

Advantage. It is neither Medicare nor an advantage. Quite the opposite, in fact.

You are accurate in your numbers, by the way, because I want people to know, as much as we respect the Senator from Illinois and his math, the numbers he identifies of \$100 billion this program is costing us, comes from the Congressional Budget Office. We didn't make up these numbers. That is the cost savings by modifying Medicare Advantage that has cost us so much and deprived the overwhelming majority of our elderly the benefits they end up paying for. So I appreciate very much the Senator's question.

Mr. BAUCUS. If the Senator will yield for another question, might I ask my friend if it isn't also true that in the June MedPAC report it states that Medicare Advantage overpayments cost taxpayers an extra \$12 billion?

Mr. DODD. That is correct. And again, that is MedPAC.

Mr. BAUCUS. Well, that is right, that is MedPAC. I think the point the Senator from Illinois is making needs to be underlined two or three or four times here—and the Senator from Connecticut has made it too—and that is there is a huge distinction between Medicare and these private insurance plans.

Mr. DODD. I think too many of our fellow citizens hear the word Medicare Advantage and assume that is the Medicare Program, and it is not.

Mr. BAUCUS. It is not. It is a private plan.

What Medicare Advantage is overpaid—that is what these insurance companies are overpaid, and a lot of that goes back to the Part D drug bill and so forth—do those overpayments necessarily mean better benefits for persons who signed up for those plans?

Mr. DODD. No. In fact, there is no evidence that overpayments to plans leads to better health care. That is again according to MedPAC.

Mr. BAUCUS. If that is true, why might that be the case, just so people understand?

Mr. DODD. Because insurers, not seniors or the Medicare Program, determine how these overpayments are used. And too often they are used to line the pockets of insurers, to increase their profits and not to provide benefits.

Mr. BAUCUS. Does Medicare decide what the benefits will be for those folks?

Mr. DODD. No, it is the private carriers that decide that.

Mr. BAUCUS. The private insurance carriers.

Mr. DODD. Yes, they are the ones that set the rates and determine where the profits go. That is why it is such a misnomer to call this Medicare Advantage, because it is neither Medicare nor an advantage.

The PRESIDING OFFICER. The time has expired.

Mr. DODD. Mr. President, I ask unanimous consent for 2 additional minutes.

The PRESIDING OFFICER. Is there objection?

Mr. COBURN. Reserving the right to object, I will ask for 2 additional minutes for my side.

Mr. DODD. Well, I gave 2 minutes to my friends earlier.

Mr. COBURN. How about 1?

Mr. DODD. OK, 1. Well, make that 2. If he wants 2 additional minutes, I have no problem giving my colleague 2 additional minutes.

Mr. BAUCUS. You already said it, but I think it is worth repeating—

The PRESIDING OFFICER. Without objection, the request is agreed to.

Mr. BAUCUS. Most seniors, as they pay Part B premiums under fee for service, don't get any benefit whatsoever?

Mr. DODD. That is correct. None whatsoever. In fact, all they do get is higher premiums.

Mr. BAUCUS. That is right. Higher premiums.

Mr. DODD. Higher premiums. And 78 percent, almost 80 percent are paying more for a program from which they never get any benefit.

Mr. BAUCUS. The figure I saw—I guess it is \$90 a year they pay extra and get no benefit from it.

Mr. DODD. So vote for the McCain amendment and you do exactly what Senator DURBIN is suggesting: Preserve Medicare Advantage, and under Medicare Advantage 78 percent of our elderly pay more premiums, never get any benefits, and the private carriers get to pocket the difference. That is a great vote around here. That is great health care reform.

Mr. DURBIN. I say to the Senator from Connecticut, could we characterize this as an earmark in the Medicare Advantage Program?

Mr. DODD. It is two ears, not even one ear. I give it two ears.

Mr. BROWN. I say to Senator DODD, we remember 10 years ago when the insurance companies came to the government and said we can do something that later became Medicare Advantage, and we can do it less expensively. They said we can do it for 5 percent less than the cost of Medicare and the government unfortunately made the agreement with them to sign up to do that. Then what happened in the last 10 years is, the insurance lobbyists came here and lobbied the Bush administration and lobbied the Congress and got bigger payments. It is a subsidy for the insurance companies, but you and Senator BAUCUS and Senator DURBIN said it is not Medicare, it is private insurance, privatized form of Medicare that serves the insurance companies very well, is that correct, but doesn't serve the seniors in this country?

Mr. DODD. I will sit here all day waiting for someone to identify a single benefit guaranteed under the Medicare Program that is cut in our bill. They are all talking about Medicare Advantage, not Medicare. There are no guaranteed benefits cut under this bill nor can those benefits be cut. Our legislation bans and prohibits any cuts in guaranteed benefits.

The PRESIDING OFFICER (Mr. CASEY). The Senator from Oklahoma is recognized.

Mr. COBURN. One of the questions and one of the promises was: If you have what you have now and you like it, you can keep it. What is happening under this bill for 11 million seniors on Medicare Advantage, that is not going to happen. If they like it, they are not going to be able to keep what they have. You can't deny that. That is the truth.

Medicare Advantage needs to be reformed. There is no question about it. I agree. As the Senator alluded to, in the Patients Choice Act we actually save \$160 billion in the Patients' Choice Act, but we don't diminish any of the benefits, and we do that because CMS failed to competitively bid it, because when it was written—and I understand who wrote it—when it was written we didn't make them competitively bid it. You could get the same savings, actually get more savings and not reduce benefits in any amount, if you competitively bid that product. But we have decided we are not going to do that.

The second point I make with my colleagues is the vast majority of people on Medicare Advantage are on the lower bottom economically. They can't afford an AARP supplemental bill. They can't afford to pay an extra \$150 or \$200 a month. So what happens most of the time with Medicare Advantage is we bring people up to what everybody else in Medicare gets because most people can afford—84 percent of the people in this country can afford to buy a Medicare supplemental policy because Medicare doesn't cover everything.

Your idea to try to save money, I agree with. But cutting the benefits I do not agree with. You are right, Senator DODD, the basic guaranteed benefits have to be supplied to Medicare Advantage and then the things above that which you get from the supplemental policy, what you can afford to buy, is what these people get. And what you are taking away from poorest of our elderly is the ability to have the same care that people get who can afford to buy a supplemental policy. That is the difference.

