Unfortunately, Senate Republicans are less interested in solving problems than they are in creating them. The day before this floor debate began, the assistant Republican leader—the junior Senator from Arizona—said: “There is no way to fix this bill.” Of course, that is absolutely totally wrong.

All Senators know there is a reliable way to improve legislation—to improve this bill. It has been in use for 220 years. It is called the legislative process. It is called doing our job.

As this bill continues to improve, I, once again, remind my colleagues not to lose sight of the bigger picture. As we delve into the details and debate the fine print, let us not forget why we are here. Our goal remains the same. It was the day we began this debate many months ago. It remains the same as it was a year and a half ago, when Senate Finance Committee chairman MAX BAUCUS first held a series of hearings that led to the legislation that is now before us.

Our goal remains the same as it was last November when the American people called in a loud and clear voice for change. It remains the same as it did 51 years ago, when Senator Ted Kennedy called in a loud and clear voice that “in our unbelievably rich land, the quality of health care available to many of our people is unbelievably poor, and the cost is unbelievably high.”

It remains the same as it did the day President Truman sounded a call to action to ensure that American families are protected from what he called “the economic effects of sickness.” That was more than 64 years ago, and more than half of today’s Senators weren’t even born then. That constant goal has been and remains this: We must make it possible for every American—each and every American—to afford to live a healthy life.

Each moment in this fight is historic. This bill to fix our health care decisions in the hands of the people has ever come this far. But the most historic days of the journey lie ahead. We can only seize that opportunity if this debate is about facts, not about fear.

I remind my colleagues that if we are to truly help the American people and the American economy, if we are to sincerely do the work our neighbors sent us to do, if we are to leave our children and grandchildren a better inheritance than a deep deficit and a broken Medicare system—if we are to do any of these things—we must work together and not against each other. We must work as partners, not as partisans.

This is not the first time I have asked my Republican friends to abandon their shortsighted strategy to bring the Senate to a screeching halt; for example, issuing an informational guide on how to stop and slow things. That doesn’t work. We need a strategy that says we can work together and get some things done. I have had a couple good conversations the last few days with some of my colleagues on the other side of the aisle. I hope we can move forward. This is a bill that doesn’t look at a person who is sick or hurt or afraid as being a Democrat or a Republican or an Independent. They are Americans. They are from Virginia, Montana, Nevada and from all over America and they are people who are calling upon us to do the right thing.

RECOGNITION OF THE MINORITY LEADER

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

HEALTH CARE REFORM

Mr. McCONNELL. Mr. President, we had a very clarifying vote on the Senate floor about the direction of our friends on the other side with regard to our health care system. Yesterday, all but two of them voted to preserve nearly $7 trillion in cuts to Medicare, the health program for our seniors. In the runup to that vote, they said these cuts were not cuts and that Medicare Advantage in particular is not a part of Medicare, arguments plainly contradicted by the text of the bill itself, by the Department of Health and Human Services, by the independent Congressional Budget Office, and by the experience of seniors themselves.

Seniors do not want Senators fooling with Medicare. Let me say that again. Seniors do not want Senators fooling with Medicare. They want us to fix it, to strengthen it, to preserve it for future generations—notraid it like a giant piggy bank in order to create some entirely new government program.

Yesterday’s vote was particularly distressing for the nearly 11 million seniors on Medicare Advantage. So today Members will have an opportunity to undo the damage they voted to do to this program. With yesterday’s vote, proponents of this measure authorized $120 billion in cuts to Medicare Advantage, which in the process they intend to violate the President’s pledge that seniors who like the plans they have can keep them. The President has said seniors who like the plans they have can keep them—because you can’t cut $120 billion from a benefits program, obviously, without cutting benefits.

The Congressional Budget Office has been crystal clear on this matter. When asked about the effect these cuts would have on Medicare Advantage, the Director of CBO was unequivocal. He said that approximately half of Medicare Advantage benefits will be cut for nearly 11 million seniors enrolled in this program under this bill. He concluded that the Director of the Congressional Budget Office being unequivocal. He said that approximately half of Medicare Advantage benefits will be cut for nearly 11 million seniors enrolled in this program under this bill. Specifically, what our other side voted for yesterday and they know it.

One Democrat last night was explicit. He admitted that after yesterday’s votes, Democrats will not be able to say that “if you like what you have you can keep it.” This is one of our Democrat colleagues yesterday saying: “If you like what you have you can keep it” can no longer be said.

He went on to say “that basic commitment that a lot of us around here have made will be called into question.” I think that is highly likely.

Our friends have a couple of choices here today. They can reaffirm their plan to cut benefits for nearly one-fourth of all seniors enrolled in Medicare, they can admit that the President’s pledge about keeping the plan you like no longer applies, or they can reverse part of yesterday’s vote later today by voting with Republicans to restore those cuts to Medicare Advantage.

I yield the floor.

RESERVATION OF LEADER TIME

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

SERVICE MEMBERS HOME OWNERSHIP TAX ACT OF 2009

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate will consider the nomination of H.R. 3590, which the clerk will report.

The assistant legislative clerk read as follows:

A bill (H.R. 3590) to amend the Internal Revenue Code of 1986 to modify the first-time home buyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

Pending:

Reid amendment No. 2786, in the nature of a substitute.

Whitehouse amendment No. 2067 (to amendment No. 2786), to promote fiscal responsibility by protecting the Social Security surplus and CLASS program savings in this act.

Hatch motion to commit the bill to the Committee on Finance, with instructions.

The ACTING PRESIDENT pro tempore. The Senator from Montana.

Mr. BAUCUS. Mr. President, we are beginning our fifth day of consideration on the health reform bill. We will be in a period of debate only until about 11:30 a.m. Pending now is the
amendment by the Senator from Rhode Island, Mr. WHITEHOUSE, on fiscal responsibility. Also pending is a motion to commit by the Senator from Utah on Medicare Advantage. It would be my hope that the Senate will vote on these matters today.

Mr. President, I suggest the absence of a quorum.

The ACTING PRESIDENT pro tempore. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

Under the previous order, the time until 11:30 a.m. will be for debate only with the time equally divided and controlled between the two leaders or their designees, with the majority controlling the first portion of time.

The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, experts and economists of every political stripe agree that preserving America’s long-term economic security means restraining the way we provide and pay for health care. Health care spending makes up one-sixth of the U.S. economy. Future generations can expect the burden of insurmountable debt if we fail to act.

The fiscal challenges we may face in years to come pale in comparison to the threat of uncontrolled Federal health care spending. The chart behind me essentially shows that. The chart shows the percentage annual growth rates beginning in 2004. The red is the economy, the blue is health care costs. Clearly, over time, especially as the economy dipped during this great recession, the gap between economic growth and health care spending has widened. And that is in future years they will widen more and more.

As you can see out to 2018, the total economy is projected. Near 2018 the economy is above 4 percent and health care spending is 7 or 8 percent.

Doing nothing means health care spending continues to grow faster than our economy. That is what that chart shows quite dramatically. Doing nothing means entitlement spending more than doubles by the year 2050. That is taking one-fifth of our gross domestic product.

But it is not simply the Federal budget on the line, it is the family budget too. Incredibly, in total we are spending 80 times as much on health care today as we did five decades ago—80 times more on health care today than we did five decades ago. Now family budgets are breaking under the strain—already. That is going to get worse if we do nothing. The cost of the average family health care plan will reach $24,000 in the year 2016. That is not too many years away from now. This represents an 84-percent increase over 2008 premium levels. That means, if we do nothing, in fewer than 10 years most families would have to dedicate half of their household budget to health insurance. For years we have heard the warnings from Federal budget experts. Now we are hearing every day from folks back home that they simply cannot afford the care they need.

We have an obligation to act. Now we have an opportunity to act. The country’s leading economists and Federal budget experts laid out strategies and options for getting costs under control. We have taken their recommendations to heart. There is a lot of agreement among those who study these issues of what we must do. Now we have a bill that does what they suggest. It also fulfills our commitment to fiscal responsibility.

We have many reasons to vote for this bill. It protects and even increases Medicare benefits for seniors. It achieves near universal coverage in less than 10 years. That means it achieves the goal of virtually everybody having health insurance in that period of time. It slows the growth of Federal health care spending. It stops insurance industry discrimination and, based on independent, nonpartisan analysis, it achieves a serious dent in our Federal deficit.

This chart behind me represents what 2 weeks ago the Congressional Budget Office and Joint Committee on Taxation confirmed in no uncertain terms. The chart shows what is happening to health care. The projections for today, if we do not reform the health care system, are very serious indeed.

Let me ascertain how much time we have and how many speakers we have. The ACTING PRESIDENT pro tempore. The Senator has 40 minutes.

Mr. BAUCUS. I yield 15 minutes to the Senator from New Mexico.

Mr. BINGAMAN. Mr. President, let me thank Senator BAUCUS for his leadership on this issue. I have mentioned to many times that my party, as I believe without his leadership, we would not be where we are today in our effort to reform health care. I congratulate him on the superb effort he has made.

I want to spend a few minutes talking about health care reform both as it affects the country but also as it affects my home State of New Mexico. First, I would like to discuss the context for this health reform bill, and that is the very serious problem we face in the country. The projections for the future, if we do not reform the health care system, are very serious indeed.

Let me allude to an article in the morning New York Times. This is by economist Paul Krugman of Princeton University. He talks about this issue of fiscal responsibility and the impact of health care reform on the deficit. It talks about how some Senators have concerns about going ahead with this health care reform bill because of what it might cost. He makes the point:

But if they’re really concerned with fiscal responsibility, they shouldn’t be worried about what would happen if health reform passed. They should, instead, be worried about what would happen if it doesn’t pass.

For America can’t get control of its budget without controlling health care costs—and this is our best, last chance to deal with these costs in a rational way.

I ask unanimous consent that the full column from the New York Times
of this morning be printed in the Record following my remarks.

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

(See exhibit 1.)

Mr. BINGAMAN. As this chart demonstrates, according to the Congressional Budget Office, if we don’t act to deal with the growth in health care costs, Federal spending on Medicare and Medicaid combined will grow from 5 percent of GDP today to almost 10 percent by 2035. By 2080, the government would be spending almost as much as a share of the economy on just its two major health care programs as it has spent on all of its programs and services in recent years.

Let me put up another chart that demonstrates that most of this increase in cost is not the result of our aging population. We do have an aging population; that does add to the cost of health care because as people get older they tend to need more health care. The dark blue shows the increase expected in health care costs by virtue of aging. But the lighter blue talks about the effect of excess cost growth that is not happening; that is, the growth in health care cost is out of control in our current system. Such spending is unsustainable. It has led the Congressional Budget Office to say:

Slowing the growth rate of outlays for Medicare and Medicaid is the central long-term challenge for fiscal policy.

Moreover, across the country, premiums continue to increase. They are becoming more and more unaffordable for individuals and for businesses. I hear on a regular basis when I go around New Mexico—and I am sure all my colleagues hear from their constituents as they travel in their States—that people cannot continue to pay more and more each year for their health care coverage. According to an August 2009 study by the Commonwealth Fund, nationally, family premiums for employer-sponsored health insurance increased 119 percent between 1999 and 2008. If cost growth continues on its current course, those premiums could increase another 94 percent to an average of $23,842 per family by 2020. I am not sure what the circumstance is in many States, but I know in New Mexico there are many families who cannot afford to pay $23,800 in health care premiums.

Nowhere is the unsustainable growth felt more acutely than in my home State. Without health reform, in my State we are projected to experience the greatest increase in health insurance premiums of any State in the Union. For example, the average employer-sponsored insurance premium for a family in New Mexico was about $8,000 in the year 2000. By 2006, this rate had almost doubled, or the cost had almost doubled to $11,000. By 2016, the amount is expected to rise to $26,000. In addition, health insurance premiums in New Mexico make up a larger percentage of New Mexico’s income, the income of the average New Mexico family, than almost all other States. We are paying 31.18 percent. Over 31 percent of the average income of a family in New Mexico is going to pay for health care. This is expected to grow to 36 percent if we do not reform our health care system.

It is important to highlight that the higher spending on health care in the United States does not necessarily prolong lives. I hear a lot of speeches about how we have the greatest health care system in the world. We are the envy of the world. People would just love to have access to our health care system. This chart illustrates that in 2000, the United States spent more on health care than any other country in the world, an average of $4,500 per person. That was in 2000. Switzerland was the second highest at $3,300, substantially less. Essentially, its cost per person was 31 percent of what it was in the United States during that year. Nevertheless, the life expectancy comes out at 27th in the world. Our life expectancy average is 77 years. Many countries, 26 could be exact, achieve higher life expectancy rates with significantly lower spending on health care.

Data from the McKinsey Global Institute clearly indicates there is a considerable level of waste in our current system. McKinsey estimates that the United States spends nearly $6 trillion in excess costs in other similarly situated nations. Of this, about $224 billion in excess costs are found in hospital care. About $178 billion are found in outpatient care. Together these account for more than 80 percent of U.S. spending above the levels of other nations.

Here is one other chart. This is one I have used before on the Senate floor. Not surprisingly, as costs and inefficiencies continue to build, access to health care for Americans is becoming more and more difficult for middle- and lower-income Americans. This chart indicates the rate of uninsurance throughout the country. First, on the left-hand side is the year 2000; on the right-hand side is 2008. We can see the dark blue States are States where 23 percent or more of the population ages 18 to 64 are uninsured. Back in the year 2000, New Mexico and Texas were the only two States where the rate of uninsurance exceeded 33 percent. By 2008, the rate of uninsurance exceeds 33 percent for 7 States, particularly across the southern part of the country.

We have a very serious problem that needs addressing. It is clear that the U.S. health care system is failing many Americans. The situation is becoming more and more urgent. According to a study published by the Harvard Medical School in August, medical costs have led to almost two-thirds of the bankruptcies in this country. More than 2 million Americans are attributing bankruptcy to health care problems. The study found that most medical debtors were well educated, owned their own homes, had middle-class occupations and, shockingly, three quarters had health insurance. So these were people who had coverage, but the coverage was not adequate to meet the needs. Unfortunately, for many individuals, high deductibles and coinsurance lead them to delay or to avoid receiving medical care altogether.

The Urban Institute reports that 137,000 people in this country died between 2000 and 2006 because they lacked medical insurance. This number was 22,000 people in 2006. Clearly, the need for national health reform has never been so great.

The Patient Protection and Affordable Care Act, the legislation we are debating, introduced by Senator Reid and others a few weeks ago, includes the key reforms we have come up with and that the experts have come up with, aimed at addressing these very serious problems, while protecting the success of our health system that are working today.

First, this bill includes long-overdue reforms to increase the efficiency and quality of the health care system while reducing overall costs. Unfortunately, the legislation includes payment reforms that I have championed to shift from a fee-for-service payment system to a bundled payment system. This will reshape our health care reimbursement system to reward better care and not simply more care as it currently does today.

Second, it includes a broad new framework to ensure that all Americans have access to affordable health care. This includes creation of a new health insurance exchange in each State which will provide Americans a centralized source of meaningful private insurance as well as refundable tax credits to ensure that coverage is affordable.

Finally, these new health insurance exchanges will help improve choices by allowing families and businesses to compare insurance plans on the basis of costs and performance. It puts families, rather than the insurance companies or the government bureaucrats, in charge of health care. It helps people to decide which quality, affordable insurance option is right for them.

The Congressional Budget Office, which is cited here—quite frankly, I notice that the Congressional Budget Office is cited by both Democrats and the Republicans in this debate, and that is a credit to why they are seen as nonpartisan, and they are nonpartisan. I congratulate Doug Elmendorf for the good work CBO has been doing in support of our efforts to come to the right answer on health care reform. The CBO foresees that this legislation would not add to the deficit.

As the chart Senator BAUCUS had a few minutes ago clearly indicates, the deficit would be reduced in the first 10 years by $130 billion. It would be reduced by $250 billion in the second 10 years, going up to 2029, by something over $600 billion.

Let me also point out the contrast. We are talking about a bill which the
Congressional Budget Office says will reduce the size of the deficit in future decades. I can remember a couple Congresses ago when we had a debate on adding subpart D to Medicare, Part D to Medicare. There are many on the floor who are concerned about cost today. They say: ‘You always add another $500 billion. That was estimated by the CBO at that time; another $600 billion over a 10-year period to the Medicare trust fund was nearing bearing.

The efforts we are making in this legislation to bring under control the cost growth in Medicare is essential if we are going to keep Medicare solvent in the future, and part of the solvency problem Medicare has in the future, frankly, is related to what we did in subpart D.

On the subject of premium cost, CBO has also found that in the individual market, the amount that subsidized enrollees pay for nonsubsidized enrollees would be roughly 56 percent to 59 percent lower, on average, than the premiums charged in the individual market under current law. Among enrollees in the individual market who would not otherwise be insured, average premiums would increase by less than 10 to 13 percent. The legislation would have smaller effects on premiums for employment-based coverage. Its greatest impact would be on smaller employers and for new health insurance tax credits. For these businesses and their employees, CBO predicts premiums would decrease by about 8 percent to 11 percent compared with their costs under current law.

This is consistent with estimates of the impact in my home State of New Mexico, where average families may see a decrease in premiums of as much as 60 percent. In addition, about two-thirds of New Mexicans could potentially obtain new health insurance coverage through the subsidies, and nearly a quarter would qualify for near full subsidies or Medicaid.

An overall decrease in premium costs also is consistent with the experience in Massachusetts where there has been an enormous reduction in the cost of nongroup insurance in the State after they enacted similar reform to what we are considering now in the Senate. After reform the average individual premium in Massachusetts fell from $8537 at the end of 2006 to $5143 in mid-2009, a 40 percent reduction while the rest of the Nation was seeing a 14 percent increase.

Finally, much of the debate on health care reform has focused on insurance coverage but it is important to recognize that as we expand coverage to include more Americans, the demand for health care services will also increase. A strong health care workforce is therefore essential for successful health reform. Within the United States, approximately 25 percent of counties are designated health profes-

sional staff to properly serve that geographic area. The problem is even more apparent in rural States such as New Mexico. For example, 32 out of 33 counties in my State has this shortage designation. As a result, New Mexico ranks last compared to all other states with regard to the health care and utilization of preventative medicine.

The Patient Protection and Affordable Care Act we are debating contains key provisions to improve access and quality of health care services throughout the Nation. These provisions include increasing the supply of physicians, nurses, and other health care providers; enhancing workforce education and training; and providing support to the existing workforce. I applaud Senators Reid, Baucus, Dodd, Harkin, and many other colleagues who have worked so hard on this bill. This legislation represents true healthcare reform. It is time for us to put partisanship aside and enact this critical and long overdue legislation. I see my time is up and there are others waiting to speak. I yield the floor.

EXHIBIT 1
[From the New York Times, Dec. 4, 2009]

By Paul Krugman

Health Care reform hangs in the balance. Its fate rests with a handful of “centrist” senators—senators who claim to be mainly worried about whether the proposed legislation is fiscally responsible. But if they’re really concerned with fiscal responsibility, they shouldn’t be worried about what would happen if health reform passes. They should, instead, be worried about what would happen if it doesn’t pass. For America can’t get control of its budget without controlling health care costs—and this is our last, best chance to deal with these costs in a rational way.

Some background: Long-term fiscal projections for America are bad news if the problem isn’t fixed soon. Unless there are major policy changes, expenditure will consistently grow faster than revenue, eventually leading to a debt crisis.

What’s behind these projections? An aging population, which will raise the cost of Social Security, is part of the story. But the main driver of future deficits is the ever-rising cost of Medicare and Medicaid. If health care costs rise in the future as they have in the past, fiscal catastrophe awaits. You might think, given this picture, that extending coverage to those who would otherwise be uninsured would exacerbate the problem. But you’d be wrong, for two reasons.

First, the uninsured in America are, on average, relatively young and healthy; covering them wouldn’t raise overall health care costs very much.

Second, the proposed health care reform links the expansion of coverage to serious cost-control measures for Medicare. Think of it as a grand bargain: coverage for (almost) everyone, tied to an effort to ensure that health care dollars are well spent.

So to the centrists still sitting on the fence over health reform: If you care about fiscal responsibility, you better be afraid of this bill.”

REFORM OR ELSE

I applaud Senators Reed, Baucus, Dodd, Harkin, and many other colleagues who have worked so hard on this bill. This legislation represents true healthcare reform. It is time for us to put partisanship aside and enact this critical and long overdue legislation. I see my time is up and there are others waiting to speak. I yield the floor.

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So to the centrists still sitting on the fence over health reform: If you care about fiscal responsibility, you better be afraid of this bill,” says Senator Tom Coburn.

If these tactics work, and health reform fails, think of the message this would convey: It would signal that any effort to deal with the biggest budget problem we face will be successfully played by political opponents as a cheat on older Americans. It should be a long time before anyone was willing to take on the challenge again; remember that after the failure of the Clinton effort, it was 16 years before the next try at health reform.

That’s why anyone who is truly concerned about fiscal policy should be anxious to see health reform succeed. If it fails, the demagogues will have won, and we probably won’t deal with our biggest fiscal problem until we’re forced into action by a nasty debt crisis.

So to the centrists still sitting on the fence over health reform: If you care about fiscal responsibility, you better be afraid of what will happen if reform fails. The ACTING PRESIDENT pro tempore. The Senator from Montana.

Mr. BAUCUS. Mr. President, how much time remains under the control of the majority?

Mr. BAUCUS. Mr. President, I yield 10 minutes to the Senator from Massachusetts.

Mr. KIRK. Mr. President, I thank the Senator from Montana.

Mr. BAUCUS. We might be able to find extra time, too, if the Senator is looking for extra time. Right now, according to the number of Senators who
want to speak, that is all we have in this first block. But sometimes we can work things out—if the Senator wants to talk a little longer. But right now it is 10 minutes.

The ACTING PRESIDENT pro tempore, the Senator from Massachusetts, Mr. KIRK. Mr. President, I thank Senator BAUCUS.

AMENDMENT NO. 2970

Mr. President, today in the United States of America, approximately 200 million of our citizens are elderly or disabled. These are not mere statistics. They are family members and loved ones—vulnerable, challenged, and often forgotten. But they were not forgotten by their friend and advocate, Senator Ted Kennedy. He understood a fair and civilized society should be judged on how it treats its most vulnerable citizens.

Sadly, millions of seniors and persons living with disabilities struggle to obtain the services and supports they need to live in their communities among their friends and families—in what they hoped would be their productive golden years.

As Senator Kennedy understood, it is morally wrong for so many disabled men and women who need assistance to be forced to face the heartbreaking choices: Do I abandon my job, spend down my savings, move out of my home, give up my American dream in order to qualify for Medicaid, the only government program that can provide me with the supports I need, or do I forgo my independence and resign myself to living the rest of my life confined to a facility?

Senator Kennedy also understood it is morally wrong when that infirm or elderly individual’s friends or loved ones must also face heartbreaking choices: Do I give up my job and commit my time to care for my infirm parent or my own family and children or do I resign myself to confining my aging mother or father to a facility?

Families across this country understand this heart-wrenching crisis all too well. A recent SCAN poll found that nearly 60 percent of those surveyed had a personal experience with long-term care. As this chart demonstrates, nearly 80 percent would be more likely to support health care reform and a long-term care program. These families know the current long-term care industry is not meeting their current needs and that change must come.

As always, Senator Kennedy cared how our society would be judged. He did not just sit by. He acted. He drafted the Community Living Assistance Services and Supports Act, known as the CLASS Act, which we are debating this morning. This program was at the heart of his effort to help people with functional limitations and their families to obtain the services and supports they need. It gives them the chance to maintain their independence and remain active, productive members of their communities.

Under the CLASS Act, a worker in Massachusetts, or any other State, can choose to pay a premium into this voluntary insurance program through affordable payroll deductions. After contributing for 5 years, they become eligible for a cash benefit of at least $50 a day if they become disabled. That cash benefit can make the difference in allowing a disabled person to live with independence, self-respect, and dignity.

For example, for having a ramp installed to their home or to pay for needed transportation or to purchase a computer to work from home and remain self-sufficient. It can also pay for a caregiver to come to their home, help them bathe, get dressed, and cook meals—services that otherwise often fall to family and friends who are forced to work reduced hours on their own jobs or quit those jobs altogether to provide that needed care.

The CLASS Act, as we know it, is paid for through a fragmented combination of sources, including family budgets, Medicaid, Medicare, and private insurance. Without a prior and voluntary insurance investment, what CLASS offers, paying for long-term care can be financially catastrophic for many individuals and families, since home care and nursing homes can cost over $70,000 a year.

Only one in five individuals can afford private long-term care insurance, and many are excluded because of pre-existing conditions. Medicare’s role in providing long-term services is extremely limited, covering only short-term skilled nursing care and home health. This lack of options forces many people to turn to Medicaid, which is our Nation’s primary payer and only safety net program providing comprehensive long-term care services and supports.

But who is eligible for Medicaid? People only qualify for Medicaid if they are or become poor. This criterion forces many families to impoverish themselves to obtain the Medicaid support they need. We have all heard the stories: The family member works hard all his or her life, and then due to an accident they cannot afford to pay for needed services and supports out of their pocket. So they now must give up their savings to become eligible to turn to the government or Medicaid to provide the proper care they need to survive. No one wins—not the disabled or elderly parent, not the family caregiver, not the government, and not Medicaid.

I have a letter from a woman who lives on Cape Cod in Massachusetts. She knows firsthand how powerful the CLASS Act could be for families. Jerilyn has been caring for her sister who is brain damaged, legally blind, paralyzed, and continent. Jerilyn writes:

Caring for my sister at home has saved the state thousands and thousands of dollars every year and we have done this care for 38 years. We fight every year to get sufficient hours for PCA care with Mass Health. We are holding down full time jobs which also support my sister for $200 a month. Instead of encouraging families who want to keep their loved ones at home and save the state money, they work against us so I believe we all give them in nursing homes ... which in turn cost the state more money ... is this not totally crazy?

She is asking the right question. The CLASS Act will help turn this serious, no-win situation into an everyone-wins result. It gives individuals with disabilities and their families the funds they need to obtain some of the services they need without having to resort to Medicaid.

The current reliance on Medicaid is not only a strain on our families, it is also a strain on our already overburdened Medicaid system. Today, Medicaid spends nearly $50 billion a year on long-term services and supports. Estimates indicate that by 2045 that spending could exceed $200 billion. Obviously, this current course is unsustainable.

In addition, the private insurance industry is not doing enough to meet the growing demand for long-term care services for aging baby boomers and longer lifespans will increase the demand for long-term care dramatically for decades to come. Yet 95 percent of people over age 45 do not have private long-term care insurance, and fewer and fewer people are able to buy such coverage.

Make no mistake, as it stands today, if someone without adequate long-term care coverage becomes disabled, they will more than likely have to turn to the already overburdened Medicaid system to get the help they need. The CLASS Act is designed to specifically remedy this looming crisis by giving people an affordable option other than Medicaid. The act will save the system over $6 billion over the next 4 years that people start receiving benefits.

Some opponents of the CLASS Act argue that the program will not be sustainable over time and that it will become insolvent and end up costing taxpayers large amounts. That argument could not be further from the truth.

Let’s give proper credit where it is due. With the help of our friends on the other side of the aisle, we have taken real steps to ensure that the program remains solvent for 75 years. The act establishes a strong work requirement to make sure the funds continue to come into the program from the payroll tax deduction or from an individual’s voluntarily paid premium. It requires the Secretary of HHS to review and set the premium annually to ensure that the program will remain solvent for the next 75 years. It directs the Secretary, in addition, to review the cost projections 20 years into the future. Finally, it mandates that no taxpayer funds will be used to pay benefits.

Let me repeat that final point, since I have often heard it misrepresented.
No taxpayer funds will be used to pay benefits. Benefits will be paid through self-funded and voluntary premiums.

During the markup in the HELP Committee this summer, Senator Dodd led a main discussion about this program. With the help of the Republicans on the especially Senator Gregg of New Hampshire, additional safeguards were included to ensure that the act will stand on strong financial footing for years to come. After the committee adopted Senator Gregg’s amendment on the solvency amendment, the program won strong words of support from both parties. We credit Senator Gregg for that constructive contribution.

This CLASS Act will do all the things it should do. It will provide financial and health security to elderly and infirm Americans. It will strengthen Medicare. It will make health reform the exact thing the American people need.

With that, I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Montana.

Mr. BAUCUS. Mr. President, I yield 8 minutes to the Senator from Wisconsin, the chairman of the Special Committee on Aging.

The ACTING PRESIDENT pro tempore. The Senator from Wisconsin.

Mr. KOHL. Mr. President, I thank very much Senator Baucus.

I want to take a few minutes this morning to talk about the many ways in which this bill will have a positive impact for seniors.

Over the past year, we have seen confusion about what health care reform will mean for Americans and particularly for seniors. I had hoped that once the Senate voted to move forward with debate on one merged bill, we could offer some definitive answers on how health reform will help them. Unfortunately, here we are on the floor, continuing to send mixed messages about some of the key provisions. As chairman of the Aging Committee, I wish to help set the record straight for older Americans.

This health reform bill is not going to cut Medicare benefits. Independent groups such as the AARP and the National Committee to Preserve Social Security and Medicare have said this bill will strengthen Medicare and not harm it. AARP believes this bill will transition Medicare to a more efficient system, where quality health care outcomes are rewarded and waste, which experts believe accounts for up to 30 percent of Medicare spending, is reduced.

In terms of the cuts to Medicare Advantage, this bill will only cut back on overpayments to these private Medicare plans. Benefits will not be affected. AARP also supports these cuts because they understand that most of the overpayments are going to insurance company profits, not to seniors’ benefits. So, this is, by necessity, complex. We cannot gloss over these vital issues. So I would like to take a minute to share with you some of the provisions that have not received as much attention but are, nevertheless, crucial to improving America’s health care system. This is a lot in this bill for older Americans, retirees, and those planning ahead for a healthy and happy long life. The Aging Committee has worked closely with the leadership of the HELP and Finance Committees to improve several of our provisions, most of which have bipartisan support. I wish to particularly thank Senator Baucus, Senator Dodd, Senator Harkin, and Majority Leader Reid for being so willing to work with us on these issues.

We have enlisted help from seniors groups of every stripe to ensure health reform makes common sense improvements that, in some cases, are desperately needed. This bill will significantly improve the standard of care in nursing homes nationwide for the first time in 22 years. I thank my colleague, Senator Grassley, for working together to make sure this important issue was not overlooked as part of health reform. In and of itself, this is a huge undertaking, but it is just one piece of the puzzle to comprehensively reform our health care system.

This bill will also train and expand the health care workforce so they are prepared to care for the growing elderly population. By implementing recommendations from the Institutes of Medicine, we will begin to address the severe shortage we face of direct care workers.

This bill will protect vulnerable patients by creating a nationwide system of background checks for long-term care workers. This policy is more than just a good idea in theory. We have implemented it in seven States and seen its results. Comprehensive background checks are routine for those who work with young children, and we should be protecting vulnerable seniors and disabled Americans in the same way.

This bill makes it easier for seniors to get the care they need in their own homes because when it comes to long-term care, one size does not fit all. The goal of long-term care should be to allow older or disabled Americans to live as independently as possible.

This bill will help update our current long-term care system in order to offer choices tailored to an individual’s needs. It will also help to alleviate the huge financial and emotional burden on married couples who need long-term care. So I yield to my colleague, Senator Cantwell, to ensure that married couples who receive care in their home and community are not required to spend the vast majority of their assets to receive assistance.

The committee has also helped to include a provision that will benefit all Americans regardless of age by helping to lower the costs of prescription drugs and medical devices.

Our policy aims to make transparent the influence of industry gifts and payments to doctors.

Although these are only a few of the Aging Committee’s priorities, this bill makes many other improvements to our current health care system for older Americans.

The Senate bill will reduce the cost of preventive services and add a new focus on paying doctors to keep patients well and not just paying them for when their patients get sick.

Today, seniors pay 20 percent of the cost of many preventive services. By eliminating the copayment and deductibles through Medicare for important services such as immunizations, cholesterol screenings, bone calcium-level screenings, and cancer screenings, we will help save lives as well as lower health care costs.

The bill will also provide for the first time an annual wellness visit at no cost to the beneficiary. Patients will be able to receive a personalized health risk assessment for chronic disease, have a complete review of their personal and family medical history, and receive a plan for their care.

This bill will remove the ability of insurance companies to deny access to consumers based on preexisting conditions. We know having health care is essential throughout one’s life from beginning to end, but many older Americans count the days until they become eligible for Medicare because they are not able to find insurance coverage at any cost due to a health condition in their past.

I could go on about the many other improvements, small and large, that will benefit our Nation’s seniors, but I will stop here and simply urge my colleagues to work to educate seniors and not scare them about the important changes this bill will make to provide them with better health care at lower cost.

Thank you, Mr. President. I yield the floor.

Mr. BAUCUS. Mr. President, how much time remains for the majority?

The ACTING PRESIDENT pro tempore. Five minutes.

Mr. BAUCUS. I ask unanimous consent that there be an additional 5 minutes on each side.

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

Mr. BAUCUS. Mr. President, I yield the remaining time to the Senator from Oregon, which should be 10 minutes.

The ACTING PRESIDENT pro tempore. The Senator from Oregon is recognized.

