subparagraph (D) and all that follows through ''thereafter''; and

(C) in subsection (z)(2)—

(i) in subparagraph (A), by inserting ''through 2019'' after ''each year thereafter''; and

(ii) in subparagraph (B)(ii)(VI), by striking ''and each subsequent year'';

(3) in section 1915(k)(2), by striking ''during the period described in paragraph (1)'' and inserting ''on or after the date referred to in paragraph (1) and before January 1, 2020'';

(4) in section 1920(e), by adding at the end the following: ''This subsection shall not apply after December 31, 2019.'';

(5) in section 1937(b)(5), by adding at the end the following: ''This paragraph shall not apply after December 31, 2019.''; and

(6) in section 1943(a), by inserting ''and before January 1, 2020,'' after ''January 1, 2014,''.

SEC. 122. REPEAL OF MEDICAID EXPANSION.

Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended—

(1) in section 1902 (42 U.S.C. 1396a)—

(A) in subsection (a)(10)(A)—

(i) in clause (i)(VIII), by inserting ''and ending December 31, 2019,'' after ''2014,'';

(ii) in clause (ii)(XX), by inserting ''and ending December 31, 2017,'' after ''2014,''; and

(iii) in clause (ii), by adding at the end the following new subclause:

''(XXIII) beginning January 1, 2020, who are expansion enrollees (as defined in subsection (nn)(1));''; and

(B) by adding at the end the following new subsection:

''(nn) EXPANSION ENROLLEES.—In this title:

''(1) IN GENERAL.—The term 'expansion enrollee' means an individual—

''(A) who is under 65 years of age;

''(B) who is not pregnant;

''(C) who is not entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII;

''(D) who is not described in any of subclauses (I) through (VII) of subsection (a)(10)(A)(i); and

''(E) whose income (as determined under subsection (e)(14)) does not exceed 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved.

''(2) APPLICATION OF RELATED PROVISIONS.—Any reference in subsection (a)(10)(G), (k), or (gg) of this section or in section 1903, 1905(a), 1920(e), or 1937(a)(1)(B) to individuals described in subclause (VIII) of subsection (a)(10)(A)(i) shall be deemed to include a reference to expansion enrollees.''; and

(2) in section 1905 (42 U.S.C. 1396d)—

(A) in subsection (y)(1), by striking ''; and'' at the end of subparagraph (D) and all that follows through ''thereafter''; and

(B) in subsection (z)(2)—

(i) in subparagraph (A), by striking ''each year thereafter'' and inserting ''through 2019''; and

(ii) in subparagraph (B)(ii), by striking ''is 80 percent'' in subclause (IV) and all that follows through ''100 percent'' and inserting ''and subsequent years is 80 percent''.

SEC. 123. REDUCING STATE MEDICAID COSTS.

(a) IN GENERAL.—

(1) STATE PLAN REQUIREMENTS.—Section 1902(a)(34) of the Social Security Act (42 U.S.C. 1396a(a)(34)) is amended by striking ''in or after the third month'' and all that follows through ''individual)'' and inserting ''in or after the month in which the individual (or, in the case of a deceased individual, another individual acting on the individual's behalf) made application (or, in the case of an individual who is 65 years of age or older or who is eligible for medical assistance under the plan on the basis of being blind or disabled, in or after the third month before such month)''.

(2) DEFINITION OF MEDICAL ASSISTANCE.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended by striking ''in or after the third month before the month in which the recipient makes application for assistance'' and inserting ''in or after the month in which the recipient makes application for assistance, or, in the case of a recipient who is 65 years of age or older or who is eligible for medical assistance on the basis of being blind or disabled at the time application is made, in or after the third month before the month in which the recipient makes application for assistance,''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to medical assistance with respect to individuals whose eligibility for such assistance is based on an application for such assistance made (or deemed to be made) on or after October 1, 2017.

SEC. 124. ELIGIBILITY REDETERMINATIONS.

(a) IN GENERAL.—Section 1902(e)(14) of the Social Security Act (42 U.S.C. 1396a(e)(14)) (relating to modified adjusted gross income) is amended by adding at the end the following:

''(J) FREQUENCY OF ELIGIBILITY REDETERMINATIONS.—Beginning on October 1, 2017, and notwithstanding subparagraph (H), in the case of an individual whose eligibility for medical assistance under the State plan under this title (or a waiver of such plan) is determined based on the application of modified adjusted gross income under subparagraph (A) and who is so eligible on the basis of clause (i)(VIII), (ii)(XX), or (ii)(XXIII) of subsection (a)(10)(A), at the option of the State, the State plan may provide that the individual's eligibility shall be redetermined every 6 months (or such shorter number of months as the State may elect).''.

(b) INCREASED ADMINISTRATIVE MATCHING PERCENTAGE.—For each calendar quarter during the period beginning on October 1, 2017, and ending on December 31, 2019, the Federal matching percentage otherwise applicable under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) with respect to State expenditures during such quarter that are attributable to meeting the requirement of section 1902(e)(14) (relating to determinations of eligibility using modified adjusted gross income) of such Act shall be increased by 5 percentage points with respect to State expenditures attributable to activities carried out by the State (and approved by the Secretary) to exercise the option described in subparagraph (J) of such section (relating to eligibility redeterminations made on a 6-month or shorter basis) (as added by subsection (a)) to increase the frequency of eligibility redeterminations.

SEC. 125. OPTIONAL WORK REQUIREMENT FOR NONDISABLED, NONELDERLY, NONPREGNANT INDIVIDUALS.

(a) IN GENERAL.—Section 1902 of the Social Security Act (42 U.S.C. 1396a), as previously amended, is further amended by adding at the end the following new subsection:

''(oo) OPTIONAL WORK REQUIREMENT FOR NONDISABLED, NONELDERLY, NONPREGNANT INDIVIDUALS.—

''(1) IN GENERAL.—Beginning October 1, 2017, subject to paragraph (3), a State may elect to condition medical assistance to a nondisabled, nonelderly, nonpregnant individual under this title upon such an individual's satisfaction of a work requirement (as defined in paragraph (2)).

''(2) WORK REQUIREMENT DEFINED.—In this section, the term 'work requirement' means, with respect to an individual, the individual's participation in work activities (as defined in section 407(d)) for such period of time as determined by the State, and as directed and administered by the State.

''(3) REQUIRED EXCEPTIONS.—States administering a work requirement under this subsection may not apply such requirement to—

''(A) a woman during pregnancy through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends;

''(B) an individual who is under 19 years of age;

''(C) an individual who is the only parent or caretaker relative in the family of a child who has not attained 6 years of age or who is the only parent or caretaker of a child with disabilities; or

''(D) an individual who is married or a head of household and has not attained 20 years of age and who—

''(i) maintains satisfactory attendance at secondary school or the equivalent; or

''(ii) participates in education directly related to employment.''.

(b) INCREASE IN MATCHING RATE FOR IMPLEMENTATION.—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by adding at the end the following:

''(aa) The Federal matching percentage otherwise applicable under subsection (a) with respect to State administrative expenditures during a calendar quarter for which the State receives payment under such subsection shall, in addition to any other increase to such Federal matching percentage, be increased for such calendar quarter by 5 percentage points with respect to State expenditures attributable to activities carried out by the State (and approved by the Secretary) to implement subsection (oo) of section 1902.''.

SEC. 126. PROVIDER TAXES.

Section 1903(w)(4)(C) of the Social Security Act (42 U.S.C. 1396b(w)(4)(C)) is amended by adding at the end the following new clause:

''(iii) For purposes of clause (i), a determination of the existence of an indirect guarantee shall be made under paragraph (3)(i) of section 433.68(f) of title 42, Code of Federal Regulations, as in effect on June 1, 2017, except that—

''(I) for fiscal year 2021, '5.8 percent' shall be substituted for '6 percent' each place it appears;

''(II) for fiscal year 2022, '5.6 percent' shall be substituted for '6 percent' each place it appears;

''(III) for fiscal year 2023, '5.4 percent' shall be substituted for '6 percent' each place it appears;

''(IV) for fiscal year 2024, '5.2 percent' shall be substituted for '6 percent' each place it appears; and

''(V) for fiscal year 2025 and each subsequent fiscal year, '5 percent' shall be substituted for '6 percent' each place it appears.''.

SEC. 127. PER CAPITA ALLOTMENT FOR MEDICAL ASSISTANCE.

(a) IN GENERAL.—Title XIX of the Social Security Act is amended—

(1) in section 1903 (42 U.S.C. 1396b)—

(A) in subsection (a), in the matter before paragraph (1), by inserting ''and section 1903A(a)'' after ''except as otherwise provided in this section''; and

(B) in subsection (d)(1), by striking ''to which'' and inserting ''to which, subject to section 1903A(a),''; and

(2) by inserting after such section 1903 the following new section:

''SEC. 1903A. PER CAPITA-BASED CAP ON PAYMENTS FOR MEDICAL ASSISTANCE.

''(a) APPLICATION OF PER CAPITA CAP ON PAYMENTS FOR MEDICAL ASSISTANCE EXPENDITURES.—

''(1) IN GENERAL.—If a State which is one of the 50 States or the District of Columbia has excess aggregate medical assistance expenditures (as defined in paragraph (2)) for a fiscal year (beginning with fiscal year 2020), the amount of payment to the State under section 1903(a)(1) for each quarter in the following fiscal year shall be reduced by ¼ of

the excess aggregate medical assistance payments (as defined in paragraph (3)) for that previous fiscal year. In this section, the term 'State' means only the 50 States and the District of Columbia.

''(2) EXCESS AGGREGATE MEDICAL ASSISTANCE EXPENDITURES.—In this subsection, the term 'excess aggregate medical assistance expenditures' means, for a State for a fiscal year, the amount (if any) by which—

''(A) the amount of the adjusted total medical assistance expenditures (as defined in subsection (b)(1)) for the State and fiscal year; exceeds

''(B) the amount of the target total medical assistance expenditures (as defined in subsection (c)) for the State and fiscal year.

''(3) EXCESS AGGREGATE MEDICAL ASSISTANCE PAYMENTS.—In this subsection, the term 'excess aggregate medical assistance payments' means, for a State for a fiscal year, the product of—

''(A) the excess aggregate medical assistance expenditures (as defined in paragraph (2)) for the State for the fiscal year; and

''(B) the Federal average medical assistance matching percentage (as defined in paragraph (4)) for the State for the fiscal year.

''(4) FEDERAL AVERAGE MEDICAL ASSISTANCE MATCHING PERCENTAGE.—In this subsection, the term 'Federal average medical assistance matching percentage' means, for a State for a fiscal year, the ratio (expressed as a percentage) of—

''(A) the amount of the Federal payments that would be made to the State under section 1903(a)(1) for medical assistance expenditures for calendar quarters in the fiscal year if paragraph (1) did not apply; to

''(B) the amount of the medical assistance expenditures for the State and fiscal year.

''(5) PER CAPITA BASE PERIOD.—

''(A) IN GENERAL.—In this section, the term 'per capita base period' means, with respect to a State, a period of 8 (or, in the case of a State selecting a period under subparagraph (D), not less than 4) consecutive fiscal quarters selected by the State.

