

When you consider that visitors from overseas spend an estimated \$4,500 every time they visit the United States, more visitors will mean more jobs for Americans at a time when unemployment continues to rise.

So I truly urge my colleagues to join me in supporting this bill as we work toward increasing our Nation's presence as a tourist destination around the world. I hope, as the week unfolds, we will have an opportunity to engage in conversation and discussion and debate about this very important tourism bill, which will help most States of this country.

The fact is we want Florida to be a significant tourism destination. We are proud of that in our State, but the fact is that States around the country all can benefit and do benefit greatly from foreign tourists visiting our country. It is a great, green way of promoting jobs and opportunities in our country and one I think is long overdue. If we are going to compete effectively with countries abroad, we must, in fact, also be competitive in how we promote and advertise ourselves to the world.

I yield the floor.

The PRESIDING OFFICER. The Senator from Tennessee.

Mr. ALEXANDER. Madam President, I ask unanimous consent to speak for up to 12 minutes as in morning business.

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

HEALTH CARE REFORM

Mr. ALEXANDER. Madam President, I am looking for a way to offer an amendment to the health care bill that would sentence every Senator who votes to increase Medicaid eligibility to 150 percent of the Federal poverty level to a term of 8 years as Governor in his or her home State, so they can have an opportunity to manage the program, to raise taxes, and to find a way to pay for that sort of proposal. If we Senators were to increase Medicaid in that way, and go home, we would find first that Medicaid is a terrible base upon which to build an improved health care system, because it is filled with lawsuits. It is filled with Federal court consent decrees that sometimes are 20 and 25 years old and take away from the Governor's and the legislature's authority to make decisions. It is filled with inefficiency. It is filled with delays. Governors request waivers to run their systems, and it may take a year or more for approval from the Federal Government for relatively simple requests. And finally, it is filled with an intolerable waste of taxpayer money because of fraud that is documented by the Government Accountability Office. As much as 10 percent of the entire program—\$32 billion a year—according to the Government Accountability Office is lost to fraud. That is the Medicaid Program.

The second thing a Senator who goes home to serve as Governor for 8 years

would find is that increasing coverage in this way will require much higher State taxes at a time when most every State is making a massive cut in services, and a few States are nearly bankrupt. For example, in my State of Tennessee, if the Kennedy bill were to pass, which would increase Medicaid expansion by 150 percent and increase reimbursement rates to 110 percent of Medicare, it would require, based on our estimates, a new State income tax of about 10 percent to pay for the increased costs just for our State, as well as perhaps adding another half a trillion dollars or so to the Federal debt.

Finally, if we were to base new coverage for the 58 million people now in Medicaid, and others who need insurance, upon this government-run Medicaid Program these Americans—who are the people we are talking about in this debate and who are the ones we hope will have more of the same kind of health care the rest of us have—we would find that a large number of them would have a hard time finding a doctor. Today 40 percent of doctors already refuse to provide full service to Medicaid patients because of the low reimbursement rates, and if we simply add more to that Medicaid Program, these people will have an even harder time getting served.

There is a better idea. Instead of expanding a failing government health care program which traps 58 million of our poorest citizens in that government-run program that provides substandard care, the better way to extend medical care to those low-income Americans now served by Medicaid is to give them government tax credits, or government subsidies, or vouchers, or money in their pockets they can use to purchase private health insurance of their choice. That sort of option for health care reform is before the Senate, if it could only be considered. It has been offered on one end by Senator COBURN and Senator BURR. It has been offered at the same time by Senator GREGG of New Hampshire. It has been offered in a bipartisan way by Senator WYDEN and Senator BENNETT who have offered a proposal that would basically give these dollars to the people who need help, let them buy their insurance, and according to the same Congressional Budget Office that said the Kennedy proposal costs at least 1 trillion more dollars, the CBO has said that Bennett-Wyden would cost zero more.

I ask that I am informed when I have 1 minute left.

The PRESIDING OFFICER. Without objection, it is so ordered. The Senator has 5 minutes remaining.