Mr. BYDEN. Mr. President, I wish to spend a few minutes this morning talking about Medicare Advantage and particularly to highlight the fact that I
think it is important to support the language put together by the chairman of the Finance Committee on Medicare Advantage and to reject the amendment offered by our friend from Utah, Senator Hatch.

I would begin my comments with respect to Medicare Advantage by pointing out that it is clear that not all Medicare Advantage is created equal. Some of Medicare Advantage is a model of efficiency, and some of it is pretty much a rip-off of both taxpayers and seniors. I would refer, as it relates to the abusive plans, to the very important hearings chaired by Senator Baucus in the Finance Committee. I recall on one occasion sitting next to our friend from Arkansas, Senator Lincoln. We had witnesses describe how Medicare Advantage was being sold door-to-door in her part of the country by individuals dressed up in scrubs as physicians and health care providers. In the discussion of how to handle it, we looked at various kinds of reforms to rein in abusive practices. I came to the conclusion that when you do something such as that, the CEOs ought to be put in jail. That is what is documented on the record as it relates to the committee and the Senate Finance Committee and why I come to the floor to make it clear that I think it is important to distinguish between the good-quality Medicare Advantage plans and those that have been living high on the hog through some of the overpayments we have documented on this floor.

My State has the highest percentage of older people in Medicare Advantage in the country. I had an opportunity to work closely with Chairman Baucus in terms of addressing Medicare Advantage, and I think that with the chairman’s leadership, it has been possible to show you can find savings in the Medicare Program without harming older people, without reducing their guaranteed benefits, their essential benefits, as we have learned, with Medicare Advantage. The way Chairman Baucus goes about doing that is by forcing the inefficient Medicare Advantage plans to follow the model of the efficient ones. The way we have been able to do that is essentially through a two-part strategy: first, encourage competitive bidding and, second, provide incentives for quality, which is done through the bonus payment provisions that are in the legislation.

First, on competitive bidding, you have plan bids, and you use the plan bids to set Medicare Advantage benchmarks which would encourage the plans to compete more directly on the basis of price and quality rather than on the level of extra benefits offered to those who are enrolling. With the competitive bidding, plans compete to be the most efficient and hold down costs among others. I commend Chairman Baucus for making this a central part of the way Medicare Advantage would be handled. Certainly our part of the country has shown this as a path to get more value for the Medicare Advantage dollar in the days ahead.

In addition, in the Finance Committee I offered an amendment with several colleagues that would boost the payments to those plans that, according to the government and the government uses a system of stars, in effect, to reward quality—our amendment would boost the payments to those Medicare Advantage plans with four- and five-star quality ratings.

So, in effect legislation there are both carrots and sticks. Competitive bidding plus bonus payments offers both, so the plans compete to provide the best value for seniors. By encouraging the plans to be more efficient, it is possible to achieve significant savings for older people, help shore up the solvency of the Medicare trust fund, and meet the cost-saving goals of the legislation.

One point that has been discussed by colleagues on the floor of the Senate is this matter of individuals being able to keep what they have. I have heard that is not the case with Medicare Advantage plans; that somehow, under the legislation that has been offered by the Finance Committee, older people would not be able to keep what they have, according to some on the floor. That is simply inaccurate. Seniors who have Medicare Advantage plans under the Baucus legislation will be able to keep those plans. They will be able to stay with what they have, keep their guaranteed, essential benefits, and through the language that has been authored now in the legislation before us, there will be lower costs for taxpayers.

Last point. I have heard a lot of talk about grandma on the floor of the Senate. I spent the bulk of my professional life in effect working with grandma. I was the cofounder of the Oregon Gray Panthers and ran the legal aid program for older people in our home State for a number of years. I want it understood that I think with the Baucus legislation on Medicare Advantage, that proves it is possible to make savings in the Medicare Program without cutting essential benefits. Using commonsense principles of competitive bidding, No. 1, and incentives for quality, I think grandma is going to be just fine under our language for Medicare Advantage.

Mr. President, with that, I yield the floor.

Mr. BAUCUS. Mr. President, how much time is remaining on the majority side?

The ACTING PRESIDENT pro tempore. Three minutes.

Mr. BAUCUS. And on the minority side?

The ACTING PRESIDENT pro tempore. Fifty-five minutes.

Mr. BAUCUS. Mr. President, I reserve the remainder of the majority time.

The ACTING PRESIDENT pro tempore. The Senator from Tennessee.

Mr. ALEXANDER. Mr. President, during the next 55 minutes, we will have several Republican Senators come to the floor. I ask unanimous consent that during that time, Senator McCain be allowed to be the manager of a colloquy among the Republican Senators.

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

Mr. ALEXANDER. Mr. President, before Senator McCain begins, if I may, I wish to take a moment to establish where we are today and what happened yesterday as a lead-in to what he is about to discuss.

Yesterday, Senator McCain offered an amendment on the floor of the Senate that would do two things: It would send this 2,074-page Democratic health care bill back to the Finance Committee and say to them, No. 1, take out the cuts in Medicare, and No. 2, any savings in Medicare must go to make Medicare more solvent. That is what the Baucus amendment accomplished. That was defeated. Fifty-eight Democrats said yes to the cuts in Medicare. They said yes to using the money that comes from these cuts to create a new entitlement program. Forty Republicans and two Democrats said, no, we don’t want cuts to Medicare and we do not want a new entitlement program.

So yesterday we made it clear that the central core of the bill includes nearly $5 trillion in cuts to Medicare. There is no question about that. Everyone concedes that. The President said that when he addressed us. The Congressional Budget Office says that. The House is whether it is a good idea or a bad idea, and yesterday, by 58 votes, the Democrats said yes to these cuts in Medicare.

Today, we want to talk about one aspect of those cuts which is Medicare Advantage. We are going to talk about these cuts in a careful, accurate way so the 11 million seniors who have Medicare Advantage understand exactly what the risk is to their Medicare Advantage policies.

We all know that a portion of the overall Medicare cuts that the Democrats approved yesterday is a $120 billion cut over the next 10 years to the Medicare Advantage program. Now, what is Medicare Advantage? Medicare Advantage is an option seniors have. If you choose this option, Medicare pays a fixed amount every year for your care, to companies that might come to you and offer a Medicare Advantage plan. One of which you can choose instead of the original Medicare plan.

Many seniors choose these plans—11 million seniors. Nearly one out of four seniors in America who are part of Medicare chooses the Medicare Advantage plan. In my home State of Tennessee, the number is about 230,000 Tennesseans.

Why do they choose it? Well, it includes some benefits they may not have in the original Medicare plan. These benefits include dental care, vision care, hearing coverage, reduced hospital deductibles, lower co-payments, lower premiums, coordinated
chronic care management, and physical fitness programs.

The distinguished Senator from Oregon was on the floor and he mentioned grandma. I have mentioned grandma a few times—no disrespect to grandma; he is in the Finance Committee, he said. He said grandma didn’t need to worry about her Medicare Advantage plan because none of the benefits would be cut. That is not what the Director of the CBO, who is often cited by the chairman of the Finance Committee, has said. He said that half of the benefits currently provided to seniors under Medicare Advantage would disappear under the Finance Committee plan, which is much like the plan we are considering. The benefits that would disappear would include those I mentioned.

Today, with Senator McCain leading the discussion, we wish to talk about the Medicare Advantage plan, and why cuts to Medicare Advantage play a central part of this $2.5 trillion bill. Cuts to Medicare Advantage amount to over half of $2.5 trillion cost, and the ones we are talking about today are the Medicare Advantage plans. I understand there will be an amendment by Senator Hatch, who has joined us, and I am sure he will talk about his own amendment. He was present on the Finance Committee when Medicare Advantage was created. I understand there will be an amendment to send this back to the Finance Committee saying don’t cut Medicare Advantage.

Mr. McCain. Yes. For those who missed Senator Hatch’s important statement last night, which he will add to today, I point out that he was able to take a trip down memory lane. In June 2003, when the Medicare Modernization Act was before the Senate, several of our colleagues, including Senators Schumer and Kerry, offered a bipartisan amendment on the floor to provide additional funding for benefits under the Medicare Advantage Program.

But amnesia is not confined to one side of the aisle around here. I ask my friend from Tennessee—you know this discussion about Medicare Advantage—we have to better understand what is this program and why is it so popular. Is it because it offers seniors a chance to get additional benefits? Maybe the Senator can give a short definition of that. I think the American people may not be totally clear on what we are discussing. And 11 million Americans—over 300,000 citizens in my own State—have chosen Medicare Advantage, and that has prompted, according to Bloomberg, Senator Casey of Pennsylvania, to say, “We are not going to be able to say ‘if you like what you have, you can keep it.’” “That basic commitment that a lot of us around here have made will be called into question.”

The title of that is “Dom Senator Says Medicare Advantage Cuts Break President’s Pledge.”

Maybe the Senator from Tennessee can give me a brief outline of what seniors get under Medicare Advantage and why it is so popular with 330,000 senior citizens in my State and 11 million in the country. The Senator is correct. If the Senator from Pennsylvania, Senator Casey, is saying that he is merely repeating what the Director of the CBO stated, when he said that fully half of the benefits of Medicare Advantage will be lost.

To answer the Senator’s question, Medicare Advantage is an option that 11 million of the 40 million seniors who are on Medicare have chosen. The reason they choose it is because it is a plan offered by private companies, often to people in rural areas, often to minorities—

Mr. McCain. Lower income seniors.

Mr. Alexander. Yes, lower income Americans also choose these. They often choose it because the plans generally offer these benefits: dental care, vision care, hearing coverage, reduced hospital deductibles, lower co-payments, lower premiums, coordinated chronic care management, and physical fitness programs.

Mr. McCain. I thank my friend. The reason I asked him to mention that Medicare Advantage would allow seniors to have dental care, vision care, hearing care, physical fitness—it is fascinating. This allows our senior citizens to have dental, vision, hearing, and physical fitness care, and that is a little strange because, as was pointed out to me, that is exactly what we have here in the Senate. About 100 paces from here, if I need some doctor care immediately, if I need some vision care, if I need some dental care, I can get it. Next to my office in the Russell Senate Office Building, for the last several months—and I don’t know at what cost, but I would like to get entered into the record how many tens of millions of dollars it is. But they are renovating a greenhouse yesterday voted against keeping the Medicare Advantage Program, when we have, right here, the best Medicare Advantage Program ever heard of in the world—free hearing, free vision, free dental—and they are expanding a gymnasium in a many-months-long project. I will get the cost of that, although that may be hard to do.

Let me get this straight. Again, the American people should understand this. We are discussing a program that seniors have taken advantage of, which gives them additional hearing, vision, dental, and physical fitness care, while we practice it here every single day. Every day, there is a physician on duty—more than one—not very far from where I speak, who is ready to give us instant care. If hospitalization is needed, we can get instant transportation to the Bethesda Naval Hospital, where we will get free care. Incredibly, the Senate, on largely partisan grounds, voted against the Medicare Advantage plan offered by private companies, which has given its full-throated support to the Democratic health care legislation, even though seniors remain largely opposed, received an $18 million grant in the economic stimulus package for a job training program that has not created any jobs, according to the Obama administration’s recovery.gov Web site. This is astonishing because from everything I have ever seen, they have created millions of jobs, including in the ninth congressional district of Arizona, where they said they created thousands of jobs. Unfortunately, we only have eight blazant transfers of funding from the Medicare Program, which the seniors have earned, into a brandnew entitlement—a $2.5 trillion entitlement program. That is what this bill is all about.

For your information, in 2006, AARP received $18 million in stimulus money. There is a job creator for you. AARP, which has given its full-throated support to the Democratic health care legislation, even though seniors remain largely opposed, received an $18 million grant in the economic stimulus package for a job training program that has not created any jobs, according to the Obama administration’s recovery.gov Web site. This is astonishing because from everything I have ever seen, they have created millions of jobs, including in the ninth congressional district of Arizona, where they said they created thousands of jobs. Unfortunately, we only have eight blazant transfers of funding from the Medicare Program, which the seniors have earned, into a brandnew entitlement—a $2.5 trillion entitlement program. That is what this bill is all about.

In February, Politico reported that AARP was putting pressure on Republican Members of Congress to support the stimulus package. Since then, AARP has moved solely for passage of health care legislation, even though Democratic proposals have called for several hundred billion dollars in cuts to Medicare—a program that the group typically defends tooth and nail when Republicans propose cutting it. It turns out that AARP is also in a position to benefit financially if the health care legislation passes, because seniors losing benefits as a result of cuts to Medicare Advantage will be forced to buy Medigap policies, which is the main source of AARP revenue. Barry Rand, chief executive of AARP, was a big donor to the Obama campaign and has retained a cozy relationship with the administration. That is shocking news.

So, my friends, also I might add that in 2006, AARP received $18 million from the Federal Government, and we are reserving additional Federal moneys that they get.

The most important thing is this, and let’s make it clear: AARP will receive direct benefits because seniors deprive them of what we have every single day we are members of the Senate. That is an exercise in hypocrisy. The Senator from Pennsylvania has it right, because the President, time after time, said to the American people: If you like the insurance policy you have today, you can keep it. How many hundreds of times have we heard him say that at townhall meetings? And his administration is saying the same thing. The Senator from Pennsylvania is right when he says, “We are not going to be able to say if you like what you have, you can keep it. That basic commitment that a lot of us around here have made will be called into question.”

I will say a couple words, and I will talk more about this later. Every time the Senator from Montana and others are on the floor, they talk about the fateful fact that A only has eight blazant transfers of funding from the Medicare Program, which the seniors have earned, into a brandnew entitlement—a $2.5 trillion entitlement program. That is what this bill is all about.

So, my friends, also I might add that in 2006, AARP received $18 million from the Federal Government, and we are reserving additional Federal moneys that they get.
who have cuts in their Medicare Advantage and other Medicare programs can buy—guess what—a Medigap insurance policy from AARP—in other words, to cover the things being cut back under this legislation, and it costs $175 a month. The Medicare Advantage plans are zero for most seniors or $35 a month. Again, if the Medicare Advantage plans go away, people would have to buy a Medigap plan sold by—you got it—AARP. And some low-income seniors could not afford them.

That is why the Senator from Tennessee stated that if we drive people out of Medicare Advantage, we are harming low-income seniors all over this country. We are harming them. We are doing them a great disservice. If you think with 17 percent real unemployment in my State that seniors who are unemployed and down on their luck are going to be able to afford the AARP Medigap policy for $175 a month, come and visit my State and I will tell you they can’t.

It is interesting, the conversation about high-income seniors, and how we are going to tax people with Cadillac plans and all of those things, when what is really going is harming the lowest income seniors in rural areas of America.

Mr. KYL. Will my colleague yield for a quick point?

Mr. MCCAIN. Yes.

Mr. KYL. The Senator was making the point that you cannot take $120 billion out of the program without hurting folks. Those on the other side of the aisle said we can do that—we can cut it by $120 billion and it still won’t hurt anybody. My colleague asked the Senator from Tennessee exactly what some of the benefits were and he repeated them. I went to get the actual statistical number of how much it will actually reduce benefits in terms of actual dollars, according to the Congressional Budget Office, in the year 2019, when fully implemented, here is the statistic: The actuarial value of the reduction in benefits under Medicare Advantage is 64 percent; in dollar terms, it goes from $135 a month down to $49 a month. In other words, the very things my colleague talks about—vision care, dental, all of those things—

Mr. MCCAIN. All of the things we routinely use in the Senate. I hope those who voted to harm the seniors in this country and not allow them to have dental, vision, and other health care would unilaterally disavow the use of the physician care and vision care and hearing care available to all of us 24 hours a day right here in the Senate.

Mr. KYL. The last point. I want to say that I hear my colleague loudly and clearly. I hope the American people do. And I cannot call a $120 billion cut something that doesn’t hurt people, and especially when the Congressional Budget Office itself says, yes, that reduces these very benefits from a value of $135 a month down to $49 a month. That is a huge cut in the value of the services they receive under Medicare Advantage. That is what we are trying to prevent by this amendment.

Mr. MCCAIN. Could I mention one other thing? I will not spend that much more time on AARP. But the reason I do is because every time the Senator from Montana stands up, he talks about AARP endorsing this rip-off of the American people.

Let me quote again from a Bloomberg article entitled “AARP’s Stealth Fees Often Sting Seniors With Costlier Insurance.” I quote from the Bloomberg article just briefly: Arthur Laupus joined AARP because he thought the nonprofit senior-citizen-advocacy group would make his retirement years easier. He signed up for an auto insurance policy endorsed by AARP, believing the advertising that said he would save money.

He didn’t. When Laupus, 71, compared his car insurance rate with a dozen other companies, he found he was paying twice the average. Why? One reason, was because AARP was taking a cut out of his premium before sending the money to Hartford Financial Services Group, the provider of the coverage.

AARP uses the royalties and fees to fund about half the expenses that pay for activities such as publishing brochures about health care and consumer fraud—as well as for paying down the $200 million bond debt that funded the association’s marble and brass-tailed Washington headquarters.

In addition, AARP holds clients’ insurance premiums for as long as a month and invests the money, which added $40.4 million to its revenue in 2007.

During the past decade, royalties and fees have made up an increasing percentage of AARP’s income, rising to 43 percent of its revenue in 2007 from 11 percent in 1999, according to AARP data.

This is a Bloomberg article. This is not from the Republican Policy Committee.

The point is, who gains? Who gains from what you are doing? It is that 17 percent of high-income seniors is having their Medicare Advantage plans go away, we are going to see a 24 percent decrease in Connecticut, there are 27,000 enrollees who will see a 24 percent decrease. In New York, there are 94,000 enrollees who will see a 14 percent decrease. By the way, some special deals have been cut for three States I understand—Oregon, New York, and Florida. We are going to try to fix that. There is no reason one State should be shielded any more than another from these draconian measures. We are going to try to fix that situation.

The reason I bring up this issue, present-day Medicare beneficiaries do not have vision, they do not have dental care, they do not have fitness. Yet we in the Senate enjoy it every single day. So yesterday we voted to deprive seniors from the ability to have the same privileges that we enjoy every single day in the Senate. I would argue that is an exercise in hypocrisy.

Mr. ALEXANDER. I might say we are operating under a colloquy managed by Senator McCaIN. So Republican Senators are free to engage in discussion.

Mrs. HUTCHISON. Mr. President, I very much appreciate what your Senators have been talking about because what Senator McCaIN is saying is that these seniors who are low income have an affordable option, and it is less expensive than the AARP option that would give them this extra care—the eye care, the dental care, the hearing aids. It is an affordable extra option.

In Texas, we have over 500,000 seniors enrolled in Medicare Advantage. One of the great things about Medicare Advantage, Mr. President, is that it is in rural areas, and it gives them choices that they might not be able to afford with other programs that are Medigap. This one is affordable. That is why we are fighting so hard to restore the cuts to Medicare Advantage.

Medicare Advantage costs about 14 percent more than traditional Medicare because it provides a wide range of these extra benefits we have discussed—dental, eye care, hearing aids in many cases, it pays for readers more. Republicans, of course, are open to discussing how to improve the Medicare Advantage payment formula. We want to be more efficient with taxpayer dollars, but do we want to do that in the context of creating a massive new entitlement program and ask Medicare to pay for it or to cut life-saving benefits for seniors? Is that what we want to do, I ask Senator CRAPPO.

Mr. CRAPPO. Mr. President.

Mr. ALEXANDER. My understanding is the answer is no. That is the reason 11 million Americans choose Medi-

Mr. MCCAIN. In Montana, there are 27,000 enrollees who will see a 24 percent decrease. In Connecticut, there are 94,000 enrollees who will see a 14 percent decrease. By the way, some special deals have been cut for three States I understand—Oregon, New York, and Florida. We are going to try to fix that. There is no reason one State should be shielded any more than another from these draconian measures. We are going to try to fix that situation.

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Mr. ALEXANDER. My understanding is the answer is no. That is the reason 11 million Americans choose Medica-

Mr. CRAPPO. That is absolutely the case. I would like to point out, when we had the Finance Committee mark-up, I asked CBO Director Elmendorf directly whether provisions in the bill,
which are still in the bill, would reduce the benefits that Medicare recipients received. His response was:

For those who would be enrolled otherwise under current law, yes.

There has been a lot of talk here about we are not cutting Medicare benefits. Is this or is that? The bottom line is, the CBO Director said it: Yes, we are cutting benefits.

I would like to ask the sponsor of this motion a question because I know there are some who are saying the reason we are cutting Medicare Advantage is that it is too expensive, and we should be cutting Medicare and controlling its costs; that it is about 14 percent more expensive than fee-for-service Medicare.

Some people say if you are defending Medicare Advantage, you are defending overpayments in health care plans. Would the Senator from Utah like to respond to that criticism some are making?

Mr. HATCH. I would be delighted to.

To be clear, so-called overpayments to Medicare Advantage plans do not go to the plans. As a matter of fact, they go to the seniors in the form of extra benefits. That is a pretty important point a lot of people miss. Seventy-five percent of the additional payments to Medicare Advantage plans are used to provide seniors with extra benefits, including chronic care management—you would think you would want to do that. We already pay for that. The other 25 percent of any extra payments are returned to the Federal Government. I cannot imagine why anybody would not want to do that.

Mrs. HUTCHISON. Mr. President, I ask the distinguished Senator from Utah to also respond to the arguments that claim that the government cannot afford now to continue overpaying these private plans and that the Medicare trust fund is going broke. Of course, we tried actually several years ago to shore up the Medicare Program, trying to do it in a responsible way, not cutting out the Medicare benefits these seniors can receive as an affordable option. What does the Senator say to that?

Mr. HATCH. The Senator from Texas pointed out the Medicare trust fund is going broke. Yet what do we have on the other side? They take almost $500 billion out of Medicare. Trust me, I am deeply concerned about the solvency of the Medicare trust fund.

Mr. MCCAIN. May I say it is my understanding that Dr. BARRASSO has actually seen Medicare Advantage patients. He and Dr. COBURN are probably the only two. Maybe we could let him give us the benefit of his experience and also not only the benefit of his experience, but I am sure he is going to tell us what the impact is going to be on the low-income seniors from his State.

Mr. BARRASSO. I agree with the Senator from Arizona that people choose to be on Medicare Advantage. Mr. President, 11 million people have chosen to be on Medicare Advantage because it is a wise choice to make because they get better benefits. They get dental care, they get the vision care, they get the hearing aids, they get the fitness thing.

Mr. MCCAIN. Dr. BARRASSO, just as we do. It works in preventive care and coordinated care.

Mr. MCCAIN. I don’t think they have as nice a gym, though, as we are going to get.

Mr. BARRASSO. It is also no surprise when people read about this and learn about it that they would want to be on Medicare Advantage. What the Senator from Utah has said, the sponsor of this motion, is that the money that goes into this program is for the benefit of the seniors. It is for services for the seniors on Medicare. To me, this whole bill basically guts Medicare, raids Medicare to start a whole new program.

Today, as the Senator from Arizona has mentioned in these articles, the Associated Press and USA Today said:

1. Senate Democrats closed ranks Thursday behind $460 billion in politically risky Medicare cuts at the heart of health care legislation.

It goes on to say:

Approval would have stripped out money to pay for expanding coverage to tens of millions of uninsured Americans.

So they are going to take $460 billion, it says, away from our seniors who depend on it for their Medicare and start a whole new government program.


I look at this and say this is not fair to our seniors, not fair to the patients I have taken care of for 25 years in Wyoming, taken care of folks—taken care of folks—when grandma breaks her hip, what we need to do for our patients. These are choices people have made.

Mr. President, 11 million Americans have chosen Medicare Advantage because there is an advantage to them for the health care they get—the additional services, the coordinated care, the preventive care. Anyone who looks at this and studies it says: I want to sign up.

It has been wonderful in rural areas and big cities. This has helped a lot of people in the country. It is not surprising that one out of four people in the country on Medicare have chosen Medicare Advantage, but yet what we are seeing here is Democrats want to get rid of Medicare Advantage.

Mr. MCCAIN. Let me get this straight. Basically, by removing the choices that seniors have as a part of Medicare Advantage—dental, vision, hearing, fitness—we are taking away from them what we ourselves enjoy every single day in the Senate?

Mr. BARRASSO. We are taking it away from seniors and using all that money to start a new government program when we know Medicare is going to go broke by 2017.

Mr. HATCH. We are listening to only one of the two doctors in the Senate who knows, who has been on the ground, has met with the people, who understands what this means to senior citizens. One-third of them are on Medicare Advantage.

In the end, I believe we not only actually help seniors be more healthy but save a lot of money in the end. Trust me, I am deeply concerned about the solvency of the Medicare trust fund. We have been sounding that alarm for years. That is why it is so shocking we are debating a $2.5 trillion health reform bill that does almost nothing to make sure Medicare is sound and, in fact, does a lot of things to make it unsound, or almost nothing to make sure Medicare is around for future generations.

Instead, we are just creating another Federal entitlement program that we cannot afford. While Medicare has $38 trillion in unfunded liabilities.

Mr. CRAPO. The Senator is absolutely right. A lot of people trying to defend these cuts are saying these extra costs in the Medicare Advantage Programs are just government insurance companies’ profits bigger and help pay for large CEO salaries. Nothing could be further from the truth. The reality is, as the Senator from Utah already indicated, 75 percent of this 14 percent extra payment in these plans go to provide the seniors with the extra benefits we are talking about, and then 25 percent is returned to the Federal Government, not to insurance companies, not to CEOs.

I have a chart. We are going to make it into a bigger one. But those who support this program say we are not cutting Medicare benefits. This chart—I apologize it is a little bit small—but this is a chart of the United States. It shows that dark red is more than 50 percent reduction in the benefits of the people in those dark red States. In the medium red color, it is between a 25- and 50-percent reduction in coverage. The only States that do not have a reduction in coverage are the white ones. There are three or four States that are not seeing deep cuts in Medicare Advantage benefits.

Those who say—the President who said it was one of his goals—if you like what you have, you can keep it—not if you live in one of the States that is not in white on this chart because your benefits will be cut.

Mr. ALEXANDER. I wonder if I might ask the Senator from Idaho to go back over a point he made a moment ago because he went over it quickly and it is such an important point. One reflected by the chart above him about what he just said. Repeatedly we are told that seniors won’t lose benefits if you cut nearly $3 trillion in Medicare. So if you could take
a moment—I believe you were in the Finance Committee markup where the bill was being written that was offered by the distinguished Finance Committee chairman, and I believe you were talking to the head of the Congressional Budget Office, who is often cited by my friend on the other side as the nonpartisan authority for exactly what the bill does, and you asked him whether the benefits of Medicare Advantage recipients would be cut. Would you describe that in a little more detail so people understand exactly the scenario?

Mr. CRAPO. Yes, I would. This chart shows the last two sentences of our colloquy when we were in the Finance Committee, but it went on for some time. But the bottom line is that I was asking the Director of CBO whether the cuts to Medicare Advantage that are in the bill would reduce benefits to senior citizens, and he said yes. And the reason he used this phrase here, which is what would be enrolled otherwise under current law,” the reason he prefaced it that way—which we don’t have on the chart—is that for future seniors it will not be a viable option. So in the future, those who are not on it now won’t have a significant viable option to get on it because it is going to be gutted.

So he was saying that for those 75 percent—and by the way, Medicare Advantage is the most popular part of Medicare today. It is the fastest growing part. It is popular because it provides these additional benefits that seniors have to pay so significantly for to get in supplemental insurance that AARP is going to provide. So what the CBO Director said was that for the future, those who aren’t already on it won’t get it.

Mr. MCCAIN. Could the Senator from Texas and I go back to one of the things I mentioned earlier, because in Texas, how many are under Medicare Advantage?

Mrs. HUTCHISON. Five hundred thousand of my constituents are on Medicare Advantage.

Mr. MCCAIN. Five hundred thousand in your State, and there is no “shielding.” According to this Bloomberg article and according to our knowledge, it says:

Senators Charles Schumer of New York, Bill Nelson of Florida, and Ron Wyden of Oregon are among those who secured special provisions shielding constituents from cuts. Casey—

Referring to Senator CASEY of Pennsylvania—
says he wants “very comparable” protections for his State—surprisingly enough—where more than one-third of Medicare beneficiaries participate in Medicare Advantage. “It’s the kind of thing that will likely be addressed on the floor,” he said.

Well, I eagerly look forward to working on the other side of the aisle with all areas from those States, with the exception of New York, Florida, and Oregon, who have earned special shielding from these cuts. I look forward to working with them, and let’s fix it for all of us; right, Senator HATCH?

Mr. HATCH. That is right. Go ahead. Mrs. HUTCHISON. Yes, I would say to the Senator from Arizona, I was wondering if every State could have the same treatment. Why not have every State get this shielding for their Medicare Advantage? That is 11 million people in this country who would then be helped by a fair assessment of all over the country.

But let me just point out one other provision. The way they have been shielded is through grandfathering. What about people who— Mr. McCAIN. And was that shielding done on the floor of the Senate, in open debate and in discussion of the issue?

Mrs. HUTCHISON. Oh, no. Now, amazingly—

Mr. McCAIN. It was done in an office over here, where we still await the white smoke.

Mrs. HUTCHISON. The white smoke, that is correct. But then the question arises: What about the future, where people will say: That is what I can afford and what I want to have. But grandfathering doesn’t include anyone who might want to join in the future; that is only the people already in the system. And for how long they live, that is great, but what about the future?

So this is a great program. It is affordable for the lower income people. This shielding is only for three States now, but I would like to see us all have the same capabilities for our constituents. And what about our future constituents?

Mr. GREGG. Would the Senator yield on that point, because the Senator from Arizona has raised an important point. If this is such a good program for these four States, why isn’t it a good program for everybody?

But more importantly, the Senator is the expert around here on earmarks. Is this not a classic earmark? And didn’t we hear from the other side of the aisle that we were going to have open government; that we were not going to have this type of exercise occur within major bills; that bills weren’t going to be loaded up with special earmarks assisting one Member or another? As the expert on the issue of earmarks, would the Senator comment?

Mr. MCCAIN. I would say this probably the classic hometown protectionism that we see in earmarking and benefits that we see in the earmarking process.

But also, I would remind the Senator from New Hampshire, as we have all discussed several times, a year ago last October, our then-candidate for President said: It is all going to be on C–SPAN. Well, the C–SPAN cameras are still waiting outside Senator Reid’s offices to go in and film these negotiations so that, as President Obama said, not only will we fall on the side of the pharmaceutical companies and who is on the side of the American people.
Mr. MCCAIN. Go ahead.

Mr. HATCH. Thank you, Mr. Chairman.

Mr. ALEXANDER. I would direct my remarks to Senator CRapo, who is the senior member of the Appropriations Committee.

Mr. CRapo. Thank you, Mr. Chairman. Thank you for the opportunity to speak a moment.

Mr. MCCAIN. Go ahead.

Mr. CRapo. Thank you, Mr. Chairman.

Mr. MCCAIN. Senator CRapo wishes to exactly emphasize the point of Senator Gregg.

Mr. CRAPO. I wish to make a comment or two and then engage with the ranking member of the Budget Committee.

Mr. MCCAIN. Has the Senator from Ohio something he would like to say?
Hampshire, too. The President of the United States said something a few weeks ago that I thought was profound and that I agree with, he said this debate is not just about health care; it is about the role of the Federal Government in the everyday lives of the American people. You are going exactly right about that, which is why so many Americans are turning against this bill.

Would the Senator from New Hampshire agree the President was correct, that this debate is about, in my words now, Washington takeovers, more taxes, more spending, and more debt? It is not just about health care. The enormous interest across the country in these votes comes from a much larger picture than this health care bill.

Mr. GREGG. I think the Senator from Tennessee has once again hit the nail on the head. I respect the President’s forthrightness. The President has said very simply he believes that prosperity comes from growing the economy. When this bill passes, we will see the largest growth in government in the history of our country. This is going to be 16 percent of our economy basically managed by the Federal Government. You are going to see the Government explode in size. Does that lead to prosperity? I don’t happen to think it does. It certainly doesn’t lead to prosperity if along with that massive expansion in the size of the government, we are going to see your deficit go up significantly, your debt go up significantly, or the tax burden go up significantly, which reduces productivity, or if you take a large segment of our society, our seniors, 35 million today, 70 million by the year 2019, and say to them they are not going to have the ability to have a sol- vent Medicare system because the way that system might have been made more solvent is now being used to create a brandnew entitlement, a massive new Federal program for a whole group of people who never paid for an insurance policy and never paid into the Medicare insurance fund.

I think the Senator has touched the base. We have seen automobiles, we have seen financial institutions, we have seen the student loans, and now we are seeing health care all taken over by the government or partially taken over by the government. Clearly the goal is, as the President said, expand the size of the government, create prosperity, use the European model. I don’t happen to be attracted to the European model. I think the American model works better where you have a government you can afford and give entrepreneurs a chance to go out and take risks and create jobs.

Mr. MCCAiN. Thank you. Thank you. The acting President pro tem will conclude.

Mrs. HUTCHISON. We have been talking about Medicare Advantage and I want to ask the Senator from Arizona, as the co-sponsor of the amendment No. 2789 requiring all Members of Congress to enroll in the new public health insurance option, I wish to add my name to Senator Coburn’s amendment. Seventeen years ago when I first ran for Congress I promised I would pay my own health insurance until Congress paid health insurance for everyone. I have paid off my pocket since then. I look forward with great eagerness to joining the public option as soon as it is available.