''(B) TIMELINE.—Each State shall submit its selection of a per capita base period to the Secretary not later than January 1, 2018.

''(C) PARAMETERS.—In selecting a per capita base period under this paragraph, a State shall—

''(i) only select a period of 8 (or, in the case of a State selecting a base period under subparagraph (D), not less than 4) consecutive fiscal quarters for which all the data necessary to make determinations required under this section is available, as determined by the Secretary; and

''(ii) shall not select any period of 8 (or, in the case of a State selecting a base period under subparagraph (D), not less than 4) consecutive fiscal quarters that begins with a fiscal quarter earlier than the first quarter of fiscal year 2014 or ends with a fiscal quarter later than the third fiscal quarter of 2017.

''(D) BASE PERIOD FOR LATE-EXPANDING STATES.—

''(i) IN GENERAL.—In the case of a State that did not provide for medical assistance for the 1903A enrollee category described in subsection (e)(2)(D) as of the first day of the fourth fiscal quarter of fiscal year 2015 but which provided for such assistance for such category in a subsequent fiscal quarter that is not later than the fourth quarter of fiscal year 2016, the State may select a per capita base period that is less than 8 consecutive fiscal quarters, but in no case shall the period selected be less than 4 consecutive fiscal quarters.

''(ii) APPLICATION OF OTHER REQUIREMENTS.—Except for the requirement that a per capita base period be a period of 8 consecutive fiscal quarters, all other requirements of this paragraph shall apply to a per capita base period selected under this subparagraph.

''(iii) APPLICATION OF BASE PERIOD ADJUSTMENTS.—The adjustments to amounts for per capita base periods required under subsections (b)(5) and (d)(4)(E) shall be applied to amounts for per capita base periods selected under this subparagraph by substituting 'divided by the ratio that the number of quarters in the base period bears to 4' for 'divided by 2'.

''(E) ADJUSTMENT BY THE SECRETARY.—If the Secretary determines that a State took actions after the date of enactment of this section (including making retroactive adjustments to supplemental payment data in a manner that affects a fiscal quarter in the per capita base period) to diminish the quality of the data from the per capita base period used to make determinations under this section, the Secretary may adjust the data as the Secretary deems appropriate.

''(b) ADJUSTED TOTAL MEDICAL ASSISTANCE EXPENDITURES.—Subject to subsection (g), the following shall apply:

''(1) IN GENERAL.—In this section, the term 'adjusted total medical assistance expenditures' means, for a State—

''(A) for the State's per capita base period (as defined in subsection (a)(5)), the product of—

''(i) the amount of the medical assistance expenditures (as defined in paragraph (2) and adjusted under paragraph (5)) for the State and period, reduced by the amount of any excluded expenditures (as defined in paragraph (3) and adjusted under paragraph (5)) for the State and period otherwise included in such medical assistance expenditures; and

''(ii) the 1903A base period population percentage (as defined in paragraph (4)) for the State; or

''(B) for fiscal year 2019 or a subsequent fiscal year, the amount of the medical assistance expenditures (as defined in paragraph (2)) for the State and fiscal year that is attributable to 1903A enrollees, reduced by the amount of any excluded expenditures (as defined in paragraph (3)) for the State and fiscal year otherwise included in such medical assistance expenditures and includes non-DSH supplemental payments (as defined in subsection (d)(4)(A)(ii)) and payments described in subsection (d)(4)(A)(iii) but shall not be construed as including any expenditures attributable to the program under section 1928 (relating to State pediatric vaccine distribution programs). In applying subparagraph (B), non-DSH supplemental payments (as defined in subsection (d)(4)(A)(ii)) and payments described in subsection (d)(4)(A)(iii) shall be treated as fully attributable to 1903A enrollees.

''(2) MEDICAL ASSISTANCE EXPENDITURES.—In this section, the term 'medical assistance expenditures' means, for a State and fiscal year or per capita base period, the medical assistance payments as reported by medical service category on the Form CMS-64 quarterly expense report (or successor to such a report form, and including enrollment data and subsequent adjustments to any such report, in this section referred to collectively as a 'CMS-64 report') for quarters in the year or base period for which payment is (or may otherwise be) made pursuant to section 1903(a)(1), adjusted, in the case of a per capita base period, under paragraph (5).

''(3) EXCLUDED EXPENDITURES.—In this section, the term 'excluded expenditures' means, for a State and fiscal year or per capita base period, expenditures under the State plan (or under a waiver of such plan) that are attributable to any of the following:

''(A) DSH.—Payment adjustments made for disproportionate share hospitals under section 1923.

''(B) MEDICARE COST-SHARING.—Payments made for medicare cost-sharing (as defined in section 1905(p)(3)).

''(C) SAFETY NET PROVIDER PAYMENT ADJUSTMENTS IN NON-EXPANSION STATES.—Payment adjustments under subsection (a) of section 1923A for which payment is permitted under subsection (c) of such section.

''(D) EXPENDITURES FOR PUBLIC HEALTH EMERGENCIES.—Any expenditures that are subject to a public health emergency exclusion under paragraph (6).

''(4) 1903A BASE PERIOD POPULATION PERCENTAGE.—In this subsection, the term '1903A base period population percentage' means, for a State, the Secretary's calculation of the percentage of the actual medical assistance expenditures, as reported by the State on the CMS–64 reports for calendar quarters in the State's per capita base period, that are attributable to 1903A enrollees (as defined in subsection (e)(1)).

''(5) ADJUSTMENTS FOR PER CAPITA BASE PERIOD.—In calculating medical assistance expenditures under paragraph (2) and excluded expenditures under paragraph (3) for a State for the State's per capita base period, the total amount of each type of expenditure for the State and base period shall be divided by 2.

''(6) AUTHORITY TO EXCLUDE STATE EXPENDITURES FROM CAPS DURING PUBLIC HEALTH EMERGENCY.—

''(A) IN GENERAL.—During the period that begins on January 1, 2020, and ends on December 31, 2024, the Secretary may exclude, from a State's medical assistance expenditures for a fiscal year or portion of a fiscal year that occurs during such period, an amount that shall not exceed the amount determined under subparagraph (B) for the State and year or portion of a year if—

''(i) a public health emergency declared by the Secretary pursuant to section 319 of the Public Health Service Act existed within the State during such year or portion of a year; and

''(ii) the Secretary determines that such an exemption would be appropriate.

''(B) MAXIMUM AMOUNT OF ADJUSTMENT.—The amount excluded for a State and fiscal year or portion of a fiscal year under this paragraph shall not exceed the amount by which—

''(i) the amount of State expenditures for medical assistance for 1903A enrollees in areas of the State which are subject to a declaration described in subparagraph (A)(i) for the fiscal year or portion of a fiscal year; exceeds

''(ii) the amount of such expenditures for such enrollees in such areas during the most recent fiscal year or portion of a fiscal year of equal length to the portion of a fiscal year involved during which no such declaration was in effect.

''(C) AGGREGATE LIMITATION ON EXCLUSIONS AND ADDITIONAL BLOCK GRANT PAYMENTS.—The aggregate amount of expenditures excluded under this paragraph and additional payments made under section 1903B(c)(3)(E) for the period described in subparagraph (A) shall not exceed $5,000,000,000.

''(D) REVIEW.—If the Secretary exercises the authority under this paragraph with respect to a State for a fiscal year or portion of a fiscal year, the Secretary shall, not later than 6 months after the declaration described in subparagraph (A)(i) ceases to be in effect, conduct an audit of the State's medical assistance expenditures for 1903A enrollees during the year or portion of a year to ensure that all of the expenditures so excluded were made for the purpose of ensuring that the health care needs of 1903A enrollees in areas affected by a public health emergency are met.

''(c) TARGET TOTAL MEDICAL ASSISTANCE EXPENDITURES.—

''(1) CALCULATION.—In this section, the term 'target total medical assistance expenditures' means, for a State for a fiscal year, the sum of the products, for each of the 1903A enrollee categories (as defined in subsection (e)(2)), of—

''(A) the target per capita medical assistance expenditures (as defined in paragraph (2)) for the enrollee category, State, and fiscal year; and

''(B) the number of 1903A enrollees for such enrollee category, State, and fiscal year, as determined under subsection (e)(4).

''(2) TARGET PER CAPITA MEDICAL ASSISTANCE EXPENDITURES.—In this subsection, the term 'target per capita medical assistance expenditures' means, for a 1903A enrollee category and State—

''(A) for fiscal year 2020, an amount equal to—

''(i) the provisional FY19 target per capita amount for such enrollee category (as calculated under subsection (d)(5)) for the State; increased by

''(ii) the applicable annual inflation factor (as defined in paragraph (3)) for fiscal year 2020; and

''(B) for each succeeding fiscal year, an amount equal to—

''(i) the target per capita medical assistance expenditures (under subparagraph (A) or this subparagraph) for the 1903A enrollee category and State for the preceding fiscal year; increased by

''(ii) the applicable annual inflation factor for that succeeding fiscal year.

''(3) APPLICABLE ANNUAL INFLATION FACTOR.—In paragraph (2), the term 'applicable annual inflation factor' means—

''(A) for fiscal years before 2025—

''(i) for each of the 1903A enrollee categories described in subparagraphs (C), (D), and (E) of subsection (e)(2), the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) from September of the previous fiscal year to September of the fiscal year involved; and

''(ii) for each of the 1903A enrollee categories described in subparagraphs (A) and (B) of subsection (e)(2), the percentage increase described in clause (i) plus 1 percentage point; and

''(B) for fiscal years after 2024, for all 1903A enrollee categories, the percentage increase in the consumer price index for all urban consumers (U.S. city average) from September of the previous fiscal year to September of the fiscal year involved.

''(4) ADJUSTMENTS TO STATE EXPENDITURES TARGETS TO PROMOTE PROGRAM EQUITY ACROSS STATES.—

''(A) IN GENERAL.—Beginning with fiscal year 2020, the target per capita medical assistance expenditures for a 1903A enrollee category, State, and fiscal year, as determined under paragraph (2), shall be adjusted (subject to subparagraph (C)(i)) in accordance with this paragraph.

''(B) ADJUSTMENT BASED ON LEVEL OF PER CAPITA SPENDING FOR 1903A ENROLLEE CATEGORIES.—Subject to subparagraph (C), with respect to a State, fiscal year, and 1903A enrollee category, if the State's per capita categorical medical assistance expenditures (as defined in subparagraph (D)) for the State and category in the preceding fiscal year—

''(i) exceed the mean per capita categorical medical assistance expenditures for the category for all States for such preceding year by not less than 25 percent, the State's target per capita medical assistance expenditures for such category for the fiscal year involved shall be reduced by a percentage that shall be determined by the Secretary but which shall not be less than 0.5 percent or greater than 2 percent; or

''(ii) are less than the mean per capita categorical medical assistance expenditures for the category for all States for such preceding year by not less than 25 percent, the State's target per capita medical assistance expenditures for such category for the fiscal year involved shall be increased by a percentage that shall be determined by the Secretary but which shall not be less than 0.5 percent or greater than 2 percent.

