Mr. PADILLA. Mr. President, I rise to introduce the PEACE Act.

This legislation recognizes the need to reform the standard for use of force with Federal officers. In order to strengthen our criminal justice system and reduce the risks posed to both law enforcement officers and the public, we must reconsider when lethal force is necessary.

This legislation would end the use of deadly force by Federal law enforcement unless there are no other reasonable alternatives.

This legislation would also condition certain DOJ funding for States on whether they enact legislation that establishes the same higher standard of conduct for local law enforcement. The current accountability structure for lethal force on the Federal level fails to accurately ensure accountability when members of the public are killed.

A lack of accountability when members of the public are killed is a breeding ground for illicit behavior. In recent years, it has been continuously shown that Black people are more likely to experience incidents involving excessive force when interacting with police.

Americans deserve better. We deserve a system that will encourage deescalation tactics and hold bad actors accountable. This is too urgent a need to go unaddressed.

Public safety is a two-way street. We trust law enforcement to maintain order. In return, we expect officers to be held to account for bad behavior. This bill is an important step to reducing unnecessary losses of life and building trust between the public and law enforcement.

I look forward to working with my colleagues to pass the PEACE Act as quickly as possible.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 875—DECLARING RACISM A PUBLIC HEALTH CRISIS

Mr. BROWN (for himself, Mr. BOOKER, Mr. PADILLA, Ms. WARREN, Ms. STABENOW, Mr. WARNOCK, Mr. MENENDEZ, Mr. CARDIN, Mr. MERKLEY, Mr. BLUMENTHAL, Mrs. FEINSTEIN, Ms. BALDWIN, Mr. CARPER, Ms. KLOBUCHAR, Mr. LEAHY, Mr. SANDERS, Ms. SMITH, Mr. VAN HOLLEN, Mr. WYDEN, Mr. MARKEY, Ms. HIRONO, Ms. DUCKWORTH, Mr. REED, and Mr. WHITEHOUSE) submitted the following resolution; which was referred to the Committee on Health, Education, Labor, and Pensions:

S. RES. 875

Whereas a public health issue is an issue—

(1) that affects many people, is a threat to the public, and is ongoing;

(2) that is unfairly distributed among different populations, disproportionately impacting health outcomes, access to health care, and life expectancy;

(3) the effects of which could be reduced by preventive measures; and

(4) for which those preventive measures are not yet in place;

Whereas public health experts agree that significant racial inequities exist in the prevalence, severity, and mortality rates of various health conditions in the United States;

Whereas examples of such inequities include—

(1) life expectancy rates for Black and Native American people in the United States being significantly lower than those of White people in the United States;

(2) Black and Native American women being 2 to 4 times more likely than White women to suffer severe maternal morbidity or die of pregnancy-related complications;

(3) Black and Native American infants being 2 to 3 times as likely to die as White infants, and the Black infant mortality rate in the United States being higher than the infant mortality rates recorded in 27 of the 36 democratic countries with market-based economies that are members of the Organization for Economic Co-operation and Development; and

(4) during the COVID–19 pandemic, Black, Hispanic/Latino, Asian American, Native Hawaiian, Pacific Islander, and Native American communities experiencing disproportionately high rates of COVID–19 infection, hospitalization, and mortality compared to the White population of the United States;

Whereas inequities in health outcomes are exacerbated for people of color who are LGBTQIA+ and have disabilities;

Whereas, historically, explanations for health inequities focused on false genetic science (for example, eugenics) and incomplete social scientific analyses that narrowly focus on individual behavior to highlight ostensible deficiencies within racial and ethnic minority groups;

Whereas modern public health discourse recognizes the broader social context in which health inequities emerge and acknowledges the impact of historical and contemporary racism on health;

Whereas, since its founding, the United States has had a longstanding history and legacy of racism, mistreatment, and discrimination that has perpetuated health inequities for members of racial and ethnic minority groups;

Whereas that history and legacy of racism, mistreatment, and discrimination includes—

(1) the immoral paradox of freedom and slavery, which is an atrocity that can be traced throughout the history of the United States, as African Americans lived under the oppressive institution of slavery from 1619 through 1865, endured the practices and laws of segregation during the Jim Crow era, and continue to face the ramifications of systemic racism through unjust and discriminatory structures and policies;

