HEALTH CARE REFORM

Mr. BROWN. Madam President, yesterday was a fateful day as we moved forward on health care legislation. Yesterday America's Health Insurance Plans, the insurance companies, unveiled a report criticizing the Senate Finance Committee's health reform legislation. This is the committee that negotiated with Republicans for 6 months; the committee that worked with the insurance industry for 6 months; a committee that has, frankly, not included a public option; a committee that has, frankly, bent over backwards to listen to insurance company interests.

America's Health Insurance Plans unveiled a report saying that as a result of this health care bill, health insurance premiums are going to increase by double-digit percentages as far as the eye can see.

Families USA pointed out that ''this criticism by the insurance lobby gives hypocrisy a bad name.''

AHIP, America's Health Insurance Plans, talked about rate shock; that if we move forward on this health insurance bill, Americans are going to be victimized by rate shock. Rate shock is a significant increase in premiums that insurance companies have inflicted upon Americans over the past decade, year after year after year.

I just got off the phone with a small business person in Cincinnati who has fought as hard as he possibly can. He came to my townhall meeting in Cincinnati, the most conservative part of the State, saying he needed to go in with other businesses in an insurance exchange, perhaps with a public option so he could get his rates in check. The insurance companies just raised his rates so dramatically that he is likely going to lose his insurance.

Rate shock is when between 2000 and 2009 average family insurance premiums for employer-based health coverage increase from $6,700 to over $13,073, an increase of 93 percent. Rate shock is when between 1999 and 2009, premiums for employer-sponsored insurance in my State—from Findlay to Gallipolis, from Galion to Youngstown—grew 108 percent. Rate shock is when 20 percent of middle-income Ohio families spend more than 10 percent of their income on health care. Rate shock is when between 2000 and 2008, the percentage of employees with an annual deductible greater than $1,000 increased from 1 percent to 18 percent. One out of five Ohioans is paying a more than $1,000 deductible. Rate shock is when since 2000, insurance costs for small businesses have increased 129 percent.

Who is going to provide the jobs in this economy to get us back on our feet as a nation? It is small businesses. Yet the insurance companies have more than doubled insurance premiums for small business, a 129-percent increase in less than a decade. Rate shock is when small business workers pay an average of 18 percent more in premiums than those in large firms for the same benefits.

When America's Health Insurance Plans, the insurance industry, talks about rate shock, rate shock is what they have inflicted on the American public, what they have inflicted on large corporations, what they have inflicted on small business people, what they have inflicted on individual American workers, on individuals holding insurance plans.

Here is what rate shock, inflicting these huge premiums, has done. We know what it has done to the American public. We know what it has done to small business. We know what it has done to workers. We know what it has done to taxpayers. We know what it has done to local and State governments wrestling with insurance costs while providing other education, health care, public safety, public service services.

Here is what it has meant to insurance companies. Between 2000 and 2007, rate shock, inflicting high costs on ratepayers, has meant profits at 10 of the country's largest publicly traded health insurance companies going up 428 percent. They are doing just fine, thanks to the rate shock they are imposing upon American business and American individuals.

From 2007, CEOs of these companies collected a combined total compensation—10 companies, 1 year—of $118.6 million, $11.9 million each, 468 times more than the $25,000 an average American worker made that year. The CEOs of the insurance companies made $11.9 million each while they are saying to people: Sorry, you can't get insurance. You have a preexisting condition. Sorry, we are going to rescind your policies because you got too sick and you spent too much. Sorry, we will not cover you. We will cancel your policy because you are the wrong age or the wrong gender or live in the wrong place or you have the wrong disability.

The first half of this year, to top it all off, here is what rate shock meant to the insurance industry. AHIP spent $3.9 million on in-house lobbying efforts and another $500,000 on outside lobbying firms and consultants.

