Not later than five days following the first exit of such a newly produced non-deployed road-mobile launcher, and its entry into Treaty accountability, Section I of the Notification Protocol requires the Party producing the new Treaty-accountable item to provide a notification of this change in data. Except for transits, Parties are proscribed from locating non-deployed mobile launchers outside the boundaries of the START-declared facilities identified in subparagraph 9(b) of Article IV of the Treaty.

Finding. Russia continues to violate START provisions relevant to these obligations.

Deployed SS–25 Road-Mobile Launchers Based Outside Their Designated Restricted Areas. Russia based some deployed SS–25 road-mobile launchers outside their declared restricted areas (RAs) at two road-mobile ICBM bases while these RAs were under construction. The United States and Russia concluded a temporary, interim policy arrangement regarding the conduct of inspections and cooperative measures at the facilities where the launchers were housed during the period of construction. This arrangement permitted U.S. inspectors to conduct data update inspections and RVOSIs that they had not previously been able to perform, and allowed Russia to cooperate fully with providing cooperative measures access for the launchers that were previously unavailable. All of these road-mobile ICBMs and their launchers have since been transferred from their bases, and their declared RAs have been eliminated as START facilities.

Finding. Notwithstanding the interim policy arrangement, Russia's practice of locating deployed SS–25 road-mobile launchers outside their declared RAs for long periods of time constituted basing in a manner that violated the provisions of paragraphs 1 and 9 of Article VI of the Treaty. This practice has ceased and the United States considers this issue closed.

Denial of the Right to Measure Certain Deployed ICBM Launch Canisters on Mobile Launchers. U.S. inspectors have been prevented from exercising the Treaty right to measure certain ICBM launch canisters on mobile launchers, both deployed and non-deployed, that are encountered during data update inspections to confirm data regarding the type of item of inspection. Russia, for instance, has prevented U.S. inspectors from measuring launch canisters for SS–24 ICBMs contained in rail-mobile launchers that are located within the boundaries of an inspection site. Similar concerns have arisen with regard to launch canisters for SS–25 and SS–27 mobile ICBMs located on road-mobile launchers. With regard to launch canisters for these latter types, Russia and the United States have agreed upon a policy arrangement to address this issue, though it has not yet been implemented for the SS–27 ICBM.

Subparagraph 20(a) of Section VI of the Inspection Protocol identifies ICBM launch canisters as one of the items of inspection for data update inspections. In accordance with the procedures in Annex 1 to the Inspection Protocol, inspectors have the right to confirm the number and, if applicable, the types of items of inspection that are specified for the facility to be inspected and declared for the inspection site, and the right to confirm the absence of any other item of inspection at the inspection site. Pursuant to paragraph 6 of Annex 1, inspectors may view and measure the dimensions of a launch canister declared to contain an item of inspection to confirm it is of the declared type.

Finding. Russia prevented U.S. inspectors from exercising their Treaty right to measure launch canisters for SS–24 ICBMs contained in rail-mobile launchers that are located within the boundaries of an inspection site, in contravention of paragraphs 1 and 6 of Annex 1 to the Inspection Protocol. With regard to launch canisters for SS–25 and SS–27 ICBMs located on road-mobile launchers, the Parties have agreed upon a policy arrangement to address this issue, but it has not yet been implemented for the SS–27 ICBM.

TELEMETRY ISSUES

As part of the START verification regime, the Parties are obligated to notify each other of missile flight tests and to exchange telemetry tapes, tape summaries, interpretive data, and acceleration profiles for each flight test of a START-accountable ICBM or SLBM. The United States has raised several concerns regarding Russia's failure to provide all Treaty-required telemetry materials for some START-accountable flight tests in violation of paragraphs 4 and 5 of Article X of the Treaty, and paragraph 1 of Section I and paragraphs 1 and 2 of Section II of the Telemetry Protocol.

Finding. Russia has in some instances failed to comply with Treaty requirements regarding the provision of telemetry information on missile flight testing pursuant to Article X of the START Treaty and Sections I and II of the Telemetry Protocol.