''(C) RULES OF APPLICATION.—

''(i) BUDGET NEUTRALITY REQUIREMENT.—In determining the appropriate percentages by which to adjust States' target per capita medical assistance expenditures for a category and fiscal year under this paragraph, the Secretary shall make such adjustments in a manner that does not result in a net increase in Federal payments under this section for such fiscal year, and if the Secretary cannot adjust such expenditures in such a manner there shall be no adjustment under this paragraph for such fiscal year.

''(ii) ASSUMPTION REGARDING STATE EXPENDITURES.—For purposes of clause (i), in the case of a State that has its target per capita medical assistance expenditures for a 1903A enrollee category and fiscal year increased under this paragraph, the Secretary shall assume that the categorical medical assistance expenditures (as defined in subparagraph (D)(ii)) for such State, category, and fiscal year will equal such increased target medical assistance expenditures.

''(iii) NONAPPLICATION TO LOW-DENSITY STATES.—This paragraph shall not apply to any State that has a population density of less than 15 individuals per square mile, based on the most recent data available from the Bureau of the Census.

''(iv) DISREGARD OF ADJUSTMENT.—Any adjustment under this paragraph to target medical assistance expenditures for a State, 1903A enrollee category, and fiscal year shall be disregarded when determining the target medical assistance expenditures for such State and category for a succeeding year under paragraph (2).

''(v) APPLICATION FOR FISCAL YEARS 2020 AND 2021.—In fiscal years 2020 and 2021, the Secretary shall apply this paragraph by deeming all categories of 1903A enrollees to be a single category.

''(D) PER CAPITA CATEGORICAL MEDICAL ASSISTANCE EXPENDITURES.—

''(i) IN GENERAL.—In this paragraph, the term 'per capita categorical medical assistance expenditures' means, with respect to a State, 1903A enrollee category, and fiscal year, an amount equal to—

''(I) the categorical medical expenditures (as defined in clause (ii)) for the State, category, and year; divided by

''(II) the number of 1903A enrollees for the State, category, and year.

''(ii) CATEGORICAL MEDICAL ASSISTANCE EXPENDITURES.—The term 'categorical medical assistance expenditures' means, with respect to a State, 1903A enrollee category, and fiscal year, an amount equal to the total medical assistance expenditures (as defined in paragraph (2)) for the State and fiscal year that are attributable to 1903A enrollees in the category, excluding any excluded expenditures (as defined in paragraph (3)) for the State and fiscal year that are attributable to 1903A enrollees in the category.

''(d) CALCULATION OF FY19 PROVISIONAL TARGET AMOUNT FOR EACH 1903A ENROLLEE CATEGORY.—Subject to subsection (g), the following shall apply:

''(1) CALCULATION OF BASE AMOUNTS FOR PER CAPITA BASE PERIOD.—For each State the Secretary shall calculate (and provide notice to the State not later than April 1, 2018, of) the following:

''(A) The amount of the adjusted total medical assistance expenditures (as defined in subsection (b)(1)) for the State for the State's per capita base period.

''(B) The number of 1903A enrollees for the State in the State's per capita base period (as determined under subsection (e)(4)).

''(C) The average per capita medical assistance expenditures for the State for the State's per capita base period equal to—

''(i) the amount calculated under subparagraph (A); divided by

''(ii) the number calculated under subparagraph (B).

''(2) FISCAL YEAR 2019 AVERAGE PER CAPITA AMOUNT BASED ON INFLATING THE PER CAPITA BASE PERIOD AMOUNT TO FISCAL YEAR 2019 BY CPI-MEDICAL.—The Secretary shall calculate a fiscal year 2019 average per capita amount for each State equal to—

''(A) the average per capita medical assistance expenditures for the State for the State's per capita base period (calculated under paragraph (1)(C)); increased by

''(B) the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) from the last month of the State's per capita base period to September of fiscal year 2019.

''(3) AGGREGATE AND AVERAGE EXPENDITURES PER CAPITA FOR FISCAL YEAR 2019.—The Secretary shall calculate for each State the following:

''(A) The amount of the adjusted total medical assistance expenditures (as defined in subsection (b)(1)) for the State for fiscal year 2019.

''(B) The number of 1903A enrollees for the State in fiscal year 2019 (as determined under subsection (e)(4)).

''(4) PER CAPITA EXPENDITURES FOR FISCAL YEAR 2019 FOR EACH 1903A ENROLLEE CATEGORY.—The Secretary shall calculate (and provide notice to each State not later than January 1, 2020, of) the following:

''(A)(i) For each 1903A enrollee category, the amount of the adjusted total medical assistance expenditures (as defined in subsection (b)(1)) for the State for fiscal year 2019 for individuals in the enrollee category, calculated by excluding from medical assistance expenditures those expenditures attributable to expenditures described in clause (iii) or non-DSH supplemental expenditures (as defined in clause (ii)).

''(ii) In this paragraph, the term 'non-DSH supplemental expenditure' means a payment to a provider under the State plan (or under a waiver of the plan) that—

''(I) is not made under section 1923;

''(II) is not made with respect to a specific item or service for an individual;

''(III) is in addition to any payments made to the provider under the plan (or waiver) for any such item or service; and

''(IV) complies with the limits for additional payments to providers under the plan (or waiver) imposed pursuant to section 1902(a)(30)(A), including the regulations specifying upper payment limits under the State plan in part 447 of title 42, Code of Federal Regulations (or any successor regulations).

''(iii) An expenditure described in this clause is an expenditure that meets the criteria specified in subclauses (I), (II), and (III) of clause (ii) and is authorized under section 1115 for the purposes of funding a delivery system reform pool, uncompensated care pool, a designated State health program, or any other similar expenditure (as defined by the Secretary).

''(B) For each 1903A enrollee category, the number of 1903A enrollees for the State in fiscal year 2019 in the enrollee category (as determined under subsection (e)(4)).

''(C) For the State's per capita base period, the State's non-DSH supplemental and pool payment percentage is equal to the ratio (expressed as a percentage) of—

''(i) the total amount of non-DSH supplemental expenditures (as defined in subparagraph (A)(ii) and adjusted under subparagraph (E)) and payments described in subparagraph (A)(iii) (and adjusted under subparagraph (E)) for the State for the period; to

''(ii) the amount described in subsection (b)(1)(A) for the State for the State's per capita base period.

''(D) For each 1903A enrollee category an average medical assistance expenditures per capita for the State for fiscal year 2019 for the enrollee category equal to—

''(i) the amount calculated under subparagraph (A) for the State, increased by the non-DSH supplemental and pool payment percentage for the State (as calculated under subparagraph (C)); divided by

''(ii) the number calculated under subparagraph (B) for the State for the enrollee category.

''(E) For purposes of subparagraph (C)(i), in calculating the total amount of non-DSH supplemental expenditures and payments described in subparagraph (A)(iii) for a State for the per capita base period, the total amount of such expenditures and the total amount of such payments for the State and base period shall each be divided by 2.

''(5) PROVISIONAL FY19 PER CAPITA TARGET AMOUNT FOR EACH 1903A ENROLLEE CATEGORY.—Subject to subsection (f)(2), the Secretary shall calculate for each State a provisional FY19 per capita target amount for each 1903A enrollee category equal to the average medical assistance expenditures per capita for the State for fiscal year 2019 (as calculated under paragraph (4)(D)) for such enrollee category multiplied by the ratio of—

''(A) the product of—

''(i) the fiscal year 2019 average per capita amount for the State, as calculated under paragraph (2); and

''(ii) the number of 1903A enrollees for the State in fiscal year 2019, as calculated under paragraph (3)(B); to

''(B) the amount of the adjusted total medical assistance expenditures for the State for fiscal year 2019, as calculated under paragraph (3)(A).

''(e) 1903A ENROLLEE; 1903A ENROLLEE CATEGORY.—Subject to subsection (g), for purposes of this section, the following shall apply:

''(1) 1903A ENROLLEE.—The term '1903A enrollee' means, with respect to a State and a month and subject to subsection (i)(1)(B), any Medicaid enrollee (as defined in paragraph (3)) for the month, other than such an enrollee who for such month is in any of the following categories of excluded individuals:

''(A) CHIP.—An individual who is provided, under this title in the manner described in section 2101(a)(2), child health assistance under title XXI.

''(B) IHS.—An individual who receives any medical assistance under this title for services for which payment is made under the third sentence of section 1905(b).

''(C) BREAST AND CERVICAL CANCER SERVICES ELIGIBLE INDIVIDUAL.—An individual who is eligible for medical assistance under this title only on the basis of section 1902(a)(10)(A)(ii)(XVIII).

''(D) PARTIAL-BENEFIT ENROLLEES.—An individual who—

''(i) is an alien who is eligible for medical assistance under this title only on the basis of section 1903(v)(2);

''(ii) is eligible for medical assistance under this title only on the basis of subclause (XII) or (XXI) of section 1902(a)(10)(A)(ii) (or on the basis of a waiver that provides only comparable benefits);

''(iii) is a dual eligible individual (as defined in section 1915(h)(2)(B)) and is eligible for medical assistance under this title (or under a waiver) only for some or all of medicare cost-sharing (as defined in section 1905(p)(3)); or

''(iv) is eligible for medical assistance under this title and for whom the State is providing a payment or subsidy to an employer for coverage of the individual under a group health plan pursuant to section 1906 or section 1906A (or pursuant to a waiver that provides only comparable benefits).

''(E) BLIND AND DISABLED CHILDREN.—An individual who—

''(i) is a child under 19 years of age; and

''(ii) is eligible for medical assistance under this title on the basis of being blind or disabled.

''(2) 1903A ENROLLEE CATEGORY.—The term '1903A enrollee category' means each of the following:

''(A) ELDERLY.—A category of 1903A enrollees who are 65 years of age or older.

''(B) BLIND AND DISABLED.—A category of 1903A enrollees (not described in the previous subparagraph) who—

''(i) are 19 years of age or older; and

''(ii) are eligible for medical assistance under this title on the basis of being blind or disabled.

''(C) CHILDREN.—A category of 1903A enrollees (not described in a previous subparagraph) who are children under 19 years of age.

''(D) EXPANSION ENROLLEES.—A category of 1903A enrollees (not described in a previous subparagraph) who are eligible for medical assistance under this title only on the basis of clause (i)(VIII), (ii)(XX), or (ii)(XXIII) of section 1902(a)(10)(A).

''(E) OTHER NONELDERLY, NONDISABLED, NON-EXPANSION ADULTS.—A category of 1903A enrollees who are not described in any previous subparagraph.

''(3) MEDICAID ENROLLEE.—The term 'Medicaid enrollee' means, with respect to a State for a month, an individual who is eligible for medical assistance for items or services under this title and enrolled under the State plan (or a waiver of such plan) under this title for the month.

''(4) DETERMINATION OF NUMBER OF 1903A ENROLLEES.—The number of 1903A enrollees for a State and fiscal year or the State's per capita base period, and, if applicable, for a 1903A enrollee category, is the average monthly number of Medicaid enrollees for such State and fiscal year or base period (and, if applicable, in such category) that are reported through the CMS–64 report under (and subject to audit under) subsection (h).

