This kind of collaborative effort by local groups can be the kind of national model other struggling rural communities should consider as they work to rebuild their infrastructure and economies. Cities across America are realizing that investing in outdoor recreation options like bikeways is an affordable way to significantly improve their quality of life and, in the process, improve their competitiveness to attract new businesses and jobs.

It is time to remember that our infrastructure can't just be focused on ways to bring more cars onto our already stressed roads. Fixing highways and bridges is critically important, but for better health, relaxation, and the economic benefits they can bring, bikeways can also be part of the solution to fix our infrastructure and help revive struggling communities back home.

RESPONSE TO SLATE ARTICLE BY JACOB WEISBERG

Mr. GRASSLEY. Mr. President, I would like to address an article written by Jacob Weisberg for Slate magazine on December 12, 2009. This article is entitled, ''Are Republicans Serious About Fixing Health Care? No, and here's the proof.'' In this article, Mr. Weisberg unfairly and misleadingly takes aim at my position in the current health reform debate.

The author reports that I have criticized the Reid bill for creating an ''indefensible new entitlement'' and that it ''expands the deficit, threatens Medicare, and does too little to restrain health care inflation.''

I don't dispute Mr. Weisberg attributing these criticisms of the Reid bill to me. But, Mr. Weisberg can't dispute these serious shortcomings of the Reid bill that I and other Members on this side of the aisle have been discussing on the Senate floor for the past weeks. In fact, both the nonpartisan Congressional Budget Office, CBO, and the independent Department of Health and Human Services, HHS, Chief Actuary have confirmed that the Reid bill would not only establish this indefensible new entitlement, but also represent the largest expansion of government-run health care in history. But let me go through each criticism of the Reid bill that Mr. Weisberg has correctly reported.

The Reid bill will expand the deficit. Mr. Weisberg identifies the 10-year CBO score of the bill to be $848 billion, but that is comprised of 10 years of Medicare cuts and tax increases and only 6 years of outlays. So if he were intellectually honest, Mr. Weisberg would have used the cost of 10 years of outlays, which budget analysts assume to be closer to $2.5 trillion. But the use of budget gimmickry does not end there when supporters of the Reid bill claim that it is deficit neutral.

One of the biggest problems in Medicare that we have to address in Congress every year is the Medicare physician payment formula or the sustainable growth rate, SGR. Comprehensively fixing the SGR costs well over $200 billion. Only providing a two-month temporary patch for the problem will result in a more than 20-percent drop in Medicare physician payments beginning in March of next year. To me and many other Members of Congress, health care reform includes fixing the SGR so that physicians can be assured of not facing drastic Medicare payment cuts year after year and so that beneficiaries can be assured of having access to physicians. But there is no SGR fix in the Reid bill. Do the math and you will see why. A comprehensive SGR fix of over $200 billion would wipe away the $132 billion in budgetary savings that the Reid bill is currently reported to have.

In fact, the Congressional Budget Office noted that the estimated cost of repealing the SGR and replacing it with a permanent freeze would be about $207 billion once physician-administered drugs were removed from the calculation of the SGR formula. That was done in the physician rule that CMS finalized on October 30, 2009. However, according to CBO, the removal of those drugs from the SGR formula will increase Medicare's spending for physician services, as well as federal spending under TRICARE by $78 billion over the 2010–2019 period. The net impact on the budget would be close to $300 billion over 10 years, none of which is reflected in the Reid bill.

And let's take a look at what is in the bill. I certainly hope Mr. Weisberg did when he wrote his article. A good portion of the budgetary savings in the Reid bill is from the CLASS Act. This program apparently produces budgetary savings during the first 10 years, but only because no benefits pay out for the first 5 years. This makes the revenues outpace the program's outlays. But CBO has stated that outlays will outpace revenues after the first 10 years. This means that the CLASS act will result in deficit spending over the long run. In fact, the chairman of the Budget Committee, a Democrat, called the CLASS Act a massive government ponzi scheme. So this casts serious doubt on those who tout that the Reid bill is deficit neutral or saves money.

