[Rollcall Vote No. 196 Ex.]

YEAS—80

Alexander	Fischer	Peters
Baldwin	Gardner	Portman
Barrasso	Graham	Reed
Blackburn	Grassley	Risch
Blunt	Hassan	Roberts
Boozman	Hawley	Romney
Braun	Hoeven	Rosen
Brown	Hyde-Smith	Rounds
Burr	Inhofe	Rubio
Capito	Isakson	Sasse
Cardin	Johnson	Schatz
Carper	Jones	Schumer
Casey	Kaine	Scott (FL)
Cassidy	Kennedy	Scott (SC)
Collins	King	Shaheen
Coons	Lankford	Shelby
Cornyn	Leahy	Sinema
Cortez Masto	Lee	Sullivan
Cotton	Manchin	Tester
Cramer	McConnell	Thune
Crapo	McSally	Tillis
Cruz	Menendez	Toomey
Daines	Moran	Van Hollen
Durbin	Murkowski	Warner
Enzi	Murphy	Whitehouse
Ernst	Paul	Wicker
Feinstein	Perdue	

NAYS—14

Bennet	Klobuchar	Stabenow
Blumenthal	Markey	Udall
Cantwell	Merkley	Warren
Harris	Murray	Wyden
Hirono	Smith	

NOT VOTING—6

Booker	Gillibrand	Sanders
Duckworth	Heinrich	Young

The nomination was confirmed.

EXECUTIVE CALENDER

The PRESIDING OFFICER. The clerk will report the next nomination.

The bill clerk read the nomination of Damon Ray Leichty, of Indiana, to be United States District Judge for the Northern District of Indiana.

The PRESIDING OFFICER. The question is, Will the Senate advise and consent to the Leichty nomination?

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

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The clerk will call the roll.

The clerk called the roll.

Mr. DURBIN. I announce that the Senator from New Jersey (Mr. BOOKER), the Senator from Illinois (Ms. DUCKWORTH), the Senator from New York (Mrs. GILLIBRAND), the Senator from New Mexico (Mr. HEINRICH), and the Senator from Vermont (Mr. SANDERS) are necessarily absent.

The PRESIDING OFFICER (Mr. LANKFORD). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 85, nays 10, as follows:

[Rollcall Vote No. 197 Ex.]

YEAS—85

Alexander	Cantwell	Cotton
Baldwin	Capito	Cramer
Barrasso	Cardin	Crapo
Bennet	Carper	Cruz
Blackburn	Casey	Daines
Blunt	Cassidy	Enzi
Boozman	Collins	Ernst
Braun	Coons	Feinstein
Brown	Cornyn	Fischer
Burr	Cortez Masto	Gardner
Graham	McSally	Scott (FL)
Grassley	Menendez	Scott (SC)
Hassan	Merkley	Shaheen
Hawley	Moran	Shelby
Hirono	Murkowski	Sinema
Hoeven	Murphy	Sullivan
Hyde-Smith	Paul	Tester
Inhofe	Perdue	Thune
Isakson	Peters	Tillis
Johnson	Portman	Toomey
Jones	Reed	Udall
Kaine	Risch	Van Hollen
Kennedy	Roberts	Warner
King	Romney	Whitehouse
Lankford	Rosen	Wicker
Leahy	Rounds	Wyden
Lee	Rubio	Young
Manchin	Sasse	
McConnell	Schumer	

NAYS—10

Blumenthal	Markey	Stabenow
Durbin	Murray	Warren
Harris	Schatz	
Klobuchar	Smith	

NOT VOTING—5

Booker	Gillibrand	Sanders
Duckworth	Heinrich	

The nomination was confirmed.

The PRESIDING OFFICER. Under the previous order, the motion to reconsider is considered made and laid upon the table, and the President will be immediately notified of the Senate's action.

The PRESIDING OFFICER. The Senator from Wyoming.

EXECUTIVE CALENDAR

Mr. BARRASSO. Mr. President, I ask unanimous consent that the Senate resume consideration of the King nomination.

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

The clerk will report the nomination.

The senior assistant legislative clerk read the nomination of Robert L. King, of Kentucky, to be Assistant Secretary for Postsecondary Education, Department of Education.

ORDER FOR RECESS

Mr. BARRASSO. Mr. President, I ask unanimous consent that the Senate recess from 3 p.m. to 4 p.m. today.

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

The Senator from Wyoming.

HEALTHCARE

Mr. BARRASSO. Mr. President, I come to the floor because Democrats out on the campaign trail continue to spin their one-size-fits-all healthcare plan that they call Medicare for All. The name itself is misleading. I will state that as a doctor who has practiced medicine in Wyoming for 24 years.

Even many Democrats in the first Presidential debate sounded confused about their own proposal. The candidates were asked a simple question. They were asked to raise their hands if they supported eliminating private health insurance. That is the health insurance people get from work. ''Just four arms went up over the two nights,'' but ''five candidates who kept their hands at their sides,'' the New York Times has now reported, ''have signed onto bills in [this] Congress that do exactly that''—take health insurance away from people who get it from work.

On one point, though, they all raised their hands. That was on the question that was asked of all 10 Democrats in round 2 of the debate. They all endorsed taxpayer-funded healthcare for illegal immigrants. Every hand went up.

It seems Democrats have actually been hiding their real, radical agenda. ''Most Americans don't realize how dramatically Medicare-for-all would restructure the nation's health care system.'' That is not just me talking; that is according to the latest Kaiser Family Foundation poll. We need to set the record straight, and I am ready to do that right now.

The fact is, Democrats have taken a hard left turn, and they want to take away your health insurance if you get it from work. The proposal abolishes private health insurance, the insurance people get from work. In its place, they would have one expensive, new government-run system. Still, Democrats know most of us would rather keep our own coverage that we get from work. Even the people on Medicare Advantage—20 million people—would lose it under the Democrats' proposal. The Kaiser poll confirms Americans' top concern is, of course, lowering their costs or, as the Washington Post ''Health'' column put it, people simply want ''to pay less for their own health care.''

That is what we are committed to on this side of the aisle.

Many Democrats running for President continue to promote and support this radical scheme by Senator SANDERS. The Sanders legislation would take away healthcare insurance from 180 million people who get their insurance through work, through their jobs. In addition, 20 million people who buy their insurance would lose coverage as well.

You also need to know that the Democrats' proposal ends the current government healthcare programs. Medicare for seniors would be gone. Federal employees' health insurance would be gone. TRICARE for the military would be gone, and the children's health coverage also would be gone under this Democratic healthcare, one-size-fits-all plan. That is confirmed by the Congressional Research Service.

The Congressional Research Service recently sent me a formal legal opinion. I requested it from them. It is a formal, legal opinion, stating: Medicare for All ''would . . . largely displace these existing federally funded health programs'' that I just mentioned—Medicare, Federal employees' health insurance, TRICARE, children's health coverage. It would largely displace these existing Federal health programs as well as private health insurance, the insurance people get from work.

Mr. President, I ask unanimous consent to have printed in the RECORD the

Congressional Research Service memorandum, dated May 29, 2019.

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

MEMORANDUM

To: Senator John Barrasso, Attention: Jay Eberle.

From: Wen S. Shen, Legislative Attorney.

Subject: Effect of S. 1129 on Certain Federally Funded Health Programs and Private Health Insurance.

Pursuant to your request, this memorandum discusses the legal effect of S. 1129, the Medicare for All Act of 2019 (MFAA or Act) on various public and private health care programs or plans. Specifically, the memorandum analyzes whether the MFAA would authorize the following programs or plans to continue in their current form:

Medicare (including Medicare Advantage and Part D);

Medicaid (including the Children's Health Insurance Program);

TRICARE;

Plans under the Employee Retirement Income Security Act; and

Individual, Small and Large Group Market Coverage.

For reasons discussed in greater detail below, the Program created by the MFAA would, following a phase-in period and with some limited exceptions, largely displace these existing federally funded health programs as well as private health insurance. This memorandum begins with a description of the key provisions of the MFAA before turning to its legal effect on the programs and plans that are the subject of your request.

MEDICARE FOR ALL ACT OF 2019

The MFAA aims to establish a national health insurance program (Program) that would ''provide comprehensive protection against the cost of health care and health-related services'' in accordance with the standards set forth under the Act. Specifically, under the Program, every resident of the United States, after a four-year phase-in period following the MFAA's enactment, would be entitled to have the Secretary of Health and Human Services (Secretary) make payments on their behalf to an eligible provider for services and items in 13 benefits categories, provided they are ''medically necessary or appropriate for the maintenance of health or diagnosis, treatment or rehabilitation of a health condition.'' Except for prescription drugs and biological products, for which the Secretary may set a cost-sharing schedule that would not exceed $200 annually per enrollee and meet other statutory criteria, no enrollee would be responsible for any cost-sharing for any other covered benefits under the Program. The bill would direct the Secretary to develop both a mechanism for enrolling existing eligible individuals by the end of the phase-in period and a mechanism for automatically enrolling newly eligible individuals at birth or upon establishing residency in the United States.

