with such requirements, such amount shall be increased to $2,000,000.

"(3) REDUCTION FOR NONCOMPLIANCE.—If a State does not submit such an amendment, the Secretary shall reduce the Federal medical assistance percentage otherwise applicable under this title by 1 percentage point until the State submits such an amendment.

"(4) ONGOING REDUCTION.—If at any time the Secretary determines that a State is not in compliance with section 1902(a)(25), regardless of the status of the State's submission of a State plan amendment under this subsection or previous determinations of compliance such requirements, the Secretary shall reduce the Federal medical assistance percentage otherwise applicable under this title for the State by 1 percentage point during the period of non-compliance as determined by the Secretary.".

SEC. 604. STRENGTHEN MEDICARE PROVIDER ENROLLMENT STANDARDS AND SAFEGUARDS.

(a) PROTECTING AGAINST THE FRAUDULENT USE OF MEDICARE PROVIDER NUMBERS.—Subject to subsection (c)(2)—

(1) SCREENING NEW PROVIDERS.—As a condition of a provider of services or a supplier, including durable medical equipment suppliers and home health agencies, applying for the first time for a provider number under the Medicare program and before granting billing privileges under such title, the Secretary shall screen the provider or supplier for a criminal background or other financial or operational irregularities through fingerprinting, licensure checks, site-visits, other database checks.

(2) APPLICATION FEES.—The Secretary shall impose an application charge on such a provider or supplier in order to cover the Secretary's costs in performing the screening required under paragraph (1) and that is revenue neutral to the Federal government.

(3) PROVISIONAL APPROVAL.—During an initial, provisional period (specified by the Secretary) In which such a provider or supplier has been issued such a number, the Secretary shall provide enhanced oversight of the activities of such provider or supplier under the Medicare program, such as through prepayment review and payment limitations.

(4) PENALTIES FOR FALSE STATEMENTS.—In the case of a provider or supplier that makes a false statement in an application for such a number, the Secretary may exclude the provider or supplier from participation under the Medicare program, or may impose a civil money penalty (in the amount described in section 1128A(a)(4) of the Social Security Act), in the same manner as the Secretary may impose such an exclusion or penalty under sections 1128 and 1128A, respectively, of such Act in the case of knowing presentation of a false claim described in section 1128A(a)(1)(A) of such Act.

(5) DISCLOSURE REQUIREMENTS.—With respect to approval of such an application, the Secretary—

(A) shall require applicants to disclose previous affiliation with enrolled entities that have uncollected debt related to the Medicare or Medicaid programs;

(B) may deny approval if the Secretary determines that these affiliations pose undue risk to the Medicare or Medicaid program, subject to an appeals process for the applicant as determined by the Secretary; and

(C) may implement enhanced safeguards (such as surety bonds).

(b) MORATORIA.—The Secretary may impose moratoria on approval of provider and supplier numbers under the Medicare program for new providers of services and suppliers as determined necessary to prevent or combat fraud a period of delay for any one applicant cannot exceed 30 days unless cause is shown by the Secretary.

(c) FUNDING.—

(1) IN GENERAL.—There are authorized to be appropriated to carry out this section such sums as may be necessary.

(2) CONDITION.—The provisions of paragraphs (1) and (2) of subsection (a) shall not apply unless and until funds are appropriated to carry out such provisions.

SEC. 605. TRACKING BANNED PROVIDERS ACROSS STATE LINES.

(a) GREATER COORDINATION.—The Secretary of Health and Human Services shall provide for increased coordination between the Administrator of the Centers for Medicare & Medicaid Services (in this section referred to as "CMS") and its regional offices to ensure that providers of services and suppliers that have operated in one State and are excluded from participation in the Medicare program are unable to begin operation and participation in the Medicare program in another State.

(b) IMPROVED INFORMATION SYSTEMS.—

(1) IN GENERAL.—The Secretary shall improve information systems to allow greater integration between databases under the Medicare program so that—

(A) medicare administrative contractors, fiscal intermediaries, and carriers have immediate access to information identifying providers and suppliers excluded from participation in the Medicare and Medicaid program and other Federal health care programs; and

(B) such information can be shared across Federal health care programs and agencies, including between the Departments of Health and Human Services, the Social Security Administration, the Department of Veterans Affairs, the Department of Defense, the Department of Justice, and the Office of Personnel Management.

(c) MEDICARE/MEDICAID "ONE PI" DATABASE.—The Secretary shall implement a database that includes claims and payment data for all components of the Medicare program and the Medicaid program.

(d) AUTHORIZING EXPANDED DATA MATCHING.—Notwithstanding any provision of the Computer Matching and Privacy Protection Act of 1988 to the contrary—

(1) the Secretary and the Inspector General in the Department of Health and Human Services may perform data matching of data from the Medicare program with data from the Medicaid program; and

(2) the Commissioner of Social Security and the Secretary may perform data matching of data of the Social Security Administration with data from the Medicare and Medicaid programs.

(e) CONSOLIDATION OF DATA BASES.—The Secretary shall consolidate and expand into a centralized data base for individuals and entities that have been excluded from Federal health care programs the Healthcare Integrity and Protection Data Bank, the National Practitioner Data Bank, the List of Excluded Individuals/Entities, and a national patient abuse/neglect registry.

(f) COMPREHENSIVE PROVIDER DATABASE.—

(1) ESTABLISHMENT.—The Secretary shall establish a comprehensive database that includes information on providers of services, suppliers, and related entities participating in the Medicare program, the Medicaid program, or both. Such database shall include, information on ownership and business relationships, history of adverse actions, results of site visits or other monitoring by any program.

(2) USE.—Prior to issuing a provider or supplier number for an entity under the Medicare program, the Secretary shall obtain information on the entity from such database to assure the entity qualifies for the issuance of such a number.

(g) COMPREHENSIVE SANCTIONS DATABASE.—The Secretary shall establish a comprehensive sanctions database on sanctions imposed on providers of services, suppliers, and related entities. Such database shall be overseen by the Inspector General of the Department of Health and Human Services and shall be linked to related databases maintained by State licensure boards and by Federal or State law enforcement agencies.

(h) ACCESS TO CLAIMS AND PAYMENT DATABASES.—The Secretary shall ensure that the Inspector General of the Department of Health and Human Services and Federal law enforcement agencies have direct access to all claims and payment databases of the Secretary under the Medicare or Medicaid programs.

(i) CIVIL MONEY PENALTIES FOR SUBMISSION OF ERRONEOUS INFORMATION.—In the case of a provider of services, supplier, or other entity that submits erroneous information that serves as a basis for payment of any entity under the Medicare or Medicaid program, the Secretary may impose a civil money penalty of not to exceed $50,000 for each such erroneous submission. A civil money penalty under this subsection shall be imposed and collected in the same manner as a civil money penalty under subsection (a) of section 1128A of the Social Security Act is imposed and collected under that section.

DIVISION G—PATHWAY FOR BIOSIMILAR BIOLOGICAL PRODUCTS

SEC. 701. LICENSURE PATHWAY FOR BIOSIMILAR BIOLOGICAL PRODUCTS.

(a) LICENSURE OF BIOLOGICAL PRODUCTS AS BIOSIMILAR OR INTERCHANGEABLE.—Section 351 of the Public Health Service Act (42 U.S.C. 262) is amended—

(1) in subsection (a)(1)(A), by inserting "under this subsection or subsection (k)" after "biologics license"; and

(2) by adding at the end the following:

"(k) LICENSURE OF BIOLOGICAL PRODUCTS AS BIOSIMILAR OR INTERCHANGEABLE.—

"(1) IN GENERAL.—Any person may submit an application for licensure of a biological product under this subsection.

"(2) CONTENT.—

"(A) IN GENERAL.—

"(i) REQUIRED INFORMATION.—An application submitted under this subsection shall include information demonstrating that—

"(I) the biological product is biosimilar to a reference product based upon data derived from—

"(aa) analytical studies that demonstrate that the biological product is highly similar to the reference product notwithstanding minor differences in clinically inactive components;

"(bb) animal studies (including the assessment of toxicity); and

"(cc) a clinical study or studies (including the assessment of immunogenicity and pharmacokinetics or pharmacodynamics) that are sufficient to demonstrate safety, purity, and potency in 1 or more appropriate conditions of use for which the reference product is licensed and intended to be used and for which licensure is sought for the biological product;

"(II) the biological product and reference product utilize the same mechanism or mechanisms of action for the condition or

conditions of use prescribed, recommended, or suggested in the proposed labeling, but only to the extent the mechanism or mechanisms of action are known for the reference product;

"(III) the condition or conditions of use prescribed, recommended, or suggested in the labeling proposed for the biological product have been previously approved for the reference product;

"(IV) the route of administration, the dosage form, and the strength of the biological product are the same as those of the reference product; and

"(V) the facility in which the biological product is manufactured, processed, packed, or held meets standards designed to assure that the biological product continues to be safe, pure, and potent.

"(ii) DETERMINATION BY SECRETARY.—The Secretary may determine, in the Secretary's discretion, that an element described in clause (i)(I) is unnecessary in an application submitted under this subsection.

"(iii) ADDITIONAL INFORMATION.—An application submitted under this subsection—

"(I) shall include publicly available information regarding the Secretary's previous determination that the reference product is safe, pure, and potent; and

"(II) may include any additional information in support of the application, including publicly available information with respect to the reference product or another biological product.

"(B) INTERCHANGEABILITY.—An application (or a supplement to an application) submitted under this subsection may include information demonstrating that the biological product meets the standards described in paragraph (4).

"(3) EVALUATION BY SECRETARY.—Upon review of an application (or a supplement to an application) submitted under this subsection, the Secretary shall license the biological product under this subsection if—

"(A) the Secretary determines that the information submitted in the application (or the supplement) is sufficient to show that the biological product—

"(i) is biosimilar to the reference product; or

"(ii) meets the standards described in paragraph (4), and therefore is interchangeable with the reference product; and

"(B) the applicant (or other appropriate person) consents to the inspection of the facility that is the subject of the application, in accordance with subsection (c).

"(4) SAFETY STANDARDS FOR DETERMINING INTERCHANGEABILITY.—Upon review of an application submitted under this subsection or any supplement to such application, the Secretary shall determine the biological product to be interchangeable with the reference product if the Secretary determines that the information submitted in the application (or a supplement to such application) is sufficient to show that—

"(A) the biological product—

"(i) is biosimilar to the reference product; and

"(ii) can be expected to produce the same clinical result as the reference product in any given patient; and

"(B) for a biological product that is administered more than once to an individual, the risk in terms of safety or diminished efficacy of alternating or switching between use of the biological product and the reference product is not greater than the risk of using the reference product without such alternation or switch.

"(5) GENERAL RULES.—

"(A) ONE REFERENCE PRODUCT PER APPLICATION.—A biological product, in an application submitted under this subsection, may not be evaluated against more than 1 reference product.

"(B) REVIEW.—An application submitted under this subsection shall be reviewed by the division within the Food and Drug Administration that is responsible for the review and approval of the application under which the reference product is licensed.

"(C) RISK EVALUATION AND MITIGATION STRATEGIES.—The authority of the Secretary with respect to risk evaluation and mitigation strategies under the Federal Food, Drug, and Cosmetic Act shall apply to biological products licensed under this subsection in the same manner as such authority applies to biological products licensed under subsection (a).

"(D) RESTRICTIONS ON BIOLOGICAL PRODUCTS CONTAINING DANGEROUS INGREDIENTS.—If information in an application submitted under this subsection, in a supplement to such an application, or otherwise available to the Secretary shows that a biological product—

"(i) is, bears, or contains a select agent or toxin listed in section 73.3 or 73.4 of title 42, section 121.3 or 121.4 of title 9, or section 331.3 of title 7, Code of Federal Regulations (or any successor regulations); or

"(ii) is, bears, or contains a controlled substance in schedule I or II of section 202 of the Controlled Substances Act, as listed in part 1308 of title 21, Code of Federal Regulations (or any successor regulations);

the Secretary shall not license the biological product under this subsection unless the Secretary determines, after consultation with appropriate national security and drug enforcement agencies, that there would be no increased risk to the security or health of the public from licensing such biological product under this subsection.

"(6) EXCLUSIVITY FOR FIRST INTERCHANGEABLE BIOLOGICAL PRODUCT.—Upon review of an application submitted under this subsection relying on the same reference product for which a prior biological product has received a determination of interchangeability for any condition of use, the Secretary shall not make a determination under paragraph (4) that the second or subsequent biological product is interchangeable for any condition of use until the earlier of—

"(A) 1 year after the first commercial marketing of the first interchangeable biosimilar biological product to be approved as interchangeable for that reference product;

"(B) 18 months after—

"(i) a final court decision on all patents in suit in an action instituted under subsection (l)(5) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product; or

"(ii) the dismissal with or without prejudice of an action instituted under subsection (l)(5) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product; or

"(C)(i) 42 months after approval of the first interchangeable biosimilar biological product if the applicant that submitted such application has been sued under subsection (l)(5) and such litigation is still ongoing within such 42-month period; or

"(ii) 18 months after approval of the first interchangeable biosimilar biological product if the applicant that submitted such application has not been sued under subsection (l)(5).

For purposes of this paragraph, the term 'final court decision' means a final decision of a court from which no appeal (other than a petition to the United States Supreme Court for a writ of certiorari) has been or can be taken.

"(7) EXCLUSIVITY FOR REFERENCE PRODUCT.—

"(A) EFFECTIVE DATE OF BIOSIMILAR APPLICATION APPROVAL.—Approval of an application under this subsection may not be made effective by the Secretary until the date that is 12 years after the date on which the reference product was first licensed under subsection (a).

"(B) FILING PERIOD.—An application under this subsection may not be submitted to the Secretary until the date that is 4 years after the date on which the reference product was first licensed under subsection (a).

"(C) FIRST LICENSURE.—Subparagraphs (A) and (B) shall not apply to a license for or approval of—

"(i) a supplement for the biological product that is the reference product; or

"(ii) a subsequent application filed by the same sponsor or manufacturer of the biological product that is the reference product (or a licensor, predecessor in interest, or other related entity) for—

"(I) a change (not including a modification to the structure of the biological product) that results in a new indication, route of administration, dosing schedule, dosage form, delivery system, delivery device, or strength; or

"(II) a modification to the structure of the biological product that does not result in a change in safety, purity, or potency.

"(8) PEDIATRIC STUDIES.—

"(A) EXCLUSIVITY.—If, before or after licensure of the reference product under subsection (a) of this section, the Secretary determines that information relating to the use of such product in the pediatric population may produce health benefits in that population, the Secretary makes a written request for pediatric studies (which shall include a timeframe for completing such studies), the applicant or holder of the approved application agrees to the request, such studies are completed using appropriate formulations for each age group for which the study is requested within any such timeframe, and the reports thereof are submitted and accepted in accordance with section 505A(d)(3) of the Federal Food, Drug, and Cosmetic Act the period referred to in paragraph (7)(A) of this subsection is deemed to be 12 years and 6 months rather than 12 years.

"(B) EXCEPTION.—The Secretary shall not extend the period referred to in subparagraph (A) of this paragraph if the determination under section 505A(d)(3) of the Federal Food, Drug, and Cosmetic Act is made later than 9 months prior to the expiration of such period.

"(C) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subsections (a), (d), (e), (f), (h), (j), (k), and (l) of section 505A of the Federal Food, Drug, and Cosmetic Act shall apply with respect to the extension of a period under subparagraph (A) of this paragraph to the same extent and in the same manner as such provisions apply with respect to the extension of a period under subsection (b) or (c) of section 505A of the Federal Food, Drug, and Cosmetic Act.

"(9) GUIDANCE DOCUMENTS.—

"(A) IN GENERAL.—The Secretary may, after opportunity for public comment, issue guidance in accordance, except as provided in subparagraph (B)(i), with section 701(h) of the Federal Food, Drug, and Cosmetic Act with respect to the licensure of a biological product under this subsection. Any such guidance may be general or specific.

"(B) PUBLIC COMMENT.—

"(i) IN GENERAL.—The Secretary shall provide the public an opportunity to comment on any proposed guidance issued under subparagraph (A) before issuing final guidance.

"(ii) INPUT REGARDING MOST VALUABLE GUIDANCE.—The Secretary shall establish a process through which the public may provide the Secretary with input regarding priorities for issuing guidance.

"(C) NO REQUIREMENT FOR APPLICATION CONSIDERATION.—The issuance (or non-issuance) of guidance under subparagraph (A) shall not preclude the review of, or action on, an application submitted under this subsection.

"(D) REQUIREMENT FOR PRODUCT CLASS-SPECIFIC GUIDANCE.—If the Secretary issues product class-specific guidance under subparagraph (A), such guidance shall include a description of—

"(i) the criteria that the Secretary will use to determine whether a biological product is highly similar to a reference product in such product class; and

"(ii) the criteria, if available, that the Secretary will use to determine whether a biological product meets the standards described in paragraph (4).

"(E) CERTAIN PRODUCT CLASSES.—

"(i) GUIDANCE.—The Secretary may indicate in a guidance document that the science and experience, as of the date of such guidance, with respect to a product or product class (not including any recombinant protein) does not allow approval of an application for a license as provided under this subsection for such product or product class.

"(ii) MODIFICATION OR REVERSAL.—The Secretary may issue a subsequent guidance document under subparagraph (A) to modify or reverse a guidance document under clause (i).

"(iii) NO EFFECT ON ABILITY TO DENY LICENSE.—Clause (i) shall not be construed to require the Secretary to approve a product with respect to which the Secretary has not indicated in a guidance document that the science and experience, as described in clause (i), does not allow approval of such an application.

"(10) NAMING.—The Secretary shall ensure that the labeling and packaging of each biological product licensed under this subsection bears a name that uniquely identifies the biological product and distinguishes it from the reference product and any other biological products licensed under this subsection following evaluation against such reference product.

"(l) PATENT NOTICES; RELATIONSHIP TO FINAL APPROVAL.—

"(1) DEFINITIONS.—For the purposes of this subsection, the term—

"(A) 'biosimilar product' means the biological product that is the subject of the application under subsection (k);

"(B) 'relevant patent' means a patent that—

"(i) expires after the date specified in subsection (k)(7)(A) that applies to the reference product; and

"(ii) could reasonably be asserted against the applicant due to the unauthorized making, use, sale, or offer for sale within the United States, or the importation into the United States of the biosimilar product, or materials used in the manufacture of the biosimilar product, or due to a use of the biosimilar product in a method of treatment that is indicated in the application;

"(C) 'reference product sponsor' means the holder of an approved application or license for the reference product; and

"(D) 'interested third party' means a person other than the reference product sponsor that owns a relevant patent, or has the right to commence or participate in an action for infringement of a relevant patent.