(2) the failure of the United States to carry out the responsibilities and promises made in more than 350 treaties ratified with sovereign indigenous communities, including American Indians, Alaska Natives, and Native Hawaiians, as made evident by the chronic and pervasive underfunding of the Indian Health Service and Tribal, Urban Indian, and Native Hawaiian health care, the vast health and socioeconomic inequities faced by Native American people, and the inaccessibility of many Federal public health and social programs in Native American communities;

(3) the enactment of immigration laws in the United States, such as—

(A) the Page Act of 1875, which effectively prohibited the entry of East Asian women into the United States;

(B) the Chinese Exclusion Act in 1882, which ostracized thousands of Chinese-born laborers, who were essential in the completion of the transcontinental railroad and development of the West Coast; and

(C) the Immigration Act of 1917, which barred all immigrants from the ''Asiatic zone'' and prevented the migration of individuals from South Asia, Southeast Asia, and East Asia, scapegoating Asians, separating families, and branding Asians as perpetual outsiders in the United States;

(4) during the Great Depression Era, the deportation by the United States of approximately 1,800,000 individuals based on their Mexican ethnic identity, when approximately 60 percent of the individuals deported to Mexico were United States citizens, and the targeting of individuals of Mexican descent for ''repatriation'' due to scapegoating efforts, which blamed them for ''stealing'' jobs from ''real'' Americans; and

(5) in 1967, President Lyndon B. Johnson establishing the National Advisory Commission on Civil Disorders, which concluded that White racism is responsible for the pervasive discrimination and segregation in employment, education, and housing, resulting in deepened racial division and continued exclusion of Black communities from the benefits of economic progress;

Whereas overt racism was embedded in the development of medical science and medical training during the 18th, 19th, and 20th centuries, causing disproportionate physical and psychological harm to members of racial and ethnic minority groups, including—

(1) the unethical practices and abuses experienced by Black patients and research participants, such as the Tuskegee Syphilis Study, which serve as foundations for the mistrust the Black community has for the medical system; and

(2) the egregiously unethical and cruel treatment enslaved Black women were forced to endure as subjects of insidious medical experiments to advance modern gynecology, including those perpetuated by the so-called ''father of gynecology'', J. Marion Sims;

Whereas structural racism cemented historical racial and ethnic inequities in access to resources and opportunities, contributing to worse health outcomes;

Whereas examples of that structural racism include—

(1) that, before the enactment of the Medicare program, the United States health care system was highly segregated, and, as late as the mid-1960s, hospitals, clinics, and doctors' offices throughout northern and southern States complied with Jim Crow laws and were completely segregated by race, leaving Black communities with little to no access to health care services;

(2) the landmark case *Simkins* v. *Moses H. Cone Memorial Hospital* (323 F.2d 959 (4th Cir. 1963)), which challenged the use of public funds by the Federal Government to expand, support, and sustain segregated hospital care, and provided justification for title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.) and the Medicare hospital certification program, establishing Medicare hospital racial integration guidelines that applied to every hospital that participated in the Federal program;

(3) Pacific Islanders from the Freely Associated States experiencing unique health inequities resulting from United States nuclear weapons tests on their home islands, while they have been categorically denied access to Medicaid and other Federal health benefits; and

(4) language minorities, including Chinese-, Korean-, Vietnamese-, Russian-, and Spanish-speaking Americans, not being assured nondiscriminatory access to federally funded services, including health services, until the signing of Executive Order 13166 (42 U.S.C. 2000d–1 note; related to improving access to services for persons with limited English proficiency) in 2000;

Whereas, although overt racism has been outlawed in the United States, subtle or implicit racism in all sectors of the medical service profession continues to cause disproportionate physical and psychological harm to members of racial and ethnic minority groups;

Whereas examples of subtle or implicit racism in the medical service profession include—

(1) the history and persistence of racist and nonscientific medical beliefs, which are associated with ongoing racial inequities in treatment and health outcomes;

(2) implicit racial and ethnic biases within the health care system, which have an explicit impact on the quality of care experienced by members of racial and ethnic minority groups, such as the undertreatment of pain in Black patients;

(3) nearly 1 in 5 Hispanic/Latino Americans avoiding medical care due to concern about being discriminated against or treated poorly;

(4) the United States health care system and other economic and social structures remaining fraught with biases based on race, ethnicity, sex (including sexual orientation and gender identity), and class that lead to health inequities;