''(f) SPECIAL PAYMENT RULES.—

''(1) APPLICATION IN CASE OF RESEARCH AND DEMONSTRATION PROJECTS AND OTHER WAIVERS.—In the case of a State with a waiver of the State plan approved under section 1115, section 1915, or another provision of this title, this section shall apply to medical assistance expenditures and medical assistance payments under the waiver, in the same manner as if such expenditures and payments had been made under a State plan under this title and the limitations on expenditures under this section shall supersede any other payment limitations or provisions (including limitations based on a per capita limitation) otherwise applicable under such a waiver.

''(2) TREATMENT OF STATES EXPANDING COVERAGE AFTER JULY 1, 2016.—In the case of a State that did not provide for medical assistance for the 1903A enrollee category described in subsection (e)(2)(D) as of July 1, 2016, but which subsequently provides for such assistance for such category, the provisional FY19 per capita target amount for such enrollee category under subsection (d)(5) shall be equal to the provisional FY19 per capita target amount for the 1903A enrollee category described in subsection (e)(2)(E).

''(3) IN CASE OF STATE FAILURE TO REPORT NECESSARY DATA.—If a State for any quarter in a fiscal year (beginning with fiscal year 2019) fails to satisfactorily submit data on expenditures and enrollees in accordance with subsection (h)(1), for such fiscal year and any succeeding fiscal year for which such data are not satisfactorily submitted—

''(A) the Secretary shall calculate and apply subsections (a) through (e) with respect to the State as if all 1903A enrollee categories for which such expenditure and enrollee data were not satisfactorily submitted were a single 1903A enrollee category; and

''(B) the growth factor otherwise applied under subsection (c)(2)(B) shall be decreased by 1 percentage point.

''(g) RECALCULATION OF CERTAIN AMOUNTS FOR DATA ERRORS.—The amounts and percentage calculated under paragraphs (1) and (4)(C) of subsection (d) for a State for the State's per capita base period, and the amounts of the adjusted total medical assistance expenditures calculated under subsection (b) and the number of Medicaid enrollees and 1903A enrollees determined under subsection (e)(4) for a State for the State's per capita base period, fiscal year 2019, and any subsequent fiscal year, may be adjusted by the Secretary based upon an appeal (filed by the State in such a form, manner, and time, and containing such information relating to data errors that support such appeal, as the Secretary specifies) that the Secretary determines to be valid, except that any adjustment by the Secretary under this subsection for a State may not result in an increase of the target total medical assistance expenditures exceeding 2 percent.

''(h) REQUIRED REPORTING AND AUDITING; TRANSITIONAL INCREASE IN FEDERAL MATCHING PERCENTAGE FOR CERTAIN ADMINISTRATIVE EXPENSES.—

''(1) AUDITING OF CMS–64 DATA.—The Secretary shall conduct for each State an audit of the number of individuals and expenditures reported through the CMS–64 report for the State's per capita base period, fiscal year 2019, and each subsequent fiscal year, which audit may be conducted on a representative sample (as determined by the Secretary).

''(2) AUDITING OF STATE SPENDING.—The Inspector General of the Department of Health and Human Services shall conduct an audit (which shall be conducted using random sampling, as determined by the Inspector General) of each State's spending under this section not less than once every 3 years.

''(3) TEMPORARY INCREASE IN FEDERAL MATCHING PERCENTAGE TO SUPPORT IMPROVED DATA REPORTING SYSTEMS FOR FISCAL YEARS 2018 AND 2019.—In the case of any State that selects as its per capita base period the most recent 8 consecutive quarter period for which the data necessary to make the determinations required under this section is available, for amounts expended during calendar quarters beginning on or after October 1, 2017, and before October 1, 2019—

''(A) the Federal matching percentage applied under section 1903(a)(3)(A)(i) shall be increased by 10 percentage points to 100 percent; and

''(B) the Federal matching percentage applied under section 1903(a)(3)(B) shall be increased by 25 percentage points to 100 percent.

''(4) HHS REPORT ON ADOPTION OF T–MSIS DATA.—Not later than January 1, 2025, the Secretary shall submit to Congress a report making recommendations as to whether data from the Transformed Medicaid Statistical

Information System would be preferable to CMS–64 report data for purposes of making the determinations necessary under this section.''.

(b) ENSURING ACCESS TO HOME AND COMMUNITY BASED SERVICES.—Section 1915 of the Social Security Act (42 U.S.C. 1396n) is amended by adding at the end the following new subsection:

''(l) INCENTIVE PAYMENTS FOR HOME AND COMMUNITY-BASED SERVICES.—

''(1) IN GENERAL.—The Secretary shall establish a demonstration project (referred to in this subsection as the 'demonstration project') under which eligible States may make HCBS payment adjustments for the purpose of continuing to provide and improving the quality of home and community-based services provided under a waiver under subsection (c) or (d) or a State plan amendment under subsection (i).

''(2) SELECTION OF ELIGIBLE STATES.—

''(A) APPLICATION.—A State seeking to participate in the demonstration project shall submit to the Secretary, at such time and in such manner as the Secretary shall require, an application that includes—

''(i) an assurance that any HCBS payment adjustment made by the State under this subsection will comply with the health and welfare and financial accountability safeguards taken by the State under subsection (c)(2)(A); and

''(ii) such other information and assurances as the Secretary shall require.

''(B) SELECTION.—The Secretary shall select States to participate in the demonstration project on a competitive basis except that, in making selections under this paragraph, the Secretary shall give priority to any State that is one of the 15 States in the United States with the lowest population density, as determined by the Secretary based on data from the Bureau of the Census.

''(3) TERM OF DEMONSTRATION PROJECT.—The demonstration project shall be conducted for the 4-year period beginning on January 1, 2020, and ending on December 31, 2023.

''(4) STATE ALLOTMENTS AND INCREASED FMAP FOR PAYMENT ADJUSTMENTS.—

''(A) IN GENERAL.—

''(i) ANNUAL ALLOTMENT.—Subject to clause (ii), for each year of the demonstration project, the Secretary shall allot an amount to each State that is an eligible State for the year.

''(ii) LIMITATION ON FEDERAL SPENDING.—The aggregate amount that may be allotted to eligible States under clause (i) for all years of the demonstration project shall not exceed $8,000,000,000.

''(B) FMAP APPLICABLE TO HCBS PAYMENT ADJUSTMENTS.—For each year of the demonstration project, notwithstanding section 1905(b) but subject to the limitations described in subparagraph (C), the Federal medical assistance percentage applicable with respect to expenditures by an eligible State that are attributable to HCBS payment adjustments shall be equal to (and shall in no case exceed) 100 percent.

''(C) INDIVIDUAL PROVIDER AND ALLOTMENT LIMITATIONS.—Payment under section 1903(a) shall not be made to an eligible State for expenditures for a year that are attributable to an HCBS payment adjustment—

''(i) that is paid to a single provider and exceeds a percentage which shall be established by the Secretary of the payment otherwise made to the provider; or

''(ii) to the extent that the aggregate amount of HCBS payment adjustments made by the State in the year exceeds the amount allotted to the State for the year under clause (i).

''(5) REPORTING AND EVALUATION.—

''(A) IN GENERAL.—As a condition of receiving the increased Federal medical assistance percentage described in paragraph (4)(B), each eligible State shall collect and report information, as determined necessary by the Secretary, for the purposes of providing Federal oversight and evaluating the State's compliance with the health and welfare and financial accountability safeguards taken by the State under subsection (c)(2)(A).

''(B) FORMS.—Expenditures by eligible States on HCBS payment adjustments shall be separately reported on the CMS-64 Form and in T-MSIS.

''(6) DEFINITIONS.—In this subsection:

''(A) ELIGIBLE STATE.—The term 'eligible State' means a State that—

''(i) is one of the 50 States or the District of Columbia;

''(ii) has in effect—

''(I) a waiver under subsection (c) or (d); or

''(II) a State plan amendment under subsection (i);

''(iii) submits an application under paragraph (2)(A); and

''(iv) is selected by the Secretary to participate in the demonstration project.

''(B) HCBS PAYMENT ADJUSTMENT.—The term 'HCBS payment adjustment' means a payment adjustment made by an eligible State to the amount of payment otherwise provided under a waiver under subsection (c) or (d) or a State plan amendment under subsection (i) for a home and community-based service which is provided to a 1903A enrollee (as defined in section 1903A(e)(1)) who is in the enrollee category described in subparagraph (A) or (B) of section 1903A(e)(2).''.

SEC. 128. FLEXIBLE BLOCK GRANT OPTION FOR STATES.

Title XIX of the Social Security Act, as previously amended, is further amended by inserting after section 1903A the following new section:

''SEC. 1903B. MEDICAID FLEXIBILITY PROGRAM.

''(a) IN GENERAL.—Beginning with fiscal year 2020, any State (as defined in subsection (e)) that has an application approved by the Secretary under subsection (b) may conduct a Medicaid Flexibility Program to provide targeted health assistance to program enrollees.

''(b) STATE APPLICATION.—

''(1) IN GENERAL.—To be eligible to conduct a Medicaid Flexibility Program, a State shall submit an application to the Secretary that meets the requirements of this subsection.

''(2) CONTENTS OF APPLICATION.—An application under this subsection shall include the following:

''(A) A description of the proposed Medicaid Flexibility Program and how the State will satisfy the requirements described in subsection (d).

''(B) The proposed conditions for eligibility of program enrollees.

''(C) The applicable program enrollee category (as defined in subsection (e)(1)).

''(D) A description of the types, amount, duration, and scope of services which will be offered as targeted health assistance under the program, including a description of the proposed package of services which will be provided to program enrollees to whom the State would otherwise be required to make medical assistance available under section 1902(a)(10)(A)(i).

''(E) A description of how the State will notify individuals currently enrolled in the State plan for medical assistance under this title of the transition to such program.

''(F) Statements certifying that the State agrees to—

''(i) submit regular enrollment data with respect to the program to the Centers for Medicare & Medicaid Services at such time and in such manner as the Secretary may require;

''(ii) submit timely and accurate data to the Transformed Medicaid Statistical Information System (T–MSIS);

''(iii) report annually to the Secretary on adult health quality measures implemented under the program and information on the quality of health care furnished to program enrollees under the program as part of the annual report required under section 1139B(d)(1);

''(iv) submit such additional data and information not described in any of the preceding clauses of this subparagraph but which the Secretary determines is necessary for monitoring, evaluation, or program integrity purposes, including—

''(I) survey data, such as the data from Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys;

''(II) birth certificate data; and

''(III) clinical patient data for quality measurements which may not be present in a claim, such as laboratory data, body mass index, and blood pressure; and

''(v) on an annual basis, conduct a report evaluating the program and make such report available to the public.

''(G) An information technology systems plan demonstrating that the State has the capability to support the technological administration of the program and comply with reporting requirements under this section.

''(H) A statement of the goals of the proposed program, which shall include—

''(i) goals related to quality, access, rate of growth targets, consumer satisfaction, and outcomes;

''(ii) a plan for monitoring and evaluating the program to determine whether such goals are being met; and

''(iii) a proposed process for the State, in consultation with the Centers for Medicare & Medicaid Services, to take remedial action to make progress on unmet goals.