"(2) HANDLING OF CONFIDENTIAL INFORMATION.—Any entity receiving confidential information pursuant to this subsection shall designate one or more individuals to receive such information. Each individual so designated shall execute an agreement in accordance with regulations promulgated by the Secretary. The regulations shall require each such individual to take reasonable steps to maintain the confidentiality of information received pursuant to this subsection and use the information solely for purposes authorized by this subsection. The obligations imposed on an individual who has received confidential information pursuant to this subsection shall continue until the individual returns or destroys the confidential information, a court imposes a protective order that governs the use or handling of the confidential information, or the party providing the confidential information agrees to other terms or conditions regarding the handling or use of the confidential information.

"(3) PUBLIC NOTICE BY SECRETARY.—Within 30 days of acceptance by the Secretary of an application filed under subsection (k), the Secretary shall publish a notice identifying—

"(A) the reference product identified in the application; and

"(B) the name and address of an agent designated by the applicant to receive notices pursuant to paragraph (4)(B).

"(4) EXCHANGES CONCERNING PATENTS.—

"(A) EXCHANGES WITH REFERENCE PRODUCT SPONSOR.—

"(i) Within 30 days of the date of acceptance of the application by the Secretary, the applicant shall provide the reference product sponsor with a copy of the application and information concerning the biosimilar product and its production. This information shall include a detailed description of the biosimilar product, its method of manufacture, and the materials used in the manufacture of the product.

"(ii) Within 60 days of the date of receipt of the information required to be provided under clause (i), the reference product sponsor shall provide to the applicant a list of relevant patents owned by the reference product sponsor, or in respect of which the reference product sponsor has the right to commence an action of infringement or otherwise has an interest in the patent as such patent concerns the biosimilar product.

"(iii) If the reference product sponsor is issued or acquires an interest in a relevant patent after the date on which the reference product sponsor provides the list required by clause (ii) to the applicant, the reference product sponsor shall identify that patent to the applicant within 30 days of the date of issue of the patent, or the date of acquisition of the interest in the patent, as applicable.

"(B) EXCHANGES WITH INTERESTED THIRD PARTIES.—

"(i) At any time after the date on which the Secretary publishes a notice for an application under paragraph (3), any interested third party may provide notice to the designated agent of the applicant that the interested third party owns or has rights under 1 or more patents that may be relevant patents. The notice shall identify at least 1 patent and shall designate an individual who has executed an agreement in accordance with paragraph (2) to receive confidential information from the applicant.

"(ii) Within 30 days of the date of receiving notice pursuant to clause (i), the applicant shall send to the individual designated by the interested third party the information specified in subparagraph (A)(i), unless the applicant and interested third party otherwise agree.

"(iii) Within 90 days of the date of receiving information pursuant to clause (ii), the interested third party shall provide to the applicant a list of relevant patents which the interested third party owns, or in respect of which the interested third party has the right to commence or participate in an action for infringement.

"(iv) If the interested third party is issued or acquires an interest in a relevant patent after the date on which the interested third party provides the list required by clause (iii), the interested third party shall identify that patent within 30 days of the date of issue of the patent, or the date of acquisition of the interest in the patent, as applicable.

"(C) IDENTIFICATION OF BASIS FOR INFRINGEMENT.—For any patent identified under clause (ii) or (iii) of subparagraph (A) or under clause (iii) or (iv) of subparagraph (B), the reference product sponsor or the interested third party, as applicable—

"(i) shall explain in writing why the sponsor or the interested third party believes the relevant patent would be infringed by the making, use, sale, or offer for sale within the United States, or importation into the United States, of the biosimilar product or by a use of the biosimilar product in treatment that is indicated in the application;

"(ii) may specify whether the relevant patent is available for licensing; and

"(iii) shall specify the number and date of expiration of the relevant patent.

"(D) CERTIFICATION BY APPLICANT CONCERNING IDENTIFIED RELEVANT PATENTS.—Not later than 45 days after the date on which a patent is identified under clause (ii) or (iii) of subparagraph (A) or under clause (iii) or (iv) of subparagraph (B), the applicant shall send a written statement regarding each identified patent to the party that identified the patent. Such statement shall either—

"(i) state that the applicant will not commence marketing of the biosimilar product and has requested the Secretary to not grant final approval of the application before the date of expiration of the noticed patent; or

"(ii) provide a detailed written explanation setting forth the reasons why the applicant believes—

"(I) the making, use, sale, or offer for sale within the United States, or the importation into the United States, of the biosimilar product, or the use of the biosimilar product in a treatment indicated in the application, would not infringe the patent; or

"(II) the patent is invalid or unenforceable.

"(5) ACTION FOR INFRINGEMENT INVOLVING REFERENCE PRODUCT SPONSOR.—If an action for infringement concerning a relevant patent identified by the reference product sponsor under clause (ii) or (iii) of paragraph (4)(A), or by an interested third party under clause (iii) or (iv) of paragraph (4)(B), is brought within 60 days of the date of receipt of a statement under paragraph (4)(D)(ii), and the court in which such action has been commenced determines the patent is infringed prior to the date applicable under subsection (k)(7)(A) or (k)(8), the Secretary shall make approval of the application effective on the day after the date of expiration of the patent that has been found to be infringed. If more than one such patent is found to be infringed by the court, the approval of the application shall be made effective on the day after the date that the last such patent expires.

"(6) NOTIFICATION OF AGREEMENTS.—

"(A) REQUIREMENTS.—

"(i) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANT AND REFERENCE PRODUCT SPONSOR.—If a biosimilar product applicant under subsection (k) and the reference product sponsor enter into an agreement described in subparagraph (B), the applicant and sponsor shall each file the agreement in accordance with subparagraph (C).

"(ii) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANTS.—If 2 or more biosimilar product applicants submit an application under subsection (k) for biosimilar products with the same reference product and enter into an agreement described in subparagraph (B), the applicants shall each file the agreement in accordance with subparagraph (C).

"(B) SUBJECT MATTER OF AGREEMENT.—An agreement described in this subparagraph—

"(i) is an agreement between the biosimilar product applicant under subsection (k) and the reference product sponsor or between 2 or more biosimilar product applicants under subsection (k) regarding the manufacture, marketing, or sale of—

"(I) the biosimilar product (or biosimilar products) for which an application was submitted; or

"(II) the reference product;

"(ii) includes any agreement between the biosimilar product applicant under subsection (k) and the reference product sponsor or between 2 or more biosimilar product applicants under subsection (k) that is contingent upon, provides a contingent condition for, or otherwise relates to an agreement described in clause (i); and

"(iii) excludes any agreement that solely concerns—

"(I) purchase orders for raw material supplies;

"(II) equipment and facility contracts;

"(III) employment or consulting contracts; or

"(IV) packaging and labeling contracts.

"(C) FILING.—

"(i) IN GENERAL.—The text of an agreement required to be filed by subparagraph (A) shall be filed with the Assistant Attorney General and the Federal Trade Commission not later than—

"(I) 10 business days after the date on which the agreement is executed; and

"(II) prior to the date of the first commercial marketing of, for agreements described in subparagraph (A)(i), the biosimilar product that is the subject of the application or, for agreements described in subparagraph (A)(ii), any biosimilar product that is the subject of an application described in such subparagraph.

"(ii) IF AGREEMENT NOT REDUCED TO TEXT.—If an agreement required to be filed by subparagraph (A) has not been reduced to text, the persons required to file the agreement shall each file written descriptions of the agreement that are sufficient to disclose all the terms and conditions of the agreement.

"(iii) CERTIFICATION.—The chief executive officer or the company official responsible for negotiating any agreement required to be filed by subparagraph (A) shall include in any filing under this paragraph a certification as follows: 'I declare under penalty of perjury that the following is true and correct: The materials filed with the Federal Trade Commission and the Department of Justice under section 351(l)(6) of the Public Health Service Act, with respect to the agreement referenced in this certification: (1) represent the complete, final, and exclusive agreement between the parties; (2) include any ancillary agreements that are contingent upon, provide a contingent condition for, or are otherwise related to, the referenced agreement; and (3) include written descriptions of any oral agreements, representations, commitments, or promises between the parties that are responsive to such section and have not been reduced to writing.'.

"(D) DISCLOSURE EXEMPTION.—Any information or documentary material filed with the Assistant Attorney General or the Federal Trade Commission pursuant to this paragraph shall be exempt from disclosure under section 552 of title 5, United States Code, and no such information or documentary material may be made public, except as may be relevant to any administrative or judicial action or proceeding. Nothing in this subparagraph prevents disclosure of information or documentary material to either body of the Congress or to any duly authorized committee or subcommittee of the Congress.

"(E) ENFORCEMENT.—

"(i) CIVIL PENALTY.—Any person that violates a provision of this paragraph shall be liable for a civil penalty of not more than $11,000 for each day on which the violation occurs. Such penalty may be recovered in a civil action—

"(I) brought by the United States; or

"(II) brought by the Federal Trade Commission in accordance with the procedures established in section 16(a)(1) of the Federal Trade Commission Act.

"(ii) COMPLIANCE AND EQUITABLE RELIEF.—If any person violates any provision of this paragraph, the United States district court may order compliance, and may grant such other equitable relief as the court in its discretion determines necessary or appropriate, upon application of the Assistant Attorney General or the Federal Trade Commission.

"(F) RULEMAKING.—The Federal Trade Commission, with the concurrence of the Assistant Attorney General and by rule in accordance with section 553 of title 5, United States Code, consistent with the purposes of this paragraph—

"(i) may define the terms used in this paragraph;

"(ii) may exempt classes of persons or agreements from the requirements of this paragraph; and

"(iii) may prescribe such other rules as may be necessary and appropriate to carry out the purposes of this paragraph.

"(G) SAVINGS CLAUSE.—Any action taken by the Assistant Attorney General or the Federal Trade Commission, or any failure of the Assistant Attorney General or the Commission to take action, under this paragraph shall not at any time bar any proceeding or any action with respect to any agreement between a biosimilar product applicant under subsection (k) and the reference product sponsor, or any agreement between biosimilar product applicants under subsection (k), under any other provision of law, nor shall any filing under this paragraph constitute or create a presumption of any violation of any competition laws.".

(b) DEFINITIONS.—Section 351(i) of the Public Health Service Act (42 U.S.C. 262(i)) is amended—

(1) by striking "In this section, the term 'biological product' means" and inserting the following: "In this section:

"(1) The term 'biological product' means";

(2) in paragraph (1), as so designated, by inserting "protein (except any chemically synthesized polypeptide)," after "allergenic product,"; and

(3) by adding at the end the following:

"(2) The term 'biosimilar' or 'biosimilarity', in reference to a biological product that is the subject of an application under subsection (k), means—

"(A) that the biological product is highly similar to the reference product notwithstanding minor differences in clinically inactive components; and

"(B) there are no clinically meaningful differences between the biological product and the reference product in terms of the safety, purity, and potency of the product.

"(3) The term 'interchangeable' or 'interchangeability', in reference to a biological product that is shown to meet the standards described in subsection (k)(4), means that the biological product may be substituted for the reference product without the intervention of the health care provider who prescribed the reference product.

"(4) The term 'reference product' means the single biological product licensed under subsection (a) against which a biological product is evaluated in an application submitted under subsection (k).".

(c) PRODUCTS PREVIOUSLY APPROVED UNDER SECTION 505.—

(1) REQUIREMENT TO FOLLOW SECTION 351.—Except as provided in paragraph (2), an application for a biological product shall be submitted under section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act).

(2) EXCEPTION.—An application for a biological product may be submitted under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) if—

(A) such biological product is in a product class for which a biological product in such product class is the subject of an application approved under such section 505 not later than the date of enactment of this Act; and

(B) such application—

(i) has been submitted to the Secretary of Health and Human Services (referred to in this Act as the "Secretary") before the date of enactment of this Act; or

(ii) is submitted to the Secretary not later than the date that is 10 years after the date of enactment of this Act.

(3) LIMITATION.—Notwithstanding paragraph (2), an application for a biological product may not be submitted under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) if there is another biological product approved under subsection (a) of section 351 of the Public Health Service Act that could be a reference product with respect to such application (within the meaning of such section 351) if such application were submitted under subsection (k) of such section 351.

(4) DEEMED APPROVED UNDER SECTION 351.—An approved application for a biological product under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) shall be deemed to be a license for the biological product under such section 351 on the date that is 10 years after the date of enactment of this Act.

(5) DEFINITIONS.—For purposes of this subsection, the term "biological product" has the meaning given such term under section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act).

SEC. 702. FEES RELATING TO BIOSIMILAR BIOLOGICAL PRODUCTS.

Subparagraph (B) of section 735(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 379g(1)) is amended by inserting ", including licensure of a biological product under section 351(k) of such Act" before the period at the end.

SEC. 703. AMENDMENTS TO CERTAIN PATENT PROVISIONS.

(a) Section 271(e)(2) of title 35, United States Code is amended—

(1) in subparagraph (A), by striking "or" after "patent,";

(2) in subparagraph (B), by adding "or" after the comma at the end;

(3) by inserting the following after subparagraph (B):

"(C) a statement under section 351(l)(4)(D)(ii) of the Public Health Service Act,"; and

(4) in the matter following subparagraph (C) (as added by paragraph (3)), by inserting before the period the following: ", or if the statement described in subparagraph (C) is provided in connection with an application to obtain a license to engage in the commercial manufacture, use, or sale of a biological product claimed in a patent or the use of which is claimed in a patent before the expiration of such patent".

(b) Section 271(e)(4) of title 35, United States Code, is amended by striking "in paragraph (2)" in both places it appears and inserting "in paragraph (2)(A) or (2)(B)".

The SPEAKER pro tempore. Pursuant to House Resolution 903, the gentleman from Ohio (Mr. BOEHNER) and a Member opposed each will control 30 minutes.

The Chair recognizes the gentleman from Ohio.

□ 2015

Mr. BOEHNER. Mr. Speaker, all of us know that our health care delivery system needs help. There could be broad bipartisan agreement on the kinds of steps that we need to take in order to lower the cost of health care in America and expand access. The bill before us, in my view, is a big government takeover of our health care system that will replace the current health care that Americans get.

Republicans have offered better solutions all year on the major bills that have come to this floor. I think we had a much better solution on the stimulus bill that would have created twice the jobs at half the cost. I think our better solution on the budget clearly had less spending, less debt and lower deficits.

I think our all-of-the-above American energy plan was a much better solution to the national energy tax, the so-called cap-and-trade bill, that was on this floor in June. I believe that what we have before us, as a Republican substitute, is a commonsense plan that takes steps towards reducing the cost of health insurance in America and expand access. Simple things, like allowing people to buy insurance across State lines, allowing groups of individuals or small businesses to group together for the purposes of buying health insurance like big businesses and unions can today. How about getting rid of junk lawsuits that drive up the cost of health care in America and the defensive medicine that doctors have to practice as a result.

I think what we have before us and the bill that we are offering is a commonsense approach that does take major steps in the right direction to bring down the cost of health care and to expand access.

I reserve the balance of my time.

Mr. WAXMAN. Mr. Speaker, I seek to control the time in opposition, and I ask unanimous consent that the time for opposition speakers on the substitute amendment be divided such that the first 10 minutes is controlled by Chairman MILLER of the Committee on Education and Labor; the second 10 minutes is controlled by Chairman RANGEL of the Committee on Ways and Means; and the final 10 minutes is controlled by Chairman WAXMAN of the Committee on Energy and Commerce.

The SPEAKER pro tempore. The gentleman from California (Mr. WAXMAN) is recognized to control the time in opposition.

Without objection, that time will be so divided, subject to the Chair's discretion as to the order of recognition.

There was no objection.

The SPEAKER pro tempore. The Chair recognizes the gentleman from California (Mr. MILLER).

Mr. GEORGE MILLER of California. Mr. Speaker, I yield 2 minutes to the gentleman from New York (Mr. TONKO).

Mr. TONKO. Mr. Speaker, I am here to speak in support of the Affordable Health Care for America Act, one of the most important pieces of legislation this body has considered since the passage of Medicare in 1965 and Social Security in 1935.

Mr. Speaker, every Member of this body has been listening to her or his constituents, and they are saying that they are ready for health insurance reform. They need health insurance reform.

We listened when seniors said they wanted better care from their doctors, and the doughnut hole eliminated. This bill does that. We listened when young adults told us they were having trouble finding insurance and wanted to stay on their parents' insurance until age 27. This bill does that. We listened when the uninsured told us heartbreaking stories about going without needed health care and asked us to give them affordable, quality health care insurance. This bill does that. We listened when the insured told us they were paying too much for insurance and they needed more protections for their health insurance. This bill does that.

Our colleagues on the other side of the aisle have not listened. They are offering a substitute bill that would not accomplish any of the things our constituents have asked for. Instead, they are offering a bill that does not end the discrimination based on preexisting conditions; does not reduce the number of uninsured Americans; does not offer assistance to those struggling to afford health insurance; does not repeal the antitrust exemption for health insurers; and does not stop price gouging by insurance companies. Our bill does all these things and more.

Mr. Speaker, the Affordable Health Care for America Act not only brings quality health care within reach of tens of millions of Americans, it enhances the care that those with insurance and Medicare already receive. This bill is as much about the insured as it is about the uninsured. It is a monumental bill. I urge defeat of the Republican substitute and, indeed, encourage passage of H.R. 3962.

The SPEAKER pro tempore. Without objection, the gentleman from Michigan will control the time on the proponent's side.

There was no objection.

Mr. CAMP. Mr. Speaker, I yield myself 4 minutes.

Mr. Speaker, the American people deserve and demand a commonsense approach to health care reform that, one, makes health care more affordable; two, that guarantees all Americans, regardless of preexisting condition, have access to affordable health care; and, three, does so without raising taxes, without increasing the deficit and without the Federal Government making health care decisions that should be made by patients and doctors.

The Common Sense Health Care Reform and Affordability Act, the House Republican health care bill, does that. The plan offered today by the Speaker does not.

Just some of the highlights of the Republicans' Common Sense Health Care Reform and Affordability Act include:

Lowering health care premiums: The Republican plan will lower health care premiums for American families and small businesses, addressing Americans' number-one priority for health care reform.

