consensus. A ''nay'' vote undermines the bipartisan consensus.

I yield the floor.

I yield back any remaining time.

The PRESIDING OFFICER (Mrs. FISCHER). All time is yielded back.

The joint resolution was ordered to a third reading and was read the third time.

The PRESIDING OFFICER. The joint resolution having been read the third time, the question is, Shall the joint resolution pass?

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

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The clerk will call the roll.

The bill clerk called the roll.

Mr. CORNYN. The following Senator is necessarily absent: the Senator from Georgia (Mr. ISAKSON).

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

The result was announced—yeas 50, nays 49, as follows:

[Rollcall Vote No. 84 Leg.]

YEAS—50

Alexander	Fischer	Paul
Barrasso	Flake	Perdue
Blunt	Gardner	Risch
Boozman	Graham	Roberts
Burr	Grassley	Rounds
Capito	Hatch	Rubio
Cassidy	Heller	Sasse
Cochran	Hoeven	Scott
Collins	Inhofe	Shelby
Corker	Johnson	Strange
Cornyn	Kennedy	Sullivan
Cotton	Lankford	Thune
Crapo	Lee	Tillis
Cruz	McCain	Toomey
Daines	McConnell	Wicker
Enzi	Moran	Young
Ernst	Murkowski	

NAYS—49

Baldwin	Harris	Peters
Bennet	Hassan	Portman
Blumenthal	Heinrich	Reed
Booker	Heitkamp	Sanders
Brown	Hirono	Schatz
Cantwell	Kaine	Schumer
Cardin	King	Shaheen
Carper	Klobuchar	Stabenow
Casey	Leahy	Tester
Coons	Manchin	Udall
Cortez Masto	Markey	Van Hollen
Donnelly	McCaskill	Warner
Duckworth	Menendez	Warren
Durbin	Merkley	Whitehouse
Feinstein	Murphy	Wyden
Franken	Murray	
Gillibrand	Nelson	

NOT VOTING—1

Isakson

The joint resolution (H.J. Res. 57) was passed.

EXECUTIVE SESSION

EXECUTIVE CALENDAR

The PRESIDING OFFICER. Under the previous order, the Senate will proceed to executive session to consider the following nomination, which the clerk will report.

The bill clerk read the nomination of Seema Verma, of Indiana, to be Administrator of the Centers for Medicare and Medicaid Services.

The PRESIDING OFFICER. The Senator from Florida.

FREEDOM FOR BOB LEVINSON

Mr. NELSON. Madam President, I come to the floor with a heavy heart because 10 years ago today, Robert Levinson, a former FBI agent, was detained in Iran on the tourist island of Kish Island in the Persian Gulf.

Bob is a very respected, long-time FBI agent who had served his country for 28 years and had since retired. He is the longest held civilian in our Nation's history. He is a husband, a father of seven, and now a grandfather of six, and he deserves to be reunited with his family.

Since Bob's detention, American officials have sought Iran's cooperation in locating and returning Bob to his family. Of course, Iranian officials have promised over and over their assistance, but after 10 long years, those promises have amounted to nothing. Bob still is not home.

The bottom line is, Iran is responsible for returning Bob to his family. If Iranian officials don't have Bob, then they sure know where to find him. So today we renew our call on Iran to make good on those promises and return Bob, return him to where he ought to be, with his family.

Iran's continued delay in returning him, in addition to the very serious disagreements the United States has with the Government of Iran about its missile program, its sponsorship of terrorism, and its human rights abuses, is just another obstacle Iran must overcome if it wants to improve relations with the United States.

We also urge the President and our allies to keep pressing Iran to make clear that the United States has not forgotten Bob and will not forget him until he is home. Obviously, we owe this to Bob, a servant of America, and we certainly owe it to his family.

To Bob's family, we recognize your tireless efforts over those 10 long years to bring your dad home, and we offer our sympathies.

Madam President, I yield the floor.

The PRESIDING OFFICER. The majority whip.

AMERICAN HEALTH CARE ACT

Mr. CORNYN. Madam President, this week the Senate continues to press forward on a number of congressional review actions; in this case, a disapproval that will roll back and repeal many Obama-era regulations that have hurt people across the country and strangled our economic growth.

By doing away with excessively burdensome rules and regulations, we are delivering on our promise to the American people to actually do what we can to help the economy, to grow the economy, to create jobs and not hurt it with unnecessary, expensive, and burdensome redtape.

Earlier this year, we began the legislative process to deliver on our biggest promise: repealing and replacing ObamaCare with more affordable and more accessible healthcare options, options that will work for all American families. The American Health Care Act, introduced in the House on Monday, is the first step in fulfilling that promise.

ObamaCare is collapsing. It has already failed countless families across the country, and it has forced people off good insurance plans they liked and strong-armed them to sign up for plans that were more expensive, offered less care, and didn't even let them use the doctor of their choice. So we would be revisiting healthcare even if Hillary Clinton had been elected President of the United States because ObamaCare is in a meltdown mode.

ObamaCare has also saddled our economy with more than a trillion dollars in new taxes. Most of those taxes are so hidden that most Americans are probably not aware of the fact that there is even a tax charged on the premium for their health insurance policy, for example. Well, all of these taxes end up being absorbed and have to be paid by American families.

At its very core, the individual mandate of ObamaCare was a major power play and overreach by the Federal Government. Basically, what it said was, if you don't buy the government-prescribed health insurance plan, we are going to fine you; we are going to penalize you.

The government should not be able to force anyone to spend their own hard-earned money for something they don't want but have to buy under a threat of financial penalty. The American people have spoken up loudly and clearly and rightfully demanded that Congress do better, and we will.

Since the 2010 timeframe—when our colleagues on the other side of the aisle passed ObamaCare with 60 votes in the Senate, a majority in the House, and with the White House—they have lost the majority in the Senate, they have lost the majority in the House, and they have lost the White House. I think ObamaCare has been one of the major reasons why, because people, the more they learn about it, the less they like it, and they don't appreciate Washington forcing them to do things they don't want to do with their own money.

About 2 months ago, one of my constituents in Texas wrote me about her skyrocketing healthcare costs. Before last year, her premium was about $325 a month. A short time later, that was revised to $436 a month. This same Texan later moved from one city to another and, because of her change of address, her premium jumped to $625 a month. It started at $325 and is now $625. In 2017, thanks to ObamaCare, her premium went up again to an astronomical $820 a month. It started at $325 before ObamaCare and is now $820 a month. I don't know many people who could absorb that kind of increase in their healthcare insurance premium.

In about a year, her monthly healthcare payment jumped by more

than 150 percent—150 percent. That is hardly what I would call affordable; thus, the misnamed Affordable Care Act should be the un-Affordable Care Act.

To make matters worse, she then found that her provider would be putting a halt to individual plans in Texas, something that has been a recurring theme in my State and across the country. So while President Obama said: If you like your plan, you can keep your plan, as a result of ObamaCare, she was not able to keep her plan so she had to find a new plan and a new doctor, a plan ultimately with less care, less flexibility, and even a higher price.

Suffice it to say, for this constituent of mine and for millions more like her, ObamaCare is not working. ObamaCare is not affordable, and it is hurting Texans. It is time for Congress to keep its promise that we have made in every election since that given the privilege of governing—of being in the majority, being in a position to change things—we would repeal and replace ObamaCare with options that fit the needs of all Americans and their families at a price they can afford.

Mr. SANDERS. Will my friend from Texas yield for a question?

Mr. CORNYN. I will not, not at this time.

Fortunately, we now have a President in the White House who clearly sees the failure of ObamaCare and wants to do something about it. Republicans in Congress have introduced a bill, which is now being marked up in the House, that the President can actually sign, once it is passed, to get us out of this mess. The American Health Care Act is the vehicle to do just that, and I am glad President Trump endorsed the plan earlier this week.

It is a work in progress. The House committees are marking it up as we speak. There will be changes along the way, but, ultimately, the House will pass the bill and send it to the Senate. Then we will have an opportunity to offer our amendments during the course of its passage. The important point to make, though, is that this legislation will actually put patients first so they are not forced into a plan that they don't want or that provides coverage they can't afford. It does away with the outrageous new taxes and the penalties that have made the economy worse off and have made life harder for American families.

The legislation will also give families more flexibility so they can get the healthcare specific to their needs that actually works for them. If they decide, for example, to get a major medical policy that is relatively inexpensive and then use a health savings account to use pretax dollars to pay for their regular doctors' visits, they will have the flexibility to do that. So this legislation promotes sensible reforms to ensure that big ticket items like Medicaid are put on a more sustainable fiscal path.

I have heard some suggestions that this legislation actually guts Medicaid. That is false. That is not true. It actually continues at current levels in this shared State and Federal program, but it is subject to a cost-of-living index that will actually put Medicaid on a more sustainable path. Just as importantly, it will also return the authority back to the States to come up with the flexible programs they need to deal with the specific healthcare needs of the people of their State.

This legislation makes sure that Medicaid doesn't lose sight of its design, which is to serve the most vulnerable among us who can't afford access to quality healthcare. It provides them that access—and better access—by providing flexibility to the States.

We know that the States and the Federal Government spend an awful lot of money on Medicaid. In Texas, for example, my State spent close to one-third of its budget on Medicaid last year—one-third of all State spending—and it is uncapped, so it goes up every year by leaps and bounds. Under the American Health Care Act, Medicaid will be tied to the number of people in the State using it, a per capita rate, which makes sense, and it represents the first major overhaul of the program in decades.

ObamaCare left us with unchecked government spending, more taxes, and fewer healthcare options. This bill is the opposite of ObamaCare in every way. It will control spending in a commonsense way, it will repeal ObamaCare's taxes and the individual and employer mandate, and it will provide more flexible free market options for families across the country. That is not just a bumper sticker or advertisement; that is actually what is contained in the legislation.

I look forward to working with my colleagues in the House, in the Senate, and in the Trump administration to get this done in the next few weeks.

Madam President, I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The senior assistant legislative clerk proceeded to call the roll.

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

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

Mr. MARKEY. Madam President, here we go again, debating the nomination of a Trump candidate who is both unqualified and reflects an extreme ideology for the Department she will hope to lead. In this case it is Seema Verma, and the Department is the Centers for Medicare and Medicaid, or CMS, as it is often called.

Why is CMS, an acronym for a department that most Americans don't even know about, so important that its nominee would make it to the floor of the U.S. Senate for debate? Because 100 million Americans receive health insurance coverage under one of our Federal insurance programs—Medicare, Medicaid, the Children's Health Insurance Program, and the health insurance marketplace created by the Affordable Care Act, all of which are under the jurisdiction of CMS.

CMS is the traffic cop of our Federal Government healthcare system. It makes sure that Americans have access to affordable, quality healthcare by administering and overseeing all aspects of our Federal health program. It promotes healthcare innovation and works to reduce waste, fraud, and abuse throughout our healthcare system.

Under the Trump administration and Republican leadership, which has vowed to repeal ObamaCare and get rid of Medicaid as we know it, the leader of CMS will be the person responsible for reducing Federal spending on public insurance programs, particularly for the poor, the elderly, and the disabled. Seema Verma is President Trump's nominee to try to meet that misguided and heartless challenge.

Republicans have an ancient animosity toward Medicaid, and it would seem that Ms. Verma shares that prejudice. Ms. Verma is most well known for proposals that penalize and create roadblocks to coverage for low-income Americans. She supports changes to Medicaid that would make it harder for those who need Medicaid to access it. This stance is fundamentally antithetical to the core principle of Medicaid, which is providing coverage for those who cannot afford it. For the most part, we are talking about poor people in the United States of America in 2017.

Despite the fact that research shows the onerous premiums or cost sharing for low-income individuals served as barriers to enrolling in and obtaining care, Ms. Verma supported a plan to require Medicaid enrollees to pay premiums through monthly contributions to a health savings account. Guess what. People who are poor enough to qualify for Medicaid rarely have enough money to dedicate to savings accounts of any kind. They are living day to day, week to week, month to month.

She also supports putting in place restrictions that put more burdens on low-income Americans than even private insurance. It will be Grandma and Grandpa who will pay the highest price.

Medicaid isn't just a line in our healthcare budget; it is a lifeline for millions of seniors in every State of the country. Here are the facts about the importance of Medicaid to our seniors. It is anticipated that by 2060, there will be more than 98 million Americans over the age of 65. The number of individuals over the age of 85 is expected to reach 14.6 million in 2040—triple the number in 2014. Of this population, 70 percent will likely use long-term services and supports, of which Medicaid is the primary player. Medicaid spent $152 billion on long-term support services like nursing home care in 2014.

Let me say that again. The entire defense budget is about $550 billion. We spent as a nation $152 billion—a little less than one-third of the defense budget—to take care of Grandma and Grandpa in nursing homes in 2014. They may have Alzheimer's, they may have other diseases, but, unfortunately, most families can't save $50, $60, $70,000 for year after year of nursing home coverage; that is Grandma and Grandpa.

The anticipated growth rate for Medicaid beneficiaries over the age of 65 is four times the rate of growth for all Medicaid beneficiaries. The only thing growing faster than the need for Medicaid is the number of people who are opposed to repealing the Medicaid expansion under ObamaCare. Medicaid pays for nearly two-thirds of individuals living in nursing homes.

Can I say that again? Medicaid pays for two-thirds of individuals living in nursing homes in our country. So if you know a family member who is in a nursing home who has Alzheimer's or some other disease, you can just assume that Medicaid is helping that family to ensure that Grandma or Grandpa is getting the care they deserve for what they did to build this great country.

Fundamentally restructuring Medicaid will place additional strain on already strapped State budgets because nursing facility care is a mandated Medicaid benefit. States may offset the increased costs in covering this service by further cutting payments to providers or removing benefits that seniors want and need, like home- and community-based services. It also puts more strain on working-class families because if Medicaid isn't picking up the cost of putting your grandma in a nursing home, that comes out of the pockets of other contributors to the family.

Unfortunately, Republicans want to undermine the Medicaid expansion under the Affordable Care Act, which is benefiting millions of seniors. They want to force seniors to pay more out-of-pocket for healthcare or forgo coverage because they cannot afford it.

What Republicans refuse to accept is that the Affordable Care Act is the most important program we have put in place for seniors since Medicare. The uninsured rate for Americans aged 50 to 64 dropped by nearly half after the passage of the ACA. The uninsured rate for this older population living in Medicaid expansion States was 4.6 percent while the uninsured rate for the same population living in a non-Medicaid expansion State was 8.7 percent—almost double.

Not only does the Republican proposal amount to an age tax by substantially increasing the amount an insurance company can charge for an older person, but it provides older Americans with fewer resources than what is available under ObamaCare to help cover their increased costs for care.

Unfortunately, as Republicans attempt to repeal ObamaCare, CMS is authorized by President Trump's Executive order to ''minimize the unwarranted economic and regulatory burdens'' of ObamaCare. In simple terms, that means undoing and privatizing vital provisions of the Affordable Care Act as soon as possible under the law.

CMS has also picked up a sledgehammer. It has already proposed new rules of slashing open enrollment times for the exchanges by over a month. It has proposed rules to relax the minimum standards for what qualifying health plans sold on the exchanges have to cover.

Now, more than ever, we need a leader at CMS who understands and respects the fundamental need for healthcare for our seniors, and for so many of them, that need is met by Medicaid. Ms. Verma's disdain for Medicaid is simply an insurmountable problem for the millions of older Americans in this country who rely upon this fundamental program.

Given her lack of experience and extreme views, several major groups that represent millions of working-class Americans have voiced strong opposition to her confirmation.

This is what the American Federation of State, County and Municipal Employees of the AFL–CIO said:

''Leading CMS is too important a role to be held by an individual who is committed to policies so radical they would jeopardize the health and lives of ordinary Americans.''

I could not agree more.

Seema Verma is the wrong person to run CMS at a time when millions of Americans are relying on the dignity and coverage that Medicare and Medicaid provide.

Instead of cutting funding for defense, Donald Trump wants to cut programs for the defenseless. The Trump administration would rather bestow billions more to the Pentagon to pay for new nuclear weapons, which we do not need and cannot afford, all the while supporting cuts to Medicaid and senior health. We should be cutting Minuteman missiles instead of Medicaid. We should be cutting gravity bombs instead of Grandma's prescriptions.

The Trump administration's plan for Medicaid and our overall healthcare system would be a nightmare for Grandma and Grandpa and millions of middle-class Americans.

I am opposed to Seema Verma's nomination, and I call on my colleagues to join me in voting no on her nomination when it is presented on the Senate floor.

I yield the floor.

The PRESIDING OFFICER (Mr. SASSE). The Senator from Colorado.

NOMINATION OF NEIL GORSUCH

Mr. GARDNER. Mr. President, I rise to support the nomination of Judge Neil Gorsuch to the U.S. Supreme Court. Hopefully, we will see his confirmation in the weeks to come.

As I have come to the floor and talked about before, Judge Gorsuch is a fourth-generation Coloradan who serves on the Tenth Circuit Court of Appeals, which is the U.S. circuit court that is housed in Denver, CO. It is the circuit court that oversees about 20 percent of the land mass in the States of Colorado, Oklahoma, and places in between. Once he is confirmed to the Supreme Court, Neil Gorsuch will become the second Coloradan to have served on the Court.

We have a great history of another Supreme Court Justice who served on the highest Court. Associate Justice Byron White had the distinction of being the only Supreme Court Justice to lead the NFL in rushing, and he was also from Colorado.

If Judge Gorsuch is confirmed, Justice Gorsuch will join Byron White as another Coloradan on the High Court. Justice Rutledge also received his bachelor's of law degree from the University of Colorado. So we do have a great history of Colorado westerners joining our Nation's highest Court.

Mr. Gorsuch was confirmed to the Tenth Circuit Court a little over 10 years ago—11 years ago—in 2006, by a unanimous voice vote. He was so popular and so well supported that there was not even a rollcall vote taken in this Chamber. It was a simple acclamation by a voice vote. In fact, Gorsuch's nomination hearing was deemed so noncontroversial that the last time, Senator GRAHAM was the only committee member to attend.

One may ask oneself what made and continues to make Judge Gorsuch such a mainstream nominee. I do not think we need to look any further than his original Judiciary Committee questionnaire to see that Judge Gorsuch possesses the right temperament and the right view of the role of judges.

I thought it was important that I read this from 11 years ago when Judge Gorsuch was confirmed to the Tenth Circuit Court. The questionnaire he filled out for the Judiciary Committee included then-Neil Gorsuch's—trying to be Judge Gorsuch—response to judicial activism and what it meant to Neil Gorsuch prior to his confirmation to the Tenth Circuit Court.

Here is what he replied to the Judiciary Committee in that committee questionnaire:

> The Constitution requires Federal judges to strike a delicate balance. The separation of powers embodied in our founding document provides the judiciary with a defined and limited charter.
>
> Judges must allow the elected branches of government to flourish and citizens, through their elected representatives, to make laws appropriate to the facts and circumstances of the day.
>
> Judges must avoid the temptation to usurp the roles of the legislative and executive branches and must appreciate the advantages these democratic institutions have in crafting and adapting social policy as well as their special authority, derived from the consent and mandate of the people, to do so.
>
> At the same time, the Founders were anxious to ensure that the judicial branch never becomes captured by or subservient to the other branches of government, recognizing

that a firm and independent judiciary is critical to a well-functioning democracy.

The Constitution imposes on the judiciary the vital work of settling disputes, vindicating civil rights and civil liberties, ensuring equal treatment under the law, and helping to make real for all citizens the Constitution's promise of self-government. There may be no firmly fixed formula on how to strike the balance envisioned by the Constitution in specific cases, but there are many guideposts discernible in the best traditions of our judiciary.

A wise judge recognizes that his or her own judgment is only a weak reed without being fortified by these proven guides.

For example, a good judge recognizes that many of the lawyers in cases reaching the court of appeals have lived with and thought deeply about the legal issues before the court for months or years. A lawyer in the well is not to be treated as a cat's paw but as a valuable colleague whose thinking is to be mined and tested and who, at all times, deserves to be treated with respect and common courtesy.