''(I) Such other information as the Secretary may require.

''(3) STATE NOTICE AND COMMENT PERIOD.—

''(A) IN GENERAL.—Before submitting an application under this subsection, a State shall make the application publicly available for a 30 day notice and comment period.

''(B) NOTICE AND COMMENT PROCESS.—During the notice and comment period described in subparagraph (A), the State shall provide opportunities for a meaningful level of public input, which shall include public hearings on the proposed Medicaid Flexibility Program.

''(4) FEDERAL NOTICE AND COMMENT PERIOD.—The Secretary shall not approve of any application to conduct a Medicaid Flexibility Program without making such application publicly available for a 30 day notice and comment period.

''(5) TIMELINE FOR SUBMISSION.—

''(A) IN GENERAL.—A State may submit an application under this subsection to conduct a Medicaid Flexibility Program that would begin in the next fiscal year at any time, subject to subparagraph (B).

''(B) DEADLINES.—Each year beginning with 2019, the Secretary shall specify a deadline for submitting an application under this subsection to conduct a Medicaid Flexibility Program that would begin in the next fiscal year, but such deadline shall not be earlier than 60 days after the date that the Secretary publishes the amounts of State block grants as required under subsection (c)(4).

''(c) FINANCING.—

''(1) IN GENERAL.—For each fiscal year during which a State is conducting a Medicaid Flexibility Program, the State shall receive, instead of amounts otherwise payable to the State under this title for medical assistance

for program enrollees, the amount specified in paragraph (3)(A).

''(2) AMOUNT OF BLOCK GRANT FUNDS.—

''(A) IN GENERAL.—The block grant amount under this paragraph for a State and year shall be equal to the sum of the amounts determined under subparagraph (B) for each 1903A enrollee category within the applicable program enrollee category for the State and year.

''(B) ENROLLEE CATEGORY AMOUNTS.—

''(i) FOR INITIAL YEAR.—Subject to subparagraph (C), for the first fiscal year in which a 1903A enrollee category is included in the applicable program enrollee category for a Medicaid Flexibility Program conducted by the State, the amount determined under this subparagraph for the State, year, and category shall be equal to the Federal average medical assistance matching percentage (as defined in section 1903A(a)(4)) for the State and year multiplied by the product of—

''(I) the target per capita medical assistance expenditures (as defined in section 1903A(c)(2)) for the State, year, and category; and

''(II) the number of 1903A enrollees in such category for the State for the second fiscal year preceding such first fiscal year, increased by the percentage increase in State population from such second preceding fiscal year to such first fiscal year, based on the best available estimates of the Bureau of the Census.

''(ii) FOR ANY SUBSEQUENT YEAR.—For any fiscal year that is not the first fiscal year in which a 1903A enrollee category is included in the applicable program enrollee category for a Medicaid Flexibility Program conducted by the State, the block grant amount under this paragraph for the State, year, and category shall be equal to the amount determined for the State and category for the most recent previous fiscal year in which the State conducted a Medicaid Flexibility Program that included such category, except that such amount shall be increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) from April of the second fiscal year preceding the fiscal year involved to April of the fiscal year preceding the fiscal year involved.

''(C) CAP ON TOTAL POPULATION OF 1903A ENROLLEES FOR PURPOSES OF BLOCK GRANT CALCULATION.—

''(i) IN GENERAL.—In calculating the amount of a block grant for the first year in which a 1903A enrollee category is included in the applicable program enrollee category for a Medicaid Flexibility Program conducted by the State under subparagraph (B)(i), the total number of 1903A enrollees in such 1903A enrollee category for the State and year shall not exceed the adjusted number of base period enrollees for the State (as defined in clause (ii)).

''(ii) ADJUSTED NUMBER OF BASE PERIOD ENROLLEES.—The term 'adjusted number of base period enrollees' means, with respect to a State and 1903A enrollee category, the number of 1903A enrollees in the enrollee category for the State for the State's per capita base period (as determined under section 1903A(e)(4)), increased by the percentage increase, if any, in the total State population from the last April in the State's per capita base period to April of the fiscal year preceding the fiscal year involved (determined using the best available data from the Bureau of the Census) plus 3 percentage points.

''(3) FEDERAL PAYMENT AND STATE MAINTENANCE OF EFFORT.—

''(A) FEDERAL PAYMENT.—Subject to subparagraphs (D) and (E), the Secretary shall pay to each State conducting a Medicaid Flexibility Program under this section for a fiscal year, from its block grant amount under paragraph (2) for such year, an amount for each quarter of such year equal to the Federal average medical assistance percentage (as defined in section 1903A(a)(4)) of the total amount expended under the program during such quarter as targeted health assistance, and the State is responsible for the balance of the funds to carry out such program.

''(B) STATE MAINTENANCE OF EFFORT EXPENDITURES.—For each year during which a State is conducting a Medicaid Flexibility Program, the State shall make expenditures for targeted health assistance under the program in an amount equal to the product of—

''(i) the block grant amount determined for the State and year under paragraph (2); and

''(ii) the enhanced FMAP described in the first sentence of section 2105(b) for the State and year.

''(C) REDUCTION IN BLOCK GRANT AMOUNT FOR STATES FAILING TO MEET MOE REQUIREMENT.—

''(i) IN GENERAL.—In the case of a State conducting a Medicaid Flexibility Program that makes expenditures for targeted health assistance under the program for a fiscal year in an amount that is less than the required amount for the fiscal year under subparagraph (B), the amount of the block grant determined for the State under paragraph (2) for the succeeding fiscal year shall be reduced by the amount by which such expenditures are less than such required amount.

''(ii) DISREGARD OF REDUCTION.—For purposes of determining the amount of a State block grant under paragraph (2), any reduction made under this subparagraph to a State's block grant amount in a previous fiscal year shall be disregarded.

''(iii) APPLICATION TO STATES THAT TERMINATE PROGRAM.—In the case of a State described in clause (i) that terminates the State Medicaid Flexibility Program under subsection (d)(2)(B) and such termination is effective with the end of the fiscal year in which the State fails to make the required amount of expenditures under subparagraph (B), the reduction amount determined for the State and succeeding fiscal year under clause (i) shall be treated as an overpayment under this title.

''(D) REDUCTION FOR NONCOMPLIANCE.—If the Secretary determines that a State conducting a Medicaid Flexibility Program is not complying with the requirements of this section, the Secretary may withhold payments, reduce payments, or recover previous payments to the State under this section as the Secretary deems appropriate.

''(E) ADDITIONAL FEDERAL PAYMENTS DURING PUBLIC HEALTH EMERGENCY.—

''(i) IN GENERAL.—In the case of a State and fiscal year or portion of a fiscal year for which the Secretary has excluded expenditures under section 1903A(b)(6), if the State has uncompensated targeted health assistance expenditures for the year or portion of a year, the Secretary may make an additional payment to such State equal to the Federal average medical assistance percentage (as defined in section 1903A(a)(4)) for the year or portion of a year of the amount of such uncompensated targeted health assistance expenditures, except that the amount of such payment shall not exceed the amount determined for the State and year or portion of a year under clause (ii).

''(ii) MAXIMUM AMOUNT OF ADDITIONAL PAYMENT.—The amount determined for a State and fiscal year or portion of a fiscal year under this subparagraph shall not exceed the Federal average medical assistance percentage (as defined in section 1903A(a)(4)) for such year or portion of a year of the amount by which—

''(I) the amount of State expenditures for targeted health assistance for program enrollees in areas of the State which are subject to a declaration described in section 1903A(b)(6)(A)(i) for the year or portion of a year; exceeds

''(II) the amount of such expenditures for such enrollees in such areas during the most recent fiscal year involved (or portion of a fiscal year of equal length to the portion of a fiscal year involved) during which no such declaration was in effect.

''(iii) UNCOMPENSATED TARGETED HEALTH ASSISTANCE.—In this subparagraph, the term 'uncompensated targeted health assistance expenditures' means, with respect to a State and fiscal year or portion of a fiscal year, an amount equal to the amount (if any) by which—

''(I) the total amount expended by the State under the program for targeted health assistance for the year or portion of a year; exceeds

''(II) the amount equal to the amount of the block grant (reduced, in the case of a portion of a year, to the same proportion of the full block grant amount that the portion of the year bears to the whole year) divided by the Federal average medical assistance percentage for the year or portion of a year.

''(iv) REVIEW.—If the Secretary makes a payment to a State for a fiscal year or portion of a fiscal year, the Secretary shall, not later than 6 months after the declaration described in section 1903A(b)(6)(A)(i) ceases to be in effect, conduct an audit of the State's targeted health assistance expenditures for program enrollees during the year or portion of a year to ensure that all of the expenditures for which the additional payment was made were made for the purpose of ensuring that the health care needs of program enrollees in areas affected by a public health emergency are met.

''(4) DETERMINATION AND PUBLICATION OF BLOCK GRANT AMOUNT.—Beginning in 2019 and each year thereafter, the Secretary shall determine for each State, regardless of whether the State is conducting a Medicaid Flexibility Program or has submitted an application to conduct such a program, the amount of the block grant for the State under paragraph (2) which would apply for the upcoming fiscal year if the State were to conduct such a program in such fiscal year, and shall publish such determinations not later than June 1 of each year.

''(d) PROGRAM REQUIREMENTS.—

''(1) IN GENERAL.—No payment shall be made under this section to a State conducting a Medicaid Flexibility Program unless such program meets the requirements of this subsection.

''(2) TERM OF PROGRAM.—

''(A) IN GENERAL.—A State Medicaid Flexibility Program approved under subsection (b)—

''(i) shall be conducted for not less than 1 program period;

''(ii) at the option of the State, may be continued for succeeding program periods without resubmitting an application under subsection (b), provided that—

''(I) the State provides notice to the Secretary of its decision to continue the program; and

''(II) no significant changes are made to the program; and

''(iii) shall be subject to termination only by the State, which may terminate the program by making an election under subparagraph (B).

''(B) ELECTION TO TERMINATE PROGRAM.—

''(i) IN GENERAL.—Subject to clause (ii), a State conducting a Medicaid Flexibility Program may elect to terminate the program effective with the first day after the end of the

program period in which the State makes the election.

''(ii) TRANSITION PLAN REQUIREMENT.—A State may not elect to terminate a Medicaid Flexibility Program unless the State has in place an appropriate transition plan approved by the Secretary.

''(iii) EFFECT OF TERMINATION.—If a State elects to terminate a Medicaid Flexibility Program, the per capita cap limitations under section 1903A shall apply effective with the day described in clause (i), and such limitations shall be applied as if the State had never conducted a Medicaid Flexibility Program.

''(3) PROVISION OF TARGETED HEALTH ASSISTANCE.—

''(A) IN GENERAL.—A State Medicaid Flexibility Program shall provide targeted health assistance to program enrollees and such assistance shall be instead of medical assistance which would otherwise be provided to the enrollees under this title.

''(B) CONDITIONS FOR ELIGIBILITY.—

''(i) IN GENERAL.—A State conducting a Medicaid Flexibility Program shall establish conditions for eligibility of program enrollees, which shall be instead of other conditions for eligibility under this title, except that the program must provide for eligibility for program enrollees to whom the State would otherwise be required to make medical assistance available under section 1902(a)(10)(A)(i).

