

## SHERIFF DELAYS AUCTION

Philadelphia's Residential Mortgage Foreclosure Diversion Pilot Program began with a resolution passed by the City Council in March 2008, calling on Sheriff John D. Green to scrap the sheriff's sale scheduled for April. Low-income neighborhoods were already experiencing a surge of foreclosures involving subprime loans given to people with tainted credit. With unemployment growing, lost paychecks were now pushing people into delinquency, reaching into middle-class and even wealthy neighborhoods. In early 2008, nearly 200 homes a month were being auctioned by the sheriff's office, about one-third more than in 2006.

In West Philadelphia, Councilman Curtis Jones Jr., one of the sponsors of the resolution, watched his childhood neighborhood consumed by foreclosure, as the homes of working families—their porches once lined with flower pots—were boarded up with plywood.

"It becomes a blight on your entire community," Mr. Jones said. "It creates an environment that fosters everything bad, from prostitution to drug dealing to wildlife, like raccoons taking over whole houses. One house becomes 10, and 10 becomes the whole block."

In response to the resolution, Sheriff Green canceled the April sale. Meanwhile, Judge Annette M. Rizzo, who oversaw a local task force on stemming foreclosures, joined with the president judge of Philadelphia's Court of Common Pleas to develop the program.

For Judge Rizzo, a high-energy woman who has long taken an interest in housing policy, the moratorium presented both a crisis and an opportunity. The sheriff was effectively refusing to fulfill his mandated responsibilities, leaving his office vulnerable to legal challenge. But if the mortgage companies could be persuaded to participate in an alternative way of addressing foreclosures, more people could stay in their homes.

"I realized we're either going to go down in flames or we're going to be a national model," Judge Rizzo said. "We're going to look at these cases and see what we can work out."

Mr. Hall knew none of this. What he knew was that his life seemed to be unraveling.

## HOME TO FOUR GENERATIONS

Ever since he was a teenager, he had earned a middle-class living with his hands. He had been raised by his grandfather in his three-bedroom house on Akron Street, in a predominantly Irish Catholic working-class neighborhood in Northeast Philadelphia.

He had attended St. Martin's, the Catholic school around the corner, married his childhood sweetheart and still remained in his grandfather's house, sending his own children—two boys (now in their 20s) and a 12-year-old girl—to the same school.

Mr. Hall, a soft-spoken yet intense man with a silver-tinged goatee, had worked seven days a week for much of this decade, bringing home weekly pay of about \$1,000—enough to build a deck in his backyard; enough to obtain a fixed-rate mortgage and buy the house for \$44,000 when his grandfather succumbed to Alzheimer's disease in the mid-1990s; enough for a motorcycle and a boat.

But three years ago, Mr. Hall committed the sort of mistake that has upended millions of households. At the recommendation of a for-profit credit counselor, he took out a new mortgage—a variable-rate loan from Countrywide Financial, which is now owned by Bank of America. He paid off some credit card debt, and he borrowed an extra \$15,000 to renovate his home, expanding his mortgage balance to \$63,000.

The loan began with manageable payments of about \$500 a month. But Mr. Hall's inter-

est rate soon soared—something he says was never explained to him—lifting his payments to \$950 a month.

"When I got the mortgage, I didn't really understand it," he said. "They told me this would improve my credit and that was it. It was just, 'sign here,' and 'initial here.'"

## NO MORE CONSTRUCTION WORK

He might still have managed had construction not come to a halt. By 2007, Mr. Hall's employer was cutting work hours. In August 2008, it shut down, turning his \$1,000 weekly paycheck into an \$800 monthly unemployment check.

Every day, he set the alarm clock and headed to the union hall at 5 a.m., waiting and hoping for work. Every day, he went home, still jobless and discouraged, now confronting the displeasure of his wife, who worked as a nurse, and who he said never came to terms with their diminished spending power. After months of bickering, she left him last December, taking their daughter.

"She was saying, 'How are we going to have Christmas? How are we going to go on vacation?'" he recalled. "She just seen it getting worse instead of better, and she got depressed."

In January, his truck was repossessed, leaving him to walk through the winter dawn to the union hall for his daily ritual of defeat.

He watched the For Sale signs proliferating on his block, as mostly elderly neighbors found themselves unable to make their mortgage payments. He saw their belongings piled up on their front lawns as they abandoned their homes to foreclosure.