Mr. ALEXANDER. Madam President, during the last 6 months, the four words we have heard most in Washington are "more debt" and "Washington takeover," and all four words apply to the health care debate. We have seen a Washington takeover of banks, of insurance companies, of student loans, of car companies, and now,

perhaps, of health care. The President insists on a government-run insurance option as part of a health care reform plan which would inevitably lead to a Washington-run health plan.

Why would it do that? Well, putting a government-run and subsidized plan in competition with our private health insurance plans would be like putting an elephant in a room with some mice and saying: OK, guys and gals, compete. I think we know what would happen. The elephant would win the competition and the elephant would be your only remaining choice.

As for more debt, the Congressional Budget Office, in a letter sent to Senator KENNEDY, estimated that his bill, which is the only legislation the Senate Health Committee is considering, would add another \$1 trillion during the next 10 years in order to cover 16 million uninsured Americans, leaving 30 million uninsured. That is another \$1 trillion over the next 10 years that, according to yesterday's Washington Post, already is nearly three times as much as was spent in all of World War II. The Post said the proposed new debt over the next 10 years, before we get to the health care bill, is three times as much as we spent in World War II. The Congressional Budget Office estimate didn't even consider the cost of the Kennedy bill's proposals to expand Medicaid coverage.

So let's talk about Medicaid. Every State offers it. It provides health care in a variety of ways to low-income Americans who are not eligible for Medicare. The Federal Government pays about 60 percent of the costs and writes most of the rules; the States pay the rest. Fifty-eight million low-income Americans are trapped in Medicaid. It is the only place of any significant size where we don't have competition in our health care system. Think of the elephant in the room.

It was my experience as Governor—I believe it is for most Governors—that it is not only an administrative mess with substandard care, the Medicaid Program, but its costs have spiraled out of control, threatening the viability of public universities and community colleges because there is no money left for the States to support them.

Here is what would happen in Tennessee if the Kennedy bill passed, according to the State of Tennessee's Medicaid director. Our State costs would go up \$572 million if we increased coverage to 150 percent of Federal poverty. If the Fed pays for this, the Fed's cost would be \$1.6 billion—I mean the Federal budget paying for all of it, because normally the Federal budget pays two-thirds, the State one-third. If the State has to also provide Medicaid payments to physicians at 110 percent of Medicare, this would add another \$600 million in costs to the State of Tennessee. Thus, the proposal of the combination of the Health and the Finance Committees' bills that are being considered would be 1.2 billion new dollars for Tennessee. If you add the Federal Government's increase in costs

just for the Tennessee program to which the Tennessee program was expanded, it would be \$3.3 billion.

So you can see why the Kennedy bill has been called so expensive. That is not all. The Finance Committee has been discussing turning back to the States by 2015 these increased costs, although the Finance Committee is talking about a smaller expansion of coverage. So imagine a Senator going home to the State of Tennessee—it won't be me, because I have already had the privilege of being Governor—but say if one went back to be Governor of Tennessee, what would one find if we passed the Kennedy bill as it is now proposed? We would find a bill by 2015 of 1.2 billion in today's dollars, and where would the Governor get the money? Well, when one Governor proposed a 4-percent State income tax in Tennessee in 2004, a 4-percent income tax would bring in 400 million new dollars. We need \$1.2 billion under the Kennedy bill to pay for the expansion of Medicaid. So to raise nearly \$1.2 billion, a new State income tax of more than 10 percent would be needed, if all other services were held flat, and the Governor has already said that most State functions will see a decrease in funding after the stimulus money goes away.

This same problem would be true for all States. The National Governors Association says if we assume that all individuals under 150 percent of poverty are covered and there is no change in reimbursement rates, the cost to the States would be \$360 billion more over the next 10 years. If you also increase the reimbursement rate for physicians from say 72 percent to 83 percent, the Governors Association says the new cost is \$500 billion more over 10 years.

Then there is the fraud in the Medicaid Program. The Government Accountability Office says 10 percent of it is fraud—\$32 billion a year—about three-fourths of the amount we spend on prescription drugs for all seniors. Then there is the problem of access of care, with 40 percent of doctors already not being willing to provide full service to patients who are on Medicaid. So why would we expand this government-run program when it is filled with inefficiencies, delay, and waste, when it would bankrupt States, when it would add hundreds of billions of dollars to the Federal debt, and when it would provide substandard service when, instead, we could pass the Coburn-Burr bill, or the Gregg bill, or the Wyden-Bennett bill and give to the 58 million low-income Americans who are trapped in a failing government program the dollars they need to purchase private health insurance much like the rest of us have?