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

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

The legislative clerk proceeded to call the roll.

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

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

HEALTH CARE REFORM

Mr. KYL. Mr. President, I believe my colleague, Senator THUNE from South Dakota, will be here in a few minutes. Until he arrives, I thought this might be of interest. I promised my constituents I would tell my colleagues what they told me to tell them. I think it would be of interest to share some of these remarks.

I went to a meeting on Saturday morning that I thought was going to be a rather staid affair with folks who were primarily senior citizens, but not all of them were. It turned out to be a little bit reminiscent of some of those townhall meetings we saw on television during August because the subject most people wanted to talk about was health care. They weren't happy with what they were hearing the Senate was about to do. Among other things, they wanted to get it clear with me right off that I would pass on their concerns about this to my colleagues. I promised that I would. So let me summarize what some of them had to say and what I think the clear consensus of the group was.

First of all, they have a hard time understanding how Senators would pass a bill before we read it or even know how much it costs. I assured them that the procedure we would follow in the Senate was that we would have at least 72 hours after the bill had been finally written and after the Congressional Budget Office had scored the bill—that is to say, told us how much it would cost in all of its component parts and the ways it would be paid for. The reason I can feel fairly certain that will happen is because a number of colleagues on both sides of the aisle have either written to the majority leader or made it clear to him that they will not support a motion to proceed to a bill until we have had an opportunity to, in effect, read it and see how much it costs. That process could take some time, I told my friends. The Congressional Budget Office Director told the members of the Finance Committee, on which I sit, that it can take 2 to 3 weeks after the bill is written to come up with all of these calculations.

You will hear many people say we need to move this process on, even before we have the numbers. But I think that given the fact that most of us are committed to ensuring we have the numbers and can digest them and share them with our constituents before we debate and amend the bill, I assume the process will unfold in the Senate in such a way that we do know what it costs, and that means after the final CBO report is provided to us.

The next thing they wanted me to convey was that they were very worried about—in fact, maybe that would be a euphemism. They were more than concerned about the degree of government involvement in health care once this process is over. They fail to understand why we had to have what amounts to a government takeover of insurance in this country and dictating everything from what kind of insurance policy you have to have, to how doctors and hospitals are paid, in order to solve the two key problems that exist: No. 1, there are some Americans who need help buying insurance; second, that the costs of health care premiums continue to go up every year, and it is especially hard for small businesses to provide coverage for employees.

They asked me: Why do we have to change the entire system, with the government essentially taking it over?

I happen to believe we don't. I provided the two basic alternatives to them. One is a step-by-step approach that targets specific problems we have and matches up specific solutions to the problems, on the one hand, which is the approach I favor; on the other hand, essentially changing the insurance we all have today, creating a new insurance exchange, and all insurance would have to go through there. Even if you like your policy, it will change, and you are not going to be able to keep it.

Estimates are that, as a result of all of this, in an effort to cover 18 or 20 million more people with insurance, it is going to cost us close to a trillion dollars. It will raise taxes, it will raise insurance premiums, and it will require deep cuts in Medicare. They didn't like that. I guess that brings up the third thing.

With regard to Medicare, they were pretty perceptive in asking me the following basic question. One person said: One of two things is going to happen. Either it will be business as usual where we say we will make cuts in Medicare, but the Senate and the House never have the courage to do that, in which case this bill is going to cost a lot of money that is not offset by concomitant savings, or the savings are going to be made, and when they are made, it is going to deeply cut our benefits under Medicare.

That person was right. One of those two things is true, and neither one is a good result.

I remember a few years ago when we tried to reduce the growth in Medicare by about $10 billion. Republicans and President Bush were excoriated; we were going to ruin Medicare, and our colleagues on the Democratic side took great glee in the public reaction to that proposal to decrease the growth in Medicare by $10 billion.

Now we are talking about cutting Medicare by—I said $500 billion. The Finance Committee money is actually $450 billion. So let's be accurate. If that is the way this bill comes out, $450 billion, $120 billion of that is reduction of benefits under Medicare Advantage. So when people say: You would not have your benefits cut, that first $120 billion is a direct cut in benefits, and in my State a lot of seniors have Medicare Advantage policies.