A good judge will diligently study counsels' briefs and the record and seek to digest them fully before argument and then listen with respectful discernment to the arguments made by his or her colleagues at the bar.

A good judge will recognize that few questions in the law are truly novel, that precedents in the vast body of Federal law reflect the considered judgment of those who have come before us and embody the settled expectation of those in our own generation.

A good judge will seek to honor precedent and strive to avoid its disparagement or displacement.

A good judge will listen to his or her colleagues and strive to reach consensus with them. Every judge takes the same judicial oath; every judge brings a different and valuable perspective to the office.

A good judge will appreciate the different experiences and perspectives of his or her colleagues and know that reaching consensus is not always easy but that the process of getting there often tempers the ultimate result, ensuring that the ultimate decision reflects the collective wisdom of multiple individuals of disparate backgrounds who have studied the issue with care.

Throughout the process of adjudicating an appeal, a good judge will question not only the positions espoused by the litigants but also his or her own perceptions and tentative conclusions as they evolve.

And a good judge will critically examine his or her own ideas as readily and openly as the ideas advanced by others.

A good judge will never become so wedded to any view of any case so as to preclude the possibility of changing his or her mind at any stage—from argument through the completion of a written opinion.

Pride of position, fear of embarrassment associated with changing one's mind, along, of course, with personal politics or policy preferences have no useful role in judging; regular and healthy doses of self-skepticism and humility about one's own abilities and conclusions always do.

This is the response that then-Neil Gorsuch, prior to his becoming Judge Gorsuch, gave to the Senate Judiciary Committee and in response to a questionnaire about judicial activism and about what makes a good judge in his talking about fidelity to precedent, talking about the ability to reach a conclusion that may be in disagreement with one's own personal opinions, making sure that we respect the different branches of government, making sure that one listens to one's colleagues who are arguing a case and who have spent years in their getting to know the case and its every detail, and scrubbing your mind to question the positions that you thought you had to make sure that they mesh with the law, not with opinion.

Judge Gorsuch, when he was introduced at the White House when being nominated by the President, said that a judge who agrees with every opinion he reaches is probably a bad judge.

The institution we serve has that fidelity to the Constitution that we must preserve, that we must guard. Guardians of the Constitution, which judges represent, is something we confirm. It is our job to make sure the kind of judges we place on courts represent the kind of judge Neil Gorsuch truly is.

It is this temperament, this fidelity to the Constitution, this appropriate temperament, and remarkable humility that has made Judge Gorsuch a consensus pick in the past and, I believe, that could be a consensus pick in the near future.

It is reflected in the fact that, on February 23, Senator BENNET and I, along with the Judiciary Committee, received a letter from Colorado's diverse legal community in support of Judge Gorsuch's nomination to the Supreme Court.

The letter reads as follows:

As members of the Colorado legal community, we are proud to support the nomination of Judge Neil Gorsuch to be our next Supreme Court Justice. We hold a diverse set of political views as Republicans, Democrats, and Independents. Many of us have been critical of actions taken by President Trump. Nonetheless, we all agree that Judge Gorsuch is exceptionally well qualified to join the Supreme Court. He deserves an up-or-down vote.

We know Judge Gorsuch to be a person of utmost character. He is fair, decent, and honest, both as a judge and as a person. His record shows that he believes strongly in the independence of the judiciary. Judge Gorsuch has a well-earned reputation as an excellent jurist. He voted with the majority in 98% of the cases he heard on the 10th Circuit, a great portion of which were joined by judges appointed by Democratic Presidents. Seven of his opinions have been affirmed by the U.S. Supreme Court—four unanimously—and none has been reversed.

We ask that Colorado's Senators join together and support this highly qualified nominee from Colorado. Regardless of the politics involved in prior confirmation efforts, including what many consider to be the mistreatment of Judge Garland's nomination, a filibuster now will do Colorado no good.

Judge Gorsuch deserves a fair shake in the confirmation process. Please vote against a filibuster and vote for Judge Gorsuch's confirmation to the Supreme Court.

This letter from James Lyons is another such letter talking about the importance of the confirmation of Judge Gorsuch. I couldn't agree more with this letter and the letter that I read.

Judge Gorsuch is an exceptionally qualified jurist, to use their words, and he deserves a fair shake in the confirmation process that includes a timely up-or-down vote.

I ask unanimous consent that this letter be printed in the RECORD.

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

FEBRUARY 7, 2017.

Hon. CHUCK GRASSLEY,
Chairman, Committee on the Judiciary,
U.S. Senate.

DEAR SENATOR GRASSLEY: I write this letter in strong support of the nomination and confirmation of Judge Neil Gorsuch for Associate Justice of the United States Supreme Court.

Judge Gorsuch has been known to me professionally for over twenty years, and his family even longer. In the mid-nineties, we were counsel together in successfully representing co-defendants in a major securities matter involving class action and derivative lawsuits in several jurisdictions across the country as well as SEC and Congressional investigations. Over the course of that complex representation in the following years, I came to observe first-hand his considerable lawyering skills, intellect, judgment and temperament. He was one of the finest trial lawyers with whom it has been my pleasure to be associated in my career. We also became personal and good friends which continued during the following years at his firm, later during his time at the Department of Justice and since returning to Denver to serve on the bench.

I was delighted by his appointment to the U.S. Court of Appeals for the Tenth Circuit based here in Denver. (He honored me by having me be one of two lawyers to introduce him to the court at his formal investiture.) Over his years of service on that court, he has distinguished himself with his work ethic, keen and thorough understanding of the case under review, his formidable analytical ability, and the clarity of his opinions. I have read many of his opinions and watched him in oral argument. He is engaging, courteous to counsel and demonstrates a full and unusual appreciation for the human impact of his decisions on the people involved. These are the qualities of an outstanding jurist.

Judge Gorsuch has been active and an important voice in the legal community and academy. He has written extensively, lectured and taught in continuing legal education seminars and served on the important federal Rules Committee, among others. He also has found time to sit on student moot courts and teach both ethics and federal jurisdiction at the University of Colorado Law School. He is regularly regarded by his students as one of their very best law professors—effective, challenging and personable.

Judge Gorsuch's intellect, energy and deep regard for the Constitution are well known to those of us who have worked with him and have seen first-hand his commitment to basic principles. Above all, his independence, fairness and impartiality are the hallmarks of his career and his well-earned reputation.

Sincerely,

JAMES M. LYONS.

Mr. GARDNER. Mr. President, I look forward to working with my colleagues across the aisle to make sure we fill this vacancy on the Supreme Court with one of this Nation's truly brilliant legal minds.

Mr. President, I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

The PRESIDING OFFICER (Mr. KENNEDY). Without objection, it is so ordered.

CUBA TRADE ACT

Mr. MORAN. Mr. President, I come to the floor today to speak about legislation I have recently introduced, although it is a follow-on to legislation I pursued over a number of years.

We have now introduced in this Congress the Cuba Trade Act. This is legislation which would lift the trade embargo to allow farmers and ranchers and small businesses and other private sector industries to freely conduct business, to sell products—agricultural products in particular—to the nation of Cuba and to its people.

Last month, I spoke about the terrific difficulties our farmers in Kansas and across the country are facing due to low commodity prices. The farm economy has fallen by nearly 50 percent since 2013, and that decline is expected to continue in 2017, making this perhaps, if not the worst, certainly one of the worst economic downturns in farm country since the Great Depression.

In 2016, harvests in our State and across much of the country were recordbreaking yields and historic in their magnitude, in fact. What that means is there are still piles of wheat, corn, and other grains all across Kansas just sitting on the ground next to the grain mill bins that are already filled to capacity. To sell this excess supply, our farmers need more markets to sell the food and fiber they produce.

Approximately 95 percent of the world's customers live outside U.S. borders. Markets in the United States will continue to grow, and they will evolve and will continue to meet the domestic consumer demand, providing the best, highest quality, safest food supply in the world, but in order to boost prices for American farmers, we need more markets. We need them now, we need them in the future, and we need to be able to indicate to our farmers that hope is in the works in global markets.

We have talked about the importance of trade, of exports from the United States, and particularly for the citizens of Kansas. That is particularly true for an agricultural State like ours where, again, 95 percent of the consumers live someplace outside of the United States. Cuba is only 90 miles off our border. They offer the potential for increased exports of all sorts of products but especially Kansas wheat.

In fact, while we are introducing this legislation now, we started down this path to increase our ability to sell agriculture commodities, food, and medicine to Cuba back when I was a Member of the House of Representatives. I offered an amendment then to an appropriations bill that lifted the embargo—the ability to sell; it would allow the ability to sell those foods, agricultural commodities, and medicine to Cuba for cash, up front. That bill was passed. It was controversial then. This issue of what our relationship ought to be with Cuba has always been contentious. But I remember the vote was about I think 301 to 116. A majority of Republicans and a majority of Democrats said it is time to do something different with our relationship with Cuba.

This was a significant step in opening up the opportunity to the products of American farmers and ranchers to that country. No longer were food, medicine, and agriculture commodities prohibited from being sold. And it worked for a little while, but unfortunately, in 2005, the Treasury Department changed the regulations, and it complicated the circumstances related to the embargo.

Cuba imports the vast majority of its food. In fact, wheat is Cuba's second largest import, second only to oil.

A point I would stress is that this is a unilateral sanction. Keep in mind that when we don't sell agricultural commodities to Cuba, somebody else does. While our unilateral trade barriers block our own farmers and ranchers from filling the market, willing sellers such as Canada, France, China, and others benefit at American farmers' expense. When we can't sell wheat that comes from a Kansas wheat field to Cuba, they are purchasing that wheat from France and Canada and other European countries. When the Presiding Officer's rice crop can't be sold to Cuba, it is not that they are not buying rice; they are buying it from Vietnam, China, or elsewhere.

It costs about $6 to $7 per ton to ship grain from the United States to Cuba. It costs about $20 to $25 to ship that same grain from the European Union. However, we lose this competitive advantage because of the regulations in place that drive up the cost of Cuban consumers dealing with the United States.

To understand what we are missing out on in Cuba, consider our current trade relationship with the Dominican Republic. The DR is also a nearby Caribbean nation with a population comparable to Cuba. Income levels and diet are similar. Between 2013 and 2015, the Dominican Republic imported an average of $1.3 billion of U.S. farm products. During that same time span, Cuba imported just $262 million—over $1 billion in difference. That is right. That is $1 billion of exports that U.S. farmers are missing an opportunity on because of the U.S. trade restrictions on Cuba. This example helps illustrate the substantial potential that exists for increased sale of agriculture commodities to Cuba.

The Cuba Trade Act I just introduced simply seeks to amend our own country's laws so that American farmers can operate on a level playing field with the rest of the world. While boosting American exports remains the primary goal of lifting the embargo, I also think there is an opportunity for us to increase the reforms and to improve the lives of the Cuban people as well.

I have often said here on the Senate floor and on the House floor and back home in Kansas we often say: We will try something once. If it doesn't work, we might even try it again. Maybe we will try it a third or a fourth time. But after more than 50 years of trying to change the nature of the Cuban Government through this kind of action, through this embargo, many Kansans would say it is time to try something else.

The Cuban embargo was well-intentioned at the time it was enacted. Today, however, it only serves to hurt our own national interests by restricting Americans' freedom to conduct business with that country. In my view, it is time to make a change, and we ought to be able to sell wheat, rice, and other agricultural commodities from the United States for cash to Cuba. This legislation would allow that at no expense to the American taxpayer.

KANSAS WILDFIRES

Mr. President, there is a lot to be proud about in being a Kansan. We have lots of challenges in our State, and we are undergoing serious ones at the moment. For those who have noticed on the news, although it is not particularly a story here in the Nation's Capital, Kansas is ablaze. Fires are devastating acres and acres. In fact, nearly 700,000 acres of grasslands in our State have been burned. Fires have started. We have had winds for the last 3 days of 50 to 60 miles an hour, and dozens of communities and counties have been evacuated. Lots of places have been hard hit. My home county of Rooks experienced those fires. Hutchinson, a community of 50,000 people, had to evacuate 10,000 people in what we would consider in our State a pretty big place. So they have been rampant and they have been real, and there have been significant consequences to many lives in our State.

As people know, Kansas is an agriculture place. We raise lots of crops, but we are certainly a livestock State, and our ranchers are experiencing the significant challenges that come from loss of pasture, the death of their cattle, and the burning of their fences.

On my way over here, I was reading a couple of articles that appeared in the Kansas press that I wanted to bring to my colleagues' attention. There is nothing here that necessarily asks for any kind of government help, but it does highlight the kind of people I represent.

There is a farm in Clark County. The county seat is Ashland. It is on the border with Oklahoma. Eighty-five percent of the county's grassland, 85 percent of the acres in that county have been burned. This means the death of hundreds, if not thousands, of cattle in that county. That is the economic driver of the communities there. Ashland, the county seat, has a population of

about 900 or 1,000—the biggest town in the county—and its future rests in large part upon what happens in agriculture.

There are lots of great ranch families in our State. One of those is the Gardiners. The Gardiner Ranch is in Clark County. Their story is told a bit in today's edition of the Wichita Eagle. They are known as some of the best ranchers in the country. For more than 50 years, they have provided the best Angus cattle. They have customers across the country. It is a family ranch. This is multigenerational, and three brothers now ranch together. It is not an unusual way that we do business in Kansas.

In addition to the economic circumstances that agriculture presents in our State, it is one of the reasons I appreciate the opportunity to advocate on behalf of farmers and ranchers. It is one of the last few places in which sons and daughters work side by side with moms and dads, and grandparents are involved in the operation. Grandkids grow up knowing their grandparents. There is a way of life here that is important to our country. Our values, our integrity, and our character are often transmitted from one generation to the next in this circumstance because we are still able to keep the family together, working generation to generation. The Gardiners are an example of that, but there are hundreds of Kansans who exemplify this.

I would like to tell the story of Mr. Gardiner, as reported by the Wichita Eagle. Mr. Gardiner said that he was slowly driving by some of his estimated 500 cattle that had died in this massive wildfire, and he complained on their behalf that they never had a chance. The fire was so fast. His ranch, as I said, is one of the most respected. The quality of the family's Angus cattle has been a source of pride and national attention for more than 50 years.

Like others, the Gardiners have endured plenty of bumps—and this is him telling their story—over five generations of ranching. The drought and dust of the 1930s was tough, he said, and there were even drier times in the 1950s. About 5 years ago, there was another drought in our State that was so devastating. He said his family lost 2,000 acres when they couldn't make a payment to the bank. Blizzards in 1992 killed a lot of cattle.

My point is that nothing is easy about this life, but there is something so special about it. The point I want to make is that people are responding to help, and I thank Kansans and others from across the country who are responding to the disasters that are occurring across our State throughout this week and into the future. This isn't expected to go away anytime soon.

Mr. Gardiner said that more hay is on the way, and the process of rebuilding fences will begin, hopefully, within a few weeks. He said he was sent word that Mennonite relief teams were coming from two Eastern States to work on his fences and to do so without pay. Truckloads of hay are already en route and rolling in. This story indicates that many of those truckloads of hay are coming from ranchers who in the past have bought livestock from the Gardiners.

Mr. Gardiner's veterinarian, Randall Spare, said that the Gardiners have long been known for taking exceptional care of their customers. The veterinarian says, ''Now it's their turn'' for the customers to repay them. ''The Gardiners are the cream of the crop, like their cattle. I'm not surprised so many people [from so many places] are wanting to help them.''

The reporter says that while he was talking to Mr. Gardiner for this interview, Mr. Gardiner answered his cell phone as his pickup slowly rolled across a landscape that now looked so barren. The reporter said that many of the calls were from clients who just called to send their best or to be brought up to date and to ask the Gardiners how they could help and how the Gardiners were holding up.

Mr. Gardiner said:

It's really something [special], when you hear a pause on the other end of the line and you know it's because [the person who called is] crying because they care that much. It gets like that with ranching. It's like we're all family.

That is a great thing about our State. It is like that with Kansas. We are all a family. But the fact is that his family is still alive. He tells the story of not knowing whether his brother and his wife were alive. The fire swept around them, but they found a place that avoided the fire, a wheat field where the wheat was still green and so short that the fire didn't intrude. But he stopped his truck to think a bit and, the story indicates, to sob a bit.

He watched as his brother Mark and his wife Eva disappeared behind a wall of fire as they tried to save their horses and dogs at their home. Ultimately, the house was destroyed. Mr. Gardiner, the one the reporter was talking to, said:

I had no choice but to turn around and drive away, with the fire all around me. For a half-hour I didn't know if my brother and his wife were dead or alive. I really didn't.

He said that then his brother and his wife and some firefighters gathered in the middle of that wheat field. It was so short and so green, it wouldn't burn. He said:

It was so smoky I didn't even know exactly where we were at. But then a firefighter came driving by and told us everybody made it out. That's when I knew Mark and his wife were alive. That's when I knew everything would eventually be all right. I am telling you, that's when you learn what's really important.

So today I come to the Senate floor to express my gratitude for the opportunity to represent Kansans like the Gardiners, farmers and ranchers across our State but city folks, as well, who know the importance of family, who know that living or dying is an important aspect of life but that how they live is more important, and to thank those people—not just from Kansas but from across the country—who have rallied to the cause to make sure there is a future for these families and for the farming and ranching operations.

It is a great country in which we care so much for each other, and that is exemplified in this time of disaster that is occurring across my State. I am grateful to see these examples, and I would encourage my colleagues that we behave the way Kansas farmers and ranchers do—live life for the things that are really meaningful and make sure we take care of each other.

Mr. President, I yield the floor.

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

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

CLOTURE MOTION

The PRESIDING OFFICER. Pursuant to rule XXII, the Chair lays before the Senate the pending cloture motion, which the clerk will state.

The bill clerk read as follows:

CLOTURE MOTION

We, the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, do hereby move to bring to a close debate on the nomination of Seema Verma, of Indiana, to be Administrator of the Centers for Medicare and Medicaid Services, Department of Health and Human Services.

Mitch McConnell, Steve Daines, John Cornyn, Tom Cotton, Bob Corker, John Boozman, John Hoeven, James Lankford, Roger F. Wicker, John Barrasso, Lamar Alexander, Orrin G. Hatch, David Perdue, James M. Inhofe, Mike Rounds, Bill Cassidy, Thom Tillis.

The PRESIDING OFFICER. By unanimous consent, the mandatory quorum call has been waived.

The question is, Is it the sense of the Senate that debate on the nomination of Seema Verma, of Indiana, to be Administrator of the Centers for Medicare and Medicaid Services, shall be brought to a close?

The yeas and nays are mandatory under the rule.

The clerk will call the roll.

The bill clerk called the roll.

Mr. CORNYN. The following Senators are necessarily absent: the Senator from Georgia (Mr. ISAKSON), and the Senator from Florida (Mr. RUBIO).

Further, if present and voting, the Senator from Florida (Mr. RUBIO) would have voted ''yea.''

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

The yeas and nays resulted—yeas 54, nays 44, as follows:

[Rollcall Vote No. 85 Ex.]

YEAS—54

Alexander	Fischer	Moran
Barrasso	Flake	Murkowski
Blunt	Gardner	Paul
Boozman	Graham	Perdue
Burr	Grassley	Portman
Capito	Hatch	Risch
Cassidy	Heitkamp	Roberts
Cochran	Heller	Rounds
Collins	Hoeven	Sasse
Corker	Inhofe	Scott
Cornyn	Johnson	Shelby
Cotton	Kennedy	Strange
Crapo	King	Sullivan
Cruz	Lankford	Thune
Daines	Lee	Tillis
Donnelly	Manchin	Toomey
Enzi	McCain	Wicker
Ernst	McConnell	Young

NAYS—44

Baldwin	Gillibrand	Peters
Bennet	Harris	Reed
Blumenthal	Hassan	Sanders
Booker	Heinrich	Schatz
Brown	Hirono	Schumer
Cantwell	Kaine	Shaheen
Cardin	Klobuchar	Stabenow
Carper	Leahy	Tester
Casey	Markey	Udall
Coons	McCaskill	Van Hollen
Cortez Masto	Menendez	Warner
Duckworth	Merkley	Warren
Durbin	Murphy	Whitehouse
Feinstein	Murray	Wyden
Franken	Nelson	

NOT VOTING—2

Isakson	Rubio

The PRESIDING OFFICER. On this vote, the yeas are 54, the nays are 44.