I hope I can find a way to offer an amendment that would require any Senator who votes for a 150-percent increase in Medicaid, who says that Medicaid expansion will go to 150 percent of the Federal poverty level, will be sentenced to go home and serve for 8 years

as Governor of his or her State so they can find out what it is like to manage such a program or to raise taxes to pay for it.

I ask unanimous consent to have printed in the RECORD following my remarks the letter from Douglas Elmendorf of the Congressional Budget Office to Senator KENNEDY of June 15 stating that his bill would add \$1 trillion more over the next 10 years to the debt, and that doesn't even include the Medicaid expansions I have talked about.

I also ask unanimous consent that an article from the Wall Street Journal of yesterday talking about State budget gaps, which shows what dire straits many States are in be printed in the RECORD.

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

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, June 15, 2009.

Hon. EDWARD M. KENNEDY,
Chairman, Committee on Health, Education,
Labor, and Pensions, U.S. Senate, Wash-
ington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) have completed a preliminary analysis of the major provisions related to health insurance coverage that are contained in title I of draft legislation called the Affordable Health Choices Act, which was released by the Senate Committee on Health, Education, Labor, and Pensions (HELP) on June 9, 2009. Among other things, that draft legislation would establish insurance exchanges (called "gateways") through which individuals and families could purchase coverage and would provide federal subsidies to substantially reduce the cost of that coverage for some enrollees.

The attached table summarizes our preliminary assessment of the proposal's budgetary effects and its likely impact on insurance coverage. According to that assessment, enacting the proposal would result in a net increase in federal budget deficits of about \$1.0 trillion over the 2010-2019 period. Once the proposal was fully implemented, about 39 million individuals would obtain coverage through the new insurance exchanges. At the same time, the number of people who had coverage through an employer would decline by about 15 million (or roughly 10 percent), and coverage from other sources would fall by about 8 million, so the net decrease in the number of people uninsured would be about 16 million.

It is important to note, however, that those figures do not represent a formal or complete cost estimate for the draft legislation, for reasons outlined below. Moreover, because expanded eligibility for the Medicaid program may be added at a later date, those figures are not likely to represent the impact that more comprehensive proposals—which might include a significant expansion of Medicaid or other options for subsidizing coverage for those with income below 150 percent of the federal poverty level—would have both on the federal budget and on the extent of insurance coverage.

KEY PROVISIONS RELATED TO HEALTH INSURANCE COVERAGE

Subtitles A through D of title I of the Affordable Health Choices Act would seek to increase the number of legal U.S. residents who have health insurance. Toward that end, the federal government would provide grants to states to establish insurance exchanges

and—more importantly—would subsidize the purchase of health insurance through those exchanges for individuals and families with income between 150 percent and 500 percent of the federal poverty level; those subsidies would represent the greatest single component of the proposal's cost. The proposal would also impose a financial cost on most people who do not obtain insurance, the size of which would be set by the Secretary of the Treasury.

The draft legislation released by the HELP Committee also indicates that certain features may be added at a later date. Because they are not reflected in the current draft, however, CBO and the JCT staff did not take them into account. In particular, the draft legislation does not contain provisions that would change the Medicaid program, although it envisions that the authority to extend Medicaid coverage will be added during Senate consideration of the bill. (By itself, adding such provisions would increase the proposal's budgetary costs and would also yield a larger increase in the number of people who have health insurance.) The draft legislation also indicates that the committee is considering whether to incorporate other features, including a "public health insurance option" and requirements for "shared responsibility" by employers. Depending on their details, such provisions could also have substantial effects on our analysis. (A summary of the key provisions that were included in this analysis is attached.)

IMPORTANT CAVEATS REGARDING THIS PRELIMINARY ANALYSIS

There are several reasons why the preliminary analysis that is provided in this letter and its attachments does not constitute a comprehensive cost estimate for the Affordable Health Choices Act:

First, this analysis focuses exclusively on the major provisions on health insurance coverage contained in certain subtitles of title I of the draft legislation. Although other provisions in title I, along with provisions in the other five titles of the legislation, would have significant budgetary effects, the analysis contained in this letter and its attachment is limited to the provisions in subtitles A through D regarding health insurance coverage.