The Reid bill also threatens Medicare. I don't think Mr. Weisberg can argue that close to $½ trillion in Medicare cuts won't jeopardize beneficiary access to care. Even the White House's own Chief Actuary confirmed that the Reid bill jeopardizes beneficiary access to care. He raised concerns in particular about two categories of these Medicare cuts. First, the Chief Actuary warned about the permanent productivity adjustments to annual payment updates. Under the Reid bill, these productivity adjustments automatically cut annual Medicare payment updates based on productivity measures of the entire economy. Referring to these cuts, he wrote that ''the estimated savings . . . may be unrealistic.'' In his analysis of these provisions, Medicare's own Chief Actuary stated, ''it is doubtful that many could improve their own productivity to the degree achieved by the economy at large,'' and that they ''are not aware of any empirical evidence demonstrating the medical community's ability to achieve productivity improvements equal to those of the overall economy.'' In fact, the Chief Actuary's conclusion is that it would be difficult for providers to even remain profitable over time as Medicare payments fail to keep up with the costs of caring for beneficiaries. Ultimately, the Chief Actuary's conclusion is that providers who rely on Medicare might end their participation in Medicare, ''possibly jeopardizing access to care for beneficiaries.''

The Chief Actuary even has numbers to back up these statements. His office ran simulations of the effects of these drastic and permanent cuts. And based on these simulations, the Chief Actuary found that during the first 10 years, '' 20 percent of Medicare Part A providers would become unprofitable as a result of the productivity adjustments.'' That's one out of five hospitals, nursing homes and hospices. It is for this reason that the Chief Actuary found, ''reductions in payment updates based on economy-wide productivity gains, are unlikely to be sustainable on a permanent annual basis.''

The second category of Medicare cuts that the Chief Actuary raised concerns about would be imposed by the new Independent Payment Advisory Board created in the Reid bill. This is the new body of unelected officials that would have broad authority to make even further cuts in Medicare. These additional cuts in Medicare would be driven by arbitrary cost growth targets. This board would have the authority to impose further automatic Medicare cuts even absent any Congressional action. The Chief Actuary gave a reality check to this proposal. He showed how tall an order the Reid bill's target for health care cost growth actually is. According to the HHS Chief Actuary, limiting cost growth to a level below medical price inflation ''would represent an exceedingly difficult challenge.'' He pointed out in this analysis that Medicare cost growth was below this target in only 4 of the last 25 years.

The HHS Chief Actuary also pointed out that the backroom deals that carved out certain types of providers would complicate this board's efforts to cut Medicare cost growth. According to the analysis, ''[t]he necessary savings would have to be achieved primarily through changes affecting physician services, Medicare Advantage payments and Part D.'' So providers like hospitals will escape from this board's cuts at the expenses of doctors, seniors enrolled in Medicare Advantage plans and seniors who will pay higher premiums for their Medicare drug coverage. If we surveyed the nation's seniors, I doubt very much they would say that raising their premiums for Medicare drug coverage or limiting preventive benefits in Medicare Advantage is

what they would call health care reform.

And this board is guaranteed to have to impose these additional Medicare cuts. According to the Chief Actuary's analysis of the Medicare cuts in the Reid bill, even though the Medicare cuts already in the Reid bill are ''quite substantial'' they ''would not be sufficient to meet the growth rate targets.'' So this means the board will be required by law to impose even more Medicare cuts in addition to the massive Medicare cuts already in the Reid bill. And this will make it even harder for our seniors to find providers who will treat them.

Not only does the Reid bill ''[do] too little to restrain health care inflation,'' it actually increases health care inflation. According to the HHS Chief Actuary, the Reid bill would bend the health care cost curve the wrong way. Over the next 10 years, the Administration's own Actuary stated that ''total national health expenditures under this bill would increase by an estimated total of $234 billion.'' As a result of that increase, health care would then be projected to grow from 17 percent to 20.9 percent of the gross domestic product in 2019. So using the Reid bill to curb health care cost growth would be like putting out a fire with gasoline.