All state-licensed health care providers who meet the applicable state and federal provider standards may participate in the Program, provided they file a participation agreement with the Secretary that meets specified statutory requirements. The Secretary would pay participating providers pursuant to a fee schedule that would be set in a manner consistent with the processes for determining payments under the existing Medicare program. Participating providers would be prohibited from balance billing enrollees for any covered services paid under the Program, but providers would be free to enter into private contracts with enrollees to provide any item or service if no claims for payment are submitted to the Secretary and the contracts meet certain statutory requirements.

With respect to payment for covered pharmaceuticals, medical supplies, and medically necessary assistive equipment, the Secretary would negotiate their payment rate annually with the relevant manufacturers. The bill would further direct the Secretary to establish a prescription drug formulary system that would encourage best practices in prescribing; discourage the use of ineffective, dangerous, or excessively costly medications; and promote the use of generic medications to the greatest extent possible. Off-formulary medications would be permitted under the Program, but their use would be subject to further regulations the Secretary issues.

With respect to the Program's administration, the bill would authorize the Secretary to develop the relevant policies, procedures, guidelines, and requirements necessary to carry out the Program. The Secretary would also establish and maintain regional offices—by incorporating existing regional offices of the Centers for Medicare & Medicaid Services where possible—to assess annual state health care needs, recommend changes in provider reimbursement, and establish a quality assurance mechanism in the state aimed at optimizing utilization and maintaining certain standards of care.

To fund the Program, the bill would create a Universal Medicare Trust Fund. Funds currently appropriated to Medicare, Medicaid, the Federal Employees Health Benefits Program (FEHBP), TRICARE, and a number of other federally funded health programs would be appropriated to the new fund.

The MFAA also includes a number of other provisions related to the administration of the Program, including an enforcement provision aimed at preventing fraud and abuse, provisions relating to quality assessment, and provisions concerning budget and cost containment.

EFFECT OF THE MFAA ON CERTAIN FEDERALLY FUNDED HEALTH PROGRAMS AND PRIVATE HEALTH INSURANCE

Federally Funded Health Programs

The federal government currently funds a number of health programs, including (1) Medicare, which generally provides health insurance coverage to elderly and disabled enrollees, (2) Medicaid, which is a federal-state cooperative program wherein states receive federal funds to generally provide health benefits to low-income enrollees, (3) the Children's Health Insurance Program (CHIP), which is a federal-state cooperative program that provides health benefits to certain low-income children whose families earn too much to qualify for Medicaid but cannot afford private insurance; (4) the FEHBP, which generally provides health insurance coverage to civilian federal employees, and (5) TRICARE, which provides civilian health insurance coverage to dependents of active military personnel and retirees of the military (and their dependents). Following an initial phase-in period, the MFAA would prohibit benefits from being made available under Medicare, FEHBP, and TRICARE while also prohibiting payments to the states for CHIP. These payment prohibitions would effectively terminate these programs in their current form. This reading is confirmed by §701(b)(2) of the MFAA, which redirects funding for these programs to the national Program.

With respect to Medicaid, the MFAA would significantly limit its scope. After the MFAA's effective date, Medicaid would only continue to cover services that the new national Program would not otherwise cover. Thus, Medicaid benefits for institutional long-term care services (which are not among the 13 categories of covered services under the MFAA) and any other services furnished by a state that the Program would not cover, would continue to be administered by the states. The bill would direct the Secretary to coordinate with the relevant state agencies to identify the services for which Medicaid benefits would be preserved and to ensure their continued availability under the applicable state plans.

PRIVATE HEALTH INSURANCE

Currently, private health insurance in the United States consists of (1) private sector employer-sponsored group plans, which can be self-insured (i.e., funded directly by the employer) or fully insured (i.e., purchased from insurers), and (2) group or individual health plans sold directly by insurers to the insured (both inside and outside of health insurance exchanges established under Section 1311 of the Affordable Care Act). The MFAA would prohibit employers from providing, and insurers from selling, any health plans that would ''duplicate[]the benefits provided under [the MFAA].'' Given that the benefits offered under many existing private health plans would likely overlap with—i.e., be the same as—at least some of the benefits within the Program's 13 categories of covered benefits, those existing health plans would likely ''duplicate'' the benefits provided under the MFAA. Thus, this prohibition of duplicate coverage would effectively eliminate those existing private health plans. Employers and insurers, however, would be allowed to offer as benefits or for sale supplemental insurance coverage for any additional benefits not covered by the Program. As a result, employers and insurers could offer, for instance, coverage for institutional long-term care services, which are not among the 13 categories of covered services.

Mr. BARRASSO. Mr. President, this report details how the bills cut off funding.

The CRS memo concludes: These payment prohibitions would effectively terminate all of those programs I mentioned in their current form.

The Congressional Research Service finds that Medicare for All actually terminates Medicare in this country. So Democrats want to turn Medicare, currently for 60 million seniors, into Medicare for None. It will become Medicare for None, not Medicare for All. Plus, 22 million people would lose Medicare Advantage. I know many of my patients who signed up for Medicare Advantage because there are advantages to doing it—coordinated care, working on preventive medicine. There are reasons for signing up for Medicare Advantage. That would all be gone under the one-size-fits-all approach that the Democrats are proposing.

That is not all. This report says the Sanders bill ends Federal employee health insurance. There are more than 8 million Federal workers, families, and retirees who rely on this Federal Employee Health Benefits Program.

The Congressional Research Service says that this bill, sponsored by over 100 Members who are Democrats in the House of Representatives and sponsored by a number of Democrats in this body, will abolish TRICARE, the insurance for the military. More than 9 million military members, their families,

and retirees rely on TRICARE for their healthcare.

The report says the bill ends the Children's Health Insurance Program. Nine million of our Nation's children rely on the CHIP program.

Interestingly, ObamaCare would end as well, according to the CRS report. After less than a decade, Democrats want to repeal and replace their failed ObamaCare healthcare law with a one-size-fits-all system.

Again, the Congressional Research Service says the bill bans private health insurance. One hundred eighty million people get their insurance through work.

To sum up, hundreds of millions of American citizens—American citizens—stand to lose their insurance, and I believe that is just the start of the pain for American families. In the new system, we would all be at the mercy of Washington bureaucrats. That means we would be paying more to wait longer for worse care—pay more to wait longer for worse care. The Democrats' massive plan is expected to cost $32 trillion. That is trillion with a ''t.'' That is a 10-year pricetag.

Guess who is going to pay for that mind-boggling bill—of course, every American taxpayer. Senator SANDERS admitted in the Democratic debate the other night that his proposal would raise taxes on middle-class families. His proposal will raise taxes, he said, on middle-class families.

In fact, even doubling our taxes wouldn't cover the huge cost of what they are proposing. So Washington Democrats are planning to drastically cut payments to doctors, nurses, hospitals, and to people who are providing care. The bureaucrats would ration care, restrict care—the care you get that you need—and it would be restricted in terms of treatment as well as technology. People would lose the freedom to choose the hospital or doctor they want.

As a doctor, I am especially concerned about the impact on patient care. Patients could wait weeks, even months, for urgently needed treatment. Keep in mind care delayed is often care denied. So the Democrats' grand healthcare vision is to force you to pay more to wait longer for worse care.

As a Senator and a doctor, of course, I want to improve your care, make it less costly. You should get insurance that is appropriate for you and affordable. You should be free to make your own medical decisions. That is what it is like in America.

No question, healthcare needs to be more affordable, and Republicans are working to lower costs without lowering standards. To me, that is the big difference. Democrats are proposing the reverse. Their plan would lower your standard of care and raise your costs. Democrats can keep campaigning hard left on healthcare. That is where they are headed.

Republicans are going to stay focused on real reforms that promote more affordable healthcare, cheaper prescription drugs, protections for patients with preexisting conditions, and, of course, the end of surprise medical bills. President Trump recently took Executive action that increases price transparency to lower the costs that patients pay.

You just need to know the facts about the Democrats' one-size-fits-all healthcare. Don't let far-left Democrats fool you. Radical Democrats want to take away your current healthcare. There would be no more Medicare or private plans, just a one-size-fits-all Washington plan.

Why pay more to wait longer for worse care? Instead, let's give patients the care they need from a doctor they choose at lower costs. That is our goal. That is our objective, and that is what we are going to accomplish.

I yield the floor.

The PRESIDING OFFICER (Mr. ROMNEY). The Senator from Illinois.

Mr. DURBIN. Mr. President, I ask unanimous consent to speak as in morning business.

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

PRESCRIPTION DRUG COSTS

Mr. DURBIN. Mr. President, just a few minutes ago, four young people from the State of Illinois visited my office. They were a variety of different ages, from 10 years of age to the age of 17. They all came because they had a similar life experience, and they wanted to share it with me. Each one of them had been diagnosed with type 1 diabetes.