Second, CBO and the JCT staff have not yet completed modeling all of the proposed changes related to insurance coverage. For example, the proposal would allow parents to cover children as dependents until they are 27 years old, and our analysis has not yet taken that provision into account. (Other instances are listed in the attachment.) Although this analysis reflects the proposal's major provisions, taking all of its provisions into account could change our assessment of the proposal's effects on the budget and insurance coverage rates—though probably not by substantial amounts relative to the net costs already identified. As our understanding of the provisions we have analyzed improves, that could also affect our future estimates.

Third, the analysis of the proposal's effects on the federal budget and insurance coverage reflects CBO's and the JCT staff's understanding of its key features and discussions with committee staff—but does not represent a full assessment of the legislative language that was released by the committee. Although our reading of the draft language has informed our analysis, we have not had time to complete a thorough review of that language, which could have significant effects on any subsequent analysis provided by CBO and the JCT staff.

In particular, the draft legislation includes a section on "individual responsibility" that would generally impose a financial cost on

people who do not obtain insurance—but is silent about whether people are required to have such coverage. On the basis of our discussions with the committee staff, we understand that it was the committee's intent to impose a clear requirement for individuals to have health insurance, and this analysis reflects that intent. However, the current draft is not clear on this point, and if the language remains ambiguous, that would affect our estimate of its impact on federal costs and insurance coverage.

Fourth, some effects of the insurance proposals that we have modeled have not yet been fully captured. For example, we have not yet estimated the administrative costs to the federal government of implementing the proposal or the costs of establishing and operating the insurance exchanges, nor have we taken into account the proposal's effects on spending for other federal programs. Those effects could be noticeable but would not affect the main conclusions of this analysis.

Fifth, the budgetary information shown in the attached table reflects many of the major cash flows that would affect the federal budget as a result of the proposal and provides our preliminary assessment of its net effects on the federal budget deficit. Some cash flows would appear in the budget but would net to zero and not affect the deficit; CBO has not yet estimated all of those cash flows.

LIKELY EFFECTS OF THE PROPOSAL

The proposal would have significant effects on the number of people who are enrolled in health insurance plans, the sources of that coverage, and the federal budget.

Effects on Insurance Coverage. Under current law, the number of nonelderly residents (those under age 65) with health insurance coverage will grow from about 217 million in 2010 to about 228 million in 2019, according to CBO's estimates. Over that same period, the number of nonelderly residents without health insurance at any given point in time will grow from approximately 50 million people to about 54 million people—constituting about 19 percent of the nonelderly population. Because the Medicare program covers nearly all legal residents over the age of 65, our analysis has focused on the effects of proposals on the nonelderly population.

People obtain insurance coverage from a variety of sources. Under current law, about 150 million nonelderly people will get their coverage through an employer in 2010, CBO estimates. Similarly, another 40 million people will be covered through the federal/state Medicaid program or the Children's Health Insurance Program (CHIP). Other nonelderly people are covered by policies purchased individually in the "nongroup" market, or they obtain coverage from various other sources (including Medicare and the health benefit programs of the Department of Defense).

According to the preliminary analysis, once the proposal was fully implemented, the number of people who are uninsured would decline to about 36 million or 37 million, representing about 13 percent of the nonelderly population. (Roughly a third of those would be unauthorized immigrants or individuals who are eligible for Medicaid but not enrolled in that program.) That decline would be the net effect of several broad changes, which can be illustrated by examining the effects in a specific year. In 2017, for example, the number of uninsured would fall by about 16 million, relative to current-law projections. In that year, about 39 million people would be covered by policies purchased through the new insurance exchange. At the same time, about 147 million people would be covered by an employment-based health

plan, 15 million fewer than under current law. Smaller net declines (totaling about 8 million) would occur in coverage under Medicaid and CHIP and in nongroup coverage because of the subsidies offered in the exchanges.