Mr. BAUCUS. Mr. President, I think I will use my 2 minutes 20 seconds. The ACTING PRESIDENT pro tempore. There is 2 minutes 20 seconds.

Mr. BAUCUS. Mr. President, I ask unanimous consent to add the Hatch amendment as a substitute to the Coburn amendment No. 2789 requiring all Members of Congress to enroll in the new public health insurance option. I wish to add my name to Senator Coburn’s amendment. Seventeen years ago when I first ran for Congress I promised I would pay my own health insurance until Congress paid health insurance for everyone. I have paid off my pocket since then. I look forward with great eagerness to joining the public option as soon as it is available.

Mr. BAUCUS. Mr. President, I think I will use my 2 minutes 20 seconds. The ACTING PRESIDENT pro tempore. And 15 seconds.

Mr. BAUCUS. OK. I want to make three basic points. The Senator from Arizona talks about gee, all these Medicare Advantage plans have dental and vision coverage. He goes on to say, so do Members of Congress.

The fact is that is not automatically true. The fact is Members of Congress have Medicare Advantage plans, some plans offer dental and vision, some do not. Aetna is a company that Members of Congress could choose from under FEHBP and others that Members of Congress can choose from. Those do provide dental and vision coverage. But there are others—I think Blue Cross and Blue Shield does not provide dental and vision coverage. And I don’t think that point is exactly what we are trying to set up in these exchanges. People could participate in the exchanges, where they would buy private coverage and they could choose among various private plans which coverage they want. Do they want a plan that has dental and vision, or not? That is exactly what we are trying to do in the exchange, as is the case for Members of Congress. Medicare Advantage plans do provide dental and vision. I think that is great.

I see my time has expired. At the appropriate time I wish to go into greater detail and explain why we do in this bill I think makes eminent sense. The ACTING PRESIDENT pro tempore. The Senator from Iowa is recognized.

Mr. GRASSLEY. Mr. President, I yield myself such time as I might take. I don’t think I am going to speak more than 6 or 7 minutes, for the benefit of my colleagues who may want some of this time.

I want to tell my colleagues why I am supporting the Hatch amendment. In my home State of Iowa there are 64,000 seniors enrolled in Medicare Advantage plans. These are plans which we have come to rely on lower cost and particularly additional benefits that Medicare Advantage provides, as opposed to traditional Medicare. Yesterday I came to the floor to point out that my colleagues on the other side of the aisle are playing word games to cover up the fact that they are raiding Medicare, cutting benefits by 64 percent for these 11 million seniors who have chosen voluntarily to go on Medicare Advantage and pay $1,000 to $1,500 a month. I repeat: This bill cuts Medicare benefits, or let’s say raids Medicare, by 64 percent for 11 million Medicare beneficiaries.

My friends on the other side of the aisle keep saying they are not cutting and they use these words, “they are not cutting guaranteed benefits.” But this is not even the case. Because we have this new independent Medicare advisory board that is set up in this legislation, it is given specific authority to cut payments to Medicare Part D. This will result in higher costs and less guaranteed benefits for Medicare beneficiaries enrolled in Medicare Part D.

But I want to leave that debate for later. I want to visit with my colleagues now about Medicare Advantage. Mr. President, 64,000 seniors in Iowa and 11 million seniors nationwide do not care about the gobbledy-gook type words we use here in town, as long as there are “guaranteed benefits” on the one hand and the words “additional benefit” on the other hand. In other words, guaranteed benefits or,
as the other side wants us to believe, somehow additional benefits provided under Medicare.

I say that is Washington nonsense. I want to bring a little bit of Midwestern common sense to this debate. Our constitu-
tion says that it is not cutting Medicare benefits they have come to rely upon and that would include, under Medicare Advantage, dental care, eyeglasses, hearing aids, and other additional benefits provided by this program that they voluntarily chose, Medicare Advantage.

I know that to be the case. I have at least 1,000 letters I have received since last summer on this point. But I want to reissue Purification S. Gallardo of Iowa City, IA.

I am writing to urge you to oppose cuts to Medicare Advantage. . . . This plan was a great help to me when my late husband, who passed away in May, was hospitalized. . . . I was able to afford to pay the hospital without going bankrupt. We seniors who live on a fixed income depend on our benefits from Medicare Advantage. I am retired and don’t know how I would have managed without [Medicare Advantage].

Some of my colleagues on the other side of the aisle don’t want seniors, even poor seniors, who are my constituents from Iowa City, Ms. Gallardo, to know that this 2,074-page bill is cutting their benefits. Because the other side will say they are simply cutting so-called overpayments in Medicare Advantage plans. That doesn’t make any difference to Ms. Gallardo. They fail to mention, 75 percent of these so-called overpayments must be spent for additional benefits—not only free money for a company to use or free money that benefits a Medicare Advantage recipient without any concern about what it costs—75 percent of these payments must be spent for additional benefits. Not only free money for a company to earn income. We are in a time of joblessness, people are worried about having lost their jobs, where they are going to get health care. We have seniors who are still not able to earn income. We are in a distressed time there is no doubt about it. To talk about cutting Medicare by almost $500 billion is astounding. I am concerned about hospitals. We talked for the last 45 minutes about the cuts to benefits—the hearing aids, the dental care seniors need.

What about the cuts to care provided in a hospital? Hospitals that treat a large share of low-income seniors get an extra payment from Medicare. Medicare already makes reduced payments to providers, to doctors but also to hospitals, to hospice, to nursing homes, and home health agencies for senior services. And yet proposed is a cut of almost $500 billion. All of these serve our seniors in such great ways. Look at the cuts, almost a $1 trillion over 10 years. This is not sustainable. We cannot take away from Medicare, cut services, cut reimbursements to hospitals to make the poor pay more to get health insurance than the rich.

I wish to talk about taxes, which is our subject, and in a different way than others did. The stated purpose of the Democrats’ health care proposal is to do two things: lower cost and increase coverage. This bill is a miserable failure on both counts. Under the plan, premiums are expected to increase, as a result of new taxes, new regulations, and restrictions. In general, you are not going to pay more for health care, and we are already hitting hospitals serving seniors and not getting paid the full cost of the treatment. Yet we are talking about cutting these services.

Of the $135 billion in Medicare cuts to hospitals, $2 billion is for the reimbursement rates that will no longer be making hospitals whole. I went to the major medical centers in Texas—in Dallas, Houston. Then I went to rural areas. It is the topic of conversation. Anyone who is dealing with a hospital in a rural area, they are all saying: What are you doing?

Of course, we are not doing anything. We are fighting these health care cuts. But we have to make sure they know what is happening so we can achieve this result.

I understand my time has expired. I think the Senator from Oklahoma has the rest of the time on our side.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Oklahoma.

Mr. INHOFE. Mr. President, I thank the Senator from Texas. I yield myself the remainder of our time, which I understand is until 10 after the hour.

I wish to talk about taxes, which is our subject, and in a different way than others did. The stated purpose of the Democrats’ health care proposal is to do two things: lower cost and increase coverage. This bill is a miserable failure on both counts. Under the plan, premiums are expected to increase, as a result of new taxes, new regulations, and restrictions. In general, you are not going to pay more for health insurance than the rich.

I wish to talk about taxes, which is our subject, and in a different way than others did. The stated purpose of the Democrats’ health care proposal is to do two things: lower cost and increase coverage. This bill is a miserable failure on both counts. Under the plan, premiums are expected to increase, as a result of new taxes, new regulations, and restrictions. In general, you are not going to pay more for health care, and we are already hitting hospitals serving seniors and not getting paid the full cost of the treatment. Yet we are talking about cutting these services.
meets the approval of bureaucrats in Washington and of politicians. The bill makes it a crime not to have health insurance. If you don’t get it, you get taxed.

Lastly, a total of 14 million of the 47 million are currently eligible for current government programs—Medicare, Medicaid, SCHIP, and so forth—and choose not to sign up. If you do the math, that reduces that 47 million down, if you take out the illegals and the ones for reasons I stated, to about 14 million. So this, by and large, is what people are talking about when they mention the 47 million uninsured Americans. These numbers shed some interesting light on the composition of the number of uninsured Americans that gets thrown around. President Obama, interestingly, uses a different number. He doesn’t use 47 million. He uses 30 million. I think he wants to avoid the immigration issue, and it is probably wise of him to do so. He doesn’t want to be accused of giving rich benefits to people who are here illegally. I noted, with great interest, the CBO’s estimate of the number of Americans who will not have health insurance, even if this bill were to be enacted. And that is a majority of the American people, 24 million. This bill still leaves 24 million Americans uninsured, after spending $2.5 trillion to do just that, while at the same time making health care more expensive for everyone.

I hear the other side often throwing numbers around without any documentation. I use the CBO and other nonpartisan, credible sources so we can avoid doing that. President Obama wants to spend $2.5 trillion in new health care promises at a time when the country can’t afford the promises we have already made, and we have a record 1-year budget deficit which, by the way, means that 47 cents out of every dollar the government spends this year is borrowed. In 10 years, 16 percent or nearly $1 out of every $5 the government spends will be spent solely on interest payments on the debt. President Obama’s budget doubles the Federal debt in 5 years and triples it in 10 years. We have talked about this on the floor. I don’t think there is disagreement.

On top of this, we face $67 trillion in unfunded liabilities from our current entitlements—Social Security, Medicare, and Medicaid. This health care plan layers yet another unaffordable entitlement on top of Medicare and Medicaid and Social Security and the other entitlements we have, all in a system that is already crumbling. It seems to me this bill is exactly what the American people do not need. That is why most Americans are reporting that this bill is something they do not want at this time or ever. I think it is common sense.

Reading through the legislation, one is struck by the myriad of ways this bill raises taxes on America’s citizens—from job-creating small businesses, to middle-class families. I count about a dozen of them, adding up to about $500 billion in tax increases over the next few years—$1 trillion in new taxes. So everyone should get ready to pay a higher health care bill and a higher tax bill under this legislation.

Some might be inclined to say: But President Obama promised he would not raise taxes. That was, indeed, a campaign promise of the current administration, that no one making under $22,000 per year would see their taxes go up.

Let me just go ahead and quote that. This is what President Obama said during the campaign:

I can make a firm pledge . . . no family making less than $250,000 will see their taxes increase—no your income taxes, not your payroll taxes, not your capital gains taxes, not any of your taxes.

So we started analyzing this bill, and guess what we found out. When the bill is fully enacted, the nonpartisan Joint Committee on Taxation—keep in mind, I am quoting sources here that are credible sources and nonpartisan sources. The Joint Committee on Taxation found that, on average, individuals making over $50,000 and families making over $75,000 would see their taxes go up. Let me repeat that. Individuals making over $50,000 and families making over $75,000 would have their taxes go up under this bill. Indeed, according to the Joint Committee on Taxation, $42 million middle-class families and individuals—those making less than $200,000, on average, $112,000. President Obama’s health care reform bill currently under consideration in the Senate raises revenues to a large extent on the backs of middle-class Americans despite Candidate Obama’s pledge not to do that.

So let’s look at some of these instances where we get taxed. I am getting this, again, from the Joint Tax Committee and from CBO. If you have the good fortune to need a medical device, you get taxed. According to the nonpartisan Congressional Budget Office, new excise taxes applied to health insurance providers will end up taxing the beneficiaries. This tax also has the effect of increasing premiums as well. So you are doubly taxed on this deal.

Now, that is if you do have health insurance. What if you do not have health insurance? You still get taxed. Under this bill, you get taxed if you do not carry health insurance, a penalty. Where does this burden fall? You guessed it: middle-class Americans. CBO has said that half of the Americans affected by this provision make between $22,800 and $68,000 for a family of four. That is middle-class America.

If you take prescription drugs, you get taxed. That is another area. According to the JTC and CBO, new taxes in the bill applied to the provision of prescription drugs will end up raising the cost of those drugs. So you are taxed again.

If you happen to need a medical device—this is something I am really sensitive to, and I have not heard much discussion of this issue on the floor so far. It is a difficult thing. I was talking to Senator Enzi. He said people do not really know what medical devices are. The stents—these are things that are available here in America. You cannot find them in many of the other countries. So if you need a medical device, you get taxed. If you have high out-of-pocket medical bills, you get taxed.

My son-in-law, Brad Swan, installs pacemakers, among other things. This morning, I was talking to him, and he told me what happened last night. He said that at 1 o’clock in the morning, they got a call to go out to the emergency room of St. Francis Hospital in my city of Tulsa, OK, and they had an 8-year-old boy who had no heartbeat. He was born with congenital heart disease. He put in a pacemaker at that time, and he was perfectly healthy in the morning. I think most doctors agree that this child would not have lived. My older sister Marilyn faced a similar situation 9 years ago. She is alive today. She is healthy today. She would not be alive today without it. That is how serious this is.

Dr. Stanley DeFehr is from Bartlesville, OK. I talked to him this morning about this, about the significance of the medical devices. I am going to quote his answer. I wrote it down. He said:

The decision of who needs a pacemaker could be complicated, particularly the decision to put in a pacemaker on someone we might consider quite elderly. But it’s a false choice to deny pacemakers in because of their risk of failing (breaking a hip or shoulder). In the case where they fail, the costs become quite high. The cost of a pacemaker pales in comparison to the cost of a stroke or multiple fractures.

A pacemaker, by the way, costs about $5,000 and lasts about 10 years. That is $500 a year—not a bad deal. So I think this is a quality-of-life issue that we could lose some people on because of their risk of failing (breaking a hip or shoulder). In the case where they fail, the costs become quite high. The cost of a pacemaker pales in comparison to the cost of a stroke or multiple fractures.

So those are some examples of what we can do to pay higher taxes under this bill. If you have health insurance, you pay higher taxes. If you do not have it, you pay higher taxes. If you purchase a medical device, you have higher taxes. If you pay your own medical bills out of your pocket, you have higher taxes. If you take prescription drugs, you have higher taxes. All of these activities are taxed mercilessly under this legislation.

I want to turn now to examine one tax provision in particular that I find strikingly dishonest, damaging, and expensive to the taxpayer. It is an additional Medicare payroll tax that is in this legislation, and it is a perfect example of how this bill is going to tax you. You have to go into the bill to find these things. There are clandestine taxes in the bill that will hit you when you do not expect them to.

Basically, the bill says that people making $200,000 a year are going to pay an additional payroll tax called the
hospital insurance payroll tax that raises over $53 billion. Keep in mind, this is above the taxes we are already paying. They are getting these people at $200,000. You might think that is a lot of money. But there is a catch to this. They index it. So if you do not index the $200,000, then each year the amount of time goes by, and it is far less than the amount it sounds like today. In fact, I would say in 10 years from now that $200,000 would pretty much fit a lot of the middle-income people in America. So this alone with an additional Medicare payroll tax in this bill that raises $50 billion. It is not indexed, and we know how that is going to extend to other people now.

I remember Candidate Obama making a firm pledge not to raise taxes on middle-class Americans. However, this health care reform bill before us breaks that pledge on numerous occasions. But it is not unlike the new taxes which will be imposed on other measures that the Democratic Congress and the President Obama would like to enact. I just mentioned the $500 billion in new taxes this health bill raises.

There is another tax in another program going on, which I have talked about hundreds of times; that is the cap and trade. That is still on the floor. That could come up at any time. Of course, that is not something that would be $500 billion over a 10-year period; that would tax the American people in excess of $300 billion every year.

I have quoted my sources: the Wharton School of Economics, MIT, CRA, and others that have done evaluations. So it is not just this bill, even though this bill is what we are talking about today; we still have the problem of other legislation being promoted by the President and by the Democrats here.

The Obama administration’s own Treasury Department estimated that cap-and-trade legislation would cost each family in America $1,761 a year. It is much more than that in heartland America. In Oklahoma, it would be closer to $3,300 a year. So we are talking about some very large tax increases.

But, again, back to the health care bill, I noted earlier that the government-run health care system, as proposed by the President and by the Democrats, is expected to cost $2.5 trillion on top of the already exploding record deficits. This bill will increase payments we make on our country’s ever-explooding Federal debt. This Democratic Congress’s agenda clearly includes more tax on Americans. They may be hidden, but they are there. It is disingenuous. It is costly. It is another reason this bill should not be passed by the Senate. I say “another.” The other and the main reason is that a government-run health system does not work.

I yield the floor.

The PRESIDING OFFICER (Mr. Burr). The Senator from Montana.

Mr. BAUCUS. Mr. President, I understand we are now under the order where there is a half hour allocated to the majority side; is that correct?

The PRESIDING OFFICER. That is correct. The Senator has 30 minutes.

Mr. BAUCUS. Mr. President, I yield myself 10 minutes.

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

Mr. BAUCUS. Mr. President, I just want to help people understand this legislation. I am sure many do, but I am sure there are some who do not with respect to the choices people will have.

We have a uniquely American system of health care in America. It is roughly half public, half private. The goal of this legislation is to retain what we have; that is, basically have that same balance of public and private. It has worked pretty well for America. It is uniquely American. We are not Canada. We are not Great Britain. We are not Switzerland. We are the United States of America. We have to build on our current system and make our current system work better.

I am prompted to explain the choices, in part by the statements by the senior Senator from Arizona, who said Medicare Advantage plans enable people to get eyeglass and dental care. And that is true. But he went on to say that, gee, shouldn’t Members of Congress, who like all that and want to keep all that—that Members of Congress get free dental and free eyeglasses. Well, that is really not true. Members of Congress do not get that. But it is true Members of Congress participate in—all Federal employees, Members of Congress, people in the Forest Service, people all around the country—all Federal employees participate in the same system. It is called FEHBP. It is the Federal Employees Health Benefits Plan, where Federal employees and Members of Congress, all together, the same, can choose among many different private health insurance plans. There is an open enrollment season—in fact, we are in the midst of it right now—where Members of Congress and all Federal employees can look to see if they want to choose a different insurance company or not. Some of those companies do provide dental and vision coverage. Some do not. So if a Federal employee wants to choose a plan that covers dental and vision, he or she can do so. Just pay the premium, and you are covered with dental insurance.

We are setting up under this legislation an exchange that is very similar—almost identical—to the FEHBP, where people who do not have health insurance can go look on the exchange and choose among private companies, which one makes the most sense for them. Some may have dental, some may have eyeglass coverage, some may not. That is just a choice people can make.

In addition to that, there is even more choice, because currently a Federal employee does not have to join FEHBP. A Federal employee can choose not to get health insurance if he or she does not want to or maybe they get it through their spouse somewhere else. The same can be true with the exchange set up in this legislation. The person could buy among different competing private plans that offer health insurance. Of course, if a person can go outside the exchange because he or she thinks they can get a better deal, if that person wants to. So I just want to make it clear that we are encouraging choice. We are encouraging competition. And I might say that under the legislation, Members of Congress who fully participate in this will be coequal with others. If there is a private option, Members of Congress can participate in that as well. In fact, we are requiring Senators and their staffs—they do not have to participate in the exchange, but it is certainly available to them, and they can opt out if they want to.

Let me just say a little bit about Medicare Advantage. Several years ago, Congress established an advisory board that is now called MedPAC to advise them on how Medicare should pay providers in traditional fee-for-service and private health insurers in Medicare Advantage. Again, Medicare Advantage is with private companies. They have executives. They have stockholders. They are private companies. Medicare Advisory Panel advises us how much Congress should pay MedPAC and other Medicare providers in traditional fee for service. It is an independent agency. Its experts are nonpartisan, highly respected.

Each year, they send a report to Congress that examines issues in Medicare. Here is what MedPAC had to say about the current state of Medicare Advantage in its 2009 June report. I am going to quote now from this independent advisory panel:

First, we estimate that in 2009 Medicare paid $122 billion more for enrollees in Medicare Advantage plans than it would if it were fee-for-service Medicare.

Second: Current high payments have resulted in some plans that bring no innovation but simply mimic fee-for-service Medicare at a much higher cost to the program.

In other words, they are saying that Medicare Advantage plans get paid for a lot more but with no innovation compared to the fee-for-service Medicare.

MedPAC says:

This situation is unfair to taxpayers and beneficiaries not enrolled in Medicare Advantage who subsidize the higher costs.

Well, that is pretty obvious.

In addition, MedPAC goes on to say:

The excessive payments encourage inefficient plans to enter the program, further raising costs to Medicare.

There are so many dollars currently given to Medicare Advantage plans, according to MedPAC, that encourages inefficient plans to enter the program. Why not? They are getting all of this extra money.

Further quoting:
The cost of Medicare Advantage subsidies is borne by taxpayers who finance the Medicare program and by all Medicare beneficiaries via Part B premiums.

Or to say it differently, about 78 percent of Americans who are not in Medicare Advantage plans are paying, in effect, a $90-per-year tax for which they get no benefit which goes into the Medicare Advantage plans.

In addition:

The Part B premium for all beneficiaries is increased by about $3 a month, regardless of whether you receive the benefit.

A couple of more quotes from MedPAC:

The additional Medicare Advantage payments hasten the insolvency of the Medicare Part A trust fund by 18 months.

That is an interesting statement.

The additional payments hasten the insolvency of the Medicare Part A trust fund by 18 months.

Going with quotes from MedPAC:

Although many plans are available, only some are of high quality.

In addition, continuing the quote:

Only about half of the beneficiaries nationwide have access to a plan that CMS rates as above average in overall plan quality.

That is what MedPAC says. That is the nonpartisan expert that helps advise Congress on what reimbursement levels should be.

We have heard day after day that this bill is cutting Medicare benefits for our seniors. When my colleagues on the other side of the aisle realized this bill does not cut, reduce, ration, or eliminate a single guaranteed benefit, they turned their argument to Medicare Advantage. I think they finally recognize there are no guaranteed benefits cut in this legislation, so they turn to Medicare Advantage. They argue that the efficiencies and savings achieved by ending billions of dollars of overpayments to these private plans will either end the program or dramatically reduce the beneficiaries.

But let’s just look at the numbers. I have a chart behind me. This chart shows the yearly spending for Medicare Advantage in billions of dollars. So you can see from the chart that in the year 2009, $110 billion will be spent on Medicare Advantage plans. That is the far left. Moving to the right, 10 years later, in the year 2019, about $204 billion is spent. So if we total it all up, about $1.7 trillion will be spent on Medicare Advantage plans over the next 10 years.

You see that little—what color is that? It is kind of orange, it is kind of an interesting sort of red—whatever it is, at the top of that chart. That represents the reduction in Medicare Advantage plan payments under this legislation. It is not very much, as you can tell by looking at the chart. It averages out, I think, to around a 10-percent reduction in Medicare Advantage payments.

So let’s take these big crocodile tears, and we hear Medicare Advantage is being cut; when we hear all of these dramatic statements that so much is going to be taken away from seniors because Congress is cutting Medicare Advantage, the fact is, we are reducing the rate of increase in Medicare Advantage payments by only about 10 percent, and under this legislation about $1.7 trillion will be spent on Medicare Advantage payments. Remember, MedPAC says these are overpayments. MedPAC says this 10 percent reduction is what they should be paid.

Remember, too, these are private plans. These are private companies. It is not Medicare Advantage companies receiving these payments, and they are insurance companies. It is interesting to me that a lot of Members of Congress aren’t too wild about insurance companies. Well, Medicare Advantage companies are insurance companies. That is what they are. They are private insurance companies. They have their private insurance company chief executive. They have their private insurance company administrative costs and marketing expenses. They are private insurance companies. That is what they are. So we should not lose sight of all of that.

I wish to also point out that as private insurance companies, these Medicare Advantage plans are doing pretty well. Let me quote from an Oppenheimer Capital analyst in a November 12th report about Medicare Advantage plans. He said:

Between 2006 and 2009, we estimate that Medicare Advantage accounted for nearly 75 percent of the increase in gross profits among the larger plans in the industry, highlighted by an estimated gross profit increase of $1.9 billion in 2009, relative to commercial risk earnings gains of nearly $600 million.

Commercial risk earnings gains are the ordinary insurance company earnings, but 75 percent of the gross profit increase was under Medicare Advantage plans, not traditional health insurance.

I might say, too—I don’t have the papers; maybe I can find them. It is worth noting, it underlines the point that these are private companies. It is not traditional Medicare. Here it is. Because it is interesting, let’s look at the compensation of these insurance company executives of these Medicare Advantage plans, the CEOs.

The total compensation of a CEO at Aetna is $24 million a year. The total compensation of the CEO at Coventry is $9 million a year; at Wellcare, $8 million; at Humana, $4.7 million a year; and at United Health Care, $3 million. Now, people should be able to make some money and officers of companies should be able to do OK, but here we are talking about very high salaries that these insurance companies pay to their top executives. Frankly, if there is a 10-percent reduction in the $1.7 trillion over 10 years, they could, you would think, take some of that 10 percent maybe in salary reduction or dividends to stockholders, make other cost savings. It doesn’t have to come out of the beneficiaries. It is they, the executives, who are making these decisions of where the 10-percent reduction is allocated.

On the whole, I just wish to say I am not opposed to Medicare Advantage plans. Frankly, I think it is good we have Medicare Advantage plans. Medicare Advantage plans provide the competition to Medicare. They help keep the system on its toes. But we have an obligation as Members of Congress to the taxpayers and to seniors to cut waste and to cut overpayments in a way that does not harm beneficiaries.

These are reductions recommended to Congress by the best advisory board of experts we could find. They didn’t just come out of thin air and Members of Congress thought this up. This was recommended to us by the MedPAC advisory board.

Second, there is no reduction in guaranteed benefits to seniors. That is absolute. There is no reduction in guaranteed benefits to Medicare Advantage participants. So A, we are being fair. This chart shows it. We are trying to find the right level of reimbursement that is fair to beneficiaries. There is no reduction in beneficiaries’ benefits. In fact, in this legislation, we add more benefits for Medicare participants, Medicare Advantage, as well as traditional fee-for-service Medicare. I might add in this legislation we give an increase to Medicare Advantage plans that show demonstrated improvement in quality.

As I mentioned, MedPAC said a lot of these plans are totally inefficient. A lot of these plans have no coordinated care. A lot of these plans don’t have any quality, but they get the extra money. So we are saying let’s get to a compensation level that is fair. We do it on a competitive bidding basis, take the average bid for an area, and we also say let’s make sure there is no reduction in guaranteed benefits at the same time. I think that is a responsible thing to do.

So all of these arguments, these sound bites, frankly, that you hear from the other side of the aisle are just that, they are sound bites. They are not the honest analysis of what is going on.

So I encourage us to keep in mind, keep in perspective what we are doing so we can help provide a better health care system for our country. This is only one part of it. There are many other parts, but this is just this one part.

How much time do we have remaining, Mr. President?

The PRESIDING OFFICER. There are 13½ minutes.

Mr. BAUCUS. I see Senator Dodd is on the floor. At this time I yield to the Senator from Michigan.

The PRESIDING OFFICER. The Senator from Michigan is recognized.

Ms. STABENOW. Mr. President, first, I wish to thank our distinguished chairman of the Finance Committee.
for debunking what has just been said on the Senate floor by our colleagues on the other side of the aisle, laying out the facts of what is and is not happening with Medicare Advantage. I wish to build on that as well.

I want to make sure anyone who is interested to go to the Web site of AARP, one of the organizations we know to be champions for seniors, and take a look at what they say about the myth that health care reform will hurt Medicare. They lay out several things. One is:

None of the healthcare reform proposals being considered by Congress would cut Medicare benefits or increase your out-of-pocket costs for Medicare services.

Then, just this week, in supporting our efforts, they have put out a statement, a letter, and at the end, again, they reiterated:

Most importantly, the legislation does not reduce any guaranteed Medicare benefits.

I find it interesting that a few years ago our colleagues quoted AARP all the time we were debating the Medicare prescription drug bill—I would guess that every single one of our Republican colleagues used their support in putting forward their bill—and now they are trying to disparage AARP as a very credible organization, because they don’t agree with what AARP is saying. But I think the millions of people who belong to AARP will be listening to what they are saying about the fact that we are not, in fact, ensuring the guaranteed Medicare benefits.

In addition to that, we have the Alliance for Retired Americans and the National Committee to Preserve Social Security and Medicare all saying they support what we are doing and they have debunked the Republicans’ scare tactics point by point.

So what is happening here? The reality is that colleagues on the other side of the aisle, since the inception of Medicare, have been fighting against the existence of Medicare. It was Democrats and a Democratic President in 1965 who passed Medicare over their objections. The same arguments we are hearing today, we heard then. Now everyone sees that Medicare is a great American success story. But we have seen so many efforts.

In the 1990s, when I was a Member of the House, Speaker Gingrich said in his Contract With America in 1994 that they were going to change Medicare, they wouldn’t do it directly, so they would do it through the back door and let it “wither on the vine”—those famous words that we heard at that time in terms of trying to privatize Medicare, which is what I believe Medicare Advantage really is.

Then, recently, in the debate on the floor of the House of Representatives, we had 80 percent of the House Republicans support an effort to do away with Medicare at all, as we know it, as a guaranteed benefit. Instead, give vouchers to seniors to buy from private for-profit insurance companies. We know the reality of this. This is about the for-profit insurance industry that right now is receiving overpayments. Whether it is the CBO or MedPAC—any analysis will say they are receiving overpayments right now, and we are trying to ratchet that back.

What is happening is the for-profit insurance companies$1.14 to do the same thing that Medicare does for $1. That is what these efforts are about. I hope we will see good discussion.

The PRESIDENT proctor from Connecticut is recognized.

Mr. DODD. Mr. President, let me, first of all, commend our colleague from Michigan, who has chaired the Finance Committee and has been a stalwart defender of the traditional Medicare Program and of our elderly not only in her State but around the country. She has offered, I think, very cogent and worthwhile information this morning once again on this subject matter.

We keep going around and around in this debate. It is a little frustrating because we are talking about basically whether or not we are going to support to some degree the profits of some private insurance companies that are under the rubric of something called Medicare Advantage. Again, these are private companies that are receiving subsidies, supported by Medicare beneficiaries and the taxpayers of this country. We are not talking about eliminating Medicare Advantage but rather—we had a big chart a few minutes ago. We will get it in a few minutes. It shows what if not eliminating the program, we are restraining profit growth in the program.

We are rewarding Medicare Advantage in the bill, as the chairman pointed out. Based on performance and quality, we actually give bonuses in Medicare Advantage—contrary to the arguments you have heard by those who are heralding Medicare Advantage, despite the fact that the very companies who are making those promises said they were going to prove how they could reduce costs and be more efficient. In fact, today, it is quite the opposite. Right now the government pays these Medicare Advantage insurance companies $1, which is quite a lot of money for seniors that Medicare does for $1. That is basically, on average, what it amounts to.

The question is, can we reduce the cost of the overpayments, which are basically ending up in the pockets of insurance companies? There is nothing wrong with profits in private companies, but let’s declare what they
are. This is not traditional Medicare. They are private companies that are anxious not only, I presume, to provide benefits to their beneficiaries, but they are also looking to make a profit. There is nothing wrong with that, but since the premiums were set by statute, the obligation to try to keep our costs down, we are trying to do so because the promises that were made have not been kept. The costs are vastly exceeding the promises made.

The amendment we are going to hear about from our friends on the other side is nothing more than a recycled compilation of some of the “greatest hits” we have heard: stalling with arcane obstruction tactics, while standing up for some of the private companies—and I have no objection to standing up for private companies that do a good job, but when you do so at the expense of scaring seniors with baseless claims, then I do object. That is what is going on here, quite frankly. If you do the math, today almost 80 percent of our elderly are paying $90 a year in additional premium costs, without getting any benefit from it whatsoever, to provide benefits under the Medicare Advantage Program. That is not equitable. The 80 percent of our elderly need to know that they are being disadvantaged by this.

What the Finance Committee, under the leadership of Max Baucus, is trying to do is bring some equity back into this. He pointed out—and it deserves being repeated—that nothing in the bill does away with Medicare Advantage. We are trying to get it back to a sense of reality and not, again, disadvantage 80 percent of our seniors.

Right now, there is Medicare “disadvantage”—that is what it ought to be called, because that is what it does—disadvantages. Why should 80 percent of the elderly in this country pay higher premiums, with no benefits, at the expense of the 20 percent who are going to get some small advantage under this—but very little, because most of it ends up in profits. I will tell you why that happens in a minute.

To make my point, according to the Oppenheimer Capital analyst Carl McDonald, in a report issued a month ago:

Between 2006 and 2009, we estimate that Medicare Advantage accounted for nearly 75 percent of the increase in gross profits among the larger plans in the industry, high-lighted by an estimated gross profit increase of $1.9 billion in 2009, relative to commercial lighted by an estimated gross profit increase of $600 million.

I know the chairman of the Finance Committee that I spoke to earlier said twenty-five percent of the increase in gross profits came from the Medicare Advantage plans. These profits come out of the pockets of the American taxpayer because of the subsidies and, of course, the Medicare beneficiaries who are paying those extra dollars every year without receiving any of the benefits at all. Our bill will protect and strengthen Medicare and extend the life of the trust fund, as you have heard over and over again. That is not a fact to dispute. That is a fact. We extend the life of the Medicare Program. Part of the way our bill adds to the use of Medicare is to eliminate wasteful over-payments. These are overpayments far beyond what was anticipated when the program was written.

As I mentioned a moment ago, the government pays insurance companies in the Medicare Advantage Program $1.14 to do things for seniors that traditional Medicare does not do for $1. So those are the overpayments we are trying to rein in. There is no evidence these wasteful overpayments do anything to improve the care of our seniors. At the same time, they speed Medicare’s descent into bankruptcy and raise premiums for all Medicare beneficiaries.