Ten-year-old Owen from Deerfield told a story—the cutest little kid; great reader; read me a presentation that he put together—and the young women who were with him all talked about how their lives changed when they learned at the age of 7 or 8 that they had type 1 diabetes. For each one of them, from that point forward, insulin became a lifeline. They had to have access to insulin, and they had to have it sometimes many times a day, in the middle of the night. It reached a point where, through technology, they had continuous glucose monitoring devices and pumps that were keeping them alive, but every minute of every day was a test to them as to whether they were going to get sick and need help.

It was a great presentation by these young people, whose lives were transformed, and their parents, who were hanging on every word as they told me their life stories.

They brought up two points that I want to share on the floor this afternoon. The first is the importance of medical research. As one young woman said—she is about 17 now. She has lived with this for 8 or 9 years. She said she is a twin, and her brother told her when she was diagnosed that he hated the thought that, as an old woman, she would still be worried about her insulin every single day. She said: I told my brother ''We are going to find a cure before I am an old woman.''

Well, I certainly hope that young girl is right, but she will be right only if we do our part here on the floor of the Senate and not just give speeches. What we have to do is appropriate money to the National Institutes of Health. It is the premier medical research agency in the world.

We have had good luck in the last 4 years. I want to salute two of my Republican colleagues and one of my Democratic colleagues for their special efforts. For the last 4 years, Senator ROY BLUNT, Republican of Missouri; Senator LAMAR ALEXANDER, Republican of Tennessee; and Senator PATTY MURRAY, Democrat of Washington, have joined forces—I have been part of that team too—to encourage an increase in medical research funding every single year, and we have done it.

The increase that Dr. Collins at NIH asked for was 5 percent real growth a year. That is 5 percent over inflation. Do you know what we have done in 4 years? NIH has gone up from $30 billion to $39 billion. Dramatic. A 30-percent increase in NIH research funding.

We are going to have a tough time with this coming budget, as we have in the past, but I hope we really reach a bottom line, as Democrats and Republicans, that we are committed to 5 percent real growth in medical research every single year so that we can answer these young people who come in dealing with diabetes, those who are suffering from cancer, heart disease, Alzheimer's, Parkinson's—the list goes on and on—that we are doing our part here in the Senate; that despite all the political battles and differences, there are things that bring us together, and that should be one.

The second point they raised—one of the young girls there, Morgan of Jerseyville, started telling me a story about the cost of insulin. As she was telling the story about the sacrifices being made by her family to keep her alive, she broke down and cried. What she was telling me—her personal experience, her family experience—was something that every family with diabetes knows: The cost of insulin—charged by the pharmaceutical companies—has gone up dramatically, without justification, over the last 20 years.

In 1999, one of the major insulin drugs—called Humalog, made by Eli Lilly—was selling for $21 a vial. That was 20 years ago. In 1999, it was $21 a vial. The price today is $329 a vial. What has caused this dramatic increase? There is nothing that has happened with this drug. It is the same drug. And, I might add, Eli Lilly of Indianapolis, IN, is selling the same insulin product—Humalog—in Canada for $39. So it costs $329 in the United States and $39 in Canada.

These families told me they were lucky to have health insurance that covered prescription drugs. That sounds good, except they each had large copays—$8,000 a year. And what it meant was that for this young girl, this beautiful little girl who was in my office and who has juvenile diabetes,

they would spend $8,000 a year at the beginning of the year for 3 months of insulin before the health insurance kicked in and started paying for it. Of course, there are families who aren't so lucky—they don't have health insurance to pay for their drugs.

So what are we going to do about it? It happens to be something the Senate is supposed to take up. We are supposed to debate these things and decide the policy for this country. We will see. Very soon, we will have a chance. A bill is coming out of the Health, Education, Labor, and Pensions Committee, and we will have a chance to amend it on the floor and to deal with the cost of prescription drugs. I will have an amendment ready if my colleagues want to join me—I hope they will—on the cost of insulin, and we will have a chance if Senator MCCONNELL, the Republican leader, will allow us—it is his decision. We will have a chance to decide whether these kids and their families are going to get ripped off by these pharmaceutical companies for years to come.

It isn't just insulin; it is so many other products. It is time for us to stand up for these families and their kids, to put money into medical research, and to tell pharma once and for all: Enough is enough. Insulin was discovered almost 100 years ago. What you are doing in terms of increasing the cost of it for these families is unacceptable and unconscionable.

BORDER SECURITY

Mr. President, in the last 2½ years of this administration, we have seen an incredible situation when it comes to immigration and our border. We have seen, unfortunately, some of the saddest and most heartbreaking scenes involving children at the border between the United States and Mexico.

The pattern started with the President's announcement shortly after he was sworn in that he was imposing a travel ban on Muslim countries. That created chaos at our airports and continues to separate thousands of American families.

Then the President stepped up and repealed DACA, the Executive order program created by President Obama that allowed more than 800,000 young immigrants to stay in this country without fear of deportation and to make a life in the only country many of them had ever known.

Then the President announced the termination of the Temporary Protected Status Program, a program we offer—and have throughout our modern history—for those who are facing oppression or natural disaster in their countries. President Trump announced that he was going to terminate it for several countries, affecting the lives of 300,000 immigrants.

Then came the disastrous separation of thousands of families at the border—2,880 infants, toddlers, and children separated from their parents by the Government of the United States. This zero-tolerance policy finally was reversed by President Trump after the public outcry against it.

Then what followed was the longest government shutdown in history over the President's demand that he was going to build a border wall, even at the cost of shutting down the Government of the United States for 5 weeks.

We've also seen the tragic deaths of 6 children apprehended at the border and 24 people in detention facilities in the United States.

The President then announced that he was going to block all assistance to the Northern Triangle countries—El Salvador, Guatemala, and Honduras, the source of most of the immigrants who come to our border—and that he would shut down the avenues for legal migration, driving even more refugees to our border.

Now, on President Trump's watch, we have an unprecedented humanitarian crisis. We have seen that crisis exemplified by the horrifying image of Oscar Alberto Martinez Ramirez and his 23-month-old daughter, Valeria, who fled El Salvador and drowned as they tried to cross the Rio Grande 2 weeks ago.

We have seen this crisis play out in the overcrowded and inhumane conditions at detention centers at the border.

In April, I visited El Paso, TX. What I saw in the Border Patrol's overcrowded facilities was heartbreaking.

In May, I led 24 Senators in calling for the International Committee of the Red Cross and the inspector general of the Department of Homeland Security to investigate our Border Patrol facilities. I never dreamed that I would be asking the International Red Cross to investigate detention facilities in the United States. They do that, but usually you are asking them to look into some Third World country where inhumane conditions are being alleged.

After being in El Paso, after seeing what is going at our border, I joined with 23 other Senators in asking the International Red Cross to investigate the U.S. detention facilities.

Later that same month, the inspector general of the Department of Homeland Security released a report detailing the inhumane and dangerous overcrowding of migrants at the El Paso port of entry. The Inspector General's Office found that overcrowding is ''an immediate risk to the health and safety'' of detainees and DHS employees.

One week ago, the Inspector General's Office issued another scathing report, this time about multiple Border Patrol facilities in the Rio Grande Valley. The Inspector General's Office asked the Department of Homeland Security to take immediate steps to alleviate the dangerous overcrowding and prolonged detention. They stated: ''We are concerned that overcrowding and prolonged detention represent an immediate risk to the health and safety of DHS agents and officers, and to those detained.''

Congress recently passed legislation 2 weeks ago that included $793 million in funding to alleviate overcrowding at these CBP facilities and other funding to provide food, supplies, and medical care to migrants. The bill also includes critical funding for the Office of Refugee Resettlement to care for migrant children.

We must now make sure that this money is spent effectively by the Trump administration. We gave them over $400 million in February, and they came back to us within 90 days and said: We are out of money. I would like to know how they are spending this money, and I want to make sure it is being spent where it is needed.

There is a gaping leadership vacuum at the Trump administration's Department of Homeland Security. Think of this: In 2½ years, there have already been four different people serving as head of that Department. Every position at the Department of Homeland Security with responsibility for immigration or border security is now being held by a temporary appointee, and the White House refuses to even submit nominations to fill these positions.

Two weeks ago, I met with Mark Morgan, one of those temporary appointees. In May, President Trump named him Acting Director of U.S. Immigration and Customs Enforcement. Mr. Morgan was asked at that time to carry out the mass arrests and mass deportations of millions of immigrants the President had threatened by his infamous tweets.

Shortly before I met with Mr. Morgan to ask him about the mass arrests and mass deportations, there was a change. They took him out of that position and named him Acting Director of U.S. Customs and Border Protection. He went from internal enforcement to border enforcement. Now he is in charge of solving the humanitarian crisis that President Trump has created at our border.

The Trump administration can shuffle the deck chairs on this Titanic, but we must acknowledge the obvious: President Trump's immigration and border security policies have failed. Tough talk isn't enough. We need to do better.