Budgetary Impact of Insurance Coverage Provisions. On a preliminary basis, CBO and the JCT staff estimate that the major provisions in title I of the Affordable Health Choices Act affecting health insurance coverage would result in a net increase in federal deficits of about \$1.0 trillion for fiscal years 2010 through 2019. That estimate primarily reflects the subsidies that would be provided to purchase coverage through the new insurance exchanges, which would amount to nearly \$1.3 trillion in that period. The average subsidy per exchange enrollee (including those who would receive no subsidy) would rise from roughly \$5,000 in 2015 to roughly \$6,000 in 2019. The other element of the proposal that would increase the federal deficit is a credit for small employers who offer health insurance, which is estimated to cost \$60 billion over 10 years. Because a given firm would be allowed to take the credit for only three consecutive years, the pattern of outlays would vary from year to year.

Those costs would be partly offset by receipts or savings from three sources: increases in tax revenues stemming from the decline in employment-based coverage; payments of penalties by uninsured individuals; and reductions in outlays for Medicaid and CHIP (relative to current-law projections).

The proposal would not change the tax treatment of health insurance premiums. Nevertheless, the reduction in the number of people receiving employment-based health insurance coverage, relative to current-law projections, would affect the government's tax revenues. Because total compensation costs are determined by market forces, CBO and the JCT staff estimate that wages and other forms of compensation would rise by roughly the amounts of any reductions in employers' health insurance costs. Employers' payments for health insurance are tax-preferred, but most of those offsetting changes in compensation would come in the form of taxable wages and salaries. As a result, the shift in compensation brought about by the proposal would cause tax revenues to rise by \$257 billion over 10 years. (Those figures are generally shown as negative numbers in the attached table because increases in revenues reduce the federal budget deficit.)

The government would also collect the payments that uninsured individuals would have to make. CBO and the JCT staff assume that the annual amount, which would be set by the Treasury Secretary, would be relatively small (about \$100 per person). Moreover, individuals with income below 150 percent of the federal poverty level would not have to pay that amount. As a result, collections of those payments would total \$2 billion over 10 years.

Finally, although the proposal would not change federal laws regarding Medicaid and CHIP, it would affect outlays for those programs. CBO assumes that states that had expanded eligibility for Medicaid and CHIP to people with income above 150 percent of the federal poverty level would be inclined to reverse those policies, because those individuals could instead obtain subsidies through the insurance exchanges that would be financed entirely by the federal government. Reflecting those reductions in enrollment, federal outlays for Medicaid and CHIP would decline by \$38 billion over 10 years.

I hope this preliminary analysis is helpful for the committee's consideration of the Affordable Health Choices Act. If you have any questions, please contact me or CBO staff.

The primary staff contacts for this analysis are Philip Ellis, who can be reached at (202) 226-2666, and Holly Harvey, who can be reached at (202) 226-2800.

Sincerely,

DOUGLAS W. ELMENDORF,
Director.

Attachments.

A SUMMARY OF THE KEY PROVISIONS OF THE HELP COMMITTEE'S PROPOSAL

Congressional Budget Office, June 15, 2009

Most of the proposal's key provisions would become operative in a state when that state establishes an insurance exchange (called a "gateway") through which its residents could obtain coverage; such exchanges might start offering health insurance in some states in 2012; all exchanges would be fully operational by 2014.

The proposal is assumed to require most legal residents to have insurance (though the draft language is not explicit in this regard). In general, the government would collect a payment from uninsured people, but individuals with income below 150 percent of the federal poverty level (FPL) would be exempt and the payment would be waived in certain other cases. The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) assumed that the annual payment amount, which would be set administratively, would be relatively small (about \$100 per person).

New health insurance policies sold in the individual and group insurance markets would be subject to several requirements regarding their availability and pricing. Insurers would be required to issue coverage to all applicants, and could not limit coverage for preexisting medical conditions. In addition, premiums for a given plan could not vary because of enrollees' health and could vary by their age to only a limited degree (under a system known as adjusted community rating). Existing policies that are maintained continuously would be "grandfathered."

There would be no change from current law regarding Medicaid or the Children's Health Insurance Program (CHIP).