(5) women of color, including Black, Native American, Hispanic/Latina, Asian American, Native Hawaiian, and Pacific Islander women, continuing to face attacks on their prenatal, maternal, and reproductive health and rights throughout history; and

(6) physicians routinely, through the late 1960s and early 1980s, sterilizing members of racial and ethnic minority groups, specifically African American and Latina women, performing excessive and medically unnecessary procedures without their informed consent;

Whereas structural racism perpetuates racial and ethnic inequities in the social determinants of health, which produces unintended negative health outcomes for members of racial and ethnic minority groups;

Whereas examples of that structural racism include—

(1) that there are fewer pharmacies, medical practices, and hospitals in predominantly Black and Hispanic/Latino neighborhoods, compared to White or more diverse neighborhoods;

(2) environmental hazards, such as toxic waste facilities, garbage dumps, and other sources of airborne pollutants, being disproportionately located in predominantly Black, Hispanic/Latino, Asian American, Native Hawaiian, Pacific Islander, and low-income communities, resulting in poor air quality conditions, which can increase the likelihood of chronic respiratory illness and premature death from particle pollution;

(3) that employed Black adults are 10 percent less likely to have workplace insurance than are employed White adults because of racial segregation in occupation sectors and types of organizations they work in, and that certain groups of nonelderly Asian American adults, including Native Hawaiian, Pacific Islander, Korean, Vietnamese, and Cambodian adults, also have lower levels of insurance than White adults;

(4) that several States with higher percentages of Black, Hispanic/Latino, and Native American populations have not expanded their Medicaid programs, continuing to disenfranchise minority communities from access to health care to this day;

(5) discriminatory housing practices, such as redlining, which have, for decades, systemically excluded members of racial and ethnic minority groups from housing, robbing them of capital in the form of low-cost, stable mortgages and opportunities to build wealth, and the Federal Government using its financial power to segregate renters in newly built public housing;

(6) social inequities such as differing access to quality health care, healthy food and safe drinking water, safe neighborhoods, education, job security, and reliable transportation, which affect health risks and outcomes;

(7) that, as much as 60 percent of the health of a person in the United States can be determined by their zip code;

(8) that the COVID–19 pandemic has exacerbated economic, health, housing, and food security barriers for Black, Hispanic/Latino, and Native American households, which already suffer from disproportionately higher rates of food insecurity; and

(9) members of the Black, Native American, Alaska Native, Asian American, Native Hawaiian, Pacific Islander, and Hispanic/Latino communities being disproportionately impacted by the criminal justice and immigration enforcement systems and facing a higher risk of contracting COVID–19 within prison populations and detention centers due to the over-incarceration of members of those communities;

Whereas structural racism perpetuates ongoing knowledge gaps in data, research, and development, which produces unintended negative health outcomes for members of racial and ethnic minority groups;

Whereas examples of that structural racism include that—

(1) most participants in clinical trials are White, so there is insufficient data to develop evidence-based recommendations for people from racial and ethnic minority groups;

(2) medical research equipment and medical devices are typically developed by majority-White teams and thus can have racial blind spots unintentionally built into their design, rendering them less effective for people from racial and ethnic minority groups, such as—

(A) electroencephalogram (EEG) electrodes used in neuroimaging research do not collect reliable data when used on scalps with thick, curly hair; and

(B) pulse oximeters produce less accurate oxygen saturation readings when used on fingertips with darker skin;

(3) a lack of images depicting darker skin in medical textbooks, literature, and journals contributes to higher rates of underdiagnosis or misdiagnosis in patients with darker skin; and

(4) many health-related studies fail to include disaggregated data on, or do not disaggregate data among, Asian Americans, Native Hawaiians, and Pacific Islanders, leading to their invisibility in health data and unjust resource allocation and policies;

Whereas racism produces unjust outcomes and treatment for members of racial and ethnic minority groups, with such negative experiences serving as stressors that over time have a negative impact on physical health (leading, for example, to high blood pressure or hypertension) and mental health (leading, for example, to anxiety or depression);

Whereas there is evidence that racial and ethnic minority groups continue to face discrimination in the United States, examples of which include that—

(1) compared to White Americans, Black Americans are 5 times more likely to report experiencing discrimination when interacting with the police, Hispanic/Latino Americans and Native Americans are nearly 3 times as likely, and Asian Americans, Native Hawaiians, and Pacific Islanders are nearly twice as likely;