This morning, I met with Dr. Goza, the president of the American Academy of Pediatrics. She came to give me a report about her visit to several border facilities that has been well documented and reported in the press. She said that it was hard for her, as a doctor for children, to see these things and realize they were happening in the United States.

Yes, children are being held in caged facilities with wire fences and watchtowers around them, some of them very young children. As a pediatrician, she told me those things have an impact on a child—on how that child looks at the world and how that child looks at himself.

She said that she took a lot of notes as she went through these facilities, but it wasn't until she got on the airplane on the way home that she read

through them. She said: Then I started crying. I am supposed to be a professional who can take this, but I couldn't imagine what we were doing to these children at the border. There just aren't enough medical professionals there—not nearly enough.

The United States is better than that. We can do better than that. We can have a secure border and respect our international obligations to provide a safe haven to those who are fleeing persecution, as we have done on a bipartisan basis—Democrats and Republicans—for decades.

I stand ready, and I believe my party stands ready, to work with Republicans on smart, effective, and humane solutions to the crisis at our border. I suggest that the following be included:

Crack down on traffickers who are exploiting immigrants. That is unacceptable.

Provide assistance to stabilize the Northern Triangle countries. That is long overdue.

Provide in-country processing and third-country resettlement so that migrants can seek safe haven under our laws without making the dangerous and expensive trek to our border.

Eliminate the immigration court backlog so that asylum claims can be processed more quickly.

We have authorized more than 100 immigration court judges, and this administration can't find people to fill them. They want more judges. They have authority to hire 100 more, and they have been unable to do it.

We need to ensure that children and families are treated humanely when they are in the custody of the U.S. Government.

Eventually, the history of this period will be written, and there will be accountability, not just for the officials in government but for all of us—those of us in the Senate and the House and those in journalism and other places. We are going to have to answer for the way these people have been treated. Whether or not they qualify for legal status in the United States, I hope we can hold our heads up high and say that, at least from this point forward, we are going to show them that we are humane and caring people. No matter where they come from, no matter how poor they may be, we will take care that children are treated in a merciful way and a compassionate way; that the adults are given appropriate opportunities to exercise whatever rights they have under the laws of our country; and that at the end of the day we can hold our heads high because we have done this in a fashion consistent with the values of the United States of America.

We haven't seen it yet. It is time for the President to acknowledge that get-tough, bizarre tweets just aren't enough. We have to have a policy that makes sense to bring stability to our border.

I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

PRESCRIPTION DRUG COSTS

Ms. ERNST. Mr. President, I recently received a letter from a gentleman living in Cedar Falls, IA, who suffers from Parkinson's disease. As I speak, he is going without his $1,450-per-month LYRICA prescription in order to keep a roof over his head. That is right, folks. He must choose between making a mortgage payment and getting his prescription.

Here is another story a woman from Davenport, IA, shared with me. Last October, she was able to get a 3-month supply of blood pressure medication for $17, but when she went to the pharmacy for her refill in late December, she was told the price had nearly tripled to $55. She wrote to me and said:

> Thinking this was a mistake, I refused the refill and checked online about the change in price and found I couldn't get it cheaper anywhere else. So I went back in ten days and thought I would just have to pay the new cost [which was $55]. In that time . . . the prescription had gone up to $130!

Whether I am talking to folks back home in my townhalls and other events on my 99 County Tour or in meetings right here in Washington, DC, the cost of prescription drugs is the No. 1 issue I hear about from Iowans. Every day, I hear stories just like these about the outrageous costs associated with their prescription medications.

For too long, hard-working Iowans have borne the brunt of skyrocketing prescription drug prices. Stories like the man from Cedar Falls and the woman from Davenport have become the norm. We have to change that, and that is exactly what we are doing here in the Senate.

We have been hard at work in advancing bills to drive down drug prices, increase competition, and close costly loopholes that are being exploited by those bad actors. I am proud to lead on three such bills that were recently approved in committee.

First, I have teamed up with Senator COTTON on a bill that aims to eliminate an egregious loophole in the patenting process. This loophole allows drug companies to take advantage of the well-intentioned concept of sovereign immunity for Native American Tribes in order to dismiss patent challenges and unfairly stifle competition.

Our legislation would put an end to this manipulative practice and actually provide Iowans with access to cheaper options for their prescription drugs. That is not all we are doing in the Senate to make more low-cost generic drugs available to folks in Iowa. We have also been working across the aisle on a bipartisan bill that would put a powerful check on drug companies seeking to keep generics off the market.

The bill would empower the makers of generic drugs to file lawsuits against brand-name manufacturers if they fail to provide required resources, such as drug samples, needed for generics to clear the regulatory process. In turn, we would see cheaper alternatives available for my folks in Iowa.

I am also working with my fellow Iowan, Senator GRASSLEY, on a bill that focuses on the middlemen behind some of the prescription drug price hikes we have seen recently. The bill would direct the Federal Trade Commission to examine anti-competitive behavior in the prescription drug market. As mergers push drug prices higher and higher, this bill will be instrumental in helping Congress develop policies to increase competition and lower those costs for both patients and our taxpayers.

Make no mistake. The rising cost of prescription drugs is an issue that significantly impacts hard-working Iowans. We in Congress have a responsibility to take action, to give folks a voice, and to make sure no family is ever forced to choose between making a mortgage payment and purchasing their medications.

That is what we are doing. We have some great bills in the Senate—bills from both Republicans and Democrats—that can help lower those drug prices, increase competition, and close loopholes. Let's build on this effort and continue working together in a bipartisan way to get these bills and others across the finish line and signed into law. Iowans are counting on us.

I yield the floor.

The PRESIDING OFFICER (Mr. PERDUE). The Senator from Florida.

Mr. SCOTT of Florida. Mr. President, as is now obvious to everyone, ObamaCare made healthcare even more expensive. Premiums are up. Copays are up. Deductibles are way up. ObamaCare has been a disaster, and even the Democrats are admitting it.

Let's all remember, ObamaCare was sold and based on a bunch of lies. You didn't get to keep your doctor, your health plan, and your premiums didn't go down.

The Democrats want Medicare for All, which will absolutely ruin the Medicare system and throw 150 million people off of the employer-sponsored health insurance they like. That would be a disaster. There is something we can do and must do right now to help American families: We must lower prescription drug costs.

This is very personal to me. I grew up in a family without healthcare. My mom struggled to find care for my brother who had a serious disease. Eventually she found a charity hospital 4 hours away for his treatment. I remember asking my mom how much lower drug costs would have to be for her to consider changing pharmacies. Without missing a beat, she said: a dollar.

This story is not uncommon. All over my State I hear the same thing: Drug prices are rising, and we are having trouble affording the lifesaving medication we need.

I recently met Sabine Rivera, a 12-year-old from Naples, FL, who was diagnosed with type 1 diabetes more than 2 years ago. She is 12 years old, and she is already worried about how she will

afford the rising cost of insulin—something no 12-year-old should ever have to stress about.

Patients want to shop for better coverage and lower costs, but too often they can't or don't know how. At the same time, pharmaceutical companies are charging low prices for prescription drugs in Canada, Europe, and Japan but charging American consumers significantly more. Why? Because for too long politicians have done nothing.

American consumers are subsidizing the cost of prescription drugs in Europe and Canada and all over the world. Why should we be doing that? That certainly is not putting America first, and that is not putting American families first. That is why I am working with President Trump and Republicans and Democrats in Congress to fix this problem.

I recently introduced the America First Drug Pricing Plan with Senator JOSH HAWLEY to take real steps to lower costs for patients and put the consumers back in charge of their healthcare decisions. Part one of my bill focuses on transparency.

First, pharmacies must inform patients what it will cost to purchase drugs out of pocket instead of using their insurance and copays. If patients choose to pay out of pocket, which is sometimes cheaper, the total cost would be applied to their deductible.

Second, insurance companies should, and must, inform patients of the total cost of their prescription drugs 60 days prior to open enrollment. This allows patients to be consumers and shop around for the best deal.

Finally, my bill would simply require that drug companies cannot charge American consumers more for prescription drugs than the lowest price they charge consumers in other industrialized nations.

I have found that provision to be controversial in Washington. Do you know where it is not controversial? Everywhere else. In Tampa and Orlando, Miami and Panama City, all over Florida, this just makes sense. I don't spend a lot of time outside of Florida, but I would wager and say that across the country my bill would make a lot of sense too.

Why would we as American consumers, who make up 40 percent of the market for prescription drugs, pay two to six times more for drugs than consumers in Europe or Canada or Japan? That needs to change. My bill takes real steps to change this, and I believe it should have bipartisan support.

I also led seven of my colleagues in a letter to pharmaceutical companies asking them to work with us on solutions to lower the cost of prescription drugs. We are still waiting to hear back.

American consumers are facing a crisis of rising drug costs, and we can't wait any longer. I will not and cannot accept the status quo of rising drug costs. We need to get something done this year, and I am fighting every day to make sure we do.

I yield the floor.