In September, the envelope finally landed with his default notice. A canvasser knocked on his door, proffering a flier urging him to call the city hot line. When he called, a housing counselor helped him assemble the paperwork for a loan modification and prepare for his conciliation conference.

When he arrived inside courtroom 676 in October, Mr. Hall carried a sheaf of wrinkled papers in a white plastic grocery bag. He occupied a solid wooden chair as an announcer called off cases for hearing. "Number 27, Wachovia Mortgage versus . . . ." A girl no older than 6, with flower-shaped plastic barrettes in her hair, fidgeted as her mother applied for legal representation.

Mr. Hall was struggling to come to terms with what he assumed was the end.

"I put my whole life into this house," he said. "After I do all this work, they want to take it from me. You've got to regroup and move, but where? If I can't pay my mortgage, how am I going to pay rent? And I have a whole house full of furniture."

When he got the news that he had a few weeks' reprieve, relief quickly gave way to the worry that had dominated his thoughts for months.

"It's postponing the inevitable," he said.

"I'm a man," he kept saying, trying to make sense of how a lifetime of working on other people's homes had put him here, staring at the potential loss of his own home; still hoping for relief.

"I don't want no handouts," he said. "I just want a reasonable loan that I can afford to pay so I can get on with my life."

Mr. SPECTER. I thank the Chair and yield the floor.

The PRESIDING OFFICER. The Senator from South Dakota is recognized.

Mr. THUNE. Mr. President, I ask unanimous consent that at the conclusion of my remarks, the Senator from Michigan, Senator STABENOW, be recognized.

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

## HEALTH CARE REFORM

Mr. THUNE. Mr. President, we now have a draft of the Senate majority's health care reform bill, after spending several weeks behind closed doors producing that bill. Some of the details are starting to emerge.

I think it is critical that all Members in the Senate have an opportunity to look very closely at what is in the bill. It should come as no surprise that it is a 2,000-plus page bill. Much was made of the bill in the House of Representatives being a 2,200-page bill when it was all said and done. This one is 2,074 pages. It hasn't been amended yet, so that will probably expand it as this bill comes to the floor.

I think we at least now have something we can look at and review. There was a lot made last night by the majority when they rolled this bill out—how fiscally responsible this bill is and how much of an improvement it is over recent drafts of this legislation. I wish to point out a couple things that I think, perhaps, put into perspective what this bill would do, what it entails, and how, with all the rhetoric about how it differs and improves upon previous drafts of the bill, it comes down to basically the same elements that have been in all the bills we have seen.

First is with respect to the costs. It is very clear the cost of this bill—which was stated last night as \$849 billion—is dramatically understated relative to its true cost when fully implemented. There are several reasons. One, they push back the effective implementation date to 2014 for many of the provisions to take effect. So you will not see the actual spending in the bill start to kick in until January 1 of 2014.

However, many of the revenue components in the bill begin to kick in next year, on January 1, 2010. So the tax increases, which are multiple and hundreds of billions of dollars, would begin to take effect immediately, starting January 1, 2010, while much of the spending in the bill would be deferred until much later in the budget window—not taking effect until January 1, 2014.

That distorts the true picture of what this legislation would cost and distorts it substantially.

The other point I will make is that there are a couple other provisions in the bill that, by its absence in one case and its inclusion in the other, understate the cost of the bill. One is the absence of the sustainable growth rate formula, or the so-called physician fee fix, the reimbursement form, that is a \$247 billion hole—\$247 billion in additional spending that is not included in the bill. That, obviously, understates the overall cost.

There is also a \$72 billion assumption in there for a program called the CLASS Act. I wish to read for you something that one of my colleagues on the Democratic side said about the CLASS Act. This was the Senator from North Dakota, chairman of the Budget

Committee in the Senate. He called the CLASS Act “a ponzi scheme of the first order, the kind of thing that Bernie Madoff would be proud of.” That is how he refers to this CLASS Act included in the bill and the savings that are associated with it. In fact, the \$72 billion it shows as revenue in the first 10 years turns into a deficit in the second 10 years. So when you back out the \$72 billion that, it is assumed, would add to the revenues in the bill and you add to the cost of the bill the \$247 billion that would be required to fund the physician fee formula over a 10-year period, the so-called surplus that this bill generates actually turns into a deficit. It goes from a surplus of \$130 billion to a deficit of \$189 billion.