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. COBURN. I appreciate my chairman for his courtesy in yielding the time.

#### RECESS

The PRESIDING OFFICER. Under the previous order, the Senate stands in recess until 12:30 p.m.

Thereupon, the Senate, at 11:35 a.m., recessed until 12:30 p.m. and reassembled when called to order by the Presiding Officer (Mrs. HAGAN).

#### SERVICE MEMBERS HOME OWNERSHIP TAX ACT OF 2009—Continued

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Madam President, on Monday the Congressional Budget Office sent a letter to the Senator from Indiana, Mr. BAYH, that provides a very comprehensive analysis of what health insurance premiums will look like as a result of this 2,074-page bill before us, introduced by Senator REID. Listening to that discussion, I am starting to wonder if anyone actually read the letter. I hear a lot of people saying this letter proves that premiums will go down under the Reid bill, even though that is not what the letter says. I am here to tell my colleagues what the letter really says.

The letter makes it very clear that premiums will increase on average by 10 to 13 percent for people buying coverage in the individual market. Since it seems to fly by everybody what this letter actually said about increasing premiums, I brought down a chart to show everyone in case they missed it.

The letter from the CBO says very clearly that for the individual market, premiums are going to go up 10 to 13 percent. My colleagues keep saying premiums are going to go down, conveniently forgetting, then, to mention this 10- to 13-percent increase. They prefer to talk about the 57 percent of Americans in the individual market who are getting subsidies. It is true that government is spending \$500 billion in hard-earned taxpayer money to cover up the fact that this bill drives up premiums faster than current law. So we might as well repeat it: Premiums will go up faster under this bill.

Supporters of this bill are covering this increase in cost how? By handing out subsidies. If you are one of the 14 million who doesn't happen to get a subsidy, you are out of luck. You are stuck with a plan that is 10 to 13 percent more expensive and also, simultaneous with it, an unprecedented new Federal law that mandates that you purchase insurance. If you don't purchase insurance, you are going to pay a penalty to the IRS every time you file your income tax. Some may say this is just the individual market. It only accounts for a small portion of the total market. If you are comfortable with 14 million people paying more under this bill than they would under current law, let's look at the employer-based market.

The Congressional Budget Office analysis says this bill maintains the status quo in the small group and large group insurance market. Is that something to be celebrating? Are expectations so low at this point that my friends on the other side of the aisle are celebrating that this bill will increase premiums for some and maintain the status quo for everyone else? I am being generous in using the phrase "status quo" because this bill actually makes things worse for millions of people. This bill is so bad that my friends on the other side of the aisle are trying to convince the American people that this is just more of the same, when that doesn't happen to be the case.

Whatever happened to bending the growth curve? If that is too Washingtonese for people, the goal around here of a bill at one time was to make sure the inflation in insurance didn't continue to go up so much that it would go the other way.

Then what about the President's promise that everyone would save \$2,500? According to the Congressional Budget Office, almost every small business will pay between 1 percent more to 2 percent less for health insurance. That means, of course, that compared to what businesses would have paid under current law, this bill will either raise premiums 1 percent or decrease them a whopping 2 percent. It doesn't sound like this bill is providing any real relief or, for sure, not providing \$2,500 savings for every American, as President Obama repeatedly pledged during the campaign. Larger businesses will pay the same or up to 3 percent less for health insurance. Once again, that doesn't sound like relief; it sounds like more of the same.

In fact, the Congressional Budget Office has confirmed that between now and 2016, premiums will continue to grow at twice the rate of inflation. I thought Congress was considering health reform to put an end to unsustainable premium increases.

So this bill cuts Medicare by \$500 billion, raises taxes by \$500 billion, restructures 17 percent of our economy, and spends \$2.5 trillion. Yet some of my colleagues on the other side of the aisle are celebrating that they have achieved the status quo when, in fact, the situation will be worse. I always thought the status quo was unacceptable. I thought businesses could not afford the status quo. I thought the status quo was killing American businesses, killing jobs, and making this country less competitive. But Member after Member keeps coming down to the floor to celebrate spending \$2.5 trillion on the status quo. We could have done that for free. Am I missing something? Did people really read the same letter I did from the CBO?

When President Obama visited Minneapolis in September, he didn't sound as though he was celebrating maintaining the status quo. On the contrary, I have a chart with one of his quotes:

I will not accept the status quo. Not this time. Not now. . . .

Some Members seem to disagree. Some Members are celebrating that they are making things worse for millions of Americans and maintaining the status quo for everyone else.

Here is what Vice President BIDEN said:

The status quo is simply unacceptable. Let me say that again—the status quo is simply unacceptable. Rising costs are crushing us.

That doesn't sound like a call for more of the same. Once again, Members on the other side of the aisle seem quite comfortable investing \$2.5 trillion in more of the same. That is taxpayer dollars we are talking about.

If I asked most Iowans how they would feel about government spending

\$2.5 trillion and premiums would still increase as fast or faster, they would say that was a pretty bad investment. Well, I will not argue with what our constituents would say on that point. I agree with them.

This Congressional Budget Office letter tells me that we are debating a pretty bad investment. Our constituents want lower costs. That is their main concern. But this bill fails to address that concern because it raises premiums. Despite offering new ideas throughout the committee process and on the floor of the Senate, Republicans are being accused of supporting the status quo. CBO has spoken, and it is pretty clear that my colleagues are not only OK with the status quo, they are OK with making things worse: higher taxes, higher premiums, increased deficit, less Medicare. They are celebrating that they spent \$2.5 trillion to raise premiums for 14 million people, not bending the growth curve of inflation in health care, and not cutting costs. Don't take my word for it. Read the letter. Read the letter from the Congressional Budget Office. I have copies I will pass out if anybody wants them. I have this chart that demonstrates that point.

I also wish to take a few minutes at this time to correct some inaccurate comments made earlier by some of my colleagues. When we are talking about 17 percent of the economy and something that touches the lives of every single American, I want to make sure we have an honest and accurate debate. This morning I heard at least three Members on the other side of the aisle say that Medicare Advantage is not part of Medicare. This is totally false.