The PRESIDING OFFICER. The Senator from West Virginia.

Mrs. CAPITO. Mr. President, I am pleased to join my colleague on the Senate floor to talk about an extremely important topic—that is, lowering the cost of prescription drugs in this country. Just a few weeks ago, on June 20, West Virginia celebrated our 156th birthday. There is plenty to celebrate about West Virginia, from its breathtaking beauty and wonderful families to our kind and hospitable West Virginia spirit.

Unfortunately, West Virginia has its challenges, too, including health challenges. We have some of the highest rates in the Nation for heart disease, diabetes, cardiovascular disease, cancer, and arthritis. While there are many nonpharmaceutical steps people are taking to prevent and control diseases, for many, their prescription medicine is the difference between wellness and illness or even between life and death.

That is why it is so important that West Virginians are able to secure their medications and that we as a Congress make sure they are not paying too much for those medications. Of all the issues that my constituents come to me with—whether it is a phone call, a letter, or casually running into them at the grocery store—this is the issue I hear most about because it is something that affects so many West Virginians' way of life, and it is something that affects them every day. If it doesn't affect them, it affects somebody in their family.

The same can be said for Americans across this country, and that is why it has become one of our Nation's top priorities, one that is shared by Republicans and Democrats and one that is a significant bipartisan focus of this administration and this Congress. It is a far-reaching problem with many different factors contributing to it, and that is why we have to address it on many different fronts.

The chairman of the HELP Committee is here today. He has worked through his committee diligently, and I applaud him for his efforts and look forward to joining him on the floor in support of those efforts.

As we all know, the path a medication takes from the manufacturer to the patient is very complex, with many factors impacting the price a consumer pays. While making changes to this pathway is very important, my constituents really don't care about the pathway. They are more concerned with the total on their bill that their pharmacist is ringing up. That is why I have focused a lot of my personal efforts on the important role that our pharmacists play in lowering drug costs.

In many small towns and rural communities—which is my entire State—pharmacists are the healthcare providers people go to quite regularly, and they are often some of the most trusted, friendly, and welcoming. It is essential that patients, especially seniors, are able to access the local pharmacy.

West Virginians and Americans across the country should be able to trust that their pharmacist is not being restricted about telling them how to get the best prescription drug prices. They need to know they aren't facing higher cost sharing for drugs and being accelerated into the coverage gap or the doughnut hole phase of Medicare Part D due to an overly complicated system of fees and price concessions that nobody really understands—certainly not at the pharmacist's desk.

In order to ensure that seniors have access to a pharmacy of their choice, Senator BROWN and I introduced the Ensuring Seniors Access to Local Pharmacies Act last Congress. We will be reintroducing this bill, which requires that community pharmacists in medically underserved areas be allowed to participate in the Medicare Part D preferred pharmacy networks.

Why is this important? If a local pharmacy is not included in a preferred network, a senior must either switch to a preferred network pharmacy, which could be a lot farther away or less convenient, or pay higher copayments and coinsurance to access their local pharmacy. In some cities and towns, you can find a pharmacy on nearly every corner. In rural areas, that is just not the case, and accessing a preferred pharmacy could require significant time and difficult travel.

Additionally, many seniors rely on their local pharmacies not only to access prescription drugs but also to receive those needed services like preventive screenings and medication therapy management.

As important as access to a local pharmacy is, it is also essential that patients can trust their pharmacists to let them know which payment method provides the most savings when purchasing their prescription drugs.

I was proud to join Senator COLLINS last year as a cosponsor of the Patient Right to Know Drug Prices Act. This commonsense bill, which the President signed into law in October, bans the use of the pharmacy gag clause. It was hard to believe this still existed. These clauses were put into place by insurers and pharmacy benefit managers, and they prevented our pharmacists from proactively telling consumers that their prescriptions could cost less—less—if they paid out of pocket rather than relying on their insurance plan.

I am also currently working with Senators TESTER, CASSIDY, and BROWN on legislation that would help improve transparency and accuracy in Medicare Part D drug spending. Our bill would reform the application process of pharmacy price concessions, also known as direct and indirect remuneration, or DIR fees, in the Medicare Part D Program. It sounds complicated, but it is driving up the cost of our pharmaceuticals.

This will ensure that our seniors are not facing higher cost sharing for their drugs or, again, being accelerated into the coverage gap. It will also help ensure that local pharmacies are able to stay open. This is critical. We have to keep our local pharmacies open for a vast majority of rural America and have them continue to stay open and continue to serve Medicare beneficiaries and other communities that rely on them. It would provide needed financial certainty for these pharmacies, which are often small businesses.

My colleagues and I hope to see this legislation included in the soon-to-be-released Senate finance package. These are just a few examples of how we are working to lower prescription drug costs.

I have been listening to my colleagues and have heard a lot of other ideas. They are small but much needed steps that can be, and already are, making a real difference in our constituents' lives, but our work is far from over. We have to continue looking at both commonsense and complex solutions to the problem. This is a complex problem. While as a Congress and a country we may not agree on the best way to do that, we do all agree that it is a problem that needs to be solved.

I look forward to continuing to work with Senator ALEXANDER and Senator LANKFORD, who are on the floor here today, and my other colleagues and the administration to find that pathway forward to lowering the cost of prescription drugs.

I yield back.

The PRESIDING OFFICER. The Senator from Tennessee.

Mr. ALEXANDER. Mr. President, I thank the Senator from West Virginia for working to reduce the cost of prescription drugs. That is the question I hear most often in Tennessee: How can I reduce what I pay for out of my own pocket for healthcare costs? The most obvious way to reduce what you pay out of your own pocket for healthcare costs is to reduce the cost of prescription drugs.

Shirley, from Franklin, TN, is one of those Americans who asked me that question. This is what she said:

> As a 71 year old senior with arthritis, I rely on Enbrel to keep my symptoms in check. My copay has just been increased from $95.00 to $170.00 every ninety days. At this rate I will have to begin limiting my usage in order to balance the monthly budget.

There has never been a more exciting time in biomedical research, but that progress is meaningless if patients can't afford these new lifesaving drugs.

Last month, as Senator CAPITO mentioned, our Senate Health Committee passed legislation by a vote of 20 to 3 that included 14 bipartisan provisions to increase prescription drug competition as a way of lowering generic drug costs and biosimilar drugs that reach patients.

Here is what that includes: The CREATES Act—the Senator from Iowa, Mr. GRASSLEY, is on the floor. He, Senator LEAHY, and many others have proposed the CREATES Act, which will help bring more lower cost generic drugs to patients by eliminating anticompetitive practices by brand drugmakers. That is in the bill we approved. It also includes helping biosimilar companies speed drug development through a transparent, modernized, and searchable patent database. That was proposed by Senators COLLINS, KAINE, BRAUN, HAWLEY, MURKOWSKI, PAUL, PORTMAN, SHAHEEN, and STABENOW. This legislation we have was approved 20 to 3. There are 55 different proposals by 65 different U.S. Senators—about the same number of Republicans and Democrats—all to reduce healthcare costs.

Here are some other examples. The bill improves the Food and Drug Administration's drug patent database by keeping it more up to date to help generic drug companies speed product development, a proposal offered by Senator CASSIDY and Senator DURBIN.

Another provision is it prevents the abuse of citizens' petitions. These are used to unnecessarily delay drug approvals. This was proposed by Senators GARDNER, SHAHEEN, CASSIDY, BENNET, CRAMER, and BRAUN. President Trump included that in his 2020 budget.

Another provision is it clarifies that the makers of brand biological products, such as insulin, are not gaming the system to delay new, lower cost biosimilars. That came from Senators SMITH, CASSIDY, and CRAMER.

Another provision is it eliminates exclusivity loopholes. These allow drug companies to get exclusivity and delay patient access to less costly generic drugs by just making small tweaks to an old drug. That came from Senators ROBERTS, CASSIDY, and SMITH, which President Trump also proposed in his budget.

Another provision prevents the blocking of generic drugs. This is done by eliminating a loophole that allows a first generic to submit an application to FDA and block other generics from the market. Again, the President included this in his budget.

Another provision in our bill prevents delays of biosimilar drugs by excluding biological products from compliance with U.S. Pharmacopeia standards. That sounds pretty complicated, but what it means is that it could delay patient access and lower the cost of drugs. Again, that is another proposal by President Trump.

Another provision is it increases transparency on price and quality information by banning the kind of gag clauses Senator CAPITO talked about. These are gag clauses in contracts between providers and health plans that prevent patients, plan sponsors, or referring physicians from seeing price and quality information.

Another provision bans pharmacy benefit managers from charging more for a drug than it paid for the same drug.

Instead of remaining stuck in a perpetual partisan argument over ObamaCare and health insurance—and I can guarantee you that is going to continue to go on for a while—we have Senators on that side of the aisle and Senators on this side of the aisle working together to lower the cost of what Americans pay for healthcare out of their own pockets.