According to the Congressional Budget Office, the Republican health care reforms would reduce premiums by up to 3 percent for Americans who get insurance through a large business, up to 8 percent for Americans without employer-sponsored insurance, and up to 10 percent for those working for a small business. CBO has not made a claim that the Democrats' bill would lower premiums at all.

What do these numbers mean? It means families who do not have health insurance in 2016 through their job could buy health insurance that is $5,000 less expensive than the cheapest plan the Democrats offer.

The Republican plan guarantees access to affordable health care for those with preexisting conditions. Republicans create universal access programs that expand and reform high-risk pools and reinsurance programs to guarantee that all Americans, regardless of preexisting conditions or past illnesses, have access to affordable care, while lowering costs for all Americans.

The Republican plan reduces the number of junk lawsuits, which saves taxpayers' money and lowers premiums, by enacting medical liability

reforms modeled after the successful State laws of California and Texas.

The Republican plan prevents insurers from wrongly canceling a policy unless a person commits fraud.

The Republican plan encourages Small Business Health Plans so these employers can pool together and offer health care at lower prices, just as large corporations and labor unions do today.

The Republican plan encourages innovative programs by rewarding States that reduce premiums and the number of uninsured. In comparison, the Democrat bill adds a new unfunded mandate States cannot afford with their over $400 billion expansion of Medicaid.

The Republican plan allows Americans to buy insurance across State lines and find the health care plan that best meets their needs at a cost they can afford.

The Republican plan promotes prevention and wellness by. more than doubling the financial incentives employers may reward employees who adopt healthier lifestyles.

Republicans enhance health savings accounts by allowing Americans to use HSA funds to pay premiums for high deductible health insurance.

And the Republican plan allows dependents to remain on their parents' policies up to the age of 25.

The health insurance reforms in the Republican bill will significantly reduce health care premiums, insure millions of Americans, guarantee those with preexisting conditions have access to quality, affordable care.

We do all of this without raising taxes, without spending $1 trillion we don't have, without cutting Medicare and without putting some new health czar in between doctors and patients, which is what the Democrat majority does in their government takeover bill.

Clearly the bill offered by the Speaker is not what the American people want. Americans are clamoring for lower cost health care and that is what the Republican plan offers.

I urge my colleagues to reject the Democrats' government takeover of health care and vote "yes" on the Republican substitute that will lower health care premiums.

I reserve the balance of my time.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair would remind Members not to traffic the well when another Member is under recognition.

Mr. GEORGE MILLER of California. Mr. Speaker, I yield 2½ minutes to the gentleman from Massachusetts (Mr. TIERNEY), a member of the committee.

Mr. TIERNEY. I thank the gentleman.

Since 1995, when our Republican colleagues held the majority in the House of Representatives, until 2007 when they relinquished that and the voters threw them out, they had done exactly nothing, nothing, with respect to the health care crisis in this country.

Now they want to come in and they want to do something. They want to have you pay less for getting less. This is their great plan.

The one thing they tried to do in 2003 would put pharmaceutical prescription drugs in Medicare which they did by giving seniors a so-called doughnut hole they had to pay for and costing us $600 billion on our current debt.

My friends, the only ones they made happy then were the pharmaceutical companies, and the only ones they want to make happy now are the private insurance companies. They want to try to kill reform. If they can't kill reform, they want to give them this gift of a Republican substitute.

While they sat idle since 1995, family health insurance policies rose from 7 percent of median income to 17 percent. Sixty percent of families reporting bankruptcies did so in part because of health care costs. Forty-six million Americans went uninsured, 85 percent of those in working families.

Small business premiums went up 129 percent. Twenty-eight million of our uninsured are small business owners, employees or their families. Small businesses are projected to lose $52.1 billion going forward in the next decade if we continue on the Republican path of do nothing.

The question is, who is on our side? Who is on the side of the consumers, the individuals, the small businesses and the families, and that is the bill that the Democrats have put forward on this floor. It is affordable; it is health care for every American.

If you compare the two bills, you will see the Congressional Budget Office says the Republicans may—may—save you from 0 to 3 percent on 80 percent of the private premiums.

The Democratic bill saves you 12 percent. The Democratic bill covers 96 percent of Americans. The Republicans in 2019 will leave you exactly where you are today, covering only 83 percent of the people, leaving by that time 52 million uninsured.

We will end the discrimination against people with preexisting conditions. They will study it.

We will have an exchange for small businesses and employees so they get better prices comparable to what large companies have now been able to get. They will do nothing of the kind except let you shop for a place, but to get your insurance it might cost you less because you get less, because you will have a race to the bottom, where insurance companies will be able to avoid consumer protections of States and practice fraud almost indiscriminately. There will be no way of cutting it back. You pay less because you get less.

Mr. CAMP. Mr. Speaker, I yield myself 15 seconds.

When Republicans were in the majority, we passed a children's health initiative; a prescription drug plan for seniors; we put wellness into Medicare; we established portability so people could change jobs and keep their health care; and we established health savings accounts. Our record on health care is strong. What we need is this continuation of this step-by-step approach to comprehensive health care reform.

I would now yield 5 minutes to the distinguished gentleman from Indiana (Mr. PENCE).

Mr. PENCE. Mr. Speaker, I rise in support of the Republican substitute.

After months of overwhelming public opposition to a government takeover of health care, liberal Democrats here in Washington are choosing to ignore the clear voice of the American people, bringing forth a freight train of runaway Federal spending, bloated bureaucracy, mandates and higher taxes.

And even a few courageous Democrats have been willing to speak out. In opposing the bill, the distinguished Democrat chairman of the Armed Services Committee, IKE SKELTON, a man who knew President Truman, said that he, quote, had serious concerns for Missourians who have private insurance plans they like.

And my Democrat colleague, DAN BOREN of Oklahoma, said, and I quote, the worst thing we could do in a recession is raise taxes, and this bill does just that.

□ 2030

As these Democrat colleagues attest, if the Pelosi health care bill passes today, you probably will lose your health insurance, and you might just lose your job. The Pelosi health care plan targets us when we are most vulnerable. Illness, our own, or, more importantly, the illness of a parent, spouse or a child, has the capacity to suspend our priorities. What was important before the crisis grows dim in the harsh light of disease affecting a loved one. The result, little by little, in the midst of a family crisis we yield our freedoms and our resources to the ever-growing appetite of the Federal Government.

But if liberal Democrats think this is what our Nation wants, they don't know the America that I know.

Mike Schwaller is my cousin. He is an extraordinary young man. He has been struggling with cancer, but throughout has maintained his faith in Christ and his courage. He has been an inspiration to us all.

Mike wrote me an email the other day, and he gave me permission to share it. As a cancer patient with limited treatment options, he is awaiting insurance approval for experimental treatment. He seems like just the kind of American that my Democrat colleagues keep telling us want government-run insurance. But they don't know Mike.

As he wrote about his coverage recently, he said, If this was a government bureaucracy, I have no faith that it would be processed in a timely manner, and even then, if it would be approved. The idea of a public health care option, he wrote, as a chronic cancer patient scares the living hell out of me. I feel that at this moment in time you are fighting for me, and my life. Please, please, don't give up or give in.

Michael, we won't.

The truth is, this debate is not just about health care. It is about who we are as a nation. As President Reagan said, it is about "whether we abandon the American revolution and confess that a little intellectual elite in a far distant capital can plan our lives better for us than we can plan them for ourselves."

You know, earlier today I greeted about 50 Hoosiers, mostly in wheelchairs, unit caps and uniforms, down at the World War II Memorial. These heroes were gathered for their first and maybe their only visit to that monument built in their honor.

As I made my way back to the Capitol, I thought about those brave men and what sustained them in those days where the survival of democracy hung in the balance. I believe it must have been because they were fighting for a cause more important than their health or even their lives, and that cause was freedom.

In the coming hours, we are going to take a vote of incalculable significance to the American people, and we will see what our so-called Blue Dog Democrat colleagues are made of. We will see whether Democrats who profess to believe in limited government will take a stand, or whether they will fold under the weight of the Democratic majority in the White House.

Look, I know from personal experience, it is no easy thing to take on your President or your party on a major piece of legislation. But let me assure my colleagues, decent Americans all, if you will take this stand for freedom, for the right to live and work and care for a family without the unnecessary intrusion of the government, I believe with all my heart that you will know for the rest of your lives just what those men in wheelchairs have known every day since they came home, that when freedom hung in the balance, you did freedom's work, and the American people will never forget it.

Mr. GEORGE MILLER of California. I yield 1½ minutes to the gentleman from Virginia (Mr. SCOTT), a member of the committee.

Mr. SCOTT of Virginia. Mr. Speaker, all afternoon we have heard about the freedom to be uninsured. Seniors in my district do not want us to repeal government-run Medicare so that they can enjoy a freedom to be uninsured, and those without insurance now do not view themselves as enjoying some freedom. They want insurance.

The Republican substitute responds to the comprehensive Affordable Healthcare for America Act with a bill that fails to reduce costs, fails to cover uninsured Americans, and it may study, but it does not help, those with preexisting conditions. It does, however, attack innocent victims of medical malpractice.

One recent study showed that medical malpractice represents less than one-third of one percent of all health care costs, and yet the Republican substitute seeks to blame our broken health care insurance system on innocent victims of malpractice. For those victims, the bill limits the ability to hire a lawyer, complicates the lawsuit, shifts the cost of medical malpractice from the doctor to the victim's own private insurance, and, in some cases, causes the injured victims to lose the right to sue before they even know they have been injured.

None of these unfair provisions were passed during previous attempts when the Republicans controlled the House, the Senate and the White House, and they should not be passed now.

The substitute should be defeated.

Mr. CAMP. Mr. Speaker, I yield 3 minutes to the distinguished gentleman from Michigan (Mr. MCCOTTER).

Mr. MCCOTTER. I thank the gentleman.

Mr. Speaker, as the health redistribution bill before us attempts to put its skid marks on history, it further proves Democrats are the party of the past. Their antiquated government-run takeover of Americans' health care is as ill-suited to our times as a leeching is to laser surgery.

We do not live on a government-run globe. We live in a people-powered world, one belatedly awakening to America's revolutionary experiment in human freedom and self-government. Today, from the palms of our hands, we can traverse distant strands of Earth to access friends and goods. Why in the world would we put in the palm of a bureaucrat's hand our health care?

Yet, this is precisely what the hoary voices of hidebound ideologues demand; namely, that our generation's innovation revolution and its unprecedented expansion of human empowerment be buried beneath big government.

They are gravely mistaken. Amidst our constantly changing and challenging times during this age of globalization, our generation's innovation revolution is burying big government in the ash bin of history.

Thus, the public and Republicans oppose the Democrat's fossilized model of a mammoth government-run takeover of Americans' health care. Instead, we embrace and harness our generation's innovation revolution to empower Americans as citizens and consumers and advance patient-centered wellness.

Our plan will increase the supply of health care to meet rising demand and reduce costs through such sensible, affordable, and helpful reforms as ending exclusions for preexisting conditions, reforming medical liability laws, expanding Health Savings Accounts, allowing small businesses to band together to provide coverage for employees, permitting health insurance sales across State lines, and incentivizing preventative health care and wellness.

All this can be achieved without trillions of dollars in new spending, taxes, deficit and debt, and without big government controlling your health care decisions.

Trapped in the past, there are those who ignore behind closed doors the opportunities of our age. If Democrats impose their government-run takeover of health care on the American people, the consequences will be higher costs, lower quality, fewer choices, and lost jobs during this painful recession.

But for those with an abiding faith in our free Republic's people and their future, there is a better way—maximizing America's innovation revolution to advance patient-centered wellness in our people-powered world.

Pray we do.

Mr. GEORGE MILLER of California. I yield 2 minutes to the gentleman from New Jersey (Mr. ANDREWS), a member of the committee.

Mr. ANDREWS. Mr. Speaker, when you can't win an argument on the facts, you resort to emotion. The minority can't win the argument with insured people because they preserve the right of insurance companies to discriminate on the basis of preexisting conditions.

They can't win the argument with senior citizens because they ignore the doughnut hole that they created in 2003 in the Medicare part D.

And they don't ignore the uninsured. I will give them some credit for that. There are going to be 50 million uninsured in 2010. They do change that. Their plan would make it 55 million uninsured 10 years from now.

So they are standing on a motion, and we hear a Member say this: "We cannot stand idly by now, as the Nation is urged to embark on an ill-conceived adventure in government medicine, the end of which no one can see, and from which the patient is certain to be the ultimate sufferer."

But the Member wasn't a current Member, and the time wasn't now, and the issue wasn't this bill. The Member was Durward Hall, the time was 1965, and the issue was Medicare.

They were wrong then, they are wrong now, and their substitute is wrong. You should vote no.

Mr. GEORGE MILLER of California. I yield myself 2 minutes.

Mr. Speaker, if the Republicans' health care plan was a plan for a fire department, they would rush into a

burning building, and they would rush out and leave everybody behind. If their plan was an evacuation plan, it would be like Katrina. When they got all done evacuating people, they left them all behind.

They say their plan is inexpensive. They say their plan saves somebody money. But 10 years from now there are as many uninsured as there are now.

At the end of their watch, after 12 years of control of this Congress, 8 years of control of the White House at the same time, they left behind 37 million Americans without health insurance. That is what they left behind on their watch. Now they come forth with a plan for the future, and over the next decade they are going to leave behind 50 million Americans.

Want to buy it? Want to try it? Want to sell it? Come on, America. Buy this one. You are guaranteed to be left behind if you are left behind today.

What a plan. Ha. God save us.

Mr. CAMP. At this time I yield 3 minutes to the distinguished gentleman from Texas (Mr. BARTON), the ranking member of the Energy and Commerce Committee.

Mr. BARTON of Texas. Mr. Speaker, I asked to go after the distinguished chairman of the Education and Labor Committee because what we have here is a failure to communicate, or perhaps a difference in philosophy.

The Democrats have decided that the bottom line is coverage. By golly, coverage no matter what. Whether you want to be covered or not, you are going to be. We are going to have an employer mandate. We are going to have an employee mandate and an individual mandate. We are going to have a premium mandate.

We are going to have how you cover the insurance, a "comparative research council," to dictate the practice of medicine. We are going to raise Medicaid to 150 percent of poverty, and automatically enroll every individual in this country who is unmarried, whether they want to be or not.

We are going to tell every young American who has decided that they don't want to pay those premiums, they want to save up to get married or to buy a home, that, by golly, they are going to have to take insurance, and they are going to pay three to four times what they would under the current system because there is only a two-to-one ratio. So they are going to get their coverage, at a cost of $1.2 trillion.

Now, we have a different philosophy. We think you need to control costs, but we also agree that you have to provide access to the private insurance market if you can't get it today and you want it.

Congressman MILLER talks about the 40 to 50 million Americans that are not insured, and he is right. But of those 40 to 50 million, 15 to 20 million are in this country illegally. Ten or 15 million are young Americans who don't want insurance.

When you really boil it down, there are 5 to 10 million Americans who have a preexisting condition or work where insurance is not provided and they can't afford it.

□ 2045

Our plan covers them. It gives them the opportunity. That doesn't give them the money, but it gives them the opportunity. So we have a difference in a philosophy.

We don't believe in mandates and make no apology about it, but we do believe in the individual opportunity. We believe in individual choice. We believe in the American system of free enterprise. We believe in lowered taxes, and we believe in a plan that's going to lower premiums an average of $5,000 per person per year for the next 10 years. That's what CBO says. That's not me. That's the CBO.

So there is a choice. Bigger government, more mandates, more control, less freedom, or lower costs, more opportunity, more freedom, more choice. I vote for more freedom.

Vote "no" on the Big Government plan. Vote "yes" on the individual opportunity plan.

Mr. RANGEL. At this time, I yield 1 minute to the gentleman from California (Mr. STARK), the chairman of the Ways and Means Subcommittee on Health.

I would like to take this time to thank him for the great work he's done over the years, not just for our committee, but for this Congress, and I would like to thank him publicly.

Mr. STARK. I thank the chairman for yielding.

Mr. Speaker, the Republican substitute is not a substitute on health reform. It substitutes gifts to the wealthy insurance companies for morality and dignity. Their bill spends $61 billion over the next decade, and what would the American public get for that investment? It would get 5 million more uninsured people than we have in America today. That's not a conservative solution. It's no solution at all.

Our legislation expands coverage to 36 million more Americans, reforms the insurance market to end abusive practices, provides financial assistance to lower-income and middle-income families, creates a public health insurance option that will make health insurance companies compete on quality, provides security for our seniors, and protects our children's futures by not adding one dime to the deficit.

A vote for the Republican substitute is nothing more than a vote for transferring money to wealthy insurance companies. Vote "no" on the Republican substitute and "yes" to provide affordable, quality health care for all Americans.

Mr. CAMP. At this time, I yield 1 minute to the gentleman from South Carolina (Mr. BROWN).

Mr. BROWN of South Carolina. Mr. Speaker, I rise in strong support of the Republican amendment and true health care reform. Our plan makes the cost-saving changes so sorely needed in our health care system without forcing our children and grandchildren into unending debt.

This amendment will allow insurance to be bought across State lines to drive down costs and allow small businesses to band together in order to negotiate fair and affordable coverage. Furthermore, this amendment improves quality, putting you and your doctor in charge of your care by removing the powers of insurance companies and trial lawyers.

Finally, this amendment ensures that the taxpayer dollars my constituents in South Carolina's First Congressional District pay into the Federal Treasury never find their way into abortion clinics.

Mr. Speaker, Republicans have a better plan. I urge all of my colleagues to support this amendment and urge them to vote "no" on final passage.

Mr. RANGEL. Mr. Speaker, I yield 2 minutes to the gentleman from Washington, Dr. MCDERMOTT, who worked his whole career down here to improve the quality of health care for all Americans.

Mr. MCDERMOTT. Mr. Speaker, the Republican health plan and proposal has been in effect since 1995. A friend of mine came to New York, had some problems, got on the phone to call a doctor, and the first question that is always asked is what kind of insurance do you have. When he said he didn't have any, they said, Well, we can't take care of you unless you come to the office with $250 in cash. We'll see you if you do that. He said, I don't have that kind of money. They said, Then go to the emergency room. That's where 50 million people in this country are today. Go to the emergency room if you can't come with the cash to hand it to the doctor.