The other way in which Medicare is cut—there are basically two things. One is reducing the amount of money we pay doctors and hospitals, and that cannot help but reduce the care we get. The final mechanism is a Medicare Commission is being established to provide—I think it is every year; maybe every 2 years, but let's say every year—an amount of money that will have to be cut and will automatically be cut from Medicare unless the Congress finds a different way to do it, but Congress would still have to cut the same amount. So we either do it the way we want to do it or we do it the way the commission recommends it. In any event, their recommendation automatically goes into effect if Congress does not act.

I have a couple thoughts about that point. We have never been able to effect these cuts in the past because seniors know that it cuts deeply into their care, and they have told us and we have reacted by saying: OK, we will not do it. We could react that way again, in which case all of the savings, or at least a great deal of the savings, that were supposed to result and offset the costs of the bill would not be there. So now the bill is no longer deficit neutral. Now it is not balanced. Now it does add to the deficit and to the debt. If we do allow those cuts to go into effect, seniors are clobbered by deep reductions in the care they receive all the way from nursing homes to physicians to hospitals to hospice, medical devices—you name it. As I said, neither of these results is a good result.

There were several people who wanted me to convey their thoughts in that regard. I happen to agree with them, so I could do that.

I met, after visiting with this group, with a group of spinal surgeons from all over the country and, in fact, from outside this country. I saw the agenda of their meeting. I was the last speaker. For a layman, such as you and I, Mr. President, it was daunting to read through that agenda—all of the latest techniques in using new laser and stints and all kinds of things that I did not understand, but it was the very latest technology and techniques for treating spinal diseases and conditions.

What they told me was—I was the last person to make a presentation—all of these great things we are doing for our patients we are not going to be able to do under this legislation, first of all, because it will be presumed to cost too much; second, because it will take the FDA and the other government agencies way too long to authorize its use for treating Medicare patients, for example; and, third, because the comparative effectiveness research which has in the past been used by these doctors to help them appreciate the best way, clinically, to treat someone is now going to be used to decide what Medicare can afford to pay. A lot of the more leading-edge techniques and technologies are not going to be approved for that purpose.

Their point was that people in China and Europe are going to be treated with the latest techniques more than Americans will because the American system of health care is going to deny people such as these experts the ability to do what they do.

One way this is being accomplished is by taking money away from specialists and giving it to general practitioners. There is a rationale for paying general practitioners—family doctors—more money. They are not making enough, and they are the first place most of us enter the medical world. If we have something that does not feel right, we go to our doctor. It is usually a family doctor. Frequently, he can help us, but frequently he says: I think there is something about what you have here that tells me I have to send you to a specialist. We go to the specialist then and he orders some specialized tests and he examines them and he may end up having to provide some kind of very specialized treatment and care that is probably going to cost more money.

While the family doctor needs to be paid more, we don't solve that problem by taking money away from the specialists. If we have to add money to the system to ensure that we have enough doctors who can provide quality care, then there is no free lunch and we have to pay for what we get. We should not make it a zero-sum game and take it from Dr. B in order to pay Dr. A. That was another strong message of these specialists.

I also happened to meet on Friday afternoon with a group of physicians in Phoenix from all different practices—from specialists to generalists, hospital physicians to others. To a person, they had this question for me. The way they asked it was, Why isn't anybody talking about medical malpractice reform?

I said: I am talking about medical malpractice reform.

They said: You are not getting through.

I said: The problem is there are a bunch of folks on the other side of the aisle who don't want medical malpractice reform, and you know why. And, yes, they understood the answer why.

I remind friends who might not have remembered, Howard Dean, a former Governor of Vermont and a former Democratic candidate for President and a former Democratic Party chairman was very candid in a townhall meeting in Northern Virginia on August 17 with Representative MORAN where he told the group assembled there that the reason medical malpractice reform was not in the legislation is because they did not want to take on the trial lawyers.