The motion is agreed to.

The Senator from Kansas.

Mr. MORAN. Mr. President, I ask unanimous consent that notwithstanding the provisions of rule XXII, following leader remarks on Monday, March 13, the Senate resume executive session for the consideration of Executive Calendar No. 18, and that the vote on confirmation occur at 5:30 p.m.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. MORAN. Mr. President, on behalf of the majority leader, there will be no further votes this week in the U.S. Senate.

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

The PRESIDING OFFICER. The clerk will call the roll.

The assistant bill clerk proceeded to call the roll.

Mr. WYDEN. 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. WYDEN. Mr. President and colleagues, today the Senate turns to consider the nomination of Seema Verma to be the Administrator of the Centers for Medicare and Medicaid Services.

I would be the first to say that in coffee shops across the land, people are not exactly buzzing about the office known as CMS, but the fact is, this is an agency that controls more than a trillion dollars in healthcare spending every year. Even more important and more relevant right now, if confirmed, and if TrumpCare somehow gets rammed through the Congress over loud and growing opposition, this is going to be a major issue on her plate right at the get-go.

I thought it would be useful to just give one example of the connection involved in this legislation. TrumpCare cuts taxes for the special interests and the fortunate few by $275 billion, stealing a chunk of it from the Medicare trust fund that pays for critical services to the Nation's older people.

If TrumpCare passes and Ms. Verma is confirmed, under section 132 of the bill, she would be able to give States a green light to push the very frail and sick into the high-risk pools that have historically failed at offering good coverage to vulnerable people at a price they can afford. Under section 134 of TrumpCare, Ms. Verma would be in charge of deciding exactly how skimpy TrumpCare plans would be and how much more vulnerable people would be forced to pay out of their pockets for the care they need.

Under section 135 of the bill, if confirmed, Ms. Verma could be paving the way for health insurers to make coverage more expensive for older people approaching retirement age.

Given all that, I want Members to understand there is a real link between this nomination and the debate about TrumpCare, and this is, in effect, the first discussion we have had about TrumpCare since these bills started to get moving without any hearings and getting advanced in the middle of the night.

The odds were against Republicans writing a single piece of legislation that would make healthcare more expensive, kick millions off their coverage, weaken Medicare and Medicaid, and produce this Robin Hood in reverse, this huge transfer of wealth from working people to the fortunate. Nobody thought you could do all of that at the same time, but somehow the majority found a way to do it. Republicans are rushing to get it passed before the American people catch on.

As part of this debate about Seema Verma, we are going to make sure people understand this nomination is intertwined with what happens in the discussion about TrumpCare and how these particularly punitive provisions with respect to Medicare and Medicaid would affect our people.

For 7 years, my colleagues on the other side have pointed to the Affordable Care Act as pretty much something that would bring about the end of Western civilization and, at a minimum, would basically continue a system responsible for every ill in our healthcare system. That was the argument. The Affordable Care Act is responsible for just about every ill and will practically be the end of life as we know it.

Their slogan was to ''repeal and replace,'' and it was a slogan they rode through four elections to very significant success. The only problem was, it was really repeal and run, and that replacement was nowhere in sight. Now the curtain has been lifted. The lights are shining on TrumpCare, and it sure looks to me like there are a lot of people not enjoying the movie. TrumpCare goes back to the days when healthcare in America mostly worked for the healthy and the wealthy.

We have a lot of debate ahead, so we are not going to just lay it all out here in one shot.

I do want to mention some key points on the roll that Ms. Verma, if confirmed, would play. I want to start by addressing what this means in terms of dollars and cents.

If you look at the fact that the Medicare tax, which everybody pays every single time they get a paycheck, and that money is used to preserve this program that is the promise of fairness to older people—the Medicare tax would be cut for only one group of Americans in this bill. I find this a staggering proposition. The people who need it the least, couples with incomes of over $250,000, people who need it the least would be given relief from the Medicare tax—not working families, just the wealthy.

As I indicated, we are talking all told about $275 billion worth of tax cuts to the special interests and the fortunate few, and it is largely paid for by taking away assistance to working people to help, for example, pay for their premiums.

I brought up the ACA Medicare payroll tax for a reason because I think when Americans look at their next paycheck—if you are a cop or a nurse and you get paid once or twice a month and you live, say, in Coos Bay, OR, or in Medford, another Oregon community, you will see it on your paycheck. If you are a cop or a nurse, no tax relief for you, but if you make over $250,000—on a tax that is used to help strengthen Medicare's finances, at a time when we are having this demographic revolution—the relief goes to people right at the top, and you reduce the life expectancy of the trust fund for 3 years.

The first thing I will say with respect to what this means, the provision I have just outlined breaks a clear promise made by then-Candidate Trump not to harm Medicare.

I remember these commercials—we all saw scores and scores of them—Candidate Trump said to America's older people—many of whom voted for him, I think, to a great extent because they heard this promise—he said: You know, you have worked hard for your Medicare. We are not going to touch it. We are not going to mess with it.

When the President was asked about cutting Medicare, here is what he said: Medicare is a program that works. People love Medicare, and it is unfair to them. I am going to fix it and make it better, but I am not going to cut it.

The President of the United States said he is not going to cut it.

Well, that promise not to harm Medicare lasted 6½ weeks into the Trump administration so the wealthy—the wealthy—could get a tax reduction, the fortunate few who need it least, and

the effect would be to cut by 3 years the life of the Medicare trust fund.

I think that ought to be pretty infuriating and concerning for people who work hard—cops and nurses and people who are 50, 55, 60 today. They are counting on Medicare to be around when they retire, but because TrumpCare made it a focus to give tax relief to the fortunate few, that tax relief cuts 3 years off the life of the Medicare trust fund.

If that wasn't enough, people who are 50, 55, 60, before Medicare, they are going to get another gut punch. This one is in the form of higher costs.

In parts of my home State—particularly in rural areas like Grant County, Union County, and Lake County—I am sure I am going to hear about this. I have townhall meetings in each one of my counties. A 60-year-old who makes $30,000 a year—now those are the people we have long been concerned about, particularly people between 55 and 65 because they are not yet eligible for Medicare.

A 60-year-old, in communities like I just mentioned, who makes $30,000 a year, could see their costs go up $8,000 or more. The reason that is the case is a big part of TrumpCare. It is based on something we call an age tax.

Back in the day when I was the director of the Oregon Gray Panthers—and I was really so fortunate at a young age to be the director of the group for close to 7 years—we couldn't imagine something like the hit on vulnerable older people that this age tax levies. Republicans want to give the insurance companies the green light to charge older Americans five times as much as they charge younger Americans. The reality is that older people are going to pay a lot more under TrumpCare. That is what we were trying to prevent all those years with the Gray Panthers. We didn't want to see older people pay more for their healthcare, the way they are going to under TrumpCare if they are 50 or 55 or 60.

I think the real question is whether they are going to be able to afford insurance at all. The reality is that a lot of those older people whom I have just described—and I have met them at my townhall meetings—every single week they are walking on an economic tightrope. They balance their food costs against their fuel costs and their fuel costs against their rent costs. Along comes TrumpCare and pushes them off the economic tightrope where they just won't be able to pay the bills, particularly older people in rural areas.

So the reality is that it is expensive to get older in America, and we ought to be providing tools to help older people. But what TrumpCare does is, instead of giving tools to older people to try to hold down the costs, TrumpCare basically empties the toolbox of assistance and basically makes older people pay more.

Next, I want to turn to the Medicaid nursing home benefit. Working with senior citizens, I have seen so many older people—the people who are on an economic tightrope, who are scrimping and saving—even as they forego anything that wouldn't be essential, burn through their savings. So when it is time to pay for nursing home care, they have to turn to Medicaid. The Medicaid Program picks up the bill for two out of every three seniors in nursing homes.

Now, today the Medicaid nursing home benefit comes with a guarantee. I want to emphasize that it is a guarantee that our country's older people will be taken care of. All of those folks—the grandparents whom we started working for in those Gray Panther days—had an assurance that grandparents wouldn't be kicked out on the street. TrumpCare ends that guarantee.

You could have State programs forced into slashing nursing home budgets. You could see nursing homes shut down and the lives of older people uprooted. We could, in my view, have our grandparents that are depending on this kind of benefit get nickeled and dimed for the basics in home care that they have relied on.

When it comes to Medicaid, TrumpCare effectively ends the program as it exists today, shredding the healthcare safety net in America. It doesn't only affect older people in nursing homes. It puts an expiration date—a time stamp—on the Medicaid coverage that millions of Americans got through the Affordable Care Act. For many of those vulnerable persons, it was the first time they had health insurance. So what TrumpCare is going to come along and do is to put a cap on that Medicaid budget and just squeeze them down until vulnerable persons' healthcare is at risk.

If low-income Americans lose their coverage through Medicaid, it is a good bet that the only TrumpCare plans they will be able to afford are going to be worth less than a Trump University degree.

I want to move next to the effects of the bill on opioid abuse. Clearly, by these huge cuts to Medicaid, TrumpCare is going to make America's epidemic of prescription drug abuse-related deaths even worse. Medicaid is a major source of coverage for mental health and substance use disorder treatment, particularly after the Affordable Care Act, but this bill takes away coverage from millions who need it. We have had Republican State lawmakers speaking out about this issue as well as several Members of the majority in the Congress.

Colleagues, just about every major healthcare organization is telling the Congress not to go forward with the TrumpCare bill—physicians, hospitals, AARP—that is just the beginning. But the majority is just charging forward, rushing to get this done as quickly as possible.

We are going to have more to say about these issues.

I see my colleagues here.

To close, just by intertwining, how this appointment is going to be a key part of the discussion of TrumpCare revolves around the questions we asked Ms. Verma.

For example, I was trying to see if this bill would do anything to help older people hold down the cost of medicine. Now we have heard the new President talk about how he has all kinds of ideas about controlling the cost of medicine. Here was a bill that could have done something about it.

I see my colleagues, Senator STABENOW and Senator CANTWELL.

I said to the nominee: I would be interested in any idea you have—any idea you have—to hold down the cost of medicine. On this side we have plenty of ideas. We want to make sure that Medicare could bargain to hold down the cost of medicine. We have been interested in policy to allow for the importation of medicine. We said: Let's lift the veil of secrecy on pharmaceutical prices.

I asked Ms. Verma: How about one idea—just one—that you would be interested in that would help older people with their medicine costs. She wouldn't give us one example.

I am going to go through more of those kinds of questions, because the reality is—and I see Senators STABENOW and CANTWELL here—that what we got in the committee was essentially healthcare happy talk. Every time we would ask a question, she would say: I am for the patients; I want to make sure everybody gets good care.

So I thank my colleagues, and I yield for Senator CANTWELL.

The PRESIDING OFFICER. The Senator from Washington.

Ms. CANTWELL. Mr. President, will the Senator yield for a question?

Mr. WYDEN. Of course.

Ms. CANTWELL. Mr. President, I ask this of my colleague, the Senator from Oregon, because Washington, Oregon, and so many other States spend so much time innovating. The proposal we are seeing coming out of the House of Representatives really isn't innovation. I like to say that if you are looking at this, just at the specifics, the per capita cap is really just a budget mechanism. It doesn't have anything to do with innovation. It just has to do with basically triggering a cut to Medicaid and shifting that cost to the States. My concern is that we already do a lot with a lot less, and we know how to innovate. We would prefer that the rest of the country follow that same model. I would ask the Senator from Oregon: Do you see any innovation in this model, in capping and cutting the amount of Medicaid and shifting that to the States?

Mr. WYDEN. My colleague from Washington is ever logical.

When I looked at this, I thought of it as an innovation desert because I was looking for some new, fresh ideas. We have seen some of them from Senator CANTWELL's State, and I think the Senator from Washington makes a very

important point with that poster because the reality is that this is a cap. This is a limit on what States are going to get. As I touched on in my comments, I think what is going to happen is this cap is not going to be enough money for the needs. I think this is going to slash the help for nursing home care under Medicaid, which pays two-thirds of the bill, and I think the nursing home care under this flawed TrumpCare proposal is going to get nickeled and dimed.

My colleague from Washington is right. I tried to read section by section, and we have read it several times. But we wanted to make sure to look—to my colleague's point—for innovation, and this proposal is an innovation desert.

Ms. CANTWELL. I ask the Senator from Oregon this through the Presiding Officer. The innovation that was already in the Affordable Care Act really did address the Medicaid population, in which so much of that cost is for long-term care and nursing home care. So Medicaid equals long-term care for so many Americans. In the Affordable Care Act we accelerated the process of shifting the cost to community-based care because it is more convenient for patients and up to one-third of the cost of a nursing home. So if we keep more people in their homes, that is better innovation.

In the Affordable Care Act, we incentivized States. In fact, we had 21 States take us up on that—including Arkansas, Connecticut, Georgia, Iowa, Kentucky, Louisiana, New Hampshire, Texas, Ohio, Nevada, Nebraska. There are many States that are doing this innovation and basically trying to move the Medicaid population to community-based care so we can save money.

Savings from rebalancing could make up for a large portion of the money the House is trying to cut in this bill. Basically, they are not saving the money. They are shifting the burden to the States, instead of giving innovative solutions to people to have community-based care; that is, long-term care services and staying in their home longer. Who doesn't want to stay in their home longer? Then we support them through community-based delivery of long-term healthcare services, and we save the Nation billions of dollars.

In fact, our State did this over a 15-year period of time, and we saved $2.7 billion. That is the kind of innovation we would like to see. But instead of implementing the innovation we started in the Affordable Care Act, they are trying to cap the Medicaid funding, which basically is changing the relationship from a mutually supported State and Federal partnership to a capped federal block grant. They are just saying: We are going to cost-shift this burden to you the States.

I saw that the Center on Budget and Policy Priorities analyzed the current House proposal and found it would result in a $387 billion cost shift to the States. Does the Senator from Oregon think that Oregon has the kind of money to take its percentage of that $370 billion?

To my colleague from Michigan: Does the Senator think the State of Michigan has the dollars to take care of that Medicaid population with that level of a cut?

Ms. STABENOW. If I might lend my voice on this and thank both of my colleagues. Senator CANTWELL has been the leader in so many ways on innovation in the healthcare system as we debated next to each other in the Finance Committee on the Affordable Care Act.

I wanted to share that in Michigan, where we expanded Medicaid, because of changes that have been made and work that is being done in the budget going forward in the new year, there is now close to $500 million more in the State of Michigan budget than was there before because of Medicaid expansion and the ability to manage healthcare risk. People have more healthcare coverage. We actually have 97 percent of the children in Michigan who can see a doctor today, which is incredible. At the same time the State is going to save close to $500 million in the coming year's budget.

Mr. WYDEN. If I can add this, because I think my colleagues are making a very important point. If you look at the demographics, there are going to be 10,000 people turning 65 every day for years and years to come. Senators STABENOW and CANTWELL are making a point about flexibility. The reality is, if I look at the demographic picture, we are going to need more out of a lot of care options—institutional care, community-based coverage. But I think the point Senator CANTWELL started us on is that, at a time when we have a demographic where we are going to need more for a variety of care options—a continuum of care—what my State is basically saying is that we are going to get less of everything. There is going to be less money for the older people who have nursing home needs. I am looking at a new document from the Oregon Department of Human Services, and it indicates that we are going to lose substantial amounts—something like $150 million for community-based kinds of services. So I appreciate the point my two colleagues are making.

Ms. CANTWELL. Mr. President, if I could, I will ask the Senator from Oregon one more question, and maybe my other colleagues will join in.

When you do not realize the savings and you cost-shift to the States, some of the key populations that you hurt are pregnant women and children. We do not want to have less money. If you think about Medicaid, pregnant women and children are a big part of the population.

I know our colleague from Pennsylvania has joined us, and he has been a champion for the Children's Health Insurance Program—CHIP—and everything that we do for women and children. I don't know if he has seen this in his State. I don't know if the Senator from Oregon or the Senator from Michigan or the Senator from Pennsylvania wants to comment on this—on the notion that we are not realizing the savings from delivery innovations like rebalancing, and then figuring out how to best utilize those for the delivery of the services that so many people are counting on. With a per capita cap, you are really going to be starting in a very bad place with the people who need these resources the most, and when it comes to Medicaid, women and children are front and center in this debate.

I hate the fact that somebody is going to cost-shift to the States, that the States are not going to have enough money, and then the very people who would end up paying the price are the women and children. I don't know if the Senator from Oregon, the Senator from Michigan, or the Senator from Pennsylvania wants to comment on that.

Ms. STABENOW. I thank the Senator very much. I will say this briefly and then turn to our colleague from Pennsylvania, who has been such a champion for children.

I would say first—again, as I said a moment ago—that, because of Medicaid, because of the healthcare expansion, 97 percent of the children in Michigan now can see a doctor. That means moms who are pregnant and babies, and moms and dads are less likely to be going to bed at night and saying: Please, God, do not let the kids get sick, because they can actually go to a doctor.

It reminds me, though, of the other thing happening on the floor and the larger question of the nominee for the Centers for Medicare and Medicaid Services. In the larger context, I asked her about whether or not maternity care and prenatal care should be covered as a basic healthcare requirement for women. I mean, it is pretty basic for us. She wouldn't answer the question. Essentially, she said women can buy extra if they want it. The new Secretary of Health and Human Services said that we, as women, can buy extra coverage for basic healthcare coverage for us. So it all comes together—Medicaid, the nominee on the floor, and what the House is doing to take away maternity care. It is really just bad news for moms and babies.

Mr. WYDEN. I would only add that what we learned in our hearings and in our discussion is that women, particularly the women served by the Medicaid Program, are really dealing with the consequences of opioid addiction as well.

In our part of the world, I would say to Senator STABENOW and Senator CASEY—in Oregon and Washington—we feel like we have been hit with a wrecking ball with this opioid problem. Again, when Senator CANTWELL talks about shifting the costs, she is not talking about something abstract. This

is going to take away money for opioid treatment.

So I am very pleased that my colleague is making these points, and I look forward to the presentation.

Mr. CASEY. Mr. President, I thank Senator CANTWELL for raising the issue about the impact of this decision that the Congress will make with regard to a particular healthcare bill and then also, particularly, the Medicaid consequences.

I was just looking at what is a 2-page report that was just produced today and that I was just handed from the Center on Budget and Policy Priorities. It is State specific.

In this case, looking at the data from Pennsylvania—I will not go through all of the data on Medicaid—just imagine that three different groups of Americans have benefited tremendously from the Medicaid Program every day. That is why what is happening in the House is of great concern to us.

We have in Pennsylvania, for example—just in the number of Pennsylvanians who have a disability—722,000 Pennsylvanians with disabilities who rely upon Medical Assistance for their medical care. Medical Assistance is our State program that is in partnership with Medicaid. There are 261,000 Pennsylvania seniors who get their healthcare through Medicaid. Hundreds and hundreds of thousands of people who happen to be over the age of 65 or who happen to have a disability of one kind or another are totally reliant, on most days, on Medicaid. The third group, of course, is the children, and 33 percent of all of the births in Pennsylvania are births that are paid for through Medicaid.

When we talk about this bill that is being considered in the House or when we talk about the confirmation vote for the Administrator for the Centers for Medicare and Medicaid Services, this is real life. What happens to this legislation and what happens on this nomination is about real life for people who have very little in the way of a bright future if we allow some here to do what they would like to do, apparently, to Medicaid.

It sounds very benign to say that you want to cap something or that you want to block-grant. They are fairly benign terms. They are devastating in their impact, and we cannot allow it to happen. That is why this debate is so critical.