Insurance policies covering required benefits that are sold through the exchanges would have actuarial values chosen by the Secretary of Health and Human Services from specified ranges within three tiers. (A plan's actuarial value reflects the share of costs for covered services that is paid by the plan.) CBO and the JCT staff assumed that the chosen actuarial values would be 95 percent (for the highest tier), 85 percent (for the middle tier), and 76 percent (for the lowest tier). Plans would be allowed to offer added coverage or benefits for an extra premium.

The subsidies available through the exchanges would be tied to the average of the three lowest premium bids submitted by insurers in each area of the country for each tier of coverage. For people with income between 150 percent and 200 percent of the FPL, the subsidies would apply to that average bid for the highest-tier plans; for people with income between 200 percent and 300 percent of the FPL, the subsidies would apply to that average bid for the middle-tier plans; and for people with income between 300 percent and 500 percent of the FPL, the subsidies would apply to that average bid for the lowest-tier plans.

The subsidies would cap premiums as a share of income on a sliding scale starting at 1 percent for those with income equal to 150 percent of the FPL, rising to 10 percent of income at 500 percent of the FPL. Those income caps would be indexed to medical price inflation, so that individuals would (on average) pay a higher portion of their income for exchange premiums over time. Individuals

and families with income below 150 percent of the FPL would not be eligible for those subsidies. (The proposal envisions that Medicaid would be expanded to cover those individuals and families but the draft legislation does not include provisions to accomplish that goal.)

Subsidies would be delivered by the Department of Health and Human Services via the insurance exchanges with some provisions for income verification. Subsidy amounts would be determined using a measure of income for a previous tax year, implying that subsidies received for a given year (for example, in 2013) would be based on in-

come received two years prior (for example, in 2011). Individuals might be eligible for larger subsidies if their income declined significantly in the intervening period or if other extenuating circumstances arose. (The draft legislation's provisions regarding verification of income are unclear, which is reflected in the analysis.)

The proposal does not include a "public plan" that would be offered in the exchanges, nor does it contain provisions that would require employers to offer health insurance benefits or impose a fee or tax on them if they did not offer insurance coverage to their workers.

In general, individuals with an offer of employer-sponsored insurance would not be eligible for exchange subsidies under the proposal. However, employees with an offer from an employer that was deemed unaffordable could get those subsidies; because the exchange subsidies would limit the share of income that enrollees would have to pay (as described above), CBO and the JCT staff assumed that an "unaffordable" offer from an employer would be one that required the employee to pay a larger share of income for that plan than he or she would have to pay for coverage in an exchange.

6/15/2009

Preliminary Analysis of HELP Committee's Insurance Proposal

NOTE: Figures in table do not reflect all elements of the proposal (see text)

EFFECTS ON COVERAGE OF NON ELDERLY PEOPLE^a		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	
(Millions of people, by calendar year)												
Current Law	Medicaid/CHIP	40	39	39	38	35	34	35	35	35	35	
Coverage	Employer	150	153	156	158	161	162	162	162	162	162	
	Nongroup	13	12	12	12	13	14	14	14	14	15	
	Other	14	14	14	14	14	15	15	15	15	16	
	Uninsured	<u>50</u>	<u>51</u>	<u>51</u>	<u>51</u>	<u>51</u>	<u>51</u>	<u>52</u>	<u>53</u>	<u>53</u>	<u>54</u>	
	TOTAL	267	269	271	273	274	276	277	279	281	282	
Change (+/-)	Medicaid/CHIP	-1	-1	*	1	-4	-3	-2	-2	-2	-2	
	Employer	2	2	-1	-7	-14	-14	-15	-15	-15	-15	
	Nongroup/Other	*	*	-1	-2	-5	-5	-5	-6	-6	-6	
	Exchanges	0	0	5	17	38	38	38	39	39	40	
	Uninsured	-1	-1	-3	-9	-15	-16	-16	-16	-17	-17	
Post-Policy Uninsured ^b	Number of People	49	51	48	42	36	35	36	36	37	37	
	as a Share of Non elderly	19%	19%	18%	15%	13%	13%	13%	13%	13%	13%	