The Chief Actuary also found that a good portion of the increase in national health expenditures would be caused by the so-called fees in this bill on medical devices, on prescription drugs and on health insurance premiums. He stated, that these ''fees would be passed through to health consumers in the form of higher drug and device prices and higher insurance premiums.'' This would result in, ''an associated increase of approximately 11 billion dollars per year in overall national health expenditures.''

Higher premiums from the Reid bill are no trifling matter. In fact, one estimate concluded that the Senate bill would increase premiums by about 50 percent on average for individuals without employer-based coverage, and more than 20 percent for small businesses. And even the Congressional Budget Office's more conservative analysis predicts that premiums will increase 10 to 13 percent for 14 million Americans as a result of the Reid bill.

But that is where my agreement with Mr. Weisberg ends. He then proceeds to lob several troubling and incorrect claims at me in his attempt to portray me as ''incoherent.''

Mr. Weisberg distorts what I said in response to a constituent's question at a town hall meeting in Iowa last August when he accuses me of playing the ''age card.'' This is what Mr. Weisberg claims that I said: ''There is some fear, because in the House bill, there is counseling at the end of life. And from that standpoint, you have every right to fear ''

But this is what was actually said at that meeting:

Question from Iowan: ''Thank you, Senator GRASSLEY, for coming. The Democrats tell us all the time that it's a right of every American to have health care. Yet it seems this Obama plan will systematically deny those rights to certain groups like the elderly. And I, as a person in my 60's I'm getting very concerned about the health care that I might be able to have if this bill passes. . . .

Iowan Restating the Question: ''Ok . . . [the question] involves limited coverage because of a person's background and age, race, physical condition such as that. Basically it was on the lady's age.''

Senator GRASSLEY: ''''[V]ery recently in things that we've been talking about in our negotiations has been just exactly what you brought up. I won't name people in Congress or people in Washington, but there's some people that think that it's a terrible problem that Grandma's laying in the hospital bed with tubes in her, and think that there ought to be some government policy that enters into that. I'm just on the opposite. I think that's a family and a religious and or ethical thing that needs to be dealt with and there's some fear because in the House bill there's counseling for end of life. And from that standpoint, you have every right to fear. You shouldn't have counseling at the end of life. You ought to have counseling 20 years before you're going to die. You ought to plan these things out. And, you know, I don't have any problem with things like living wills, but they ought to be done within the family. We should not have a government program that determines you're going to pull the plug on Grandma. Thank you all very much for coming.''

Mr. Weisberg is not the first who has taken what I said during this exchange and twisted it to attempt to portray me as a fearmongerer. And unfortunately he probably won't be the last. What's even more unfortunate is that Mr. Weisberg and those like him fail to see the legitimate cause for concern when you have a combination of the expanded role of government in health care generally plus funding for advance care planning consultations alongside cost containment proposals. Some commentators took my comments and twisted them and even quoted me as saying the House health care reform bill would establish death panels, and this was blatantly incorrect. As you can see from what was said at the town meeting, I said no such thing. As I said then, putting end-of-life consultations alongside cost containment and government-run health care causes legitimate concern.

And to address another point that Mr. Weisberg makes, a provision that provided for the option of advance care planning was in a bill I supported. In 2003, Congress enacted a narrow provision to offer coverage for hospice consultation services for Medicare beneficiaries who have been diagnosed as terminally ill. Under this provision, this consultation would be covered only when provided by a health care provider with expertise in end-of-life issues such as a hospice physician. The covered services include a pain and care management evaluation, counseling about hospice care and other optional services such as advice on advance care planning. This provision was designed to assure that advice on advance care planning in this context is only offered by qualified professionals and done in an appropriate manner.

In his article, Mr. Weisberg misses the point. The core of this issue is when it comes to advance care planning, what role, if any, the government should play. When the government attempts to influence these sensitive decisions, it raises the possibility that the government's interests may be different and potentially incompatible with the patient's interests.