But don't take my word for it. I would like to have Members turn to page 50 of the handbook, "Medicare and You." Presumably it has the date of 2010 on it. It is sent out every year. In fact, I think I have two copies of this in my household. If anybody wants to save paper and not waste taxpayer money, they can get on the Internet and tell them only to send one to their house next year. I have done that.

This book says, for those who say Medicare Advantage is not part of Medicare:

A Medicare Advantage plan is another health coverage choice that you may have as part of Medicare.

I repeat, despite what Members were saying earlier, the "Medicare and You" handbook says very clearly: Medicare Advantage Plans are part of Medicare. So if you are cutting Medicare Advantage benefits, you are, in fact, cutting Medicare benefits.

Next, I hear a lot of Members talking about guaranteed benefits versus statutory benefits. I can't speak for my other 99 colleagues, but the seniors in Iowa who have come to rely upon the free flu shots, eyeglasses, and dental care that Medicare Advantage provides don't care if they are guaranteed or if they are statutory. Seniors in Iowa just want to know they will still have

these benefits after health reform is passed.

The Senator from Connecticut challenged any Member to come down to the Senate floor and point out where this bill will cut benefits. He even read a section from page 1,004 of this 2,074-page bill that talks about how the Medicare Commission cannot cut benefits or ration care. I have read page 1,004. What Senator DODD failed to mention is that this section only refers to Parts A and B of Medicare. It fails to provide any protection to Medicare Part D, the prescription drug benefit, or the Medicare Advantage Program that covers 11 million seniors.

Are we now going to start hearing that Medicare Part D is not part of Medicare either? In fact, on page 1,005, it specifically says the Medicare Commission can “[i]nclude recommendations to reduce Medicare payments under parts C and D.”

I have asked CBO, and they have confirmed this authority could result in higher premiums and less benefits to seniors. In fact, this is what Congressional Budget Office Director Elmenhorst said, and we have that on a chart for you to see the quote I am going to read: “A reduction in subsidies to [Part D] would raise the cost to beneficiaries.”

Lastly, I wish to raise an issue about access to care. I keep hearing my friends on the other side of the aisle talk about how these cuts will not affect seniors. They say they are just overpayments to providers. Well, in my opinion, if you cannot find a doctor or if you cannot find a home health provider or a hospice provider to deliver care, then that tends to be a very big problem. I would even consider that a cut in benefits or hurting access to care.

But, once again, do not take my word for it. In talking about similar cuts to Medicare in the House bill, the Office of the Actuary at the Centers for Medicare & Medicaid Services said providers that rely on Medicare might end their participation, “[p]ossibly jeopardizing access to care for beneficiaries.”

So let's be accurate and let's be honest. Medicare Advantage is part of Medicare, and this bill cuts benefits seniors have come to rely upon. The Medicare Commission absolutely has authority to cut benefits and to raise premiums, and this bill will jeopardize that access to care.

Those are all facts. They are not my facts but facts taken directly from the language of this 2,074-page bill and from reports of the Congressional Budget Office and the Office of the Actuary at the Centers for Medicare & Medicaid Services.

I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Madam President, it seems I am following the Senator from Iowa every day. I, first, wish to acknowledge my friendship and respect for him. But the Medicare Advantage

Program, which the Republican side is trying to protect, is a program which is private health insurance.

The largest political opponent to health care reform in America is the private health insurance industry. We estimate they have spent \$23 million so far lobbying to defeat this bill because they are doing very well under the current system. They are very profitable companies, and they realize, if they face competition, limitations on the way they do business, it will cut into their bottom line and their profits, and, naturally, are fighting the bill.

The amendment before us, the motion to commit by Senator MCCAIN—the first thing it does is to protect the Medicare Advantage Program. That is a private health insurance program that was created with the promise that it would be cheaper than traditional government-run Medicare. In some cases, they have offered a cheaper policy. But, overall, these private health insurance companies are charging the Medicare Program 14 percent more than the actual cost of the government-run system.

The promise that the private sector could do it more cheaply and better turned out not to be true. So we are paying a subsidy in profits—extra profits—to private health insurance companies. The McCain amendment, which has been supported by Senator GRASSLEY and others who have come to the floor, is an effort to stop us from eliminating this subsidy.

What is this subsidy worth? This subsidy to private health insurance companies will cost the Medicare Program \$170 billion over the next 10 years—no small amount. We believe that money is better spent on extending benefits to Medicare beneficiaries, not in providing additional profits to already profitable private health insurance companies.

Yes, Medicare Advantage policies are offering Medicare benefits, but they are charging more for it than the government. So it did not turn out to be a bargain. It turned out to be a loss to the Medicare Program. They did not do what they promised to do. We want to hold them accountable. The McCain amendment wants to let them off the hook and basically say: Private health insurance companies, keep drawing that money out of Medicare. We are not going to hold you accountable.

That earmark of the Medicare Advantage Program, that decision by Congress to give them a special privilege in selling this health insurance, is too darn expensive for senior citizens and people who rely on Medicare. That is why we are opposing the McCain amendment.

I might add, this is the third day of the debate on health care reform in America. We have yet to vote on a single amendment because the Republicans refuse to allow us to bring an amendment to the floor for a vote. How can you have an honest debate about a bill of this seriousness and magnitude

if you cannot bring a measure to a vote on the floor?

Those who follow the Senate know it is a peculiar institution and its rules protect minorities, and individual Senators can object to a vote. The Republican Senators have objected to a vote, even on the McCain amendment, which I believe was filed on Monday, and here we are on Wednesday. We have talked about it. We know what is in it. We should vote on it. But the Republicans do not want to vote on it. They want to drag this out in the hopes that our desire to go home for Christmas means we will walk away from health care reform.

Well, if a few of the Republican Senators could have just left the Democratic caucus, they would know better. We are determined to bring this bill to a vote. We are determined to bring real health care reform to this country. We know what is at stake.

The current health care system in America is not affordable for most Americans. Health insurance premiums have gone up dramatically in cost. Individuals cannot afford to buy a policy. Businesses are dropping coverage of their employees. We know the costs are unsustainable.