My office phone today has been ringing off the hook with people demanding that we have health care now. The Republican alternative doesn't help anyone, except protects the insurance companies. The bankruptcy of this plan is pretty clear to everybody. Health analysts, the media, The New York Times, the CBO all agree that the Republican plan would leave 42 million people with nothing.

Now, the Republican plan does nothing to help the seniors. It really isn't a plan. It's just a bunch of stuff they scraped up off the floor that they had laying around for 12 years and did nothing.

Now, why don't they put forward a plan? Well, I will tell you. I've cracked the code. This plan they brought out

here, they either haven't read their own bill—because you couldn't keep a straight face and come out here and say it was a plan—or they would rather spend more time hating government than helping people. Remember what they did in New Orleans. That's what their attitude about government is. Don't make it work for the people. Just let people understand, You're on your own, folks. That's our plan. We believe in freedom; you're free to be on your own. But most people can't take care of their health care problems on their own. They're lucky if they can.

Vote against this proposal, and vote for the bill.

The phones in my office have been ringing off the hook because my constituents want secure quality affordable healthcare now. Meanwhile the Republicans have put forward an alternative that doesn't help anyone but protect insurance companies.

The bankruptcy of the Republican plan is not just my opinion—analysts, the media, and the Congressional Budget Office all agree the Republican plan will leave 42 million out in the cold. The Republican plan does nothing to help people with pre-existing conditions or to help seniors. The Republican plan is no plan.

How could they have put forward a plan that doesn't solve any of the healthcare problems Americans face? Well, I may have cracked the code. Either they haven't read their own bill or they'd rather spend more time hating government than helping people.

The Republican approach is just a continuation of the status quo while the Democratic plan covers 96% of Americans. My constituents have demanded action. The time is now.

Mr. RANGEL. No one has worked harder on this bill than Congressman Lloyd Doggett from Texas, and it's my honor to now yield 2 minutes to the gentleman.

Mr. DOGGETT. To help cover huge medical bills in Bastrop, Texas, they held a Main Street pancake supper, an auction at the American Legion. Well, essential health care shouldn't depend on the kindness of strangers or the goodness of neighbors and certainly not on the "just say no" of the Republican Party or the weak TEA parties brewed up by the insurance lobby.

Now, belatedly, they offer a scheme as skimpy as a hospital gown. They do nothing to help seniors. Their proposal is inefficient, it's ineffective, and it's wasteful. Masquerading as reform, their bill authorizes insurers to continue denying coverage for preexisting health conditions, such as acne or a C-section. Republican obstructionism has itself become one giant preexisting condition to meaningful change.

This is a typical old-time Republican medicine show. Do a little bit for 5 percent of the people. Do nothing for the other 95 percent of the uninsured, and leave the portion of American families who are uninsured the same tomorrow as today. The only thing they propose more of is more insurance policy loopholes.

Freedom. They want the freedom to go broke after a medical emergency, the freedom to have more bankruptcies, medical bills—the number one cause of personal bankruptcy in America today. We cannot secure bipartisan support for health insurance reform tonight because they don't support any real solutions for the uninsured.

Our Democratic plan is a lifesaver for 12 times as many Americans, and it's a dollar saver, responsibly reducing the national debt by $36 billion more than this phony Republican scheme.

Now is the time for a truly historic choice. The Republicans have chosen to side again with the big insurance monopolies. We choose to strengthen Medicare. We chose to stand up for the millions of struggling families who have been denied health care access for too long.

Mr. RANGEL. Could I ask how much time I have remaining, Mr. Speaker?

The SPEAKER pro tempore. The gentleman from New York has 5 minutes remaining.

Mr. RANGEL. I yield 2 minutes of that time to the gentleman from Oregon (Mr. BLUMENAUER) and ask him to share the great contribution he has made and the loopholes we find in the Republican substitute.

Mr. BLUMENAUER. I appreciate the gentleman's courtesy.

I hope every American examines the plan that has been offered to us by the Republicans.

Our citizens are outraged by practices of taking away insurance when you need it or denying coverage for preexisting conditions. Our bill fixes it. You won't find it in the Republican bill. Republicans strip out provisions so important to Oregon and other low-cost, high-quality States. Republicans do not deal with those vast regional disparities.

They ignore the extra costs faced by seniors caught in the prescription drug doughnut hole while Democrats provide financial relief within the next 2 months. If Republicans have their way, there will be more uninsured Americans in 10 years than there are today. Weaker protections ignore the needs of the most vulnerable, yet the CBO says the Republican plan will increase the deficit by $36 billion more than the Democratic plan.

Mr. Speaker, this is a colossal failure of imagination. The Republicans could have passed this package any time during the 6 years they and George Bush ran everything. They didn't bother because it wasn't worth it.

Last March, Republican Minority Leader BOEHNER famously said that his Members shouldn't legislate. With this package as the best they could do, the Republicans have met the challenge not to legislate.

Mr. CAMP. Mr. Speaker, at this time, I yield 3 minutes to the gentleman from Missouri (Mr. BLUNT).

Mr. BLUNT. Mr. Speaker, I thank the gentleman for yielding.

The Republican Congresses did send important parts of this plan, the House, to the other body. We sent lawsuit abuse reform seven times. We sent associated health plans at least a half dozen times. They didn't get to the floor. We continue to send the elements of this plan that save every taxpayer money and also save every insured American money. This is the only plan that reduces the cost of insurance for every group of insured Americans.

One of the goals that the President set for health care reform was to reduce the cost of premiums. This is the only plan that does that. It does it for individuals. It does it for small businesses. It does it for large groups.

This is a plan where we could provide access to coverage for everyone regardless of preexisting conditions. Now, we don't spend $1.3 trillion to do that. We spend about $23 billion to make the risk pools work better and ensure access for everybody. We're for access for everybody to coverage; we're just not for spending $1 trillion to create that access.

This plan lowers premiums. It prohibits insurance companies from canceling policies. It prohibits insurance companies from capping the lifetime expenditures that those policies might incur.

One of the reasons that there were more people uninsured at the end of the 10 years under this plan is, when our friends on the other side insisted on the children's health insurance plan, they put everybody that goes on that plan in the first 5 years back into no insurance in the last 5 years. Look at the numbers. That's where those numbers go up. You could pretend that our plan puts the numbers up. We're not the one that said we're going to insure all children for 5 years and in the second 5 years they're back to where they are today. Check the numbers. Look at what this does for premiums. Look at what this does for families. Look at what this does for individuals.

This is a plan that truly does keep what works and fixes what's broken. The President repeatedly has said, Everyone, if you like what you have, you should be able to keep it. This is the only plan that would allow that pledge to be made and be kept.

Mr. Speaker, I encourage my colleagues to support this plan. Let's take these first steps that work without bankrupting the American people. I urge support of this plan.

The SPEAKER pro tempore. The gentleman from New York has 3½ minutes remaining.

Mr. RANGEL. Mr. Speaker, I yield 2 minutes to the gentleman from Wisconsin, RON KIND, and thank him for the great contributions he has made to looking at health care the way it should be, and that is value and not volume.

□ 2100

Mr. KIND. Mr. Speaker, let's be clear. We really face three choices here tonight: our plan, their plan, and the consequences of doing nothing.

But we know what inaction will bring already. We will pay more, we will get less, and we will bankrupt ourselves as a Nation due to rising health care costs. So let's just take a moment and compare the two plans before us this evening.

According to the Congressional Budget Office, not only is our health care reform plan completely paid for, but we reduce the national deficit by $109 billion in the first 10 years alone; they by only $68 billion. We cover an additional 36 million uninsured Americans in this country; they increase the number of uninsured from 47 million today to over 52 million by 2019. We cover 96 percent of Americans under our plan; they, 83 percent. We give small businesses tax credits to use in the national exchange to make it more affordable for them; they do nothing. We ban the discrimination based on preexisting conditions; they do nothing. We close the doughnut hole for seniors in Medicare; they do nothing.

But, most importantly, they do nothing to reform how health care is delivered and how we pay for it in this country. We change the fee-for-service payment under Medicare, which is all volume based, to a reimbursement system that rewards quality and the value of care. Why is this important? Because studies show that we are spending over $800 billion every year on tests and procedures that don't work. They don't improve patient care, and because of overtreatment in too many instances, we're making patients worse off rather than better off.

Our payment reform plan has the best potential of increasing the quality of care for all Americans at a substantially lower price. They do nothing.

Mr. Speaker, just 2 months ago President Obama stood in this Chamber and reminded us what the true character of the American spirit is all about. He reminded us that we did not come here to fear our future, but to shape it. That is the historic opportunity that we have before us this evening.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. RANGEL. I yield the gentleman an additional 30 seconds.

Mr. KIND. I thank the gentleman.

I ask my colleagues to support true reform and provide all Americans with access to affordable and quality care that they all deserve.

Mr. RANGEL. Mr. Speaker, I yield myself the balance of my time.

I'm not going to be as difficult with the Republicans as some of my colleagues because I'm glad at the end of the day they finally understood the problem. And even though it was only Tuesday that they actually put something together for us to look at, at least we know that some of them are going in the right direction.

It's going to be tragic to explain this to the American people not only now but in the future as to when they had a great opportunity. They lost it on Social Security. They said government would become too big. They lost it on Medicaid. They said that would be too much for the poor folks, that they should have freedom instead of health care. And they certainly lost it in Medicare where they made it appear as though it was going to be a Big Government takeover.

And now it just seems to me that they've proven how well government can do in these programs. And the fact that in lieu of just plain freedom, in lieu of telling people that they can get insurance if they're at risk, the whole idea that they're proud of people who cannot afford to do this at least to have the opportunity to do it.

So, Mr. Speaker, I just hope that some of those on the other side might allow morality to go beyond just party loyalty.

At this time it gives me pleasure to present to this body Chairman WAXMAN, who has done so much to make this a reality.

Mr. CAMP. Mr. Speaker, I reserve the balance of my time.

Mr. WAXMAN. Mr. Speaker, I'm pleased to yield 1 minute to the gentleman from Vermont (Mr. WELCH).

Mr. WELCH. Mr. Speaker, tonight the question before Congress is neither new nor complicated: Will we do what it takes to make health care affordable and available to all Americans?

Our predecessors in Congress faced similar choices when they extended voting rights to all Americans, established Social Security and Medicare for all seniors. Mr. Speaker, Congress faced those challenges and we are the better for it. We did so not without conflict and controversy but with some bipartisan support.

Tonight is different, unique. Our Republican friends have assured us that not a single member of their caucus will vote for health care reform. Every single person will vote "no."

The Republicans' alternative says to Americans with a preexisting condition, you are on your own. To the 47 million Americans without insurance, you're on your own. To the millions of Americans who can't afford the coverage that they have, you're on your own.

Our health care bill has a different philosophy, the one that prevailed when Democrats, and some Republicans, passed Social Security, voting rights, and Medicare: We are in it together.

Mr. WAXMAN. Mr. Speaker, I'm pleased to yield 2 minutes to a very distinguished member of our committee, the chairman of the Energy Subcommittee, previously chairman of the Telecommunications Subcommittee, and a very highly respected Member of this body, the gentleman from Massachusetts (Mr. MARKEY).

Mr. MARKEY of Massachusetts. The Republican plan is really quite simple: you're on your own.

The Republican plan tells Americans if you get sick and you don't have insurance, you're on your own. The Republican plan tells Americans if you are denied coverage because of a preexisting condition, you're on your own.

The Republican leaders in Washington seem to be suffering from their own preexisting condition: a heart of stone. If you kicked them in the heart, you would break your toe.

They say that the Democratic plan will put the government between you and your doctor, but the doctors who make up the American Medical Association support the Democratic bill and not the Republican bill. The Republicans claim the Democratic bill will hurt seniors, but AARP has endorsed the Democratic bill and not the Republican bill. Why does AARP support the Democratic bill? Because the Democratic bill will close the Medicare part D doughnut hole for seniors. The Republican bill does not. We provide support for low-income seniors; they do not. We will extend the solvency of Medicare; they do not. Right now 60 percent of all bankruptcies in America are because of medical expenses. The Democratic bill makes sure that never happens again; the Republican bill does not.

You know, the GOP used to stand for Grand Old Party. Now it stands for "grandstand, oppose, and pretend." They grandstand with phony claims about nonexistent death panels. They oppose any real reform. And with this substitute they pretend to offer a solution while really doing nothing. GOP: grandstand, oppose, and pretend.

And make no mistake about it, the Republican substitute is not real reform. It does nothing to curb skyrocketing health care costs. It does nothing to provide real insurance coverage to millions who are now uninsured. It does nothing to stop the unfair practices of insurance companies.

I urge my colleagues to vote "no" on the Republican "do-nothing" substitute.

Mr. CAMP. Mr. Speaker, I yield 1 minute to the gentleman from Florida (Mr. MICA).

Mr. MICA. Mr. Speaker, this is a sad day for the Congress and particularly a sad day for Americans who lack health care coverage. While Democrat efforts to resolve health care problems may be well intended, in fact they totally miss the mark. People want lower premiums, increased access, less cost, and less red tape. They want choice and quality health care.

Instead, the Democrat health care plan dramatically expands government, cuts Medicare, and imposes significant costs to taxpayers. The creation of 118 new Federal programs, agencies, and czars adds bureaucracy and red tape rather than providing a cure to bring health care costs down and accessibility up. The $729 billion in new taxes on Americans and small businesses will result in a loss of 5.5 million more jobs at a time when our country can least afford it and unemployment has topped a record 10.2 percent.

I oppose the cuts of nearly a half trillion dollars in Medicare. This is the wrong solution at the wrong time.

Mr. WAXMAN. Mr. Speaker, I'm pleased at this time to yield 1 minute to the gentleman from Texas (Mr. GONZALEZ).

Mr. GONZALEZ. Mr. Speaker, I rise in strong opposition to the substitute.

This substitute includes medical liability reforms that draw on the Texas model. I'm from Texas. Let me tell you about the Texas experience.

We were promised that medical malpractice reform in Texas would result in attracting doctors to underserved areas. Today, Texas ranks 43rd out of the 50 States in the number of doctors per capita.

We were promised that it would rein in health costs. Health care costs in Texas with Medicare alone rose 24 percent in the 3 years after Texas tort reform.

We were told that it would reduce the cost of health care insurance for Texans. Premiums actually increased 86.8 percent from the years 2000 to 2007. The average insurance policy for a family in Texas went from $6,638 to $12,403.

We were told that it would make health insurance plans more readily available for Texans. Today, Texas has the highest rate of uninsured adults and the highest rate of uninsured children.

If ever there was a time not to mess with Texas, it is tonight. Vote "no" on the substitute.

Mr. WAXMAN. Mr. Speaker, I'm pleased at this time to yield 2 minutes to the gentleman from New York (Mr. WEINER), an important member of our committee and a leader in health care reform.

Mr. WEINER. You know, there are honorable people on both sides of this debate; but there are moments that come along, and they come along about every generation or so, that make it clear why this side of the aisle are Republicans and why we're Democrats.

In 1935 when there was the Social Security Act and we decided we weren't going to allow 30 percent of seniors to slip into poverty, Democrats proposed, Democrats passed; Republicans opposed Social Security.

In 1965 when Medicare was passed, Democrats proposed, Democrats supported; Republicans opposed, and now Medicare is a fact of life. And the very same arguments that were made against Medicare then are being made tonight.

I hear this talk about the single-payer plan that's going to creep over. I can tell you I wanted a single-payer plan. I would like it to be there, but it's not. But you opposed it then, and now you claim to support it.

There's been a lot of talk about how big the bill is, but here's what it's all about: this is what Members of Congress get. This is a guidebook with affordable health care plans, many choices, deep discounts because we pool people together, minimum standards for each plan. This is what Members of Congress get, but they don't want you, the American people, to get it.

This is what it's about: they say they want to protect Medicare, but it was they who wanted to eliminate it. They say they want to protect Social Security. It was they who wanted to privatize it. Now they say we don't want to cover those who are uninsured because you shouldn't care.

Well, I say to my colleagues, who pay those bills? The bill fairy? Who pays those bills are you, the taxpayer. They say they want you to pay those, too.

When you look at how big the bills are, remember this document. Eight million Americans who work for the Federal Government, including my colleagues, get this document in the mail. They get good health care. We want it for you. They're going to get Medicare at 65. They don't say we don't want Medicare because we don't believe in single-payer. They want it because they want to take and take and take, but they don't want it for you.

The Democrats want this for you and the Republican Party just wants it for themselves.

□ 2115

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair would remind Members to address their remarks to the Chair.

Mr. CAMP. Mr. Speaker, I yield myself 15 seconds.

As a Senator from Maine who voted for the Senate finance bill remarked on the House legislation pending said, I do not know what world they live in, but all I know is it is totally detached from the average person, the average business owner who is struggling to keep their doors open, and to have that level of taxation is breathtaking in its dimension. I just think it is so out of proportion with reality, with Main Street, America, that it is hard to believe, frankly.

I now yield 5 minutes to a distinguished member of the Ways and Means Committee, the distinguished minority whip from Virginia (Mr. CANTOR).

Mr. CANTOR. Mr. Speaker, today brings the culmination of an extensive and spirited debate over health care reform. Both parties agree that the status quo is unacceptable. Obviously, we disagree on how to fix what is broken. And as the gentleman from New York just said, there are times in this body when we really can tell the difference between us Republicans and you Democrats, and this is certainly one of them.

Mr. Speaker, the Democrat solution is a 1,990-page, trillion-dollar overhaul of the health care system we know, a sweeping new entitlement that raises taxes, cuts benefits to seniors and, Mr. Speaker, it spends over a trillion dollars that we don't have.

Republicans believe there is a better way. We have proposed an alternative approach that offers a stark contrast to the majority's plan. It is a fiscally responsible and reasoned approach.

The majority's proposal overturns the whole system. We keep what works and then try to fix what is wrong.

Their bill puts the government between families and their doctors. Ours doesn't.

Their plan cuts Medicare benefits to seniors. Ours retains them.

Their proposal blows a hole in the deficit. Ours actually saves money.

Their bill imposes penalties and mandates on our small businesses that cost jobs. Ours does not.

Specifically, Mr. Speaker, our bill will help you access health care if you lose or change your job. And it will ensure that you have access to medical care if you have a preexisting condition. And we also, Mr. Speaker, deliver on something that the majority refuses to even talk about, and that's real, meaningful medical liability reform.