Our bill would end that waste and use the money we save to help seniors pay for prescription drugs by closing the doughnut hole. The result can be quite dramatic. In less than a week, our friends on the other side are using these tactics to halt progress completely, fighting for these profits and overpayments that, again, come out of the hide of taxpayers.

If you look at this chart, if you extend to 2019, almost 10 years from now, what is the difference between what our bill does and what those who want no change do? The difference is $20 billion. In the post-reform period, in 2019, it is $183 billion going to Medicare Advantage. What the opposition wants is to hold it at $204 billion in 2019. That is $20 billion. That is the savings we are looking for in order to reduce over-payments and provide those resources to the elderly so they can afford prescription drugs.

If you want to side with these companies—they are still going to make a profit. This will not deprive them of all the money that is under the table, but it will be far more realistic and it will reduce subsidies, as well as overpayments being made by the elderly who receive nothing from this program at all.

Let me make my case on this point. Senator Stabenow listed the guaranteed benefits under Medicare. The chairman did it as well. Also, we add benefits as a result of our bill. In addition to the inpatient hospital care, doctor office visits, lab tests, kidney dialysis, in the post-acute period, inpatient rehabilitation, organ transplants—all of these issues—we also do things in our bill that are not available presently. We reduce the size of the Medicare doughnut hole. That is an added benefit that does not exist today. We reduce premiums to pay for drugs and medical care. We eliminate the copays. What an advantage that is here. Ask yourself whether you would like to eliminate copays or watch private companies make an additional $20 billion? Is this a better choice? Ask the overwhelming majority of seniors which they would rather have—an elimination of the copays they are paying today, or continue to provide excess profits for the companies here that have made so much under the Medicare Advantage Program.

Lastly, of course, and most important, is what we help keep Medicare solvent.

People say: Give me some examples on why the differences exist between Medicare and Medicare Advantage. I have a couple of examples from my home State that I think highlight the point. These come from the Center for Medicare Advocacy. This is a nonprofit organization, as my colleagues know, that does casework on behalf of individuals who need assistance dealing with Medicare Advantage plans. They provided two cases from my State. I presume most of my colleagues could find cases in their own States.

A woman living in Madison, CT, a shoreline community in Connecticut, had Lou Gehrig’s disease, ALS. We are all familiar with ALS. She was denied for home health care because she was said to be “stable.” That was the quote, “she was still stable.” That is not a valid reason for denial, and she was hardly stable with ALS. CMA, the Center for Medicare Advocacy, had to go to Federal court to get her care covered despite firm written support regarding her medical condition from her doctor.

Here is a woman under Medicare Advantage with ALS being declared by Medicare Advantage “she was stable.” Her doctors said anything but the case. When my friends talk about rationing of care under the present system, here is Medicare Advantage, a private firm, making a medical decision that should have been made between her and her doctor. They eventually got it overturned, but they had to go to Federal court to get it overturned. That would not have happened under Medicare. If she had been under Medicare, she would have gotten that help, no questions asked.

When people say there is no distinction, this is a live case.

Let me give the second one. A woman from Vernon, CT, and her husband traveled to Florida to visit their daughter living there. When she got to Florida, she fell down and sustained some severe physical injuries. While being treated at a Florida hospital for her injuries, it was discovered that she had a brain tumor, the reason she had the fall. She had no idea of this beforehand.

The Medicare Advantage plan covered treatment for the fall as an emergency—which Medicare Advantage plans must cover, even out of network, by the way—but not any diagnosis or treatment for the brain tumor.

The woman had another daughter who was a nurse who lived in Utah. So the family traveled from Florida to Utah, where she went for the cancer treatment for the brain tumor. While undergoing chemotherapy, this woman had a
life-threatening reaction to one of the medications from which she almost died. The Medicare Advantage plan denied coverage for all of this care because it was out of network. She was in Utah. They said no, leaving the client and her husband with $100,000 in bills.

Again, the Center for Medicare Advocacy went to court and battled against this decision. They were successful in recovering $90,000 out of the $100,000. This woman is now deceased, but she and her family were left with over $10,000, which would have been covered under traditional Medicare, but she had gone into a Medicare Advantage plan. In both instances, they would have avoided having to go to Federal court, having to fight as hard as they did, going through the trauma and turmoil. It is bad enough you have to wrestle with cancer or wrestle with a brain tumor, but then you get saddled with $100,000 in bills and Medicare would have taken care of them. This Medicare Advantage Program ran roughshod over her in the process.

These are examples of how private Medicare Advantage does not always operate in good faith. They are not always there when you need them. There are significant differences between Medicare Advantage and Medicare. With traditional Medicare, you know what services you get.

I ask unanimous consent to have printed in the RECORD a list of services so people can read about it. If people have the chance to read that.

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

No one is removing Medicare benefits. Every senior in America will still get these benefits: Inpatient Hospital Care and Nurses; Doctor’s Office Visits; Laboratory Tests and Preventive Screenings; Prescription Drugs; Ambulance Services; Durable Medical Equipment; Hospice; Emergency Room Care; Kidney Dialysis; Outpatient Mental Health Care; Occupational and Physical Therapy; Imaging (X-rays, CTs, and EKGs); Organ Transplants; and “Welcome to Medicare” Physical.

And under our legislation: Reduces the Size of the Medicare “Donut Hole”; Reduces premiums seniors pay for drugs and medical care; Eliminates copays; and Helps keep Medicare solvent.

Mr. DODD. Mr. President, all medically necessary hospital care and doctor office visits are covered under Medicare. You know you can get these services from any Medicare provider anywhere in the country. Out of network you get this kind of help, whether you are in Utah, Florida, or Vernon, CT, where one woman was from. Medicare provided that help. Here she was bouncing around the country and denied one place after another under Medicare Advantage. With traditional Medicare, she would not have had to worry about a private insurance plan playing games with her coverage.

The Medicare Advantage plans run the show. They change the benefits. Cost sharing goes on. This is why Medi-care Advantage is not like traditional Medicare. So when people say it is just like Medicare, no, it is not just like Medicare. If you doubt me, then call that family in Madison, CT, or call that woman’s family from Vernon, CT. Ask them whether Medicare Advantage is just like Medicare. You will get an earful from them on what they went through.

We should be clear that we are not eliminating Medicare Advantage. Again, I appreciate Senator Baucus’s efforts in making it work this time over and over again. We are not eliminating it at all. We are reducing payments to private plans and making the system work more uniformly. We actually give bonus payments for care coordination and quality improvements. These plans can use those payments to improve benefits for beneficiaries. So we are hardly eliminating it. We are making it work better.

I have serious reservations about how this plan works. I will say that, but I would not advocate on the floor of the Senate the elimination of Medicare Advantage. I do want to make it work better, and I do want to cut back when we have overpayments occurring. I don’t think it is fair that 80 percent of the seniors in my State or elsewhere are paying $90 a year extra to cover this program and get none of the help from it and people under Medicare Advantage, who could have been protected, are not because they opted to be in that plan and then found out it is anything but what they thought it was.

We are going to hear these arguments over and over about Medicare Advantage. A little truth in advertising is necessary here. So people understand, it is not Medicare and it is not an advantage, not under the present system, not at all. That is what we have been trying to say over and over again here so people understand. This is not Medicare. This is a Medi-advantage. A little truth in advertising is necessary here. So people understand, it is not Medicare and it is not an advantage, not under the present system, not at all. That is what we have been trying to say over and over again here so people understand. This is not Medicare. This is not Medicare Advantage. It is not Medicare and it is not an advantage, not under the present system, not at all. That is what we have been trying to say over and over again here so people understand.

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Federal appropriations from being used to pay benefits to ensure the program is self-funded.

Finally, at the request of several Senators, the distinguished majority leader made sure we did not use any of the states CLASS Act for any other purpose than to pay for the CLASS Act itself. This amendment offered by Senator WHITEHOUSE will give Senators a chance to commit themselves to that purpose. Senators who claim the CLASS Act will hurt the Federal budget, of course, should vote for this amendment because statutorily it will prohibit any of those funds from being used for any other purpose other than for the CLASS Act and the recipients who want to use them. I commend him for that move and thank him. When that vote occurs, I urge colleagues to vote for the Whitehouse amendment.

Lastly, I ask unanimous consent to be included as a cosponsor, along with my colleague from Maryland, Senator MIKULSKI, of Senator COBURN’s amendment No. 2789 which adds Members of Congress to the public option.

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

Mr. ENZI. Mr. President, we added that provision to the HELP Committee bill. Senator COBURN offered that amendment. Senator Kennedy, myself, and others voted for that Coburn amendment. I think it may have shocked the Senator from Oklahoma at the time that we actually voted for his amendment. I know Senator BROWN has been added as a cosponsor. I have no objection to that amendment. That is how much I think the public option would be worth. If we have a public option in this plan—and my hope is we will—there is nothing wrong with existing Members of Congress being included in that public option proposal. His amendment suggests that. We supported it in committee, and I am prepared to support it again on the floor of the Senate.

I point out, I wish we could get Members as well who are reluctant to support this bill to recognize that as Members of Congress today, we all have pretty good health care plans under the Federal employees benefits package, some 23 options every year that are available to us, along with the 8 million Federal employees in this country under those plans. I wish we could get others to recognize how valuable that is to all of us and our fellow Federal employees. Unfortunately, that does not seem to be the case.

I hope before this is concluded we will have far more support for this effort we have crafted and proposed to our colleagues for their consideration.

Again I compliment the Finance Committee and my friend from Montana for the work he has done on this issue. It is very well thought out, very balanced and fair.

I said this over and over: I challenge any Member to come to the floor and identify a single guaranteed benefit under Medicare that is cut out under this bill. There is not one. Three days have gone by since I made the charge that not a single guaranteed benefit under Medicare is cut. You will not find one; not one.

I see my friend from Wyoming has come to the floor. I know I have probably gone over my time.

I yield the floor.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. BAUCUS. Mr. President, we are playing things by ear. I ask unanimous consent that the Senator from Wyoming be recognized to speak for debate only, and at a later point, we will figure out allocation of time on both sides, if he wishes to speak now.

Mr. ENZI. Yes, Mr. President, I wish to speak.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. ENZI. Mr. President, it is my understanding we would be in charge of the next 30 minutes and then it would revert to the other side for 30 minutes after that.

Mr. BAUCUS. I might modify that so this side gets the next 30 minutes after that.

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

Mr. ENZI. It is also my understanding that at any time there is an agreement to vote, we will cancel out what we are doing. But there is no agreement yet.

I thank the Senator from Connecticut for setting up my speech so well. He said there was no place that anybody can show any decline in guaranteed benefits. With what I am about to say, I will try to do that. Of course, the words “guaranteed benefits” do not show up anywhere in what we are doing. “Benefits” does but not “guaranteed benefits.” In my opinion, getting to be in a nursing home or being able to see a doctor; some of those ought to be considered guaranteed benefits. I will get into that a little bit in my speech and cover some of these areas that I think are very important to seniors. I am opposed to the $5 trillion of Medicare cuts in the Reid bill that are not going only to solve Medicare.

Some of my Democratic colleagues have attempted to argue this bill does not cut or reduce any guaranteed Medicare. They have tried to argue that this bill is self-funded. They have also argued that no beneficiaries will lose their benefits—their guaranteed benefits. They are very careful on that, and I understand why they are careful on that because there are other benefits that are being cut that will be considered by those people who will lose that benefit to be a guaranteed benefit.

Unfortunately, all of those statements are false. It does not matter how many times my colleagues repeat these claims, they do not become any more accurate. This bill cuts $464 billion from the Medicare Program. It slashes payments to hospitals, nursing homes, home health agencies, and hospices. These are cuts to the Medicare Program, and I even have the page numbers on those.

The money from these cuts do not go to shore up Medicare. The money goes to new programs for others. These cuts will affect the care provided to Medicare beneficiaries.

The American Health Care Association, which represents nursing homes, said the cuts in the Reid bill would force layoffs, lower salaries, reduce benefits, and ultimately would hurt patients’ quality of care. A commission was set up to make even more cuts to seniors’ Medicare. It is in the Reid bill. There is a commission in there.

So with the side deals that have been made with lobbyists, the only place these cuts can come from is from seniors. I will cover that in a little more detail. I have heard similar statements from home health providers, that is more than $40 billion in cuts; hospice providers, which is $8 billion in cuts; and hospitals, which is $130 billion in cuts. If these Medicare cuts go into effect, it could drive providers out of the Medicare Program. That will mean patients do not have the care they expect and they need.

Some of my Democratic colleagues have accused us of trying to scare Medicare beneficiaries. If seniors are scared by our statements, they should be terrified by what the administration has to say about the Democrats’ health reform bill. The administration’s own chief actuary, Richard Foster, recently wrote that the steep Medicare cuts in the House-passed health reform bill would make it difficult for many providers to remain profitable and cause them to end their participation in Medicare. I want to note this could jeopardize Medicare beneficiaries’ access to care.

As the senior Senator from Tennessee noted yesterday, it is the Medicare cuts in the Reid bill that are actually scaring seniors. Our beneficiaries understand that if providers are no longer able to take Medicare patients, they—the seniors—will not get care. A lot of grandmas and grandpas have figured it out, and they are not going to stand for it.

The chairman of the Finance Committee has repeatedly said this bill will not cut or reduce any guaranteed Medicare benefit. That statement seems to be at odds with what this House provider. If a Medicare patient cannot get into a nursing home, they do not have nursing home benefits. If they can’t find a home health aide willing to take Medicare patients, they do not have those benefits. On top of the promise for coverage, when you can’t get a doctor to see you, is not health care. You don’t have benefits if you can’t get a provider to treat you. Unfortunately, that is exactly what this bill will do.

Some of my Democratic colleagues have also attempted to justify the Medicare cuts in the Reid bill by arguing that many of the trade associations
representing health care providers have endorsed this bill. They are correct that several Washington-based trade associations and their lobbyists have endorsed the Reid bill. It is probably worth exploring why some of the groups have chosen to endorse this legislation.

In some cases, motivation is obvious. Some drug manufacturers are clearly motivated by self-interest and greed. They negotiated a secret deal with the White House that will actually increase what Medicare spends on brand-name drugs—brand-name drugs. They didn’t touch the generics. They are interested in the brand-name drugs.

Under the terms of their deal, the drug manufacturers will provide discounts on brand-name prescription drugs when the seniors are in the Medicare coverage gap—known as the doughnut hole. They make the payments directly to the customer. It doesn’t go through Medicare but directly to the customer. That way they can maintain the customer contact and keep them addicted to the brand name.

Generics are cheaper. A lot of people, when they go to the doughnut hole, switch to generics because that saves them money, and it saves us money. When they get through the doughnut hole, they will stay with whatever they are on while in the doughnut hole. So if they are forced to stay on a brand name to get a little extra discount as they go through the doughnut hole, they will stay with the brand name when the taxpayers are paying for it when it goes above the doughnut hole, which is the rest of the year. That could be a huge number. So while it looks generous by the drug companies, beware; their generosity is suspect with what they will make when it gets through the doughnut hole.

Under the terms of the sweetheart deal between the White House and the drug companies, discounts are provided for these brand-name drugs. This will encourage seniors to continue to get those more expensive drugs, and it will actually cost the taxpayers $15 billion because the deal will actually increase Medicare costs.

In other cases, provider groups were promised special deals if they agreed to support the Reid bill—or whatever bill they were working on at that time. For instance, recent press reports have described how the American Medical Association was promised a permanent fix to the Medicare payment formula for doctors if they agreed to support this bill or a 1-year fix if there was an end to junk lawsuits. Under current law, doctors’ Medicare payments are scheduled to be cut by more than 40 percent over the next decade. That is already in place. That is not a part of the bill. The cost of fixing the flawed government-mandated formula will be more than $250 billion. We know that because we discussed it on the Senate floor, and we decided we were going to have to pay for that if we were going to do it.

So let’s see. $464 billion in Medicare money we are using on other things. That is why I keep saying Medicare money only ought to go to Medicare benefits, and that $250 billion for the doctors’ fix might make it possible for people to see the doctors. I think the reason why doctors want to fix this flawed government price-control system—and that is what it is because they are telling the doctors what they can charge a customer, regardless of how long a time it is going to take them to get paid. For a lot of them, they have discovered it costs more than what they are able to get. If they continue to do that, they have to go out of business. That is kind of the small business philosophy: You take in less money than what it costs to be in business, and you are out of business. So I don’t think they like that kind of a government price-control system.

As a result, 40 percent of the doctors will not take a patient on Medicaid, and it is growing in percentage now on Medicare in the same way. When you fix the price, some people can’t afford to provide it for that, so they can’t take those patients.

I was talking a friend of mine from Florida who said: Every time you call a doctor now, they say: Are you on Medicare? If you say yes, they say: We are not taking any new patients. If you can’t afford a doctor, you don’t have a benefit. It shows the exact problems that result from letting government bureaucrats use price controls to set payment rates. What I don’t understand is why the AMA continues to support the bill when they got nothing for their deal. We didn’t fix the $250 billion problem, and we haven’t fixed the junk lawsuit problem.

I remember the President appearing at the National Convention of the American Medical Association and promising the AMA that there would be a rapid reform; that there would be an end to these junk lawsuits. All of our attempts, either in the HELP Committee or in the Finance Committee, to even bring that up have been either voted down or denied. As a result, there is nothing in this bill that is going to solve that problem. The bill does nothing to fix the Medicare payment formula for the doctors. Instead, it cuts $464 billion from Medicare and uses that money to cover the uninsured.

Even without cutting billions out of Medicare without hurting seniors, the Republicans are saying: Use the money only for Medicare. Medicare money for Medicare. Medicare funds should be used to fix Medicare’s problems, such as this flawed payment formula that keeps doctors from taking seniors. Taking hundreds of billions of dollars out of the Medicare Program now will only guarantee that it will be much harder to permanently fix the doctor payment issue in the future.

I cannot understand why the AMA continues to support this terrible deal for doctors. If you can’t see a doctor, your benefits—your guaranteed benefits—have been cut. Apparently, the members of the AMA don’t like the deal either. At a recent convention, up to 40 percent of the current membership of the AMA voted to reject this deal. I know that is not a majority, but most associations have one consensus agreement. That means almost all of their membership agrees with the tack they are taking, not just slightly more than half. Their membership is less than 20 percent of all doctors. It is a deal they had to take. They were given the choice to silently accept devasting cuts rather than oppose them and risk being utterly destroyed. One of the Medicare Advantage providers is Humana, and I will use them as an example. CMS said they couldn’t let their customers know what was going to happen, and chastised them for sending out a letter. I thought the customer deserved to know and that we were in a new era of transparency. That doesn’t sound very transparent to me. So how can that happen in America?

At any rate, I hope my colleagues and the American people will take these facts into account when they hear Senators talk about provider groups supporting this bill. Unfortunately, the health care sector for this bill is being driven primarily by greed or stupidity or fear. We know this bill will not fix the problems in the American health care system. It will not lower health care costs. It will not lower insurance premiums. It will still leave 25 million people uninsured. What this bill will do is spend $2.5 trillion and guarantee a much bigger role for the government in dictating how health care will be delivered in this country. If you are not under Medicare, yes, your government is going to tell you what is adequate coverage, and they are going to force you to buy it or pay a penalty.

Given the recent experiences that doctors have had with Medicare price controls, this is not an outcome that bodes well for America’s health care providers or their patients. I remind everybody that in August there was an uproar, and that uproar continues. We don’t notice it as much because we are not going to get to go home this weekend to talk to our constituents. That
might be by design because we already know what our constituents are saying. They are saying: This bill is a bad deal for us. Where is the promise that you were going to cut costs for us? Where are the other promises that were made? Job-based coverage will cost $13,200 on the average, but under this health care bill it should jump to $15,200. That is not very good news for the people in my State or any other State. No big cost rise in U.S. premiums is seen in the study, said the New York Times.

The Washington Post declared: Senate health bill gets a boost. The White House crowed that the CBO report was more good news about what reform will mean for families struggling to keep up with skyrocketing premiums under the broken status quo. The Finance chairman, the Senator from Montana, chimed in from the Senate floor that health care reform was fundamentally about lowering health care costs.

Yes, lowering costs is what health care reform is designed to do—lowering costs. But then he said: And it will achieve this objective. Except that it won’t.

CBO says it expects employer-sponsored insurance costs to remain roughly in line with the status quo. That is the failure of this bill. Meanwhile, fixing the individual market is expensive and unstable, largely because it does not enjoy the favorable tax treatment given to job-based coverage. You know, if you are buying insurance on your own, you are not getting a tax break on it. If companies buy insurance for the people working for them, they are getting a tax break.

In my 10 steps to solving health care, I mentioned job-based coverage making that fair. You have to be fair for both sides. The Wyden-Bennett bill concentrates on making it fair for both sides. That is one of the issues people in this country are concerned about, making it fair for both sides. This bill doesn’t make it fair for both sides.

Talking about fixing the individual market, that is expensive and it is largely unstable, I will say again, due to the treatment of job-based coverage. That is supposed to be the purpose of reform. But CBO is confirming that new coverage mandates will drive premiums higher.

Democrats are declaring victory, claiming these high insurance prices don’t count because they will be offset by new government subsidies. About 57 percent of the people who buy insurance through the bill’s new exchanges that will supplant today’s individual market will qualify for subsidies that cover two-thirds of the total premium so the bill will increase cost but then disguise those costs by transferring them to taxpayers from individual.

higher costs can be conjured away because they are suddenly on the government balance sheet.

The Reid bill has $371.9 billion in new health taxes that are apparently not a new cost because they would be passed along to consumers they will be hidden in lost wages. This is the paleo-liberal school of brute force wealth, redistribution and a very long way from the repeated White House claims that reform is all about bending the cost curve. The only thing being bent here is the budget truth.

Moreover, CBO is almost certainly underestimating the cost increases. Based on its county-by-county actuarial data, the insurer WellPoint has calculated that this bill will cause some premiums to triple in the individual market. I don’t go by WellPoint, I go by what I found out in Wyoming itself and that is an accurate picture, particularly for the young people in our State. Those who are young and healthy will see a 21 percent rise, I think they are going to notice that. I don’t think they are going to be happy with it. Other associations have come to similar conclusions. The reason for that is the community rating, which forces insurers to charge nearly uniform rates regardless of customer health status or habits. Habits is an important one on that. CBO does not think this will have much of an effect, but costs inevitably rise when insurers are not allowed to price based on risk. That is why today some 35 States impose no limits on premium variation and 6 allow wide differences among consumers.

That is not just WellPoint that is saying that. I have some peer-reviewed documents that also show that same thing from people from different colleges. They have found that the State community rating laws raise premiums in the individual market by 21 percent to 35 percent. In New Jersey, which also requires the insurers to accept all comers, so-called guaranteed issue, premiums increased by as much as 227 percent.

Let’s see, we just had some elections in New Jersey and things didn’t go well there. It probably wasn’t just tied to insurance costs.

The political tragedy is that there are plenty of reform alternatives that put participants in the insurance. According to CBO, according to the Congressional Budget Office which we quote a lot, they did an evaluation on the relatively modest House GOP bill. The Republicans in the House were limited to one amendment. There were three amendments total in a 1-day debate and passage of the health care bill over there. That roused a lot of people in America, too. If you only get one amendment, they had to do what we have avoided doing. We have four different bills with nine amendments that the President said he wanted solved. That is not counting the Wyden-Bennett bill that also solves what the President said, that is not included in this bill.

What the House put together—it is relatively modest, but it would actually reduce premiums by 5 percent to 8 percent in the individual market in 2016 and by 7 percent to 10 percent for small businesses. It would not increase the premiums, it would decrease the premiums.

The GOP reforms would also do so without imposing huge new taxes. We have concentrated on numbers about talking about the Medicare money that is being stolen to provide for the changes. We have not talked yet about the extra taxes that are going to be put into place. That is the other half of the package. But the Democrats do not care because this bill, they say, is about lowering costs. No, it is about putting Washington in charge of health insurance at any cost.

I see the Senator from Wyoming is here. We have 10 minutes remaining on debate. If the Senator wishes to make some additional comments? He and I have been traveling in Wyoming.

What it says is: Senate Democrats closed ranks Thursday behind $600 billion in politically risky Medicare cuts at the heart of health care legislation. It goes on to say: Approval would have stripped out money to pay for expanded coverage to tens of millions of uninsured Americans.

As I read this, it says the Republicans tried to keep the Medicare money for people on Medicare, but the Democrats want to take $460 billion away from seniors who depended upon Medicare and use it to start a whole new government program. Am I reading this correctly?

Mr. ENZI. That is the way I read it. That is the way the people in Wyoming are reading it and that is apparently the way people all over the country are reading it. The Democratic Newman League.

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Mr. BARRASSO. Mr. President, I would say when my colleague from Wyom- ing and I held townhall meetings around the State of Wyoming, people have a number of concerns about their Medicare. Yet what I see this bill doing is cutting our Medicare and specifically, right now, there are thousands of people in Wyom- ing who are on a program called Medicare Advantage. There is an ad- vantage to this program. That is why so many Americans have signed up for the program.

As a matter of fact, about one in four Americans who depend upon Medicare for their health care in this country has chosen Medicare Advantage, be- cause there are some advantages being in this program called Medicare Advan- tage: dental, vision, hearing, fitness. Also, as a practicing doctor for 25 years, taking care of families, and families have decided to go into 2010 next month. If you make and that is why they are choosing Medicare Ad- vantage. It is because it is a choice that they make and that is why we right into this program continuously, with- out having to impoverish yourself and put- ting to then impoverish themselves or to limit their outside earnings, given the fact that they may be able to con- tinue to perform and, in fact, would like to continue to work.

The question was, how much of that do they get back in value? They think about 50 cents on the dollar. That is a national Gallop Poll. They have been polling on this for a long time and it is the high- est number ever of what Americans think, in terms of the fact that they are getting little value for their tax dollars. They see games being played. That is what I hear when I have telephone townhall meetings in Wyom- ing. They know Senator REID’s bill steals $464 billion from Medicare. They know in this program they depend upon, not to make Medi- care stronger, not to make Medicare more solvent, but as my colleague from Wyoming tells me, to create a brandnew entitlement program. They are raiding Medicare to start another government program. That is itself going to be insolvent.

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I ask my colleague from Wyoming, are you seeing what I am seeing? Mr. ENZI. I am seeing what you are seeing, and the people do not know what an entitlement actually is. That is a bill that goes on forever, that the Secretary of Health and Human Services has to make sure that it is paid in perpetuity unless there is some other congressional action that happens. We keep paying that bill over and over again. I think the Sen- ator from Wyoming recognizes entitle- ments and some of the difficulties in- volved with that.

Mr. BARRASSO. Mr. President, an article in Bloomberg yesterday said the Kaiser Family Foundation poll re- leased this past month found that 60 percent of seniors said they would be better off if Congress did not change the health care system.

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Mr. BARRASSO. Mr. President, an article in Bloomberg yesterday said the Kaiser Family Foundation poll re- leased this past month found that 60 percent of seniors said they would be better off if Congress did not change the health care system.

We know we need to do some changes. But this massive bill, this 2,000-page bill that weighs 20 pounds, is not the right change we need. For our seniors, people who rely on Medicare for their health care, we absolutely want $464 billion from Medicare. Our almost $1 trillion, there is a point where more people—the baby boomers, more and more people are added to the rolls every day. To raid this program to start a whole new government program is not the right prescription for Amer- ica. It is not what our seniors want. It is not what they signed up for. It is not why they are choosing Medicare Ad- vantage. It is because it is a choice they make and that is why we right now have almost 11 million Americans who are 20 years on Medicare Advantage. We have 11 million seniors—that represents almost one-quarter of all Medicare patients in this country.

Mr. ENZI. WE are being notified our time is up. We will continue. I have several letters from Wyoming organi- zations that I want to have printed in the RECORD, and I will do that at a later time.

I thank the Chair and yield the floor.}

Mr. DODD. Mr. President, a few mo- ment ago I started to describe an amendment that will be offered by our colleague from Rhode Island, Senator WHITEHOUSE, regarding the CLASS Act.

As a bit of background, the CLASS Act is a proposal that was originally conceived by a former colleague and dear friend, Ted Kennedy of Massachu- setts, years ago, the idea behind it being that we ought to try to figure out a way to support people in this country who end up with disabilities. So many Americans have figured out that Medicare Advantage is not what they signed up for. It is not what our seniors want. It is not the right prescription for Amer- ica. It is not what our seniors want. It is not what they signed up for. It is not why they are choosing Medicare Ad- vantage. It is because it is a choice they make and that is why we right now have almost 11 million Americans who are 20 years on Medicare Advantage. We have 11 million seniors—that represents almost one-quarter of all Medicare patients in this country.

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I thank the Chair and yield the floor.
Five million people under the age of 65 living in the community have long-term care needs, and there are over 70,000 workers with severe disabilities in the Nation today who need daily assistance to maintain their jobs and their independence. Long-term care services and supports and services are an area that is not currently affordable or accessible for millions of our fellow citizens. It is estimated that 65 percent of all those who are 65 or over today will spend some time at home in need of long-term care services, for which average costs run at least $18,000 a year.

Mr. President, 11.5 million people today are in nursing homes, and roughly 9 million of our fellow elderly Americans will need help with activities of daily living during the current year. By the year 2030, that number will increase to 14 million, as we watch the baby boom population age. And while those lives will be extended and hopefully the quality improved, we all accept the notion that as we get older, we have greater needs physically. That certainly is something anyone over the age of 65 can tell you. So as the years progress, the quality of care, longevity tables increase, the number of people who will spend some form of time in a nursing home another will jump from 9 million today to roughly 14 million. Those numbers are apt to increase.

Many people who need long-term services and supports rely on their care family and friends to provide that care. They have children or grandchildren who are around to provide that kind of assistance. A lot can’t, of course. But ultimately many of these individuals have to impoverish themselves to qualify for Medicaid. We know what happens. They transfer the house, their assets increase, the number of people who will spend some form of time in a nursing home another will jump from 9 million today to roughly 14 million. Those numbers are apt to increase.

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Let me tell you how the improved version of this act protects the taxpayer. There are issues raised about how they are going to be protected under this program. All CLASS Act benefits are paid by voluntary participants, not taxpayers. The CLASS Act actually would save taxpayer dollars by reducing Medicaid costs—according to CBO, almost $2 billion. CLASS Act premiums must be set at a level sufficient to guarantee actuarial soundness of the program.

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We thank Senator Gregg for his amendment on the CLASS Act bill when it came up in committee.

The current CLASS Act includes significant improvements over earlier versions. It includes new standards, a new reserve requirement, and an absolute prohibition on the use of taxpayer dollars to pay benefits. The Congressional Budget Office determined that the improved program is totally actuarially sound.

This bill, the Patient Protection and Affordable Care Act, creates a voluntary insurance program. Under the program, working people pay premiums for at least 5 years before it would vest. After that individual has paid in for 5 years and worked for at least 3 of those 5 years and develops a disability, they can receive a cash benefit of no less than $50 a day for as long as that disability persists. Contrary to popular belief, Medicare and most private health insurance only pay for long-term care for a short period, meaning that most people pay out of their own income or assets or their family’s assets to provide this kind of benefit. Those with the most intense needs will frequently exhaust these assets and have to rely on Medicaid, thus impoverishing themselves in order to qualify.

The CLASS Act provides essential options for 65 percent of those age 65 and older who will need long-term care services at some point in their lives and for the 70,000 workers with severe disabilities in the Nation today who need daily assistance to maintain their jobs and their independence.

It has been said that this program is not financially stable and amounts to nothing more than a Ponzi scheme. This program, they say, will create a new government entitlement program. It is not a government entitlement program—anything but. The CLASS Act does not confer rights or an obligation on the government, funding, nor does it affect receipt of or eligibility for other benefits. The program stands on its own financial feet.

CBO has estimated the program to be actuarially sound for the next 75 years. The CLASS Act would help people live independently at home or in the community, and, in many cases, continue to work.

Beyond being self-supporting and voluntary, this program can actually generate savings in Medicaid. Direct offset of the $75 daily benefit is applied toward any Medicaid long-term care costs. Beyond that, the CLASS Act program will help people live independently at home or in the community. When people with disabilities have access to the services they need, they are less likely to spend down to get Medicaid and less likely to enter a nursing home or hospital, all of which generates additional Medicaid savings.
know people who are on Medicaid and know the frustration particularly of someone who is otherwise healthy but suffers from disabilities who would like to work and wants to keep independent. Yet if you go into the Medicaid case, there are constraints on your ability to do so. By this program, aside from financially reducing Medicaid costs, we are actually providing that additional sense of human dignity and decency that just becomes a disability and you need help doesn’t mean you don’t want to be self-sufficient and keep working. There is the gratification of knowing you are contributing in some way other than being shuttered away, having impoverished yourself, relying on others’ assets to take care of you because you do not have those resources.