That is true, but it does not make it right. Maybe somebody should take on the trial lawyers because there are a lot of estimates of how much money could be saved through meaningful medical malpractice reform. This jackpot justice system of ours that pays trial lawyers and requires physicians to pay as much as $200,000 a year in liability insurance premiums—all of which, of course, have to be passed on to the cost of our care, and perhaps even worse than that, practice what is called defensive medicine—raises the cost of our health care. Defensive medicine is having all kinds of tests performed and maybe putting someone in the hospital an extra day or two all in order to protect from a liability claim that their doctor did not do everything he could to take care of this poor patient and, as a result, the patient got sicker and something bad happened.

There are a lot of estimates. First, one estimate is from a study that says 10 cents on every dollar spent on health care is paid in insurance premiums by physicians. Obviously, some of that will still have to be paid with medical malpractice reform, but it could be reduced as has been the experience in the State of Arizona and the State of Texas, which is the reason Senator CORNYN from Texas and I have introduced legislation that will provide modest reforms to the tort system by putting some modest caps on noneconomic damages awards and providing that expert witnesses who testify have to be really expert witnesses in the area of the alleged malpractice.

These two things have saved enormous amounts of money. In Arizona, we don't even have caps on damages, but the Requirement that expert witnesses really be expert has ended up saving millions of dollars and reducing the malpractice premiums for physicians in the State of Arizona.

This is a reform we could accomplish on a bipartisan basis that not only would not cost anything, it would actually reap financial benefits. The Congressional Budget Office says just the savings to the U.S. Government—because we provide care under Medicaid, Medicare, and to our veterans—would save $54 billion. There are a lot of estimates that are higher than that. There is one estimate that is over $100 billion a year.

The Director of CBO acknowledged to people of the Finance Committee when we asked that $54 billion savings would actually be approximately doubled if we take into account the private sector as well. In other words, not only the Federal Government would save that much money, which pays about half of all health care dollars in the United States, the private sector, which pays the other half, could save a like amount of money.

These constituents wanted to know why doesn't anybody ever talk about it. I had to tell them we are talking about it. It is just that nobody is listening.

That kind of brings up the last point I want to pass on. After meeting with these three different groups in Phoenix and talking with people elsewhere I went over the weekend, it is pretty clear to me people are becoming very frustrated with their government, and this is not good. They don't think their government is listening to them. We are elected to be their representatives, to bring their ideas to Washington. Since they can't all study up on the issues as thoroughly as we are supposed to do, they trust us to not just to do what they want, not what they say, but to use our best judgment. But they do want us to listen to what they are saying and translate that into action.

What I hear them saying and what public opinion polls verify is they are very worried about the breadth and the depth of this proposed health care reform. They say it costs too much money; it is going to get us in debt; it will raise taxes which are going to be passed through to them; it is going to raise insurance premiums; and it is going to involve a massive government intrusion into what is primarily a private matter between them and their physician, with their insurance company added into the mix. They see this along the same lines as the government takeover of banks and insurance companies and car companies and everything else, and they don't like it.

One of the reasons they don't like it is because they see their own health care being delayed or denied as a result. They appreciate the fact that if the government gets so involved that it can begin to tell insurance companies what they can pay for and tell doctors what they can do for patients, that the next thing that will happen is their care will be delayed and denied and ultimately rationed.

I read a chapter in a book by our former colleague, former majority leader of the Senate, Dr. Bill Frist, a renowned heart surgeon. I talked with former Senator Frist about it last week. He actually served for about a year in England under their health system. He makes the point in his book that there are some good things about their health system. He said the bad thing is that if someone has a serious condition, unless they are at the top of the list, they run the risk of never having their serious condition dealt with.