When provisions to increase the government role in advance care planning are included alongside cost containment provisions, it raises the concern that the purpose for the proposal is to save money rather than to ensure appropriate care at the end of life. And that is in fact what has already happened. This idea of encouraging living wills was originally proposed by the Carter administration in 1977 as an option to produce both federal and system-wide savings in health expenditures. More recently, the Urban Institute published a paper in July 2009 that identified proposals like advance care planning consultations as a way to help cut costs to offset spending for health care reform. Compassion and Choices, formerly known as the Hemlock Society, has also advocated for the inclusion of advance care planning consultations in health care reform legislation. Minimizing such an important issue or trying to turn it into an amusing story as Mr. Weisberg has done debases the important discussion that needs to occur on this sensitive and personal issue.

Mr. Weisberg then criticizes Medicare Part D, which I championed, in his attempt to question my opposition to the Reid bill. In 2003, Medicare was 37 years old and functioning a lot like it had on day one. It emphasized treatment, not prevention, not disease management. It was a horse-and-buggy version of health care compared with the kind of coverage that other Americans received through their employers. Then, as now, employer-based health plans often covered prescription drugs. Employers realized it was cost-effective to pay for a relatively cheap cholesterol-lowering drug if it meant avoiding a triple bypass down the road. But Medicare beneficiaries were stuck in 1965 when prescription drugs were less vital than they are today. And because Medicare didn't cover prescription drugs, they often were forced to forgo medications, pay out of pocket, try to find an affordable supplemental policy, or take a bus to Canada to get their medicines.

Republicans and Democrats alike agreed Medicare beneficiaries deserved 21st century health care coverage, including prescription drug coverage. However, there were still differences on how much the government could afford to spend on providing this new benefit. In May of 2002, Republicans put forth a $350 billion proposal to provide comprehensive drug coverage to America's

seniors. The Democrats thought this was insufficient and put forth their own proposal totaling close to $600 billion. At the end of the day, the fiscal year 2004 budget resolution included a $400 billion reserve fund for the creation of the drug benefit.

While there was bipartisan support for the drug benefit, Democrats nevertheless continued to argue that Congress should be spending more. For example, former Senator Bob Graham of Florida said, ''Some would argue that this budget includes $400 billion for a Medicare prescription drug benefit. They know full well that $400 billion is inadequate to provide an affordable, comprehensive, universal prescription drug benefit for America's seniors.'' The late Senator Edward Kennedy stated, ''This budget has far less funding than is necessary to provide a meaningful prescription drug benefit for all seniors.'' And Senator TOM HARKIN stated, ''We need a budget that is balanced, that takes the approach that we need to reduce the debt to take care of the baby boomers and provide for a decent drug benefit for the elderly. Clearly, the $400 billion proposed for prescription drugs and other medical reforms is far too low for that purpose.'' Congress eventually passed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Medicare Modernization Act, Public Law 108–173, on a bipartisan basis and created the drug benefit that year. In contrast to the process we are witnessing this year on health care reform, the final conference report from the MMA passed the Senate with the support of 11 Democrats and one Independent. And yet I can't help but think that if the Democrats had their way on the total amount of spending almost twice as much on the drug benefit, then far more than this responsible bipartisan amount would have been spent. And certainly despite the criticism that the new drug benefit is often subjected to from the left, not even the most staunch opponents of Part D have proposed repealing the drug benefit for our Nation's seniors.

Now in addition to the bipartisan support for the creation of the benefit, the vast majority of Medicare beneficiaries also like their prescription drug coverage. Survey after survey consistently shows that the benefit enjoys broad support from beneficiaries. According to Medicare Today, 88 percent of Part D enrollees are satisfied with the program. And the program has come in $239 billion under budget. When was the last time you could say that about a government program? Furthermore, the fact that Medicare beneficiaries are able to obtain their prescription drugs and afford them means fewer hospitalization and emergency room visits when diseases like diabetes, heart disease, and pulmonary disease are properly managed with modern prescription drug therapy.

How is adding prescription drug coverage to Medicare different from the current health care debate?

Medicare was already 37 years old when Congress added prescription drug coverage. The Medicare structure was well-established. Congress worked in a bipartisan way to set aside the funding to improve the program and do so without disrupting the parts that already worked for tens of millions of people. Don't forget that 76 senators voted in favor of the Senate bill for the drug benefit including 35 Democrats and one Independent. We certainly can't say the same for the current health care reform effort in the Senate.