Senator Kennedy generated this idea years ago, and now I think it is improved because of the amendments and ideas that have been suggested by a number of our colleagues here, as well as others, and we have actually strengthened the concept to give it the kind of financial independence Members want it to have, sheltering these dollars against being used for other purposes, going off to get other program that people may have a great desire to fund by tapping into these resources. We prohibit that from happening. If employers do not want to have a payroll deduction, they do not have to have that. No one is required to join the program. We believe, though, when members of our society and country see the benefits of this, they will gravitate to it as a wonderful way to ensure that they will resoundingly defeat the efforts to shut people away, that they will stand up against that. I think that they will resoundingly defeat the efforts to shut people away, to be self-sufficient and keep working. Yet if you go into the Medicaid case, there are constraints on your ability to do so. By this program, aside from financially reducing Medicaid costs, we are actually providing that additional sense of human dignity and decency that just becomes a disability and you need help doesn’t mean you don’t want to be self-sufficient and keep working. There is the gratification of knowing you are contributing in some way other than being shuttered away, having impoverished yourself, relying on others’ assets to take care of you because you do not have those resources.

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Mr. DODD. I yield the floor.

THE PRESIDING OFFICER (Mr. KAUFMAN). The Senator from Iowa.

Mr. HARKIN. Mr. President, I wish to thank our friends and leader on this issue, Senator DODD, for his eloquence in supporting what so many of our elders in this country want more desperately than just about anything else; that is, the peace of mind of knowing that if they should become disabled, they will not be forced to go into a nursing home, they will have some support, and they will be able to live in their homes in their communities.

Talk to anyone with a disability—not just the elderly, but a disability—and they will tell you how important it is that you have that kind of assurance that if, God forbid, you become disabled, your only hope will not be to go into a nursing home for the rest of your natural life.

Senator Kennedy worked on this for years. The couple times I talked to him this summer and this spring, this is what he wanted to talk to me about: making sure we included this in this bill. This was his cause, to make sure that all the people with a disability that have a disability—just the elderly, anyone with a disability—and they will tell you how important it is that you have that kind of assurance that if, God forbid, you become disabled, you can get some support to stay at home, maybe with your own family, maybe with just enough support so you can get another job and work even though you have a disability. This is voluntary.

I do not understand the move by my Republican friends to strike this. This is not a mandatory program. This does not force anyone to pay a dime. It is all voluntary. We say, if you want to, you can put your own money in a fund that will vest so that if you become disabled, you can get some support to stay at home, maybe with your own family, maybe just enough support so you can get another job and work even though you have a disability. This is voluntary.

I ask my friends on the other side of the aisle, why are you against a voluntary program that will enable people to have that kind of peace of mind? Well, I have heard it said: Well, maybe with your own family, maybe with just enough support so you can get another job and work even though you have a disability. This is voluntary.

I will tell you this: In the committee, Senator GREGG—Senator GREGG from New Hampshire, Republican Senator GREGG, my good friend—offered an amendment to make sure the contributions were the only things that would sustain this program, that it would not become an entitlement. Here is what he said, his own words:

I offered an amendment, which was ultimately accepted, that would require that...
CLASS Act premiums be based on a 75-year actuarial analysis of the program’s costs. My amendment ensures that instead of promising more than we can deliver, the program will be fiscally solvent and we won’t be passing the buck—or really, passing the debt—to future generations. I’m pleased the HELP Committee unanimously accepted this amendment.

The CBO has scored this. This is completely paid for over 75 years—over 75 years. I do not understand why anyone would want to strike it. What Senator Whitehouse has said—again, I think this is very appropriate for us—is that any savings we get from this be reinvested either in the CLASS Act—so when people do get disabled, maybe they will get a little bit more money. So we have some savings in the CLASS Act. What Senator Whitehouse has said is, put those savings back in the CLASS Act or Social Security. It makes sense to me. So again, I think it is an improvement on the bill, what Senator Whitehouse is suggesting.

I said—please—with my fellow Senators, do not kill this program aborning. We stood here on this floor 19 years ago, on July 20, 1990. We stood on this floor to pass the Americans with Disabilities Act. There were few votes then. In fact, there are one or two people still here who voted against it. I think if you asked them now, they would say it has been a pretty darn good bill. It has broken down a lot of barriers, opened a lot of doors for people with disabilities in our country, changed our environment in this country, not only in terms of physical access, but I think, more importantly, it has changed how we view people with disabilities, no longer looking at people with a disability to say, what is their disability, we now look at those people and say, what are your abilities, what can you do—not just looking at someone’s disability. So we have come a long way.

The one thing we have never been able to really do is to set up a functioning system so people could put some money aside to protect themselves in case they got disabled. Well, this is it. This is our chance. This is a big part of this health care bill, a big part.

Well, maybe, I suppose, if you are trying to kill the bill, you would want to kill the CLASS Act. But this is vitally important for our country. It is really a logical step after the Americans with Disabilities Act. It is going to provide for so many people in this country that security and that peace of mind of knowing they will not have to go into a nursing home or an institution if they become disabled. And it can happen to any one of us here on the Senate floor, our families, our staff, our loved ones. No one knows what might happen to us either from an accident or a physical ailment. No one knows. But wouldn’t it at least have been a step forward with this health reform bill that provides that kind of voluntary program? No one is forced into anything. I guess that is what perplexes me more than anything else—why my Republican friends want to prevent something like a voluntary program—a voluntary program—from going into existence that would do this, that is fiscally sound for 75 years. I just do not get it.

So I hope we will support the Whitehouse amendment and make sure this fund is totally solvent. I think he is on the right track, that if there are savings, to put the money back in there, so maybe that $75 a day could be maybe $90 a day, or something like that, to help people.

I see, Mr. President, we now have a statement from the AARP about the CLASS program. Here is what they said. They said:

Decades of talking to our members tell us that older Americans want to live in their homes as they age. That’s why AARP strongly supports the Community Living Assistance Services and Supports (CLASS) program, which recognizes that older individuals and people with disabilities should have the right to live independently in their own homes and communities, and to receive the help they need without having to spend down to poverty.

Mr. President, I ask unanimous consent to have that statement from the AARP printed in the Record.

WASHINGTON.—AARP Executive Vice President Nancy LeaMond released this statement today in support of the Community Living Assistance Services and Supports (CLASS) program:

“Decades of talking to our members teach us that older Americans want to live in their homes as they age. That’s why AARP strongly supports the Community Living Assistance Services and Supports (CLASS) program, which recognizes that older individuals and people with disabilities should have the right to live independently in their own homes and communities, and to receive the help they need without having to spend down to poverty.

“With nearly 40 million members age 50-plus, AARP has fought to strengthen long-term services and supports. We thank the House and Senate for including the CLASS program in their health care reform bills. The voluntary CLASS insurance program will promote independence, choice, dignity and personal responsibility. It is fiscally sound and fiscally responsible. AARP believes the CLASS program has been strengthened throughout the legislative process. We look forward to working with Congress, and the Administration to enact this critical program. America’s seniors and persons with disabilities deserve nothing less.”

Mr. HARKIN. Mr. President, I am going to read a little bit in personal terms. Personal terms. I have told this story before, and I am going to tell it again because I think it indicates why we need a program such as this.

I have a nephew, Kelly; my sister’s boy. He got injured at a very young age; he was only 19 years old. It made him a paraplegic. My sister and her husband did not have any money at all. Yet Kelly was able to go to college—go to school. He was able to get a job, able to live in a house by himself. He had his own little home. He had his own van he drove that had a lift on it, and he could get his wheelchair in there and drive it to work. He actually was self-employed and employed some people. He has lived a full life. He is now a man of about 50. He has had a great life. Even with that disability, he has been able to get around and do things. He is a taxpayer. He has paid taxes. He has employed people. Every night when he goes home, he has to have a nurse come in the home and get him ready for bed and for him to do his exercises and things such as that. Then, in the morning, he has to have another nurse to get him out of bed and take care of his needs, get him ready to go. Actually, Kelly gets his own meals and stuff. Then he goes off to work and comes back. This happens every day.

How was he able to afford to do that? He did not have any money. He did not have any insurance. How was he able to afford to do that? He got injured in the military. He actually started a small business and for him to do his exercises and things such as that. Then, in the morning, he has to have another nurse to get him out of bed and take care of his needs, get him ready to go. Actually, Kelly gets his own meals and stuff. Then he goes off to work and comes back. This happens every day.

What about so many other people who got injured like my nephew Kelly who are not in the military, maybe even injured before they could go into the military? I have often thought, this is wonderful, but why should that just be for people who are in the military? What about so many other people who got injured like my nephew Kelly who are not in the military, maybe even injured before they could go into the military? He was only 19 when it happened to him. So for all these years, I have thought we should have some system in this country that would allow people like my nephew—who were not in the military but who, through an unfortunate accident, became disabled—that they could live in their own homes in their own communities with their own families, have their own friends. That is why this is so important. This is perhaps one of the most important things we have done since the passage of the Americans with Disabilities Act to make sure people with disabilities have a full, enjoyable, productive, quality life.

I hope Senators will decisively defeat the amendment that wants to strike this. Say yes, say yes to so many people with disabilities and young people today and working people today. Say yes that we are going to have a system whereby you will have the peace of mind of knowing that you want to contribute the money, you will be able to do so. Say no to the amendment that would strike that, and say yes to the Whitehouse amendment that actually supports the CLASS Act, makes sure that, yes, by putting it in a program it is reinvested in that program.

I thank the President and I yield the floor.
The PRESIDING OFFICER. The Senator from Connecticut.

Mr. DODD. Before we go to our next speaker, I wish to ask if I could request that the next half hour be equally divided; is that OK?

The PRESIDING OFFICER. The Republican deputy leader.

Mr. KYL. I had hoped to take the next half hour, but if we could do 40 minutes, equally divided, I could take 20.

Mr. DODD. Forty minutes, equally divided.

Mr. KYL. Would I be able to take the first 20 minutes then?

Mr. DODD. Yes. That would be under the same order as we had before, I would ask the Chair.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from Arizona is recognized.

Mr. KYL. Mr. President, we are discussing the Hatch motion to preserve Medicare Advantage. I wish to give a little bit of background about the Medicare Advantage Program. It was established with the goal of ensuring that all across the country would actually have Medicare choices. Under the program, private health plans receive government payments in order to serve Medicare beneficiaries. In addition to offering comparable coverage to Part A, which is for inpatient and Part B, physician services, Medicare Advantage plans can also offer Part D coverage, prescription drug benefits.

The central goal of the Medicare Advantage provisions was to ensure that beneficiaries across the Nation, not just those in populous areas, would have access to health plan options. Under the law, Medicare Advantage plans must provide all physician and hospital Medicare benefits.

Here is the key. I hope my colleagues will think about this for a moment because this has been a little bit perhaps distorted in the conversation we have had. If a plan's costs to provide all the Medicare benefits is less than the government payment, then by law, the plan must apply the difference to provide additional benefits to the beneficiary or to reduce premiums.

It seems to me that is what this whole reform was about in the first instance, to try to ensure quality care and reduce the cost of insurance to beneficiaries.

But what are these extra benefits? We have heard them discussed. They include, first of all, lower cost sharing, including out-of-pocket limits on beneficiary cost sharing, as well as specific health benefits such as vision, dental care, hearing services, routine physical, cancer screenings, and so on.

Plans can also offer management services, which can be particularly important for those with chronic illnesses, and that is a protection, by the way, that does not exist in regular fee-for-service Medicare.

Today, every beneficiary has health plan choices. Since 2003, the number of Medicare beneficiaries enrolled in private plans has nearly doubled from 5.3 million to 10.2 million in the year 2009, according to the Kaiser Family Foundation. So these are very popular plans and growing in popularity.

Let's go back in time just a little bit to consider the history, back to 1972, because in past years my colleagues on the other side of the aisle were all for Medicare Advantage. Over the years, Congress allowed plans to spend less by reducing payments to private Medicare plans. One problem was, severe payment reductions resulted in the elimination of plan options. For example, in 1997, the Balanced Budget Act reduced plan payments by $74.5 billion over 10 years. What happened? Well, about three-quarters of a million beneficiaries, from 1999 to 2003, had to change plans or else lose their health plan altogether. This included not only large and more rural areas of the country but also areas such as Long Island, NY.

Well, Congress heard from these senators loudly and clearly. They were angry about losing their coverage. Many remember the Medicare Modernization Act was a landmark achievement which provided seniors with prescription drug coverage, but it was necessary for another reason as well and that was to respond to the call of the senators who wanted their private options back.

So, in 2003, the Medicare Modernization Act expanded plan options to include regional PPOs and restore plan payments. It was a deliberate, bipartisan decision to increase the plan's payments so they could enter rural areas of the country and even some of the urban areas—as I mentioned, Long Island. If my colleagues don't remember, let me remind them.

Former Senator Clinton from New York, for example, said that these Medicare-Choice plans—that is now what we call the Medicare Advantage plans, and I am quoting:

... are feeling the squeeze in a system caught between rapidly exploding costs and rapidly imploding finances. We need to debate the future of Medicare, we need to recognize that there are people right now in our States who depend on these plans today.

The current senior Senator from Massachusetts said at the time, and I quote:

I urge my colleagues to support the additional funding that is urgently needed to strengthen the Medicare-Choice program for seniors. This should be among our highest priorities in this new Medicare debate.

It was, and we did. So this is not something bad that we provided this money to these plans. We provided it so the plans could provide the benefits to seniors, particularly in areas where otherwise they wouldn't have those choices.

So why has this all of a sudden become unpopular with our friends on the other side of the aisle? Well, obviously, first and foremost, they need trillions of dollars to fund their bill, so they look around for where they can get some money and decide: Well, we can get $120 billion from here; this is one way we can help pay for the new entitlements under the plan, or as it is called, the new benefits under Medicare. Of course, that argument presupposes that government health care is always superior to the plans offered in the private market, which these seniors have made clear, by doubling the enrollment in the private plans, not the case. As I said, they have made their preference clear.

They asked us for choices, as Members of Congress enjoy. They want access to private plans and these additional benefits, and we delivered as much as we could. We gave them choices. Republicans and Democrats alike. Now they need the money, so they decide this is a way to get some money to pay for their new entitlement.

My friends on the other side of the aisle have been talking about overpayments. There is no such thing as an overpayment in this program under the law. No money goes to the plans. It is not as if the insurance companies get the money from the government. The insurance companies know is under what the traditional Medicare bid is, have to return 25 percent of it to the U.S. Government and the other 75 percent, by law, must go to their beneficiaries, either in the form of lower premiums or additional benefits. So these aren't overpayments to the plans, as has been represented. As I said, 75 percent of the additional payments must be used to provide seniors with extra benefits, which could include lowering premiums, including chronic care management, and so on. The other 25 percent is returned to the government, so there is no overpayment.

Some on the other side argue that they are protecting guaranteed benefits. Well, this is semantics. Nobody is going after the benefits Medicare has traditionally supplied. What we are pointing out and what this amendment would prevent from happening is, the Medicare Advantage would not be cut, and there is no question—nobody can deny—that those benefits would be cut. In fact, according to the CBO, by the year 2019, they will have been cut by 64 percent, a huge—almost $360—over $30 in actuarial insurance companies. As I said, according to the Congressional Budget Office, the legislation would cut benefits from $135 a month actuarial value to $49 actuarial
value. That is a real cut. It may not sound like much to some people, but to our seniors, it is a huge hit. They are asking what happened to this promise to let them keep what they have.

There is an interesting memo by James P. Roberts II, Robert Book, and Robert Book that write for the Heritage Foundation on the Medicare Advantage cuts, and here is what they say:

Reform should mean more patient choice and health plan accountability. But these current proposals head in the wrong direction—a toward system of less choice, less accountability, and eventually lower-quality health care.

That is what the Hatch motion is attempting to prevent, to preserve these benefits for seniors.

I have gotten tons of calls, about 500 calls just in the last several days, opposing cuts to Medicare Advantage. I haven’t, by the way, received a single call from a senior citizen asking us to make these cuts. I have been reading from these letters. I have read about a dozen of these letters. Let me read a few from constituents who tell us the real effect these cuts would have on them. In my State we have about 329,000 seniors who are enrolled in Medicare Advantage plans.

One constituent from Phoenix says:

For the past month I have heard a lot about proposed Medicare cuts. Finally, after years of being unemployed and being unable to afford only high deductible insurance, I am now in Medicare and have a Medicare Advantage plan. Please tell me you are not cutting Medicare Advantage. Have a heart. Leave Medicare and Medicare Advantage alone.

We are trying.

A constituent from Peoria, AZ, says:

I oppose cuts to Medicare Advantage. I have two family members receiving health care under this program. The care has consistently been outstanding due to the efforts of our case manager in coordinating patient care between providers and patients. We have a voice in determining type and scope of our care. Please do not cut Medicare Advantage.

Here is a note from a constituent from Apache Junction:

I have heard reports that if passed, the new government health care plan would do away with or cut Medicare Advantage. If so, it would nearly double my health care costs with my current employer and being unable to afford only high deductible insurance, I am now in Medicare and have a Medicare Advantage plan. Please tell me you are not cutting Medicare Advantage. Have a heart. Leave Medicare and Medicare Advantage alone.

Here is a note from a constituent from Prescott:

I have Medicare Advantage. My husband wants to retire from his job where he has excellent health coverage for some serious health concerns. So long as he has good medical coverage, he does well. Should Medicare Advantage be cut, his health would necessarily suffer. We do not afford higher supplemental coverage. I don’t want to lose my husband. I have spent many a sleepless night wondering how to keep my husband alive. I have several friends currently undergoing chemotherapy and they are wondering if their health would be in jeopardy if Medicare Advantage is cut. Are we not worth saving? Clearly, there are many who want to spend our money on their own priorities. God bless you, sir, for advocating on our behalf.

These are real concerns from real people. They don’t want us to cut Medicare Advantage.

The final point I wish to make is one of our colleagues was saying: Well, there are bad Medicare Advantage plans and good Medicare Advantage plans. How do we know which ones are good and bad? It turns out the senior Senator from Florida devised a formula which protects a lot of folks in his State, especially in Broward County, Miami, and Palm Beach, but doesn’t protect very many other folks.

Maybe this is the definition of good versus bad. There are a few that are protected in Colorado, Maryland, Mississippi, Oklahoma, and Texas. In my State of Arizona, with a lot of retirees, very few are exempt from the cuts. This is not going to go over well—to exempt only a few in certain key areas, and none of the others.

Again, what happened to the promise that everyone gets to keep what they have?

My bottom line in supporting the Hatch amendment is that we should protect seniors and good Medicare Advantage plans. How do we know which ones are good and bad? It turns out the senior Senator from Florida devised a formula which protects a lot of folks in his State, especially in Broward County, Miami, and Palm Beach, but doesn’t protect very many other folks.

That is what the Hatch motion is attempting to prevent, to preserve these benefits for seniors.

For instance, I will read from the letter:

For nearly 5 million Medicare beneficiaries across America, Medicare Plus Choice—

That is what it was called before Medicare Advantage—

is an essential program that provides high quality, comprehensive, affordable health coverage. These seniors and disabled Americans have voluntarily chosen to receive their health coverage through Medicare HMOs and other private sector plans because they have excellent value. To preserve this important option for seniors across the country, bipartisan legislation was introduced in the Senate as S. 590, the “Medicare Plus Choice Equ- ity and Access Act.”

Et cetera, et cetera. We have plenty of history in the Senate that is bipartisan that we ought to maintain—Medicare Advantage—rather than do an injustice to it, as this legislation before the Senate is trying to do.

I ask unanimous consent to have this letter printed in the RECORD.

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

U.S. SENATE,

DEAR MEDICAID ADVOCATE,

I am writing to ask you, as a member of the Medicare conference committee, to ensure that the final Medicare bill includes a meaningful increase in Medicare+Choice funding for fiscal years 2004 and 2005. While the Senate bill makes a modest step toward this goal, we hope that the stronger provisions in the House bill will be preserved in conference.

For nearly 5 million Medicare beneficiaries across America, Medicare+Choice is an essential program that provides high quality, comprehensive, affordable health coverage. These seniors and disabled Americans have voluntarily chosen to receive their health coverage through Medicare HMOs and other private sector plans because of their excellent value. To preserve this important option for seniors across the country, bipartisan legislation was introduced in the Senate as S. 590, the “Medicare+Choice Equity and Access Act.”

Co-sponsored by Senators Schumer and Santorum, S. 590 sought to increase reimbursement rates and add new reimbursement options for Medicare+Choice plans. Although the Senate version of the Medicare bill does include a modest increase in reimbursement rates in FY 2005, we were pleased to see that the House version contains a modest comprehensive commitment to strengthening Medicare+Choice beginning in 2004.

Medicare+Choice uses private sector innovations to offer all of the traditional Medicare benefits in addition to extra benefits such as prescription drug coverage, vision benefits, and hearing aid coverage. These extra benefits are particularly important to low-income seniors who cannot afford the high out-of-pocket costs they would incur under the fee-for-service system. In many cases, this program is the only option for low-income seniors to receive comprehensive, affordable health coverage.

In recent years, despite inadequate government funding for the Medicare+Choice program has steadily reduced the health plan choices and benefits of seniors across the nation. Funding increases have actually fallen short of rising health care costs, seniors have watched the quality of their health
Medicare Advantage has continued to vantage. We are talking about seniors their health care through Medicare Advantage and receive Medicare. At this point, 11 million It is one of the choices they have under Medicare Advantage because it gives them specific symptom. We hear a lot about the failings of the health care system, and there are many ways to improve them. One of them is that care is not coordinated. People go from specialist to specialist. We need coordinated care. Medicare Advantage does a much better job at coordinating care than traditional Medicare.

It is baffling to me that the plan in front of us in the Senate today is trying to eliminate Medicare Advantage to the tune of over $100 billion. When one looks at the cuts that are in this plan—the largest private insurers cut, $135 billion for hospitals, $42 billion for home health agencies, $15 billion for nursing homes, and $8 billion for hospice providers. But it is $120 billion for Medicare Advantage—the program that provides more stable care to Medicare recipients, who want to sign up for, because it is an advantage to them to have their health care through a program which focuses on preventive care, coordinated care, and helps them stay healthy and live longer. Yet this Senate and this bill on the floor is trying to completely gut that program and deny our seniors who rely upon it from receiving the care they have earned.

Mr. GRASSLEY. Mr. President, does the Senator from Wyoming want the remainder of our 20 minutes?

Mr. BARRASSO. No.

The PRESIDING OFFICER. The Senator from Wyoming is recognized.

Mr. BARRASSO. Mr. President, to correct something I heard on the floor today, when the senior Senator from Connecticut had some concerns about this, he said how private health plans deny claims. He said Medicare doesn’t deny claims.

In the United States of America, the No. 1 denier of claims for health care is Medicare. The study that is out from a full year, from March 2007 to March 2008, Medicare rejected 475,000 claims of its 6.9 million claims filed, at the rate of 6.85 percent. When you compare that to private insurance companies, the industry average for the claims that are rejected is about 4.65 percent.

So, with a 10 times more than the largest private insurance company. A lot of these claims—I have followed this closely because I have been the medical director of something called the Wyoming Health Fairs, where people can get their blood tested at a low cost. It is a preventive or prevention-designed program. Yet Medicare refuses to pay for prevention. It refuses to pay for these blood tests because they are preventive as opposed to diagnosing a specific problem in a specific patient with a specific symptom.

What do our seniors in America do? They turn to a program called Medicare Advantage because it gives them the advantage of choosing this program. It is one of the choices they have under Medicare. At this point, 11 million Americans have chosen to participate in Medicare Advantage and receive their health care through Medicare Advantage. We are talking about seniors who are dependent on Medicare for their health care. The number of people signing up for Medicare Advantage has continued to increase, and now there are 11 million people—or one out of every four seniors—they know who they are and they like the program. The reason they like the program is because they get additional services beyond what some—some—some programs on Medicare Advantage do, such as dental care, hearing care, eye care, preventive care, and coordinated care.

Over 10 million Americans are currently in need of long-term care, and that number is expected to rise to 15 million in the next 10 years. These individuals struggle to remain independent with limited assistance, and many turn to Medicaid as an insurer of last resort. In order to qualify, however, people need to go through a stressful, time-consuming process and commit to unemployment to remain eligible. Mr. President, this is totally inefficient. Instead of ensuring that an individual can remain an independent and functional member of society, the current policy requires that to receive assistance, a person basically becomes a ward of the State. Medicaid pays for half of long-term care costs and increased expenditures to exceed $43 billion each year to Medicaid over the next decade. Not only is this unsustainable it is nonsensical.

This is as much about protecting people’s dignity as it is about fiscal responsibility. Too many times we fall on hard times, becoming disabled from an accident or illness, with no safety net to help them stay independent. Ensuring that these people have an alternative to Medicaid, so that they can remain active and independent, will reduce the Federal deficit by $73.4 billion over 10 years and save Medicaid $1.6 billion in the first 4 years benefits are available. Medicaid savings will continue to grow over time as more beneficiaries utilize CLASS Act benefits instead of Medicaid.

And thanks to amendments accepted in the Senate Health, Education, Labor, and Pensions Committee, the bill language is stronger than ever. The Senator from Wisconsin who chairs the Committee on the Budget Committee, amended the bill to require the Secretary of Health and Human Services to set premiums that are actuarially sound for a 75-year window, and maintain sustainable enrollment and benefit structure. While some proposed an increase, the CLASS Act is fiscally not sound, the Gregg amendment should put those concerns to rest.

Long-term care reform has been a cornerstone of my work in public office since my days in the Wisconsin State Senate. I have seen how important it is to give people options so that they can match the level of care and assistance to their personal needs. Pushing anyone and everyone into Medicaid, or into a nursing home, is a waste of potential, a waste of opportunity, and a waste of money. Medicaid and our Nation’s nursing homes have a critical role to play for some Americans. But for many Americans, it is simply not the right fit. The CLASS Act will ensure that taxpayer dollars are spent enrolling only those who truly need Medicaid into the program, and help others save for a time when they might need some assistance to remain independent. The CLASS Act is a critical part of this health reform bill, and I urge my colleagues to oppose any effort to weaken or strike this program from the bill.

I yield the floor.

Mr. DODD. Mr. President, the Senator from Rhode Island wants to be heard.

The PRESIDING OFFICER. The Senator from Rhode Island is recognized.

Mr. WHITEHOUSE. Mr. President, I will speak for just a moment because I know the Senator from Pennsylvania wishes to speak. When he comes to the floor, I will quickly yield to him. While there is a moment in between, I want
to speak to some of the arguments we have heard.

There is always the question of the substance of an argument. There is also the question of the credibility of an argument. I think as people watch this debate and discuss the credibility of the concern expressed by our friends on the other side of the aisle about the deficit impact of the CLASS Act, it is worth considering a few facts just to evaluate that.

First is that the CLASS Act is required to be actuarially self-sustaining. People pay into it and, from those funds, under the insurance principle, funds come back out. It is required to be self-sustaining that way.

Second, it is voluntary. Nobody has to contribute. If you want to contribute, then you can become eligible for the benefit once you have vested. But nobody is forced into this; it is entirely voluntary. The CBO, on which we rely in a nonpartisan fashion, has said for 75 years.

Finally, because we think—at least on this side—this matters. It will help the disabled and elderly at that critical point of decision, when their ability to stay home, their ability to stay independent, their ability to stay at work depends on just a little bit of help to accommodate their age or disability, it is then that this will make a difference. What a difference it will make in human lives.

I know the Senator from Connecticut wishes to use an example. I will yield to him on his signal. We have seen this before. We saw this not long ago on the public option, which would compete with insurers head to head on a fair and level playing field. It was completely voluntary, and it had to be actuarially self-sustaining. It had to meet the solvency laws of the State in which it operated. In both cases, our colleagues on the other side have rushed to the floor to talk about deficits and how these will contribute to the deficit.

These are both actuarially self-sustaining programs required to stay solvent. Yet here they come to raise the specter of deficits. But this is the same party that pays for 14 percent subsidies to private insurers to compete with Medicare. As my son would say, duh, if you are getting 14 percent extra, it is pretty easy to compete.

What was the Senator for that deal, they promised they would drive costs down. In fact, they have driven costs up, and they put it in their pockets. It is not fair to the insurers that are not in the program. It is greedy on their part. All we want to do is hold them to their promises.

Do we hear any concerns about the deficit problem on the 14-percent subsidy for the Medicare Advantage Program? No, dead silence—guess what—because it helps the insurance industry.

When the Part D program came in, our friends on the other side forced through a provision—a unique provision—that gave the pharmaceutical industry a special privilege that the U.S. Government could not negotiate with it over price—could not negotiate with it. Lord knows how much that has added to our deficit. But have they ever come to this Senate and then suddenly said, because the beneficiary is the pharmaceutical industry. But when things help regular people, when things help competition in the insurance market, even where they are required to be actuarially self-sustaining, then suddenly, when they turn up. They can detect the threat of deficit in parts per billion when it helps somebody. But a patent, actual living, breathing, deficit-enhancing subsidy that is on the books called the Medicare Advantage Program. It is greedy on their part. All they promised they would drive costs down.

Pretty easy to compete.

You are getting 14 percent extra, it is Medicare. As my son would say, duh, if you have a disability, maybe have someone help you get ready for work, whether that is getting in the shower, shaving, whatever you have to do to get ready for work in the morning—activities of daily living, things people who have disabilities take for granted. That is the first thing you have to have is that need that we can all understand.

Secondly, this person would have to pay premiums for at least 5 years before they could qualify for anything. I said "premiums." I did not say a "government subsidy." We are talking about premiums here, and this is a program that certainly has its origin in government, but this is not exactly similar to the Children’s Health Insurance Program, for example, or Medicaid, where it is a government program that helps a particular person, a person who happens to have a disability or is a child. In this case, people are paying premiums, and they have to pay those premiums for 5 years.

In addition to the need and paying premiums, the third requirement is they have to work at least 3 of those 5 years. We are talking about people who are employed, working people who happen to have a disability. This is a creative program to help them do that.

Why do we get the opposition we do from across the aisle? I think it is pretty simple. We have a lot of folks across the aisle who want to kill this bill. So they are going to try to strike the CLASS Act, which is outrageous and insulting. They are going to try to strike whatever they can, if they can, to kill the bill. So this is a bill-killing exercise. This is not at the finer points of the CLASS Act. This is a bill-killing exercise. It is very simple, and I think it will tell a lot about where people stand.

Let me go into a couple more details. I know we are already short. Here is what happens to that beneficiary—a person working, a person who has a need, and a person who has paid premiums. That beneficiary receives a lifetime cash benefit based on the degree of impairment, not just any old formula. We want this, because the benefit corresponds to someone’s impairment, their inability to do their job or live their life the way they hope
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Mr. President, I yield the floor.

Mr. DODD. Mr. President, I yield whatever time we may have remaining to Senator KIRK of Massachusetts, who has done an incredible job in very difficult circumstances— replacing our beloved former colleague Ted Kennedy from Massachusetts. He has been a valuable contribution over these days he has been here. I know he wishes to say a few words as well.

The PRESIDING OFFICER. The Senator from Massachusetts.

There is 3 minutes remaining.

Mr. KIRK. Mr. President, I thank Senator DODD and Senator BAUCUS for their tireless leadership on this entire health care bill.

If I may say a word about the CLASS Act. We have heard Senator DODD and others say this is the core element of this health reform bill championed by Senator Edward Kennedy. I say if he were here today, he would say this is not about politics; this is about the content of the character of our Nation. He believed, as I do, and I know Senator DODD does, this Nation is judged or should be judged on how we treat the infirm and the weakest among us. This CLASS Act, as was eloquently pointed out by Senator Casey of Pennsylvania, involves no taxpayer funds, is fiscally solvent, and does what everyone says we must do: provide independence, self-respect, and dignity to our society.

Second, it keeps the caregivers and the loved ones from carrying that burden all by themselves and not having to sacrifice their jobs and their time and their heartache to share their children's needs with their parents and dividing a family in that way.

This is at the heart of what our country should be about. It is not who wins—the Republicans or the Democrats. It is not a government program. It is self-funded. It is voluntary. There is no taxpayer money involved. So what other reason could there be but politics to keep people from coming together on this issue?

I urge my colleagues—all on this side and my fellow colleagues on the other side—to think about those families who are facing this plight. They are Republicans, they are Independents, and they are Democratic families as well. This is an American program for some veterans and others who have sacrificed.

I think the only thing we can do, the only right thing we can do, if this is going to be a reflection of the character of this Nation, is to support the CLASS Act.

I thank Senator DODD once again. I am proud to be standing at the desk of Senator Edward Kennedy who believed deeply in this issue, who started a long time ago and wanted to see it fulfilled this afternoon.

I yield the floor.

The PRESIDING OFFICER. The time of the majority has expired.

Mr. DODD. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

Mr. DODD. Mr. President, I am about to, on behalf of the majority leader, propose a unanimous consent request.

Mr. President, I ask unanimous consent that at 3:30 p.m. today, the Senate proceed to vote in relation to the following amendments and motion to commit, as listed in this agreement, with no other amendments, motions to commit, or any other motion except a motion to reconsider and table upon the conclusion of any vote, being in order during thependency of this agreement; further, that prior to the second and succeeding votes, there be 2 minutes of debate, with all time equally divided and controlled in the usual form; that any amendment or motion covered under this agreement be subject to an affirmative 60-vote threshold, and that if any achieve that threshold, then it be agreed to and the motion to reconsider be considered made and laid upon the table; that if it does not achieve that 60-vote threshold, then it be withdrawn; that after the first vote in this sequence, the succeeding votes be 10 minutes in duration:

A Senator WHITEHOUSE amendment re: Social Security fiscal responsibility; the Republican leader's designee amendment re: Social Security responsibility; Senator STABENOW's side-by-side amendment re: Medicare Advantage; and Senator HATCH's motion to commit re: Medicare Advantage.