He gave an example of a list of 100 patients who needed heart surgery. He said they would do two a day and gradually work down the list. He said what he found was that after a few weeks, peoples' names were being taken off the list. They didn't need the surgery anymore because they had died. He said that would never happen in America. He said if we have 100 people who need heart surgery in America, we would figure out a way to get that heart surgery for them right away, and we wouldn't do two a day until we ran out of time and they ran out of life. He said that is really the difference in a system in which we are controlled by the amount of money the government chooses to put into the system every day versus the kind of system we have that takes care of people and worries about the cost later. That is why it is possible for us to say that even people without insurance get cared for. No one in this country should die because they don't have insurance because we will take care of them.

Obviously, having insurance makes the delivery of care easier, more timely, and much more cost-effective, which is why at the end of the day we want to see that everybody is insured.

The bottom line is that we do not need to throw out the baby with the bathwater, get rid of the system we have that currently takes care of most people very well in order to insure that last group of folks who don't have insurance. We can provide a voucher or subsidy to them and get them coverage.

The other thing we have to do is help to bring down the costs. Republicans have offered numerous solutions on how to do that without having the government take over the system. I mentioned one: Medical malpractice reform. It does not cost a dime, it will save billions of dollars, and it is good policy besides. So why don't we do it? Because there is a vested special interest that does not want it done. It will take money out of their pockets. That is wrong.

My question to all of my colleagues is, When are we going to stand up to the special interests? Everybody likes to whack at the insurance companies. How about taking a good hard look at the trial lawyers? And, by the way, while we are talking about insurance companies, Republicans offered several ideas on how to add more competition for the insurance companies so in those situations where they have it good, if we provide for certain reforms that we have offered, such as association health plans, small business plans, more flexible HSAs, interstate sales of insurance, all these things would provide more competition for the insurance companies and force them to lower their rates. This would make health care more affordable because it would help small businesses in providing health care for their employees.

All these things came up during these meetings. As I said, I promised my constituents I would be sure to pass their ideas on to my colleagues, and I make these comments in that spirit, hoping that we will listen to our constituents not just in Arizona but in South Dakota and everywhere else around the country. And as a result of listening to a bunch of pretty commonsense folks, perhaps we will make wiser decisions here than we otherwise would have.

I see my colleague from South Dakota is here. He had some very erudite comments to make on one of the television shows on Sunday, and I am happy to yield the floor for Senator THUNE.

The ACTING PRESIDENT pro tempore. The Senator from South Dakota.

Mr. THUNE. Mr. President, I thank my colleague for yielding the floor, and I appreciate listening to his observations about the current state of the health care debate.

Mr. President, I ask unanimous consent that I be allowed to speak for up to 20 minutes.

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

Mr. THUNE. Mr. President, as my friend from Arizona noted, there are many things about the current debate that I think raise questions with the American people. He was discussing what he had heard back in his State of Arizona regarding the current debate that is before the Congress and the concerns people have, the anxiety, the frustration, and, frankly, the fear that I think a lot of Americans have about what happens and what the ultimate result may be. For instance, will this health care reform effort lead to higher costs for them? Will it lead to questions about whether they will be able to retain that fundamental, essential relationship between the patient and the doctor?

Those are, I think, very valid questions. Frankly, we don't have answers to them because, one, we don't have a bill. We haven't seen a bill. That bill is being written, we are told, in the majority leader's office. There will be a handful of people in that room. There will not be input from our side, let alone from many Democrats in the Senate. It is going to be basically cranked out and at some point we will have a bill that will be put on the floor before the entire Senate. Having said that, it is interesting to me that this week we are going to have a vote in the Senate on an issue which, frankly, is very much a part of the debate over

health care reform and yet that vote is being separated out. I think there is a reason for that, which I will come back to in a moment.

I think it is important and telling that the first vote on health care reform here in the Senate is going to be to add a quarter of a trillion dollars to the Federal debt. That is right, $250 billion—or $247 billion, to be precise—is going to be added to the Federal debt because what the majority leader has decided to do is to bring legislation to the floor this week that would address the physician reimbursement issue. We all believe that needs to be addressed. There is no one on our side of the aisle who doesn't believe we need to address the challenge that we will face in January of this coming year. Physicians across this country, if we don't take steps, are going to be subjected to a 21½ percent pay cut. That is not something anybody I know of in this Chamber is willing to abide.