Again, a lot of gimmicks are being used to understate the true cost of the bill to the American people. All that being said, if you look at the overall cost, when fully implemented over 10 years, you come up with this: Remember, when the HELP Committee passed its version of this bill out of committee, the 10-year, fully-implemented cost was \$2.2 trillion.

When the Finance Committee passed its version of the health care reform bill out of the committee, the 10-year, fully-implemented cost of that bill was \$1.8 trillion. So that is \$1.8 trillion for the Finance Committee bill and \$2.2 trillion for the Health, Education, Labor, and Pensions Committee bill. Guess what the pricetag is on the bill that was merged together and has now been unveiled for all the world to see. It is \$2.5 trillion in overall cost—10-year, fully-implemented cost. That is a \$2.5 trillion expansion of the Federal Government in Washington, DC, associated with the fully implemented cost of the bill.

The point I am trying to make is this: The cost of the bill is being dramatically understated by the authors of the bill to make it look like it comes in under \$1 trillion, when, in fact, when you back out the two components I mentioned, it is over \$1 trillion in the first 10 years, and that is because they delay implementation of many provisions until January 1, 2014—a budgetary gimmick designed to understate the true cost of the bill.

When you look at the fully implemented, 10-year cost of the legislation, without the gimmick of the delayed implementation date and the other gimmicks in here, it is \$2.5 trillion in additional costs to the taxpayers of this country. Of course, that \$2.5 trillion has to be paid for somehow. The way it is paid for isn't any different than in any of the other bills we have seen so far. It is paid for with higher taxes on small businesses and higher taxes on individuals. It is paid for with cuts to Medicare Programs that would impact senior citizens in this country, as well as medical providers, from hospitals to home health agencies, to hospice—you name it—and medical device manufacturers get hit hard in this legislation. Everybody gets hit when it

comes to the reimbursement side to pay for this.

Of course, the American taxpayer gets hit hard when it comes to the tax increases included in there—\$1½ trillion in tax increases and \$1½ trillion in Medicare cuts to finance this \$2.5 trillion expansion of the Federal Government to create a new entitlement program.

The other thing this bill does, which wasn't included in a previous version, it has an increase in the payroll tax on Medicare. The argument is, it only applies to people in the higher income categories. They tried to carve out people under \$200,000 a year. Remember, the Medicare tax—and the payroll tax that every employee in this country pays, which is 1.45 percent on their income, matched by their employer, for a total of 2.9 percent—is increased. It gets increased to pay for not reforming or making Medicare more sustainable, a program we all know is destined to be bankrupt by 2017.

The increase in the Medicare tax will fund a whole new entitlement program unrelated to Medicare. The argument will be it is a health care program. But the fact is, the Medicare payroll tax was put into place to fund Medicare, a program people would pay into so that when they retire, they would have the security of health care coverage.

The payroll tax included in this bill, first off, will hit a lot of people. If you are a couple who both make a couple hundred—or \$100,000 a year, you are already into the category where you are going to be hit by the tax. One of my main objections—and I am not for this tax increase—one of my main objections is the majority has chosen to use that tax increase not to make Medicare more sustainable but to create a whole new entitlement program with this bill.

The other thing I wish to point out, because it has come up in the last day or two, is there has been all this discussion about mammograms, this U.S. Preventive Services Task Force that came out with a recommendation that women under 40 should not go through mammogram screening; and, of course, a few years ago they made the opposite recommendation—back in 2002—when the U.S. Preventive Services Task Force made the recommendation that women 40 and older should undergo annual mammogram checks for breast cancer. That recommendation was completely reversed earlier this week. The 16-member task force ruled that patients under 50 or over 75, without special risk factors, no longer need annual screening. What is being said about that? They are backing away from that in a hurry. The HHS Secretary, Kathleen Sebelius, said: No, no, no, nothing will change. This is just a recommendation. It is not binding.

That may be true today. Here is the problem with government-run health care, the problem with the direction we are heading with this legislation: A greater level of government involve-

ment and intervention and more requirements imposed on those who offer insurance products, particularly those who contract with the government. I think it is safe to assume that. There are many new creations in this legislation, and there is a new Medicare advisory board. They will have recommendations that are not just recommendations and advisory but, in fact, binding.