I have more to say, but I do commend and salute the work by Senator CANTWELL, Senator STABENOW, and Senator WYDEN in fighting these battles.

I will read just portions of a letter that I received from a mom in Coatesville, in Southeast Pennsylvania, about her son, Rowan. The mom's name is Pam. She wrote to us about her son, who is on the autism spectrum. In this case, she is talking about the benefits of Medicaid—Medical Assistance we call it in Pennsylvania.

Here is what she wrote in talking about the benefits that he receives. After he was enrolled in the program, she said that Rowan had the benefit of having a behavioral specialist consultant. That is one expert who was helping Rowan, who was really struggling at one point. A second professional they had helping him was a therapeutic staff support worker. So there was real expertise to help a 5-year-old child get through life with autism.

Here is what his mom Pam wrote in talking about, since he was enrolled, how much he has benefited and how much he has grown and progressed:

He benefited immensely from the CREATE program by the Child Guidance Resource Centers, [which is a local program in Coatesville]. Thankfully, it is covered in full by Medicaid.

She goes on to write the following, and I will conclude with this:

Without Medicaid, I am confident I could not work full time to support our family. We would be bankrupt, and my son would go without the therapies he sincerely needs.

Here is how Pam concludes the letter. She asks me, as her representative—as her Senator—to think about her and her family when we are deliberating about a nomination like this and about healthcare legislation.

She writes:

Please think of us when you are making these decisions. Please think about my 9-month-old daughter, Luna, who smiles and laughs at her brother, Rowan, daily. She will have to care for Rowan later in life after we are gone. Overall, we are desperately in need of Rowan's Medical Assistance and would be devastated if we lost these benefits.

This is real life for people. Sometimes it is far too easy here in Washington for people to debate as if these things are theoretical—that if you just cut a program or cap a program or block-grant a program, you are just kind of moving numbers around and moving policy around. This is of great consequence to these families, and we have to remember that when we are making decisions around here.

Everyone who works in this building as an employee of the Federal Government gets healthcare. We do not have someone else around the country who is debating whether or not we are going to have healthcare, like those families on Medicaid are having to endure.

I thank the Senator from Washington. I know that Senator STABENOW from Michigan may have more to add on this. We have a big battle ahead, but this is a battle that is not only worth fighting, but it is absolutely essential that we win the battle to protect and support Medicaid.

Ms. STABENOW. Mr. President, as Senator WYDEN's colloquy comes to an end, I will make a few comments in addition to those of my colleagues, and I very much appreciate all of their work.

There are so many different things to talk about as it relates to how healthcare impacts people. As Senator CASEY said, this is very personal; it is not political. There are a lot of politics around this, but it is very, very personal.

In Michigan, when we are talking about healthcare, in Medicaid alone we are talking about 650,000 people who have been able to get coverage now. Most of them are working in minimum wage jobs, and they now are able to get healthcare but couldn't before, as well as their children. That adds to the majority of seniors who are in nursing homes now, folks getting long-term care, folks getting help for Alzheimer's and other challenges and who are relying on Medicaid healthcare to be able to cover their costs.

I want to share a letter, as well, from Wendy, a pediatric nurse practitioner from Oakland County in Michigan. We have received so many letters—I am so grateful for that—and emails.

She writes:

As a pediatric nurse practitioner, I have seen so many of my patients benefit from the Affordable Care Act. Physical exams for the kids are now covered in full, with no co-pay. This means the kids are in to see us, which means we catch healthcare issues and early problems with growth or development that otherwise might be undetected and left untreated until it became a much bigger problem.

Isn't that what we all want for our children, to catch things early?

Immunizations are covered, which keeps everyone safer. Screening tests are covered, so potential problems are caught while they can still be managed. This better care keeps kids healthier and happier and prevents longer term care costs.

She goes on to write:

The Medicaid expansion means even more kids are covered, keeping not only those children healthier but keeping everyone around them healthier. Previously, parents of children who did not have insurance coverage would not seek care until the children were so ill that they could not see another option. Frequently, these children then utilized emergency room care—

Which, by the way, is the most expensive way to treat health problems—

[it was] not only a missed opportunity for complete and preventative healthcare but at a cost passed on to the community.

On a much more personal level, in 2015, our granddaughter, at age 3, was diagnosed with epilepsy related to a genetic condition . . . which made her brain form abnormally. On top of the epilepsy, she has developmental delays and autism, all related to her double cortex syndrome. Although our daughter and son-in-law are fully employed (teacher and paramedic), she qualifies for Children's Special Health Care (under Medicaid). This has been a huge blessing for us, and without it our family would have been financially devastated.

We are hopeful that my granddaughter will continue to have good seizure control and will develop to reach her full potential, but without the care that her private insurance and Children's Special Health Care provides, she would not have much of a chance of getting anywhere near her potential. I do not want to even consider how it will affect her future if insurance companies can refuse to cover her care due to her preexisting condition.

She concludes:

Please do not let partisan politics take precedence over doing what is right and what is best for the health of every U.S. citizen.

I know we are all getting hundreds of thousands of letters and emails and phone calls of very similar stories because healthcare is personal to each of

us—to our children, our grandchildren, our moms, and dads, and grandpas and grandmas. It is not political.

I am very grateful for my colleagues' being here today. I want to speak not only about the importance of expansion under Medicaid but also about the person who would be in charge of that very, very important set of services. That is the nomination in front of us, that of Seema Verma to be the Administrator of the Centers for Medicare and Medicaid Services.

This is a critical position, especially given the ongoing efforts that we are seeing right now to repeal healthcare—the Affordable Care Act—and replace it with legislation that would literally rip away coverage for millions of people and pull the thread that unravels our entire healthcare system. The decisions of the Administrator, both as an adviser to the President and as someone with the authority to make large changes in the implementation of existing law, will have far-ranging consequences for all of us—certainly, for the people whom we represent and especially for those who need healthcare, have begun receiving it, and now may very well see it taken away.

In the Finance Committee, when I asked Ms. Verma about Medicaid, I found that her positions would hurt families in Michigan, would hurt seniors in nursing homes, and would hurt children. And looking at her long record as a consultant on Medicaid, we know that Mrs. Verma's proposals limit healthcare coverage and make it harder to afford healthcare coverage, putting insurance companies ahead of patients and families once again.

I am also very concerned about her position on maternity coverage. During the hearing, I asked Ms. Verma whether women should get access to basic prenatal care and maternity care coverage as the law now allows—I am very proud of having authored that provision in the Finance Committee—or whether insurance companies should get to choose whether to provide basic healthcare coverage for women. I reminded her that before the Affordable Care Act, only 12 percent of healthcare plans available to somebody going out to buy private insurance offered maternity care—the vast majority did not—and that the plans that did often charged extra or required waiting periods. Her response indicated that coverage of prenatal and maternity care should be optional—optional. We as women cannot say our healthcare is optional.

The next CMS Administrator should be able to commit to enforcing the law requiring maternity care to be covered and commit to protecting the law going forward for women. Being a woman should not be a preexisting condition. Getting basic healthcare should not mean we have to buy riders or extra coverage because being a woman and the coverage we need is somehow not viewed as basic by the insurance company. We have had that fight. Women won that fight with the Affordable Care Act. We should not go backward.

I followed up with Ms. Verma, along with many colleagues, but have not received a response.

Over 100 million Americans count on Medicare and Medicaid. They need a qualified Administrator who puts their needs first, and I cannot vote for a nominee who does not guarantee that she will fight for the resources and the healthcare that the people of Michigan count on and need.

TRUMPCARE

Finally, I wish to take a moment to talk about the healthcare bill that has now come out of committees in the House and will be voted on in the House and then coming to us in the Senate. Frankly, let me start by saying that this is a mess—it is a mess on process, and it is a mess on substance.

As a member of the Finance Committee, I can tell my colleagues firsthand that this was not rammed through the Senate Finance Committee when we passed the Affordable Care Act. We had months and months and months of hearings, of which I attended every one, I think, and after that, the floor debate and that discussion and the discussion in the House. We knew what it would cost before we brought it up, by the way, which saved a lot of money by doing a better job of managing healthcare costs and creating innovation for our providers.

But the truth is that when we look closely at what is being debated in the House, for families in Michigan and across the country, it is really a triple whammy: higher costs, less healthcare coverage, and more taxes. Overall, it means more money out of your pocket as an American citizen, unless you are very wealthy, and it means less healthcare. This is not a good deal.

It cuts taxes for the very wealthy and for insurance companies. It gives an opportunity for insurance company execs to get pay increases and cuts taxes for pharmaceutical companies. Someone making more than $3.7 million a year would save almost $200,000. Let me say that again. Someone making more than $3.7 million a year would put $200,000 in their pocket as a result of this healthcare bill, TrumpCare. To put that in perspective, 96 percent of Michigan taxpayers would not qualify for this. Ninety-six percent of everybody in Michigan who gets up every day, goes to work, works hard—some take a shower before work, some take a shower after work—they are working hard every single day, and they would pay more, while the small percentage of those at the very top would get $200,000 back in their pockets.

As I indicated, it provides a tax break for insurance company CEOs to get a raise of up to $1 million but increases taxes and healthcare costs for the majority of Americans. Middle-class Americans and those working to get into the middle class would see tax increases and lose healthcare coverage at the same time—such a deal.

For seniors, this would allow insurance companies to hike rates on older Americans by changing the rating system. AARP, a nonpartisan organization, has indicated that premiums would increase up to $8,400 for somebody who is 64 years of age earning $15,000 a year. So they earn $15,000 a year, and their premiums could go up by more than half of what they are making. To put that in perspective—again, a comparison of who wins and loses under this plan—if you are 64 years old and earn $15,000 a year, you pay more—$8,400 more. If you are 65 years of age and earn over $3.5 million a year, you put $200,000 more back in your pocket. This is a rip-off for the majority of Americans and should not see the light of day.

On top of that, TrumpCare creates Medicaid vouchers. We have been talking with colleagues about the change in Medicaid. What does that mean? Well, instead of being a healthcare plan that covers nursing home care, whether that is someone who needs very little care or someone who has Alzheimer's or other extensive needs, your mom and dad or grandmom and granddad would get a voucher, and if it didn't cover the care in the nursing home, as it does now, then your family would have to figure out a way to make up the difference. We could very possibly have the situation we had before the passage of the Affordable Care Act where a lot of folks were going bankrupt trying to figure out—you use the equity in your home, except because of what happened in the financial crisis, you may not have much equity in your home anymore. So you try to figure out, how do I make up the difference to help my mom or dad or granddad and grandmom in the nursing home? That will be a very common discussion, I would guess, if this passes. So turning Medicaid into a voucher system would cut nursing home care and healthcare for families.

Let me also say that when there is a healthcare emergency like we had in Flint, MI, with 100,000 people being poisoned with lead and over 9,000 children under the age of 6 with extensive lead poisoning, and we had the President and the past administration step in to help those children because of the health problems from the lead exposure, that would not be possible under this new regime. It will not be possible to step in when there is a healthcare emergency for children or for a community.

In Michigan today, 150,000 seniors depend on healthcare through Medicaid for long-term care. Three out of five seniors in nursing homes in my State—three out of every five seniors—count on Medicaid for their long-term care. This radically changes and dismantles that healthcare system. We have nearly 1.2 million children in Michigan and 380,000 people with disabilities who use this system.

So we have a situation where we would see a radically different

healthcare system for seniors and additional costs for seniors, which is why the AARP is calling this the senior tax. We would see children losing their healthcare. We would see insurance companies being put back in charge of decisions—decisions about whether women can get basic care and what, if any, kind of preexisting condition coverage happens. What I have seen is something that doesn't work and is going to put more costs back onto families.

There is mental healthcare and the ability to make sure that if you have a healthcare challenge, such as cancer or some other kind of challenge, your doctor is going to be able to treat you and give you all the care you need, not just a lump sum that the insurance company has decided that they are willing to spend. Then there is accountability as it relates to how much of your healthcare dollars that you spend goes into your medical care. There are a whole range of things that have been put in place so that you have more confidence that at least you are getting what you are paying for. Those things go away and insurance companies are put back in charge. They are given a big tax cut. The insurance company execs are given an opportunity for big increases in their pay, while everybody else is paying more.

So let me go back to where I started. TrumpCare, the bill being voted on in the House, is really a triple whammy for the people of Michigan: higher costs, less coverage, and more taxes. It makes no sense. I will strongly oppose it when it comes to the Senate. I am hopeful that we can put this aside, stop all of the politics about repeal, and have a thoughtful discussion about how we can work together to bring down costs and to be able to address concerns to make healthcare better, not take it away.

Thank you, Mr. President.

The PRESIDING OFFICER (Mr. CASSIDY). The Senator from Rhode Island.

Mr. REED. Mr. President, I rise today in opposition to the nomination of Ms. Seema Verma to be Administrator of the Centers for Medicare and Medicaid Services, or CMS.

As a $1 trillion agency with oversight over Medicare, Medicaid, and the Children's Health Insurance Program, as well as State health insurance marketplaces, CMS is providing affordable health insurance to 100 million Americans, including nearly half a million Rhode Islanders.

Given the responsibility that this post entails of ensuring access to health care coverage for our most vulnerable citizens, coupled with a lack of commitment to fighting back against proposals by this administration and some of my colleagues on the other side of the aisle to dismantle these programs, I cannot support Ms. Verma's nomination to be CMS Administrator.

CMS is responsible for a key aspect of the Affordable Care Act—the health insurance marketplaces—which provide an avenue for all consumers to shop for the health insurance options that fit their needs and connect consumers with tax credits and subsidies that make the coverage affordable.

President Trump and his new Health and Human Services Secretary Tom Price are adamant about repealing the ACA and rolling back these benefits. In her confirmation hearing, Ms. Verma was asked multiple times to commit to protecting the ACA for the millions of Americans who were able to access coverage for the first time because of the law, but she would not do so. This, to me, is unacceptable.

CMS also works with States and other agencies at the Department of Health and Human Services to ensure that the plans offered on the exchanges are not only affordable but also provide real coverage for when it is most needed. I am concerned with Ms. Verma's beliefs about what health insurance coverage should look like.

During her confirmation hearing, she spoke at length about providing consumers more choices about their healthcare. Yet she opposes many of the protections the ACA provides for consumers. For example, she implied that she thought maternity care should be optional. It seems to me that for many families, they would be left with the choice to either pay for maternity care entirely out-of-pocket—all the while paying premiums and copays to the insurance company—or to go without care at all. I don't think these are the kinds of choices we should be imposing on families.

Turning my attention to Medicaid for a minute, I am deeply concerned about the Republican proposals to fundamentally change Medicaid and shift costs to States and to consumers. These proposals aren't new. Year after year, Republicans—often under the leadership of then-Congressman, now-HHS Secretary Tom Price—have proposed block-granting Medicaid, cutting the program by hundreds of billions of dollars. While Ms. Verma is not yet confirmed, she did express support in her confirmation hearing for this very concept—block-granting or capping Medicaid spending. Just this week, we saw a new version of this proposal, which simply delays cuts to Medicaid until 2020. In my opinion, this is just a veiled attempt to help gain support for the effort now and then turn around and decimate Medicaid in a few years.

In my home State of Rhode Island, nearly 300,000 Rhode Islanders access healthcare through Medicaid. That is about one-third of our population, roughly. That is a significant number for a small State like Rhode Island. Let's break down that number to see who would be impacted by these across-the-board cuts to Medicaid.

One out of four children in Rhode Island gets care from Medicaid and half of the births in the State are financed through Medicaid. One in two Rhode Islanders with disabilities are covered by Medicaid, and 60 percent of nursing home residents in the State get their care from Medicaid. Think about what would happen if this funding is cut—and that is the trajectory of the Republican proposals—States would have to decide, among these populations, who will get health care, children or the elderly in nursing homes, the disabled or other Medicaid recipients. If States try to make up the difference, that would result in cuts elsewhere, such as education and infrastructure. Indeed, given the demands for health care, given the tensions between seniors and nursing homes, and children needing care, the States will try their best to pull from other areas. What is the next biggest area of State expenditure? Education. Now you will have pressure on State education budgets. Higher education particularly will be pressured. All of this will be the ripple effect from these proposed cuts to Medicaid. And make no mistake, when Ms. Verma and my colleagues talk about converting Medicaid to a block grant program or capping spending, it is not about flexibility for the States, it is about reducing the Federal commitment to providing funding to the States.

Lastly, I am concerned about Ms. Verma's ability to safeguard Medicare for our seniors. Over 200,000 Rhode Islanders access care through Medicare, a benefit they have worked for and earned over their entire careers. I believe Medicare is essential to the quality of life for Rhode Island's seniors and for seniors across the country, and indeed for the children and families of these seniors. In fact, I supported the ACA because it made key improvements to Medicare that strengthened its long-term solvency and increased benefits, such as closing the prescription drug doughnut hole and eliminating cost-sharing for preventive services such as cancer screenings.

Over 15,000 Rhode Islanders saved $14 million on prescription drugs in 2015, an average of $912 per beneficiary. In the same year, over 92,000 Rhode Islanders took advantage of free preventive services, representing over 76 percent of the beneficiaries. Repealing the ACA means repealing these benefits for seniors and shortening the life of the Medicare trust fund by over a decade.

Unfortunately, Ms. Verma has little to no experience working with Medicare, and in her hearing and written responses to questions, she appeared to have very little to no familiarity with major aspects of Medicare. In her confirmation hearing and accompanying documents, she simply has not proven herself to be an effective advocate for protecting these earned benefits for our seniors.

We need an Administrator for CMS who will work to safeguard health care coverage for children, seniors, and people with disabilities, who will seek to strengthen Medicaid, Medicare, CHIP, and our entire healthcare system. For the reasons I have outlined, along with other reasons some of my colleagues have raised, Ms. Verma, in my opinion,

is not up to this task. As such, I will oppose the nomination and encourage my colleagues to do the same.

I yield the floor.

Mr. President, I request the ability to yield the remainder of my postcloture time to Senator WYDEN.

The PRESIDING OFFICER. The Senator has that right.

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

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

TRUMPCARE

Mr. WYDEN. Mr. President, here we are, with our colleagues on their way home, and I thought it would be helpful to take a minute and give an assessment of where the TrumpCare debate is at this point because we have seen the two major committees in the House act. Some $300 billion was slashed from safety net health programs, while insurance company executives making over $500,000 annually were given a juicy tax break as a bonus.

To put this into perspective, this tax break that the insurance companies' CEOs seem to have after two committees in the other body have acted on TrumpCare—the amount of the bonuses for the insurance company executives would be enough to cover the TrumpCare-created shortfall in Oregon's community-based services for the elderly and the disabled two or three times over.

What we are talking about is how hundreds of billions of dollars in tax breaks are going to the fortunate few and special interests, while some of the money is coming from stealing a chunk of those dollars from the Medicare trust fund. And this is very much intertwined with the nominee's work because she would be overseeing Medicare payments to rural hospitals in places like Louisiana and Oregon.

What I am going to turn to now is what TrumpCare, based on these two committees, means for rural areas. And, of course, it repeals the Medicaid expansion. It caps the Medicaid Program. In my own view, and I know the Senator from Louisiana knows a lot about healthcare, in rural communities—and most of our towns are under 10,000 in population. I am from southeast Portland. I love southeast Portland. The only regret is I didn't get to play for the Portland Trail Blazers. Most of the communities in our State are under 10,000 in population. As the Senator from Louisiana knows, we are talking about critical access facilities. We are talking about sole community hospitals. We are talking about the facilities that deal with acute care.

During the last major break over the President's holiday, I started what is going to be a yearlong effort for me, and I called it the rural healthcare listening tour. It is eye-popping to have those rural healthcare providers who in my State have worked so hard to find ways to get beyond turf and battles, to work together—the hospitals, the doctors, the community health centers, and the like. They have built an extraordinary effort that helps to wring more value out of scarce dollars. Their programs are based on quality, not on volume.