But we have a fundamental difference about whether that ought to be addressed in a way that is paid for, that actually doesn't borrow $250 billion from future generations. The reason I say it should have been in the health care reform bill, but wasn't, is because it is a part of that debate. In fact, the House of Representatives included the physician reimbursement issue in their version of health care reform and put it out of balance, but at least they were honest. They dealt with it in the context of health care reform, because it is fundamental to addressing the health care issues we have in this country. The reason I think it was left out of the Finance Committee bill, the Baucus bill, is because they knew if they put that in the bill, it would put their bill out of balance, and we had the big proclamation that had come out about how this is deficit neutral, that it is going to add $81 billion in surplus, that it is actually going to save money in the long run.

Obviously, if you back out $250 billion, you can make your books balance in the near term. But what you are doing is adding a quarter of a trillion dollars to the debt, which this year was $1.4 trillion—three times what we have ever seen here in the last 40 years or so. The last time we have seen debt of this magnitude in terms of a percentage of our gross domestic product was right after World War II. But the debt this year is three times what we have seen in recent history—at least in this last decade.

I think the first point I would make is that the first vote out of the gate on health care reform should not be to add a quarter of a trillion dollars to the Federal debt and to pile this burden on future generations of Americans. In fact, there is a bumper sticker going around right now, which I think is perhaps pretty descriptive of what is happening in Washington, and it says something to the effect: ''Don't tell those people out in Washington, DC what comes after a trillion dollars.'' I think the American people are sitting out there wondering, when we talk about billions and billions and billions, and now we are talking trillions and trillions and trillions, what comes after that? And yet we continue to spend and borrow as if there is no tomorrow. I think the American people are picking up on that, and obviously they want to see a government that lives within its means just as they have to every single day in their personal lives, in their businesses, and most people who have to live within balanced budgets.

It is a lesson I think Washington could learn. It is essential that we don't continue to pile this burden of debt on future generations of Americans. The deficit last year was $1.4 trillion. It is estimated if we stay on the current trajectory that we will double the Federal debt in 5 years, triple it in 10 years, and at the end of the 10-year period, the average part that each household in this country will own of that entire Federal debt obligation is $188,000. So if you are a family in America today or say you are a young couple who has just gotten married, and looking at your life ahead of you and planning for your future, you are going to get a wedding gift from the Federal Government—a big old IOU for $188,000. That will be everyone's share of the Federal debt.

What we do here with the first vote out of the gate on health care reform is add a quarter of a trillion dollars to that Federal debt. A quarter of a trillion dollars used to be a lot of money in this town. When you start talking about $1.4 trillion deficits, maybe it doesn't seem like that anymore. I think that is why the American people are asking, and probably fairly so, what comes after a trillion dollars. When you add a quarter of a trillion dollars to the debt, the total interest payment on that amount over the 10-year period, if you can believe this, is $136 billion. So we are adding $136 billion in additional interest payments that we are going to have to make over the course of the next 10 years by borrowing an additional quarter of a trillion dollars to address the physician reimbursement issue.

I say all that because I think it bears on the bigger question of health care reform and the fact that right now we have competing bills: One in the House, called the tricommittee bill, if you will, which does spend, over a 10-year period, about $2.4 trillion; the Senate HELP Committee bill, which over a 10-year period spends $2.2 trillion; and the Senate Finance Committee bill, which over a 10-year time period spends $1.8 trillion—until now. When we add in this $250 billion for physician reimbursements, that now pushes the number on that particular bill up to about $2 trillion as well.