Unless we start bringing those costs down, this great health care system is going to collapse. We need to preserve the things that are good in this system and fix those that are broken. Affordability is the first thing we need to address. The second thing we need to address, quite obviously, is to make sure every American has the right, as a consumer, to get coverage when they need it.

How many times have you heard the story of people who pay their health insurance premiums their whole lives, then somebody gets sick in their house—a new baby, a child, your wife, your husband—a big medical bill is coming, you go to the health insurance company, and you are in for a battle. They will not pay it. They say: Oh, we took a look at your application you filed a few years ago. You failed to disclose that you had acne when you were an adolescent. Am I making that up? No. That is an actual case. Because you did not disclose that you had acne as an adolescent, you failed to disclose a preexisting condition, so we have no obligation to pay for anything. If this sounds farfetched, believe me, it is an actual case—and there are many others like it.

Private insurance companies have spent a fortune hiring an army of people, sitting in front of computer screens, talking to the people who are paying the premiums, and above their computers is a sign that says: “Just Say No.” They say no consistently because every time they say no, their profits go up. But it leaves individuals and families in a terrible situation—denied coverage because of a preexisting condition; denied coverage because they could not carry their health insurance policy with them after they

lost their job; denied coverage because of a cap in the amount of money the policy would pay; rescinded, where they walk away from an insurance policy because of some objection they have, legal objection; or how about one of your kids who turned age 24, no longer covered by your family health plan, now out on their own, maybe fresh from college, and has no job and no health insurance.

This bill addresses those issues. This bill eliminates the concern people will have over a preexisting condition. It takes away the power of the health insurance companies to say no. It finally creates a situation, which we have waited for for a long time. America is the only civilized, industrialized country in the world where a person can die for lack of health insurance. It does not happen anywhere else—only in America. Madam President, 45,000 people a year die for lack of health insurance.

Who are these people? Let me give you an example, one person whom I met. Her name is Judie, and she works in a motel in southern Illinois. She is 60 years old, a delightful, happy woman. She is the one who takes the dishes at the end of this little breakfast they offer at the motel. She could not be happier and nicer. She is 60 years old, with diabetes. She never had health insurance in her life—never. She goes to work every day, works 30 hours a week, and makes about \$12,000 a year. She does not have health insurance, but she does have diabetes. She said to me: If I had health insurance, I would go to the doctor. I have had some lumps that have concerned me for a little while here, but I can't afford it, Senator.

That is an example of a person who does not have the benefit of health insurance. This bill we are talking about—this bill we are going to produce for everyone to read on the Internet; it is already there; it has been there for 10 days already; it will continue to be there—this bill makes sure that 94 percent of the people in America have health insurance coverage. That is an alltime high for the United States of America.

I might also say, despite the criticisms—and they are entitled to be critical on the Republican side of the aisle—they have yet to answer the most basic criticism I have offered. Where is your bill? Where is the Republican health care reform bill? They cannot answer that question because it does not exist. They have had a year to explore their ideas and develop them, but they have failed. They cannot produce a bill. They are for the current system, as it exists, that is unsustainable, unaffordable, leaving too many Americans vulnerable to health insurance companies that say no and too many Americans without health insurance.

I wish to address one particular issue that seems to come up all the time, and it is the issue of medical mal-

practice. I know my Republican colleagues are going to bring up that issue. Senator MCCAIN has, many others have as well. President Obama recently recognized this as an issue of concern. Our bill will as well. We are going to explore, encourage, and fund State efforts to find ways to reduce medical malpractice premiums and to reduce, even more importantly, the incidence of medical errors.

Medical malpractice reform proposals are based in States. The Federal Government does not have a medical malpractice law, not in general terms. It does for specific programs such as Indian health care, for example, or federally qualified clinics. But when it comes to the general practice of medicine, that is governed by State laws, and the States decide when you can sue, what you can sue for, and the procedures you have to follow.

In almost every State there has been a system that has developed over the years to handle these cases. States regularly change and update their laws. The States try to strike a balance to protect patients, preserve their hospitals and doctors and other medical providers, ensure that those who are injured have a chance for compensation, and manage the cost of their system.

At least twenty-eight States, as of last year, have decided to impose caps on noneconomic damages in medical malpractice cases. A long time ago, before I came to Congress, I used to be a practicing lawyer in Springfield, IL, and I handled medical malpractice cases. So I do not profess to be an expert, nor even have current knowledge of medical malpractice, but I did in a previous life have some experience. I defended doctors, when they were sued, for a number of years on behalf of insurance companies, and I represented plaintiffs who were victims of medical negligence. So I have been on both sides of the table. I have been in the courtroom. I have gone through the process.

Here is what it comes down to. If you are a victim of medical malpractice, medical negligence, the jury can give you an award, which usually includes a number of possibilities: pay your medical bills, pay for any lost wages, pay for any additional expenses that may be associated with the court case, and pay for pain and suffering. Those are the basic elements that are involved in a medical malpractice lawsuit.

The pain and suffering part of it—it is pain, suffering, loss of a spouse or child, loss of fertility, scars, and disfigurement—is an area where many States have said: We want to limit the amount you can recover for pain and suffering, what they call noneconomic losses. It is not medical bills. It is not lost wages. So my State, for example, has a limitation of \$500,000 on noneconomic damages in a medical malpractice case, recently enacted by our general assembly. In the State of Texas, it is \$250,000. Those are so-called

caps, limitations on the amount of money a jury can award for pain and suffering, when they find, in fact, you were a victim of medical negligence.

Some States have decided to establish caps on pain and suffering, how much you can recover; others have not. The reason many imposed caps was because they wanted to bring down the cost of medical malpractice insurance for doctors and hospitals. Well, a number of States have done that. At least twenty-eight States have done that, and we have been able to step back and take a look: How did it work? If you put a cap, a limitation, on recovery for pain and suffering, noneconomic loss, does that mean there will be lower malpractice premiums for doctors? In some cases, yes; in some cases, no.

Minnesota is an interesting example. Minnesota does not have caps on damages. Yet it has some of the lowest malpractice premiums in America. Twenty-five States, including Minnesota, use a certificate of merit system which means before you can file a lawsuit you need a medical professional to sign an affidavit that you have a legitimate claim before you even get into the court. That is in Minnesota, it is in Illinois, and a number of other States to stop so-called frivolous lawsuits.