One key difference is the fact that the prescription drug benefit is purely voluntary, unlike the mandatory system of insurance coverage for everyone proposed in the current health reform bills that is backed up with the imposition of stiff fines on those who don't comply. Under the Medicare benefit, seniors who don't need prescription coverage or who don't see it is a good value for the premium don't have to get it. The drug benefit is provided and administered by private entities, which compete for beneficiaries' business. And this competition between plans has kept the overall cost of the program down.

And let's not forget what we were trying to do back in 2003 compared to what is happening in Congress now. Back in 2003, we were operating on a budget surplus, and there was bipartisan support to address a need by creating the Medicare drug benefit. The Medicare Modernization Act met this need.

The situation is totally different in 2009. We are now operating on record budget deficits. So the goal of any health reform legislation should be to bend the cost curve. But as the HHS Chief Actuary has established, the Reid bill fails to do so.

In response to those who say the drug benefit only added to Medicare's expenses, the Medicare Modernization Act also expanded coverage of preventive services to emphasize less expensive prevention over more costly treatment. The law created a specific process for overall program review if general revenue spending exceeded a specified threshold. And it took the politically bold step of introducing the concept of income testing into Medicare, with higher income people paying larger Part B premiums beginning in 2007.

Also, Mr. Weisberg makes several additional points about Medicare Part D that are simply wrong. For example, he states that the government prohibition from negotiating drug prices with manufacturers only raises the Medicare Part D pricetag. CBO, the Chief Actuary, and noted economists have all found the exact opposite to be true. The Chief Actuary stated that ''direct price negotiation by the Secretary would be unlikely to achieve prescription drug discounts of greater magnitude that those negotiated by Medicare prescription drug plans responding to competitive forces.'' And CBO has concluded that ''the Secretary would be unable to negotiate prices across the broad range of covered Part D drugs that are more favorable than those obtained by PDPs under current law.'' Even the Washington Post editorial page has stated that ''governments are notoriously bad at setting prices, and the U.S. government is notoriously bad at setting prices in the medical realm.'' What's more, the idea of private negotiation on drug costs originated with none other than President Bill Clinton. Under President Clinton's plan, he proposed that ''[p]rices would be determined through negotiations between the private benefit administrators and drug manufacturers.'' President Clinton's plan was introduced on April 4, 2000 as S. 2342 by the late Senator Moynihan by request.

Mr. Weisberg also uses incorrect data to compare the 10-year cost of Medicare Part D and the Reid bill. Medicare Part D costs do not ''dwarf'' the Reid bill costs as Mr. Weisberg claims because the true 10-year cost of the Reid bill, as acknowledged by supporters of the bill on the Senate floor, is $2.5 trillion and not the $848 billion figure that he uses.

So attempting to portray me as being ''incoherent'' for opposing the Reid bill even though I championed the Medicare Modernization Act is absolute nonsense.

The Medicare Modernization Act did not impose a $2½ trillion tab on Americans. It did not kill jobs with taxes and fees that go into effect 4 years before the reforms kick in. It did not kill jobs and lower wages with an employer mandate. It did not impose a half a trillion in higher taxes on premiums, on medical devices, on prescription drugs, and more. It did not jeopardize access to care with massive Medicare cuts. It did not impose higher health care costs. And it did not raise health premiums for millions of Americans like the Reid bill will do.

Mr. President, I ask unanimous consent to have printed in the RECORD the December 12, 2009, Slate article by Jacob Weisberg.

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

[From the Slate, Dec. 12, 2009]

ARE REPUBLICANS SERIOUS ABOUT FIXING HEALTH CARE?

(By Jacob Weisberg)

Iowa Sen. Charles Grassley, the top Republican on the Senate finance committee, has emerged as one of the harshest critics of what the right likes to call ''Obamacare.'' After spending the first half of the year working with Democrats to find a bipartisan compromise, Grassley has spent the second half trying to prevent one. He attacks the bill now being debated on the Senate floor as an indefensible new entitlement. He complains that it expands the deficit, threatens Medicare, and does too little to restrain health care inflation. At a town hall meeting in August, the 76-year-old Iowan played the age card. ''There is some fear, because in the House bill, there is counseling for end of life. And from that standpoint, you have every right to fear,'' he told an audience in John Wayne's hometown of Winterset.