EFFECTS ON THE FEDERAL DEFICIT^{a,c}		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
(Billions of dollars, by fiscal year)												
Exchange Subsidies		0	0	17	66	148	183	196	209	223	237	1,279
Employer Subsidies ^d		4	8	8	5	4	7	7	6	6	7	60
Payments by Uninsured Individuals		0	0	0	*	*	*	*	*	*	*	*
Medicaid/CHIP Outlays		-1	-2	-1	2	-6	-7	-6	-6	-6	-6	-38
Tax Revenue Effects of Coverage Changes ^e		1	2	-2	-15	-30	-37	-40	-43	-45	-48	-257
NET IMPACT		4	7	21	58	116	146	157	166	177	189	1,042

* = Less than 0.5 million people or spending/savings of less than \$0.5 billion

Notes: a. Components may not sum to totals because of rounding. b. The count of uninsured people includes unauthorized immigrants and people eligible for, but not enrolled in, Medicaid. c. Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit. d. The effects on the deficit from employer subsidies include their impact on taxable compensation. e. Increases in tax revenues reduce the deficit.

Sources: Congressional Budget Office and Joint Committee on Taxation.

The proposal would offer subsidies to small employers whose workers have low average wages and who offer health benefits to those workers. The amount of the subsidy would vary with the size of the firm (up to a limit of 50 workers), and firms that contribute larger amounts toward their workers' health insurance would receive larger subsidies. The credit would be available indefinitely, but firms would be eligible to take the credit for only three consecutive years at a time.

KEY PROVISIONS NOT YET TAKEN INTO ACCOUNT

There are several features of the proposal that CBO and the JCT staff have not yet reflected in their budget estimates. The most significant features of the proposal that have not yet been estimated would do the following:

Require insurers to offer dependent coverage for children of policyholders who are less than 27 years of age.

Delegate authority to a Medical Advisory Council to establish minimum requirements for covered health benefits and to determine the level of coverage that individuals would need to obtain in order to qualify as having insurance.

Require insurers to maintain a minimum level of medical claims paid relative to premium revenues (otherwise known as a "medical loss ratio"), or to repay certain amounts to policyholders; the HHS Secretary would have the authority to set the minimum medical loss ratio.

Apply "risk adjustment" (a process that involves shifting payments from plans with low-risk enrollees to plans with high-risk enrollees) to all health insurance policies sold in the individual and group insurance markets.

Allow employers to buy health coverage through the exchanges.

Require health insurance plans participating in the new exchanges to adopt measures that are intended to simplify financial and administrative transactions in the health sector (such as claims processing).

[From the Wall Street Journal, June 15, 2009]

STATES' BUDGET GAPS ARE ANOTHER TEST FOR WASHINGTON

(By Jonathan Weisman)

As the White House eagerly scans the economic landscape for signs of recovery, a looming drought in the form of state budget deficits could make any "green shoots" wilt.

States face a cumulative shortfall of \$230 billion from this year through 2011, and there is little sign in bailout-weary Washington of any attempt to create yet another aid program to solve that problem. But if the federal government did want to hold that drought at bay, it has options: passing another stimulus plan; assisting states in the bond market; assuming a greater share of Medicaid payments. If the recovery stalls a few months from now, those may suddenly become central to the rescue efforts.

While discouraging talk right now of any federal response to state budget woes, the Obama administration is anxiously eyeing state efforts to close persistent budget gaps. So far, 42 U.S. states have slashed enacted budgets to cope with rising demand for services and plunging revenue, according to the National Governors Association. About half have also raised taxes.

Those policies run counter to Washington's efforts to prime the economic pump, with a \$787 billion stimulus plan, plus hundreds of billions of dollars more in new lending, mortgage relief and other efforts. About \$246 billion of the stimulus funds are already going to the states, to offset rising Medicaid costs, stave off education cuts and help with infrastructure problems. Friday, the Treasury made \$25 billion in bond authority avail-

able for state and local governments under the Recovery Zone Bonds program, a little-known piece of the massive stimulus law.

But all that money will start drifting away next year, when the administration hopes a recovery will be taking hold. And that is exactly when states anticipate their fiscal problems could be even worse. "The states have so few options to respond," said Nick Johnson, director of the state fiscal project at the Center on Budget and Policy Priorities, a liberal think tank. "Drawing down reserve funds, various accounting gimmicks—those options are either gone or won't do enough. The remaining options threaten to slow the recovery."