By the way, they are a huge source of economic growth and jobs for our rural communities. I spent the President's Day recess, and the next major recess as well getting out and listening to them. The verdict from Oregon's healthcare providers, who have worked very hard at being innovative, trying to make better use of what are called nontraditional services, said these kinds of cuts are not an option if you want to meet the needs of so many who have signed up as a result of the Medicaid expansion.

TrumpCare ends the Medicaid expansion, rolling back Federal matching funds in 2020. The rural hospitals in my State are frequently the only healthcare provider available for hundreds of miles. The Medicaid expansion helped these hospitals keep their doors open.

I don't think it is hard to calculate why the hospitals are speaking out against the flood approach of TrumpCare. They have a lot of facilities in rural areas that are already on tight margins. If these communities lose the ability to cover needy people, some of the essential hospitals—and I just described three types of them—are going to have to close, and the reality is going to be that patients aren't going to have any doctor anywhere nearby.

Understand, if the majority insists on ramrodding TrumpCare through—and at this point we have, I believe—staff just told me that there aren't any budget estimates. As of now, the Congressional Budget Office is tasked with providing accurate assessments of the budget implications. There are not any budget implications.

So here is the latest. It comes from media that I think is not considered by many Trump supporters to be a purveyor of fake news. This comes from FOX News. They said: Unknown in the new healthcare plan, unknown in TrumpCare—the cost. How many lose or gain insurance?

I am very pleased that my colleague from New Hampshire has come to join me because some of this, I would say to my friend from New Hampshire, leaves you incredulous because this comes from FOX News. FOX News is hardly a source for what many Trump supporters would consider fake news. FOX News is asking the question because they are saying it is unknown. It is unknown in the new healthcare plan, Senator SHAHEEN, according to FOX News. The cost is unknown, and how many lose or gain insurance is unknown.

I would say to my colleagues, because my friend from Louisiana has joined the Finance Committee, and I remember welcoming him and Senator MCCASKILL, our new members. My colleague from Louisiana is a physician and is very knowledgeable about these issues. I don't know how you have a real healthcare debate in America—and I have been working on this since I was director of the Gray Panthers at home back in the days when I had a full head of hair and rugged good looks. When we would start a debate, nobody would consider starting it without having an idea of costs or how many lose or gain insurance. How much more basic, I say to Senator SHAHEEN, does it get than that? Are these ''gotcha'' questions? Are these alternative facts? Are these people who are hostile to conservatives? I think not. FOX News—unknown in the new healthcare plan.

I have been outlining what this means in terms of the transfer of wealth from working families in New Hampshire and Oregon to the most fortunate in our country—people who make $250,000 or more. They are actually going to be the only people in America who get their Medicare tax cut. So you have this enormous transfer of wealth, what I call the reverse Robin Hood: taking from the working people and giving to the fortunate few.

After two committees have now acted in the other body—two committees have acted—FOX News says the big questions are outstanding. The Senator from New Hampshire knows a lot about rural healthcare. I was just outlining to my colleagues what this means for critical access hospitals, sole community hospitals, acute care facilities. These are the centerpieces of many rural communities, the essence of rural life. You can't have rural life without rural healthcare.

Here we are on Thursday afternoon—with many of our colleagues out there tackling jet exhaust fumes heading home—and the big questions, according to FOX News, are outstanding.

I am very pleased the Senator is here. As usual, she is very prompt and appreciated.

I look forward to her remarks.

The PRESIDING OFFICER. The Senator from New Hampshire.

Mrs. SHAHEEN. Mr. President, before my colleague from Oregon leaves, I want to ask him a question.

I am reminded, in 2009 and 2010, as we were working on the Affordable Care Act, that the HELP Committee held 14 bipartisan roundtables, 13 bipartisan hearings, 20 bipartisan walkthroughs on healthcare reform. The HELP Committee then considered nearly 300 amendments and accepted more than 160 Republican amendments, and the Finance Committee—where my colleague is the ranking member—held 17 roundtables, summits, and hearings on the topic. The Finance Committee also held 13 member meetings and walkthroughs, 38 meetings and negotiations, for a total of 53 meetings on

healthcare reform. During its process, the Finance Committee adopted 11 Republican amendments.

Don't you find it particularly ironic that we are seeing this TrumpCare legislation being pushed through on the House side—and what we are hearing, the rumors about what is going to happen in the Senate is it is not going to have any hearings and it is going to be brought to the floor and we are expected to vote on it without having a chance for the public to know what is in it.

Mr. WYDEN. My colleague is making a very important point. I think we all know the Senate budget process is a lot of complicated lingo. People in the coffee shops in New Hampshire and Oregon don't follow all the fine points of reconciliation.

As the Senator has just said, what they are using is a process that is known as reconciliation. That is the most partisan process you can come up with. There is no more partisan kind of process, and we were talking about the tally. As of this afternoon, two committees in the House have acted.

The Senator from New Hampshire just mentioned, I think, there were 11 Republican amendments in just one of the committees.

Mrs. SHAHEEN. Right.

Mr. WYDEN. As of this afternoon at 4, after hours and hours of debate, I am of the impression that not a single significant Democratic amendment has been adopted—so the Senator's point of highlighting the difference in the process, where we had all of the hearings and all of the opportunities that you have to have to get a good, bipartisan bill.

As my colleague knows, I don't take a backseat to anybody in terms of bipartisan approaches in healthcare. I have worked with Republicans—Chairman HATCH, chronic care. Senator BENNET and I worked on a bill with eight Democrats and eight Republicans. I appreciate your making this point.

As of this afternoon, as far as I can tell, no Democratic amendment has been adopted. You highlighted 11 Republican amendments getting adopted in just one committee. As we indicated, FOX News—not exactly hostile to some of the ideas being advanced by the majority—has certainly called them out on this.

Mrs. SHAHEEN. I appreciate the eloquent comments from the Senator from Oregon and all of his efforts to make sure we don't take away healthcare for so many people who desperately need it.

That is why I came to the floor today, because I spent the week we were back home—not last week but the week before—talking to constituents in New Hampshire and listening to what their concerns were.

What I heard was that people were deeply, deeply concerned and very upset by the efforts here to repeal the Affordable Care Act, when they didn't know what the replacement meant for them. In dozens of conversations and roundtable discussions at a townhall forum, Granite Staters shared stories of how the Affordable Care Act has been a lifeline for them. I heard from people who say their lives have been saved by the law.

In fact, we can see what is at risk in the State of New Hampshire, where we have almost 600,000 Granite Staters who have preexisting conditions. We have 118,000 people who could lose coverage. We have 50,000 Granite Staters with marketplace plans who are in the exchange, 42,000 who are enrolled in Medicaid, and 31,000 who have tax credits that lower the cost of healthcare for them. If that is taken away, so many of those people have no option for getting healthcare.

What we know now, after we have finally seen the plan Republican leaders are talking about, we know those fears were well founded that they were worried they were going to lose their healthcare. What we have seen is legislation to repeal the Affordable Care Act that would have catastrophic consequences not only for people in New Hampshire but for people across this country.

It is especially distressing that TrumpCare—as it has been introduced by the Republicans—would roll back expansion of the Medicaid Program, which has, in New Hampshire and across this country, been an indispensable tool in our efforts to combat the opioid epidemic. In addition, we are seeing, as the Senator from Oregon pointed out, that TrumpCare would terminate healthcare subsidies for the middle class and for other working Americans, and it would replace those subsidies with totally inadequate tax credits—as low as $2,000, which doesn't begin to pay for healthcare coverage for an individual, much less a family. This means as many as 20 million Americans could lose their healthcare coverage.

Even as the bill makes devastating cuts to the middle class, it gives the wealthiest Americans a new tax break worth several hundred thousand dollars per taxpayer. I think this proposed legislation is totally out of touch with the lives of millions of working Americans, people whose health and financial situation would be turned upside down by the bill.

Last week, in his response to President Trump's address to Congress, former Gov. Steve Beshear of Kentucky said something that really resonated with me. He reminded us that people who have access to healthcare thanks to ObamaCare are ''not aliens from some other planet.'' As he described, ''They are our friends and neighbors. . . . We sit on the bleachers with them on Friday night. We worship in the pews with them on Sunday morning. They're farmers, restaurant workers, part-time teachers, nurses' aides, construction workers, entrepreneurs,'' and often minimum wage workers. ''And before the Affordable Care Act, they woke up every morning and went to work, just hoping and praying they wouldn't get sick, because they knew they were just one bad diagnosis away from bankruptcy.''

To understand why people in New Hampshire are so upset and fearful about efforts to repeal the Affordable Care Act, we have to look again at this chart because some 120,000 Granite Staters could lose their health insurance. That is nearly 1 in every 10 people in the State of New Hampshire.

In particular, repeal of the Affordable Care Act would very literally have life-or-death consequences for thousands of people who are fighting opioid addiction, who have been able to access lifesaving treatment thanks to the expansion of Medicaid and the Affordable Care Act.

Sadly, one of the statistics we are not happy about in New Hampshire is that we have the second highest rate of per capita drug overdose deaths in the country. We trail only West Virginia. The chief medical examiner in New Hampshire projects that there were 470 drug-related deaths in 2016, including a sharp increase in overdose deaths among those who were 19 years old or younger. For a small State like New Hampshire, this is a tragedy of staggering proportions, affecting not just those who overdose but their families and entire communities.

I am happy to say, in the last couple of years, we made real progress in combating this epidemic because we had the Affordable Care Act and its expansion of Medicaid, which has given thousands of Granite Staters access to lifesaving treatment. Over the past year, I had a chance to visit treatment centers all across New Hampshire. I met with individuals who are struggling with substance use disorders and providers who are trying to make sure they get the treatment they need.

Last month, at a center in the Monadnock region of New Hampshire, I had an amazing private meeting with more than 30 people in recovery from substance use disorders. They are putting their lives back together, hoping to reclaim their jobs, to get back with their families, and they are able to do that largely because of treatment that is made possible by the Affordable Care Act.

One patient shared her story with me. As with so many others in treatment, her story is one of making mistakes, of falling into dependency, of struggling with all her might to escape her addiction. She is in recovery for the second time, and she said that this time for her is a life-or-death situation. She has no family support. She worries that she will be homeless when she leaves the treatment program, but she is grateful for the Affordable Care Act because it has given her one more shot at getting sober and the chance for a positive future.

At a forum in Manchester—New Hampshire's largest city—a courageous woman named Ashley Hurteau said

that access to healthcare as an enrollee in Medicaid expansion was critical to her addiction recovery. She had been arrested following the overdose death of her husband. Ashley said an understanding police officer and a drug court were key to her recovery. She added this:

I am living proof that, by giving individuals suffering with substance use disorder access to health insurance, we, as a society, are giving people like me the chance to be who we really are again.

Without that access to treatment, where would Ashley be?

Several weeks ago I received a letter from Nansie Feeny, who lives in Concord, the capital of New Hampshire. She told me the Affordable Care Act had saved her son's life. This is what she wrote:

[My son] Benjamin went to Keene State College with the same hopes and dreams many have when building their American dream. While there he tried heroin. Addiction overcame him but did not stop him from graduating. After graduation he suffered a long road of near death existence. After a couple of episodes where he had to be revived (fentanyl) he chose recovery. And it was due to ObamaCare that we were able to get him insured so he could get the proper help he needed and [into] a suboxone program that assisted him with staying ''clean.''

In April—

She wrote, and you could read between the lines how relieved she was—

it will be a year for Ben in his recovery. Without ObamaCare, this would not have been possible. . . . I can't find the words to define my gratitude to President Obama. I believe my son would not be alive today if it were not for this plan that provided the means he needed to get the help he needed at the time he needed it. Ben still has a long road ahead of him but I will see to it that he never walks it alone.

I also want to share a powerfully moving letter from Melissa Davis, an attorney in Plymouth, NH. Ms. Davis writes:

I am a lawyer who frequently works on behalf of clients who are suffering from substance use disorder, mental health conditions, or a combination of both. I have been working with these clients for over 10 years and I can tell you that access to health insurance has always been the biggest obstacle in obtaining quality and consistent treatment. Since passage of the Affordable Care Act and the expansion of Medicaid, my clients are actually able to access real treatment in ways they never were before. Before the ACA, there were far too many times where my clients were unable to afford private substance use disorder treatment, wait lists at community mental health agencies were extremely long, and AA and NA were not enough. Without treatment, these clients often ended up in jail or worse, dead. I still have clients who face obstacles to obtaining quality treatment, but the ability to get insurance removes a huge obstacle.

Ms. Davis concludes with this warning:

I am sincerely afraid for what will happen to my clients and my community if access to quality substance use disorder and mental health treatment is taken away from those people who need it most because they are unable to get insurance. Please do everything you can to save the ACA.

In dozens of visits to New Hampshire during the campaign, President Trump pledged aggressive action to combat the opioid crisis. In his address to Congress last week, he once again promised action to expand treatment and end the opioid crisis. But despite these bold words and big promises, the President's actions have sent a totally different signal. His actions threaten an abrupt retreat in the fight against the opioid epidemic.

By embracing the House Republican leadership's plan to repeal the Affordable Care Act, President Trump has broken his promise to the people of New Hampshire. This misguided bill would roll back the expansion of Medicaid, and it could terminate treatment for hundreds of thousands of people in New Hampshire and across America who are recovering from substance use disorders.

Meanwhile, the President's nominee to serve as Administrator of the Centers for Medicare and Medicaid Services, Seema Verma, has been an outspoken advocate of deep cuts to Federal funding for Medicaid. As we have seen with so many of the Trump administration nominees, Ms. Verma has an underlying hostility to the core mission of the agency that she has been asked to lead.

Seema Verma is currently a health policy consultant who has called for less Federal oversight of the Medicaid Program and advocated for policies expressly designed to discourage patients from seeking care—for instance, by imposing cost-sharing burdens on Medicaid recipients. In addition, she is a staunch advocate of block-granting Medicaid and turning it into a per capita cap system. Over time, this would lead to profound cuts to Medicaid, forcing States to raise eligibility requirements and terminate coverage for millions of recipients.

Let's be clear as to who these recipients are. In 2015, the 97 million Americans covered by Medicaid included 33 million children, 6 million seniors, and 10 million people with disabilities. Seniors, including nursing home costs, account for nearly half of all Medicaid expenditures.

These are some of the most vulnerable people in our society, and they will be the targets of Ms. Verma's determined efforts to cut funding for Medicaid and terminate coverage for millions of current recipients.

I also have deep concerns about this nominee's commitment to protecting women's healthcare. During her confirmation hearing in the Finance Committee, Ms. Verma was asked if women should get access to prenatal care and maternity coverage as afforded under the Affordable Care Act or whether insurance companies should get to choose whether to cover this for women.

Ms. Verma tried to clarify when she met with me that she hadn't really meant what she said. But what she said was that maternity coverage should be optional, that women should pay extra for it if they want it. Of course, the problem with this position is that it takes us backward to the days before the ACA, when only 12 percent of policies on the individual insurance market offered maternity coverage.

In the State of New Hampshire, before the Affordable Care Act, you could not buy an individual policy that covered maternity benefits. They were not written. Insurers who offered coverage charged exorbitant rates with high deductibles, plus benefit caps of only a few thousand dollars. This is a major reason why, before the Affordable Care Act, women were systematically charged more for health insurance than men. In the eyes of insurance companies, being a woman was seen as a preexisting condition, and they charged us more accordingly.

Well, the American people don't want drastic cuts to Medicaid, cuts that will threaten coverage for children, for seniors, for people with disabilities, and for those receiving treatment for substance use disorders. That is why I intend to vote against the confirmation of Seema Verma to head CMS.

In recent years, we have made impressive gains, securing health coverage for millions of Americans and significantly improving the health of the American people. I can't support a nominee who wants to reverse these gains.

In recent weeks, all of our offices have been flooded with calls, with emails, with letters opposing the Trump administration's plans to repeal ObamaCare and undermine both the Medicare and Medicaid Programs. We need to listen to these voices. We need to keep the Affordable Care Act and the expansion of Medicaid.

There are things we can do to make it better, and we should work together to do that. But we have heard from people loud and clear across this country. It is time now to respect their wishes, to come together to fix this landmark law, and to ensure that it works even better for all Americans.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. WYDEN. Mr. President, before my colleague from New Hampshire leaves, does she have a quick minute for a question?

Mrs. SHAHEEN. Absolutely.

TRUMPCARE

Mr. WYDEN. I thank her for her presentation. It was factual and very specific, and I think it really highlighted so many of the concerns that we have at this point.

I want to see if I could get this straight on the opioid issue. Here you all are in New Hampshire, right in the center of the Presidential campaign. All of the candidates are coming through, and they are practically trying to outdo each other in terms of their pledges to deal with this wrecking ball that is the opioid addiction that has swept through New Hampshire

and, of course, my own home State as well.

I remember then-Candidate Trump being particularly strong and assertive about how he was going to fight opioids.

I think what my colleague said—and I am curious, so I am going to ask a couple of questions because I don't think folks even in my home State are aware of some of these things. So I am going to ask my colleague about it.

Are folks in New Hampshire aware at this point—my colleague put up that Trump chart, showing how the people didn't know what was being cut and how much it was going to cost and all the rest. Are people in New Hampshire at this point aware of the fact that this is essentially after a campaign in their home State, which certainly put out a lot of TV commercials and campaign rhetoric in the fight on opioids?

I think my colleague said that when people unpack this, they are going to see that this is a major broken promise, that TrumpCare is a major broken promise on opioids because, in terms of the time sequence, they all had debates and commercials, then we finally got some money in order to have treatment.

And I think what my colleague said is that now, as a result of TrumpCare and the cap on Medicaid, there will not be the funds to get the treatment to people who are so needy. Is that what this is going to be about in New Hampshire?

Mrs. SHAHEEN. That is absolutely correct.

I remember meeting one young man early in the fall, in the middle of the campaign early last year. He came up to me in Manchester and said: I am so worried about what is going to happen in this election because I am in recovery; I am an addict. He said: I am worried that whoever gets elected is not going to continue to make sure that I can get the treatment I need. He said: I am worried about Mr. Trump.

As my colleague pointed out, Donald Trump, when he was campaigning in New Hampshire, made a lot of promises about how he was going to address the heroin and opioid epidemic, how he was going to make sure that people could get treatment, treatment at a cost they could afford.

Well, thanks to the Affordable Care Act and the expansion of Medicaid and the great work by our Republican legislature and our Democratic Governor—then-Governor HASSAN, who is now in the Senate—we passed a plan to make sure that people who had substance use disorders could get treatment.

Last year we had 48,000 applications submitted under the expansion of Medicaid for treatment of substance use disorders. If we pulled the plug on that Medicaid expansion so that people couldn't get that treatment, they wouldn't have anywhere to go.

That is what I heard when I was at Phoenix House in Dublin, in the western part of New Hampshire, a couple of weeks ago. I was sitting around with about 30 people in recovery, people who are hopeful for the first time in a long time because they are in treatment and they can see they can put their lives back together.

I said to them: What happens if we no longer have the Medicaid Program?

They said: We don't have any other options. We don't have treatment.

What we heard from President Trump is that he was going to introduce a healthcare plan that was going to cover more people for less money and better quality. Well, that is not what we are seeing.

The TrumpCare that was introduced in the House this week that they marked up and that is going to be coming to the Senate doesn't do that. It reduces coverage under the Medicaid Program. It would throw thousands of people off of their treatment for substance use disorders, and there is nowhere else for them to go.

This is not an acceptable plan. This does not do what the President promised he was going to do. It is not what he promised in New Hampshire, it is not what he promised in the campaign, and it is not what he has promised since he became President.

Mr. WYDEN. I think my colleague's point is well taken.

As we have been saying, this is very much intertwined with the Seema Verma nomination because what we learned in the committee is, in Indiana, where she touts her pioneering work, if somebody had an inability to pay for a short period of time, they would be locked out of the program. So in terms of Medicaid, this is going to cause a real hardship.