Some States such as Vermont have low malpractice premiums and don't have any malpractice reforms. It is hard to track cause and effect here between tort reform, malpractice changes, and the actual premiums charged physicians.

There are ways Congress can help States build on what already works for each State. Senator BAUCUS, who is here on the floor and who is chairman of the Senate Finance Committee, has worked with Senator ENZI to create incentives for State programs to look for innovative ways to reduce malpractice premiums and the incidence of medical negligence. I think that is a good idea and I hope it will ultimately be included in this bill.

One of the major considerations when it comes to malpractice reform is making sure we focus on real facts. One myth we hear over and over again is about frivolous lawsuits flooding the courts. I have heard many colleagues come to the floor and call it "jackpot justice," frivolous lawsuits, fly-by-night lawyers filing medical malpractice lawsuits. I am sure there is anecdotal evidence for each and every statement, but when you look at the record, you find that malpractice claims and lawsuit payouts are actually decreasing in America.

In 2008, according to the Kaiser Family Foundation, there were 11,025 paid medical malpractice claims against physicians nationwide. One year in America, the total number of medical malpractice claims paid, according to the Kaiser Family Foundation, was 11,025. There are 990,000 doctors in America, so roughly 1 percent of doctors is being charged with malpractice

and paying each year. This is a decrease from 2007 where the number was 11,478. So the number of malpractice claims has gone down. The number of paid claims for every 1,000 physicians has decreased from 25.2 in 1991 to 11.1 in 2008. That is a little over 1 percent of doctors actually paying malpractice claims.

Not only is the number of claims decreasing, but the amount they are paying to victims is decreasing as well. The National Association of Insurance Commissioners—not a group that is biased one way or the other when it comes to plaintiffs or defendants—said in 2003, malpractice claim payouts peaked at \$8.46 billion. In 2008 that number had been cut in half. In 5 years it went down from \$8.4 billion to \$4 billion. So rather than a flood of frivolous lawsuits, fewer lawsuits are being filed and dramatically less money is being paid out.

Incidentally, the New York Times in a summary of research in September of this year found that only 2 to 3 percent of medical negligence incidents actually lead to malpractice claims. So it is not credible to argue that we have this flood of malpractice cases—they are going down—or this flood of payouts for malpractice in America. It has been cut in half in 5 years.

A third key consideration in this debate is cost. One of the main goals of pursuing health care reform is to try to reduce the cost to the system and we want to try to do that in a way that won't compromise the quality of care. There has been a lot of talk about the Congressional Budget Office report that was ordered up by Senator HATCH on October 9. The Congressional Budget Office for years said they could not put a pricetag on medical malpractice reform in terms of savings to the system, but on October 9 they reported to Senator HATCH that they could. Senator HATCH asked them what would be the impact on our health care system if we had a Texas-style cap, which is \$250,000 for pain and suffering—I see the Senator from Texas on the floor and I hope I am quoting the Texas law correctly. He was a former Texas supreme court justice. Am I close?

Mr. CORNYN. Close.

Mr. DURBIN. Close. That is all I will get from the Senator from Texas, close. But the fact is that Senator HATCH said to the CBO, what if we had the Texas-style cap on every State in the Union, what would be the net result? They came back and said there would be a savings of over \$50 billion over the next 10 years. They said 40 percent of the savings would come from lower medical liability premiums, 60 percent through reduced utilization of health care services.

I don't question the Congressional Budget Office reaching that conclusion. They worked hard to come up with their figures. But there are other ways to reach results they want to achieve of lowering medical liability premiums and saving overall health care expendi-

tures rather than adopting Federal damage caps. Keep in mind, these caps on what you can recover are for people who have been judged by a jury of their peers to have been victims. These are not people who have said I think I was hurt. We are talking about people who have a right to recovery in a lawsuit who are being told even though you were hurt, and somebody did something wrong, we are going to limit how much you can be paid when it comes to these noneconomic losses.

The CBO analysis that Senator HATCH received went on to say:

Because medical malpractice laws exist to allow patients to sue for damages that result from negligent health care, imposing limits on that right might be expected to have a negative impact on health outcomes.

They cited one study which found that a 10-percent reduction in costs related to medical malpractice liability would increase the Nation's overall death rate by .2 percent. By calculation that means that if the Hatch proposal were applied nationwide, according to the CBO—and this is a cited study—4,853 more Americans would be killed each year by medical malpractice—or more than 48,000 Americans over a 10-year period of time that the CBO examines. So if you accept their projection on the savings for medical malpractice reform asked for by Senator HATCH, you cannot escape the fact that they say yes, you will save money, but more Americans will die because there will be more malpractice.

Let's look at the savings that can be achieved through reduced malpractice insurance premiums. The CBO said a \$250,000 Federal damage cap would reduce overall malpractice premiums by about 10 percent and would reduce overall health care spending by .2 percent. Do we need a federally mandated cap to achieve that? Malpractice insurance premiums are already going down. According to the Medical Liability Monitor's comprehensive survey of premiums in the areas of internal medicine, general surgery and OB/GYN: "The most recent three years have shown a leveling and now a reduction in the overall average rate change" for medical malpractice premiums. There was a time in the early 2000s where malpractice premiums were going up 20 percent a year, in 2003, 2004, and 9 percent in 2005. Since then they have gone down each year by less than 1 percent in 2006, by .4 percent—I am sorry, .4 percent increase in 2007, but a 4.3 percent decrease in 2008. That is without any Federal cap on damages.

Let's also consider the issue of defensive medicine. Many people claim that doctors do things such as order tests to cover themselves because they are afraid of being sued. I agree that there are undoubtedly some doctors who think that way. There was a famous article printed in the New Yorker where a surgeon from Boston, Dr. Gawande, who went to McAllen, TX—you probably saw this, Senator CORNYN—and he wanted to know in this article why in

McAllen, TX, they were paying more for Medicare patients than any other place in the United States. So he visited with doctors and surgeons and hospital administrators to ask them why. What is peculiar about that city and its elderly people? He sat down with the doctors, and the first doctor said, Well, it is defensive medicine. We are doing all of these extra tests and extra costs to Medicare to cover ourselves, to protect ourselves. The doctor sitting next to him said, Oh, come on. With the Texas law, nobody is filing malpractice lawsuits around here. We are doing these extra procedures because it is a fee-for-service system. You are paid more when you do more. So at least in this case there was a dispute as to whether this was truly defensive medicine or overbilling.