This is exactly the point many colleagues have been making about government-run health care. When you start down that path—and we have seen the model in Europe and Canada—where the government imposes cost control measures, that leads to rationing. Pretty soon, people are denied care, and care is delayed when people want to get a particular procedure. It has been concluded that this is not cost-effective, and some of these decisions that have traditionally been made between patients and doctors are made by the government.

I will read for you something that was in an editorial in the Wall Street Journal today. It gets at the very heart of what I am talking about. It says:

More important for the future, every Democratic version of ObamaCare makes this task force an arbiter of the benefits that private insurers are required to cover as they are converted into government contractors. What are now merely recommendations will become de facto rules, and under national health care these kinds of cost analyses will inevitably become more common as government decides where finite tax dollars are allowed to go.

In a rational system, the responsibility for health care ought to reside with patients and their doctors. James Thrall, a Harvard medical professor and chairman of the American College of Radiology, tells us that the breast cancer decision shows the dangers of medicine being reduced to “accounting exercises subject to interpretations and underlying assumptions,” and based on costs and large group averages, not individuals.

He goes on to say:

I fear that we are entering an era of deliberate decisions where we choose to trade people's lives for money.

What is important about that observation is that he is pointing out what a lot of people will be very concerned about. If you are a woman in my home State of South Dakota, and let's say you are 42 years old, the recommendation made by this task force, which everybody is now dismissing and saying don't worry about it, it is not binding—under legislation such as this, where you create a board that actually does have statutory powers and is enabled to make many of these decisions based on what is cost-effective, you could have someone in a State such as mine, or any woman in any State in this country who is in their forties—because they said 50 should be the baseline now, the age at which you get mammograms or breast cancer screening done—that you could actually have women in this country who would be denied the opportunity to do that.

Of course, we all know and everybody can relate to people in this country

who, by virtue of that screening process and that test, have been detected early and able to beat breast cancer, which is something that afflicts a great number of women across this country.

That is one example. I use that as an example of how this new type of government-run program might work. But there are countless other examples of the very same thing.

As we head into this debate, again I remind my colleagues this type of undertaking—reforming health care—ought to be about driving down costs, it ought to be about providing more access to Americans, it ought to be about maintaining that important relationship between a physician and their patient and not getting to where we have the government making those decisions, where we are actually bending the cost curve up rather than driving it down.

By the way, the CBO said in response to the majority's bill that was unveiled yesterday that it actually increases costs by \$160 billion. To me, the fundamental goal of health care reform for most Americans, the key concern they have about health care today, is its costs. Everything we have seen so far, including this most recent version which we are going to have at some point on the floor of the Senate, probably sometime after the Thanksgiving holiday, increases costs, drives the cost curve up.

How can you be for something that cuts Medicare to providers and seniors across this country, that raises taxes on small businesses, the economic engine that creates jobs in this country, raises taxes on middle-income Americans and which also, ironically, raises the cost of health care, increases the cost of health care? I am not saying this is the CBO. That has been consistent through all the bills that have been produced. It is consistent with this one as well that the proposals and all the new provisions that will be included—again, \$2.5 trillion, 10-year fully implemented costs paid for by Medicare cuts, \$1/2 trillion in Medicare cuts, \$1/2 trillion in tax increases, and obviously much more than that when you get into the fully implemented time period, all that—all that—to raise health care costs for people in this country. How can we label that reform?

I hope the American people, as they listen to this debate, will engage, will take a hard look at this 2,074-page bill. It is going to be a lot of legislative, arcane language. We are all going to do our best to make sense out of it. But it is a massive bill, just in terms of its volume. It also includes a massive expansion of the Federal Government in Washington, DC, at tremendous cost to the taxpayers, to Medicare beneficiaries and, in the end, doesn't do anything to drive down the cost of health care. It simply increases it and puts at risk, I would argue, many of the types of things I talked about with regard to breast cancer screening. When government is making decisions

rather than patients and doctors, that is a world in which I don't think I want to enter, and certainly I think most Americans don't either.

Mr. President, I ask unanimous consent to have printed in the RECORD a Wall Street Journal editorial.

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

#### A BREAST CANCER PREVIEW

A government panel's decision to toss out long-time guidelines for breast cancer screening is causing an uproar, and well it should. This episode is an all-too-instructive preview of the coming political decisions about cost-control and medical treatment that are at the heart of ObamaCare.