It is just a question of fairness. The question of fairness says to all of us, this is not right. People are paying more and more for their insurance. People are losing their insurance because they cannot afford it. People are getting cut off their insurance because of preexisting conditions. People are being discriminated against because of disability or gender or age or location. That—coupled with the salaries, the CEO compensation—all of that is not fair.

But what does that mean individually? Why, other than questions of fairness—which really matter. Another is productivity in our economy. As these health care costs are so burdensome to employers, they simply cannot hire people. I spoke today to a group. I had a roundtable, one of about 140 I have done around Ohio, in my hometown of Mansfield, OH, with about 15 manufacturers, people who are struggling with all kinds of things.

They cannot get credit. They are victimized by the Chinese currency problems that American industry faces and our government will not do enough about. They are badly hurt by health insurance costs. So we know about the question of fairness. It is not fair what has happened to our workers, to our small manufacturers, to our companies, to our taxpayers, while CEOs are doing so well.

But let me talk about what this really means. I am going to read four or five letters from people in Ohio about why this matters, why this insurance crisis matters. I know the Presiding Officer gets letters—whether they come from Hanover or whereever they come from in her State—she gets letters such as this too. Most of the letters I get are from people who thought they had pretty good insurance, and then they get sick and their insurance is canceled or then they find out that one of their children has a preexisting condition or a spouse has a preexisting condition and they cannot renew their insurance or it gets so costly they cannot renew it. That is what comes through in so many of these letters.

Let met share a few of them. This is a letter from Robert from Lake County. It is a county just east of Cleveland on Lake Erie in northeast Ohio:

> In 1986 my wife was terminally ill with cancer and several other illnesses. When I switched jobs and looked for new insurance, we were denied because of her pre-existing condition.
>
> In 2001, when I was 58, I lost my job. When COBRA ran out, I was denied insurance based on my pre-existing conditions of diabetes and heart disease.
>
> I managed to limp through until I turned 65 and became eligible for Medicare.
>
> I'm sure the fear and anxiety I suffered over health insurance hasn't been at all beneficial to my overall health.

I have heard person after person—in talking to people one-on-one or looking at the letters they write or reading something they have written on the Internet—tell me they are not quite 65, they might be 55, they might be 62, and they just hope they can hold on until they are 65 so they can get a decent government-sponsored health plan, Medicare. That tells me why the public is demanding the public option. The public understands a public option—which is just an option—will make the insurance companies more honest.

A public option will not cancel people for having a preexisting condition anymore than Medicare does. A public option will give people choice. It will discipline the insurance companies and keep costs in check.

We know, when you look at this report I just talked about—this AHIP report that talked about rate shock—that is as good an argument for a public option as any I have ever heard of because the insurance companies say: We are going to raise rates even higher

than we have already raised them, an even higher percentage than we have already raised them, an even faster climb than we have already done in the last decade. That is why we need a public option, to discipline the insurance companies, to compete with them. They seem to be competing to raise rates, not competing to keep things in check, unlike the way competition used to work in this country. That is why a public option is so important.

Shelly from Coshocton, a community in sort of southeast, east central Ohio, writes:

I have no health insurance coverage for myself or my son. My husband is disabled and receives Social Security Disability and Medicare.

My son was born with a congenital heart defect [and] has already had one open heart surgery.

Along with my pre-existing condition, neither of us can afford private coverage.

Pre-existing conditions should be illegal for insurance companies to use to delay health care for Americans.

Shelly is right. When she says that, understand that, yes, we are going to change the law so we are going to ban the whole practice of ''preexisting condition.'' No more ''preexisting condition'' under this legislation, no more caps on cost, on coverage, and no more annual or lifetime caps, no more discrimination based on gender or disability or geography or age.

But even with that, we clearly need a public option to enforce those rules so the insurance companies cannot find a way to game the system, as they have over and over, year after year after year. That should be our commitment to Shelly from Coshocton.

Tina from Cuyahoga County—the Cleveland area—writes:

My husband and I have been married for 30 years.