Dr. Carolyn Clancy, the director for the Agency of Healthcare Research and Quality in the Department of HHS, has called medical errors a national problem of epidemic proportions. According to that agency, the rate of adverse events has risen about 1 percent in each of the past 6 years. The Institute of Medicine estimated in 1999 that up to 98,000 people died in America due to preventable medical errors. These medical errors cost a lot. A 2003 study published in the Journal of the American Medical Association found the medical errors in U.S. hospitals in the year 2000—just 1 year—led to approximately 32,600 deaths, 2.4 million extra days of patient hospitalization, and an additional cost of \$9.3 billion.

I wish to also say a word about the medical malpractice insurers. Remember, insurance companies and organized baseball are the only two businesses in America exempt from the antitrust laws. What it means is that insurance companies can literally legally sit down and collude and conspire when it comes to the prices they charge, and they do. They have official organizations—one used to be known as the Insurance Services Offices—that would sit down to make sure every insurance company knew what the other insurance company was charging, and they could literally work out the premiums, how much they charge.

The same thing was true in market allocation. Insurance companies, unlike any other business in America, can pick and choose where they will do business: Company X, you take St. Louis; company Y, you take Chicago; company Z, you get Columbus, OH. They can do it legally.

So the obvious question is: If this is not on the square in terms of real competition from health insurance companies, are these companies, in fact, paying out the kind of money they should?

Let me see if I can find a chart here. My staff was kind enough to bring these out. Well, I can't. They are great charts, but I can't find the one I am looking for at this moment.

According to the information of the National Association of Insurance Commissioners, in 2008, medical malpractice insurers charged \$11.4 billion

in premiums, but only paid out \$4.1 billion in losses. In other words, they took in \$7 billion more than they paid out in losses. That is a loss ratio of 36 percent, which means they are basically collecting \$3 for every \$1 they pay out—pretty close. How does that compare to the rest of the insurance industry? Well, it turns out that private automobile liability insurance had a loss ratio of 66 percent, a payout of \$2 out of every \$3; homeowners, 72 percent, workers comp insurance, 65 percent. These medical malpractice insurance companies are holding back premiums and not paying them out. It reached a point in my State where our insurance commissioner ordered that they declare a dividend and pay back some of the premiums they had collected from doctors and hospitals when it came to malpractice insurance.

But rather than get lost in statistics, as important as they are, I think it is important that we also talk about the real life stories that are involved in medical malpractice. I hear these terms such as “frivolous lawsuits” and “jackpot justice” and people taking advantage of the system, but let’s not forget the real life stories that lie behind medical malpractice. Let me show my colleagues a picture here of a couple. This is Molly Akers of New Lenox, IL, a lovely young lady, with her husband. Molly Akers had a swelling in her breast and went to her doctor who performed a biopsy that showed she had breast cancer. Molly had several mammograms which found no evidence of a tumor, but the doctors decided that despite the mammograms, she must have a rare form of breast cancer. They recommended a mastectomy, removing Molly Akers’ right breast. After the operation, the doctor called her into the office and said that on further review, she never actually had breast cancer. The radiologist had made a mistake. He reviewed her slides and accidentally switched Molly’s slides with someone else. Molly was permanently disfigured by an unnecessary surgery. She said afterwards:

I never thought something like this could happen to me, but I know now that medical malpractice can ruin your life.

By the way, that other woman whose slides were switched with Molly’s was told she was cancer free. What a horrific medical error that turned out to be.

This next picture is of Glenn Steinberg of Chicago. He went into surgery for the removal of a tumor in his abdomen. Ten days after the surgery, while still in the hospital, Glenn was having severe gastrointestinal problems. The doctors x-rayed his abdomen where the original surgery took place, and they found a 4-inch metal retractor from the surgery lodged against his intestine. A second surgery was performed to remove the metal piece, during which Glenn’s lungs aspirated, and he died later that night.

Glenn’s wife, Mary Steinberg, lost her husband. She said:

Not a day goes by that I don’t miss Glenn’s companionship and the joy he brought to our household. Because of gross negligence, he was not here to support me when my son went off to serve our country in Iraq.

In this photo is a group of kids, including Martin Hartnett of Chicago. When Martin’s mom Donna arrived at the hospital to deliver, her labor wasn’t progressing. Her doctor broke her water and found out that it was abnormal.

Rather than considering a C-section, Donna’s doctor started to administer a drug to induce contractions. Six hours later, she still hadn’t delivered, but her son’s fetal monitoring system began indicating that he was in severe respiratory distress. The doctor finally decided it was time to perform an emergency C-section, but it was another hour before Donna was taken into the operating room.

During that time, the doctor failed to administer oxygen or take immediate steps to help Martin breathe. After he was born, Martin was in the intensive care unit for 3 weeks. Later, Donna learned that Martin had substantial brain damage and cerebral palsy—a direct result of the doctor’s failure to respond to indications of serious oxygen deprivation and delivery in a timely manner.

Donna’s doctor told her not to have any more children because there was a serious problem with her DNA, which could result in similar disabilities in any of her future kids. Since then, Donna has given birth to three perfectly healthy sons.

Donna sued the doctor responsible for Martin’s delivery and received a settlement. She is thankful she has money from the settlement to help cover the costs associated with Martin’s care that aren’t covered by health insurance, such as the wheelchair-accessible van that she bought for \$50,000 and the \$100,000 she spent making changes to her home so her son can get around the house in a wheelchair.

What would Donna have done without the money from that settlement? It is a scary thought because Martin is going to require a lifetime of care. When we put caps on recoveries and say there is an absolute limit to how much someone who has created a problem has to pay out, we have to think about it in terms of real-life stories, such as Martin’s. Martin will live for a long time, and he is going to need help. Somebody needs to be responsible for that. The person who caused this should be responsible for it. That is pretty basic justice in America.