I had already outlined that it is going to cause a hardship in another program that is important to New Hampshire, and that is Medicare, because we are implementing what is called the MACRA, the new reimbursement system for doctors. We asked her questions about rural care, and she didn't know the answer either.

I particularly wanted my colleague to walk us through this situation with respect to how New Hampshire residents are going to see TrumpCare as it relates to opioid addiction after they have all these grandiose promises and the many debates and commercials.

I thought I would ask if my colleague has time for one other question.

In New Hampshire, as in Oregon, we have a lot of seniors. It looks to me as if somebody who is, say, 58 years old or 62 years old is just going to get hammered by what we call the age tax because in these bills, which are now moving like a freight train with the House already moving in two committees, Republicans want to give insurance companies a green light to charge older people five times as much as they charge younger people. So I cited a number of my small, rural counties—Grant County, Union County, Lake County—and how a 60-year-old who makes $30,000 a year can see their insurance costs, because of the age tax, go up something like $8,000 a year.

I don't have the numbers as of now—Finance staff is still working on that for every single State—but obviously that tax sure looks like it is going to hit somebody in New Hampshire, an older person, people before they are eligible for Medicare, and particularly in that 55-to-65 bracket. It looks like it is going to hit them very hard. How is that going to be received, because in my time in New Hampshire, we talked about it, and a lot of those people really are walking on economic tightropes. They are balancing their food bill against their fuel bill and their fuel bill against their rent bill. I know my colleague spends a lot of time trying to advocate for them, help them through small business approaches. How are they going to be able to absorb what is clearly going to be thousands of dollars in new out-of-pocket health costs?

Mrs. SHAHEEN. I think that is a huge problem. New Hampshire has a population that is one of the fastest aging in the country. As Senator WYDEN points out, not only does the TrumpCare legislation change how people on Medicare are charged for their health insurance, but it also would change the other aspects of the Affordable Care Act that have been beneficial, such as preventive care under Medicare.

It would also change the effort to close the doughnut hole—the cost of the prescription drugs that seniors buy. That has been a huge benefit to people in New Hampshire over the last few years because they are beginning to see their costs for prescription drugs affected positively. So it will have a huge impact on seniors in New Hampshire.

The other issue that will have an impact not only on seniors but on everybody is what will happen to our rural hospitals. In New Hampshire, because we have a lot of rural areas in the State, we have a lot of small towns. Most of our hospitals are small and rural. They have benefitted significantly under the Affordable Care Act because they have been able to get paid for people who come to the emergency room for treatment. We have gotten a lot of people out of emergency rooms and into primary care. Most hospitals have seen about a 40-percent decline in people using emergency rooms for their healthcare. That has been a huge, important benefit to our rural hospitals that are operating on very thin margins that we need to keep open, not just because of the healthcare they provide but because of the jobs they provide. In most of our small communities, those hospitals are among the biggest employers.

There are huge impacts if we repeal the Affordable Care Act and we put in place this TrumpCare policy that doesn't cover as many people. It is going to cost more, it is going to reduce the help people are getting

through their healthcare coverage, and it is going to have a detrimental impact on people in the State of New Hampshire and across this country.

Mr. WYDEN. I thank my colleague.

We have heard Republicans say repeatedly that anything they are going to do with Medicare is not going to hurt today's enrollees or people nearing retirement. The fact is, TrumpCare hurts both. It is going to shorten the life expectancy of the Medicare trust fund, and those older people—I will be curious, when my colleague returns—I will be very interested to hear what seniors in New Hampshire who are 56 to 68 and are walking on that economic tightrope are going to say.

I thank my colleague from New Hampshire for the excellent presentation.

Mrs. SHAHEEN. I thank the Senator, and thank the Senator for his fight to help as we try to prevent people across this country from losing their healthcare.

Mr. WYDEN. I thank my colleague, and we are going to prosecute this cause together.

I see that the chairman of the Finance Committee has arrived. He graciously said I could take another 5 minutes or so of our time.

Before we wrap up this part of our presentation, I want to point out that we have outlined how people who are dealing with the consequences of opioid addiction would be hurt by TrumpCare. We have outlined how seniors who are not yet eligible for Medicare are going to be hurt and how seniors who are now on Medicare are going to certainly be hurt by reducing access to nursing home benefits. Now I would like to wrap up by going to the other end of the age spectrum and talk for a moment about children.

Nearly half of Medicaid recipients are kids, and the program of the Republicans—now that we have two committees in effect out of chute with their proposals—restructures the program in the most arbitrary way, using these caps, shifting costs to States. And the reality is that Medicaid is a major source of help for children. There is early and periodic screening, diagnosis, and treatment benefits. But with reduced funding, the States are going to be forced to make difficult decisions about which benefits they can keep providing. States are going to be forced to reduce payments to providers, particularly for kids, providers such as pediatric specialists, and limit access to lifesaving specialty care.

My own sense is that this is shortsighted at best, and it is like throwing the evidence about children and their health needs in the trash can. Children receiving Medicaid benefits are more likely to perform better in school, miss fewer days of school, and pursue higher education.

Before I yield the floor to my good friend and colleague Chairman HATCH, I want to come back to what disturbs me the most about all of this. All of these dramatic changes to Medicare and Medicaid that strip seniors and some of our most vulnerable citizens are being made at the cost of hundreds of billions of dollars to these programs while, in effect, there is an enormous transfer of wealth given to the most fortunate in America in the two bills that were passed by the other body today in the committee. In effect, for example, people who make over $250,000 will not have to make the additional payments under the Medicare tax. If ever there were a group of people in America who doesn't need additional tax relief, it is those people.

As we wrap up this portion of the presentation, I want people to just think about looking at their paycheck. Every time you get a paycheck in America, there is a line for Medicare tax. Everybody pays it. It is particularly important right now because 10,000 people will be turning 65 every day for years and years to come.

What the tax provisions of this legislation mean—and they are part of hundreds of billions of dollars of tax cuts—for insurance executives making over $500,000 annually, there are yet additional juicy writeoffs, while seniors and those of modest means are going to bear the brunt of those reductions. Nothing illustrates it more than cutting the Medicare tax, colleagues.

I don't know how anyone can go home in any part of the country and say: You know, we are going to have to charge older people between 50 and 65 a lot more for their coverage, and by the way, insurance company executives making $500,000 a year are going to get more tax relief. I don't think it passes the smell test in America. It is reverse Robin Hood. There is no other way to describe it. It is transferring wealth from working families and those who are the most vulnerable. When working Americans see their paycheck and see the Medicare tax, I hope they remember that in this bill, the Medicare tax is reduced for only one group of people—people making more than $250,000 a year.

I want tax reform. The chairman of the Finance Committee knows that. I have introduced proposals to do that. But I don't know how we get tax reform when they are giving the relief to the people at the top of the economic ladder and it is coming out of the pockets of working people and working families. Everybody is going to be able to see it right on their paycheck, right there with the Medicare tax.

I think we will continue this debate, but on issue after issue, with the nominee on the floor, Ms. Verma, what she will do if confirmed is directly related to TrumpCare. For example, we told her in the committee that we wanted her to give one example—just one—of an idea to hold down pharmaceutical prices, which is something else that is important to older people.

TrumpCare, by the way, could have included proposals to try to help hold down the cost of medicine. Guess what, folks. On pharmaceutical prices, there is no there, there either. It doesn't do anything to help people.

This vote we will have on Tuesday is the first step in the discussion of how this particular nominee would handle the implementation of TrumpCare. Her job oversees Medicare payments to hospitals. It is really intertwined, this nomination and TrumpCare, and we couldn't get any responses to how she meets the needs of working families, as I just mentioned, with respect to pharmaceuticals, and we are pretty much in the dark with respect to how she would carry out her duties. As of now, we don't see how she is going to do much to try to eliminate some of the extraordinary harm that is going to be inflicted on the vulnerable and seniors on Medicare and Medicaid as a result of TrumpCare.

I reserve the remainder of my time, and I yield the floor.

The PRESIDING OFFICER. The Senator from Utah.

REPUBLICAN HEALTHCARE BILL

Mr. HATCH. Mr. President, I rise today to speak once again on the so-called Affordable Care Act and the ongoing effort to repeal and replace. We all know the House of Representatives has produced a repeal and replace package, and both the Ways and Means and Energy and Commerce Committees have been marking it up. We don't know what it is right now. In other words, the endeavor to right the wrongs of ObamaCare is moving steadily forward on the other side of the Capitol, and soon it will be the Senate's turn to act. I commend my colleagues for introducing this legislation and moving it forward. This is an important step, and I don't think I am alone when I say that I am watching the progress in the House very carefully to see how things proceed and what the final House product will look like.

Of course, virtually all Republicans in Congress want to repeal and replace ObamaCare. We are in unison there. While there are some differences of opinion on how best to do that, there is generally unanimity on that point. I am confident that whatever differences exist among House Members will be worked out through the House's legislative process.

In addition, whatever passes in the House will be subject to the input and review of the Senate and to the rules of the budget reconciliation process. I want to note that I have heard from a number of Senators who have items they would like to see included when the bill comes before the Senate. I actually have several ideas of my own. However, there are limits as to what we can do under the budget reconciliation rule. Many of the proposed policy changes I have heard, although they have merit, would be banned by the rules and subject to the 60-vote threshold. That said, I am committed to working with my colleagues on both sides of the floor to ensure that the

Senate process on this bill is productive and that it yields a result we can support.

Long story short: This process is far from over. We have a lot more work to do. It is worth pointing out that the vast majority of the policies at play in this discussion and virtually all of the spending fall under the exclusive jurisdiction of the Senate Finance Committee, which I chair. Make no mistake. The Finance Committee is already hard at work and has been for some time. In many respects, I suppose you could say we have been working on this effort since the day ObamaCare was signed into law. However, for obvious reasons, our work has intensified over the past several months.

In working through this process, I have been in constant contact with Chairmen BRADY and WALDEN, who head up the relevant committees in the House. I have also been working closely with the Speaker's office, and I have been gathering input from Governors around the country. In addition, I have been working closely with the distinguished chairman of the Senate Budget Committee, Senator ENZI, who has the chief responsibility of navigating the budget process and shepherding a final repeal-and-replace bill through all the necessary rules and restrictions.

In all of those conversations, we have been talking about the process, and we have been talking about the timing. Most importantly, we have been talking about the substance of the healthcare reforms and how we can best serve the interests of the American people.

Throughout this effort, we have been reminded that Republicans currently control the White House and both Chambers in Congress due, in large part, to our stated commitment to repeal and replace ObamaCare, and we intend to deliver on that promise.

I would like to take a few minutes to talk about some of the policies we will need to tackle as we take up the House healthcare bill in the coming weeks.

Once again, the vast majority of the policies and virtually all of the spending involved in this effort fall under the Finance Committee's exclusive jurisdiction, and I intend to make sure all of my colleagues are well informed on the issues and that in the end whatever version of the bill we pass in the Senate reflects the collective will of a majority of Senators.

All told, there are five major policy areas that are addressed in the House bill that fall under the Finance Committee's purview.

First, there are the provisions to repeal the ObamaCare taxes. This is big. If one recalls, I came to the floor a few weeks ago and pointed out how misguided it would be, in my view, to start picking and sorting through the ObamaCare taxes to decide which to keep and which to leave in place. The House bill repeals them, along with the individual and employer mandates, both of which reside in the Tax Code. I have been working with Chairman BRADY on this issue. In the end, I believe the Senate version of the bill should do the same, and I am going to continue to push to ensure it does.

Second, there is the issue of premium tax credits. Chairman BRADY and I have been working extensively on this issue as well. The House bill replaces the ObamaCare premium subsidies with a refundable tax credit for the purpose of State-approved health insurance, limited to those who do not qualify for other governmental healthcare programs and who have not been offered insurance benefits from their employers. Most major ObamaCare replacement proposals that we have seen contain some version of health insurance tax credits. The House approach represents a significant improvement over the ObamaCare premium subsidies. The Senate, when it takes up the bill, will have to consider how best to implement the tax credits. I will continue to work with my House and Senate colleagues to ensure that the tax credits are designed to help those lower and middle-income Americans who are the most in need.

Third, there are the issues surrounding Medicaid. Chairman WALDEN and his predecessor, Chairman UPTON, and I have been working extensively on this matter. As we know, the vast majority of the newly insured people who the proponents of ObamaCare have cited as proof that the system is working have been covered by the expanded Medicaid Program.

The problem, of course, is that the Affordable Care Act did not do anything to improve Medicaid, which was already absurdly expensive for States, and ultimately unsustainable, not to mention the fact that it provides substandard healthcare coverage.

The House bill draws down the ObamaCare Medicaid expansion and makes a number of significant changes to the underlying program. Most notably, it establishes per capita caps on Federal Medicaid spending, which are intended to give States more flexibility and predictability while also controlling Federal outlays related to the program.

We have received substantial input on this matter from Governors around the country, and virtually all of them agree changes need to be made. Given these concerns and the sheer vastness of the Medicaid Program under ObamaCare, the Senate will have to tackle this issue when it takes up the budget reconciliation legislation in the next few weeks.

I am confident that in working with my colleagues in the House and Senate and with the Governors, we can find the right solution.

Fourth, there is the issue of savings accounts for healthcare costs. I have long been an advocate for the expanded use of HSAs and FSAs. Needless to say, I was particularly opposed to the ObamaCare provisions that limited the use of these savings accounts and essentially marginalized their usefulness for consumers and patients.

The House bill removes a number of restrictions on these accounts that have been imposed by ObamaCare, and it goes further to remove longstanding restrictions on HSAs in order to expand their use and give patients and consumers more options to pay for health expenses.

I am very supportive of this approach. In fact, the language from the House bill mirrors the legislation I introduced this year—the Health Savings Act of 2017.

Fifth, there are some important transition issues that need to be addressed.

To get at these issues, the House bill creates a Patient and State Stability Program, under the Social Security Act, that would distribute $100 billion to States over 10 years to enhance flexibility for States in how they manage healthcare for their high-risk and low-income populations.

For example, the funds could be used to, among other things, help individuals with cost-sharing. This program was proposed with the idea of giving States an expanded role in the healthcare system, a goal that is shared by most Republicans in Congress and something that almost all of the Governors have told us they want to see.

There are other issues from the House bill in the broader healthcare debate that will demand some attention when we consider the bill in the Senate. However, almost all of them fall under these general categories. Once again, the vast majority of them fall under the sole jurisdiction of the Senate Finance Committee, the primary committee.

There are other critical issues out there which do not involve the Tax Code, the Social Security Act, or Federal health programs. Yet they are extremely important.

The biggest mistake made by those who drafted ObamaCare and forced it through Congress was their failure to address healthcare costs in any meaningful way. After all, cost is the largest barrier preventing people from obtaining health insurance coverage, and the increasing healthcare costs are among the most prominent factors leading to wage stagnation for U.S. workers. Yet ObamaCare did little to address this problem, and in fact it has made things worse.

If we are going to fully keep our promises to the American people with regard to ObamaCare, we are going to have to eventually address these issues. After all, most people's negative interaction with the Affordable Care Act has come in the form of increased healthcare costs. If we are going to truly right all of ObamaCare's wrongs, we need to tackle the costs head on.

This will mean, among other things, fixing the draconian regulatory regime in our health insurance markets and giving individuals the ability to select only the coverage they want and need.

Many of these types of issues fall far outside of the Finance Committee's jurisdiction and are under the watchful eye of the distinguished chairman of the Senate HELP Committee.

The House bill also includes some provisions that are intended to address these concerns. I assume our distinguished colleague running the HELP Committee is working tirelessly to address the issues, and others, both through the reconciliation exercise or some alternative means.

Ultimately, if our goal is to place the healthcare system in a better position than it has been under ObamaCare, costs will have to factor heavily into the equation. I am looking forward to receiving guidance and leadership on the HELP Committee on these important market reform issues.

Overall, I believe we can and will be successful in this endeavor to fix our broken healthcare system. The American people are counting on us to do so. At the end of the day, success in that endeavor is, in my view, going to require a robust Senate process that allows this Chamber to work its will.

We have two Chambers in Congress for a reason. The House reconciliation bill needs 218 votes to pass. The Senate will also have to act when we receive the bill, and we will need to produce a package that can get at least 51 votes in this Chamber and hopefully more. That may mean some differences between the Senate and the House versions of the bill, but that is not problematic in my view. It is not particularly novel or unusual for different views and ideas to be resolved through the legislative process rather than simply dissipating when a bill is introduced. It seems to me that is not novel, and I am not the only one who has this view.

Earlier this week, Secretary Price sent a letter to the chairmen of the House Ways and Means and Energy and Commerce Committees. The letter commended the chairmen for their work and praised the legislation they unveiled to repeal and replace ObamaCare.

The Secretary also noted that this was not the end of the process but that the introduction of the House bill was a ''necessary and important first step'' and that the administration anticipated that the Congress would be ''making necessary technical and appropriate changes'' to get a final bill to the President that he can sign, which reminds us of the other important advocate in this endeavor. President Trump ultimately needs to support the bill that is passed by each Chamber of Congress, and his support for our efforts is paramount.

While, at this point, it may not be entirely clear what the final bill will look like, we do know two things for certain. First, we know that ObamaCare is not working. As the majority leader said yesterday, ObamaCare is a direct attack on the American middle class. Thanks to skyrocketing premiums, shrinking options in the health insurance market, burdensome mandates, and harmful taxes, millions of Americans are dealing with the failures of ObamaCare on a daily basis. We need to act now to fix these problems.

Second, we know that by introducing its bill and moving it through the legislative process, the House has taken significant steps in advancing this effort, and the leaders in the House should be commended for doing so.

Long story short, I have nothing but praise for the leaders in the House this week for the work they have done on these issues. Remember, this is just the beginning. I look forward to working with my colleagues in both Chambers to get this over the finish line so the Republicans can collectively make good on our promises with regard to ObamaCare.

NOMINATION OF NEIL GORSUCH

Mr. President, I rise to speak on the nomination of Neil Gorsuch to the U.S. Supreme Court.

Later this month, Judge Gorsuch will come before the Senate Judiciary Committee for his confirmation hearing. I wish to speak today on what we can and should expect to happen during that hearing.

First, some background. This will be the 14th Supreme Court confirmation hearing I have participated in. I have seen some truly outstanding hearings in which both the nominee and the Senators acquitted themselves well. I have also seen some hearings that have gone far off the rails, in which some Senators hurled unfounded allegations or sought to twist the nominee's clearly distinguished record. I am hopeful Judge Gorsuch's hearing will be the former type.

We have before us a supremely qualified, highly respected, and extremely thoughtful nominee. Judge Gorsuch has had a stellar legal career, and by all accounts, he is a man of tremendous integrity, kindness, and respect. He is the sort of person all Americans should want on the Supreme Court. He does not approach cases with preconceived outcomes in mind. He seeks to apply the law fairly and impartially in line with what the democratically elected representatives who enacted the law had in mind. He will be a truly outstanding Justice.

Judge Gorsuch's hearing will focus on his background, his temperament, and his approach to judging. So let's talk a little about what we know about Judge Gorsuch. We know he has an outstanding academic record. He graduated from Columbia University and Harvard Law School and obtained a doctor of philosophy in law from Oxford University. We know he had a highly successful legal career before becoming a judge.

He clerked for two Supreme Court Justices before entering private practice here in Washington. He made partner in only 2 years, which shows how highly his colleagues at the firm thought of him and his work.

Following a decade in private practice, Judge Gorsuch was appointed Principal Deputy Associate Attorney General at the Department of Justice, where he oversaw the Department's antitrust, civil, and environmental tax units.

In 2006, President Bush nominated Judge Gorsuch to the U.S. Court of Appeals for the Tenth circuit—the circuit in which I reside. The Senate confirmed Judge Gorsuch unanimously by voice vote a short 2 months later. At Judge Gorsuch's investiture, then-Senator Ken Salazar, who later served as President Obama's Interior Secretary, praised Judge Gorsuch's ''sense of fairness and impartiality.'' That fairness and impartiality, which was evident to my colleagues even then, was a large reason why Judge Gorsuch won confirmation without a single dissenting vote.