Since January, Senator MURRAY and I have been working in parallel with Senator GRASSLEY and Senator WYDEN of the Finance Committee. They are continuing to work on their own bipartisan bill. Last month, the Senate Judiciary Committee also voted to lower the cost of prescription drugs. In the House, the Energy and Commerce, Ways and Means, and Judiciary Committees have all reported out bipartisan bills on the cost of prescription drugs.

As I have mentioned, President Trump and Secretary Azar have been focused on this. Last year, the administration released a blueprint on steps the President would take to lower prescription drugs. Last year, the Food and Drug Administration set a new record for generic drug approvals. Generic drugs can be up to 85 percent less expensive than brand drugs.

So I believe the cost of prescription drugs is an area where Democrats and Republicans in Congress and the administration can find common ground to help Americans reduce the cost of healthcare that they pay for out of their own pockets.

I am very hopeful that our bill, with 55 proposals from 65 Senators, which has been reported to the Senate floor, will be placed by the majority and minority leaders on the Senate floor before the end of the month. We can pass it, the House will do their job, and we can send it to the President to lower prescription drug costs.

I yield the floor.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. LANKFORD. Mr. President, I rise to talk to this body again about healthcare and the cost of healthcare. This has been an issue and an ongoing dialogue for a long time around the Senate and around Congress.

It is an issue that was supposedly settled when the Affordable Care Act was passed, but, ironically enough, my Democratic colleagues have now joined Republicans in saying they want to repeal and replace the Affordable Care Act. They are not using the term ''repeal and replace''; they are just saying they want to do Medicare for All. Built into that is completely taking out the Affordable Care Act and replacing it with something different.

So, ironically, in some ways, we are in the same spot. We have both come to the same realization that the Affordable Care Act didn't pass—it actually did pass, but it is not working. So now the challenge is what to do with healthcare.

We are now trying to break into pieces what we can actually do together to get this done, beginning with the cost of prescription drugs.

I continue to hear from Oklahomans all over the State about how hard it is to deal with the cost of prescription drugs, how rapidly the costs are increasing, and how sporadic the cost changes really are. They will have a drug that costs a small amount one month and come back a month later and find a dramatic increase for the exact same drug. They can go pharmacy to pharmacy and find a different price for the exact same drug or find that the pharmacy closest to them doesn't offer that drug, and a different pharmacy is the only one that is allowed to have that drug. The complexity is driving them crazy and rightfully so.

As we peel back the layers on pharmacy issues, we are finding that the complexity is that cost overruns being built in are too high.

For the past few months, we have looked at every step in the drug process, from the approval to research and development, to try to figure out how the cost is actually getting to the consumer.

Along the way, several things have occurred. The administration has aggressively been approving generics. In fact, the administration has approved a record number of generics. Those generic pharmaceuticals are much less expensive than the branded pharmaceuticals. Many of those have been waiting a very long time at the Food and Drug Administration to actually be approved. The Food and Drug Administration is rapidly getting those out the door, and that helps consumers.

Something else we have done in Congress is to try to address something called the gag clause. The gag clause is one of those things that was behind the scenes that no one knew about except for the pharmacists because, if you came in with your insurance card to pick up your prescription, the pharmacist knew the actual cost you would pay if you paid in cash. Often, you could get that same prescription for less by paying in cash than you could if you were to pay with your insurance card, but the pharmacist was prohibited from actually telling you that. We have addressed that in Congress, in a bipartisan way, to release that gag clause and allow pharmacists to actually tell people their options on pricing.

You might say: That is an absolutely crazy thing. Who put that gag rule in?

Well, the system, and the structure behind the scenes that negotiates all of it, said: If you want to be a pharmacy that sells these drugs, you have to submit to these rules. As we found, the culprit behind many of these issues is a group called pharmacy benefit managers. You will hear it referred to as just the PBMs.

Those pharmacy benefit managers are supposed to negotiate between the manufacturers and the insurance plans to lower the prices. In many areas, they have lowered prices, but they have also given preferred formulary placement to some of their preferred pharmacies so some pharmacies get that drug and other pharmacies that are competing with them don't get access to that drug. Often, it is the drug that is the highest margin drug only their pharmacies will get and other pharmacies will not.

It has become an anti-competitive piece in the background, when it was supposed to be something that was a highly competitive piece to actually help the consumer.

Unfortunately, PBMs have created one of the most elaborate, complex, and opaque system of pricing, which has a tremendous amount of market distortion and at times has limited patients' access to those drugs. Oftentimes, it is a system they have been able to take advantage of and have created financial incentives to help their bottom line in the process rather than actually help the consumer.

Many consumers have heard about rebates, but they wonder who is getting a rebate. They go to their pharmacy to pay for their drugs, and they are not getting the rebate. There is a rebate going somewhere, just not to them.

Here is the challenge. We are trying to peel back with greater transparency what is happening in the pharmacy benefit manager world and figure out how a small group—it is actually three companies that have 90 percent of the market nationwide, how that middleman in the process actually handles pricing and negotiation.

If you talk to any pharmacist anywhere in the country—and certainly across my great State—who is an independent pharmacist, they will all express their frustration with pharmacy benefit managers and their access to some drugs and not others and the stipulations they deliberately put there to hurt them and help others.

I have joined my colleague Senator CANTWELL in trying to shine some light on the operations of PBMs within the drug chains. Consumers deserve greater transparency. That will help us understand the actual cost of drugs and how those costs are actually getting to consumers or not to consumers in the process. The PBMs need greater examination, and we are finally taking that up to walk through the process.

On the Finance Committee, we are dealing with several issues. Led by Senator GRASSLEY, we are walking through Part B of Medicare, Part D of Medicare, and trying to examine what can be done to help the actual consumer. Our goals are how do we actually increase the options in drugs that are out there, how do we stop the cost increases, and how do we decrease out-of-pocket costs for pharmaceuticals.

In Part B—these are drugs that are often intravenous, but they are done in a hospital setting or in an inpatient setting. As we are working through that process, we are trying to find the perverse incentives that are built in because, right now, physicians are actually paid a percentage of the medicine they prescribe in Part B. That means if there are three medications that are out there, if a doctor prescribes the highest cost medication, they get a much higher reimbursement. It is not a flat amount. Now, all three may be intravenous, but whichever is the most expensive actually helps the doctor the most. I am not challenging doctors and saying they are always prescribing the branded drugs and the most expensive in the process—that is between the doctor and the patient to determine—but there is no doubt a perverse incentive is built into this; that if they prescribe a more expensive drug, the doctor and his office actually benefit from it. We need to fix that.

In Part D, there are reforms that can actually slow the growth in cost increases and allow people to have greater access to drugs. We are not interested in some kind of formula where we are actually going to decrease the patients' options of what drugs they can actually get in their formulary. That is a great thing about being an American; that we don't have limited formularies. It is very open in the process so Americans can try different pharmaceuticals to see which one works best for them. That is not chosen by government; it is chosen by them and their doctors. The Part D definitely needs a redesign of the benefit structure because right now things like the doughnut hole drive up costs for consumers. We are exploring a way to limit the out-of-pocket costs for beneficiaries so there is a lifetime cap sitting out there. There is an opportunity to know that if I end up with cancer or some other rare disease, I am not going to have these out-of-control costs on the pharmaceutical side and know there is not a doughnut hole waiting for me, where when I get a couple thousand dollars in, I am suddenly going to have a very expensive time. So I can afford my insurance in January, February, and March, but from April to August, I can't afford prescriptions anymore. We can't have that. We have to address those issues because that dramatically affects the out-of-pocket costs.

There are lots of other options we are looking at while working through this process, like the rebates, as I mentioned before, actually getting to the consumer, not to the companies behind the scenes, and dealing with how to take greater advantage of biosimilar drugs—very similar to the generic drugs but just in a different category and at a reduced cost—to allow them to have opportunities to get to those drugs faster. We have to deal with some of the patent issues to make sure drug manufacturers can't hold on to their patents abnormally long so the generics can't actually get out to people or bundle them together to restrict their patents.

We have to end this practice of surprise medical bills. Some folks have no

idea what that is, and other folks know all too well. They look at their insurance. They go to a hospital that is in network, and their doctor is in network. So they go to a hospital that is in network, and they go to a doctor who is in network, but they get a giant bill from an out-of-network anesthesiologist, or the lab is out of network and the hospital is in network, and they get a giant bill from the lab. We are working to end the practice of having labs that are out of network or certain specialists a doctor has sent them to—the patient assumes they are in network, but then they find out that certain individuals who have taken care of them are out of network.

We are also dealing with the issue of air ambulance surprise bills, which has been a great challenge for those folks in rural America who are having to be transferred long distances to get to a hospital and then are getting an enormous bill for an out-of-network air ambulance as a surprise billing. There are ways we can address this to deal with the out-of-pocket costs.

We are focused on areas where we can find agreement and things we can do to work through this process.

There is much to be done in the area of prescription drugs and in the area of in network, out of network, and surprise medical bills. We should be able to find common ground, and I am grateful I am part of this dialogue to help try to find ways we can come together, get this resolved, and get a better situation for American consumers and patients in the days ahead.