And most importantly, Mr. Speaker, we produce cost savings for workers, families, and small businesses. The Congressional Budget Office says that the Democrats' new government-run system won't reduce costs. CBO says our legislation lowers health care costs. In fact, CBO says that the Republican plan cuts premiums by up to 10 percent for employees covered by small businesses, up to 8 percent for those not covered by employers, and up to 3 percent for employees covered by large businesses.

Mr. Speaker, in the face of 10.2 percent unemployment, Americans want jobs. They want less government spending and more economic security. The majority's bill shows they have not listened. Ours shows we have.

Interestingly, Mr. Speaker, the only bipartisanship on Capitol Hill today will be in opposition to Speaker PELOSI's trillion-dollar-plus government overhaul of America's health care system.

With that, Mr. Speaker, I urge passage of this substitute.

Mr. WAXMAN. Mr. Speaker, I ask unanimous consent that the 2 minutes that has been reserved for the Education and Labor Committee debate

time in opposition to the Republican substitute be transferred to the Energy and Commerce Committee's time.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

There was no objection.

Mr. WAXMAN. Mr. Speaker, at this time I yield 1 minute to the gentlewoman from the District of Columbia (Ms. NORTON).

Ms. NORTON. Mr. Speaker, I thank the gentleman for yielding and for the extraordinary work that he and others have done on this bill.

The extraordinary diversity of our Democratic Caucus, Mr. Speaker, from right to left, has ensured that this bill represents a cross-section of our country, urban, suburban and rural. The incredible diversity of our Democratic Caucus, representing Republicans, right-leaning, moderate, and progressive areas meant that we could not come to this floor today without a bill that sensitively put all of America together into one convincing bill. That is why we have produced a bill that satisfies deficit hawks who are more wary of increasing deficits than of most other issues, as well as single-payer advocates who believe that only Medicare for all can markedly reduce costs while providing adequate health care for the middle class and the uninsured.

Thus, there can be no doubt this evening that the Affordable Health Care for America Act is a balanced bill and the best bill for the citizens of the United States of America.

The extraordinary diversity of our Democratic Caucus—from right to left has ensured that this bill represents a cross-section of the our country—urban, suburban, and rural. The incredible diversity of our Democratic Caucus, representing Republican, right-leaning, moderate, and progressive areas, meant that we could come to this floor today only with a bill that sensitively put all of America together into one convincing bill. That is why we have produced a bill that satisfies deficit hawks, who are more wary of increasing deficits than of most other issues, as well as single-payer advocates, who believe that only Medicare for all can markedly reduce costs while providing adequate health care to the middle class and the uninsured. Thus, there can be no doubt that the Affordable Health Care for America Act is the best bill for the citizens of the United States of America.

The bill's greatest achievements are that it would reduce the deficit over the next 10 years and into the future while covering 96 percent of the American people; would end discrimination by insurers who dropped or refused to renew or sell coverage because of health status and would ensure that coverage is affordable by providing subsidies for people in employer-based health care or through an insurance exchange of private insurers and a consumer option to drive down the cost of health care while operating on a level playing field with other insurers.

PARLIAMENTARY INQUIRY

Mr. GOHMERT. Parliamentary inquiry.

The SPEAKER pro tempore. The gentleman will state his parliamentary inquiry.

Mr. GOHMERT. Mr. Speaker, my understanding of the rules is that there is required to be a copy of the bill, and since we have a manager's amendment, that is supposed to be somewhere. A number of us have been trying to find a copy of the manager's amendment since we are going to be voting on it. I hear some aahs, but isn't there supposed to be a copy, and if so, where would that copy be, since we are about to do this to the American people?

The SPEAKER pro tempore. The official papers are at the desk.

Mr. GOHMERT. And I was just at the desk, Mr. Speaker, so parliamentary inquiry: If you could direct me to that place on the desk where the 200 pages are, it would be very helpful.

The SPEAKER pro tempore. The Clerk has the official papers. Additional copies are in the lobby and Members have been carrying them around all day.

Mr. GOHMERT. Parliamentary inquiry. Does the Speaker know where a copy, as the rule requires, is at the desk so that we can come up and see it at the desk as a requirement of the rules?

The SPEAKER pro tempore. The Clerk has custody of the official papers.

Mr. GOHMERT. I take that as a "no."

The SPEAKER pro tempore. The gentleman from Michigan has 4 minutes remaining, and the gentleman from California has the right to close.

Mr. CAMP. We will reserve our time.

Mr. WAXMAN. We are ready to close, so use your time. Use it or lose it.

Mr. CAMP. At this time, Mr. Speaker, I yield the customary 1 minute to the distinguished minority leader, the gentleman from Ohio (Mr. BOEHNER).

Mr. BOEHNER. Let me thank my colleague for yielding, and thank him and our ranking members for the job they have done putting our substitute together.

Ladies and gentlemen, before I came here, I ran a small business. While I was running my small business, it became pretty clear to me that government was growing in my view out of control. More regulations, more taxes, more compliance costs, both for my suppliers, for my customers, and for my own little small business. It seemed to me that government was choking the goose that was laying the golden egg.

You know, we were all lucky enough to be raised in America, most of us born in America, the greatest country in the world. And it is a great country because Americans have had the freedom, the freedom to succeed, the freedom of opportunity. But I think all of us can understand that the bigger government gets, the more that it takes from the American people, the more money that individuals have to spend to comply with all of these regulations, is less money that is left in American families' pockets, small business's pockets, and as a result the opportunities, the opportunities available for our citizens get diminished.

We live in a great country. But it can only be great if we are willing to allow the freedom that Americans have had to succeed to remain. That freedom has been dimming. The bright lights of freedom have been dimming for decades because government continues to grow. One only has to look at what has happened this year to wonder why we are here tonight doing this. We all know we have had a difficult economic shock in our country over the last year.

So we see a stimulus bill that came to this floor with a promise that we were going to create jobs, jobs, jobs. And unemployment wasn't going to exceed 8 percent. Now we have unemployment rates at 10.2 percent and over 3 million Americans have lost their jobs. So all of a sudden we have a budget on the floor, a trillion-and-a-half-dollar deficit this year, and trillion-dollar deficits on average for as far as the eye can see. And I don't think there is a Member on either side of the aisle who doesn't realize that this is unsustainable, that this will wreak havoc on our country and wreak havoc on the future for our kids and our grandkids.

If there is one obligation that we have, it is to ensure that the American dream that is available to all of us is available for our kids and our grandkids. And trillion-dollar deficits for as far as the eye can see are not sustainable and will ruin their future.

But no, it wasn't enough. All of a sudden we have to have this national energy tax on the floor in June. It is called cap-and-trade because no one in America really knows what that means, but it is a giant energy tax. And it would tax anybody who drives a car, anybody who works at a place that uses electricity. Anyone who would have the audacity to flip on a light switch is going to pay a higher tax.

□ 2130

Not only are we going to pay higher taxes and have less energy and higher energy costs in America, it will ship millions of American jobs overseas at a time when Americans are asking, Where are the jobs? And the policies that have been coming down the pike all year have done nothing more than diminish the possibility that we will be creating the jobs that Americans so desperately want. That still wasn't enough. Now we are going to bring this 2,000-page bill to the floor of the House. It's going to cost over $1.3 trillion and will kill millions more American jobs.

The American people want us to focus on getting our economy moving

again because they are looking for work. They want to make sure that those who have their job can keep it. What has happened here all year is we're moving policies that are going to destroy the ability of the private sector to create those jobs. But I don't think there is anything that will diminish the job prospect in America more, of all the things that have happened this year, than this health care bill.

Now, you just think about this bill that we have in front of us. It is going to raise taxes. It is going to raise insurance premiums for those who have insurance. It's full of mandates. And as if that's not enough, we are going to cut Medicare.

Now, the President said that if you like the health insurance you have, you can keep it. And I know the President was sincere in that, but that is not what this bill represents and there's not a Member in this Chamber that doesn't understand that. Because if you're a Medicare Advantage enrollee, like 27,000 of my constituents, the Congressional Budget Office says that 80 percent of them are going to lose their Medicare Advantage.

If you look at this bill and you look at the employer mandate in this bill, you will find out that if employers don't provide health insurance, there is a tax. And for many employers, the tax will be cheaper than the actual cost of health insurance. A lot of employers in America are going to look up and say, Listen, I'd rather pay the tax, and my employees are going to have to go fend for themselves and end up in the government plan.

But it doesn't stop there. This bill also requires that every employer plan that is offered today has to be approved once again by the Department of Labor and the health choices czar; big compliance cost there. Some employers are going to say, Listen, this isn't worth it. Because it's not just getting the plan reapproved again. It has to go through the health choices czar so that the health choices czar can determine whether your plan is adequate according to some Federal bureaucrat. And so a lot of employers, they're just going to get out of it. They're not going to do it. And what is going to happen to those employees who like the coverage they have today? They are going to end up in the government plan.

But no, no, it doesn't stop there. We have an individual mandate in this bill in front of us that says every American is going to buy health insurance whether you want it or not. And if you don't want it, you're going to pay a tax. And if you don't pay the tax—listen to this. If you don't pay the tax, you're going to be subject to a fine of up to $250,000 and imprisonment up to 5 years. Now, this is the most unconstitutional thing I've ever seen in my life. The idea that we can tell Americans, force Americans by some law that they have to buy health insurance or we're going to fine you and send you to jail.

But there has been all this focus on the employer mandate and on the individual mandate, on the government option, but let me tell you where there hasn't been much attention, and that is the giant bureaucracy that is being built here in Washington in the Federal Government to take control of Americans' health care system and force you out of the insurance you have and into some government-run plan.

I know most of my colleagues, they might think this is hyperbole or it might sound political. Let me tell you, it isn't. Well, just listen to this. Most of my colleagues on the left have been down here today. They are for this because it does in fact set up this big infrastructure for the government to eventually take control of all of our health care and just go to a single-payer system.

Now, it starts with the exchange that's in this bill. Once it takes effect, the health exchange, you can't buy private insurance on your own. You can't go out and buy insurance. You have to go to the exchange, and the exchange will decide for you which plans are offered to you. So, if you change your job or you don't like what you have, guess what? You get to go to the government's health exchange to get your insurance.

But it's just not the government option that I'm talking about. When you look at this infrastructure that's there, it is going to require tens of thousands of new Federal employees. The American people want two things from health care reform: They want lower cost and they want more choices. I think the underlying bill here tonight does exactly the opposite. It raises the cost of health insurance and creates this new megabureaucracy to make health care decisions that should be left to doctors and their patients.

So let's talk about this bureaucracy for a moment. If you go to page 131, section 241 provides for an unelected "Health Choices Commissioner" who would run a "Health Choices Administration," an independent agency of the executive branch.

Now, here are some of the examples of the powers of this new health choice commissioner—let's just call him the health czar. On page 167 through 172, in section 303, the health czar will decide which treatment patients could receive and at what cost. Or you can go to page 132, section 242, the health choices czar would decide which private plans would be allowed to participate in the exchange.

Then you go to page 127, section 234. This new health czar will regulate all insurance plans both in and out of the exchange.

Then you go to page 162 to 165, section 302, the health choices czar will determine which employers are going to be allowed to participate in the exchange.

Then you go to page 174 to 178, section 304(b), the health choices czar will decide which physicians and hospitals get to participate in the government-run plan.

Then you go to page 197 to 202, section 308, the health choices czar will determine which States are allowed to operate their own exchange and to terminate any previously approved State exchange at any time.

Then you go to page 170 and 171, section 303(d), the health choices czar can override State laws regarding covered health benefits. It's in the bill. Go read it.

Page 133, section 242(a)(2). This person will determine how trillions of taxpayer and employer dollars would be spent within the exchange.

And page 133, section 242, "conduct random compliant audits." The person still has more powers here.

Page 183, section 305, automatically enroll Americans into the exchange if they don't have coverage, including potentially forcing these individuals into the government-run plan. Now, this is referred to as "random assignment."

This commissioner is charged with establishing "waiting lists" and defining such terms as "dependent," "service area," "premium rating area," "employee," "part-time employee," and "full-time employee." Let's all be honest, this is the czar to end all czars.

But it doesn't stop there. When you look at this expanding bureaucracy created in the Federal Government, on page 1322, section 2401, it creates a new Center for Quality Improvement to prioritize areas for identification, development, evaluation, and implementation of best practices for quality improvement of best practices for the delivery of health care services. We've already got Centers for Quality Improvement. We've got doctors, nurses, surgeons, hospitals, laboratories, rehab facilities. But no, no, we're going to have more bureaucracy than that. We're not even close to the end of this bureaucracy.

Page 1183, section 1904 provides for $750 million in Federal funding for a new entitlement program to offer "knowledge of realistic expectations of age-appropriate child behaviors" and "skills to interact with their child." So not only is the Federal Government going to legislate what's good for medical practices, now we're going to put $750 million into a program to help legislate how parents should parent.

Page 1198, section 1907, we establish a Center for Medicare and Medicaid innovation within the Centers for Medicare and Medicaid Services to legislate innovation as part of a bill that cuts, I think, the most innovative Medicare program we have, that's Medicare Advantage. But we still have more.

Page 25, section 101 authorizes the Secretary of Health and Human Services to reduce benefits, increase premiums, and establish waiting lists to make up for funding in the shortfalls of high-risk pools. That's right there in the bill, "establish waiting lists."

Pages 734, 738, and 1162, sections 1401 and 1802 create the Center for Comparative Effectiveness Research and the Comparative Effectiveness Research Commission and the Comparative Effectiveness Research Trust Fund. These are bureaucracies that will decide which treatments are most effective. But the bill does not provide any protection to doctors and patients that they all get to decide what's in their own best interest.

Then we get into a lot more duplicative Federal programs. Page 1432, section 2531 provides for incentive payments to States that enact new medical liability laws, but only if such laws do "not limit attorneys' fees or impose caps on damages." So we're telling States to solve the problems, but also telling them not to use the tools that work most effectively in the States that are using them.

Page 1624, section 2589 creates a new Personal Care Attendant Workforce Advisory Panel. Let me say that again, a Personal Care Attendant Workforce Advisory Panel made up in part by personal care workers, including their union representatives, to study working conditions and salaries of these workers. What does this have to do with lowering health care costs?

Page 1968, section 3103 establishes a "Committee for the Establishment of the Native American Health and Wellness Foundation." So we're going to set up a committee whose job it is is to set up a foundation, and we're going to take half a million dollars of Americans' money to do this.

Page 1330, section 2402 creates a new Assistant Secretary for Health Information. I guess this is another job saved or created.

Page 1391, section 2524 creates a "No Child Left Unimmunized Against Influenza" demonstration grant program to test the feasibility of using the Nation's elementary schools and secondary schools as influenza vaccination centers. Aren't we doing this already?

Page 1253, section 2231 creates a new Public Health Workforce Corps for the purpose of "ensuring an adequate supply of health professionals." The bill also creates a "Public Health Workforce Scholarship Program" and a "Public Health Workforce Loan Forgiveness Program." All of this duplicates the existing National Health Services Corps.

Page 1478, section 2552, the bill creates an Emergency Care Coordination Center in the Office of the Assistant Secretary for Preparedness and Response charged with working in coordination with the Federal Interagency Committee on Emergency Medical Services. And the Emergency Care Coordinator Center seeks out the advice of a Council of Emergency Care.

We're not finished yet. How about this one? Page 1515, section 2572(b) imposes a labeling requirement on all vending machines nationwide. In addition to that, we require all restaurants with more than 20 locations to post the calorie count exactly next to—and we spell this in the law—right next to the menu, whether it's the drive-in menu, the menu on the board, the one they hand out to you. Oh, yeah. We're going to require every restaurant with more than 20 locations to do this. Oh, but that's not enough.

□ 2145

Page 872, section 1433 requires the director of food services at nursing facilities that participate in Medicare or Medicaid to hold "military, academic, or other qualifications" as determined by Federal bureaucrats. So now we are going to legislate the work requirements in the background of all this off.

But I think this is the best part of the bureaucracy: on page 122, section 233(a)(3) of this 2,032-page bill, it requires the commissioner to "issue guidance on best practices of plain language writing." Oh, yes, it's right here in the bill. Go look at it.

Ladies and gentlemen, we know what's going on here. There are problems in our current health care system that we all want to address. I heard all the criticisms of our bill and the fact that it doesn't do everything that everybody wants it to do.

But do you know what it does do?

It lowers the cost of health insurance, and it solves the problem of those with preexisting conditions, and it begins to insure more Americans. That's what the American people want, a step-by-step approach to making the best health care system in the world better. We can do that. What we don't need to do is to create this giant bureaucracy, spend all of this tax money, and imprison our children's future by passing this 2,000-page bill.

So, I think we do have a better solution, a commonsense solution that Americans will support.

So, tonight, here we are. We have a choice. We can pass the 2,000-page bill. We can raise taxes. We can cut Medicare. We can impose all of these mandates on employers that are going to drive employment down and unemployment up, or we can take some commonsense approach.

As I said during my remarks, our job is to do our best to make sure that our kids and grandkids have a better chance of the American Dream than we did. I understand that we've got some tough choices to make, but that's what the American people sent us here to do is to make those tough choices. I'm not going to put my kids further in debt. I'm not going to dim the lights of freedom for my kids and theirs nor for anyone's in this country if I can avoid it.

So we have a choice. We can do what's right for the future, or we can continue down this path toward bigger and bigger government. I came here to fight for freedom. I came here to renew the American Dream for our kids and our grandkids.

So I would ask my colleagues to think about that choice. Vote for the Republican alternative, and whatever you do, please vote "no" for the underlying bill.

Mr. WAXMAN. Mr. Speaker, to close the debate on the Democratic side, I yield the balance of my time to the dean of the House, to the lead author of the underlying bill and to a man who has fought longer for national health insurance than anyone in this institution. I yield the balance of my time to Representative JOHN DINGELL from the State of Michigan.

The SPEAKER pro tempore. The gentleman from Michigan is recognized for 5 minutes.

Mr. DINGELL. Mr. Speaker, I am here tonight to urge my colleagues to vote against the Republican substitute and for the bill reported by three committees after long and hard work.

I want to tell the House—all Members—how proud I am of the discussion that has taken place today. I want to commend the three committees and their chairmen, including my good friend, the chairman of our committee, Mr. WAXMAN, for the work they have done.

You, Madam Speaker and the leadership, we thank you for the extraordinary leadership which you have given us in bringing this to the point where we are tonight. Thank you.