''(ii) MAGI.—Any determination of income necessary to establish the eligibility of a program enrollee for purposes of a State Medicaid Flexibility Program shall be made using modified adjusted gross income in accordance with section 1902(e)(14).

''(4) BENEFITS AND SERVICES.—

''(A) REQUIRED SERVICES.—In the case of program enrollees to whom the State would otherwise be required to make medical assistance available under section 1902(a)(10)(A)(i), a State conducting a Medicaid Flexibility Program shall provide as targeted health assistance the following types of services:

''(i) Inpatient and outpatient hospital services.

''(ii) Laboratory and X-ray services.

''(iii) Nursing facility services for individuals aged 21 and older.

''(iv) Physician services.

''(v) Home health care services (including home nursing services, medical supplies, equipment, and appliances).

''(vi) Rural health clinic services (as defined in section 1905(l)(1)).

''(vii) Federally-qualified health center services (as defined in section 1905(l)(2)).

''(viii) Family planning services and supplies.

''(ix) Nurse midwife services.

''(x) Certified pediatric and family nurse practitioner services.

''(xi) Freestanding birth center services (as defined in section 1905(l)(3)).

''(xii) Emergency medical transportation.

''(xiii) Non-cosmetic dental services.

''(xiv) Pregnancy-related services, including postpartum services for the 12-week period beginning on the last day of a pregnancy.

''(B) OPTIONAL BENEFITS.—A State may, at its option, provide services in addition to the services described in subparagraph (A) as targeted health assistance under a Medicaid Flexibility Program.

''(C) BENEFIT PACKAGES.—

''(i) IN GENERAL.—The targeted health assistance provided by a State to any group of program enrollees under a Medicaid Flexibility Program shall have an aggregate actuarial value that is equal to at least 95 percent of the aggregate actuarial value of the benchmark coverage described in subsection (b)(1) of section 1937 or benchmark-equivalent coverage described in subsection (b)(2) of such section, as such subsections were in effect prior to the enactment of the Patient Protection and Affordable Care Act.

''(ii) AMOUNT, DURATION, AND SCOPE OF BENEFITS.—Subject to clause (i), the State shall determine the amount, duration, and scope with respect to services provided as targeted health assistance under a Medicaid Flexibility Program, including with respect to services that are required to be provided to certain program enrollees under subparagraph (A) except as otherwise provided under such subparagraph.

''(iii) MENTAL HEALTH AND SUBSTANCE USE DISORDER COVERAGE AND PARITY.—The targeted health assistance provided by a State to program enrollees under a Medicaid Flexibility Program shall include mental health services and substance use disorder services and the financial requirements and treatment limitations applicable to such services under the program shall comply with the requirements of section 2726 of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

''(iv) PRESCRIPTION DRUGS.—If the targeted health assistance provided by a State to program enrollees under a Medicaid Flexibility Program includes assistance for covered outpatient drugs, such drugs shall be subject to a rebate agreement that complies with the requirements of section 1927, and any requirements applicable to medical assistance for covered outpatient drugs under a State plan (including the requirement that the State provide information to a manufacturer) shall apply in the same manner to targeted health assistance for covered outpatient drugs under a Medicaid Flexibility Program.

''(D) COST SHARING.—A State conducting a Medicaid Flexibility Program may impose premiums, deductibles, cost-sharing, or other similar charges, except that the total annual aggregate amount of all such charges imposed with respect to all program enrollees in a family shall not exceed 5 percent of the family's income for the year involved.

''(5) ADMINISTRATION OF PROGRAM.—Each State conducting a Medicaid Flexibility Program shall do the following:

''(A) SINGLE AGENCY.—Designate a single State agency responsible for administering the program.

''(B) ENROLLMENT SIMPLIFICATION AND COORDINATION WITH STATE HEALTH INSURANCE EXCHANGES.—Provide for simplified enrollment processes (such as online enrollment and reenrollment and electronic verification) and coordination with State health insurance exchanges.

''(C) BENEFICIARY PROTECTIONS.—Establish a fair process (which the State shall describe in the application required under subsection (b)) for individuals to appeal adverse eligibility determinations with respect to the program.

''(6) APPLICATION OF REST OF TITLE XIX.—

''(A) IN GENERAL.—To the extent that a provision of this section is inconsistent with another provision of this title, the provision of this section shall apply.

''(B) APPLICATION OF SECTION 1903A.—With respect to a State that is conducting a Medicaid Flexibility Program, section 1903A shall be applied as if program enrollees were not 1903A enrollees for each program period during which the State conducts the program.

''(C) WAIVERS AND STATE PLAN AMENDMENTS.—

''(i) IN GENERAL.—In the case of a State conducting a Medicaid Flexibility Program that has in effect a waiver or State plan amendment, such waiver or amendment shall not apply with respect to the program, targeted health assistance provided under the program, or program enrollees.

''(ii) REPLICATION OF WAIVER OR AMENDMENT.—In designing a Medicaid Flexibility Program, a State may mirror provisions of a waiver or State plan amendment described in clause (i) in the program to the extent that such provisions are otherwise consistent with the requirements of this section.

''(iii) EFFECT OF TERMINATION.—In the case of a State described in clause (i) that terminates its program under subsection (d)(2)(B), any waiver or amendment which was limited pursuant to subparagraph (A) shall cease to be so limited effective with the effective date of such termination.

''(D) NONAPPLICATION OF PROVISIONS.—With respect to the design and implementation of Medicaid Flexibility Programs conducted under this section, paragraphs (1), (10)(B), (17), and (23) of section 1902(a), as well as any other provision of this title (except for this section and as otherwise provided by this section) that the Secretary deems appropriate, shall not apply.

''(e) DEFINITIONS.—For purposes of this section:

''(1) APPLICABLE PROGRAM ENROLLEE CATEGORY.—The term 'applicable program enrollee category' means, with respect to a State Medicaid Flexibility Program for a program period, any of the following as specified by the State for the period in its application under subsection (b):

''(A) 2 ENROLLEE CATEGORIES.—Both of the 1903A enrollee categories described in subparagraphs (D) and (E) of section 1903A(e)(2).

''(B) EXPANSION ENROLLEES.—The 1903A enrollee category described in subparagraph (D) of section 1903A(e)(2).

''(C) NONELDERLY, NONDISABLED, NONEXPANSION ADULTS.—The 1903A enrollee category described in subparagraph (E) of section 1903A(e)(2).

''(2) MEDICAID FLEXIBILITY PROGRAM.—The term 'Medicaid Flexibility Program' means a State program for providing targeted health assistance to program enrollees funded by a block grant under this section.

''(3) PROGRAM ENROLLEE.—

''(A) IN GENERAL.—The term 'program enrollee' means, with respect to a State that is conducting a Medicaid Flexibility Program for a program period, an individual who is a 1903A enrollee (as defined in section 1903A(e)(1)) who is in the applicable program enrollee category specified by the State for the period.

''(B) RULE OF CONSTRUCTION.—For purposes of section 1903A(e)(3), eligibility and enrollment of an individual under a Medicaid Flexibility Program shall be deemed to be eligibility and enrollment under a State plan (or waiver of such plan) under this title.

''(4) PROGRAM PERIOD.—The term 'program period' means, with respect to a State Medicaid Flexibility Program, a period of 5 consecutive fiscal years that begins with either—

''(A) the first fiscal year in which the State conducts the program; or

''(B) the next fiscal year in which the State conducts such a program that begins after the end of a previous program period.

''(5) STATE.—The term 'State' means one of the 50 States or the District of Columbia.

''(6) TARGETED HEALTH ASSISTANCE.—The term 'targeted health assistance' means assistance for health-care-related items and medical services for program enrollees.''.

SEC. 129. MEDICAID AND CHIP QUALITY PERFORMANCE BONUS PAYMENTS.

Section 1903 of the Social Security Act (42 U.S.C. 1396b), as previously amended, is further amended by adding at the end the following new subsection:

''(bb) QUALITY PERFORMANCE BONUS PAYMENTS.—

''(1) INCREASED FEDERAL SHARE.—With respect to each of fiscal years 2023 through 2026, in the case of one of the 50 States or the District of Columbia (each referred to in this subsection as a 'State') that—

''(A) equals or exceeds the qualifying amount (as established by the Secretary) of lower than expected aggregate medical assistance expenditures (as defined in paragraph (4)) for that fiscal year; and

''(B) submits to the Secretary, in accordance with such manner and format as specified by the Secretary and for the performance period (as defined by the Secretary) for such fiscal year—

''(i) information on the applicable quality measures identified under paragraph (3) with respect to each category of Medicaid eligible individuals under the State plan or a waiver of such plan; and

''(ii) a plan for spending a portion of additional funds resulting from application of this subsection on quality improvement within the State plan under this title or under a waiver of such plan,

the Federal matching percentage otherwise applied under subsection (a)(7) for such fiscal year shall be increased by such percentage (as determined by the Secretary) so that the aggregate amount of the resulting increase pursuant to this subsection for the State and fiscal year does not exceed the State allotment established under paragraph (2) for the State and fiscal year.

''(2) ALLOTMENT DETERMINATION.—The Secretary shall establish a formula for computing State allotments under this paragraph for each fiscal year described in paragraph (1) such that—

''(A) such an allotment to a State is determined based on the performance, including improvement, of such State under this title and title XXI with respect to the quality measures submitted under paragraph (3) by such State for the performance period (as defined by the Secretary) for such fiscal year; and

''(B) the total of the allotments under this paragraph for all States for the period of the fiscal years described in paragraph (1) is equal to $8,000,000,000.

''(3) QUALITY MEASURES REQUIRED FOR BONUS PAYMENTS.—For purposes of this subsection, the Secretary shall, pursuant to rulemaking and after consultation with State agencies administering State plans under this title, identify and publish (and update as necessary) peer-reviewed quality measures (which shall include health care and long-term care outcome measures and may include the quality measures that are overseen or developed by the National Committee for Quality Assurance or the Agency for Healthcare Research and Quality or that are identified under section 1139A or 1139B) that are quantifiable, objective measures that take into account the clinically appropriate measures of quality for different types of patient populations receiving benefits or services under this title or title XXI.

''(4) LOWER THAN EXPECTED AGGREGATE MEDICAL ASSISTANCE EXPENDITURES.—In this subsection, the term 'lower than expected aggregate medical assistance expenditures' means, with respect to a State the amount (if any) by which—

''(A) the amount of the adjusted total medical assistance expenditures for the State and fiscal year determined in section 1903A(b)(1) without regard to the 1903A enrollee category described in section 1903A(e)(2)(E); is less than

''(B) the amount of the target total medical assistance expenditures for the State and fiscal year determined in section 1903A(c) without regard to the 1903A enrollee category described in section 1903A(e)(2)(E).''.

SEC. 130. OPTIONAL ASSISTANCE FOR CERTAIN INPATIENT PSYCHIATRIC SERVICES.