With that, I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Mr. President, I want to update my colleagues and the American people about efforts to reduce the cost of prescription medicine.

Last week, our country and the American people celebrated Independence Day, marking 243 years of self-government. As elected representatives, it is our job to make the government work for the people, not the other way around.

For more than two centuries, our system of free enterprise has unleashed American innovation, investment, and ingenuity. Robust competition incubates advances in science and medicine. It leads to lifesaving cures and promising treatments for cancer, Alzheimer's, diabetes, and other debilitating diseases.

However, prescription medicine too often smacks consumers with sticker shock at the pharmacy counter. The soaring prices leave taxpayers with a big tab—particularly under the Medicare and Medicaid Programs—and they weigh heavily on the minds of moms and dads all across the country.

Last week, I held meetings with my constituents in 12 counties across Iowa. The cost of prescription drugs comes up at nearly every single Q-and-A county meeting that I hold. Iowans want to know why prices keep climbing higher and higher. They want to know why the price of insulin keeps going up and up and up—nearly 100 years after the lifesaving discovery was made. They want to know what can be done to make prescription drugs more affordable.

I am chairman of the Senate Finance Committee, and in that position, I have been working with Ranking Member WYDEN from Oregon on a comprehensive plan to do just that. We have held a series of hearings to examine the drug price supply chain. We are working on a path forward. We are taking care to follow the Hippocratic Oath: ''First, do no harm.'' In other words, let's be sure we don't try to fix what is not broken. Americans don't want to give up high-quality lifesaving medicine. That is why I support market-driven reforms to boost competition and transparency, because with transparency brings accountability and the marketplace working more free of secrecy.

Congress needs to get rid of perverse incentives and fix problems that undermine competition in the drug pricing system, including withholding samples by brand-name pharmaceutical companies, pay for delay, product-hopping, and rebate-bundling. There is too much secrecy in the pricing supply chain. Consumers can't make heads or tails of why they are charged what they pay for their medicine.

President Trump has made reducing drug prices a top priority of this administration, and they have taken several steps under various laws—including even under ObamaCare—to do things that give more freedom to consumers of medicine and on other healthcare priorities.

In another instance, on Monday, the Federal court took a negative move, knocking down a rule that would require drug companies to disclose the price of their drugs in television ads. This is very, very disappointing. Senator DURBIN and I worked on this in the last Congress, and I am going to continue to work with Senator DURBIN to get this job done. Congress must correct what the Federal court said the administration didn't have the authority to do. I disagree with the court, but Congress can fix that. Big Pharma is already required to disclose side effects in their ads. Consumers ought to know what the advertised drug will cost. Today, I call upon my colleagues to climb aboard that effort Senator DURBIN and I will be pursuing.

Let's pass the bipartisan healthcare bills thoughtfully crafted in various committees. The previous three speakers spoke to some of those issues. Let's get these various bills correcting some of these problems over the finish line. Working together, we can drive down the price of prescription drugs without derailing quality and without derailing innovation, all of which saves lives and improves the quality of life for the American people.

I yield the floor.

The PRESIDING OFFICER. The Senator from Indiana.

Mr. BRAUN. Mr. President, Senator GRASSLEY and I attended the rollout of President Trump's Executive order to get the healthcare industry on the move. The chairman of the Finance Committee, the chairman of the Health, Education, Labor, and Pensions Committee, and Senators like me—I am a mainstream entrepreneur—came to the Senate to discuss issues just like this.

I have probably been on the floor more than any other Senator, and every time I do it, I tell the industry: Wake up. I took you on 10, 11 years ago, in my own business, to give good healthcare coverage to my employees. Year after year, it was a litany of, you are lucky your premiums are only going up 5 to 10 percent this year. You have all heard it before. It took risk, and it took some novel thinking, but it can be done. Most entrepreneurs aren't going to put the time I put into it to make it work for my own employees.

When you hear Democrats, Republicans, three or four committees, and the President of the United States talking about a healthcare system that is broken, you should get it through your thick head that there need to be changes made. It shouldn't be coming from Congress, even though it will keep coming.

I think the message is out loud and clear: Wake up and start fixing these things, or you are going to have a business partner whose name is BERNIE SANDERS and another idea of Medicare for All that we would regret once we got it. But, like most things here, like most big problems in this country, we wait too long to solve the issue.

To give you a few things on what led me to be passionate about it, when I had to give up my own company's good health insurance, I had a very generic prescription that I needed to get renewed. There were eight pharmacies in the little town of Jasper, roughly, so I knew I would be able to get quotes. I had no health insurance. I was in between being a CEO of a company and a Senator. I said, I am going to try to see what this is going to be like. I knew it should cost 20 or 25 bucks, maybe a little less.

The first place I called, they stumbled around and couldn't even give me a quote on a common prescription. Finally, after about 3 to 4 minutes, they said $34.50. I called another place that I thought would be a little quicker on its feet. It took 10 seconds, I got a quote for $10, and they said: By the way, you can pick it up in 10 minutes.

That is more the way the rest of the economy works, but healthcare consumers have gotten used to not doing any of that heavy-lifting themselves. And believe me, the industry has evolved from Big Pharma, to big hospital chains, to the health insurance industry, which is in the middle of all of it. There are pharmacy benefit managers, and the drug companies give

them $150 billion worth of rebates, and through their costs and profits, less than half of that makes it to the consumer or to the pharmacy.

The case is out there. We, as Senators and Congressmen on the other side, shouldn't need to be going to the floors of our Chambers to tell you the obvious: If you don't do these things, I don't believe we here—at the speed at which we normally operate—can do it quickly enough for you to save yourselves from that other business plan, which is Medicare for All.

So what do we do to prevent that? No. 1, the industry should be out there doing what all other companies do—be transparent. In any other part of our economy, where do you not ask for and have plenty of information to work with. What does it cost, and what is the quality? I know that where I live, people would drive 60 miles to save 50 bucks on a big-screen TV that costs a thousand bucks.

When I instituted a plan in my own business that encouraged my employees to do that, to have skin in the game, amazing things happened. Every time you pick up the phone or get on the web and look for that comparison, it is kind of hard to find, but it is there. The industry just needs to give more of it and not hide behind a system that has benefitted them. When we created that in my own business, people shopped around for prescriptions and routinely saved 30 to 70 percent, as they do on MRIs, CAT scans, and most other procedures.

I put the time and effort into it. Most CEOs—and you always hear about how employees are happy with their employer-provided insurance. That is because the employers are generally paying for anywhere from 85 to 100 percent of it. So folks working somewhere don't really have skin in the game.

Consumers of healthcare need to do what they do in all other industries and in all other things that they buy—take the time to ask how much it costs, what is the quality, and then the industry get with it so that we can fix the system before the other option actually takes place. There aren't enough CEOs and there aren't enough legislators to, I think, get the industry in shape, and the industry itself knows what these problems are. Get with it before you have a different business partner whom you won't like.

I yield the floor.

The PRESIDING OFFICER. The Senator from Louisiana.

Mr. CASSIDY. Mr. President, I, too, come to speak today regarding pharmaceutical costs and what we can do to make lifesaving medications—and sometimes these medications make our lives a little bit better—more affordable to the average American.

I happen to be a doctor, and I will approach these remarks as a fellow who has seen medicine evolve, who has seen the incredible, positive benefits of pharmaceutical innovation, but also as a doctor who sometimes saw that patients were unable to afford innovation. The question in my mind is, How do we give the patient the power to afford these innovative medicines, because if she cannot afford them, it is as if the innovation never occurred, and for her, it never did occur. So give the patient power.

Let me make some remarks about pharmaceutical companies. There are some incredible examples.

When I was in medical school, cutting away a part of one's stomach—not the belly but part of the stomach; as I would tell patients, where the food goes after you swallow it—cutting away a part of the stomach because of ulcerative disease was one of the most common procedures done in surgery. Then histamine blockers came along, H2 blockers. Cimetidine was the first. All of a sudden, a surgery that was done multiple times a week was scarcely ever done. Those medicines are now sold over the counter.

This morning, I got a little bit of arthritis, so I took my nonsteroidal anti-inflammatory, which used to be sold by prescription and now is over the counter, along with my H2 blocker, my Pepcid, which used to be sold by prescription but now is over the counter. I take them in the morning, and my back feels better. All of these are medicines that are generic, routine, and we almost—in fact, we indeed take the innovation for granted.

I can go on. I am a liver doctor. Hepatitis C used to be an incurable disease which, in a certain percentage of those affected, would lead to cirrhosis, vomiting blood, liver cancer, and death. Now hepatitis C is cured by taking pills for several weeks. Amazing.

Human immunodeficiency virus, AIDS. When I was in residency, if you got HIV, you died. There was no cure whatsoever. Now people live with it for decades. It is a disease you live with but do not die from. We speak of actually now developing cures for HIV.