When you establish an artificial cap on noneconomic losses for pain and suffering, then you are saying there is a limit to how much can be paid. I recall the case of a woman in Chicago who went into a prominent hospital—one that I have a great deal of respect for—to have a mole removed from her face—a very simple mole removal. They gave her a general anesthesia. In the course of that anesthesia, they gave her oxy-

gen. The oxygen tank—in the administration of it—caught fire, literally burning off her face. She went through repeated reconstructive surgeries. I have met her. There was scarring and, as you can imagine, a lot of pain. Was \$250,000 too much money for that, for what she went through? Her life will never be the same. That is the kind of disfigurement covered by noneconomic losses that would be limited by medical malpractice caps.

There are better ways to do this. We can, in fact, reduce the cost of medical malpractice insurance. We can, in fact, reduce medical errors. We should not do it at the expense of innocent victims—people who went in, with all the trust in the world, to doctors and hospitals and had unfortunate and tragic results.

Every time I get up to speak on this subject I always make a point of saying—and I will today—how much I respect the medical profession in America. There isn’t one of us in this Chamber, or anyone watching this, who can’t point to men and women in the practice of medicine who are true heroes in their everyday lives, who sacrifice greatly to become doctors, and who work night and day to get the best results for their patients. They richly deserve not only our praise but our respect.

But there are those who make mistakes—serious mistakes. There are innocent victims who end up with their lives changed or lost because of it. We cannot forget them in the course of this debate. This is about more than dollars and cents. It is about justice in this country. I urge my colleagues, when the issue of medical malpractice comes before us, to remember the doctors but not to forget the victims and their families.

I yield the floor.

The PRESIDING OFFICER. The Senator from Texas is recognized.

Mr. CORNYN. Madam President, while our colleague from Illinois is still on the Senate floor, I always enjoy listening to him. He is one of the most effective advocates, and he is an outstanding lawyer. He and I frequently disagree, but I always enjoy listening to his arguments. That isn’t what I came to talk about, but I am glad I happened to be here when he talked about the successful effort we have had in Texas, through medical liability reform laws, to make medical liability insurance more affordable for physicians and, as a consequence, increase the number of doctors who have moved to our State, including rural areas, which has increased the public’s access to good, quality health care. We have seen, in 100 counties, where they didn’t even have an OB-GYN, or obstetrician—a doctor who delivers babies—after medical liability reform, that has changed dramatically, along with a number of other high-risk specialties that have moved to these counties where they were previously afraid to go for risk of litigation and what that might mean to their future and career.

This is an important topic. We will talk about it more. I appreciate the Senator raising the issue. We have a different view about it. If we can save \$54 billion and still allow each of these people who were harmed by medical negligence to recover—which, in fact, they would be under the Texas cap on noneconomic damages—each of these individuals would be able to recover their lost wages, their medical bills, and they would be able to receive large amounts of money for pain and suffering—I am sure not enough to compensate them for what they have been through. But no one should understand that these individuals would somehow be precluded or that the courthouse doors would be shut to people who are victims of medical negligence.

There needs to be some reasonable limitations that will help, in the end, make health care more accessible, which is what we are talking about.

I want to focus briefly on the cuts to Medicare in this new, huge piece of legislation we are considering. Of course, we are told by the CBO that as a result of Medicare cuts and the huge number of tax increases this bill is “paid for.” In other words, assuming the assumptions that the CBO took into account, which span for a 10-year budget window and are almost never true in the end—but if you take it on faith that we are going to raise taxes by  $\frac{1}{2}$  trillion and cut Medicare by  $\frac{1}{2}$  trillion, they say this is a budget-neutral bill—notwithstanding the fact that it spends \$2.5 trillion over 10 years—basically, what we are saying to America’s seniors, those already vested in the Medicare Program, is that we are going to take \$464 billion that would go into the Medicare Program and we are going to use it to create a new government entitlement program.

Our record of fiscal responsibility, when it comes to entitlement programs, is lousy, to say the least. We know Medicare, Social Security, which is another entitlement program, and Medicaid have run up tens of trillions of dollars in unfunded liabilities. Most of them are riddled with fraud, waste, and abuse.

The question I have, and I think many have, is why in the world would you take money out of the Medicare Program that is scheduled to go insolvent in 2017, that has tens of millions of dollars in unfunded liabilities—why would you take  $\frac{1}{2}$  trillion out of Medicare to create yet another entitlement program that, no doubt, will have many of the problems we see now under our current entitlement programs? It just doesn’t make sense, if you are guided by the facts.

Of course, our colleagues on the floor have said: We can cut \$465 billion out of Medicare and, you know what, Medicare beneficiaries would not feel a thing.

Well, I don’t think that is possible when you cut \$135 billion in hospital payments, when you cut \$120 billion out of Medicare Advantage on which 11

million seniors depend, on which they depend for their health care, or when you cut \$15 billion from payments to nursing homes, another \$40 billion in home health care. I think one of the most effective ways of delivering low-cost health care is in people’s homes. You cut \$40 billion from that, and you cut \$8 billion from hospice, which is where people go during their final days in their terminal illness.

Some of my colleagues claim these cuts would not hurt patients, but many people, including me, disagree. As a matter of fact, to quote President Obama’s own Medicare actuary, he said providers might end their participation in the program. In other words, as in Medicare now, in my State, 58 percent of doctors will see a new Medicare patient because reimbursements—payments to providers—are so low, which means that 42 percent will not see a new Medicare patient.

In Travis County, Austin, TX, the last figures showed that only 17 percent of physicians in Travis County will see a new Medicare patient because reimbursement rates are so low. Yet we are going to take money from Medicare to create a new entitlement program. There is no question in my mind that providers—in the words of the Medicare actuary—might be hedging their bets. I think he is hedging his bets. He also said many will end their participation in the program and thus jeopardize access to care for beneficiaries.

We have heard some of the debate earlier about when our side of the aisle made proposals to fix some of the problems with the Medicare Program—not to create a new entitlement program—by taking this amount of money, \$464 billion, from it. When we tried to fix it earlier, some colleagues, including the majority leader, called those cuts immoral and cruel. To quote President Obama on the campaign trail, he was one of those who criticized Senator McCain for some of the proposals he made to try to fix the broken Medicare Program.