(2) 42 percent of United States employees have experienced or witnessed racism in the workplace;

(3) social scientists have documented racial microaggressions in contemporary United States society, including—

(A) assumptions that members of racial and ethnic minority groups are not true Americans;

(B) assumptions of lesser intelligence;

(C) statements that convey color-blindness or denial of the importance of race;

(D) assumptions of criminality or dangerousness;

(E) denial of individual racism;

(F) promotion of the myth of meritocracy;

(G) assumptions that one's cultural background and communication styles are pathological;

(H) treatment as a second-class citizen; and

(I) environmental messages of being unwelcome or devalued;

(4) Muslims, South Asians, and Sikhs were unjustly targeted for profiling, surveillance, arrest, discrimination, harassment, assault, and murder after 9/11;

(5) xenophobic rhetoric, including anti-immigrant rhetoric and scapegoating people of East Asian and Southeast Asian descent for the COVID–19 pandemic, has resulted in a surge of hate incidents against Asian Americans, Native Hawaiians, and Pacific Islanders, including increased harassment, discrimination, bullying, vandalism, and assault; and

(6) more than 50 percent of Hispanic/Latino adults experience at least one form of discrimination due to their racial or ethnic heritage, such as being treated as if they were not smart, criticized for speaking Spanish, told to return to their country, called offensive names, or unfairly stopped by the police;

Whereas Black people in the United States experience overt and direct forms of violence that, when not fatal, can cause severe physical or psychological harm;

Whereas examples of such forms of violence include—

(1) Black people being confronted and threatened by armed citizens while performing everyday tasks, such as jogging in neighborhoods, driving while Black, or playing in a park;

(2) Black people being 3 times more likely to be killed by police than White people, and police violence being the sixth leading cause of death for young Black men;

(3) Black communities leading the United States in mourning the killings of Ahmaud Arbery, Breonna Taylor, George Floyd, Elijah McClain, and countless other Black Americans, and in calling for justice and long-term changes to dismantle systems of oppression;

(4) that it took the United States 66 years after the senseless and brutal murder of 14-year-old Emmett Till to make lynching a Federal crime;

(5) since 2015, mass shootings around the country, such as in Buffalo, New York, and Charleston, South Carolina, serving as reminders of the unresolved history of racism in the United States and highlighting the threats Black people must take into consideration when going about their daily lives, both when outside their communities and within those communities; and

(6) the real threat of brutality and violence adversely impacting mental health among Black communities;

Whereas Native Americans, Alaska Natives, Hispanic/Latinos, Asian Americans, Native Hawaiians, and Pacific Islanders experience racially motivated kidnapping, murders, and mass violence, such as shootings in Oak Creek, Wisconsin, El Paso, Texas, Atlanta, Georgia, and Indianapolis, Indiana, that, even when not fatal, can cause severe physical or psychological harm;

Whereas, throughout the history of the United States, members of racial and ethnic minority groups have been at the forefront

of civil rights movements for essential freedoms, human rights, and equal protection for marginalized groups and continue to fight for racial and economic justice today;

Whereas racial inequities in health continue to persist because of historical and contemporary racism;

Whereas public health experts agree that racism meets the criteria of a public health crisis, because—

(1) the condition affects many people, is seen as a threat to the public, and is continuing to increase;

(2) the condition is distributed unfairly;

(3) preventive measures could reduce the effects of the condition; and

(4) those preventive measures are not yet in place;

Whereas the Centers for Disease Control and Prevention—

(1) declared racism a serious threat to public health; and

(2) acknowledged the need for additional research and investments to address that serious threat;

Whereas a Federal public health crisis declaration defines racism as a pervasive health issue and alerts the people of the United States to the need to enact immediate and effective cross-governmental efforts to address the root causes of structural racism and the downstream impacts of that racism; and

Whereas such a declaration requires the response of governments to engage significant resources to empower the communities that are impacted: Now, therefore, be it

Resolved, That the Senate—

(1) supports the resolutions drafted, introduced, and adopted by cities and localities across the United States declaring racism a public health crisis;

(2) declares racism a public health crisis in the United States;

(3) commits to—

(A) establishing a nationwide strategy to address health disparities and inequities across all sectors in society;

(B) dismantling systemic practices and policies that perpetuate racism;

(C) advancing reforms to address years of neglectful and apathetic policies that have led to poor health outcomes for members of racial and ethnic minority groups; and

(D) promoting efforts to address the social determinants of health for all racial and ethnic minority groups in the United States, and especially for Black and Native American communities; and

(4) places a charge on the people of the United States to move forward with urgency to ensure that the United States stands firmly in honoring its moral purpose of advancing the self-evident truths that all people are created equal, that they are endowed with certain unalienable rights, and that among these are life, liberty, and the pursuit of happiness.