Further, that once this agreement is entered, the Republican leader's designee be recognized to call up the fiscal responsibility amendment; and that once it has been reported by number, Senator STABENOW be recognized to call up the Medicare Advantage side-by-side amendment; that the composition of the amendments and the motion in this agreement, the next two matters for consideration will be a Senator LINCOLN amendment regarding insurance executive compensation, and Republican leader's motion to commit regarding home health agencies; that for the remainder of today's session, no further amendments or motions to commit be in order, with the time until then being equally divided between the leaders or their designees, with Members permitted to speak up to 10 minutes each.

The PRESIDING OFFICER. Is there objection?

Mr. MCCONNELL. Mr. President, reserving the right to object, and I will not be objecting, I see the assistant majority leader on the Senate floor. I think it would be helpful, as soon as the majority leader or someone on that side can do so, to indicate at what point during the day tomorrow and at what point during the day on Sunday we might be having additional votes. It might be helpful to our colleagues on both sides of the aisle in terms of planning for the weekend.

The PRESIDING OFFICER. The majority leader.

Mr. REID. Mr. President, I would say through the Chair to my distinguished colleagues, the senior Senator from Kentucky, that we are going to come in at 10 in the morning. At this time, it appears Senator LINCOLN will be offering an amendment, and I would hope we will be ready at that time to have whatever the minority wants to do in regard to that amendment. Then we are going to have an amendment offered by the Republicans. I would hope that we can dispose of those two amendments tomorrow in the early afternoon—maybe 2:30 or 3 o'clock start voting on them.

Mr. MCCONNELL. So am I correct in assuming that the votes are most likely going to be in the afternoon tomorrow, or both morning and afternoon?

Mr. REID. In the afternoon. I think we will need some debate in the morning.
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Mr. McCONNELL. I think we are going to need some debate time. Oh, we will have that in the afternoon.

Then on Sunday, the savings, we would not go in until noon on Sunday, and the votes will be—

Mr. REID. There is an event in Washington that a number of Senators are obligated to go to that is in the evening, but everybody out of here by 6, 6:30 that night, at the latest.

I would also say, Mr. President, through the Chair to my friend, that we Democrats are going to have a caucus—tentatively scheduled to have one Sunday afternoon.

The PRESIDING OFFICER. Is there objection to the request?

Hearing no objection, it is so ordered.

The Senate from South Dakota.

AMENDMENT NO. 279 TO AMENDMENT NO. 2786

Mr. THUNE. Mr. President, I would like to call up amendment No. 2901 and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report the amendment.

The bill clerk read as follows:

The amendment from South Dakota [Mr. THUNE] proposes an amendment numbered 2901 to amendment No. 2786.

The amendment is as follows:

(Purpose: To eliminate new entitlement programs and limit the government control over health care of American families)

Beginning on page 1925, strike line 15 and all that follows through line 15 on page 1979.

Mr. THUNE. Mr. President, I want to speak to the amendment that we just filed at the desk. This amendment is very straightforward and very simple. It does what a number of my colleagues on the other side have asked to do, and that is to strike the CLASS Act from the underlying health care reform bill that is being debated on the floor of the Senate right now.

I want to read some excerpts from a letter that seven Democratic Senators, including the chairman of the Senate Budget Committee, Senator CONRAD, put together asking that this CLASS Act not be included as part of this legislation.

Mr. President, I ask unanimous consent to have printed in the RECORD the letter from which I will be quoting.

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


Hon. Harry Reid,
Majority Leader, The Capitol, Washington, DC.

Dear Leader Reid: We write regarding the merger of the Finance and HELP Committee health reform bills. We know you face a great many difficult decisions now, one of which is whether to include provisions from the HELP Committee bill known as the CLASS Act in the merged bill.

We urge you not to include these provisions in the Senate's merged bill, nor to use the savings as an offset for other health items in the merger. While the goals of the CLASS Act are laudable—finding a way to provide long term care insurance to individuals—the effect of including this legislation in the merged Senate bill would not be fiscally responsible for several reasons.

CBO currently estimates the CLASS Act would reduce the deficit by $73 billion over ten years. But the results from the fact that the initial payout of benefits wouldn't begin until 2016 even though the program begins collecting premiums in 2011. It is also clear that the legislation increases the deficit in decades following the first ten years. CBO has confirmed that the legislation stand-alone would face a long-term deficit problem.

Some have argued that the program is actuarially sound. But this is the case because premiums are collected and placed in a trust fund, which begins earning interest, and because the HHS Secretary is instructed to increase premiums to maintain actuarial solvency. We have grave concerns that the real effect of the provisions would be to create a new federal entitlement program with large, long-term spending increases that far exceed revenues. This case if seen from the first decade of the program are spent on other health reform priorities.

Slowing the growth of health care costs should be a top priority as we move forward with health reform. Inclusion of the CLASS Act would reduce the amount of long-term cost savings that would otherwise occur in the merged bill. The act provides the health care cost curve in the wrong direction and should not be used to help pay for other health provisions that will become more expensive over time.

Thank you for your consideration. We hope that fiscally responsible measures to improve access to long-term care can be considered in the future.

Sincerely,

KENT CONRAD,
JOE LIEBERMAN,
MARY L. LANDRIEU,
EVAN BAYH,
BLANCHE L. LINCOLN,
E. BENJAMIN NELSON,
MARK R. WARNER.
U.S. Senators.

Mr. THUNE. Mr. President, the letter said:

We urge you not to include these provisions in the Senate's merged bill, nor to use the savings as an offset for other health items in the merger. While the goals of the CLASS Act are laudable—finding a way to provide long term care insurance to individuals—the effect of including this legislation in the merged Senate bill would not be fiscally responsible for several reasons.

The letter goes on to say:

[N]early all the savings result from the fact that the cost of benefits wouldn't begin until 2016 even though the program begins collecting premiums in 2011. It is also clear that the legislation increases the deficit in decades following the first 10 years.

They go on to say in this letter, Mr. President:

We have grave concerns that the real effect of the provisions would be to create a new Federal entitlement program with large, long-term spending increases that far exceed revenues. This is especially the case if savings from the first decade of the program are spent on other priorities.

That, Mr. President, is a letter that was signed by the chairman of the Senate Budget Committee, Senator CONRAD of North Dakota, Senator LIEBERMAN, Senator LANDRIEU, Senator LINCOLN, Senator WARNER, Senator NELSON, and Senator BAYH. Seven Democratic Senators have gone on the record saying the CLASS Act shouldn't be included in this legislation because it is not fiscally responsible.

The fact is, the chairman of the Senate Budget Committee, Senator CONRAD, has described this as a Ponzi scheme of the first order—something the administration and Senator Moynihan Madoff is good at.

Now, I have heard my colleagues get up and talk about how solvent this is and what a great program this is. Well, there are programs out there that are available for people to buy long-term care insurance. The problem with this one is that it takes all the money that comes in in the early years and spends it on other government programs—in this case health care reform—but who knows what other government programs are going to be going to do? They will use the revenues that come in from this plan that supposedly a lot of people are going to sign up for, and CBO says it is going to be fewer than 4 percent that will sign up.

In fact, no senior today is going to benefit from it because you have to work for 5 years. If you are a senior who is retired, you will not see any benefit. This doesn't impact seniors, contrary to the assertions of some of my colleagues on the other side. It will impact future generations of Americans who are going to be stuck with the deficits and the debt that gets piled on them because of the outyears when this liability is incurred as people start getting paid out, from having paid in, and there is no money there. It is the classic definition of a Ponzi scheme: The money comes in today, it gets spent on other things, and then someday, when the liability comes in and people start saying: I paid into this program, and I should get some benefit, there will be no money there. So we will borrow for it or tax for it or something else.

But, well, it is actuarially solvent over 75 years. Well, maybe, because you are running surpluses in the early years. But in the later years, you are running huge deficits. In the early years the surpluses are being spent. They are not being put into paying benefits for this program, when those benefits start being demanded by the people who have participated in the program.

Just look at what others have said about this program, Mr. President. I have quoted for you what the chairman of the Budget Committee, Senator CONRAD, said with regard to this program; that it is a Ponzi scheme of the first order, and that it is not fiscally responsible. But this is what the administration's chief health actuary said about the CLASS Act. He said it would result "in a net Federal cost in the longer-term. The chief actuary also described the program as "a significant risk of failure" because the high cost will attract sicker people and lead to low participation.
The Congressional Budget Office agreed, saying:

The CLASS program included in the bill would generate net receipts for the program in the initial years when total premiums would exceed benefit payments, but it would eventually lead to net outlays when benefits exceed premiums. . . . In the decade following 2029, the CLASS program would begin to increase budget deficits.

This particular quote could come as a bit of a surprise because this comes not from the CBO or the CMS actuary, but it comes from the Washington Post. The Washington Post called the CLASS Act a “gimmick” and not “savings” that health care is fully paid for.” The Post goes on to say:

[The money that flows in during the 10-year budget window will flow back out again. These are not “savings” that can honestly be counted on the balance sheet of reform.]

Even the Washington Post recognizes this for what it is. It is a sham. This is a budget gimmick. Mr. President, that is designed to obscure the cost of the program’s future liabilities in the early years. It is supposed to generate $72 billion in the first 10-year window, so that counts on the balance sheet of health care reform to make it look better. But this program is going to run deficits far for the foreseeable future. We can see—once the chickens come home to roost. Who will pay the bill for that? Future generations of Americans.

Mr. President, this is not good policy. Certainly, if you look at programs we already have like the Medicare system, health care is destined to be bankrupt in the year 2017. We have big problems down the road—unfunded liabilities in Social Security. This would create a huge new liability down the road that would be unfunded because all the money that comes in during the early years is going to be spent. This is more of the same old business as usual in Washington, DC, that the American people are fed up with. We can make people happier by making sure we are creating this new program that makes the majority’s health care reform bill look better because it obscures the real cost of this bill by rolling in these revenues in the early years. But there is a long-term impact, according to the CBO, according to the actuary at Health and Human Services, and according to a lot of our colleagues on the other side—the seven Democrats who signed the letter, including the chairman of the Budget Committee. Mr. Coburn, I said, has called this program a Ponzi scheme of the first order; something that would make Bernie Madoff proud.

I don’t know how my colleagues on the other side, with a straight face, can come to the Senate floor and say this is a great program, that it is actuarially sound. Sure, it may be a benefit to a few people, but I have to tell you, somewhere down the road, when the chickens come home to roost, there is going to be a huge liability that is going to future generations of Americans, as we start to pile up more deficits and more debt as a result of this Ponzi scheme.

This is a sham. Mr. President. I hope my colleagues will support this amendment. It would strike the CLASS Act from the underlying bill, not allow those revenues to be assumed in paying for or understating the cost of this bill, and not pile mountains of debt onto future generations.

Mr. President, I reserve the remainder of my time.

Mr. KYL. Mr. President, the Community Living Assistance and Services and Support Act, known as the CLASS act, is a new, government-run, government-funded program for long-term care, intended to compete with long-term care plans provided by private insurers.

One of the oft-repeated arguments we have heard in favor of the CLASS act is that it would reduce budget deficits between 2010–2019.

First, when has a government program ever reduced budget deficits? Second, the Congressional Budget Office tells us that this program will actually add to future Federal budget deficits. The CBO writes: “The program would add to future Federal budget deficits in large and growing fashion.”

Why would it do this?

The program offers returns that payments made into the system cannot cover—just like a Ponzi scheme, as Senator Conrad said. Participants would have to pay into the system for five years but not electing benefits. Under the Senate proposal, only active workers could enroll in the program. So this would not be a program that would not benefit seniors or the currently disabled. So, if a worker began making payments in 2011, he or she could not collect benefits until 2016. So, for a time, the program would generate surplus receipts for the government while Americans are paying in and not collecting benefits. But eventually, we will reach a point when payments made into this program cannot sustain promised benefits.

As the CBO tells us, the program would “lead to net outlays when benefits exceed premiums.” (By the third decade of program operation—2008–2098—CBO assumes that CLASS begins to generate net increases in Federal outlays. The net increase in Federal outlays is estimated to be “on the order of tens of billions of dollars for each (succeeding) ten-year period.”)

Second, the Congressional Budget Office in its most recent Federal Budget outlook estimates that premiums be set to ensure the program’s solvency over 75 years. The solvency requirement counts interest income paid to the program’s trust fund as available to pay future benefits. However, CBO notes that those interest payments are an intra-governmental transfer within the Federal budget. Thus, CBO notes that from a budget scorekeeping perspective, the CLASS program would inevitably add to future deficits (on a cash basis) by more than it reduces deficits in the near term, even though the premiums would be set to ensure solvency of the program.

The administration’s chief health actuary said the CLASS Act would result in “a net federal cost in the longer term.”

Bottom line, this program is not sustainable outside the 10-year window. That is why the Washington Post called it, “a gimmick . . . designed to pretend that healthcare is fully paid for.”

The Post goes on:

Money that flows in during the 10-year budget window will flow back out again. This means that they will not be counted on the balance sheet of reform.

Mr. DODD. Mr. President, how much time remains?

Mr. President, I reserve the remainder of my time.

Mr. KYL. Mr. President, the Community Living Assistance and Services and Support Act, known as the CLASS act, is a new, government-run, government-funded program for long-term care, intended to compete with long-term care plans provided by private insurers.

Mr. DODD. Mr. President, I rise today to ask unanimous consent to be added as a cosponsor to the amendment of Senator Coburn, amendment No. 2789, to require all Members of Congress to enroll in the public option. I am pleased to cosponsor this amendment because I strongly support the public option and I will have no qualms at all enrolling in this plan.

There is a lot of misinformation about the public option, so I want to be clear about why we need a public option and why I would be proud to enroll in a public health insurance plan.

We need a public option because health insurance premiums for Minnesota residents have risen 90 percent since 2000 and because 444,000 Minnesotans went without health insurance in 2008. We need a public option because while millions of Americans struggle to pay for health care, insurance executives continue to make bloated, obscene salaries. From 2000 to 2007, Americans continue to make bloated, obscene salaries. From 2000 to 2007, American families saw their premiums almost double. During that same time, we saw more than 6 million more Americans become uninsured. During that same period, insurance companies’ profits rose 428 percent—428 percent in 8 years. They are making outrageous profits by gouging American families.

That is why we need a public option.

The public option will offer affordable premiums and a comprehensive benefits package for Americans struggling with their health care costs. It is good public policy because it provides affordable health care to all Americans. That is why we need a public option.

The public option will offer affordable premiums and a comprehensive benefits package for Americans struggling with their health care costs. It is good public policy because it provides affordable health care to all Americans.
It is important to remember that a public option doesn’t mean private health insurance goes away. In fact, after health reform, 188 million Americans will have coverage through a private insurer. Only 2 percent of the overall insured population is projected to enroll in the public option. This is just another option you will have. It is an option because that is what the bill is about.

Mr. BROWN. Will the Senator from Minnesota yield?

Mr. FRANKEN. Absolutely.

Mr. BROWN. I know my colleague joined with Senator DODD, Senator MIKULSKI, and me to push this amendment that Members of the House and Senate actually go on the public option, partly to show we believe in it. It is a little curious that two of the sponsors, at least, Senator COBURN and Senator VITTER and some others, are so much against the public option that they want to pass this amendment. It sounds to the Senate like they are seri-

ous about going on it, as I am, correct?

Mr. FRANKEN. I talked to my wife Franni. We have been married 34 years now. I talked to her a couple of weeks ago. I said if this passes, we should do the public option. She said, absolutely. Yes, I am perfectly serious about this.

The PRESIDING OFFICER (Mr. REED). The Senator from Minnesota has consumed 4 minutes allotted by the Senator from Connecticut.

Mr. DODD. Mr. President, I yield 4 minutes to the Senator from Utah, Mr. HATCH.

Mr. HATCH. The Senator from Utah is recognized.

Mr. HATCH. The legislation passed by the Senate Finance Committee this fall. But those protec-

tions primarily apply to Medicare Ad-

vantage beneficiaries in Florida, Oregon, and New York—beneficiaries liv-

ing in other parts of the country. Rural areas will not be protected.

So let’s be clear when we say Medi-

care Advantage beneficiaries’ benefits will not be cut. These extra benefits in-

clude lower premiums, deductibles, and copayments, dental coverage, and hearing aids, to name only a few.

Bottom line: Most Medicare Advantage beneficiaries may not keep what they have, contrary to the President’s promise to them.

The PRESIDING OFFICER. Who yields time?

Mr. DODD. The Senator has 4 minutes to the Senator from Michigan.

The PRESIDING OFFICER. The Senator from Michigan is recognized for 4 minutes.

Ms. STABENOW. Mr. President, I have an amendment that will be sent to the desk pursuant to the unanimous consent agreement. I now call up my amendment No. 2899.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

Amendment No. 2899 to Amendment No. 2786

Ms. STABENOW. Amendment No. 2899 in the name of Senator Kennedy proposes an amendment number 2899 to amendment No. 2786.

Ms. STABENOW. I ask unanimous consent that the reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To ensure that there is no reduc-

tion or elimination of any benefits guaran-

teed by law to participants in Medicare Ad-

vantage plans.

At the appropriate place, insert the fol-

lowing:

SEC. 2. NO CUTS IN GUARANTEED BENEFITS.

Nothing in this Act shall result in the re-

duction or elimination of any benefits guaran-

teed by law to participants in Medicare Ad-

vantage plans.

Ms. STABENOW. Mr. President, this is a very important amendment to

Oregon. This is not about Medicare Ad-

vantage insurance companies, this is about preserving the choice of coverage for seniors.

The PRESIDING OFFICER. The Senator from Utah has used 5 minutes.

Mr. HATCH. I ask for another 2 minutes.

Mr. DODD. How much time remains for both sides?

The PRESIDING OFFICER. The Senator from Iowa controls 4 minutes 46 seconds; the Senator from Connecticut, 4 minutes 42 seconds.

Mr. DODD. The Senator has 4 minutes.

Mr. HATCH. He also said that under the Reid bill, Medicare Advantage beneficiaries will be able to keep what they have due to the Nelson grandfathering amendment passed by the Senate Finance Committee this fall. But those protec-

tions primarily apply to Medicare Ad-

vantage beneficiaries in Florida, Oregon, and New York—beneficiaries liv-

ing in other parts of the country. Rural areas will not be protected.

So let’s be clear when we say Medi-

care Advantage beneficiaries’ benefits will not be cut. These extra benefits in-

clude lower premiums, deductibles, and copayments, dental coverage, and hearing aids, to name only a few.

Bottom line: Most Medicare Advantage beneficiaries may not keep what they have, contrary to the President’s promise to them.

The PRESIDING OFFICER. Who yields time?

Mr. DODD. Mr. President, I yield 4 minutes to the Senator from Michigan.

The PRESIDING OFFICER. The Senator from Michigan is recognized for 4 minutes.

Mr. DODD. The Senator has 4 minutes to the Senator from Utah.

Mr. DODD. Mr. President, I yield 4 minutes to the Senator from Utah.

Mr. HATCH. The Senator from Utah is recognized.

Mr. HATCH. The legislation passed by the Senate Finance Committee this fall. But those protec-

tions primarily apply to Medicare Ad-

vantage beneficiaries in Florida, Oregon, and New York—beneficiaries liv-

ing in other parts of the country. Rural areas will not be protected.

So let’s be clear when we say Medi-

care Advantage beneficiaries’ benefits will not be cut. These extra benefits in-

clude lower premiums, deductibles, and copayments, dental coverage, and hearing aids, to name only a few.

Bottom line: Most Medicare Advantage beneficiaries may not keep what they have, contrary to the President’s promise to them.

The PRESIDING OFFICER. Who yields time?

Mr. DODD. The Senator has 4 minutes to the Senator from Michigan.

The PRESIDING OFFICER. The Senator from Michigan is recognized for 4 minutes.

Amendment No. 2899 to Amendment No. 2786

Ms. STABENOW. Mr. President, I have an amendment that will be sent to the desk pursuant to the unanimous consent agreement. I now call up my amendment No. 2899.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Michigan [Ms. STABENOW] proposes an amendment num-

bered 2899 to amendment No. 2786.

Ms. STABENOW. I ask unanimous consent that the reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To ensure that there is no reduc-

tion or elimination of any benefits guaran-

teed by law to participants in Medicare Ad-

vantage plans.

At the appropriate place, insert the fol-

lowing:

SEC. 2. NO CUTS IN GUARANTEED BENEFITS.

Nothing in this Act shall result in the re-

duction or elimination of any benefits guaran-

teed by law to participants in Medicare Ad-

vantage plans.

Ms. STABENOW. Mr. President, this is a very important amendment to
clarify, once again, that we are not cutting any Medicare benefits. We are not cutting any of the guaranteed Medicare benefits people receive right now. In fact, AARP, which has been saying this on its Web site for months, has not received a letter now. It quotes this sentence:

Most importantly, the legislation does not reduce any guaranteed Medicare benefits.

Not only AARP but the Association for the Protection of Medicare and Social Security, the Alliance for Retired Americans, and other seniors organizations all agree.

What we are talking about is saving Medicare, cutting down on overpayments that have been in place. Right now, 80 to 85 percent of the seniors who get their benefits, their health care, through traditional Medicare are paying more in premiums, according to the Congressional Budget Office, than they otherwise would, because MedPAC estimates we are paying about $12 billion more for people in the private for-profit insurance system right now that is called Medicare Advantage. The majority of seniors are subsidizing high insurance company profits and overpayments. We have done in this bill is take out the overpayments and, in fact, put in competitive bidding. I thought that was something we could all agree to.

What are we needing in the effort, unfortunately, of my friends on the other side of the aisle supported—competitive bidding for reimbursement so we are not continuing the overpayments in Medicare Advantage that are causing Medicare to go broke much sooner and causing the majority of seniors to subsidize high insurance company profits.

What are we seeing on the effort, unfortunately, of my friends on the other side of the aisle is an effort to support huge subsidies instead of supporting competitive bidding that is in the bill. The reality is that the guaranteed benefits—long-term care, doctor visits, lab tests, preventive screenings, skilled nursing facilities, hospice care, home health care, prescription drugs, ambulance services, durable medical equipment, inpatient hospital care, kidney dialysis, outpatient mental health care, occupational and physical therapy, imaging such as x-ray, EKGs, organ transplants, and the ‘‘Welcome to Medicare’’ physical are all covered, as they have been, for all Medicare beneficiaries.

What we are doing is taking overpayments to for-profit insurance companies and putting that back into increased benefits for every senior. That is cutting prescription drug costs by closing the doughnut hole and strengthening preventive care. And the most important piece of all: lengthening the solvency of the Medicare trust fund.

I urge the adoption of my amendment at the appropriate time.

The PRESIDING OFFICER. Who yields time?

Mr. GRASSLEY. Mr. President, I yield 3 minutes to the Senator from Florida.

The PRESIDING OFFICER. The Senator from Florida.

Mr. LeMIEUX. Mr. President, I have been reviewing the amendment of the Senator from Michigan. This is very important to the people of Florida because it deals with Medicare Advantage. Medicare Advantage is a very important program that just some extra frills. It is the idea that our folks in Florida can get eye care, dental care, hearing care, diabetic supplies, preventive medicine. Last week I went down to a Medicare Advantage clinic in Miami, the Leon Center. This is a Medicare Advantage clinic that provides holistic health care. The intention of this amendment is to guarantee the benefits in Medicare Advantage, but I am not sure it is phrased that way. I have been reading the bill. I have been reading Title XVIII of the Social Security Act. I cannot find the phrase ‘‘guaranteed benefit.’’ I ask unanimous consent that the ‘‘guaranteed by law’’ phrase in this amendment offered by my colleague from Michigan be eliminated so that we would ensure that benefits of eye care, hearing care, diabetic supplies, all the other things that are provided in Medicare Advantage, are actually preserved. No one is objecting to lower costs. No one is objecting to a competitive situation where we have companies providing more services for less cost. We want to make sure the services are still there.

I ask unanimous consent to have that phrase ‘‘guaranteed by law’’ be eliminated from the amendment.

The PRESIDING OFFICER. Is there objection?

Ms. STABENOW. Reserving the right to object, I ask that my colleague work with me. We will be happy to talk about how we might address what he is concerned about. Unfortunately, the reality is, the for-profit companies are objecting to competitive bidding. The language my colleague has suggested would include items that have been offered to the in people in for-profit plans. We have health care, and other things that have been of great concern.

Given that, I would have to object.

The PRESIDING OFFICER. Objection is heard.

The time of the Senator from Florida has expired.

Mr. HARKIN. Mr. President, I yield 3 minutes to the Senator from Ohio.

The PRESIDING OFFICER. The Senator from Ohio.

Mr. BROWN. Mr. President, I have watched from my office on C-SPAN and been on this floor countless times in the last 3 or 4 days as my friends on the other side continue to do the bidding of the insurance companies. I hear them talk every Medicare beneficiary. That is important we guarantee Medicare services, as we will. We quit subsidizing insurance companies, as we should. And then that $90 tax every Medicare beneficiary has to pay, that $90 that goes to insurance subsidies, will be taken away so Medicare fee-for-service, regular Medicare members, which is 81, 82, 83 percent of Medicare beneficiaries, won’t be paying that insurance company Republican tax they have had to pay ever since Medicare Advantage subsidies to insurance companies were increased.

We need to get this bill moving. The stalling and delays should be over.

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. HARKIN. Parliamentary inquiry: How much time remains?

The PRESIDING OFFICER. The Senator from Iowa controls 6 minutes 45 seconds, and the Senator from Iowa controls 2 minutes 24 seconds.

Mr. GRASSLEY. I yield 1 minute to the Senator from Tennessee.

The PRESIDING OFFICER. The Senator from Tennessee.

Mr. CORKER. Mr. President, it was interesting to hear my friend from Ohio. I plan to support the Hatch amendment regarding Medicare Advantage, but it is not because I don’t believe we need to do some things to cause Medicare to be more solvent. I do believe that Medicare Advantage does have some subsidies to insurance companies that are higher than they should be. The fact is, this bill is taking money from a program that is insolvent, Medicare, and using that to support the Hatch amendment, even though I would love to work with my friends on the other side of the aisle to do those things that are provided in Medicare Advantage, but I am not sure it is phrased that way. I have been reading the bill. I have been reading Title XVIII of the Social Security Act. I cannot find the phrase ‘‘guaranteed benefit.’’ I ask unanimous consent that the ‘‘guaranteed by law’’ phrase in this amendment offered by my colleague from Michigan be eliminated so that we would ensure that benefits of eye care, hearing care, diabetic supplies, all the other things that are provided in Medicare Advantage, are actually preserved. No one is objecting to lower costs. No one is objecting to a competitive situation where we have companies providing more services for less cost. We want to make sure the services are still there.

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The time of the Senator from Florida has expired.

Mr. HARKIN. Mr. President, I yield 3 minutes to the Senator from Ohio.

The PRESIDING OFFICER. The Senator from Ohio.

Mr. BROWN. Mr. President, I have watched from my office on C-SPAN and been on this floor countless times in the last 3 or 4 days as my friends on the other side continue to do the bidding of the insurance companies. I hear them talk every Medicare beneficiary. That is important we guarantee Medicare services, as we will. We quit subsidizing insurance companies, as we should. And then that $90 tax every Medicare beneficiary has to pay, that $90 that goes to insurance subsidies, will be taken away so Medicare fee-for-service, regular Medicare members, which is 81, 82, 83 percent of Medicare beneficiaries, won’t be paying that insurance company Republican tax they have had to pay ever since Medicare Advantage subsidies to insurance companies were increased.

We need to get this bill moving. The stalling and delays should be over.

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. HARKIN. Parliamentary inquiry: How much time remains?

The PRESIDING OFFICER. The Senator from Iowa controls 6 minutes 45 seconds, and the Senator from Iowa controls 2 minutes 24 seconds.

Mr. GRASSLEY. I yield 1 minute to the Senator from Tennessee.

The PRESIDING OFFICER. The Senator from Tennessee.

Mr. CORKER. Mr. President, it was interesting to hear my friend from Ohio. I plan to support the Hatch amendment regarding Medicare Advantage, but it is not because I don’t believe we need to do some things to cause Medicare to be more solvent. I do believe that Medicare Advantage does have some subsidies to insurance companies that are higher than they should be. The fact is, this bill is taking money from a program that is insolvent, Medicare, and using that to support the Hatch amendment, even though I would love to work with my friends on the other side of the aisle to do those things that are provided in Medicare Advantage, but I am not sure it is phrased that way. I have been reading the bill. I have been reading Title XVIII of the Social Security Act. I cannot find the phrase ‘‘guaranteed benefit.’’ I ask unanimous consent that the ‘‘guaranteed by law’’ phrase in this amendment offered by my colleague from Michigan be eliminated so that we would ensure that benefits of eye care, hearing care, diabetic supplies, all the other things that are provided in Medicare Advantage, are actually preserved. No one is objecting to lower costs. No one is objecting to a competitive situation where we have companies providing more services for less cost. We want to make sure the services are still there.

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Ms. STABENOW. Reserving the right to object, I ask that my colleague work with me. We will be happy to talk about how we might address what he is concerned about. Unfortunately, the reality is, the for-profit companies are objecting to competitive bidding. The language my colleague has suggested would include items that have been offered to the in people in for-profit plans. We have health care, and other things that have been of great concern.

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Mr. BROWN. Mr. President, I have watched from my office on C-SPAN and been on this floor countless times in the last 3 or 4 days as my friends on the other side continue to do the bidding of the insurance companies. I hear them talk every Medicare beneficiary. That is important we guarantee Medicare services, as we will. We quit subsidizing insurance companies, as we should. And then that $90 tax every Medicare beneficiary has to pay, that $90 that goes to insurance subsidies, will be taken away so Medicare fee-for-service, regular Medicare members, which is 81, 82, 83 percent of Medicare beneficiaries, won’t be paying that insurance company Republican tax they have had to pay ever since Medicare Advantage subsidies to insurance companies were increased.

We need to get this bill moving. The stalling and delays should be over.
things, to make Medicare more solv-ent, but I think what is so objection-able to all of us is to know that we have an insolvent Medicare Program that the trustees have said will be bankrupt in the year 2017, and my friends from the other side of the aisle are taking money from that program to leverage a new entitlement.

The PRESIDING OFFICER. The time of the Senate has expired.

Who yields time?

Mr. HARKIN. I yield 2 minutes to the Senator from Illinois.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Mr. President, this is a basic choice. Will we continue to sub-sidize private health insurance compa-nies that are overcharging the Medi-care Program by 14 percent? Will we take that money out of Medicare to continue the subsidy for profitable pri-vate health insurance companies? It is that basic issue.

Mr. HARKIN. I yield 2 minutes to the Senator from Oregon.

Mr. CASEY. Mr. President, I understand the Senator from Pennsylvania, Mr. CASSEY, filed an amendment designed to spend $2.5 billion to protect Medicare Advantage, as the private insur-ance industry promised. We are doing no more than holding them to their word.

The PRESIDING OFFICER. Who yields time?

Mr. GRASSLEY. I yield the balance of my time to the Senator from Texas.

Mrs. HUTCHISON. I yield 30 seconds to Senator MCCAIN.

The PRESIDING OFFICER. The Sen-ator from Arizona.

Mr. MCCAIN. Mr. President, I under-stand every citizen has a right to an op-tion that is voluntary, not mandatory. No one is forcing them to have support. It is voluntary. It is not entitlement.

Mrs. HUTCHISON. Mr. President, toSenator GREGG offered an amendment to insist that it be actuarially sound over 75 years, and it is actuarially sound over 75 years.

Secretary Sebelius said the adminis-tration supports it. President Obama supports it. There is broad-based sup-port for the CLASS Act.

Today we received some letters from people around the country. I don’t have time to read them all but just a couple. Here is one from Arkansas:

My wife has a journalism degree, cerebral palsy and brings money to the state of Ar-kansas with her stay at home job with occa-sional travel. If her health worsens she could still earn money for the state under the CLASS Act working from home with the as-sistance from an attendant, (rather than having to go to a nursing home.)

Here is Virginia:

I don’t currently need the services under the CLASS Act, but having been born with a disability I’ve always been acutely aware of the importance of self-sufficiency on the road. . . . it would be a good thing for me, a thirty-year-old working person, (to be able to put some money away.) I beg my colleagues, for the sake of people with disabilities, let’s not adopt the amendment of the Republicans to take away the CLASS Act. It was Sen-ator Kennedy’s premier goal.

Mr. GRASSLEY. Mr. President, I take a back seat to no one on issues associated with improving the lives of seniors and the disabled.

As ranking member on the Aging Committee, I oversaw critical hearings in deep and perhaps record in our Nation’s nursing homes. I was the principal author of the Medicare Part D prescription drug bill which is cur-rently providing our seniors and people with disabilities with affordable pre-scription medications.

On the disability front, one of my proudest achievements is the enact-ment of legislation I sponsored along with the late Senator Ted Kennedy, the Family Opportunity Act, which ex-tends Medicaid coverage to disabled children.