I won't begin by spending much time on the bill offered by my Republican colleagues. It is really no substitute for H.R. 3962. According to The New York Times—and I think this sufficiently disposes of the matter—the Republican amendment does "almost nothing to reduce the scandalously high number of Americans who have no insurance, and it makes only a token stab at slowing the relentlessly rising costs of medical care."

Interestingly enough, under the Republican amendment, individuals would pay up to $2,821 more, and families would pay up to $8,188 more under the Republican plan when compared with H.R. 3962. It's not in the public interest that we should do that.

Having said that, this is historic legislation. It addresses two of the most terrifying problems we have in this country:

The first is what was the problem when my dad introduced the first legislation in 1943, that there are now some 47 million Americans without health care. This will give many of them adequate health care and a decent choice

of what they will have before them at the best possible price through an exchange, which will make it possible for them to choose without having to worry about understanding the language of Philadelphia lawyers and reading fine print that can only be read with a magnifying glass.

The bill does something more. It takes care of an economic problem that will be visited on us in 2080 when the costs of health care will equal the gross domestic product of the United States. That will bring us to a fine economic mess if we permit that to happen. Health care and GDP costs will be equal.

Now, the bill carries out the President's suggestions: deficit neutral. It provides coverage for 96 percent of Americans. It offers everyone, regardless of income, age, health status, the peace of mind that comes from knowing that they will have real access to affordable health insurance when they need it.

It does away with preexisting conditions, which the bill offered by my friends in the minority does not; and it sees to it that, when you go to bed at night, you're going to wake up knowing in the morning that you're going to have health insurance. It can't have been dropped by your employer, and it can't have been canceled by your insurance.

There is a practice, on which we just had hearings, that is engaged in by the insurance companies. It is called "rescission." They can cancel your insurance policy by the simple device of rescinding your policy because they say you have some preexisting conditions, and they can do it while you're on the gurney, being rolled into the operating amphitheater.

The bill is going to give choice and honest competition. It is going to bring security to our seniors, and it is going to reduce out-of-control health care costs that are crushing American business.

It costs $4 an hour less to make a car in Canada than it does in Michigan. Why? Because the Canadians have a program of national health insurance which ensures that the manufacturer can compete and out-compete Americans because he doesn't carry that economic burden.

Today, this may be a tough vote, but it was in 1935 when we passed Social Security. I hear my colleagues tell us that the economy, jobs and financial system overhaul, are desperately needed. True. But that was the case in '35 when we passed the Social Security Act.

Now I hear my Republican colleagues tell us this is going to stand between—or permit a government bureaucrat to stand between the insured and the doctor and each other. In point of fact, it is going to permit the government to stand between the insurance bureaucrat and the insured, and it is going to stand between him and the doctor so that the doctor can provide the care he wants.

The problems this historic legislation aims to address are real and worsening for American citizens, business, and governments. When my Dad introduced this legislation sixty some years ago, it was a simple humanitarian problem. Today it is one of impending economic disaster to America.

H.R. 3962 meets the goals President Obama outlined for us earlier this year: it is deficit neutral; it provides coverage for 96 percent of Americans; and it offers everyone, regardless of income, age or health status, the peace of mind that comes from knowing they will have real access to quality, affordable health insurance when they need it; that preexisting conditions will not bar them from insurance; that loss of job or dropping of coverage by employer will not deny insurance.

This bill will stop discrimination against people with pre-existing conditions, and it will stop rescission—the practice in which an insurer searches for problems with patients' policies while they are waiting on a gurney for emergency care.

Additionally, this bill will ensure choice and honest competition; bring security to our seniors; and will reduce the out-of-control health care costs that are crushing American businesses.

Now is the time for health care reform. We can't afford to wait. We must offer big solutions for the big problems that face the American people. We must succeed.

Mr. Speaker, I have heard from a number of my colleagues, and I appreciate the fact the vote before us today is a tough vote.

I understand there are numerous competing issues confronting the American people—the economy, jobs, financial system overhaul. That was so in 1935 when we enacted Social Security over just about the same objections.

However, we know that no issue has caused the American people to suffer longer than the issue of inaccessible health care.

History and the American people will ask what we did here this day when presented with a real opportunity to ease the strain of rising health care costs and provide quality, affordable health coverage for all.

Mr. Speaker, the vote for me today will be on behalf of American families who are forced to decide whether they will pay the mortgage or their health insurance premium.

My vote today is for American business—big and small. They are confronted with the real burden of providing quality health care for their workers or fall victim to their foreign competitors.

My vote today is for the federal government, and state and local governments throughout the country which are being stretched to make room for larger and larger health bills.

Mr. Speaker, my vote today is also personal.

It is a vote to fulfill the legacy left by a little, skinny Polack with a broken nose and a mustache who served as a proud Member of this distinguished body.

My father, John D. Dingell, Sr., was a part of the original New Dealers—a brand of big thinking Democrats—who believed that health care is a right, not a privilege and government had a responsibility to protect it people; provide for their basic rights; and ensure opportunity for all.

So, it is in that tradition that I urge my colleagues to act today to pass this bill.

Join with the AMA, the AARP, the Consumers Union, the American Cancer Society, the different medical specialist groups, the Nurses and others who support this bill.

Mr. Speaker, we have an opportunity today, to do something meaningful for the American people and for American business.

We can take advantage of this opportunity or we can shirk our responsibilites and allow the calamitous situation that faces our people to contine to grow out of hand, overwhelm the federal budget, force more and more families into bankruptcy, and shift more jobs overseas.

Reform is neither easy nor cheap, but the cost of inaction is far greater—in terms of lost lives, quality of life and dollars. If we don't reduce costs we face certain economic disaster.

So, today, we must overcome the naysayers, the loyal opposition, the lies about our plan, the fear that causes us to think the status quo is the safe thing to do.

We must overcome all of these things and we must act boldly, with conviction, and deliberately—not because of our own righteousness—but because there is no other acceptable alternative.

I urge my colleagues to vote "yes" on H.R. 3962 and give the American people the relief they so desperately need.

Ms. RICHARDSON. Mr. Speaker, I rise today to oppose the Boehner amendment and in strong support of H.R. 3962, the Affordable Health Care for America Act of 2009, because this bill is good for seniors, good for women, good for small businesses, and good for all Americans.

President Theodore Roosevelt proposed national health insurance in 1908. Forty years later in 1948, President Truman proposed it again. Under the leadership of Lyndon B. Johnson and a Democratic Congress, Medicare was enacted in 1965 which provided health care for senior citizens.

Today, we write another great chapter in the remarkable history of this country. Today, we extend to tens of millions of our fellow citizens the security that comes from knowing that they will have health care that is there when they need it and won't bankrupt their families.

The health care system we have now is not working for middle and working class families, not working for businesses trying to compete in a global economy, not working for taxpayers or for the uninsured.

There are 54 million Americans who are uninsured who need us to reform this broken system. One in five Californians are uninsured or underinsured. These numbers are staggering and if we do nothing, they will only grow worse.

Mr. Speaker, the Affordable Health Care for Americans Act is the answer to the broken health care system. This bill provides American families with stability and peace of mind. Never again will they have to choose between their health and their livelihood.

This bill provides American families with higher quality health care. It leaves important health decisions up to patients and doctors, not to insurance companies.

Finally, this bill lowers costs for American families. It eliminates co-pays and deductibles for preventive care while putting an annual cap on out-of-pocket expenses for American families.

Now, we need to stop playing politics and focus on actually improving people's lives. H.R. 3962 will reform the health care system so that it provides quality, affordable coverage that cannot be taken away. It eliminates discrimination based on gender and preexisting conditions. It eliminates the prescription drug donut hole for seniors. It ends the era of no and begins the era of yes for millions of Americans seeking coverage.

The hour is late, and the need is great. I urge my colleagues to vote "no" on the Boehner Amendment and "yes" on H.R. 3962.

Mr. GALLEGLY. Mr. Speaker, I rise in support of the amendment offered by Mr. BOEHNER. I have long supported changes to current health care system which reduce health care costs through increased efficiency and provide affordable insurance for people with preexisting conditions. But, at the same time, any changes to our current system should ensure doctors and patients are allowed to make health care decisions—not government bureaucrats.

Therefore, I support real health insurance reform and support the version offered by the Minority Leader, which would:

Lower health care premiums for working families,

Allow small businesses to join together in order to buy reasonably priced health insurance,

Reduce medical costs by limiting frivolous medical malpractice lawsuits,

Prevent insurers from unjustly cancelling health insurance policies, and Establish universal access programs that provide affordable insurance for people with preexisting conditions.

Mr. Speaker, we should not consider changes of this magnitude without a complete report from the nonpartisan Congressional Budget Office, CBO. The preliminary estimate from the CBO puts the cost of H.R. 3962 at more than $1.05 trillion, but many independent experts believe this bill will actually increase Federal expenditures by more than $1.3 trillion.

In addition, this bill would impose $730 billion in new taxes and mandates on individuals and small businesses. Most economists, including CBO experts, have concluded that these requirements could increase unemployment by discouraging businesses from hiring low-wage workers. It could also lead to wage stagnation as payroll is diverted to comply with new Federal mandates on health care coverage.

I am also concerned about the impact of this proposal on Medicare beneficiaries. H.R. 3962 would cut $400 billion from Medicare over 10 years, including a $170 billion reduction to Medicare Advantage plans, which provides insurance coverage for many seniors.

Finally, H.R. 3962 does not address the problem of frivolous malpractice lawsuits in a meaningful way. These suits lead to the practice of expensive, defensive medicine and raise the health care expenses of all patients.

I urge my colleagues to reject H.R. 3962 and support the amendment offered by Mr. BOEHNER.

Mr. SAM JOHNSON of Texas. Mr. Speaker, today, I want to add my support for the Republican substitute amendment, the Commonsense Health Care Reform and Affordability Act. This amendment is a patient centered solution to healthcare reform that our country can afford and that members on both sides of the aisle can support. It also addresses the number one concern on the mind of all Americans in this country: the high cost of health care.

The Congressional Budget Office has estimated that this Republican substitute amendment would reduce health insurance premiums by up to 8 percent for those families who currently do not have access to employer-provided coverage. My constituents have told me over and over again that the cost of healthcare is too high. They need healthcare that is more affordable, accessible and available and the Commonsense Health Care Reform and Affordability Act provides just that.

Included in the Republican substitute amendment is my bill, H.R. 2607, the Small Business Health Fairness Act. This legislation allows small businesses to band together to purchase health insurance so they can enjoy the same bargaining power large corporations and labor unions have at the purchasing table. In all parts of our economy we know that buying in bulk reduces the price tag, and healthcare is no different. Government-forced healthcare is not the way to solve our health care problem. We can and have to do better.

With almost 60 percent of the uninsured population tied to a small business, this provision in the Commonsense Health Care Reform and Affordability Act, helps bring access to affordable healthcare to those that currently don't have it. Clearly, there are better ways to make healthcare more accessible for American families—and this Republican substitute is it.

Real healthcare reform should protect doctors and hospitals from frivolous lawsuits, so they can stop practicing defensive medicine and instead focus on practicing patient-focused care. This amendment extends medical liability reform that has been successful in several States to the rest of the Nation, saving lives and saving money.

Another provision in the Republican substitute amendment I am proud to support is the State Innovations Program. The amendment provides incentives to States who adopt reforms that reduce the cost of health insurance and expand coverage to the citizens of their States.

This provision allows States the freedom to solve their health problems on their own. Speaker PELOSI's health-care bill focuses on the Federal Government trying to fix what is broken with our health care. But in my great State of Texas, I believe those that are best equipped to solve our healthcare problems are Texans. It is time for real reform that works and not the same old answers of more money and more government.

Finally, this amendment protects American innovation while ensuring patients will have more cutting edge treatment options in the area called "follow on biologics." The Commonsense Health Care Reform and Affordability Act contains a provision that will create a pathway for new, life saving products while maintaining the proper incentives for companies to research and strive to discover them. Most importantly, this provision will ensure that many of the jobs created in this industry will stay in the United States.

The Commonsense Health Care Reform and Affordability Act is exactly the solution the American public has asked Congress to pass. It saves money, lowers the cost of health care, protects the patient-doctor relationship and keeps the government out of personal healthcare decisions. I ask my colleagues to join me in supporting this amendment today.

Mr. CAMP. Mr. Speaker, I yield back the balance of my time.

Mr. WAXMAN. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. Pursuant to House Resolution 903, the previous question is ordered on the amendment.

The question is on the amendment offered by the gentleman from Ohio (Mr. BOEHNER).

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

Mr. CAMP. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to section 2 of House Resolution 903, further proceedings on this question will be postponed.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to section 2 of House Resolution 903, proceedings will now resume on the amendments printed in parts C and D of House Report 111-330 on which further proceedings were postponed, in the following order:

Amendment printed in part C by Mr. STUPAK of Michigan.

Amendment printed in part D by Mr. BOEHNER of Ohio.

The Chair will reduce to 5 minutes the time for any electronic vote after the first vote in this series.

AMENDMENT OFFERED BY MR. STUPAK

The SPEAKER pro tempore. The unfinished business is the vote on the amendment offered by the gentleman from Michigan (Mr. STUPAK) on which the yeas and nays were ordered.

The Clerk will redesignate the amendment.

The Clerk redesignated the amendment.

The SPEAKER pro tempore. The question is on the amendment.

The vote was taken by electronic device, and there were—yeas 240, nays 194, answered "present" 1, not voting 0, as follows:

[Roll No. 884]

YEAS—240

Aderholt	Barrett (SC)	Bishop (GA)
Akin	Barrow	Bishop (UT)
Alexander	Bartlett	Blackburn
Altmire	Barton (TX)	Blunt
Austria	Berry	Boccieri
Baca	Biggert	Boehner
Bachmann	Bilbray	Bonner
Bachus	Billirakis	Bono Mack

Boozman
Boren
Boustany
Brady (TX)
Bright
Broun (GA)
Brown (SC)
Brown-Waite, Ginny
Buchanan
Burgess
Burton (IN)
Buyer
Calvert
Camp
Campbell
Cantor
Cao
Capito
Cardoza
Carney
Carter
Cassidy
Castle
Chaffetz
Chandler
Childers
Coble
Coffman (CO)
Cole
Conaway
Cooper
Costa
Costello
Crenshaw
Cuellar
Culberson
Dahlkemper
Davis (AL)
Davis (KY)
Davis (TN)
Deal (GA)
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Donnelly (IN)
Doyle
Dreier
Driehaus
Duncan
Ehlers
Ellsworth
Emerson
Etheridge
Fallin
Flake
Fleming
Forbes
Fortenberry
Foxx
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gingrey (GA)
Gohmert
Goodlatte
Gordon (TN)
Granger
Graves
Griffith
Guthrie
Hall (TX)
Harper
Hastings (WA)
Heller
Hensarling
Herger
Hill
Hoekstra
Holden
Hunter
Inglis
Issa
Jenkins
Johnson (IL)
Johnson, Sam
Jones
Jordan (OH)
Kanjorski
Kaptur
Kildee
King (IA)
King (NY)
Kingston
Kirk
Kline (MN)
Lamborn
Lance
Langevin
Latham
LaTourette
Latta
Lee (NY)
Lewis (CA)
Linder
Lipinski
LoBiondo
Lucas
Luetkemeyer
Lummis
Lungren, Daniel E.
Lynch
Mack
Manzullo
Marchant
Marshall
Matheson
McCarthy (CA)
McCaul
McClintock
McCotter
McHenry
McIntyre
McKeon
McMorris Rodgers
Melancon
Mica
Michaud
Miller (FL)
Miller (MI)
Miller, Gary
Mollohan
Moran (KS)
Murphy, Tim
Murtha
Myrick
Neal (MA)
Neugebauer
Nunes
Oberstar
Obey
Olson
Ortiz
Paul
Paulsen
Pence
Perriello
Peterson
Petri
Pitts
Platts
Poe (TX)
Pomeroy
Posey
Price (GA)
Putnam
Radanovich
Rahall
Rehberg
Reichert
Reyes
Rodriguez
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rooney
Ros-Lehtinen
Roskam
Ross
Royce
Ryan (OH)
Ryan (WI)
Salazar
Scalise
Schmidt
Schock
Sensenbrenner
Sessions
Shimkus
Shuler
Shuster
Simpson
Skelton
Smith (NE)
Smith (NJ)
Smith (TX)
Snyder
Souder
Space
Spratt
Stearns
Stupak
Sullivan
Tanner
Taylor
Teague
Terry
Thompson (PA)
Thornberry
Tiahrt
Tiberi
Turner
Upton
Walden
Wamp
Westmoreland
Whitfield
Wilson (OH)
Wilson (SC)
Wittman
Wolf
Young (AK)
Young (FL)

NAYS—194

Abercrombie
Ackerman
Adler (NJ)
Andrews
Arcuri
Baird
Baldwin
Bean
Becerra
Berkley
Berman
Bishop (NY)
Blumenauer
Boswell
Boucher
Boyd
Brady (PA)
Braley (IA)
Brown, Corrine
Butterfield
Capps
Capuano
Carnahan
Carson (IN)
Castor (FL)
Chu
Clarke
Clay
Cleaver
Clyburn
Cohen
Connolly (VA)
Conyers
Courtney
Crowley
Cummings
Davis (CA)
Davis (IL)
DeFazio
DeGette
Delahunt
DeLauro
Dicks
Dingell
Doggett
Edwards (MD)
Edwards (TX)
Ellison
Engel
Eshoo
Farr
Fattah
Filner
Foster
Frank (MA)
Fudge
Garamendi
Giffords
Gonzalez
Grayson
Green, Al
Green, Gene
Grijalva
Gutierrez
Hall (NY)
Halvorson
Hare
Harman
Hastings (FL)
Heinrich
Herseth Sandlin
Higgins
Himes
Hinchey
Hinojosa
Hirono
Hodes
Holt
Honda
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Johnson (GA)
Johnson, E. B.
Kagen
Kennedy
Kilpatrick (MI)
Kilroy
Kind
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kosmas
Kratovil
Kucinich
Larsen (WA)
Larson (CT)
Lee (CA)
Levin
Lewis (GA)
Loebsack
Lofgren, Zoe
Lowey
Luján
Maffei
Maloney
Markey (CO)
Markey (MA)
Massa
Matsui
McCarthy (NY)
McCollum
McDermott
McGovern
McMahon
McNerney
Meek (FL)
Meeks (NY)
Miller (NC)
Miller, George
Minnick
Mitchell
Moore (KS)
Moore (WI)
Moran (VA)
Murphy (CT)
Murphy (NY)
Murphy, Patrick
Nadler (NY)
Napolitano
Nye
Oliver
Owens
Pallone
Pascrell
Pastor (AZ)
Payne
Pelosi
Perlmutter
Peters
Pingree (ME)
Polis (CO)
Price (NC)
Quigley
Rangel
Richardson
Rothman (NJ)
Roybal-Allard
Ruppersberger
Rush
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Schakowsky
Schauer
Schiff
Schrader
Schwartz
Scott (GA)
Scott (VA)
Serrano
Sestak
Shea-Porter
Sherman
Sires
Slaughter
Smith (WA)
Speier
Stark
Sutton
Thompson (CA)
Thompson (MS)
Tierney
Titus
Tonko
Towns
Tsongas
Van Hollen
Velázquez
Visclosky
Walz
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch
Wexler
Woolsey
Wu
Yarmuth

ANSWERED "PRESENT"—1

Shadegg

□ 2220

Mr. COHEN and Ms. JACKSON-LEE of Texas changed their vote from "yea" to "nay."