(a) STATE OPTION.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(1) in subsection (a)—

(A) in paragraph (16)—

(i) by striking ''and, (B)'' and inserting ''(B)''; and

(ii) by inserting before the semicolon at the end the following: '', and (C) subject to subsection (h)(4), qualified inpatient psychiatric hospital services (as defined in subsection (h)(3)) for individuals who are over 21 years of age and under 65 years of age''; and

(B) in the subdivision (B) that follows paragraph (29), by inserting ''(other than services described in subparagraph (C) of paragraph (16) for individuals described in such subparagraph)'' after ''patient in an institution for mental diseases''; and

(2) in subsection (h), by adding at the end the following new paragraphs:

''(3) For purposes of subsection (a)(16)(C), the term 'qualified inpatient psychiatric hospital services' means, with respect to individuals described in such subsection, services described in subparagraph (B) of paragraph (1) that are not otherwise covered under subsection (a)(16)(A) and are furnished—

''(A) in an institution (or distinct part thereof) which is a psychiatric hospital (as defined in section 1861(f)); and

''(B) with respect to such an individual, for a period not to exceed 30 consecutive days in any month and not to exceed 90 days in any calendar year.

''(4) As a condition for a State including qualified inpatient psychiatric hospital services as medical assistance under subsection (a)(16)(C), the State must (during the period in which it furnishes medical assistance under this title for services and individuals described in such subsection)—

''(A) maintain at least the number of licensed beds at psychiatric hospitals owned, operated, or contracted for by the State that were being maintained as of the date of the enactment of this paragraph or, if higher, as of the date the State applies to the Secretary to include medical assistance under such subsection; and

''(B) maintain on an annual basis a level of funding expended by the State (and political subdivisions thereof) other than under this title from non-Federal funds for inpatient services in an institution described in paragraph (3)(A), and for active psychiatric care and treatment provided on an outpatient basis, that is not less than the level of such funding for such services and care as of the date of the enactment of this paragraph or, if higher, as of the date the State applies to the Secretary to include medical assistance under such subsection.''.

(b) SPECIAL MATCHING RATE.—Section 1905(b) of the Social Security Act (42 U.S.C. 1395d(b)) is amended by adding at the end the following: ''Notwithstanding the previous provisions of this subsection, the Federal medical assistance percentage shall be 50 percent with respect to medical assistance for services and individuals described in subsection (a)(16)(C).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to qualified inpatient psychiatric hospital services furnished on or after October 1, 2018.

SEC. 131. ENHANCED FMAP FOR MEDICAL ASSISTANCE TO ELIGIBLE INDIANS.

Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended, in the third sentence, by inserting ''and with respect to amounts expended by a State as medical assistance for services provided by any other provider under the State plan to an individual who is a member of an Indian tribe who is eligible for assistance under the State plan'' before the period.

SEC. 132. SMALL BUSINESS HEALTH PLANS.

(a) TAX TREATMENT OF SMALL BUSINESS HEALTH PLANS.—A small business health plan (as defined in section 801(a) of the Employee Retirement Income Security Act of 1974) shall be treated—

(1) as a group health plan (as defined in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91)) for purposes of applying title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) and title XXII of such Act (42 U.S.C. 300bb-1);

(2) as a group health plan (as defined in section 5000(b)(1) of the Internal Revenue Code of 1986) for purposes of applying sections 4980B and 5000 and chapter 100 of the Internal Revenue Code of 1986; and

(3) as a group health plan (as defined in section 733(a)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(a)(1))) for purposes of applying parts 6 and 7 of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.).

(b) RULES.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1021 et seq.) is amended by adding at the end the following new part:

''PART 8—RULES GOVERNING SMALL BUSINESS RISK SHARING POOLS

''SEC. 801. SMALL BUSINESS HEALTH PLANS.

''(a) IN GENERAL.—For purposes of this part, the term 'small business health plan' means a fully insured group health plan, offered by a health insurance issuer in the large group market, whose sponsor is described in subsection (b).

''(b) SPONSOR.—The sponsor of a group health plan is described in this subsection if such sponsor—

''(1) is a qualified sponsor and receives certification by the Secretary;

''(2) is organized and maintained in good faith, with a constitution or bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis;

''(3) is established as a permanent entity;

''(4) is established for a purpose other than providing health benefits to its members, such as an organization established as a bona fide trade association, franchise, or section 7705 organization; and

''(5) does not condition membership on the basis of a minimum group size.

''SEC. 802. FILING FEE AND CERTIFICATION OF SMALL BUSINESS HEALTH PLANS.

''(a) FILING FEE.—A small business health plan shall pay to the Secretary at the time of filing an application for certification under subsection (b) a filing fee in the amount of $5,000, which shall be available to the Secretary for the sole purpose of administering the certification procedures applicable with respect to small business health plans.

''(b) CERTIFICATION.—

''(1) IN GENERAL.—Not later than 6 months after the date of enactment of this part, the Secretary shall prescribe by interim final rule a procedure under which the Secretary—

''(A) will certify a qualified sponsor of a small business health plan, upon receipt of an application that includes the information described in paragraph (2);

''(B) may provide for continued certification of small business health plans under this part;

''(C) shall provide for the revocation of a certification if the applicable authority finds that the small business health plan involved

fails to comply with the requirements of this part;

''(D) shall conduct oversight of certified plan sponsors, including periodic review, and consistent with section 504, applying the requirements of sections 518, 519, and 520; and

''(E) will consult with a State with respect to a small business health plan domiciled in such State regarding the Secretary's authority under this part and other enforcement authority under sections 502 and 504.

''(2) INFORMATION TO BE INCLUDED IN APPLICATION FOR CERTIFICATION.—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form which shall be prescribed by the applicable authority by regulation, at least the following information:

''(A) Identifying information.

''(B) States in which the plan intends to do business.

''(C) Bonding requirements.

''(D) Plan documents.

''(E) Agreements with service providers.

''(3) REQUIREMENTS FOR CERTIFIED PLAN SPONSORS.—Not later than 6 months after the date of enactment of this part, the Secretary shall prescribe by interim final rule requirements for certified plan sponsors that include requirements regarding—

''(A) structure and requirements for boards of trustees or plan administrators;

''(B) notification of material changes; and

''(C) notification for voluntary termination.

''(c) FILING NOTICE OF CERTIFICATION WITH STATES.—A certification granted under this part to a small business health plan shall not be effective unless written notice of such certification is filed by the plan sponsor with the applicable State authority of each State in which the small business health plan operates.

''(d) EXPEDITED AND DEEMED CERTIFICATION.—

''(1) IN GENERAL.—If the Secretary fails to act on a complete application for certification under this section within 90 days of receipt of such complete application, the applying small business health plan sponsor shall be deemed certified until such time as the Secretary may deny for cause the application for certification.

''(2) PENALTY.—The Secretary may assess a penalty against the board of trustees, plan administrator, and plan sponsor (jointly and severally) of a small business health plan sponsor that is deemed certified under paragraph (1) of up to $500,000 in the event the Secretary determines that the application for certification of such small business health plan sponsor was willfully or with gross negligence incomplete or inaccurate.

''SEC. 803. PARTICIPATION AND COVERAGE REQUIREMENTS.

''(a) COVERED EMPLOYERS AND INDIVIDUALS.—The requirements of this subsection are met with respect to a small business health plan if, under the terms of the plan—

''(1) each participating employer must be—

''(A) a member of the sponsor;

''(B) the sponsor; or

''(C) an affiliated member of the sponsor, except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or such an affiliated member of the sponsor, participating employers may also include such employer; and

''(2) all individuals commencing coverage under the plan after certification under this part must be—

''(A) active or retired owners (including self-employed individuals with or without employees), officers, directors, or employees of, or partners in, participating employers; or

''(B) the dependents of individuals described in subparagraph (A).

''(b) PARTICIPATING EMPLOYERS.—In applying requirements relating to coverage renewal, a participating employer shall not be deemed to be a plan sponsor.

''(c) PROHIBITION OF DISCRIMINATION AGAINST EMPLOYERS AND EMPLOYEES ELIGIBLE TO PARTICIPATE.—The requirements of this subsection are met with respect to a small business health plan if—

''(1) under the terms of the plan, no participating employer may provide health insurance coverage in the individual market for any employee not covered under the plan, if such exclusion of the employee from coverage under the plan is based on a health status-related factor with respect to the employee and such employee would, but for such exclusion on such basis, be eligible for coverage under the plan; and

''(2) information regarding all coverage options available under the plan is made readily available to any employer eligible to participate.

''SEC. 804. DEFINITIONS; RENEWAL.

''For purposes of this part:

''(1) AFFILIATED MEMBER.—The term 'affiliated member' means, in connection with a sponsor—

''(A) a person who is otherwise eligible to be a member of the sponsor but who elects an affiliated status with the sponsor, or

''(B) in the case of a sponsor with members which consist of associations, a person who is a member or employee of any such association and elects an affiliated status with the sponsor.

''(2) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of title XXVII of the Public Health Service Act for the State involved with respect to such issuer.

''(3) FRANCHISOR; FRANCHISEE.—The terms 'franchisor' and 'franchisee' have the meanings given such terms for purposes of sections 436.2(a) through 436.2(c) of title 16, Code of Federal Regulations (including any such amendments to such regulation after the date of enactment of this part) and, for purposes of this part, franchisor or franchisee employers participating in such a group health plan shall not be treated as the employer, co-employer, or joint employer of the employees of another participating franchisor or franchisee employer for any purpose.

''(4) HEALTH PLAN TERMS.—The terms 'group health plan', 'health insurance coverage', and 'health insurance issuer' have the meanings given such terms in section 733.

''(5) INDIVIDUAL MARKET.—

''(A) IN GENERAL.—The term 'individual market' means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

''(B) TREATMENT OF VERY SMALL GROUPS.—

''(i) IN GENERAL.—Subject to clause (ii), such term includes coverage offered in connection with a group health plan that has fewer than 2 participants as current employees or participants described in section 732(d)(3) on the first day of the plan year.

''(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of health insurance coverage offered in a State if such State regulates the coverage described in such clause in the same manner and to the same extent as coverage in the small group market (as defined in section 2791(e)(5) of the Public Health Service Act) is regulated by such State.

''(6) PARTICIPATING EMPLOYER.—The term 'participating employer' means, in connection with a small business health plan, any employer, if any individual who is an employee of such employer, a partner in such employer, or a self-employed individual who is such employer with or without employees (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employee, partner, or self-employed individual in relation to the plan.

''(7) SECTION 7705 ORGANIZATION.—The term 'section 7705 organization' means an organization providing services for a customer pursuant to a contract meeting the conditions of subparagraphs (A), (B), (C), (D), and (E) (but not (F)) of section 7705(e)(2) of the Internal Revenue Code of 1986, including an entity that is part of a section 7705 organization control group . For purposes of this part, any reference to 'member' shall include a customer of a section 7705 organization except with respect to references to a 'member' or 'members' in paragraph (1).''.

(c) PREEMPTION RULES.—Section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) is amended by adding at the end the following:

''(f) The provisions of this title shall supersede any and all State laws insofar as they may now or hereafter preclude a health insurance issuer from offering health insurance coverage in connection with a small business health plan which is certified under part 8.''.