That is the promise of a vibrant pharmaceutical industry—people who not only live when otherwise they would have passed away but who also have a better quality of life.

Now, that said, if the patient doesn't have the power, the patient has no leverage in this situation.

I was recently with others in a conversation with the new head of the Congressional Budget Office. The CBO head said: You know, everybody has leverage in the healthcare marketplace except the patient. Everybody has leverage but not the patient.

That is so true. Let me give some examples of how the patient lacks leverage in the pharmaceutical marketplace.

First, I will say, if I go to church—and I do go to church regularly—and there is a BERNIE SANDERS supporter yanking on this lapel and a Donald Trump supporter yanking on this lapel and they are complaining about the same thing, they are talking about either surprise medical bills or the high cost of drugs. It is something that touches each American, but it doesn't have to be that way.

Consumer Reports did an article over 1 year ago now in which they sent secret shoppers out to retail pharmacies to buy five generic medications, a prescription for each type—again, generic, like the over-the-counter pills I am taking. They went, and they paid anywhere from $66 to $900 for the same five drugs. Now, we can assume that the acquisition cost was about 60 bucks, because you could buy it someplace—an independent pharmacy or online—for $66, but three or four chain pharmacies were charging $900 for medications that they could acquire for less than $60.

You could argue, why did the patient pay? Because we have so little advertising, if you will, cost competition, on what a generic medicine would cost. So imagine you have a health savings account, and you are going to buy your prescriptions, and you get charged $900 for something that should cost $60. This is the situation in which the patient has no leverage.

By the way, you can ask, why didn't insurance cover it? It is because these patients were posing as uninsured. So the chain pharmacy figured out that it is the uninsured who do not have somebody working on their behalf who are going to be the most ripe for the picking for the high prices. The uninsured are the ones we are going to exploit, the ones paying cash. That is wrong. That is not the patient having the power; it is the patient being used as a victim.

There are other things we can see. One is called evergreening. You have a drug, and you make just a little bit of a tweak to it that doesn't improve its importance or the efficacy of the drug—no clinical benefit—but it extends the intellectual property protections. Now laws that were conceived of and passed by Congress to reward innovation and to encourage creativity are instead being used to stifle competition and to extend patent lives so that we, the patients and the taxpayers, have to pay more—not for innovation but, rather because, somebody figured out how to evergreen it.

So on the one hand, I am going to praise pharmaceutical companies for lifesaving drugs that have meant so much to me, my family, and everyone who is listening today, but I must also ask, why should we reward that which is not innovative but which is merely arbitraging laws meant to encourage innovation? We should not encourage arbitraging laws.

There are other issues, such as patent abuse, where companies file large numbers of patents on parts of their drugs that are not innovative but are byproducts of the production process in order to keep out competition; citizen petitions, which typically come on 6 months before a drug is about to become generic, so all of a sudden, we have all these petitions that must be navigated by the companies seeking to

introduce the generic; and the rebate system, which works to preserve market share but also to increase prices and to keep them high so patients do not benefit from competition.

If we are going to say the patient should have the power in order to have lower prices, we can say right now that the system seems to be aligned against the patient.

What can we do? Well, my office and others have several proposals in the current pieces of legislation going through, such as the so-called real-time benefit analysis. A prescription is ordered for a patient. The patient scans a barcode, and it would say: At this point, with your deductible and your copay, this is how much this drug is going to cost you, but there is a generic available, and you can get that generic instead. That would be a real-time benefit analysis that would save the patient money.

We just talked to the folks at Blue Cross California. They are coming up with so-called gainsharing. If a patient selects a lower cost medication, the patient receives some of the savings that would otherwise have all gone back to the insurance company—another great idea. Senator BRAUN was speaking about the patient having skin in the game. In this case, there will be skin in the game because the patient shares the benefit with the payor for being cost-conscious. That is the patient having the power.

We can also add value-based arrangements, which pharmaceutical companies, to their credit, have proposed. If you are the pharmaceutical company, you get paid only if the medicine works. If the medicine doesn't work, you don't get paid. If it does work, you do. That is a value-based arrangement. We have a bill with Senator WARNER that would do that.

I would also mention attempting to cap Part D exposure. If there is a senior citizen who is in the catastrophic portion of her policy, then you can cap the amount the senior might be exposed to. Under current law, she might be paying 5 percent of $100,000 worth of medicine. She is taking an essential drug to treat cancer, and she is paying 5 percent of that $100,000, in addition to 5 percent of the other medications she is receiving. This is something many seniors cannot afford and this is something we as Congress can find mechanisms by which we can cap that exposure but still hold taxpayers whole.

We have to enhance existing markets. As you might guess, my theme is that we should enhance it in terms of giving the patient the power, but we also have to preserve the innovation that has led to the great drugs I spoke about earlier. If all we do is steal intellectual property from the pharmaceutical companies, we will lose these innovative drugs. But, again, we need to have the drugs affordable for the patients. This is the tension—promote innovation but ensure affordability.

We have a number of solutions, such as those I have just mentioned, in the HELP Committee and now in the Finance Committee. Republicans have solutions. My office continues to work on those. I look forward to working with my colleagues on their implementation.

Mr. President, I yield the floor.

RECESS UNTIL 4 P.M. TODAY

The PRESIDING OFFICER. The Senate stands in recess until 4 p.m.

Thereupon, the Senate, at 3 p.m., recessed until 4:01 p.m. and reassembled when called to order by the Presiding Officer (Mrs. BLACKBURN).

EXECUTIVE CALENDAR—Continued

The PRESIDING OFFICER. The Senator from Washington.

NOMINATION OF JOHN P. PALLASCH

Mrs. MURRAY. Madam President, I come to the floor today to speak about the two nominations we are about to vote on.

The first one is the nomination of John Pallasch to be the Assistant Secretary of Labor overseeing the Employment & Training Administration. This is a critically important role that manages nearly two-thirds of the Department of Labor's budget and our Nation's workforce development programs, which serve over 22 million youth, workers, jobseekers, and seniors who are working to improve their employment opportunities and the lives of their families.

This position is particularly important now as we are seeing the Trump administration work to undermine some of the most crucial programs within the Employment & Training Administration. They are attempting to close Job Corps centers that help train at-risk youth, conserve our natural resources, and provide economic opportunities in rural areas and communities in need. They are also proposing a duplicative, lower quality apprenticeship program that would put workers at risk and give taxpayer dollars to for-profit colleges with very little accountability.

It is clear that the Employment & Training Administration needs a leader now who is knowledgeable, who is experienced, and who is committed to providing workers with the training, support, and benefits they need to succeed in this changing economy. Unfortunately, Mr. Pallasch is not that person. Throughout this nomination process, Mr. Pallasch has shown that he has very limited experience with or understanding of the programs that he would be overseeing.

I am going to vote against this nomination, and I urge my colleagues to do the same.

At this time, I also want to once again reiterate my disappointment in the unprecedented obstruction to Democratic nominees to the Equal Employment Opportunity Commission and the National Labor Relations Board. Last Congress, Republicans refused to confirm two very highly qualified and respected nominees to additional terms on the EEOC and the NLRB.

Earlier this year, Republicans broke yet another longstanding tradition by confirming a majority nominee to the EEOC without a Democratic pair.

Last week, the White House announced its intention to nominate a bipartisan pair of nominees to the EEOC. After a year of obstruction, I am encouraged by this small step toward bipartisanship and normalcy, but I am here today to urge the White House to formalize these nominations as quickly as possible so that the Senate can confirm them and restore balance to the EEOC.

I strongly urge the White House to nominate a full slate of nominees—Republican and Democrat—to both the NLRB and EEOC.

For those reasons and because of Mr. Pallasch's lack of experience and knowledge about the programs and the policies he would be responsible for, I will vote against his nomination.

NOMINATION OF ROBERT L. KING

Madam President, I also come to the floor today to oppose the nomination of Robert King to be the Department of Education's Assistant Secretary for Postsecondary Education. This position is especially important because so many of our Nation's students are struggling today in higher education.

Over the last few years, I have heard from students who are worried about how they are ever going to afford their textbooks or their rent or even their food, who are worried if their college is preparing them for a good education and if they are going to be able to get a good-paying job and pay off their loans.

First-generation college students are struggling to navigate their financial aid and how to succeed on a college campus for the first time. I am hearing about those worried about being able to get an education without being discriminated against or harassed or assaulted on campus. Those are just a snapshot of the issues students are facing in higher education today.

These challenges are not easy to solve. That is why Chairman ALEXANDER and I are working now to address all of those issues and more in our reauthorization of the Higher Education Act.

As we work to update this critically important law, we cannot ignore the current actions of this Department of Education, which is loosening and eliminating rules that benefit predatory colleges instead of protecting students. Students should have an ally at the Department of Education, someone who understands the challenges they are facing and is committed to helping students succeed.

Among other responsibilities, this Assistant Secretary for Postsecondary Education is responsible for developing rules, for developing a budget and legislative proposals for higher education,