We've lived in the same three bedroom home for the last 26 years, where we sent our two sons to college, without debt, while running our small business.

We have our own insurance, but have seen raised deductibles and scaled back coverage. I would guess we've spent some $150,000 on premiums over the healthy years of our lives.

Unfortunately, last fall I was diagnosed with non-Hodgkin's lymphoma. The deficiencies in our current policy were then made clear.

Again, a good health care policy until she really needed it, which is too much par for the course in this country.

Our plan covers only certain services. After 2 different and unsuccessful treatments, I have an $80,000 balance with the hospital.

I firmly believe most people have no idea of their exposure because they have been fortunate not to have had the need to use their insurance. I alternate between being furious and depressed.

At 53, what have I to look forward to other than single handedly having ruined my family's financial future.

Something has to be done. It is immoral that insurance companies should make a profit over people's health conditions.

I think that says it all: again, so many people have what they think is pretty good health insurance until something really bad happens. That is what health insurance should be all about. It really is not insurance if it does not work when you really need it. And Tina from the Cleveland area understands that. A public option will work to make sure she continues with her health coverage, that she cannot be denied coverage, that even when she gets really sick, she will be in a pool that will work for her.

I have two more letters, Madam President, and then I will yield the floor to the Senator from Utah.

This is a letter from Priscilla from Miami County—a county in southwest Ohio, just north of Dayton:

I am a 62-year-old widow with controlled cholesterol and high blood pressure.

I bring in $2,300 per month on fixed income but pay $1,900 per month for health insurance premiums.

So $2,300 a month she brings in, and she pays $1,900 a month for health insurance premiums. She is not quite Medicare eligible. She is 62 years old.

I keep my thermostat at 62 degrees in the winter and minimize the use of hot water, unless when needed.

I spend about $100 per month on groceries.

Since August 2007, I've spent more than $40,000 in premiums, co-pays, and out-of-pocket expenses.

My private insurer paid only $8,500 for my medical and prescription claims in that period.

Priscilla's health insurance simply does not work for her. It is a health insurance policy that too often does not respond when she needs it to respond. She likely—as so many people I know and who call my office—spends much of her time on the phone trying to get her insurance company to pay. You have to figure the stress on people, dealing with insurance companies and getting turned down time after time after time, probably compromises their health.

She has to wait another 3 years before she is Medicare eligible. This legislation will help her with that. This legislation will give her the chance to go into an insurance exchange. She can pick a private plan or she can pick the public option. Either way, she simply will not have these kinds of premiums. She will not have these kinds of out-of-pocket expenses. She will have some costs. She will get some help because she does not make very much money. That is what this country should do, I think, for people like Priscilla.

The last letter I will read is from Cheryl from my home county of Lorain—Elyria, Avon, North Ridgeville, Oberlin, Amherst, that area of the State just west of Cleveland on Lake Erie:

We are a working class family riding the fine line between blue and white collar income.

I work as a business executive assistant, aware of how big business can influence the outcome of this bill. My husband is a retired fire captain who was forced into retirement after being injured on the job.

We get insurance through my employer, but we've seen costs increased considerably in the last three years alone.

Our daughters, ages 28 and 26, both work but face difficult choices regarding their health care.

One daughter's employer plan is based on her overall health—she lives in fear that something like high blood pressure could possibly increase medical costs by hundreds of dollars a month.

My other daughter is a contract worker who has to pay for her own insurance. She makes about $45,000 a year and supports a family of three, but has out-of-pocket expenses anywhere from $2,500 to $5,000 before the deductible is even met.

These are examples of hard working people who will survive in the short term but in the long term will be paying medical insurance rather than a house payment.

Please continue the fight, you cannot let [us] down.

I know the Presiding Officer from New Hampshire gets these kinds of letters from people who are really the backbone of this country, people such as her daughter making $45,000 a year. She has had barely a middle-class standard of living. It is clear, with her job as a business executive assistant, she has all kinds of out-of-pocket costs.