Messrs. SPRATT and LEWIS of California changed their vote from "nay" to "yea."

So the amendment was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

AMENDMENT OFFERED BY MR. BOEHNER

The SPEAKER pro tempore. The unfinished business is the vote on the amendment offered by the gentleman from Ohio (Mr. BOEHNER) on which the yeas and nays were ordered.

The Clerk will redesignate the amendment.

The Clerk redesignated the amendment.

The SPEAKER pro tempore. The question is on the amendment.

This is a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 176, noes 258, not voting 0, as follows:

[Roll No. 885]

YEAS—176

Aderholt
Akin
Alexander
Austria
Bachmann
Bachus
Barrett (SC)
Bartlett
Barton (TX)
Biggert
Bilbray
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehner
Bonner
Bono Mack
Boozman
Boustany
Brady (TX)
Broun (GA)
Brown (SC)
Brown-Waite, Ginny
Buchanan
Burgess
Burton (IN)
Buyer
Calvert
Camp
Campbell
Cantor
Cao
Capito
Carter
Cassidy
Castle
Chaffetz
Coble
Coffman (CO)
Cole
Conaway
Crenshaw
Culberson
Davis (KY)
Deal (GA)
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dreier
Duncan
Ehlers
Emerson
Fallin
Flake
Fleming
Forbes
Fortenberry
Foxx
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gingrey (GA)
Gohmert
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Rohrabacher
Rooney
Ros-Lehtinen
Roskam
Royce
Ryan (WI)
Scalise
Schmidt
Schock
Sensenbrenner
Sessions
Shadegg
Shimkus
Shuster
Simpson
Smith (NE)
Smith (NJ)
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Souder
Stearns
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Terry
Thompson (PA)
Thornberry
Tiahrt
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DeFazio
DeGette
Delahunt
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Edwards (MD)
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Ellison
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Kanjorski	Mollohan	Schiff
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Kennedy	Moore (WI)	Schwartz
Kildee	Moran (VA)	Scott (GA)
Kilpatrick (MI)	Murphy (CT)	Scott (VA)
Kilroy	Murphy (NY)	Serrano
Kind	Murphy, Patrick	Sestak
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Kissell	Nadler (NY)	Sherman
Klein (FL)	Napolitano	Shuler
Kosmas	Neal (MA)	Sires
Kratovil	Nye	Skelton
Kucinich	Oberstar	Slaughter
Langevin	Obey	Smith (WA)
Larsen (WA)	Olver	Snyder
Larson (CT)	Ortiz	Space
Lee (CA)	Owens	Speier
Levin	Pallone	Spratt
Lewis (GA)	Pascrell	Stark
Lipinski	Pastor (AZ)	Stupak
Loebsack	Payne	Sutton
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Markey (CO)	Pomeroy	Titus
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Marshall	Quigley	Towns
Massa	Rahall	Tsongas
Matheson	Rangel	Van Hollen
Matsui	Reyes	Velázquez
McCarthy (NY)	Richardson	Visclosky
McCollum	Rodriguez	Walz
McDermott	Ross	Wasserman Schultz
McGovern	Rothman (NJ)	Waters
McIntyre	Roybal-Allard	Watson
McMahon	Ruppersberger	Watt
McNerney	Rush	Waxman
Meek (FL)	Ryan (OH)	Weiner
Meeks (NY)	Salazar	Welch
Melancon	Sánchez, Linda T.	Wexler
Michaud	Sanchez, Loretta	Wilson (OH)
Miller (NC)	Sarbanes	Woolsey
Miller, George	Schakowsky	Wu
Minnick	Schauer	Yarmuth
Mitchell		

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So the amendment was rejected.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

The SPEAKER pro tempore. Pursuant to House Resolution 903, the previous question is ordered on the bill, as amended.

The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

MOTION TO RECOMMIT

Mr. CANTOR. Mr. Speaker, I have a motion to recommit at the desk.

The SPEAKER pro tempore. Is the gentleman opposed to the bill?

Mr. CANTOR. Yes, Mr. Speaker, in its current form.

The SPEAKER pro tempore. Pursuant to House Resolution 903, the motion is considered as read.

The text of the motion is as follows:

Mr. Cantor moves to recommit the bill, H.R. 3962, to the Committee on Energy and Commerce with instructions to report the same back to the House forthwith with the following amendments:

Page 1209, after line 15, insert the following new title (and conform the table of contents of division B, and the table of divisions, titles and subtitles in section 1(b), accordingly):

TITLE X—SENIORS PROTECTION AND MEDICARE REGIONAL PAYMENT EQUITY FUND

SEC. 1911. FINDINGS.

Congress finds the following:

(1) When analyzing the Medicare cuts in division B, The Office of the Actuary (OACT) of the Centers for Medicare & Medicaid Services noted that "The additional demand for health services could be difficult to meet initially with existing health provider resources and could lead to price increases, cost-shifting, and changes in providers' willingness to treat patients with low-reimbursement health coverage.".

(2) When analyzing the Medicare cuts contained in division B, OACT predicts that, "Over time, a sustained reduction in payment updates, based on productivity expectations that are difficult to attain, would cause Medicare payment rates to grow more slowly than, and in a way that was unrelated to, the provider's costs of furnishing services to beneficiaries. Thus, providers for whom Medicare constitutes a substantive portion of their business could find it difficult to remain profitable and might end their participation in the program (possibly jeopardizing access to care for beneficiaries).".

(3) The Medicare Payment Advisory Commission (MedPAC) found that 28 percent of seniors currently have difficulty finding a new physician to treat them.

(4) Medicare geographic payment inequities are well documented and have been extensively studied.

(5) The Congressional Budget Office states that per capita health care spending varies widely across the United States.

(6) Low-cost, high-quality States are setting the national standard for Medicare yet they are penalized by the current Medicare reimbursement formula.

(7) Geographic payment inequities must be resolved for health care reform to be successful and for Medicare to achieve long-term sustainability.

(8) Rural counties face unique challenges in delivering health care.

(9) MedPAC finds that every senior currently has the ability to enroll in a Medicare Advantage plan instead of the traditional government program. The Commission predicts that because of Medicare cuts contained in division B, 1 in 5 seniors will no longer have this choice and be forced to receive their Medicare benefits from the traditional program.

(10) OACT predicts that the Medicare cuts contained in division B will reduce seniors' projected enrollment in Medicare Advantage plans by 64 percent.

(11) MedPAC estimates that, on average, Medicare physician reimbursements are 20 percent lower than the reimbursements physicians receive from private health plans.

(12) MedPAC predicts that, on average, Medicare hospital reimbursements will be 6.9 percent below the cost of providing care in 2009.

SEC. 1912. SENIORS PROTECTION AND MEDICARE REGIONAL PAYMENT EQUITY FUND.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall establish under this title a Seniors Protection and Medicare Regional Payment Equity Fund (in this section referred to as the "Fund") which shall be available to the Secretary to provide for improvements (described in subsection (b)(1)) under the Medicare program under title XVIII of the Social Security Act.

(b) IMPROVEMENTS MADE BY FUND.—

(1) IN GENERAL.—The improvements described in this paragraph are the following:

(A) CORRECTING PAYMENT INEQUITIES.—In order to correct inequities in Medicare payment policies that punish high-quality, low-cost counties (as defined in paragraph (2)) and to promote high quality, cost effective patient care, by providing additional funding to Medicare providers located in such counties.

(B) PRESERVING SENIORS' CHOICE.—In order to preserve seniors' ability to choose the Medicare health benefits that best meet their needs, by providing additional funding to ensure that every Medicare beneficiary continues to have access to at least 1 Medicare Advantage plan under part C of the Medicare program.

(C) ACCESS TO MEDICALLY NECESSARY CARE AND TREATMENT.—By providing such additional funding as may be necessary to ensure access by Medicare beneficiaries to medically necessary care and treatment, including care and treatment furnished by physicians, hospitals, and other health care providers under the Medicare program, without wait lines or coverage determinations based solely on the basis of cost.

(2) HIGH QUALITY, LOW-COST COUNTY DEFINED.—In this subsection, the term "high quality, low-cost county" means a county (or equivalent area) in which, as determined by the Secretary—

(A) the quality of care exceeds the national average; and

(B) the per beneficiary fee-for-service Medicare costs are substantially lower than the national average.

(c) FUNDING.—

(1) IN GENERAL.—There shall be available to the Fund—

(A) $13,500,000,000 for expenditures from the Fund during 5-year period beginning with 2010; and

(B) $40,500,000,000 for expenditures from the Fund during the 5-year period beginning with 2015.

Such amounts reflect savings in Federal expenditures and increases in Federal revenues estimated to result from the provisions of division E.

(2) FUNDING LIMITATION.—Amounts in the Fund shall be available in advance of appropriations but only if the total amount obligated from the Fund does not exceed the amount available to the Fund under paragraph (1). The Secretary may obligate funds from the Fund only if the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services and the appropriate budget officer certify) that there are available in the Fund sufficient amounts to cover all such obligations incurred consistent with the previous sentence.

Add at the end the following (and conform the table of divisions, titles, and subtitles in section 1(b) accordingly):

DIVISION E—ENACTING REAL MEDICAL LIABILITY REFORM

TABLE OF CONTENTS OF DIVISION

SEC. 4101. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

The time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first. In no event shall the time for commencement of a health care lawsuit exceed 3 years after the date of manifestation of injury unless tolled for any of the following—

(1) upon proof of fraud;

(2) intentional concealment; or

(3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person.

Actions by a minor shall be commenced within 3 years from the date of the alleged manifestation of injury except that actions by a minor under the full age of 6 years shall be commenced within 3 years of manifestation of injury or prior to the minor's 8th birthday, whichever provides a longer period. Such time limitation shall be tolled for minors for any period during which a parent or guardian and a health care provider or health care organization have committed fraud or collusion in the failure to bring an action on behalf of the injured minor.

SEC. 4102. COMPENSATING PATIENT INJURY.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any health care lawsuit, nothing in this division shall limit a claimant's recovery of the full amount of the available economic damages, notwithstanding the limitation in subsection (b).

(b) ADDITIONAL NONECONOMIC DAMAGES.—In any health care lawsuit, the amount of noneconomic damages, if available, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same injury.

(c) NO DISCOUNT OF AWARD FOR NONECONOMIC DAMAGES.—For purposes of applying the limitation in subsection (b), future noneconomic damages shall not be discounted to present value. The jury shall not be informed about the maximum award for noneconomic damages. An award for noneconomic damages in excess of $250,000 shall be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment, and such reduction shall be made before accounting for any other reduction in damages required by law. If separate awards are rendered for past and future noneconomic damages and the combined awards exceed $250,000, the future noneconomic damages shall be reduced first.

(d) FAIR SHARE RULE.—In any health care lawsuit, each party shall be liable for that party's several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. Whenever a judgment of liability is rendered as to any party, a separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

SEC. 4103. MAXIMIZING PATIENT RECOVERY.

(a) COURT SUPERVISION OF SHARE OF DAMAGES ACTUALLY PAID TO CLAIMANTS.—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants. In particular, in any health care lawsuit in which the attorney for a party claims a financial stake in the outcome by virtue of a contingent fee, the court shall have the power to restrict the payment of a claimant's damage recovery to such attorney, and to redirect such damages to the claimant based upon the interests of justice and principles of equity. In no event shall the total of all contingent fees for representing all claimants in a health care lawsuit exceed the following limits:

(1) 40 percent of the first $50,000 recovered by the claimant(s).

(2) 33⅓ percent of the next $50,000 recovered by the claimant(s).

(3) 25 percent of the next $500,000 recovered by the claimant(s).

(4) 15 percent of any amount by which the recovery by the claimant(s) is in excess of $600,000.

(b) APPLICABILITY.—The limitations in this section shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution. In a health care lawsuit involving a minor or incompetent person, a court retains the authority to authorize or approve a fee that is less than the maximum permitted under this section. The requirement for court supervision in the first two sentences of subsection (a) applies only in civil actions.

SEC. 4104. ADDITIONAL HEALTH BENEFITS.

In any health care lawsuit involving injury or wrongful death, any party may introduce evidence of collateral source benefits. If a party elects to introduce such evidence, any opposing party may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the opposing party to secure the right to such collateral source benefits. No provider of collateral source benefits shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated to the right of the claimant in a health care lawsuit involving injury or wrongful death. This section shall apply to any health care lawsuit that is settled as well as a health care lawsuit that is resolved by a fact finder. This section shall not apply to section 1862(b) (42 U.S.C. 1395y(b)) or section 1902(a)(25) (42 U.S.C. 1396a(a)(25)) of the Social Security Act.

SEC. 4105. PUNITIVE DAMAGES.

(a) IN GENERAL.—Punitive damages may, if otherwise permitted by applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer. In any health care lawsuit where no judgment for compensatory damages is rendered against such person, no punitive damages may be awarded with respect to the claim in such lawsuit. No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only upon a motion by the claimant and after a finding by the court, upon review of supporting and opposing affidavits or after a hearing, after weighing the evidence, that the claimant has established by a substantial probability that the claimant will prevail on the claim for punitive damages. At the request of any party in a health care lawsuit, the trier of fact shall consider in a separate proceeding—

(1) whether punitive damages are to be awarded and the amount of such award; and

(2) the amount of punitive damages following a determination of punitive liability.

If a separate proceeding is requested, evidence relevant only to the claim for punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether compensatory damages are to be awarded.

(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

(1) FACTORS CONSIDERED.—In determining the amount of punitive damages, if awarded, in a health care lawsuit, the trier of fact shall consider only the following—

(A) the severity of the harm caused by the conduct of such party;

(B) the duration of the conduct or any concealment of it by such party;

(C) the profitability of the conduct to such party;

(D) the number of products sold or medical procedures rendered for compensation, as the case may be, by such party, of the kind causing the harm complained of by the claimant;

(E) any criminal penalties imposed on such party, as a result of the conduct complained of by the claimant; and

(F) the amount of any civil fines assessed against such party as a result of the conduct complained of by the claimant.

(2) MAXIMUM AWARD.—The amount of punitive damages, if awarded, in a health care lawsuit may be as much as $250,000 or as much as two times the amount of economic damages awarded, whichever is greater. The jury shall not be informed of this limitation.

SEC. 4106. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

(a) IN GENERAL.—In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding $50,000 is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments. In any health care lawsuit, the court may be guided by the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

(b) APPLICABILITY.—This section applies to all actions which have not been first set for trial or retrial before the effective date of this division.

SEC. 4107. DEFINITIONS.

In this division:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term "alternative dispute resolution system" or "ADR" means a system that provides for the resolution of health care lawsuits in a manner other than through a civil action brought in a State or Federal court.

(2) CLAIMANT.—The term "claimant" means any person who brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity, or subrogation, arising out of a health care liability claim or action, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

(3) COLLATERAL SOURCE BENEFITS.—The term "collateral source benefits" means any amount paid or reasonably likely to be paid in the future to or on behalf of the claimant, or any service, product, or other benefit provided or reasonably likely to be provided in

the future to or on behalf of the claimant, as a result of the injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident, or workers' compensation law;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income-disability benefits; and

(D) any other publicly or privately funded program.

(4) COMPENSATORY DAMAGES.—The term "compensatory damages" means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities, damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature. The term "compensatory damages" includes economic damages and noneconomic damages, as such terms are defined in this section.

(5) CONTINGENT FEE.—The term "contingent fee" includes all compensation to any person or persons which is payable only if a recovery is effected on behalf of one or more claimants.

(6) ECONOMIC DAMAGES.—The term "economic damages" means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities.

(7) HEALTH CARE LAWSUIT.—The term "health care lawsuit" means any health care liability claim concerning the provision of health care goods or services or any medical product affecting interstate commerce, or any health care liability action concerning the provision of health care goods or services or any medical product affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim. Such term does not include a claim or action which is based on criminal liability; which seeks civil fines or penalties paid to Federal, State, or local government; or which is grounded in antitrust.

(8) HEALTH CARE LIABILITY ACTION.—The term "health care liability action" means a civil action brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.

(9) HEALTH CARE LIABILITY CLAIM.—The term "health care liability claim" means a demand by any person, whether or not pursuant to ADR, against a health care provider, health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, including, but not limited to, third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) health care services or medical products, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

(10) HEALTH CARE ORGANIZATION.—The term "health care organization" means any person or entity which is obligated to provide or pay for health benefits under any health plan, including any person or entity acting under a contract or arrangement with a health care organization to provide or administer any health benefit.

(11) HEALTH CARE PROVIDER.—The term "health care provider" means any person or entity required by State or Federal laws or regulations to be licensed, registered, or certified to provide health care services, and being either so licensed, registered, or certified, or exempted from such requirement by other statute or regulation.

(12) HEALTH CARE GOODS OR SERVICES.—The term "health care goods or services" means any goods or services provided by a health care organization, provider, or by any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, or treatment of any human disease or impairment, or the assessment or care of the health of human beings.

(13) MALICIOUS INTENT TO INJURE.—The term "malicious intent to injure" means intentionally causing or attempting to cause physical injury other than providing health care goods or services.