(d) PLAN SPONSOR.—Section 3(16)(B) of such Act (29 U.S.C. 102(16)(B)) is amended by adding at the end the following new sentence: ''Such term also includes a person serving as the sponsor of a small business health plan under part 8.''.

(e) SAVINGS CLAUSE.—Section 731(c) of such Act is amended by inserting ''or part 8'' after ''this part''.

(f) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this section within 6 months after the date of the enactment of this Act.

TITLE II

SEC. 201. THE PREVENTION AND PUBLIC HEALTH FUND.

Subsection (b) of section 4002 of the Patient Protection and Affordable Care Act (42 U.S.C. 300u–11) is amended—

(1) in paragraph (3), by striking ''each of fiscal years 2018 and 2019'' and inserting ''fiscal year 2018''; and

(2) by striking paragraphs (4) through (8).

SEC. 202. COMMUNITY HEALTH CENTER PROGRAM.

Effective as if included in the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (Public Law 114–10, 129 Stat. 87), paragraph (1) of section 221(a) of such Act is amended by inserting '', and an additional $422,000,000 for fiscal year 2017'' after ''2017''.

SEC. 203. CHANGE IN PERMISSIBLE AGE VARIATION IN HEALTH INSURANCE PREMIUM RATES.

Section 2701(a)(1)(A)(iii) of the Public Health Service Act (42 U.S.C. 300gg(a)(1)(A)(iii)) is amended by inserting after ''(consistent with section 2707(c))'' the following: ''or, for plan years beginning on or after January 1, 2019, 5 to 1 for adults (consistent with section 2707(c)) or such other

ratio for adults (consistent with section 2707(c)) as the State may determine''.

SEC. 204. WAIVERS FOR STATE INNOVATION.

(a) IN GENERAL.—Section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C. 18052) is amended—

(1) in subsection (a)—

(A) in paragraph (1)—

(i) in subparagraph (B)—

(I) by amending clause (i) to read as follows:

''(i) a description of how the State plan meeting the requirements of a waiver under this section would, with respect to health insurance coverage within the State—

''(I) take the place of the requirements described in paragraph (2) that are waived; and

''(II) provide for alternative means of, and requirements for, increasing access to comprehensive coverage, reducing average premiums, providing consumers the freedom to purchase the health insurance of their choice, and increasing enrollment in private health insurance; and''; and

(II) in clause (ii), by striking ''that is budget neutral for the Federal Government'' and inserting '', demonstrating that the State plan does not increase the Federal deficit''; and

(ii) in subparagraph (C), by striking ''the law'' and inserting ''a law or has in effect a certification'';

(B) in paragraph (3)—

(i) in the first sentence, by inserting ''or would qualify for a reduction in'' after ''would not qualify for'';

(ii) by adding after the second sentence the following: ''A State may request that all of, or any portion of, such aggregate amount of such credits or reductions be paid to the State as described in the first sentence.'';

(iii) in the paragraph heading, by striking ''PASS THROUGH OF FUNDING'' and inserting ''FUNDING'';

(iv) by striking ''With respect'' and inserting the following:

''(A) PASS THROUGH OF FUNDING.—With respect''; and

(v) by adding at the end the following:

''(B) ADDITIONAL FUNDING.—There is authorized to be appropriated, and is appropriated, to the Secretary of Health and Human Services, out of monies in the Treasury not otherwise obligated, $2,000,000,000 for fiscal year 2017, to remain available until the end of fiscal year 2019, to provide grants to States for purposes of submitting an application for a waiver granted under this section and implementing the State plan under such waiver.

''(C) AUTHORITY TO USE MARKET-BASED HEALTH CARE GRANT ALLOTMENT.—If the State has an application for an allotment under section 2105(i) of the Social Security Act for the plan year, the State may use the funds available under the State's allotment for the plan year to carry out the State plan under this section, so long as such use is consistent with the requirements of paragraphs (1) and (7) of section 2105(i) of such Act (other than paragraph (1)(B) of such section). Any funds used to carry out a State plan under this subparagraph shall not be considered in determining whether the State plan increases the Federal deficit.''; and

(C) in paragraph (4), by adding at the end the following:

''(D) EXPEDITED PROCESS.—The Secretary shall establish an expedited application and approval process that may be used if the Secretary determines that such expedited process is necessary to respond to an urgent or emergency situation with respect to health insurance coverage within a State.'';

(2) in subsection (b)—

(A) in paragraph (1)—

(i) in the matter preceding subparagraph (A)—

(I) by striking ''may'' and inserting ''shall''; and

(II) by striking ''only if'' and inserting ''unless''; and

(ii) by striking ''plan—'' and all that follows through the period at the end of subparagraph (D) and inserting ''application is missing a required element under subsection (a)(1) or that the State plan will increase the Federal deficit, not taking into account any amounts received through a grant under subsection (a)(3)(B).'';

(B) in paragraph (2)—

(i) in the paragraph heading, by inserting ''OR CERTIFY'' after ''LAW'';

(ii) in subparagraph (A), by inserting before the period '', and a certification described in this paragraph is a document, signed by the Governor, and the State insurance commissioner, of the State, that provides authority for State actions under a waiver under this section, including the implementation of the State plan under subsection (a)(1)(B)''; and

(iii) in subparagraph (B)—

(I) in the subparagraph heading, by striking ''OF OPT OUT''; and

(II) by striking '' may repeal a law'' and all that follows through the period at the end and inserting the following: ''may terminate the authority provided under the waiver with respect to the State by—

''(i) repealing a law described in subparagraph (A); or

''(ii) terminating a certification described in subparagraph (A), through a certification for such termination signed by the Governor, and the State insurance commissioner, of the State.'';

(3) in subsection (d)(2)(B), by striking ''and the reasons therefore'' and inserting ''and the reasons therefore, and provide the data on which such determination was made''; and

(4) in subsection (e), by striking ''No waiver'' and all that follows through the period at the end and inserting the following: ''A waiver under this section—

''(1) shall be in effect for a period of 8 years unless the State requests a shorter duration;

''(2) may be renewed for unlimited additional 8-year periods upon application by the State; and

''(3) may not be cancelled by the Secretary before the expiration of the 8-year period (including any renewal period under paragraph (2)).''.

(b) APPLICABILITY.—Section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C. 18052) shall apply as follows:

(1) In the case of a State for which a waiver under such section was granted prior to the date of enactment of this Act, such section 1332, as in effect on the day before the date of enactment of this Act shall apply to the waiver and State plan.

(2) In the case of a State that submitted an application for a waiver under such section prior to the date of enactment of this Act, and which application the Secretary of Health and Human Services has not approved prior to such date, the State may elect to have such section 1332, as in effect on the day before the date of enactment of this Act, or such section 1332, as amended by subsection (a), apply to such application and State plan.

(3) In the case of a State that submits an application for a waiver under such section on or after the date of enactment of this Act, such section 1332, as amended by subsection (a), shall apply to such application and State plan.

SEC. 205. ALLOWING ALL INDIVIDUALS PURCHASING HEALTH INSURANCE IN THE INDIVIDUAL MARKET THE OPTION TO PURCHASE A LOWER PREMIUM CATASTROPHIC PLAN.

(a) IN GENERAL.—Section 1302(e) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(e)) is amended by adding at the end the following:

''(4) CONSUMER FREEDOM.—For plan years beginning on or after January 1, 2019, paragraph (1)(A) shall not apply with respect to any plan offered in the State.''.

(b) RISK POOLS.—Section 1312(c) of the Patient Protection and Affordable Care Act (42 U.S.C. 18032(c)) is amended—

(1) in paragraph (1), by inserting ''and including, with respect to plan years beginning on or after January 1, 2019, enrollees in catastrophic plans described in section 1302(e)'' after ''Exchange''; and

(2) in paragraph (2), by inserting ''and including, with respect to plan years beginning on or after January 1, 2019, enrollees in catastrophic plans described in section 1302(e)'' after ''Exchange''.

SEC. 206. APPLICATION OF ENFORCEMENT PENALTIES.

(a) IN GENERAL.—Section 2723 of the Public Health Service Act (42 U.S.C. 300gg–22) is amended—

(1) in subsection (a)—

(A) in paragraph (1), by inserting ''and of section 1303 of the Patient Protection and Affordable Care Act'' after ''this part''; and

(B) in paragraph (2), by inserting ''or in such section 1303'' after ''this part''; and

(2) in subsection (b)—

(A) in paragraphs (1) and (2)(A), by inserting ''or section 1303 of the Patient Protection and Affordable Care Act'' after ''this part'' each place such term appears;

(B) in paragraph (2)(C)(ii), by inserting ''and section 1303 of the Patient Protection and Affordable Care Act'' after ''this part''.

(b) EFFECT OF WAIVER.—A State waiver pursuant to section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C. 18052) shall not affect the authority of the Secretary to impose penalties under section 2723 of the Public Health Service Act (42 U.S.C. 300gg–22).

SEC. 207. FUNDING FOR COST-SHARING PAYMENTS.

There is appropriated to the Secretary of Health and Human Services, out of any money in the Treasury not otherwise appropriated, such sums as may be necessary for payments for cost-sharing reductions authorized by the Patient Protection and Affordable Care Act (including adjustments to any prior obligations for such payments) for the period beginning on the date of enactment of this Act and ending on December 31, 2019. Notwithstanding any other provision of this Act, payments and other actions for adjustments to any obligations incurred for plan years 2018 and 2019 may be made through December 31, 2020.

SEC. 208. REPEAL OF COST-SHARING SUBSIDY PROGRAM.

(a) IN GENERAL.—Section 1402 of the Patient Protection and Affordable Care Act is repealed.

(b) EFFECTIVE DATE.—The repeal made by subsection (a) shall apply to cost-sharing reductions (and payments to issuers for such reductions) for plan years beginning after December 31, 2019.

PRIVILEGES OF THE FLOOR

Mr. SCHUMER. Mr. President, I ask unanimous consent that Bruce King, Charlie Ellsworth, Veronica Duron, and Matthew Fuentes of my staff be given all-access passes to the floor during the consideration of H.R. 1628.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. BLUMENTHAL. Mr. President, I ask unanimous consent that Julia Rhodes and Kyle Wesson, fellows in my office, be granted floor privileges for the remainder of the debate.

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

ORDERS FOR THURSDAY, JULY 27, 2017

Mr. ENZI. Madam President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 10 a.m. on Thursday, July 27; further, that following the prayer and pledge, the morning hour be deemed expired, the Journal of proceedings be approved to date, the time for the two leaders be reserved for their use later in the day, and morning business be closed; further, that following leader remarks, the Senate resume consideration of H.R. 1628, with the time until 2:15 p.m. equally divided between the two leaders or their designees; and finally, that at 2:15 p.m., the Senate vote in relation to the Daines amendment No. 340, as modified.

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

ADJOURNMENT UNTIL 10 A.M. TOMORROW

Mr. ENZI. Madam President, if there is no further business to come before the Senate, I ask unanimous consent that it stand adjourned under the previous order.

There being no objection, the Senate, at 7:57 p.m., adjourned until Thursday, July 27, 2017, at 10 a.m.