As recently as 2002, the U.S. Preventative Services Task Force affirmed its recommendation that women 40 and older undergo annual mammograms to check for breast cancer. Since regular mammography became standard practice in the early 1990s, mortality from breast cancer—the second leading cause of cancer death among American women—has dropped by about 30%, after remaining constant for the prior half-century. But this week the 16-member task force ruled that patients under 50 or over 75 without special risk factors no longer need screening.

So what changed? Nothing substantial in the clinical evidence. But the panel—which includes no oncologists and radiologists, who best know the medical literature—did decide to re-analyze the data with health-care spending as a core concern.

The task force concedes that the benefits of early detection are the same for all women. But according to its review, because there are fewer cases of breast cancer in younger women, it takes 1,904 screenings of women in their 40s to save one life and only 1,339 screenings to do the same among women in their 50s. It therefore concludes that the tests for the first group aren't valuable, while also noting that screening younger women results in more false positives that lead to unnecessary (but only in retrospect) follow-up tests or biopsies.

Of course, this calculation doesn't consider that at least 40% of the patient years of life saved by screening are among women under 50. That's a lot of women, even by the terms of the panel's own statistical abstractions. To put it another way, 663 additional mammograms are more expensive in the aggregate. But at the individual level they are immeasurably valuable, especially if you happen to be the woman whose life is saved.

The recommendation to cut off all screening in women over 75 is equally as myopic. The committee notes that the benefits of screening “occur only several years after the actual screening test, whereas the percentage of women who survive long enough to benefit decreases with age.” It adds that “women of this age are at much greater risk for dying of other conditions that would not be affected by breast cancer screening.” In other words, grandma is probably going to die anyway, so why waste the money to reduce the chances that she dies of a leading cause of death among elderly women?

The effects of this new breast cancer cost-consciousness are likely to be large. Medicare generally adopts the panel's recommendations when it makes coverage decisions for seniors, and the panel's judgments also play a large role in the private insurance markets. Yes, people could pay for mammography out of pocket. This is fine with us, but it is also emphatically not the world of first-dollar insurance coverage we live in, in which reimbursement decisions deeply influence the practice of medicine.

More important for the future, every Democratic version of ObamaCare makes this task force an arbiter of the benefits that private insurers will be required to cover as they are converted into government contractors. What are now merely recommendations will become de facto rules, and under national health care these kinds of cost analyses will inevitably become more common as government decides where finite tax dollars are allowed to go.

In a rational system, the responsibility for health care ought to reside with patients and their doctors. James Thrall, a Harvard medical professor and chairman of the American College of Radiology, tells us that the breast cancer decision shows the dangers of medicine being reduced to “accounting exercises subject to interpretations and underlying assumptions,” and based on costs and large group averages, not individuals.

“I fear that we are entering an era of deliberate decisions where we choose to trade people's lives for money.” Dr. Thrall continued. He's not overstating the case, as the 12% of women who will develop breast cancer during their lifetimes may now better appreciate.

More spending on “prevention” has long been the cry of health reformers, and President Obama has been especially forceful. In his health speech to Congress in September, the President made a point of emphasizing “routine checkups and preventative care, like mammograms and colonoscopies—because there's no reason we shouldn't be catching diseases like breast cancer and colon cancer before they get worse.”

It turns out that there is, in fact, a reason: Screening for breast cancer will cost the government too much money, even if it saves lives.

Mr. THUNE. Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Michigan.

Ms. STABENOW. Mr. President, I ask unanimous consent to speak for up to 20 minutes in morning business.

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

#### HEALTH CARE REFORM

Ms. STABENOW. Mr. President, first, it is a good thing our health care reform doesn't do the kinds of things the Senator is talking about. I wouldn't support it either. I don't think the Chair would either. It is a good thing that is not what we are doing. With respect to my friend from South Dakota, we have a different view of this bill.

Let me first start by saying, as the Chair knows and has said, this bill saves lives and saves money, and particularly protects Medicare and stops insurance abuses. That is what we are about.

Before going through the specifics of the bill, I wish to read from a very interesting column today in the New York Times. We can have competing newspapers, dueling newspapers on the floor. Nicholas Kristof did a column called “The Wrong Side of History.” I quote:

Critics storm that health care reform is “a cruel hoax and delusion.” Ads in 100 newspapers thunder that reform would mean “the beginning of socialized medicine.”

The Wall Street Journal's editorial page predicts that the legislation will lead to “deteriorating service.” Business groups warn