If Washington were inclined to help, the easiest approach would be a second stimulus bill pouring more money directly into state coffers. But with a federal budget deficit approaching \$2 trillion, there is little chance of that.

So creativity is in order.

House Financial Services Committee Chairman Barney Frank has been searching for low-cost ways to step in. His staff has looked into a raft of measures to loosen state borrowing and lower the interest rates state governments must offer on their bonds. The Massachusetts Democrat would like to create a reinsurance fund, financed through premiums paid by bond sellers, which would offer bond purchasers additional assurance that their money is safe.

Legislation also could mandate that ratings companies such as Standard & Poor's would have to use the same criteria to rate state bonds as are used to rate corporate bonds—a requirement that doesn't exist now, sometimes to the disadvantage of states. "Where there's the full faith in credit behind these municipal bonds, where the full taxing power of a state or city is behind them, they never default," Mr. Frank said, yet the bonds are "treated as if they're risky."

In the short run, the Treasury or Federal Reserve could use existing programs established to prop up consumer borrowing to underwrite state bond offerings, he said. That would bring more lenders into the state bond market and lower interest costs for cash-strapped states.

President Barack Obama suggested in a recent C-SPAN interview that some kind of clever bond-market moves may be in the works. "We are talking to state treasurers across the country, including California, to figure out are there some creative ways that we can just help them get through some of these difficult times," he said.

But crafting the right balance would be tough.

Treasury officials have told California state legislators that the U.S. is monitoring the situation but isn't keen to provide assistance, according to people familiar with the matter. "It's hard to help just one state," says a government official. On the other hand, there is worry about setting up a broad short-term assistance program that some fret could turn into a permanent federal subsidy.

The move to bail out California—or any other state—is made harder by the current political climate, particularly opposition from home-state Republicans on Capitol Hill.

Rep. John Campbell, one of four California Republicans on Mr. Frank's committee, said a federal intervention would only halt state efforts to come to terms with budgets and could create incentives to spend even more. "The states are kind of on their own because the bullets are out of the federal gun," he said, "not because they couldn't print some more money but because I hope there's a recognition that printing and borrowing more money is going to have extremely negative consequences."

In response, Mr. Frank shrugs: "How am I going to get representatives from Pennsylvania and New York to send money to California if Republicans from California are fighting it?"

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

Mr. ALEXANDER. I yield the floor.

The PRESIDING OFFICER. The Senator from California is recognized.

EXTENSION OF MORNING BUSINESS

Mrs. BOXER. Madam President, I ask unanimous consent that morning business be extended until 15 minutes from now.

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

HEALTH CARE REFORM

Mrs. BOXER. Madam President, I decided to come to the floor to talk about a couple of things. One is health care reform and the other is the stimulus package.

We are seeing attacks from the party of no, the Republican Party, every day on this floor, and I believe the purpose is to derail health care reform. I think it is perfectly legitimate to debate how we do it, but I think when everything is stripped away, you are going to see the Republicans as the party of the status quo.

In relation to health care reform, the status quo has to go, because it is hurting our people. I will put a couple of facts out there that are irrefutable; they are just facts. The fact is, if we don't act, soaring health care costs are unsustainable for our families. In this great Nation, we pay twice as much as any other nation for our health care. The fact is we must turn this around. As the wording is now, we must "bend that cost curve," because we cannot sustain the situation as it is. It is hurting our families. Premium rises are unbelievable. We all know it in our own circumstances. And we know the uninsured keep growing. Why? Because they cannot afford the premiums or maybe companies won't take them because they may have had high blood pressure or something, and they don't get the coverage they need. So they don't avail themselves of prevention.

We have too much obesity in this country among our kids and adults. We know that prevention in and of itself could bend that cost curve. If someone understands nutrition and diet, and they get help in making sure they change their lifestyle or that their kids don't eat sugar and fattening foods all the time, it has an enormous impact on what happens to them when they get older. Diabetes is a major problem. We can turn that around, along with the heart risks that go with it later on, and the stroke risks that go with high blood pressure. These things can be controlled.

We took a first step in prevention when we passed the bill on smoking