Judge Gorsuch's hearing will also affect us on his temperament and approach to judging. No one can seriously doubt that Judge Gorsuch has an excellent judicial temperament. A recent article in Slate—no rightwing paper, by any means—described the judge as ''thoughtful and fair-minded, principled, and consistent.''

The Denver Post, which twice endorsed President Obama for President and endorsed Hillary Clinton in this past election, also recently endorsed Judge Gorsuch's nomination, saying: ''From his bench in the U.S. Tenth Circuit Court of Appeals, he has applied the law fairly and consistently.''

Clearly, Judge Gorsuch has the right temperament to serve on the Supreme Court.

His approach to judging is also spot-on. Judge Gorsuch's opinions show that he is not only an excellent writer but also that he understands the proper role of a judge in our constitutional system. He consistently explains his reasoning by reference to fundamental constitutional principles. He does not seek to push the law toward the outcomes he favors but instead tries to apply it in harmony with the understanding of those who wrote and passed it. In so doing, he shows a healthy respect for the legislative process and for the democratically elected branches of government.

As Judge Gorsuch said in a speech shortly after Justice Scalia's passing, ''Judges should be in the business of declaring what the law is, using traditional tools of interpretation, rather than pronouncing the law as they might wish it to be in light of their own political views.''

Judge Gorsuch's opinions demonstrate that he understands fundamentally the importance of this principle and that he seeks faithfully to apply it in his own judging.

Against this impressive list of qualifications, Democrats and their liberal allies strain mightily to find plausible grounds to oppose Judge Gorsuch's nomination. They misread his opinions, misstate his reasoning, and in

general paint a picture of a man who simply does not exist. We can expect more of this at his confirmation hearing. In particular, we can expect to be raised again and again the risible and flatly false claim that Judge Gorsuch is outside the ''judicial mainstream.'' These arguments against Judge Gorsuch are not persuasive—not even close. We see hints of them in the various letters liberal interest groups have sent Congress claiming that Judge Gorsuch is a threat to the Republic—a danger to our very way of life. The over-the-top language these groups use only serves to highlight the weakness of their case against Judge Gorsuch.

One such letter called the judge ''an ultra-conservative jurist who will undermine our basic freedoms and threaten the independence of the Federal judiciary.'' The letter goes on to say that there is ''zero evidence that Judge Gorsuch will be an independent check on this runaway and dangerous administration.''

As an initial matter, I would ask: If Judge Gorsuch is such an existential threat to the Republic, where were all these groups 10 years ago when he won confirmation to the Tenth Circuit unanimously? Did Judge Gorsuch spend the first 40 years of his life hiding what a monster he is, revealing his true self only once safely ensconced on the Federal bench?

The outlandishness of these claims against Judge Gorsuch is made clear by the support he has received from prominent liberals, including President Obama's own Solicitor General, Neal Katyal. In an op-ed published in the New York Times, Neal Katyal praised Judge Gorsuch's fairness and decency and said that he had no doubt that, if confirmed, Judge Gorsuch would ''help to restore confidence in the rule of law.'' Katyal further wrote that Judge Gorsuch's record as a judge reveals a commitment to judicial independence, a record that should ''give the American people confidence that he will not compromise principle to favor the President who appointed him.''

It bears mention here that Mr. Katyal is no shrinking violet when it comes to standing up to the executive branch. He rose to prominence in the legal community through his work representing Guantanamo detainees. So when he says Judge Gorsuch will not shy away from holding Federal officials to account, frankly, his words carry weight.

Then there is the phrase we are likely to hear invoked again and again at Judge Gorsuch's hearing and beyond: ''judicial mainstream.'' Liberals will tie themselves in knots claiming that Judge Gorsuch is some sort of fringe jurist, that his views place him on the far flank of the Federal judiciary. Any honest observer will tell you that these claims are complete bunk. President Obama's Solicitor General and liberal publications like Slate would not offer praise for Judge Gorsuch if he were some kind of a nut.

In reality, the claims that Judge Gorsuch is outside the mainstream boil down to three things: a willful misreading of his decisions, a disingenuous attempt to redefine what it means to be mainstream, and an inability to count. On the misreading point, opponents of Judge Gorsuch claim that his decisions say things that they very clearly do not say or stand for propositions that even a generous reading cannot substantiate. They say he favors large corporations over employees, when really he just believes Federal employment laws mean what they say. They say he opposes contraception and family planning, when really he just believes religious liberty statutes should be enforced.

Judge Gorsuch's opponents also cite as examples of his purported extremism decisions that liberal Democratic appointees joined or that a majority of his colleagues agreed with. They will take a case in which more than half—or sometimes all—of the judges who heard the case agree with Judge Gorsuch and say the decision was outside the mainstream. I don't know about my colleagues, but I always thought that being in the mainstream had something to do with being somewhere in the vicinity of your peers or colleagues on a given issue. But, apparently, that is not what the left means.

Rather, in their failing campaign against Judge Gorsuch, liberals have redefined ''mainstream'' to really mean nothing at all. It has become a code word for liberal, for the sorts of results that liberals would like to see. But being in the mainstream and being liberal are not the same thing, despite Democrats' fondest desires. There is such a thing as diversity of thought, which the left used to venerate, at least until the confirmation wars and the rise of the conformity cult on college campuses.

So to my colleagues—and to the American people—I say: Do not be deceived when liberals say that Judge Gorsuch is outside the mainstream. He understands that the proper role of a judge in our constitutional system is to interpret the laws in accordance with the understanding of those who wrote and ratified those laws. This approach to judging leaves lawmaking power to the people's elected representatives and confines the judge's role to implementing the policy choices selected by those representatives. It is an approach consistent with our Constitution, our core values, and democracy itself.

It may be at times that this approach yields results that liberals don't like, but that doesn't place it outside the mainstream. It cannot be the case that the test of whether a judge is in the mainstream is whether that judge reaches consistently liberal results. When the people's elected representatives enact into law a conservative policy, a judge faithfully applying that law may well reach a conservative result. The opposite is true when the people's elected representatives enact into law a liberal policy.

All of this is to say that we cannot judge a nominee solely on the basis of whether we like the results he or she reaches. As Justice Scalia famously said:

> If you're going to be a good and faithful judge, you have to resign yourself to the fact that you are not always going to like the conclusions you reach. If you like them all the time, you are probably doing something wrong.

That is an interesting statement by one of the great judges, whom Judge Gorsuch will replace.

Liberals want judges who will always reach liberal results, but that is not the role of the judge. It is the role of a legislator, and a judge is certainly not a legislator.

So when you hear liberals say Judge Gorsuch is outside the mainstream, recognize that they are talking about results—specifically, liberal results—and recognize that that is not the proper inquiry for a Supreme Court confirmation hearing.

A Supreme Court confirmation hearing should be about the nominee, the nominee's experience, and whether the nominee understands his or her properly constrained role as a judge under our Constitution. On all of these metrics, Judge Gorsuch is off-the-charts qualified.

When the good judge comes before the Judiciary Committee, listen to the answers he gives. Ask yourself whether what he says is consistent with the separation of powers and the system the Framers designed. Compare his measured demeanor and thoughtful responses to the histrionics you see from his opponents on the left.

I have full confidence that when the hearing is over and the last question has been asked, Judge Gorsuch will have shown the Senate that he is unquestionably qualified and fully prepared to serve our Nation on the Supreme Court.

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

The PRESIDING OFFICER (Mr. BLUNT). The Senator from Delaware.

Mr. CARPER. Mr. President, it is good to be with my colleagues and the chair of the Senate Finance Committee. I am pleased to say a few words about the President's nominee, Seema Verma, who, if confirmed, will lead us at the Centers for Medicare and Medicaid Services. She is from Indiana, and folks I know in Indiana have said that she knows a lot about Medicaid, but not nearly so much about Medicare, which is a cause for some concern.

If confirmed, let me just say we certainly look forward to working with her and with the team she will have around her in that responsibility. It is a very tough job, as the Presiding Officer knows.

HEALTHCARE

What I would really like to focus on is that I want to go back in time, if I could. I want to go back to 1993. I am

not sure what the Presiding Officer was doing in 1993, but I was a brand-new Governor in 1993. We had a brand-new President and a brand-new First Lady. She was asked—I presume by her husband, or maybe she just decided on her own—to try to do what Presidents had talked about doing for a long time; that is, to try to make sure that everybody in our country had healthcare coverage. Her name was Clinton, and what she came up with, in consultation with a lot of folks, was something that was called HillaryCare—not always as a compliment, but sometimes, in some cases, derisively. I think our Republican friends, who were somewhat pointed in their criticism of it, were basically asked: Well, where is your idea?

In 1993, a guy named John Chafee, whom the Presiding Officer knows—we served with his son Lincoln in the Senate, and Lincoln went on to be Governor of Rhode Island—took up the challenge, along with at least 20 other Senators—I think mostly Republican and a couple of Democrats—and they offered legislation in 1993 that was the Republican alternative to HillaryCare.

At the end of the day, HillaryCare did not survive, as we know, and the Chafee proposal from that time essentially went away in that particular Congress. What he had proposed had five major concepts to it. One of those was the idea that folks who didn't have healthcare coverage should be able to get their coverage in their own State—unless they were very wealthy—and to be able to get coverage in a large group plan. They called them exchanges or marketplaces, which would be established in each State. If that sounds familiar, it should.

They also said that folks who were going to get their coverage who didn't have coverage for healthcare in these 50 States would get some help in buying down the cost of their healthcare, and they would get that by the adoption of a sliding-scale tax credit which would buy down the cost of premiums for low-income people. The lower their income, the bigger the tax credit was; the higher the income, the lower the tax credit. And finally, it phased down.

There were concerns raised by insurance companies that it would be hard to insure folks who were going to be getting healthcare coverage on these exchanges in each of these States because a lot of these people hadn't had healthcare in a long time. There was an expectation that they would have a high demand for healthcare, they would need a lot of healthcare, and they would be a hard group to insure because their need for healthcare was very large. The insurance companies were fearful that the group of people in each of the States they would be asked to insure on the exchanges would not be insurable—not in the way in which the insurance companies could break even or make money.

This idea came along. Just to insure that we have a good mix of healthy and maybe not-so-healthy people in the exchanges to insure in each of the States, Senator Chafee and these folks came up with the idea that people would be mandated to get coverage in the States—everybody. You can't make people get coverage, but under the Chafee plan, for folks who didn't, they would have to pay a fine, and the fine, over time, would go up and become stiffer. So finally, people might say: Well, I am paying all this money for no healthcare coverage. Maybe I ought to get coverage and stop having to pay this fine. At least I would have something for my money.

The two other things in the original legislation from Senator Chafee and company were something called an employer mandate, the idea that employers were mandated to provide coverage. At least employers with a minimum number of employees would have to provide coverage—to provide a large group plan within their business or within their employment. That was the employer mandate in the Chafee proposal.

The other thing that was in Chafee, as I recall, was something like a provision that said to insurance companies: You can't just stop providing coverage for people because they have a preexisting condition; you have to insure people.

So those are the five major precipes: No. 1, creating exchanges in every State or marketplaces for people to get their coverage; No. 2, sliding-scale tax credits to help drive down the costs for low-income people for their coverage in their States; No. 3, individual mandates, or trying to make sure the mix of people insured was actually insurable, without the insurance companies losing an arm and a leg; No. 4, employer mandates that employers of a certain size have to provide coverage for their employees; and, finally, the idea of knocking people off coverage because of preexisting conditions was a no-no.

As we know, HillaryCare was not adopted, and neither was the Chafee plan. But it turned out the Chafee plan had legs, as they say in show business. It means it actually lasted beyond just being a bill introduced in the Senate in 1993.

It surfaced in Massachusetts about 10 years later, thanks to Governor Mitt Romney, who was thinking about running for President. Some of the people advising him said: You know, Governor, you could probably help your chances of running for President if Massachusetts could be the first State to have universal healthcare coverage for its residents. That sounded pretty enticing.

He said: How do we do this?

They looked up the Chafee bill. They apparently knew about it, thought about it, and said: Let's take the Chafee proposal and do that in Massachusetts.

That is what they did. Guess what. They found that they did a pretty good job in terms of covering more people on the coverage side. It worked pretty well. Where it didn't work very well was on the affordability side. As we might imagine, there were the young invincibles—like some of these pages we have down here and their older brothers and sisters who maybe say: I don't need healthcare coverage. I am young and invincible. I will never get sick and go to the hospital.

They had a sliding scale. They had an individual mandate, but they had a fine people had to pay over time. Eventually, as more years went by, the young and healthy people said: I might as well get coverage. It helped provide for a better mix of folks in the exchange to provide insurance for. So they did a better job on the cost and, after a while, affordability.

When we went to work in the beginning of the Obama administration in 2009 on the Affordable Care Act, some people think Democrats just sat down in our caucus and just rolled out a plan and said: This is what we are going to do to provide healthcare coverage to people. That is not what we did. We spent a lot of time trying to figure out what we should do. We had, I want to say, dozens of hearings in the open, in public, on the Finance Committee. I am sure they had other hearings in the Health, Education, Labor, and Pensions Committee, which shares jurisdiction with Finance on this subject. We had dozens of hearings. We actually had the head of the Congressional Budget Office come and testify.

We had a pretty good idea of what it would cost. We had a pretty good idea of what impact it would have on the Medicare trust fund. It turned out that the adoption of the Affordable Care Act extended the life of the Medicare trust fund by, I think, 12 years. It actually brought down the Federal budget deficit over the next 10 years by quite a sizeable amount, and over the 10 years after that by even more. The idea was to provide coverage for a lot of people who wouldn't have it—actually, using the Chafee plan.

I think it is really ironic, sometimes almost humorous, when my Republican friends—and they are my friends—attack the Affordable Care Act. The piece that they attack is, I like to say, their stuff. They are the Chafee-Romney ideas.

I studied economics at Ohio State and studied some more in business school after the Vietnam war. I like market approaches to problems. So I find real virtue and interest in what Chafee came up with and what Romney put to work. Romney provided kind of a laboratory in Massachusetts to see how that idea would work—maybe not on a national scale but at least on a statewide scale, with a lot of people involved.

I am troubled by where we find ourselves today. During Presidential campaigns, I know people say things in campaigns that maybe they don't mean

or maybe they exaggerate or something like that. But I think the campaign might have been over and Donald Trump had been elected President. He promised, I believe shortly thereafter, that his plan to repeal and replace the Affordable Care Act would lower the cost of health insurance, while providing better coverage for everyone. That is what he said. His plan to repeal and replace the Affordable Care Act would lower the cost of health insurance, while providing better coverage for everyone.

I realize that the ink is barely dry on what the two House committees—the Ways and Means Committee and the Energy and Commerce Committee—have been working on. As best we can tell at this point in time, the bill they reported out of the committees—and I presume they are going to vote in the full House pretty soon, if they haven't already—but the House Republican bill to repeal the Affordable Care Act does just the opposite of what Donald Trump called for. It does not lower the cost of health insurance, as best we can tell, and it doesn't provide better coverage for everyone. The House Republican bill to repeal the ACA does nothing to slow down the growth of healthcare costs.

One of the great virtues of the Affordable Care Act is the focus on value. How do we get better results, better healthcare outcomes, for less money? If we go back to where we were 8 years ago and compare how much we were spending in this country for healthcare as a percentage of gross domestic product, we were spending 18 percent. One of our major competitors in the world—a major ally but a major competitor—is Japan. In 2009, while we were spending 18 percent of GDP, Japan was spending 8 percent—less than half as much, 8 percent of GDP. They got better results, and they covered everybody.

So as we were approaching the debate and eventually the markup on voting on the Affordable Care Act, we had this in the back of our mind. We looked around the world to see what seemed to be working to get better results for less money, and we looked at Massachusetts to see how that was working and what we could learn from what they called RomneyCare up there.

But the House Republican bill to repeal the ACA does, as best we can tell at this point in time, very little—maybe nothing—to slow the growth of healthcare costs, and that is a shame. Apparently, fewer people will be insured. I think Standard & Poor's estimates as many as 10 million people could lose coverage under the House Republican plan. Insurance markets will destabilize faster. I mentioned earlier that a great concern insurance companies had is that they would end up in each or in a number of States with a pool of people to insure in the exchanges that were uninsurable—the elderly, maybe the sick, people who hadn't gotten healthcare for a long time. It is hard to insure that group and stay in business if you are a health insurance company. There was a concern about destabilization and instability within the markets for health insurance.

The individual mandate is replaced by something called the continuous coverage requirement. I would like to think it is going to work. I am not sure it would. But under this, I understand that people who go without a health insurance plan for more than 2 months will be charged a 30-percent surcharge when they are able to get back on and reenroll. People with expensive healthcare conditions will be willing to pay a penalty. But how about healthier people who often chose to stay out of the health insurance markets?

Also, as best we understand, in the House Republican plan, health insurance plans will become less robust, and many Americans will only be able to afford rather skimpy insurance plans. Preliminary estimates of the House GOP plan shows that insurance costs for the average person would increase by roughly $1,500. By 2020, the average person would pay $2,400 more.

I had the privilege of representing Delaware as Governor. One of the things I was responsible for in the treasurer's office was administering fringe benefits for State employees and teachers and a lot of folks. So this is something I have thought about over the years—about healthcare coverage for people.

We have only three counties—unlike Missouri, where the Presiding Officer is from, which has probably hundreds of counties—maybe not that many. But we only have three. In our southernmost county, Sussex County, we have a lot of chickens, a lot of corn, and a lot of soybeans. We have five-star beaches. A number of people like to come to Delaware to retire. We have no sales tax. We have very low property taxes in Sussex County. And for people who are not making a ton of money, we have pretty low personal income tax.

Take the example of a 60-year-old Delawarean in Sussex County who makes $30,000 a year. Under the Affordable Care Act, they get a tax credit. I mentioned earlier a sliding-scale tax credit. If you are lower income, it is a bigger tax credit. If you are a higher income, it finally fades out when your income goes up to a certain level. But for somebody making $30,000 a year in Sussex County, under the current law—the Affordable Care Act—the tax credit in 2020 will be about $10,000 to help buy down the cost of their coverage.

As I understand it, under the GOP health plan, for their comparable tax credit for the same person in Sussex County—which, quite frankly, has a lot of people 60, 65, 70 years old who make this amount of money down there; a lot are retired or semi-retired—the tax credit in 2020 would be $4,000. That is about $6,200 less. If you happen to be this person, you may want to think twice about which of these two paths you want to take.

We have another chart here that might be helpful. This is something we got from AARP. When we are passing legislation or drafting legislation or debating legislation, we are always interested in what key stakeholders feel. AARP is a big stakeholder. They represent a lot of people 50 and older. We are interested in hearing from folks who represent seniors. AARP represents the views of a lot—not all. We are interested in the views of those like doctors, the American Medical Association, nurses, providers. We are interested in hearing from hospitals. As it turns out—again, while the ink is barely dry on what is coming out of the House of Representatives—AARP tells us they are not very excited. Well, maybe they are excited about it, but not in a good way.

They say the change in structure will dramatically increase premiums for older consumers. That is what we have seen from the previous chart. In their example, AARP tells us about a 64-year-old person who is earning about $15,000. Their premiums go up $8,400. They are making $15,000 a year. I don't know how they pay for much of anything else with that kind of increase in their premium costs. That is a concern for me and certainly a concern for the folks at AARP and the people they represent, the millions of people they represent.

TrumpCare. The House has come up with different names. Some call it ObamaCare light, ObamaCare 2.0 or .5. Some people call it TrumpCare. The House is working on it. The concern we are hearing from a lot of folks is that it forces women to pay more for basic care.