If we are going to get this economy back in shape—and I got that again today talking with those manufacturers, small companies of 30 and 50 and 100 people, most of them—if we are going to get this economy back in shape, we cannot have health care costs weighing down our businesses and individuals who simply cannot get ahead, who are fighting every day to figure out: How do I pay for this? How do I balance paying for my medicine with making my house payment, with heating my home, with buying my food? How can we in this society continue to do that?

Then, to top it off, as I said, the insurance industry, yesterday, put out a report that talked about rate shock, that if this bill passes—the kind of threat they made to this institution, to the House and the Senate, to the American people—they are going to jump health care prices.

Well, that is, again, why the public option is so important. The public option will provide competition to these insurance companies, competition they are not used to getting from each other. It might mean that the chief executive officers of the 10 biggest companies will not average $11.9 million in salaries. It might mean their profits will not continue to escalate. It might mean they have to tighten their belts and compete with a public option so their prices are more in check with what the American people can afford.

The time is now. It is imperative that we in this institution send legislation to the President of the United States for him to sign—good, strong legislation that helps small businesses, that helps people keep the insurance they have, if they want to keep it, if they are satisfied with it, and has a public option included in it to compete with insurance companies and keep them honest and to keep costs in check. It is our duty. It is our imperative. It is what we must do in the next few weeks.

Madam President, I yield the floor.

The PRESIDING OFFICER. The Senator from Utah.

ORDER OF PROCEDURE

Mr. HATCH. Madam President, I have agreed to delay my 20 minutes in favor of the distinguished Senator from Michigan having 3 or 4 minutes. I ask unanimous consent that I be given the floor after that.

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

The Senator from Michigan.

Ms. STABENOW. First, Madam President, I thank my friend from Utah for his graciousness. It is a pleasure to serve with him on the Finance Committee.

(The remarks of Ms. STABENOW pertaining to the introduction of S. 1776 are printed in today's RECORD under ''Statements on Introduced Bills and Joint Resolutions.'')

Ms. STABENOW. Madam President, I appreciate very much my friend from Utah allowing me to step in for a moment. I will be happy to talk more about this at a later point, but it is important to get this introduced this evening so it can become a part of the debate.

UNEMPLOYMENT COMPENSATION EXTENSION ACT OF 2009—UNANIMOUS CONSENT REQUEST

Ms. STABENOW. Madam President, I ask unanimous consent that the Senate proceed to the immediate consideration of H.R. 3548, which was received from the House; further, that a Reid substitute amendment, which is at the desk, be agreed to; the bill, as amended, be read a third time and passed; the motions to reconsider be laid upon the table with no intervening action or debate; and any statements related to the bill be printed in the RECORD.

The PRESIDING OFFICER. Is there objection?

Mr. HATCH. Madam President, I have to object on behalf of our side.

The PRESIDING OFFICER. Objection is heard.

The Senator from Utah is recognized.

HEALTH CARE REFORM

Mr. HATCH. Madam President, I have taken a lot of votes in my Senate service, as I have had the proud honor of representing my fellow Utahns and of course all Americans across this great Nation. I deliver these remarks with a heavy heart because what could have been a strong bipartisan vote reflecting our collective and genuine desire for responsible reform in the Senate Finance Committee has ended as another largely partisan exercise as we take another step forward toward the flawed solution of reforming one-sixth of our economy with more spending, more government, and more taxes.

Having said that, I wish to compliment the distinguished chairman of the committee, MAX BAUCUS, from Montana, for having worked so long and hard to try to get that bill through the committee. I disagree with the bill, but I also recognize that type of effort, and I have great regard for Senator BAUCUS and others on the committee as well. But I have worked through almost 4 weeks of debate in the Health, Education, Labor and Pensions Committee and now through 2 weeks of strenuous debate on the Senate Finance Committee. I was in the original Gang of 7 trying to come up with a bipartisan approach, but I realized that not enough flexibility had been given to Senator BAUCUS, and I decided to leave that group of seven, and I am glad I did, because I predicted when I left exactly what this bill would turn out to be.