(14) MEDICAL PRODUCT.—The term "medical product" means a drug, device, or biological product intended for humans, and the terms "drug", "device", and "biological product" have the meanings given such terms in sections 201(g)(1) and 201(h) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 321(g)(1) and (h)) and section 351(a) of the Public Health Service Act (42 U.S.C. 262(a)), respectively, including any component or raw material used therein, but excluding health care services.

(15) NONECONOMIC DAMAGES.—The term "noneconomic damages" means damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.

(16) PUNITIVE DAMAGES.—The term "punitive damages" means damages awarded, for the purpose of punishment or deterrence, and not solely for compensatory purposes, against a health care provider, health care organization, or a manufacturer, distributor, or supplier of a medical product. Punitive damages are neither economic nor noneconomic damages.

(17) RECOVERY.—The term "recovery" means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim, including all costs paid or advanced by any person. Costs of health care incurred by the plaintiff and the attorneys' office overhead costs or charges for legal services are not deductible disbursements or costs for such purpose.

(18) STATE.—The term "State" means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

SEC. 4108. EFFECT ON OTHER LAWS.

(a) VACCINE INJURY.—

(1) To the extent that title XXI of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a vaccine-related injury or death—

(A) this division does not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this division in conflict with a rule of law of such title XXI shall not apply to such action.

(2) If there is an aspect of a civil action brought for a vaccine-related injury or death to which a Federal rule of law under title XXI of the Public Health Service Act does not apply, then this division or otherwise applicable law (as determined under this division) will apply to such aspect of such action.

(b) OTHER FEDERAL LAW.—Except as provided in this section, nothing in this division shall be deemed to affect any defense available to a defendant in a health care lawsuit or action under any other provision of Federal law.

SEC. 4109. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this division preempt, subject to subsections (b) and (c), State law to the extent that State law prevents the application of any provisions of law established by or under this division. The provisions governing health care lawsuits set forth in this division supersede chapter 171 of title 28, United States Code, to the extent that such chapter—

(1) provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages, than provided in this division; or

(2) prohibits the introduction of evidence regarding collateral source benefits, or mandates or permits subrogation or a lien on collateral source benefits.

(b) PROTECTION OF STATES' RIGHTS AND OTHER LAWS.—(1) Any issue that is not governed by any provision of law established by or under this division (including State standards of negligence) shall be governed by otherwise applicable State or Federal law.

(2) This division shall not preempt or supersede any State or Federal law that imposes greater procedural or substantive protections for health care providers and health care organizations from liability, loss, or damages than those provided by this division or create a cause of action.

(c) STATE FLEXIBILITY.—No provision of this division shall be construed to preempt—

(1) any State law (whether effective before, on, or after the date of the enactment of this Act) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this division, notwithstanding section 4102(a); or

(2) any defense available to a party in a health care lawsuit under any other provision of State or Federal law.

SEC. 4110. APPLICABILITY; EFFECTIVE DATE.

This division shall apply to any health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this Act, except that any health care lawsuit arising from an injury occurring prior to the date of the enactment of this Act shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Virginia is recognized for 5 minutes in support of the motion.

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Mr. CANTOR. Mr. Speaker, any physician in America will tell you that the simplest way to reduce health care costs is to enact real medical liability reform. The fear of being sued by opportunistic trial lawyers is pervasive in the practice of medicine. Our system wastes billions on defensive medicine that should be going to patient care. That's why real medical liability reform is needed. In fact, CBO estimates that as much as $54 billion can be saved by the Federal Government alone. It is totally unacceptable that this money is being spent in the courtroom instead of the operating room.

At the same time, the majority has promised the American people that their health care bill will lower costs, yet the bill before us today, Mr. Speaker, contains no medical liability reforms. And why not? The truth comes from one of the Democrats' own, no less than former DNC Chair and physician Howard Dean, who said last August, The reason that tort reform is not in the bill is because the people that wrote it did not want to take on the trial lawyers in addition to everybody else they were taking on, and that is the plain and simple truth.

Mr. Speaker, the Republican motion to recommit adds real meaningful medical liability and reform and uses its $54 billion in savings to create a fund that will protect seniors, especially those in rural areas, from the steep cuts to Medicare in the Democrats' reform package. It gives Members the chance to prioritize the health of our Nation's seniors instead of lining the bank accounts of trial lawyers. It's time to get trial lawyers out of the clinics and the operating rooms and leave patient care to the people trained to handle it best—our doctors.

Mr. Speaker, to talk about this further, I now yield to the gentlewoman from Florida, Congresswoman BROWN-WAITE.

Ms. GINNY BROWN-WAITE of Florida. Betty, a constituent of mine, recently told me that if it weren't for Medicare Advantage, she would be dead. You see, Medicare Advantage covers catastrophic costs traditional Medicare does not. The bill before us today seeks to eliminate that coverage for millions of seniors, but you have a chance to make it right here, ladies and gentlemen.

The choice on the motion is simple. You can put your seniors first or your trial lawyer contributors. A Member can vote to open up the coffers of the U.S. Treasury to trial lawyers or restore some of the cuts our seniors will suffer under the Pelosi bill and ObamaCare. Remember, this bill creates 111 new bureaucracies and entitlements, but the only one it cuts, ladies and gentlemen, the only one it cuts is Medicare. It's always been my position that any money cut from Medicare should be used to save Medicare, not to bail out the trial attorneys.

Democrats have denied seniors the protection they promised. They cut Medicare to create new benefits for the young, healthy, and the wealthy. We know where the Democrat leadership stands on this issue. The Speaker put her trial lawyer cash cows ahead of our seniors. AARP put their profits ahead of our seniors.

With this motion, you have a chance to restore some of our cuts. No excuses about this amendment killing the bill can be made. No word games can get you out of this. This has to be a vote for the seniors of America. Please remember your constituents will be watching.

Mr. CANTOR. Mr. Speaker, I now yield to the gentleman from Washington (Mr. REICHERT).

Mr. REICHERT. Thank you.

This motion was and will protect seniors from drastic cuts to Medicare and stop expensive lawsuits that increase the costs of health care for every American. We've heard, If you like it, you can keep it, but the bill before us is a direct assault on America's seniors, cutting $500 billion from Medicare.

Under this bill, one out of every five seniors will lose the Medicare health plan they chose. Because of regional payment disparities in many parts of this country, Medicare Advantage plans are the only way seniors can receive needed care. It's the only way that seniors can choose their doctors, and it's the only way that seniors can choose the preventive treatment they need.

This motion is about choice. It's about living in a free country. It's about having freedom. Mr. Speaker, this commonsense motion will protect seniors' health care, lower health care costs, and preserve freedom.

Mr. HOYER. Mr. Speaker, I rise in opposition to the motion to recommit.

The SPEAKER pro tempore. The gentleman from Maryland is recognized for 5 minutes.

Mr. HOYER. Mr. Speaker, I yield to the gentleman from Iowa (Mr. BRALEY).

Mr. BRALEY of Iowa. Mr. Speaker, during this entire health care debate, we've heard a lot from our friends on the other side of the aisle about something called medical liability reform, but all day as they've been talking about this point, you have not heard one word about patient safety. If you want to talk about real meaningful health care reform, it's important to talk about the most critical aspect of true, meaningful health care reform—standing up for patients. Who will speak for the patients?

Mr. Speaker, we know who will speak for the patients. We have the reports from the highly respected nonpartisan Institute of Medicine on patient safety. The first one is on patient safety, Achieving a New Standard for Care. The second one, Preventing Medication Errors, and To Err Is Human: Building a Safer Health System.

What did the Institute of Medicine tell us about the state of patient safety? They told us that the most significant way to reduce the costs of medical malpractice is to emphasize patient safety by reducing the number of preventable medical errors. They also told us that's the only way we're going to bring about meaningful health care reform. They also told us that medical errors kill as many as 98,000 Americans every year; and that, if it were ranked by the Centers for Disease Controls, would be the sixth leading cause of deaths in America.

☐ 2240

They also told us that every year there are 15 million incidents of medical harm in this country and that patient safety is indistinguishable from the delivery of medical care. That's why they aren't telling you about what the Institutes of Medicine reported the cost of medical errors is in this country.

They reported in their studies that every year medical errors add $17 billion to $28 billion of cost, most of it in additional medical care that we end up paying for as consumers of health care. When you multiply that over the 10 years of this bill, that means it's costing us $170 billion to $280 billion if we continue to ignore this problem. That's why Democrats and the Institutes of Medicine are standing up for patients, and that's why you should reject this motion to recommit.

You hear our friends talk about what happened in California in 1976 when they put a $250,000 cap on payments for quality-of-life damages. What they don't tell you is that the value of that cap today in 2009 is $64,000, and if you

adjust that cap at the same rate of medical inflation, it would be worth $1.9 million. That's what's wrong.

Mr. HOYER. I thank the gentleman for his comments.

My colleagues, I ask you to reject this amendment. Our colleagues on the other side of the aisle demanded 72 hours' notice for the bill and they've gotten 4 or 5 months' notice. They gave us 72 seconds to consider this amendment.

This amendment deals with some very complicated subjects; and it provides, of course, as we are not surprised that it would, for substantial billions of dollars back to the insurance companies. That's what their objective is. And, yes, they say something about equity of distribution of money. No study.

We set up a very careful study to make sure that the people's money is distributed to the States in an equitable, fair, effective fashion. That is why we ought to reject this amendment for which we received no notice, no consideration, no discussion in the public. The Republicans have been outraged about that.

I ask our party, I ask each one of us, to reject this motion to recommit and pass this bill.

The SPEAKER pro tempore. Without objection, the previous question is ordered on the motion to recommit.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to recommit.

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

RECORDED VOTE

Mr. CANTOR. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 187, noes 247, not voting 0, as follows:

[Roll No. 886]

AYES—187

Aderholt	Burton (IN)	Ellsworth
Akin	Buyer	Emerson
Alexander	Calvert	Fallin
Austria	Camp	Flake
Bachmann	Campbell	Fleming
Bachus	Cantor	Forbes
Barrett (SC)	Cao	Fortenberry
Bartlett	Capito	Foxx
Barton (TX)	Cardoza	Franks (AZ)
Biggert	Carter	Frelinghuysen
Bilbray	Cassidy	Gallegly
Bilirakis	Castle	Garrett (NJ)
Bishop (UT)	Chaffetz	Gerlach
Blackburn	Childers	Gingrey (GA)
Blunt	Coble	Gohmert
Boehner	Coffman (CO)	Goodlatte
Bonner	Cole	Gordon (TN)
Bono Mack	Conaway	Granger
Boozman	Costa	Graves
Boren	Crenshaw	Griffith
Boustany	Cuellar	Guthrie
Brady (TX)	Culberson	Hall (TX)
Bright	Davis (KY)	Harper
Broun (GA)	Deal (GA)	Hastings (WA)
Brown (SC)	Dent	Heller
Brown-Waite, Ginny	Diaz-Balart, L.	Hensarling
Buchanan	Diaz-Balart, M.	Herger
Burgess	Dreier	Hoekstra
	Ehlers	Hunter
	Inglis	McMorris Rodgers
	Issa	Mica
	Jenkins	Miller (FL)
	Johnson, Sam	Miller (MI)
	Jones	Miller, Gary
	Jordan (OH)	Minnick
	King (IA)	Moran (KS)
	King (NY)	Murphy (NY)
	Kingston	Murphy, Tim
	Kirk	Myrick
	Kline (MN)	Neugebauer
	Lamborn	Nunes
	Lance	Olson
	Latham	Paulsen
	LaTourette	Pence
	Latta	Petri
	Lee (NY)	Pitts
	Lewis (CA)	Platts
	Linder	Poe (TX)
	LoBiondo	Pomeroy
	Lucas	Posey
	Luetkemeyer	Price (GA)
	Lummis	Putnam
	Lungren, Daniel E.	Radanovich
	Mack	Rehberg
	Manzullo	Reichert
	Marchant	Roe (TN)
	Matheson	Rogers (AL)
	McCarthy (CA)	Rogers (KY)
	McCaul	Rogers (MI)
	McClintock	Rohrabacher
	McCotter	Rooney
	McHenry	Ros-Lehtinen
	McKeon	Roskam
		Royce
		Ryan (WI)
		Scalise
		Schmidt
		Schock
		Sensenbrenner
		Sessions
		Shadegg
		Shimkus
		Shuster
		Simpson
		Smith (NE)
		Smith (NJ)
		Smith (TX)
		Souder
		Stearns
		Sullivan
		Terry
		Thompson (PA)
		Thornberry
		Tiahrt
		Tiberi
		Turner
		Upton
		Walden
		Wamp
		Westmoreland
		Whitfield
		Wilson (SC)
		Wittman
		Wolf
		Young (AK)
		Young (FL)

NOES—247

Abercrombie	Donnelly (IN)	Kirkpatrick (AZ)
Ackerman	Doyle	Kissell
Adler (NJ)	Driehaus	Klein (FL)
Altmire	Duncan	Kosmas
Andrews	Edwards (MD)	Kratovil
Arcuri	Edwards (TX)	Kucinich
Baca	Ellison	Langevin
Baird	Engel	Larsen (WA)
Baldwin	Eshoo	Larson (CT)
Barrow	Etheridge	Lee (CA)
Bean	Farr	Levin
Becerra	Fattah	Lewis (GA)
Berkley	Filner	Lipinski
Berman	Foster	Loebsack
Berry	Frank (MA)	Lofgren, Zoe
Bishop (GA)	Fudge	Lowey
Bishop (NY)	Garamendi	Luján
Blumenauer	Giffords	Lynch
Boccieri	Gonzalez	Maffei
Boswell	Grayson	Maloney
Boucher	Green, Al	Markey (CO)
Boyd	Green, Gene	Markey (MA)
Brady (PA)	Grijalva	Marshall
Braley (IA)	Gutierrez	Massa
Brown, Corrine	Hall (NY)	Matsui
Butterfield	Halvorson	McCarthy (NY)
Capps	Hare	McCollum
Capuano	Harman	McDermott
Carnahan	Hastings (FL)	McGovern
Carney	Heinrich	McIntyre
Carson (IN)	Herseth Sandlin	McMahon
Castor (FL)	Higgins	McNerney
Chandler	Hill	Meek (FL)
Chu	Himes	Meeks (NY)
Clarke	Hinchey	Melancon
Clay	Hinojosa	Michaud
Cleaver	Hirono	Miller (NC)
Clyburn	Hodes	Miller, George
Cohen	Holden	Mitchell
Connolly (VA)	Holt	Mollohan
Conyers	Honda	Moore (KS)
Cooper	Hoyer	Moore (WI)
Costello	Inslee	Moran (VA)
Courtney	Israel	Murphy (CT)
Crowley	Jackson (IL)	Murphy, Patrick
Cummings	Jackson-Lee (TX)	Murtha
Dahlkemper	Johnson (GA)	Nadler (NY)
Davis (AL)	Johnson (IL)	Napolitano
Davis (CA)	Johnson, E. B.	Neal (MA)
Davis (IL)	Kagen	Nye
Davis (TN)	Kanjorski	Oberstar
DeFazio	Kaptur	Obey
DeGette	Kennedy	Olver
Delahunt	Kildee	Ortiz
DeLauro	Kilpatrick (MI)	Owens
Dicks	Kilroy	Pallone
Dingell	Kind	Pascrell
Doggett		Pastor (AZ)
		Paul
		Payne
		Perlmutter
		Perriello
		Peters
		Peterson
		Pingree (ME)
		Polis (CO)
		Price (NC)
		Quigley
		Rahall
		Rangel
		Reyes
		Richardson
		Rodriguez
		Ross
		Rothman (NJ)
		Roybal-Allard
		Ruppersberger
		Rush
		Ryan (OH)
		Salazar
		Sánchez, Linda T.
		Sanchez, Loretta
		Sarbanes
		Schakowsky
		Schauer
		Schiff
		Schrader
		Schwartz
		Scott (GA)
		Scott (VA)
		Serrano
		Sestak
		Shea-Porter
		Sherman
		Shuler
		Sires
		Skelton
		Slaughter
		Smith (WA)
		Snyder
		Space
		Speier
		Spratt
		Stark
		Stupak
		Sutton
		Tanner
		Taylor
		Teague
		Thompson (CA)
		Thompson (MS)
		Tierney
		Titus
		Tonko
		Towns
		Tsongas
		Van Hollen
		Velázquez
		Visclosky
		Walz
		Wasserman Schultz
		Waters
		Watson
		Watt
		Waxman
		Weiner
		Welch
		Wexler
		Wilson (OH)
		Woolsey
		Wu
		Yarmuth

□ 2259

So the motion to recommit was rejected.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore. The question is on the passage of the bill.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

RECORDED VOTE

Mr. BURTON of Indiana. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, this 15-minute vote on passage of the bill will be followed by a 5-minute vote on the motion to suspend the rules on House Resolution 895.

The vote was taken by electronic device, and there were—ayes 220, noes 215, not voting 0, as follows:

[Roll No. 887]

AYES—220

Abercrombie	Cooper	Grayson
Ackerman	Costa	Green, Al
Andrews	Costello	Green, Gene
Arcuri	Courtney	Grijalva
Baca	Crowley	Gutierrez
Baldwin	Cuellar	Hall (NY)
Bean	Cummings	Halvorson
Becerra	Dahlkemper	Hare
Berkley	Davis (CA)	Harman
Berman	Davis (IL)	Hastings (FL)
Berry	DeFazio	Heinrich
Bishop (GA)	DeGette	Higgins
Bishop (NY)	Delahunt	Hill
Blumenauer	DeLauro	Himes
Boswell	Dicks	Hinchey
Brady (PA)	Dingell	Hinojosa
Braley (IA)	Doggett	Hirono
Brown, Corrine	Donnelly (IN)	Hodes
Butterfield	Doyle	Holt
Cao	Driehaus	Honda
Capps	Edwards (MD)	Hoyer
Capuano	Ellison	Inslee
Cardoza	Ellsworth	Israel
Carnahan	Engel	Jackson (IL)
Carney	Eshoo	Jackson-Lee (TX)
Carson (IN)	Etheridge	Johnson (GA)
Castor (FL)	Farr	Johnson, E. B.
Chu	Fattah	Kagen
Clarke	Filner	Kanjorski
Clay	Foster	Kaptur
Cleaver	Frank (MA)	Kennedy
Clyburn	Fudge	Kildee
Cohen	Garamendi	Kilpatrick (MI)
Connolly (VA)	Giffords	Kilroy
Conyers	Gonzalez	