So what we have is a whole new expansion, a whole bunch of new spending on health care by the taxpayers in this country. Obviously, it has to be paid for somehow. Most of it is paid for by cuts to Medicare reimbursements that providers in this country would receive, paid for in the form of higher taxes that would be borne by small businesses, by individuals, and would ultimately lead to the final outcome of this big debate, which is higher premiums. The whole purpose of this was to reduce the cost of health care for people in this country by reducing and driving down what they paid for health insurance. But as has been pointed out, I think over and over now in response to questions posed by members of the Senate Finance Committee in answers from the CBO Director, these tax increases—roughly dollar for dollar—will be passed on in the form of higher taxes. In fact, some of the taxes in the House bill hit squarely at small businesses and hit squarely at individuals. The CBO and the Joint Tax Committee, which looked at the Finance Committee bill, concluded that 90 percent—87 percent, I should say, as far as the Joint Tax Committee and 89 percent was the CBO estimate—of the tax burden would fall on taxpayers—on wage earners—making less than $250,000 a year. In fact, the Joint Tax Committee went so far as to say a little over 50 percent of that tax burden would fall on wage earners making less than $100,000 a year.

So the tax burden is going to be borne by people who were promised they wouldn't pay higher taxes in the health care reform proposals, and it was stated by the President and others that we wouldn't tax people who make less than $250,000 a year. That is clearly not the case. There is a 5.4 percent surcharge on high-income earners in the House bill which would be borne largely by small businesses, many of whom file, because of the way they are organized, on their individual tax returns. So you are going to have higher taxes on small businesses, higher taxes on middle-class Americans, and this explosion and expansion of Federal Government here in Washington to the tune of $2 trillion.

You would hope then that you would see that would have some positive impact on health insurance premiums. The reality is, as I said earlier, it does not. I think as the debate broadens and we become engaged on health care reform, the American people are going to come to that conclusion, which is why I think they are very concerned about what is happening here in Washington.

The other point I will make is that one of the objectives of health care reform—in fact, to me, health care reform ought to be about driving health care costs down, not increasing them, which is what all these bills do—was that it was designed to cover people who aren't currently covered, to provide access to more Americans. What we are seeing now with all these various bills is there are lots of people who get left out. Under what they call the House bill—the tricommittee bill—17 million Americans still would not have

health insurance. Under the Senate HELP Committee bill, that number is much higher. It is 34 million who would still not be covered. But there is an assumption there, although it wasn't included in the bill, that Medicaid would be expanded. That would cover more people. So that number may be overstated. But the Senate Finance Committee assumes 25 million people will be without health insurance.

So you will have higher taxes, a tremendous amount of higher spending—up to about $2 trillion under any of these bills—and an expansion of government here in Washington, DC, cuts to Medicare reimbursements—to seniors—across this country, and all for what? Higher premiums for most Americans, for people who currently have insurance, to hopefully cover some Americans. When you are spending $2 trillion, there ought to be some advantage to that, but clearly a lot of Americans are still going to be without health insurance when this is all said and done.

I am concerned. I think a lot of our colleagues here in the Senate—and not just on our side of the aisle, but I think a number on the other side too—have expressed concerns about starting the debate a quarter of a trillion dollars in the hole by putting a bill on the floor that is going to spend a quarter of a trillion dollars—$250 billion—over the next 10 years that is not paid for. That puts any bill that is considered later completely out of balance, and it is a gimmick that is designed to allow the President and the Democratic majority to say our health care reform bill is deficit neutral. Well, sure, if you take the $250 billion and back it out, it is easy to say it is deficit neutral, when in fact now it is going to be $200 billion. They have about an $80 billion overage on the bill in the Finance Committee, but it is still going to be $200 billion out of balance when you do this, again, to be financed with more debt and more borrowing, which is exactly what I think we want to avoid, and particularly when you are running deficits as far the eye can see.

This last year, about 43 cents out of every dollar that was spent here at the Federal level—in Washington, DC—was borrowed. There isn't anyplace in America where you can function like that and still be in business. If you are a person doing that in your personal household finances, you would be forced into bankruptcy. If you were a small business, you would be forced into bankruptcy. Frankly, were it not for the fact that other countries around the world are financing America's debt, we would be in bankruptcy. Because you can't borrow 43 cents of everything you spend, as we are doing here in Washington, DC. In fact, to put it in perspective—and a lot of Americans understand this—if you are a family with an annual income of $62,000, it would be the equivalent of spending $108,000. That is what we are doing here in Washington, DC. Of all the money we spend in a given year, 43 percent of that is borrowed. We cannot continue to sustain that.