In large part, through my efforts, the Money Follows the Person Rebalancing Act in this bill. I have spoken many times about that, that it is a bipartisan issue. It is like when we passed the Americans with Disabilities Act. It was a bipartisan issue. This should not be a partisan issue too. We should not let politics get involved. Over 275 groups representing people with disabilities of all ages, from AARP to Paralyzed Vet-erans of America to the Interfaith Coa-lition, support the CLASS Act. It was unanimously adopted by the HELP Committee, unanimously adopted by the House Democrats. Senator GREGG offered an amendment to insist that it be actuarially sound over 75 years, and it is actuarially sound over 75 years.

In large part, through my efforts, the Money Follows the Person Rebalancing
Act, and the option for States to implement a home- and community-based services program were included in the Deficit Reduction Act of 2005.

Along with Senator KERRY, I have introduced the Empowered At Home Act which, among other things, revises the income eligibility level for home- and community-based services for elderly and disabled individuals.

If I thought that the CLASS Act would add to this list of improvements to the lives of seniors or the disabled, I would run first in line as a proud co-sponsor of the CLASS Act.

But the CLASS Act does not strengthen the safety net for seniors and the disabled.

The CLASS Act compounds the long-term entitlement spending problems we already have by creating yet another new, unsustainable entitlement program.

The CLASS Act is just simply not viable in its current form.

It is almost certain to attract the people who are most likely to need it—this is known as adverse selection.

That will cause premiums to increase and healthier people to drop out of the program.

It is the classic “insurance death spiral.”

On November 13, the administration’s own Chief Actuary confirmed this. The Chief Actuary issued a dire warning in a report to the CLASS Act in the House bill which was virtually identical to the Senate version.

The Chief Actuary said:

There is a significant risk the program would make the CLASS Act unsustainable.

The CLASS Act has been characterized by the Washington Post editorial page as a “gimmick.”

For the first 10 years, the CLASS Act saves money at the beginning because it collects premiums before benefits start and then pays out.

But sometime afterwards, it starts to lose money.

We all know what happens from there. It will become the taxpayers’ responsibility to rescue the program as it fails.


Now go home and look at your children and grandchildren.

You’ve been protecting the premiums of a program that you know will fail is irresponsible.

Creating the unsustainable CLASS Act is irresponsible.

Adding the ticking timebomb of yet another unfunded liability to our children and grandchildren through the CLASS Act is irresponsible.

The responsible vote is to strike the CLASS Act from the bill; I urge my colleagues to support this amendment.

Mr. President, I ask unanimous consent to have an article from the Record in the Senate two items. First is an article from Fortune magazine on the CLASS Act. Second is a letter signed by seven of my Demo-
Slowing the growth of health care costs should be a top priority as we move forward with health reform. Inclusion of the CLASS Act would reduce the amount of long-term cost savings that would otherwise occur in the merged bill. The CLASS Act bends the health care cost curve in the wrong direction and should not be used to help pay for other health programs that will become more expensive over time and increase deficits.

Thank you for your consideration. We hope that fiscally responsible measures to improve access to long-term care can be considered in the future.

Sincerely,

KENT CONRAD, JOE LIEBERMAN, MARY LANDRIEU, EVAN BAYH, BLANCHE L. LINCOLN, E. BENJAMIN NELSON, MARK R. WARNER.

U.S. Senators

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

All time has expired.

Under the previous order, the question is on agreeing to amendment No. 2870, offered by the Senator from Rhode Island, Mr. WHITEHOUSE.

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

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

The result was announced—yeas 98, nays 0, as follows:

<table>
<thead>
<tr>
<th>Yeas</th>
<th>Nays</th>
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</thead>
<tbody>
<tr>
<td>98</td>
<td>0</td>
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</tbody>
</table>

The motion to lay on the table was agreed to.

AMENDMENT NO. 296

The PRESIDING OFFICER. Under the previous order, the question is on agreeing to amendment No. 2901 offered by the Senator from South Dakota, Mr. THUNE.

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

The PRESIDING OFFICER. The yeas and nays have been requested. Is there a sufficient second? There appears to be a sufficient second.

The clerk will call the roll.

The bill clerk called the roll.

The assistant legislative clerk called the roll.

Mr. DURBIN. I announce that the Senator from West Virginia (Mr. BYRD) is necessarily absent.

Mr. KYL. The following Senator is necessarily absent: the Senator from Kentucky (Mr. BUNNING).

Further, if present and voting, the Senator from Kentucky (Mr. BUNNING) would have voted “yea.”

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

The result was announced—yeas 98, nays 0, as follows:

<table>
<thead>
<tr>
<th>Yeas</th>
<th>Nays</th>
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<tbody>
<tr>
<td>98</td>
<td>0</td>
</tr>
</tbody>
</table>

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. On this vote the yeas are 98, the nays are 0.

Under the previous order requiring 60 votes for the adoption of this amendment, the amendment is agreed to.

Mrs. HUTCHISON. Mr. President, parliamentary inquiry: Are the next 3 votes 10-minute votes?

The PRESIDING OFFICER. The Senator from Texas is correct. The next 3 votes are 10-minute votes.

Mrs. HUTCHISON. Thank you, Mr. President.

Mr. LAUTENBERG. Mr. President, I move to reconsider the vote.

Mr. INOUYE. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. Under the previous order, the question is on agreeing to amendment No. 2901 offered by the Senator from South Dakota, Mr. THUNE.

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

The PRESIDING OFFICER. The yeas and nays have been requested. Is there a sufficient second? There appears to be a sufficient second.

The clerk will call the roll.

The bill clerk called the roll.

Mr. DURBIN. I announce that the Senator from West Virginia (Mr. BYRD) is necessarily absent.

Mr. KYL. The following Senator is necessarily absent: the Senator from Kentucky (Mr. BUNNING).

Further, if present and voting, the Senator from Kentucky (Mr. BUNNING) would have voted “yea.”

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

The result was announced—yeas 51, nays 47, as follows:

<table>
<thead>
<tr>
<th>Yeas</th>
<th>Nays</th>
</tr>
</thead>
<tbody>
<tr>
<td>51</td>
<td>47</td>
</tr>
</tbody>
</table>

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. On this vote the yeas are 51, the nays are 47.

Under the previous order requiring 60 votes for the adoption of amendment No. 2901, the amendment is withdrawn.

Mr. DODD. Mr. President, I move to reconsider the vote and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. On this vote, the yeas are 51, the nays are 47. Under the previous order requiring 60 votes for the adoption of amendment No. 2901, the amendment is withdrawn.

Mr. DODD. Mr. President, I move to reconsider the vote and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. On this vote, the yeas are 51, the nays are 47. Under the previous order requiring 60 votes for the adoption of amendment No. 2901, the amendment is withdrawn.

Mr. DODD. Mr. President, I move to reconsider the vote and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. On this vote, the yeas are 51, the nays are 47. Under the previous order requiring 60 votes for the adoption of amendment No. 2901, the amendment is withdrawn.
The PRESIDING OFFICER. There will now be 2 minutes of debate, equally divided, on the Stabenow amendment.

Who yields time?

The Senator from Michigan is recognized.

Ms. STABENOW. Mr. President, this amendment is very clear. My amendment states that nothing in this act shall result in the reduction or elimination of any benefits guaranteed by law to participants in Medicare Advantage plans.

Right now, CBO tells us, and we understand from MedPAC that there is $12 billion in overpayments to for-profit insurance companies, which are additional costs that the Medicare recipients pay beyond what is traditional Medicare.

Eighty-five percent of our seniors in Medicare are in traditional Medicare and, right now, we are told that every single citizen or person with disability in Medicare pays $90 extra; every couple pays $90 extra to pay for the overpayments to private for-profit insurance companies.

As AARP has said, this legislation does not reduce any guaranteed Medicare benefits. We are asking for competitive bidding—for-profit company competitive bidding—to bring down the payments. I ask for support for the amendment.

The PRESIDING OFFICER. The Senator from Florida is recognized.

Mr. LeMIEUX. Mr. President, regarding this amendment, I had a conversation with my colleague from Michigan. The phrasing "guaranteed by law doesn't guarantee anything." This isn't going to protect the benefits of Medicare Advantage. The benefits our senior citizens enjoy, such as eye care, hearing care, dental care, are not protected by this. You can vote for it if you want to. It sounds good, but it is gift wrapping an empty box.

The PRESIDING OFFICER. Under the previous order, the question is on agreeing to amendment No. 2899, offered by the Senator from Michigan, Ms. STABENOW.

Ms. STABENOW. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. The question is on agreeing to the motion. Mr. BOND, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second? There is a sufficient second. The clerk will call the roll.

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

The PRESIDING OFFICER. The question is on agreeing to the motion. Mr. BOND, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second? There is a sufficient second. The clerk will call the roll.

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

The PRESIDING OFFICER. The question is on agreeing to the motion. Mr. BOND, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second? There is a sufficient second. The clerk will call the roll.

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

The PRESIDING OFFICER. The question is on agreeing to the motion. Mr. BOND, I ask for the yeas and nays.

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The PRESIDING OFFICER. The question is on agreeing to the motion. Mr. BOND, I ask for the yeas and nays.
The PRESIDING OFFICER. On this vote the yeas are 41, the nays are 57. Under the previous order requiring 60 votes for the adoption of this motion, the motion to commit by Mr. HATCH is withdrawn.

Mr. BAUCUS. Mr. President, I move to reconsider the vote.

Mr. UDALL of New Mexico. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, the Senator from Arkansas is to be recognized for an amendment.

AMENDMENT NO. 2865 TO AMENDMENT NO. 2786

Mrs. LINCOLN. Mr. President, I call up amendment No. 2865.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Arkansas (Mrs. LINCOLN), for herself, Mr. LUTENBERG, Mr. MENENDEZ, Mr. FRANKEN, Mrs. BOXER, and Mr. REED proposes an amendment numbered 2865 to amendment No. 2786.

Mrs. LINCOLN. I ask unanimous consent the reading of the amendment be dispensed with.

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

The amendment is as follows:

(a) DOLLAR LIMIT NOT TO EXCEED COMPENSATION OF THE PRESIDENT.

(b) IN GENERAL.—Paragraph (6) of section 162(m) of the Internal Revenue Code of 1986, as added by subsection (a), is amended by adding at the end the following new subparagraph:

"(1) DOLLAR LIMIT NOT TO EXCEED COMPENSATION OF THE PRESIDENT.—In the case of a taxable year in which the $500,000 amount in clauses (i) and (ii) of subparagraph (A) exceeds the dollar amount of the compensation received by the President under section 102 of title 3, United States Code, for such taxable year, such clauses shall be applied by substituting the dollar amount provided in such section for the $500,000 amount.

(2) REVENUE INCREASE TO BE TRANSFERRED TO MEDICARE TRUST FUND.—Section 1817(a) of the Social Security Act (42 U.S.C. 1395(a)) is amended—

(A) by striking "and" at the end of paragraph (1),

(B) by striking the period at the end of paragraph (2) and inserting "; and", and

(C) by inserting after paragraph (2) the following new paragraph:

"(4) disregarding the application of the section 162(m)(8) of the Internal Revenue Code of 1986, as determined by the Secretary of the Treasury or such Secretary's delegate.''

Mrs. LINCOLN. I yield the floor.

The PRESIDING OFFICER. The Senator from Nebraska is recognized.

Mr. JOHANNS. I have a motion at the desk.

The PRESIDING OFFICER. The clerk will report the motion.

The legislative clerk read as follows:

MOTION TO COMMIT

The Senator from Nebraska (Mr. JOHANNS) moves to commit H.R. 3590 to the Committee on Finance with instructions to report the same back to the Senate with changes that do not include cuts in payments to home health agencies totaling negative $42.1 billion.

Mr. JOHANNS. Mr. President, I rise to speak in favor of the motion that was just read. The things that I think is so very important about a debate on the Senate floor is we begin to understand what this legislation does to real people. We have come to understand that $466 billion in Medicare cuts that are shown over my left shoulder have real consequences to real people all across the United States. These cuts compromise care, they compromise access to services that real people need in their daily lives. Robbing these funds from Medicare to create a dramatic new entitlement program, in my judgment, is not sound policy and it is not sound government.

That is especially true in this case when the impact on seniors’ health care is so profound. These cuts will reduce the quality of care many Americans are receiving today and reduce the care these Americans deserve.

I have to tell you, out of all these Medicare cuts, one of the largest head-scratching cuts is the one to home health. The Senate bill cuts $42.1 billion for home health care. Home health is about 3.7 percent of the Medicare budget. It is an important program. Yet 9.1 percent of the Medicare cuts in the Senate bill are taken out of home health care benefits, a Medicare benefit.

What kind of conditions do people who utilize home health agencies suffer from? I will turn to my own State to answer that question. In Nebraska, one of our agencies is in rural Cherry County. Cherry County is a very large county in western Nebraska—in fact, larger than some States. Who gets served in Cherry County? A gentleman with class III congestive heart failure. He is awaiting a heart transplant. A gentleman who lost his leg from complications from diabetes, they get home health care services. These folks are not striving to bilk the system. These folks are not some exceptional that that require the Medicare-approved home health agencies existed in 2007. I am very pleased to report to you that 74 of those are in my home State of Nebraska. Nurses, therapists, home care aides, and others who serve elderly and disabled patients in their own homes drive nearly 5 billion miles a year to provide these much needed services. They care for about 12 million real people annually, with $28 million visits, each one providing that personal touch of care.
Does it seem like an enormous step backwards when we talk about reform, when really what we are doing is cutting a program that serves people so much in need and yet saves money in the Medicare Program? Home health agencies in Nebraska have been very successful in doing exactly what we want—keeping people at home and out of the hospitals and nursing homes. Of special interest are patients with congestive heart failure. One Nebraska woman turned to home health after facing a big stack of hospital bills for rehab. Since then, she has been able to remain at home safely at a fraction of the cost. This home health agency can see a person for 60 days at a cost of about $2,500. One hospital admission, by comparison, would cost Medicare conservatively $20,000 to treat a patient with chronic heart failure. Again, home health care costs a fraction of hospital care, about 10 times less.

There are many stories from patients who are alive today who love home health care. This bill threatens them. Somewhere in the next hours, I am going to send to every Member of the Senate, all of my colleagues, a State report analysis of what the cuts will do in their States because they need to know the impact. This bill threatens to take that all away. You can’t cut $42 billion and just describe it as excess payments. You can’t cut $42 billion and say: That is just fixing the kind of damage I have described. I will make sure every Member sees the place where we want to go? We are taking out a bigger and bigger chunk of the average worker’s paycheck. These costs are breaking the backs of regular people just can’t afford. It is not going in the right direction. If we don’t act, costs will continue to skyrocket. The country spent $2.4 trillion on health care last year alone. The United States is going in the red by 2017. Wages have not kept pace with the increase in premiums. The country spent $2.4 trillion on health care last year alone. The United States is going in the red by 2017. Wages have not kept pace with the increase in premiums. That is $1 out of every $6 spent in the economy. By 2018, national health care spending is expected to reach $4.4 trillion, over 20 percent of our entire economy. Despite spending 1½ times more per person on health care than any other country, many of our people don’t even have health care coverage. Many of them are losing their coverage because of preexisting conditions or because it simply is costing too much. These costs are breaking the backs of our families and businesses. We can see here, single coverage, 1999, $2,196. Now at 2008, the last figures we have available, $4,704, a doubling. Family cost, 1999, $5,791—that is the average family’s premium—now they are paying $12,380.

Look what is happening to small businesses. A study by the Council of Economic Advisers found that small businesses pay up to 18 percent more than large businesses to provide health care coverage. In a recent national survey, nearly three in five small businesses that did not offer benefits cited high premiums as the reason.

Look at it this way: Inflation usually raises the cost of most goods and services between 2 to 3 percent per year. Health care premium costs have been going up close to 8 percent a year. That is an increase Americans can’t afford. Wages have not kept pace with the increase in premiums.

Look at this: Between 1999 and 2007, the average American worker saw his wages increase 29 percent. Obviously, the last few years it has not been that rosy. How much did his insurance premiums go up? One hundred twenty percent during the same time period. In other words, the health care premiums are taking out a bigger and bigger chunk of the average worker’s paycheck. These costs are breaking the backs of the American taxpayer.

I can give you a human story that just happened yesterday in our agency. We had a referral from a patient that lives 90 miles away. The drive time is three hours. To do the administration takes 1½ to 2 hours. Then you come back to the office and you do at least 20 pages of paperwork. It would take one person’s entire day to serve one patient. Regrettably, we had to say no. We just could not see her. There is no other agency close enough to serve her.

Can you imagine? We have a person who desperately needed these services, and we are debating whether we should cut $412 billion out of this program that will impact a State such as mine to the tune of $120 million? These agencies and the services they provide absolutely are reliant on Medicare.

According to the National Association of Home Care and Hospice:

Medicare is the largest single payer of home health care. When we cut the payments in a program like this, we cut access to care. These access concerns are rooted in real life experiences. Between 1998 and 2000, Medicare home health spending fell from $14 billion to $9.2 billion or a negative 34 percent of congressional action between 1998 and 2000. Those actions triggered the closure of 40 percent of home health agencies and reduced access for 1.5 million Medicare beneficiaries. Access becomes a real issue. If there is no home health agency, homebound patients end up with more expensive care at hospitals and nursing homes. That costs Medicare money. But, you see, we are also cutting hospitals and nursing homes in this bill.

If there is no home health provider near an area, not only are Medicare beneficiaries hurt but all citizens who need care. Any analysis is going to come to the same conclusion.

I will quote from one:

Studies from MedPAC and the Government Accountability Office also suggest that access is a growing problem for patients who require intensive services. In June 2003, MedPAC issued a report indicating that skilled nursing facilities care is now substituting for home health care for some patients, most likely at a much higher cost for Medicare.

I don’t think these are transformational reforms. These cuts are not transformational reform. They are just plain cuts, to start a new entitlement that will hurt real people, senior citizens who need our help. That is why I am offering this motion to commit this legislation back to the Finance Committee to strike these ill-advised home health care cuts. I will follow up. I will make sure every Member sees the impact of these cuts in their State so they can make an assessment if these cuts should be put in place and cause the kind of damage I have described this evening.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana, Mr. Baucus, is recognized for 10 minutes.

Mr. BAUCUS. Mr. President, I rise to speak about a true health care reform. The way I look at this in my State, it is a matter of affordability and cost. We have one of the highest percentages of people covered in the country in Minnesota. The issue is, it is becoming more and more expensive for the people to afford health care. I always try to remember three simple numbers of all the ones we will hear in the next few weeks. Those are the numbers 6, 12, and 24. Ten years ago it cost $6,000 for an average family to pay for health care a year. Now it is $12,000, with a lot of people paying a lot more. Ten years from now, if we don’t do anything, it will be somewhere between $18,000 and $36,000. Something regular people just can’t afford. It is not going in the right direction.

If we don’t act, costs will continue to skyrocket. The country spent $2.4 trillion on health care last year alone. That is a number that is going in the red by 2017. How do we do this? How do we get to the place where we want to go? We
must get our money’s worth from our health care dollars. The problem now is, we are paying too much and we are not getting a good return on what we pay. The solution must be to get the best value for our health care dollars; otherwise, we are going to see the need to wreak havoc on the backs of govern-

ment, businesses, and individual families.

Medicare is 57 percent of all Federal health spending. If we want to sustain Medicare, which we all do, to provide that high-quality health care our seniors deserve, we must do something to address the fiscal challenges.

The root of the problem is that most health care is purchased on a fee-for-service basis, so more tests, more surgery means more money. Quantity, not quality pays. According to researchers at Dartmouth Medical School, nearly $700 billion per year is wasted on unnecessary or ineffective care.

My favorite example is what Gelseal, a Clinic in Pennsylvania. They were not happy with their diabe-
tes treatment, so they decided we are going to have the routine patients see nurses. The more difficult cases will see doctors. Then those endocrinologists will review the records of the nurses and make sure this patient is progressing as we want. Guess what. Patient quality goes way up because they see nurses and they see them more regularly. Results go way up because endocrinologists are spending time on the most difficult cases and reviewing records of the other. Costs go down $200 per month per patient. Guess what. They get paid less—way, way, way less for that kind of good quality care.

This system is messed up, and we need to change it so we are rewarding based on results. We put the patient in the driver’s seat so that when that patient gets better results, then we re-
ward. In Minnesota, we have several great examples of this co-
ordinated outcome system.

At a place such as the Mayo Clinic, Park Nicollet, St. Mary’s in Duluth, the priority is value not volume. As this chart shows, if the spending per patient with chronic diseases everywhere in the country mirrored the efficient level of spending in the Mayo Clinic’s home region of Rochester, MN—this is Mayo Clinic quality health care.

For the last 4 years of chronically ill patients’ lives, if we used that same system all over the country, how much would we save, if we used this system in Texas, if we used this system in Florida? We would save $50 billion every 5 years for the taxpayers of this country and get higher quality care.

This is not like a hotel right now in this country where if you pay more money, you get a better room with a better view. No! The opposite is true. In the country, the States where you pay more money, you get less quality care. That is what we need to change to bring all of the States up to that high-quality care, efficient care, that costs less but is a better value. That is what we need to do.

How do we do it? Well, linking rewards to the outcomes for an entire payment area creates the incentive for providers to work together to improve quality and ef-

ficiency; using bundling, to bill, so you look at the whole outcome of everyone working together, so you rely on nurses when you want to rely on nurses, so you rely on doctors when you have difficulty; by reduc-
ing hospital readmissions. Who wants to go back in the hospital over and over again just because there are a bunch of infections hanging around? In fact, right now, if you go back to the hospital, the hospital gets rewarded for that. So we want to put in place proto-

cols that make hospitals safer places to treat patients. In 1 year, hospital read-

missions cost Medicare $17.4 billion, and a 2007 report by MedPAC found that Medicare paid an average of $7.200 per readmission that was likely pre-

ventable. We need to have integrated care, where you have a primary care provider, working with a team, instead of having 15 specialists running around the field running over each other. You need a quarterback, well, let’s just say Brett Favre and the Minnesota Vi-
kings. You have one quarterback who is your primary care doctor, who is in charge, with a team of doctors who look at all the medical records. That is integrated care, that is what we should be rewarding. That is what this bill does.

Looking at some of the other ineffi-
ciencies, the Presiding Officer has been a leader on Medicare fraud. Think about the money we can save. Medicare fraud alone costs taxpayers more than $60 billion every year. Instead of that money going to our seniors, do you know where that money is going? It is going to con men, people who are making up that they are providing services when they are not. The Pre-
siding Officer and I have a bill we are working together on to bring that down so that money can actually go to our seniors instead of going out to a bunch of people who are ripping off the system, ripping off our seniors.

If you look at how you save money, if you look at how you reduce costs in Medicare, well, you reduce costs in Medicare by making changes to this system and making this work. We must look to the future. That is why health care reform this year is so crucial. This bill is not about today or even next year; it is about 5 years from now. It is about 10 years from now, and beyond. We cannot afford for the people of this country to hold off any longer. We can bring these costs down. We can bring the quality up. And we can reward the people of this country for the money they are putting into care.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Sen-
ator from South Carolina.
what this is going to do: to cut from Medicare, what it is going to eventually do to benefits, cut Medicare Advantage. Now we are talking about cutting home health, which is so important, particularly in rural communities and for the more elderly constituents we serve.

There is no way you could take this money out of Medicare without hurting the programs. Instead, as we look ahead at more people retiring than ever in history and Medicare being bankrolled to be long-term sustainable ways that we can shore up this program so it will be there for generations to come.

Every Republican voted no. Every Republican in this Senate has stood with the American people and said no to a health care bill that takes over the most personal and private part of our lives. I am proud of our party and our leadership.

Americans have been asking to see the differences between the Republican and the Democratic Parties. I think now more than ever on this issue they are going to see the Democrats standing with government-controlled health care, cuts in Medicare, increased taxes and on the other side Republicans who are going to stay here through Christmas and New Year’s or whatever it takes to stop this bill and to sit down and really reform this system in a way that will lower costs and improve care to all Americans.

We need to continue to talk about these bigger issues, particularly how it affects Medicare, and we will be doing that over the weekend. But I think we owe it to the American people to begin to open this bill and explain what is in it. I can almost guarantee you, there is not one Member of the Senate who has read it yet. We are going to try to fit this in Santa’s sleigh this year so it will be delivered to every American.

I have the first part here—1,000 pages, small print, front and back—and have gone through it, putting tabs on different pages, so we can talk about the different things because sometimes they sound so extraordinary, people do not really believe they are in there. I am not sure we will ever get through the whole thing, but I just want to take a couple parts tonight and just start talking about what is really in this bill.

On page 17, in section 2713 that is titled “Coverage Of Preventive Health Services,” which is really our jargon for rationing, it says:

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall provide coverage for evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force.

We are rejecting this task force a few weeks ago. This may sound harmless enough, as you look at it, but let’s see what the really means: “evidence-based . . . ‘A’ or ‘B.’” What is not A or B?

Well, just 2 weeks ago, we found out something that was not A or B. Mammograms are a C rating. And the task force came out and said it should not be covered on anyone under 50 years old because it is not A or B. Because of the outcry, we had an amendment from the other side to give themselves a little bit of cover on that one medical procedure, mammograms. We passed it with some fanfare yesterday, but the fact is, there are going to be many C ratings that are not covered.

What are we going to do here in Congress over the next several years when we find constituents are not covered for things they need in retirement from Medicare? Are we going to pass bills to try to cover those individual things? What we should really do is throw out the bill that is causing the problem. We should not be rationing care to our seniors.

Let’s look at another page. And I know this is not as interesting as talking about theoretical stuff. But on page 33, section 2719 is called the “Appeals Process”:

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process . . . (to) provide notice to enrollees, in a culturally and linguistically appropriate manner . . .

Now, what do we think that means? Well, in fact, in 2001—this term has been used before—the Department of Health and Human Services reported that the Department had spent $10 million to figure out what that phrase means. And we still do not know. It says: “Health care services that are respectful of and responsive to cultural and linguistic needs.” But what this really means to us, according to the 2000 census, is there are at least 20 languages spoken by at least 200,000 Americans in this country, and what we are putting out there is a liability for every insurance company that does not have every aspect of their plan in those 20 languages. It may sound like a simple thing, but every page of this bill, almost—as you read it, you realize it is increasing the complexity and the cost of the system here in America.

I will just cover one more of these because I hear my colleagues in the background asking. But I do think we owe it to the American people to begin to talk about what is really in this bill.

On page 39, it says, under a funding category:

Out of all funds in the Treasury not otherwise appropriated, there are appropriated to...

The Congressional Budget Office has already told us are going to be increases. But this kind of spending and this type of bureaucracy and complexity we are creating is not going to make health care more accessible and more affordable for Americans. It is creating a complex bureaucracy with tens of thousands of workers and bureaucrats to tell doctors what to do and hospitals what to do and for us, how to manage our health care.

The Congressional Budget Office has already released a report finding that the purchasing of insurance through the health insurance exchanges that are in this bill could pay up to 16 percent more for health care than we do today. Yet we are moving ahead with the bill.

I will continue throughout this weekend, and every time I get a chance to speak, to talk about more of these things that are in this bill. But, folks, this is not a bill we should deliver to the American people for Christmas this year. This is a bill that we should throw out so we can start over and have a step-by-step approach to make health insurance more affordable and available to every American.

With that, Mr. President, I yield back.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I think we are going to go back and forth here. Mr. ROBERTS. There is no “forth.” Mr. BAUCUS. Sorry. Mr. ROBERTS. There is no “forth.” Mr. Chairman.

Mr. BAUCUS. Well, we are going to go back and forth. Here is Senator KAUFMAN.

Mr. ROBERTS. We could go back and back, sir—I do not care—and then forth and forth.

Mr. BAUCUS. Back and forth, and forth and forth, and to and fro, and this and that and it works fine for me.

The PRESIDING OFFICER (Ms. KLOBUCHAR). The Senator from Delaware is recognized.

Mr. KAUFMAN. Madam President, I ask unanimous consent to speak in morning business for up to 5 minutes.

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

(The remarks of Mr. KAUFMAN are printed in Today’s RECORD under “Morning Business.”)

The PRESIDING OFFICER. The Senator from Kansas is recognized.

Mr. ROBERTS. Madam President, I rise today in support of the motion of my good friend from Nebraska, my colleague from Nebraska, Senator JOHNSON to—official words say: to commit the bill back to the Senate Finance Committee with instructions to strike the cuts to the Medicare home health care benefit.

What the distinguished Senator is trying to do is bring some common sense to the cuts to a very vital source of health care, not just in rural areas but all over this country, and that is home health care. The bill we are considering, the bill sometimes called the
The Senator from Nebraska says that it is a head-scratcher, and it certainly is. It is more than a head scratcher; it is a Lizzi Borden amputation in regard to the Medicare Advantage Program. It is more than a head-scratcher, and it certainly is. It is a head-scratcher, and it certainly is.

Home health care is critical for our seniors. Obviously, that is the truth. As the cochair of the Senate Rural Health Care Caucus, I certainly understand that. So does the Senator from Nebraska. He was saying yesterday how many times he visits his rural hospitals, rural clinics, rural hospices, and you do that a lot if you are from Nebraska or Iowa or Texas or Kansas. At any rate, in my home State of Kansas and other rural areas, many seniors live alone or out in the country miles away from a local hospital or a doctor's office. Even if they have a very good doctor, they can't get there because of their health condition. So home health care allows those seniors the freedom and the independence to stay in their home in the comfort of knowing somebody is there assisting their health care needs. More importantly, home health care is the cost-effective care, as the Senator from Nebraska has pointed out, that keeps seniors in their home instead of being taken out of a nursing home or hospital and—guess what—saves the government money. Over the long term, if you cut home health care, you are going to increase the cost in regard to nursing homes and questions about it.

In my State I have had the pleasure of being able to see firsthand, as has the Senator from Nebraska, the great work our Kansas Home Health Care Association members do every day. Last year I was invited into the home of a lovely couple in Concordia, KS, America, not too far from Nebraska, and despite having multiple health issues, Duane and Phyllis were able to stay in their home with their little dog Josie. I tell you what. You come to their house and you make that argument that if you close down or make cuts to home health care, you don't have to like it, Phyllis is not going to like it, and Josie will bite you on your leg.

As I said, many of my Kansas home health care agencies are already operating at negative margins. Their project share of these cuts, as provided by the distinguished Senator from Nebraska, is almost $240 million. To the Senator from Montana, the distinguished chairman of the Finance Committee, my dear friend, that is $60 million in inpatient dollars, but where the distinguished majority leader lives, the chart that has been provided to me by the Senator, $263 million.

We have Senator CORNYN sitting right behind me here. Senator CORNYN, do you have a question for Texas. I might ask the Senator, What is going to happen if you get cut $6.8 billion in regard to home health care service?

Mr. CORNYN. If the Senator will yield for a response, $6.8 billion would cut not just into the muscle but into the bone and deny a lot of elderly people, particularly in rural areas, access to care entirely.

Mr. ROBERTS. I thank the Senator. The Senator from Nebraska has already pointed out what happens in Nebraska, and I know what will happen in Kansas. Nearly two-thirds of Kansas home health care agencies will have negative margins within only 5 years, probably 2 or 3, if these cuts are allowed to occur. How are these agencies supposed to stay in business with these kinds of cuts? The home health care benefit will be worthless to a Kansas Medicare patient whose home health care agencies will go out of business. So, yes, in fact, this bill will effectively cut benefits. Again, get rid of the smokescreen.

This doesn't apply just to the home health care benefit. The same can be said for the cuts that come in the Medicare Advantage program. As demonstrated by the Senator from Nebraska, for reimbursements to hospitals. This bill is going to cost the Kansas Hospital Association $1.5 billion. They have some outside experts who came in. I asked them: What is going to be the effect of the cuts? They already have cuts. They only get reimbursed 70 percent now, and $1.5 billion on top of that. We ought to have a chart—and I am sure we will have a chart—that would show Iowa or Nebraska, or Texas especially, because of the number of folks there. So hospitals, hospices, skilled nursing facilities, and all of the rest.

I want every senior to know that while maybe it is technically accurate, again, for my friends across the aisle to claim this bill doesn't cut Medicare benefits, there is no way—no way—you can slash $5 trillion from payments to providers without affecting their ability to keep their door open, especially in rural and small town America. Seniors should know they will be left with a worthless benefit. To paraphrase my friend Senator ALEXANDER from Tennessee, it would be like having a bus ticket without a bus.

Thank you, Senator JOHANNS. Thank you for the work you are doing. Thank you for this motion. I hope we are successful. I hope people will wake up and understand the severity of what these cuts will do. I urge every Member of this Senate to support Senator JOHANNS when we come to a vote on this issue.

Thank you, Mr. President. I yield the floor.

The PRESIDING OFFICER (Mr. KAUFMAN). The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, I have heard a lot here today about how this is going to hurt seniors and so on and so forth, words such as "smokescreen." The fact is there is no smokescreen here whatsoever. This is a very well thought-out, considered policy that I think strikes a very good balance between getting care to especially seniors at home, which is so important on the one hand, and making sure there is not waste on the other hand. That is our responsibility here, to make sure the program works and works well.

I have sort of a special interest in this. My mother was in the hospital. It happened about 2 weeks ago. She fortunately is doing much better. She is out of the hospital. She has spent some time with a home health caregiver with whom I was very, very impressed. This home health person is doing a great job with my mother. I have seen other instances too, but personally I was very, very happy to see my mother getting very good care from a home health care nurse.