AMENDMENTS SUBMITTED AND PROPOSED

SA 6553. Mr. DAINES (for himself, Mr. RISCH, Mr. CRAPO, and Mr. TESTER) submitted an amendment intended to be proposed by him to the bill H.R. 2617, supra; which was ordered to lie on the table.

SA 6554. Mr. JOHNSON submitted an amendment intended to be proposed to amendment SA 6552 proposed by Mr. LEAHY to the bill H.R. 2617, supra; which was ordered to lie on the table.

SA 6555. Mr. JOHNSON (for himself, Mr. BRAUN, Mr. DAINES, Ms. LUMMIS, Mr. SCOTT of Florida, Mr. TOOMEY, Ms. ERNST, Mr. LANKFORD, Mr. RISCH, Mr. GRASSLEY, Mr. HAWLEY, Mr. BARRASSO, and Mr. LEE) submitted an amendment intended to be proposed to amendment SA 6552 proposed by Mr. LEAHY to the bill H.R. 2617, supra; which was ordered to lie on the table.

SA 6556. Mr. SCHATZ proposed an amendment to the bill S. 5087, to amend the Not Invisible Act of 2019 to extend, and provide additional support for, the activities of the Department of the Interior and the Department of Justice Joint Commission on Reducing Violent Crime Against Indians, and for other purposes.

SA 6557. Mr. TUBERVILLE submitted an amendment intended to be proposed to amendment SA 6552 proposed by Mr. LEAHY to the bill H.R. 2617, to amend section 1115 of title 31, United States Code, to amend the description of how performance goals are achieved, and for other purposes; which was ordered to lie on the table.

SA 6558. Mr. CASSIDY (for himself and Mr. CASEY) submitted an amendment intended to be proposed to amendment SA 6552 proposed by Mr. LEAHY to the bill H.R. 2617, supra; which was ordered to lie on the table.

SA 6559. Mr. JOHNSON submitted an amendment intended to be proposed to amendment SA 6552 proposed by Mr. LEAHY to the bill H.R. 2617, supra; which was ordered to lie on the table.

SA 6560. Mr. COTTON submitted an amendment intended to be proposed to amendment SA 6552 proposed by Mr. LEAHY to the bill H.R. 2617, supra; which was ordered to lie on the table.

SA 6561. Mr. PAUL submitted an amendment intended to be proposed to amendment SA 6552 proposed by Mr. LEAHY to the bill H.R. 2617, supra; which was ordered to lie on the table.

SA 6562. Mr. LEE submitted an amendment intended to be proposed by him to the bill H.R. 2617, supra; which was ordered to lie on the table.

SA 6563. Mr. LEE (for himself, Mr. SCOTT of Florida, Mr. BRAUN, and Mr. JOHNSON) submitted an amendment intended to be proposed to amendment SA 6552 proposed by Mr. LEAHY to the bill H.R. 2617, supra; which was ordered to lie on the table.

SA 6564. Mr. LEE (for himself, Mr. SCOTT of Florida, Mr. BRAUN, and Mr. JOHNSON) submitted an amendment intended to be proposed by him to the bill H.R. 2617, supra; which was ordered to lie on the table.

SA 6565. Mr. LEE (for himself, Mr. SCOTT of Florida, Mr. BRAUN, and Mr. JOHNSON) submitted an amendment intended to be proposed by him to the bill H.R. 2617, supra; which was ordered to lie on the table.

SA 6566. Ms. LUMMIS submitted an amendment intended to be proposed to amendment SA 6552 proposed by Mr. LEAHY to the bill H.R. 2617, supra; which was ordered to lie on the table.

SA 6567. Ms. KLOBUCHAR (for herself and Mr. GRASSLEY) submitted an amendment intended to be proposed to amendment SA 6552 proposed by Mr. LEAHY to the bill H.R. 2617, supra; which was ordered to lie on the table.