It almost seems as though these hundreds of hours of debate in the past were for naught. It is important for Americans everywhere to understand that the bills we have spent hundreds of hours working on are not the bills that will be discussed on the Senate floor. The real bill that is currently being written behind closed doors in the dark corners of the Capitol and the White House—and we can all only hope that all of us, especially American families, will have ample opportunity, at least 72 hours, to review the full bill before we are asked to consider this on the floor and vote on it—is a bill that affects every American life and every American business. The health care reform bill is too big and too important to not have a full public review.

I wish to spend my time today talking about why the Baucus bill fails President Obama's own test for responsible health care reform. This bill is another example of Washington once again talking from both sides of the mouth and using technicalities and policy nuances to evade the promises made to our seniors and middle-class families. First, President Obama in his own words has consistently stated: ''If you like your current plan, you will be able to keep it.'' Let me repeat that: ''If you like your plan, you will be able to keep it.'' That was given on July 2, 2009, right at the White House, and we are all familiar with that particular commitment.

One of the amendments I offered in the Finance Committee simply provided that if more than 1 million Americans would lose the coverage of their choice because of the implementation of this bill, then this legislation would not go into effect. This was a simple and straightforward amendment; no nuance, no double-talk. This amendment was defeated along party lines.

It should come as no surprise to anyone on the Finance Committee that in a recent Rasmussen poll, a majority of Americans with health care coverage—almost 53 percent—said that the bill would force them to change their coverage. This bill is rife with policies that will do anything but allow you to keep your coverage. It cuts upward of $133 billion out of the Medicare Advantage Program, which will adversely impact the availability of these plans for millions of American seniors, especially in rural areas. That was what it was designed for. It is pushing for policies at the Federal level that actuaries acknowledge could increase premiums significantly for millions of Americans, not to mention the new insurance tax which will cost families another $500 in higher premiums. This will make current coverage unaffordable for countless Americans.

American families are very smart; they are very astute. They realize that there is no free lunch, especially in Washington. They are being promised an almost $1 trillion bill—that is really an understatement of what it is, and I will get into that later—that will not increase deficits, not raise taxes, and not cut benefits. Only Washington speak could try to sell a promise such as this with a straight face.

Second: The President has consistently pledged: ''We're not going to mess with Medicare.'' Once again, this is another simple and straightforward pledge that this bill has now evaded through Washington double speech or doubletalk. This bill strips, as I say, $133 billion out of the Medicare Advantage Program that currently covers 10.6 million seniors, or almost one out of four seniors in the Medicare Program. According to the Congressional Budget Office, under this bill, the value of so-called additional benefits such as vision care and dental care would decline from $135 to $42 by 2019. That is a reduction of more than 70 percent of benefits. You heard me right: 70 percent. I offered an amendment to protect these benefits for our seniors, many of whom are low-income Americans who reside in rural States. However, this amendment too was defeated in the Finance Committee. The majority chose to skirt the President's pledge about no reduction in Medicare benefits for our seniors by characterizing the benefits being lost—vision care, dental care, and reduced hospital deductibles—as extra benefits, not statutory benefits.

Let me make this point as clearly as I can. When we promise American seniors that we will not reduce their benefits, let us be honest about that promise. Benefits are benefits, so we are either going to protect benefits or not. It is that simple. Under this bill, if you are a senior with Medicare Advantage, the unfortunate answer is no, you are going to lose benefits.

Thirdly, the President has consistently stated: ''I can make a firm pledge. Under my plan, no family making less than $250,000 a year will see any form of tax increase.''

That was when the President was a candidate in New Hampshire on September 12, 2008, and he has said that since.

Let us examine the realities of this bill. As I said before, there is no such thing as a free lunch, especially when