One might credit the sincerity, if not the validity, of such concerns were it not for an inconvenient bit of history. Not so long ago, when Republicans controlled the Senate, Grassley was the chief architect of a bill that actually did most of the bad things he now accuses the Democrats of wanting. As chairman of the finance committee, Grassley championed the legislation that created a prescription-drug benefit under Medicare. The contrast between what he and his colleagues said during that debate in 2003 and what they're saying in 2009 exposes the disingenuousness of their current complaints.

Today the Medicare prescription-drug debate is remembered mainly for the political shenanigans Republicans used to get their bill through. Bush officials lied about the numbers and threatened to fire Medicare's chief actuary if he shared honest cost estimates with Congress. House Republicans cut off C–SPAN and kept the roll call open for three hours—as opposed to the requisite 15 minutes—while cajoling the last few votes they needed for passage. Former Majority Leader Tom DeLay was admonished by the House ethics committee for winning the eleventh-hour support of Nick Smith, a Michigan Republican, by threatening to vaporize Smith's son in an upcoming election. It's worth remembering these moments when Republicans criticize Democratic Majority Leader Harry Reid for his hardball tactics.

The real significance of that episode, however, is not their bad manners, but what Republicans ordered the last time health care was on the menu. Their bill, which stands as the biggest expansion of government's role in health care since the creation of Medicare and Medicaid in 1965, created an entitlement for seniors to purchase low-cost drug coverage. Grassleycare, also known as Medicare Part D, employs a complicated structure of deductibles, co-pays, and coverage limits. Thanks to something called the ''doughnut hole,'' drug coverage disappears when out-of-pocket costs reach $2,400, returning only when they hit $3,850. Simply stated, the bill cost a fortune, wasn't paid for, is complicated as hell, and doesn't do all that much—though it does include coverage for end-of life-counseling, or what Grassley now calls ''pulling the plug on grandma.''

In their 2009 report to Congress, the Medicare trustees estimate the 10-year cost of Medicare D as high as $1.2 trillion. That figure—just for prescription-drug coverage that people over 65 still have to pay a lot of money for—dwarfs the $848 billion cost of the Senate bill. The Medicare D price tag continues to escalate because the bill explicitly bars the government from using its market power to negotiate drug prices with manufacturers or establishing a formulary with approved medications.

And unlike the Democratic bills, which won't add to the deficit, the bill George W. Bush signed was financed entirely through deficit spending. While Grassley and his colleagues accuse Democrats of harming Medicare through cost cuts, it is their bill that has done the most to hasten Medicare's coming insolvency. Between now and 2083, Medicare D's unfunded obligations amount to $7.2 trillion according to the trustees. Numbers like these prompted former Comptroller General David M. Walker to call it ''. . . probably the most fiscally irresponsible piece of legislation since the 1960s.''

Grassley is not alone in his incoherence. Of 28 current Republican senators who were in the Senate back in 2003, 24 voted for the Medicare prescription-drug benefit. Of 122 Republicans still in the House, 108 voted for it. There is not space here to fully review this hall of shame, which includes Lamar Alexander of Tennessee, Mike Enzi of Wyoming, Kay Bailey Hutchison of Texas, and Orrin Hatch of Utah, among many others. Here is Kansas Republican Sam Brownback in 2003: ''The passage of the Medicare bill fulfills a promise that we made to my parents'' generation and keeps a promise to my kids' generation.'' Here is Brownback in 2009: ''This hugely expensive bill will not lower costs and will not cover all uninsured.''Here is Jon Kyl of Arizona: ''As a member of the bipartisan team that crafted the Part D legislation, I am committed to ensuring its successful implementation. I will fight attempts to erode Part D coverage.'' Kyl now calls Harry Reid's legislation: ''a trillion-dollar bill that raises premiums, increases taxes, and raids Medicare.''