I think it is also important to remind my colleagues that this amendment is generally a retreat on the McCain amendment we debated over the last few days. That is, once again, the opponents of this bill are endorsing the status quo that leaves Medicare on the brink of going bankrupt and seniors facing higher costs.

Let me remind my colleagues against what will happen if we stick with the status quo. The status quo, meaning no bill, which the other side is advocating, means Medicare will go broke in 8 years. As I said for the effect of the cuts, as demonstrated by the Senator from Nebraska, for reimbursements to hospitals, this bill is going to cost the Kansas Hospital Association $1.5 billion. They have some outside experts who came in. I asked them: What is going to be the effect of the cuts? They already have cuts. They only get reimbursed 70 percent now, and $1.5 billion on top of that. We ought to have a chart—and I am sure we will have a chart—that would show Iowa or Nebraska, or Texas especially, because of the number of folks there. So hospitals, hospices, skilled nursing facilities, and all of the rest.

I want every senior to know that while maybe it is technically accurate, again, for my friends across the aisle to claim this bill doesn't cut Medicare benefits, there is no way—no way—you can slash $5 trillion from payments to providers without affecting their ability to keep their door open, especially in rural and small town America. Seniors should know they will be left with a worthless benefit. To paraphrase my friend Senator ALEXANDER from Tennessee, it would be like having a bus ticket without a bus.
waste. I am quite surprised not all of our colleagues want to cut out the waste. In effect, they want to keep the waste that, unfortunately, is in our system.

The status quo also means each year billions of Medicare dollars will continue to be wasted on lining the pockets of private insurance companies. That might be a bit of a strong statement, but the fact is, some chief executives of private insurance companies are paying tens of millions of dollars to manage Medicare Programs, especially Medicare Advantage, and the status quo means that will continue.

The status quo also means seniors will continue struggling to pay for prescription drugs. The stakes for seniors in the Medicare Program have never been higher.

We have a choice. It is a very simple choice: either endorse the status quo or struggle. I would like people not to be institutionalized. It is much more appropriate to have care in the home, and home health care agencies provide that.

In Montana, home health care providers go the extra mile—literally—to provide care to patients across vast distances. In some cases, in rural areas they have to drive 100 miles just to see one patient. They are dedicated people. They go great distances and travel a long way to see very few patients.

Home health providers make a real difference in improving seniors’ health, and we should support their efforts. We all very much support their efforts. We should support their efforts. We all very much support their efforts. We should support their efforts. We all very much support their efforts.

I think the policies in the Senate bill achieve both goals. First, the Senate bill would “rebase” home health payments to ensure payments reflect actual costs of providing care. These changes are based on recommendations by MedPAC, which is the independent advisory commission that advises Congress on Medicare reimbursement. It is a nonpartisan group. MedPAC advises that we rebase. What do we mean by “rebase”?

When the current home health payments were set, seniors received an average of 31 visits per episode. Today, they receive 22 visits; that is, they get paid about the same for doing less. We are trying to make sure the payment reflects what they deserve. The Senate bill directs CMS to rebase payments to reflect this change. It is common sense. MedPAC recommended it and thinks it has to keep up with the times. Times have changed over the years, and the payment system should reflect that change.

There is something else I think is pretty important, and most of my colleagues would agree, the Senate bill addresses another problem: too many, especially in home health care as well as in other areas of Medicare spending. It tries to root out the fraud in Medicare payments for outlier cases.

Medicare provides an extra payment today for providers—home health folks—who treat sicker people, otherwise known as outlier patients—really sick, outliers. Unfortunately, the GAO found that some providers were gaming the system and getting much more outlier payments than they deserved.

For example, the GAO found that in one Florida county alone, home health providers were receiving 60 percent of all total outlier payments. That is nationwide. One county was getting 60 percent, even though they had less than 1 percent of the total Medicare population. I don’t want to just single out Florida. Other counties in the southern part of the country clearly have an inappropriate amount of high outlier payments.

The Senate addresses this problem by placing a cap on the amount any individual provider can receive in outlier payments.

Another change is the bill makes “market basket” changes in 2011 and 2012. That was recommended by MedPAC. Why is that important? MedPAC is actually much tougher. On the market basket and productivity changes, the Senate bill holds off on applying these reductions while the rebasing policy is taking effect.

This bill gives home health agencies extra time—much more time than is recommended by the very aggressive proposed changes by MedPAC, the House bill, and the administration. We say those are too aggressive. We in the Senate decided to give agencies extra time to adapt to the payment changes in the bill rather than having all these reductions implemented at the same time as MedPAC and the House and the administration all recommended.

Finally, with respect to rural home health providers, we are all very sensitive to the special needs of rural America. What did we do about that? From 2010 to 2015, rural providers will receive a 3-percent extra payment each year. This payment will ensure that rural providers are protected as we reform the home health system.

In total, the home health changes in the Senate bill have the right balance between ensuring seniors have access to home care, while also rooting out inappropriate payments from the system.

I hear some of my good friends say: Gee, these changes are going to hurt seniors. They are not going to hurt them. In fact, most of the changes are suggested by the home health care industry. I think all of us want to root out fraud and waste. Also, it is claimed that Medicare beneficiaries will be harmed by this bill. This is a scare tactic.

Let me say what the American Association of Retired Persons says about these claims that these changes in Medicare reimbursement are going to harm seniors.

AARP says:

Opponents of the health reform won’t rest. [They are] using myths and misinformation to distort the truth and wrongly suggesting the Medicare will be harmed. After a lifetime of hard work, don’t seniors deserve better?
That is AARP. I don’t suggest tonight that any of our colleagues are using myths and misinformation to distort the truth. The point is, AARP claims that is not true. They support the bill strongly.

I will remind my colleagues of some of the positive changes in the legislation. This legislation improves the solvency of the Medicare Program by 5 years. It puts $30 billion back into the pockets of seniors in the form of lower Medicare premiums. It makes prescription drugs more affordable, which is an added benefit in this bill that would not be available if the legislation is not passed. The bill guarantees that seniors can continue to see a doctor of their choosing. The bill provides free wellness and prevention benefits. Those are new benefits. They don’t currently exist. It will also include fair and appropriate changes for home health that protect access to care.

I don’t question the motives of my colleagues. They believe they are standing up for seniors in opposing the home health changes. But in truth they will harm them because they are hurting the care providers. I don’t think we want to hurt the Medicare Program. We are trying to help the Medicare Program by making these changes.

There is one other point I want to make. This is kind of interesting. I thought when I saw it—if I still have it—it is kind of interesting. The growth rate in home health care spending will continue to be very high after this legislation passes. Currently, the growth rate of the home health care industry is almost 11 percent per year. After the legislation, it will be almost an 8-percent annual growth in the home health care industry. That is much faster than the national health expenditures.

I think most things in life are a judgment call. I think one fairly decides that the changes in this bill are good for seniors and home health care providers are sensitive to the needs of the industry, sensitive to patients, frankly, but also responsible to the American taxpayers by making sure we are rooting out waste.

The PRESIDING OFFICER. The Senator from Texas is recognized.

Mr. CORNYN. Mr. President, I think as the American people are listening to the debate we are having on health care reform, they are being asked to accept some pretty implausible claims. One claim is that we can take $½ trillion out of Medicare and it would not have any impact on the delivery of services to Medicare beneficiaries—$½ trillion.

I think the biggest mistake about the way this bill is paid for, with the huge tax increases and huge cuts in Medicare, is the proposal to take $½ trillion out of Medicare, including $40 billion out of home health care, in order to pay for a brand new entitlement program, when we already know Medicare itself is on a fiscally unsustainable path.

I want to talk primarily about another aspect of these cuts, and that is the 11 million seniors, including 532,000 Texans, who will lose benefits under their Medicare Advantage Program because these are not inconsequential cuts. These are serious. I want to talk about some real human beings, some real Texans, who are going to be affected in a negative way by these cuts.

First of all, I think it is absolutely critical for every American to understand that Medicare itself does not provide complete coverage to seniors. That is why so many seniors end up buying supplemental insurance coverage—Medigap coverage, as it is sometimes called—in order to get their bills paid for. Medicare only pays, on average, about 80 percent to providers of what private health insurance does.

That is the reason, without additional compensation, many doctors will not see a Medicare patient. They simply cannot do it and keep their doors open to their other patients.

The truth is, Medicare Advantage was created to fix some of the flaws within Medicare fee for service to give seniors more affordable and better coordinated health care. None of us are standing up saying the proposed bill is all bad because some of the positive developments in the bill call for greater coordination of health care.

On balance, it makes things worse than it does better because of these cuts in things such as Medicare Advantage.

The President of the United States has said providing Americans with a choice of quality, affordable health care was a guiding principle for him. I agree with that statement of principle. Medicare Advantage was created for that very purpose because, as I said, Medicare itself does not always work well for patients.

Where I live in Austin, TX, which is Travis County, the last time I saw a report, only 17 percent of physicians will accept Medicare fee for service because the Medicare reimbursement rates are so low. Those problems are avoided in large part by Medicare Advantage because it pays physicians and providers better than Medicare fee for service.

According to the American Medical Association’s 2008 national health insurance report card, Medicare—not private health insurance—but Medicare had the highest percentage and the largest number of denied medical claims. In fact, Medicare denied 10 times more medical claims than private health insurers. That is another reason why seniors deserve a choice between Medicare and private plans that will offer half of the additional benefits. As I mentioned, today, 11 million Americans made that choice of better benefits and better care coordination through the Medicare Advantage Program. The proposed bill, the Reid bill, will take away those choices and the benefits of those 11 million seniors by cutting about $120 billion from the program.

Many of our friends across the aisle will say we can cut $120 billion out of Medicare Advantage, and it will have no impact on delivery of services. But the Director of the Congressional Budget Office disagrees with them, who says their additional benefits will be cut roughly in half.

We need to set the record straight on these so-called overpayments allegedly going to insurance company profits. It is simply a false statement. It is not true. Our colleagues know the so-called overpayments to Medicare Advantage plans do not go into those plans. They go to seniors in the form of additional benefits. That is because, under Federal law, 75 percent of additional payments to Medicare Advantage plans are used to provide seniors with additional benefits—benefits which they would not get under Medicare fee for service, benefits such as chronic care management, hearing aids, eyeglasses, and the like. The other 25 percent of any extra payments is returned to the Federal Government.

Let’s be clear. Cuts to Medicare Advantage would be taking away seniors’ health care benefits for those 11 million seniors. As I mentioned, ½ million Texans are on Medicare Advantage, and the Reid bill would cut their benefits by well over half. You do not have to take my word for it. Listen to what the CBO Director, Dr. Elmendorf, said when Senator BAUKER asked him during a Finance Committee hearing. He said: (Approximately half of the additional benefit would be lost to those current Medicare Advantage policy holders?)

Director Elmendorf: For those who would be enrolled otherwise under current law, yes.

Nearly one out of every four seniors in Texas would lose about $122 a month in health care benefits to create a new $2.5 trillion entitlement that their grandchildren will ultimately have to end up paying for. And $122 a month may not sound like a lot for people in Washington, but a couple from my hometown of San Antonio recently wrote to me:

Please vote to leave our Medicare Advantage plans alone. We can’t afford anything else as our portfolio was wiped out in the stock market collapse last year. My wife and I have had to go back to work, and we are in our seventies.

Yet this bill would impose another $122-per-month cut in their benefits.

Another constituent of mine from Conroe, TX, wrote:

Please do what you can to protect the Medicare Advantage plans. I’m on one and it has been beneficial to me. It has saved me an enormous amount of money and given me the benefits I’ve needed.

Some groups that support these cuts to Medicare Advantage have a conflict of interest, to say the least, because the benefits under traditional fee for service, as I mentioned, for Medicare is the point of view to what private insurance will pay. In order to get coverage, in order to pay the bills, many seniors have had to buy additional insurance.
coverage. For 11 million seniors, Medicare Advantage provides those benefits.

For many seniors, former employers sometimes provide wraparound plans. For retired military, TRICARE provides a wraparound plan. For many low-income Medicare beneficiaries, it’s cost sharing and premiums. For many other seniors, they purchase a standalone Medicare policy.

The irony is, Medicare did not think of what private sector innovators have been doing this through the Medicare Advantage Program already.

The delivery system reforms in the Reid bill would allow Medicare to experiment with different approaches to changing physician incentives, such as accountable care organizations or physician quality reporting initiatives.

Will they work? I happen to think they will. Why? Because private sector innovators have already figured out how to change physician incentives in the sorts of ways we ought to be doing more of and not punishing by cutting Medicare Advantage.

One Medicare Advantage plan, HealthSpring, serves 20,000 seniors in my State. They have been a leader for changing incentives for physicians to focus on quality rather than quantity. I met with their leadership and heard they had a program. We started to do something, and they told me they have a collaborative partnership with their physicians. They call it Partnership for Quality. Physicians are accountable for both cost and quality based on an evidence-based set of quality measures. The results are a win-win: better quality care leading to healthier seniors and physicians who succeed in meeting evidence-based quality standards and ultimately lower health care costs, which I thought was supposed to be one of the goals of health care reform.

Participating physicians were paid financial incentives for meeting their goal, but as a result of coordination of care and evidence-based quality standards, they actually ended up charging less and patients experienced better results too. Members needed fewer hospitalizations and emergency room visits, they had fewer tests, we increased mammograms by 80 percent, diabetic foot exams by 360 percent, and flu vaccinations by 246 percent.

I have heard about HealthSpring’s success from a couple in Farmers Branch, TX, who recently wrote to me. They said:

We had a Medicare supplemental policy for several years until they priced themselves out of the market. We are now with a Medicare Advantage plan called HealthSpring. We have been very happy with this plan and the way they are saving us money. Please do not change or eliminate this program.

Let me tell you about one other Texas company called WellMed. While the Reid bill would finally give Medicare the ability to experiment with medical homes and care coordination, a San Antonio-based company, a Medicare Advantage company called WellMed, has been using a medical home model to coordinate patient care and emphasize prevention for nearly 20 years.

To quote from an article last month in “Inside San Antonio”:

The health care delivery model at WellMed puts the patient at the center of a team directed by a primary care physician. The team may include a nurse, a health coach, a physical therapist, a hospitalist, a social service worker, and a physical assistant.

According to WellMed CEO Dr. George Rapiere, “We really do have to bring back the old-time primary care doctor who cared for you, who was concerned about you, who was part of your family. It’s a primary care physician who knows all about you. So if you need a specialist, they know the best specialist to see. If you need surgery, they make sure you get the appropriate care in the hospital. They are your coordinator of care. And that’s really the concept of a medical home.”

There is no question in my mind that the model has been saving lives in my State. Here is a story about one Texan whose life was saved by physicians caring for him at WellMed:

For years, Cron’s disease weakened—

We will call him Ed—Ed’s immune system and left him susceptible to infections. One morning in 2001, he lacked energy to even get out of bed. His breathing became labored. He developed a cough that sounded “whoosh.”

His worried wife called his primary care physician at WellMed, Dr. Marlene Sanchez, who wanted Ed hospitalized immediately so she could order a nuclear scan of his lungs. He resisted.

“She told me that if he refused to go, I should call 911 and have the paramedics come get him,” [his wife] Annette recalled.

“He heard Dr. Sanchez talking to me, the urgency in her voice, and that convinced him to go.”

The scan confirmed Dr. Sanchez’s suspicions: A potentially fatal blood clot had traveled from Ed’s leg to his lungs. He was successfully treated and recovered. [Ed and his wife] recently celebrated Ed’s 74th birthday.

Annette credits Dr. Sanchez for saving Ed’s life and for acting as a catalyst that keeps him thriving in their golden years.

“We have seen an abundance of doctors, from the cancer doctors to the dermatologist, the gastroenterologist, the heart specialist—Ed has grown through it all. And they’ve all been coordinated by his primary care doctor. I’ve been to other places outside WellMed and you don’t get the feeling that they are communicating like this.”

Well, many Texas seniors currently enjoy these extra benefits under Medicare Advantage, such as—another benefit—the Silver Sneakers program, the nation’s leading exercise program for older Americans. This past year, one of the Silver Sneakers members personally visited my office to deliver testimonials from other Silver Sneakers members. One Texan said:

At my age I need a program to strengthen me all over but primarily to help me with my balance and coordination. I need these skills to keep me from falling and breaking my bones.

Another participant in the Silver Sneakers program said:

I am 66, have been in the Silver Sneakers program for a year. Prior to that I led a sedentary life, which included many health problems. I had hypertension, high cholesterol, chronic bladder condition, and mild depression. Since coming to classes and utilizing the weights and cardio machines, my life has improved immensely. My blood pressure has dropped, my cholesterol has been
lowered, my chronic bladder condition has improved and I just feel better all around. I am no longer depressed because I look better and look forward to going to class and visiting my friends.

These cuts in Medicare Advantage are going to have a direct impact on the benefits my constituents in Texas are benefiting from—the 532,000 Texans who are currently on Medicare Advantage—and what they are asking me—which I can’t answer— is why in this world would we want to cut Medicare Advantage, which actually works, as opposed to Medicare fee for service, which does not work well? Why would we take a fiscally unsustainable program, such as Medicare, which is going insolvent in 2017, and use that to create a $2.5 trillion new entitlement program?

My constituents, the seniors who have paid into Medicare all these years, are saying: It is not fair to take the money we have paid into Medicare and use it to create yet another entitlement program and not to fix Medicare itself. So I believe we need to fix Medicare’s nearly $38 trillion in unfunded liabilities. We need to fix the impractical and rate of return, one out of every 10 Medicare dollars which results in somewhere on the order of a minimum of $60 billion of fraudulent payments each year. We need to put it on a fiscally sustainable path, rather than taking $5 trillion from Medicare for another ill-conceived Washington health care takeover.

I don’t believe my constituents believe you can take $5 trillion out of these programs, just as they do not believe you can take more than $100 billion out of Medicare Advantage, and it will have no impact on their benefits. They don’t buy it. They don’t believe it, and I don’t either.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Mr. President, it is late in the evening. I was going to address three different issues tonight, but out of respect for Senator BAUCUS, the chairman of my committee, I am going to address just one of these issues and I will come back tomorrow morning, on Saturday, and speak on the rest of the issues.

The one issue I am going to address this evening is my support of the Senator from Nebraska and his motion to adjourn, in my judgment, to assume these operations with limited financial resources. These labor-intensive services that I raise the productivity cuts isn’t theoretical. It is real. The threat to access to home health care services payment rates will lead to nearly 70 percent of providers nationwide at risk of closing because their costs will exceed Medicare payments. If that occurs, President Obama’s promise that Medicare beneficiaries will not be adversely affected by health care reform will be broken.

I have yet to hear from a home health care provider in Iowa that these permanent cuts will make it easier for them to care for their Medicare beneficiaries. Instead, I hear these cuts would reduce access to home health care services for many Iowans who prefer to receive services in their home.

The second letter I asked to have inserted in the Record is from the Iowa Alliance in Home Care, and they wrote:

Ensuring that Medicare home health payments are not reduced further is essential to avoid the resulting limited or no access to home health services for many Iowans who prefer to receive services in their home.

Not only is the chief actuary saying it, as the chart reflects, but people who are connected with the business of home health care are saying it: These permanent cuts will in fact jeopardize access to home health services in Iowa. So if the home health cuts in the Reid bill are allowed to go into effect, then...
Iowa’s seniors, who prefer to live full lives from their homes, will be forced to live in the more expensive settings of facilities such as nursing homes.

I believe many Members on both sides of the aisle share my concern about these cuts.

I have here a third letter, this one dated from July 27, 2007, and it is written to Senator BAUCUS and me.

Mr. President, I use this letter, even though it is 2 years older, because we were getting endless letters from 61 of our colleagues—of which 52 now still serve in the Senate—about a legislative proposal to cut Medicare home health payments in that year—2007—by $9.7 billion and hospice payments by more than $1.1 billion. They urged me and Senator BAUCUS, at that time, to ensure that home health and hospice providers receive full market basket inflation adjustments. They also urged us to oppose any cuts in payment rates through administrative actions.

In these letters, Senators wrote that home health and hospice care “have been demonstrated to be cost-effective alternatives to institutional care in both Medicare and Medicaid programs.” They stated that “reducing Medicare home health and hospice payments would place the quality of home health care and hospice and the home care delivery system at significant risk.”

Of these 61 Senators who signed this letter 2 years ago, 52 are currently here debating this bill in the Senate. Of those 52 Senators, 37 are from this side of the aisle who are now proposing $43 billion in cuts instead of $9.7 billion in home payment cuts and $1.1 billion in hospice payment cuts. I would think they would find these kinds of cuts three or four times—four times what we were talking about 2 years ago to be very unrealistic, and to keep home health as a viable organization going.

We look beyond the care when we look at the impact of these permanent cuts. I have also heard from providers in Iowa that permanent cuts such as these will make it even harder for them to keep their doors open. So around 3,500 Iowans who work at home health agencies are at risk of losing their jobs at a time when we have 10 percent unemployment, at a time when more of this country is concerned that Congress ought to be working on jobs, job loss, as opposed to the health care issue and in some cases cutting jobs. The Labor Department reported today that unemployment is 10 percent. Now is not the time to consider bills that increase unemployment rates.

About an hour ago, the Senator from Nebraska offered this motion I am speaking in favor of now, to send this bill to the Finance Committee with instructions to report a bill without these very enormous home health cuts that are in it. I would take this opportunity to fix the bill and then come back to the full Senate with a better bill. That is why I support the motion of the Senator from Nebraska to commit, and I urge my colleagues to do the same.

I yield the floor.

EXHIBIT 1
NATIONAL ASSOCIATION
FOR HOME CARE & HOSPICE,
Re Medicare Home Health Services.
Hon. CHARLES E. GRASSLEY,
U.S. Senate,
Washington, DC.

Dear Senator GRASSLEY: I am writing to thank you for your continued support of home care patients nationwide and to enlist your help to ensure that access to home health services remains a reality for more than 3 million senior and disabled individuals that benefit from these important services.

It is crucial to the survival of the home health services delivery system that you work to reduce the $43 billion in cuts currently contained in the Senate Finance Committee’s health reform package. Our analysis indicates that by 2016, the proposed cuts in home health services payment rates will lead to nearly 70% of providers nationwide at risk of closing because their costs will exceed Medicare payments. If that occurs, President Obama’s promise that Medicare beneficiaries will not be adversely affected by health care reform efforts will be broken.

Invariably, providers of services facing rate cuts always cry out that care will be lost. However, history tells us that our warning should be heeded. The Balanced Budget Act of 1997 was expected to cut home health services spending by $16.1 billion in five years. Instead, the rate changes cut over $70 billion, leading to the loss of care to nearly 1.5 million Medicare beneficiaries. That change also led to higher outlays under state Medicaid programs, as well as greater use of nursing homes, hospitals, and other institutional settings. Still today, about $17 billion is spent on home health services, as compared with about $19 billion in home health outlays in 1997.

Several factors need to be understood about the current Finance Committee proposal. First, it is not consistent with MedPAC advice. The proposal reduces rates to a point where Medicare margins will average zero. MedPAC, in its deliberations, clearly recognized some level of margin in order to stay in business. In fact, we understand that MedPAC’s executive director, Mark Miller, informed House Ways and Means members that MedPAC did not recommend a zero margin.

Second, there is a serious misunderstanding of Medicare margins. MedPAC estimates margins for 2009 will be 12.2%. However, this estimation does not include the impact of nearly 7% in rate reductions planned by way of regulation by 2011. Furthermore, it does not include nearly 3.700 important providers of home health services, hospital-based agencies. Also, it does not reveal that the “average” is made up of a very wide range of individual agency margins with over 30% below zero already. Finally, reliance on Medicare margins does not convey that the total margin of agencies is estimated at 2% by MedPAC. Obviously, Medicare Advantage losses driving the overall margin down.

Third, unlike other health care providers such as hospitals, the expansion of health insurance will not prevent the collapse of any material level. Home health patients average nearly 80 years of age and are already insured by Medicare or Medicaid. This means that Medicare payment cuts to home care agencies are not offset by new revenues from newly insured patients. Instead, the proposed cuts of over 13.5% of spending on home health services will be as real as can be.

Fourth, the home health services community has put forward a credible and substantive alternative set of proposals for reforming the Medicare and Medicaid payment system. While the Chairman’s Mark incorporates many of these proposals, the level of cuts is unsustainable. In fact, the level of cuts exceed the $24 billion President Obama’s budget recommended by nearly $10 billion. Still, the industry’s proposal itself meets or exceeds the Obama budget target.

Fifth, the home health services cuts are far disproportionate to other provider sectors. The Chairman’s Mark seeks 9.4% of all the Medicare cuts from home health care while home care makes up only 3% of the Medicare program currently. That disproportionate impact is further magnified by the fact that, unlike most other health care providers today, there will be no meaningful increase in home health care business.

This is a historic time in this country, an opportunity to secure health care for all as a fundamental right. Reform should not be done at the expense of our most vulnerable senior citizens, the home-bound and infirm. Your leadership on this issue is greatly appreciated. Please let us know what we can do to help you succeed.

You have my great respect and admiration, now and always.

Sincerely,

VAL J. HALAMANDARIS, President.

EXHIBIT 2
IOWA ALLIANCE IN HOME CARE,
Des Moines, IA, December 4, 2009.

Hon. CHARLES E. GRASSLEY,
Ranking Member, Committee On Finance, Dirksen Senate Office Building, Washington, DC.

Senator GRASSLEY: I’m contacting you today to urge your assistance concerning an issue of great significance to Iowa’s dedicated home care nurses and other providers of valuable and needed in-home health care services to Iowans. The Iowa Alliance in Home Care respectfully requests your support to have the Senate Finance committee report back to the Senate, in response to a recent action with instructions in H.R. 3590 bill that does not include cuts in Medicare payments to home health agencies totaling $21.1 billion.

Your urgent action is critically important to ensure that access to quality health care services delivered in the home setting is not compromised. Proposed cuts in Medicare home health and reimbursement would be devastating as most of Iowa’s home care providers (i.e. public health departments, small businesses) rely largely or exclusively on Medicare and Medicaid payment to justify existing operations which in turn support the home health reimbursement, recently worsened by Governor Culver’s ATB state budget cuts, has been reduced by an additional 5% effective 12/1/2009. In short, ensuring that Medicare home health payments are not reduced further is essential to avoid the resulting limited or no access to home health services access for many Iowans who prefer to receive services in their own home.

Senator, thank you for your past home health care support. We greatly appreciate your immediate attention to this most critical of needs for our Iowa home health care community.

Sincerely,

MARK WHEELER, Executive Director.
The need to pay significantly higher salaries for nurses, therapists, and home health aides to attract these individuals from the scarce supply of clinicians nationwide. Many home health agencies provide have enabled millions of our most frail and senior citizens avoid hospitals and nursing homes. Providing such in-home care, home health and hospice services save Medicare millions of dollars each year. Most importantly, they enable individuals to stay just where they want to be—in the comfort and security of their own homes. Therefore urge you to ensure that Medicare beneficiaries continue to have access to important services that have become increasingly important parts of our health care system. The kinds of highly skilled and often technically complex services provided by the home health and hospice agencies have become increasingly important to the Medicare program. As a consequence, hospital discharges have risen to the extent that they are finding it more difficult to refer patients for home health care. Additional cuts to the home health benefit could leave home health providers no alternative but to reduce the number of visits and/or patient admissions, which would ultimately affect access to care and clinical outcomes. In addition to these consequences, additional cuts to the program rising costs for pain management pharmaceuticals, and they are also finding that patients with shorter lengths of stay are requiring more intensive services.

In order to ensure that home health care and hospice remain a viable option for Medicare patients, we urge you to support full market basket updates for home health and hospice, as provided under current law, and to oppose any cuts in payment rates through administrative action. Thank you for your consideration of this important matter.

Sincerely,

Susan M. Collins; Russ Feingold; Christopher H. Dodd; Sherrod Brown; Tom Harkin; Chuck Hagel; Joseph R. Biden, Jr.; Maria Cantwell; Robert F. Bennett; Christopher J. Dodd; John W. Warner; Blanche Lincoln; Susan M. Collins; Russ Feingold; Chris-

I hope, from the rural areas of Alabama, that Senator Grassley has been so intimately involved with Medicare over the years, is it not true that every working American has money taken out of their paycheck to fund their Medicare and that they believe and view it as a compact with them that when they reach 65, they will have the benefit of that?

Mr. GRASSLEY. When they reach age 65, they will have that benefit.

Mr. SESSIONS. To the tune of 2.9 percent of payroll. That is how much a self-employed person would pay. And an employee would pay 1.45 percent and the employer would pay 1.45 percent. Then, you know this 2014-page bill adds half a percentage point to those, so you are going to get it to a point where it is almost 2 percent for the employer, 2 percent for the employee, and it would be almost 4 percent for a self-employed person paying into this that is now going to be raided to finance a brandnew entitlement program.

Mr. SESSIONS. My constituent, then, is fundamentally correct in his concern?

Mr. GRASSLEY. I sense a great deal of resentment coming through in that letter, from the words of that letter from that person, that what he has paid into, for the probably 45 years of working before he retired—that now, with Medicare already being in jeopardy, based on the trustees’ report which says that by 2017 there is not going to be any money in the trust fund, and then having $464 billion taken out of that fund, it would help finance a new entitlement program at a time when the present entitlement programs are in a great deal of financial jeopardy.

Mr. SESSIONS. I think you stated that so well. Just to reemphasize, this gentleman, Mr. Eberle, who paid into Medicare for 40 years, until he got to be 65, he got not a dime of Medicare for 40 years, until he got to be 65. I said to him, is it not true that every working American involved with Medicare over the years, is it not true that every working American has money taken out of their paycheck to fund their Medicare and that they believe and view it as a compact with them that when they reach 65, they will have the benefit of that?

Mr. SESSIONS. My colleague is right. I am 68 years old and I have paid into Medicare for 40 years. I have been so intimately involved with Medicare over the years, is it not true that every working American involved with Medicare over the years is it not true that every working American has money taken out of their paycheck to fund their Medicare and that they believe and view it as a compact with them that when they reach 65, they will have the benefit of that?
One of my staffers wrote down what he said. He said: “In all my years I have never seen such transparent dishonesty in the Congress.”

He said: “It is the biggest fraud that has been perpetrated in the history of our country,” in his opinion.

He went on to say I am going to pursue this in a little more detail. I am not going to go into great length tonight. But we have an amendment—Senator BENNETT offered an amendment yesterday that said we wouldn’t cut guaranteed benefits for Medicare. But the way this deal is being done is they are cutting payments to providers of Medicare.

We are already reaching, as Senator GRASSLEY said, a national crisis because by 2017 we will not be able to have a surplus in Medicare, we are going into default in Medicare. Where are we going to get the money?

Could we have efficiencies? Could we save in Medicare? Could we do some things to keep the program afloat? Perhaps. But if we do so, should not we use it, should not we use any efficiencies in savings that we could scrape together without damaging the commitment we have to our seniors—should we not use these savings to support Medicare that is going into default? I suggest that is a moral and legal commitment.

Mr. Eberle has written to me. He has paid for 40 years. He has not been able to draw anything out of it for the 40 years he has paid into it. Now he gets ready to draw, and we are telling him we are going to cut $465 billion out of the Medicare payment. This is not a little bitty matter.

We seem to have amazing—we seem to have this dispute. One group, from the other side, says: Don’t worry, we are not taking $465 billion from Medicare, and we wouldn’t cut Medicare, and we don’t believe in cutting Medicare, and we don’t think it is wise to cut Medicare in any way. Our side over here is saying: But you are. According to the numbers that are pretty plain in this legislation, hospitals will have a $135 billion reduction; hospices, you have $8 billion for life-ending care that has never seen such a reduction; Medicare Advantage, $120 billion; we have a $10 billion reduction; hospices, you have $8 billion for life-ending care that has never seen such a reduction; Medicare Advantage, $120 billion; and we have a $10 billion reduction; Medicare Advantage, $120 billion; home health agencies, which Senator GRASSLEY talked about, a $42 billion reduction. Are we imagining this? Have we not formulated this? It all totals up to about $465 billion.

This matter, I suggest, is not going away. Either we have reality here or not. I believe the facts will show that we are raiding Medicare, we are weakening it program at a time it is already weak. And you don’t need to have a $130 billion reduction; you don’t need to have a $120 billion reduction; you don’t need to have a $10 billion reduction; you don’t need to have a $42 billion reduction. Are we imagining this? Have we not formulated this? It all totals up to about $465 billion.

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I urge colleagues to think about this. This is perhaps the most significant fatal flaw in this legislation. It just doesn’t add up. There are others, but this one, to me, is the most dramatic, the most pernicious, the one that is most unwise. We simply need to slow down, ask ourselves how we can make our health care system better, how we can do it without breaking the bank. Aren’t there some things we can do to improve health care without a huge cost? Yes, there are. Let’s start with every single one of them we can agree on.

If we do that I think we could make a lot of progress.

Who knows, if this economy turns around—and we all hope it will—we would be in a better footing to consider a new benefit in the future. I really think this is the fly in the ointment that makes this legislation very unwise. We simply need to slow down, ask ourselves how we can make our health care system better, how we can do it without breaking the bank. Aren’t there some things we can do to improve health care without a huge cost? Yes, there are. Let’s start with every single one of them we can agree on. If we do that I think we could make a lot of progress.

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