I hope that before this bill comes to the floor, we can reach an agreement about amendments that might be offered. I would say our side, the Republican side, has amendments it would like to offer to this bill that would help pay for it, help reduce the amount or perhaps entirely reduce the amount that would be borrowed in order to finance the physician reimbursement fix, on which we all agree. As I said, there is not anybody on this side who does not agree that needs to be done. In fact, Senator CORNYN offered an amendment to the bill that would provide a 2-year fix, a 2-year solution to the problem for physician reimbursement. It was voted down. It was defeated, that amendment, in the Senate Finance Committee.

We are looking. We are proactive. We have to address this issue. This issue was created by the Balanced Budget Act back in 1987. I was a Member of the House of Representatives at the time. I voted for that balanced budget agreement, but it included what was called a sustainable growth rate formula by which physicians are reimbursed. As I said earlier, in January of this year, based upon that formula, physicians would receive a 21.5-percent reduction in their fees, in their reimbursements.

Everybody here—I should not say everybody. I can't speak for everybody. But I think most Senators on both sides of the aisle acknowledge that issue has to be addressed. We need to fix that, but we have to do it in a way that is fiscally responsible. We want an opportunity to offer amendments that would allow us to do that.

As of last week, that request was being rejected. There was going to be a cloture vote today, which I understand now has been vitiated, which means perhaps the leaders are working together on an agreement that would allow Senators on both sides to offer amendments to this legislation that would help pay for it.

I think it is telling that there are Democrats who are uncomfortable with the idea of adding $¼ trillion to the Federal debt with the very first vote we will cast on health care in the Senate Chamber.

I hope we can reach an agreement. I hope the leaders will be able to do that and this will be an open process, that we debate, and there will not be any mad rush to try to cut off debate. Rather, Senators on our side would have an opportunity to fix the issue that is going to put a lot of physicians in a very uncomfortable position if we do not address it but do it in a way that also is fair to the American taxpayer and make sure we, as a nation, are honoring the responsibility we have, not just to fix this issue for today but to provide a better and brighter and more secure future for future generations of Americans. It is a future which, I would add, is very much in jeopardy and in peril if we continue to spend and borrow and tax at the rate that is contemplated in the health care reform bill but, more important, with the very first vote on that health care proposal, which is to add $250 billion to the Federal debt.

I yield the floor.

I suggest the absence of a quorum.

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

The bill clerk proceeded to call the roll.

Mr. CASEY. I ask unanimous consent that the order for the quorum call be rescinded.

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

HEALTH CARE REFORM

Mr. CASEY. Mr. President, I rise to talk about health care in three ways, three different subjects but all vitally important to making sure we get the job done in the next couple weeks. As many Americans know, in the Senate right now, we have the HELP Committee bill that passed in July and the recent passage of the Finance Committee bill coming together in a merger process which is days away from completion or certainly in the near future. As that process unfolds, there are parts of our bill, meaning the HELP Committee bill, that I hope remain intact or at least, in large measure, are left as part of the final Senate bill.

One part is on the issue of children's health insurance. We had an important debate about this program, which was authorized in 2009, so that within the next several years, within the next 4 years, maybe by the end of 4 years, we will have as many as 14 million children across America covered by that program, a tremendous advancement from where we were even 10 years ago. It has shown results in a lot of places. It is a well-tested program.

One of the more recent debates, within the Finance Committee, was whether children in CHIP, whether that program itself would be stand-alone—as I believe and as I am glad the Finance Committee agreed with me and with others—or whether it would be folded into the exchange. They didn't do that in the Finance Committee. I am glad they did not.

In this instance, we have a program which started in States such as Pennsylvania back in the early 1990s and then became a national program in the mid-1990s, about 1997. What we have seen in Pennsylvania are tremendous results. I ask unanimous consent to have printed in the RECORD a one-page survey by the Pennsylvania Insurance Department from 2008 about uninsured numbers, ages zero to 18 and then 19 to 64.

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