The explanation for this vast collective flip-flop is—have you guessed?—politics. Medicare recipients are much more likely to vote Republican than the uninsured who would benefit most from the Democratic bills. In 2003, Karl Rove was pushing the traditional liberal tactic of solidifying senior support with a big new federal benefit, don't worry about how to pay for it. Today, GOP incumbents are more worried about fending off primary challenges from the right, like the one Grassley may face in 2010, or being called traitors by Rush Limbaugh. But what happened the last time they were in charge gives the lie to their claim that they object to expanding government. They only object to expanding government in a way that doesn't help them get re-elected.

JUDICIAL NOMINATIONS

Mr. SESSIONS. Mr. President, as the first session of the 111th Congress comes to a close, I believe it is important to correct the record regarding the Senate's processing of judicial nominations. Despite the statements of some of my Democrat colleagues to the contrary, the fact is we have been moving nominees at a fair and reasonable pace. The Judiciary Committee has held hearings for every one of President Obama's circuit court nominees and all of his district court nominees that are ripe for a hearing. At this point in President Bush's administration, 30 nominees had yet to even receive a hearing. As the numbers bear out, President Obama's nominees have fared far better.

Allegations that Republicans are delaying confirmation votes ring hollow. Democrats control 60 votes in the Senate and set the agenda for the floor. If my Democrat colleagues are dissatisfied with the pace of nominations, I suggest that they look to their leader. On Tuesday, the majority and minority leaders announced that we will vote on Judge Beverly Martin's nomination to the Eleventh Circuit Court of Appeals on January 20. As I have said many times before, Republicans have been ready and willing to proceed to a roll call vote on this nomination for months. I do not know the majority leader's reasons for not calling up the nomination sooner. Indeed, I do not claim to know the majority leader's reasons for not calling up a number of nominations. Perhaps in some cases it is because my Democrat colleagues do not want to have a debate on the merits and expose to the American people just what types of individuals the President has nominated to serve on the Federal bench and in crucial positions at the Justice Department. Or perhaps, and I sincerely hope that this is not the case, Democrats have been purposefully delaying nominees in order to create the illusion that Republicans are obstructing.

It bears mention that the average time from nomination to confirmation for nominees to the Circuit Courts of Appeal under President Bush was 350 days. And that was just the average. The majority of President Bush's first nominees to the circuit courts waited years for confirmation votes and some of them never even received a hearing, despite being highly qualified, outstanding nominees.

It has been suggested by some that roll call votes should not be required for judicial nominees, as if this is something that has never been done before. In fact, rollcall votes and time agreements for noncontroversial judicial nominees became routine in 2001, at the insistence of Chairman LEAHY and former Majority Leader Daschle. During the Bush administration, of the 327 article III judges confirmed by the Senate, 59 percent were by rollcall vote. The vast majority of those—86 percent—were consensus, noncontroversial nominees who were unanimously approved. In short, in 2001 the Democrats adopted a new standard: a presumption that all lifetime appointments receive a formal recorded vote. There is no reason that presumption should change now simply because a Democrat is in the White House. Notwithstanding that new standard, I would be remiss if I did not point out that four of the last five judicial nominees that we have confirmed have been confirmed without rollcall votes.

Over the past month, the Senate has been consumed in a debate on a healthcare bill that would create an enormous entitlement program, the likes of which we have never before seen in this country. Tomorrow morning, the Senate will proceed to a vote on this monumental piece of legislation. It can hardly be said that it has been ''business as usual'' in the Senate. While Senators have been focused on health care, as they should be, Democrats have seen fit to slip through lifetime appointments to the Federal judiciary. Just last week, Chairman LEAHY scheduled a hearing for two Fourth Circuit nominees in the middle of this historic debate. Both Judge Diaz and Judge Wynn were nominated by the President on November 4, 2009. This is a quick turnaround for any circuit court nominee, and it is especially quick for a nominee to the Fourth Circuit. During the 110th Congress, despite the 33 percent vacancy rate and overwhelming need for judges, four nominees to that court were needlessly delayed: Mr. Steve Matthews, Judge Robert Conrad, Judge Glen Conrad, and Mr. Rod Rosenstein.

President Bush nominated Steve Matthews on September 6, 2007, to the same seat on the Fourth Circuit for