SA 6568. Ms. KLOBUCHAR (for herself and Mr. KENNEDY) submitted an amendment intended to be proposed to amendment SA 6552 proposed by Mr. LEAHY to the bill H.R. 2617, supra; which was ordered to lie on the table.

SA 6569. Mr. BRAUN submitted an amendment intended to be proposed to amendment SA 6558 submitted by Mr. CASSIDY (for himself and Mr. CASEY) and intended to be proposed to the amendment SA 6552 proposed by Mr. LEAHY to the bill H.R. 2617, supra; which was ordered to lie on the table.

SA 6570. Mr. GRASSLEY (for himself and Mr. MANCHIN) submitted an amendment intended to be proposed to amendment SA 6552 proposed by Mr. LEAHY to the bill H.R. 2617, supra; which was ordered to lie on the table.

SA 6571. Mr. SCHUMER proposed an amendment to amendment SA 6552 proposed by Mr. LEAHY to the bill H.R. 2617, supra.

SA 6572. Mr. SCHUMER proposed an amendment to the bill H.R. 2617, supra.

SA 6573. Mr. SCHUMER proposed an amendment to amendment SA 6572 proposed by Mr. SCHUMER to the bill H.R. 2617, supra.

SA 6574. Mr. SCHUMER proposed an amendment to amendment SA 6573 proposed by Mr. SCHUMER to the amendment SA 6572 proposed by Mr. SCHUMER to the bill H.R. 2617, supra.

SA 6575. Mr. GRAHAM (for himself and Mr. WHITEHOUSE) submitted an amendment intended to be proposed to amendment SA 6552 proposed by Mr. LEAHY to the bill H.R. 2617, supra; which was ordered to lie on the table.

SA 6576. Mr. LEE submitted an amendment intended to be proposed to amendment SA 6552 proposed by Mr. LEAHY to the bill H.R. 2617, supra; which was ordered to lie on the table.

SA 6577. Mr. LANKFORD submitted an amendment intended to be proposed to amendment SA 6558 submitted by Mr. CASSIDY (for himself and Mr. CASEY) and intended to be proposed to the amendment SA 6552 proposed by Mr. LEAHY to the bill H.R. 2617, supra; which was ordered to lie on the table.

SA 6578. Mr. HEINRICH (for Mr. MORAN (for himself and Mr. TESTER)) proposed an amendment to the bill H.R. 7939, to make permanent certain educational assistance benefits under the laws administered by the Secretary of Veterans Affairs in the case of changes to courses of education by reason of emergency situations, and for other purposes.

SA 6579. Mr. TILLIS (for himself and Mr. BURR) submitted an amendment intended to be proposed to amendment SA 6552 proposed by Mr. LEAHY to the bill H.R. 2617, to amend section 1115 of title 31, United States Code, to amend the description of how performance goals are achieved, and for other purposes; which was ordered to lie on the table.

SA 6580. Mr. HEINRICH (for Mr. VAN HOLLEN) proposed an amendment to the bill S. 1294, to authorize the imposition of sanctions with respect to foreign persons that have engaged in significant theft of trade secrets of United States persons, and for other purposes.

SA 6581. Mr. HEINRICH (for Mr. CORNYN (for himself and Ms. KLOBUCHAR)) proposed an amendment to the bill S. 3946, to reauthorize the Trafficking Victims Protection Act of 2017, and for other purposes..

SA 6582. Mr. HEINRICH (for Mr. DURBIN (for himself and Mr. CORNYN)) proposed an amendment to the bill S. 4859, to reauthorize the Project Safe Neighborhoods Grant Program Authorization Act of 2018, and for other purposes.

SA 6583. Mr. HEINRICH (for Mr. GRASSLEY (for himself and Mrs. FEINSTEIN)) proposed an amendment to the bill S. 3949, to reauthorize the Trafficking Victims Protection Act of 2000, and for other purposes..

SA 6584. Mr. HEINRICH (for Mr. REED) proposed an amendment to the bill S. 4120, to maximize discovery, and accelerate development and availability, of promising childhood cancer treatments, and for other purposes.

SA 6585. Ms. CANTWELL (for herself, Mr. LUJÁN, Mr. SCHATZ, Ms. KLOBUCHAR, and Mr. HICKENLOOPER) submitted an amendment intended to be proposed by her to the bill H.R. 2617, to amend section 1115 of title 31, United States Code, to amend the description of how performance goals are achieved, and for other purposes; which was ordered to lie on the table.