Let's go back to the care for women. My wife and I have been married 31 years. I don't know everything about healthcare needs for women, but I do know this. A lot of women I have known—including my own family, my sister, my mom, and my wife's family—their primary healthcare provider is their OB/GYN. I didn't know that for a long time—not for everybody, but for a lot of people that is who their primary care provider is. For millions of women, surprisingly, their primary healthcare provider happens to be an OB/GYN or healthcare provider who works at Planned Parenthood.

For some people, Planned Parenthood is synonymous with abortions, but I think a very small percentage of what they do relates to abortions. What they do, for the most part, is try to make sure women get the healthcare they need, a lot of times in the OB–GYN realm but also in terms of contraception.

Somebody told me the other day that the cost of contraception for a woman in a year could be as much as $1,000. It is not cheap. The cost of a single delivery of a child from an unplanned pregnancy that is paid for by Medicaid is over $10,000, if I am not mistaken.

A lot of times, as we know, especially if a young person brings a baby into

the world, maybe doesn't finish high school or whatever, the outcome can be not that good for that child. I heard Mary Wright Edelman of the Children's Defense Fund say these words. If a 16-year-old girl becomes pregnant, does not graduate from high school, does not marry the father of her child, there is an 80-percent likelihood they will live in poverty. The same 16-year-old girl who does not have a baby, finishes high school, graduates, waits until at least 21 to have a child, marries the father of the child, there is an 8-percent likelihood they will live in poverty. Think about that.

That suggests to me that we should—particularly for young people and those not so young who are sexually active—we want to make sure that when they are ready to bring a child into the world they can do that, a healthy child, a child with a lot of promise in their life.

For those who aren't prepared to bring that child, raise that child, prepare that child for success, contraception is needed. One of the things the Affordable Care Act does is provide access for that contraception. I am fearful the plan in the House of Representatives, however well-intentioned, will take away that opportunity for a lot of women and frankly for their children.

We have other people who have arrived on the floor. I want to be mindful of their time.

I don't know if we have another chart to look at before I yield.

We have all heard of double whammy. This has been described as TrumpCare, ObamaCare light, whatever you want to call it. It has a triple whammy. One of those is higher costs, a second is less coverage, And for some people, particularly low- and middle-income folks, more taxes. For certain people whose income is over one-quarter million dollars, they get a tax break. It adds up to quite a bit for somebody who makes a lot of money, but this is not the kind of triple whammy we ought to be supporting.

When the bill gets over here, if it gets out of the House, we will have a chance to slow down and hopefully do hearings in the light of day and bring in the folks from CBO, ask them to score this, let us know what is the real impact of what is being proposed in the House. Does it really save money? Does it do what President-Elect Trump said he wanted to do, which is make sure everybody gets coverage and be less expensive. Does it really do that? And we need to find out what the impact is on taxpayers. Is this the holy grail of better results for less money or is this something altogether different?

The Presiding Officer, from Missouri, is somebody who is pretty good at working across the aisle. I would like to think I am too. We have worked together on a number of issues. When you are working on something that is this big and this complex and has this kind of impact on our country, we are always better off if we can somehow fashion a bipartisan compromise and something that would have bipartisan support.

We tried to do that in the Affordable Care Act. I know my Republican friends feel we didn't, but I was there. I know we tried. In fact, the evidence that we tried was literally the foundation for what we do for the Affordable Care Act, a Republican proposal from Senator Chafee and 20 other Republicans, including ORRIN HATCH and including CHUCK GRASSLEY from Iowa. I think that was a pretty good effort.

If this bill makes its way over here, we need to have at least a strong effort, maybe a better effort, maybe a more successful effort in the end.

If we are not going to repeal the Affordable Care Act, actually find a way to repair it and make it better, there are things we can do. I know I can think of some—I know the Presiding Officer can as well—that would move us closer to better coverage at a more affordable price.

The last thing I would say is this. I have a Bible study group that meets here on Thursdays with Barry Black, who opens our session with a prayer every day that we are in session. We also have his Bible study group that meets for about a half an hour, 45 minutes in the Capitol—Democrats and Republicans. We pray together, share things together. I describe it as the seven or eight of us who need the most help.

He is always reminding us of our obligation to the least of these. There is a passage of Scripture in Matthew 25 that a lot of us have heard of, and I am sure you have heard this in Missouri too. It says: When I was hungry, did you feed me? When I was naked, did you clothe me? When I was thirsty, did you get me to drink? When I was sick and imprisoned, did you visit me? When I was a stranger in your land, did you take me in?

It doesn't say anything about when I didn't have any healthcare coverage and my only access to healthcare was an emergency room to a hospital. It doesn't say that in Matthew 25. I think the implications are clear. They are the least of these as well. They need our help, and I think we have a moral obligation, as people of faith, to help them.

We also have a fiscal imperative because while the Federal deficit is down from $1.4 trillion 6, 7, 8 years ago, down to about one-third of that, it is still high. We need to make more progress on that. We have a fiscal imperative to meet that moral imperative.

With that, I think I will call it quits. I know my colleagues will be disappointed, but they are standing here, from all over the country, waiting to say their piece. I am going to yield to them and wish them all a good weekend, and I look forward to seeing you on Monday.

I yield the floor.

Before I do, I yield the remainder of my postcloture debate time to Senator RON WYDEN of Oregon.

The PRESIDING OFFICER. The Senator has that right.

The Senator from Arkansas.

HOMELAND SECURITY

Mr. BOOZMAN. Mr. President, when President Trump began his campaign for the White House, he made national security and, in particular, homeland security a cornerstone of his platform. His calls to secure the border to keep terrorists off U.S. soil and to protect our communities struck a chord with a large majority of Americans who for years felt that Washington ignored their very real concerns about our porous borders and broken immigration system.

As expected, the President moved quickly to deliver on his promises to fix this broken system. This week, the Trump administration rolled out a revised version of this Executive order aimed at restoring confidence in the procedures we have used to vet refugees fleeing from nations that are known to harbor radical and violent extremists.

The revised version appears to have benefited from the engagement of the President's Cabinet, especially the key input of Homeland Security Secretary Kelly. This valuable input underscores how important it is for the President to have his team in place to govern effectively.

Senate Democrats have slowed the confirmation process at every turn. I encourage them to abandon the political games so we can quickly fill the remaining vacancies that require Senate confirmation.

It is vital that every affected agency is engaged in these types of decisions. That isn't possible if the Senate is failing to do its duty to confirm the President's nominees. Congress has many problems to tackle, but protecting our Nation is at the top of that list. That requires we work together to govern.

It also requires we take a step back from the heated rhetoric and have honest conversations. Taking the fundamental steps to protect our homeland does not diminish the fact that we are a welcoming nation that strives to help the vulnerable.

It is no secret that ISIS and other volatile extremists want to exploit our Nation's generosity and welcoming spirit to sneak terrorists onto American soil. This plan has worked well in Europe. ISIS believes it can work here as well. We can, and must, take reasonable measures to prevent that.

It is reasonable, responsible, in fact, to put a pause on accepting refugees from these nations in order to fix the flaws in the process and instill confidence in the system. The revised order removes Iraq from the list of countries. That is a move in the right direction. It shows that the Iraqis have taken the right steps in agreeing to increase their cooperation with us, and effecting positive outcomes in our relations with these nations is what this pause is all about.

Four of the countries on this list don't even have a U.S. Embassy. So you can understand how difficult it is to get a complete picture of the refugees seeking asylum from those countries when we don't even have a means by which to communicate.

Once the President's Executive order goes into effect, every country will be evaluated within 20 days. If a country comes up short of where it needs to be, it will have 50 days to fix the failures and communications with us.

The reasonable measures we are taking to reduce this threat in no way run counter to the ideals our Nation is built upon. We can be proud of the resources the United States has provided to support those fleeing persecution in war-torn Syria. I have visited the refugee camps we support in Jordan and Turkey. Our commitment to their well-being is strong. The rhetoric doesn't match the realities when it comes to this issue.

The administration's efforts to secure our borders has been met with similar hyperbole. Again, there is nothing unreasonable about ensuring that we know who is coming into our Nation. We are a nation of immigrants and must remain welcoming to those who want to achieve the American dream. We should be proud of our record to naturalize those who immigrate here legally. We naturalize more new citizens per year than the rest of the world combined. Enforcing the law, ensuring the safety and security of our Nation, will not change our commitment to being a welcoming society to those who seek a better life.

But you can't create policies to secure our homeland while wearing rose-colored glasses. There are terrorists seeking to exploit our good graces so they can attack us here at home. This is not a scare tactic; this is reality, and we have to root our policies in reality.

As chairman of the Appropriations Homeland Security Subcommittee, I strongly support President Trump's efforts to get Washington to uphold our most important responsibility: protecting the American people. I stand ready to work with him, Secretary Kelly, and my colleagues to accomplish this goal.

I yield the floor.

The PRESIDING OFFICER. The Senator from Michigan.

Mr. PETERS. Mr. President, I rise today to express my opposition to the confirmation of Seema Verma as Administrator of the Centers for Medicare and Medicaid Services, known as CMS.

As CMS Administrator, Ms. Verma would oversee healthcare coverage for more than 55 million seniors and disabled individuals in the Medicare Program. In addition, she would be the primary authority for the Medicaid Program, the Children's Health Insurance Program, and our Nation's health insurance marketplace. Together, these programs cover over 70 million Americans.

I have serious concerns that if confirmed, Ms. Verma will pursue short-sighted changes to our healthcare system that could jeopardize care for working families, while providing huge benefits to corporate interests.

Ms. Verma has openly stated her desire to put insurance companies back in charge of our healthcare by allowing insurers to deny women maternity care coverage as an essential health benefit. She has also expressed support for proposals that would weaken essential health benefits that ensure coverage for mental healthcare, preventive screenings, and comprehensive pediatric care for children. These comprehensive services form the backbone of the healthcare system that invests in preventive care, improving outcomes, lowering costs, and puts consumers in charge of their own healthcare. Ms. Verma is proposing to take us back to the days when insurance companies were in control and when they would tell you what was best, not you or your doctor.

She has also expressed support for dangerous and radical proposals that would change Medicare as we know it. I believe that when it comes to Medicare, our future CMS Administrator should be doing everything he or she can to strengthen an incredibly successful program. Ms. Verma, instead, supports policies that reduce the quality of care and increase costs on older Americans.

Our Nation's seniors have worked hard their entire lives. We owe them a secure and dignified retirement. When Congress was first debating the Affordable Care Act in 2009, I heard from seniors who had split their pills in half or would forgo their prescriptions altogether just to put food on their table. This is simply unacceptable in this great country of ours.

It is important to remember that the Affordable Care Act extended the solvency of Medicare by more than a decade, while simultaneously bringing down prescription drug costs for seniors. Because of improvements to Medicare in the Affordable Care Act, the average senior in Michigan saved over $1,000 on prescription drug costs in 2015.

While this shows the success the ACA has had in helping older Americans, there is still much more work to do. We must keep moving forward to strengthen and improve Medicare. I am concerned Ms. Verma will move us backward.

During her confirmation hearing, she failed to express her opposition to proposals that would increase Medicare's eligibility age. This means that Michigan's construction workers, nurses, and autoworkers would need to spend more years on their feet before they see the coverage they have earned.

Ms. Verma provided no clear direction on what she will do to strengthen the Medicare Program, and I am concerned that she sees older Americans as just one more line on a budget. These Americans have worked hard their entire lives, and the very last thing we should be doing is making cuts at their expense. Instead, we should focus on proven advances in technology that improve Medicare and cut costs without jeopardizing care for seniors and disabled individuals.

I worked with my colleagues in Congress to introduce bipartisan proposals that will do just that. For example, Medicare spends one out of every three dollars on diabetes treatment. The total economic cost of diabetes is estimated to be $245 billion every year. I have introduced bipartisan legislation that allows Medicare to enroll individuals at risk for developing diabetes into medical nutrition therapy services proven to decrease the likelihood they will develop diabetes in the first place. I have also introduced bipartisan legislation that expands Medicare's use of telemedicine, increasing access for patients in rural and underserved communities and bringing down future health costs by ensuring patients get the preventive care they need to stay healthy.

I will keep working to improve and modernize our healthcare system without sacrificing care for the most vulnerable. Unfortunately, I do not believe Ms. Verma shares this commitment. I am voting against Ms. Verma's nomination because our seniors and working families deserve a CMS Administrator who is fighting to improve their healthcare, not one who merely sees them as a budgetary obligation.

I will oppose her confirmation, and I strongly urge my colleagues to do the same.

Mr. President, I yield 35 minutes of my postcloture debate time to Senator WYDEN.

The PRESIDING OFFICER. The Senator has that right.

Mr. PETERS. I yield the floor.

Ms. CANTWELL. Mr. President, I rise to discuss the nomination of Seema Verma for Administrator of the Centers for Medicare and Medicaid Services, CMS.

We have before us a nominee that would run an agency responsible for the healthcare of more than 100 million Americans, with an annual budget of about $1 trillion. This is the agency that administers Medicare, Medicaid, the Children's Health Insurance Program, and health insurance exchanges. In short, CMS is the single most consequential agency in health care.

Yes, I am deeply concerned about this administration's ideas on Medicare and on the individual insurance market, over both of which CMS has profound influence, but I am most concerned about their plans for Medicaid.

Based on Ms. Verma's history, her actions, her statements, and her testimony before the Senate Finance Committee, it is clear to me that Mrs. Verma is not only complicit but is leading the charge to wage a war on Medicaid.

Why do I say that? Let us look at Ms. Verma's record, actions, and testimony on Medicaid. In Indiana, Ms. Verma made millions of dollars in consulting

fees by kicking poor working people off of Medicaid for failure to pay monthly contributions similar to premiums. This plan forced people making $10,000 a year, $5,000 a year, or even homeless people with virtually no income to pay a monthly contribution or be penalized. As a result of Ms. Verma's work, about 2,500 Hoosiers have been cut from care. Evaluations of this plan by independent experts show it is confusing to beneficiaries and has not demonstrated better results than traditional Medicaid expansion. Meanwhile, enrollment is far lower than projected.

During my meeting with her and in her testimony before the Senate Finance Committee, Ms. Verma stated that Medicaid should not be an option for able-bodied people. Ms. Verma seems to think the private sector can serve this population on its own. Based on what we know about the historical affordability challenges in the individual health insurance market, I find this notion hard to believe.

My State is innovating in Medicaid through ''rebalancing'' from nursing homes to home and community care, integrating behavioral health and primary care, and adopting of innovative new waivers through collaboration with the Federal Government. In fact, Washington State realized more than $2.5 billion in savings over 15 years through rebalancing efforts; yet Ms. Verma will not commit to a single delivery system reform idea.

Ms. Verma claims Medicaid is a top-down Federal power grab. On the contrary, Medicaid is an optional State program, with all States participating. Every State participates because they know Medicaid is a good strategy for covering a low-income and vulnerable population and supporting their healthcare delivery system. Medicaid is highly flexible right now, and States have wide latitude over eligibility, benefits, provider reimbursements, and overall administration of their Medicaid programs.

Ms. Verma claims Medicaid produces poor outcomes, but she cannot offer a single credible clinical outcome or quality measure that the program is not achieving. Meanwhile, data show that patient satisfaction in Medicaid is high and the program achieves improved public health and clinical outcomes for its patients.

Most concerning, Ms. Verma has repeatedly endorsed the administration and Republicans' plan to permanently cap Medicaid, which would hurt patients, States, health providers, and local economies.

I am voting no on Seema Verma's nomination for CMS Administrator because I cannot endorse a full-scale assault on the Medicaid Program.

Mr. RUBIO. Mr. President, Seema Verma has a proven track record of helping States create patient-centered healthcare systems that improve quality and access and give individuals and families more control over their healthcare. Due to a family commitment, I was unable to participate in the cloture vote. However, I strongly support Ms. Verma's nomination and look forward to working with her on the many important healthcare issues facing Florida and our country.

The PRESIDING OFFICER. The Senator from Alaska.

TRIBUTE TO GLEN HANSON

Mr. SULLIVAN. Mr. President, I have been coming down to the floor for the past several months recognizing Alaskans who make our State great and our country better for all of us. I really enjoy doing this because it gives me an opportunity to share the excellent work my citizens are doing in their communities. It also gives me a few minutes to highlight to all my colleagues here in the Senate—and to some of those Americans who might be watching at home—to talk a little bit more about the unique place I call home and am honored to serve and represent in the Senate.

This week, I would like to honor pilot Glen Hanson, who is right now somewhere flying above racing sled dogs in the far north in Alaska, literally as we speak.

Before I get to how he is helping Alaskans and how he is this week's Alaskan of the Week, let me take you back through a remarkable bit of history that happened in Nome, AK, in 1925, when a diphtheria serum was desperately needed for the children in Nome. The nearest batch of serum was 1,000 miles away in Anchorage, AK. There weren't—and still aren't—any roads that connect Nome to Anchorage. There was very challenging winter weather during this time, so no airplanes could fly. In fact, the nearest train station was over 700 miles away from Nome, so people traveled mostly by dog sled.

On the night of January 27, 1925, musher ''Wild Bill'' Shannon tied a 20-pound package of serum wrapped in protective fur around his sled. He and his nine dogs started the journey called then the ''Great Race of Mercy'' across the frozen Alaska land. Miles later, he met up with another racer and another team of dogs, and the relay continued all across Alaska, over 1,000 miles—20 mushers and 150 sled dogs—through some of the world's most rugged terrain and some of the world's most brutal weather. In fact, right now in parts of Alaska where the Iditarod is happening, it is 40 to 50 below zero.

That original race, the Great Race of Mercy, began to be reenacted, with some twists, in 1973 and continues today. In fact, it is going on right now, the Iditarod, the Last Great Race, in my great State. People from all across the world come to participate in it and come to watch it. It is the quintessential Alaskan event that involves the work of hundreds of Alaskans, lodge owners, veterinarians, dogs, dog handlers, volunteers, pilots—hundreds, thousands.

Alaska, as you might know, is home to more veterans per capita than any other State, but we are also home to more pilots per capita than any other State. Our pilots are a vital part of our economy and transportation, and they are a vital part of the Iditarod. In fact, the race couldn't exist without them.

Every year, more than a dozen volunteer pilots load their planes for the Iditarod race with more than 100,000 pounds of dog food, hundreds of bales of hay, and lumber for tents. They fly the veterinarians, the judges, the dog handlers, and so many of the volunteers out to the checkpoints hundreds of miles away. We call them the Iditarod Air Force, and every one of them deserves recognition.

That gets me back to Anchorage resident Glen Hanson, who is our Alaskan of the Week. Glen, along with his brother Bert, is tied among this year's pilots as the longest serving volunteer in the Iditarod Air Force. He began volunteering for the Last Great Race—the Iditarod Air Force—in 1984. Glen has since put in roughly 1,500 hours of volunteer time, making sure that the Last Great Race continues and that the dogs and the mushers are taken care of—taken care of right now in 40 to 50 below zero, as this race is going on.

This year, Glen won the Alaska Air Carriers Association Iditarod Humanitarian Service Award. Upon receiving it, the Air Carriers Association wrote to Glen:

> You are obviously an accomplished pilot held in high regard by your peers. While there are many volunteers working to make the race possible, you consistently go above and beyond the call of duty. You are always quietly willing to take every assignment, no matter how unglamorous or uncomfortable. You step up time after time to fly in the challenging air strips to ensure that the musher supplies and race personnel are available to keep the race safe.

Thank you, Glen, for all you do to keep our great Alaska history alive. And thanks to all the pilots in the Iditarod Air Force this year and so many of the other volunteers who keep everybody safe—and are doing it right now during this year's Iditarod. And to all the mushers and these great dogs, good luck. Everyone involved makes this truly the last great race in America.

MORNING BUSINESS

Mr. SULLIVAN. Mr. President, I ask unanimous consent that the Senate be in a period of morning business, with Senators permitted to speak therein for up to 10 minutes each.

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

TRIBUTE TO MASTER SERGEANT KEARY MILLER

Mr. MCCONNELL. Mr. President, today it is my honor to congratulate retired MSgt Keary Miller of the Kentucky Air National Guard's 123 Special