As we have heard from a Texas Hospital Association, the Medicare cuts to hospitals simply will not work because—and this is another sort of accounting trick that in Washington, DC, and in Congress people think we can get away with and fool the American people about what is actually happening. People are a lot smarter than I think Members of Congress sometimes give them credit for. Under the Senate bill, the expanded coverage doesn’t start until 2014. But the hospital cuts begin immediately.

I have talked about the broken Medicare Program and, frankly, I think a lot of people would rather see us fix Medicare and Medicaid before we create yet another huge entitlement program that is riddled with fraud, that is on a fiscally unsustainable path, and one that, frankly, promises coverage but ultimately denies access to care because of unrealistically low pay-

ments to providers. We are going to make that worse if this bill passes, not better.

Well, this bill also includes something else that I think the public needs to be very aware of. It uses not only budget gimmicks so that our friends who support this bill can say that it extends the life of the Medicare trust fund for a few years, the problem is it doesn’t solve the fundamental imminent bankruptcy of Medicare. That is one of the reasons the bill sponsored by the distinguished majority leader creates a new, unaccountable, unelectable board of bureaucrats to make further cuts to Medicare Programs.

After the Reid bill pillages Medicare for  $\frac{1}{2}$  trillion, as I said, to pay for a new entitlement, it creates a board of unelected, unaccountable bureaucrats, the so-called Medicare advisory board, which sounds pretty innocuous, but they have been given tremendous power—to meet budget targets—another \$23 billion in the first years alone.

If Congress doesn’t substitute those cuts with other cuts to providers or benefits, the board’s Medicare cuts would go into effect automatically. That would mean Medicare patients, physicians, hospitals, and everyone else who depends on Medicare would have no say in what happens to personal medical decisions because they would just be cut and shut down by this unelected, appointed board.

The government-charted boards of experts we have in existence today are not always right. We may remember the Medicare Payment Advisory Commission, so-called MedPAC, which was created by Congress in 1997, has recommended more than \$200 billion in cost cuts in the last year alone that Congress has not seen fit to order. In other words, this MedPAC board makes recommendations, and Congress is then left with the option in its wisdom to act to make those cuts. Congress has said no to the tune of \$200 billion in the last year alone.

Then there is another relatively notorious board of experts—unaccountable, faceless, nameless bureaucrats—that we have learned a little bit about in the last few days: the U.S. Preventive Services Task Force. They are supposed to recommend preventive services but just recently said that women under the age of 50 do not need a mammogram to screen for breast cancer. Respected organizations, such as the American Cancer Society and the Komen Advocacy Alliance, disagree based on their own rigorous review of the latest medical evidence.

As the father of two daughters, I can tell you, I do not want my wife or my daughters restricted in their access to diagnostic tests that may save their lives if their doctor recommends, in his or her best medical judgment, that they get those tests. Yet what we will have in the future, if the medical advisory board is passed, is an unelected, unaccountable board of bureaucrats

that can make cuts, based on expert advice, which will ultimately limit access to diagnostic tests, including tests such as mammograms, which became very controversial. The Secretary of Health and Human Services came out immediately and said: We will never allow that to go into effect.

Not even the Secretary of Health and Human Services, under this provision, could reverse the decision of this unelected, unaccounted board which may well—I would say probably will in some cases—limit a person's access to diagnostic tests and procedures that could save their life even though their personal physician, in consultation with that patient, may say: This is what you need. When you give that power to the government, not only to render expert advice but then to decide whether to pay or not to pay for a procedure, then the government—namely, some bureaucrat in Washington, DC—is going to make the decisions based on a cost-benefit analysis.

OK, on a cost analysis, we can afford, according to the decision of the U.S. Preventive Services Task Force, to lose women to breast cancer—women between the age of 40 and 49—because we don't think they need a mammogram. And on a cost-benefit analysis, they may say: Tough luck. But that is not where we should go with this legislation.

Many health care providers are concerned about the Medicare Payment Advisory Commission. According to a letter from 20 medical specialty groups, they said:

We are writing today to reiterate our serious concerns with several provisions that were included in the health care reform bill . . . and to let you know that if these concerns are not adequately addressed when the health care reform package is brought to the Senate floor, we will have no other choice but to oppose the bill.

Included in those concerns was the “establishment of an Independent Medicare Commission whose recommendations could become law without congressional action . . .”

According to a letter from the American Medical Association today:

AMA policy specifically opposes any provision that would empower an independent commission to mandate payment cuts for physicians. . . . Further, the provision does not apply equally to all health care stakeholders, and for the first four years significant portions of the Medicare program would be walled off for savings. . . .

This is an example of another trade association that basically decided to cut a deal with the administration behind closed doors, and they have been prevented from some of these cuts under this Medicare Commission while physicians have not been accorded similar treatment, and they do not think it is fair. They think it is unfair, and I agree with them.

This letter goes on to say:

In addition, Medicare spending targets must reflect appropriate increases in volume that may be a result of policy changes, innovations that improve care, greater longevity,

and unanticipated spending for such things as influenza pandemics. These are critical issues with the potential for significant adverse consequences for the program, which must be properly addressed through a transparent process that allows for notice and comment.

Sounds to me as if the American Medical Association thinks this is a lousy idea, and I agree with them.

Artificial budget targets that the Medicare advisory board would have to meet leave virtually no room for medical innovation. It is unbelievable what medical science in America and across the world has done to increase people's quality of life—their longevity as a result of heart disease, for example. People who would have died in the seventies are today living healthy because they are taking prescription medications to keep their cholesterol in check, and they have access to innovative surgical procedures, such as stents and other things that can not only improve their quality of life but their longevity as well.

If we have the Medicare advisory board saying: We are not going to pay for some of these things, it will crush medical innovation and have a direct impact on quality of life and longevity. What if we find a cure for Alzheimer's in 2020, but because this board says: It is too expensive, we are not going to pay for it, you are out of luck. What if there are things we cannot anticipate today, which we know there will be because who ever heard of the H1N1 virus or swine flu just a year ago?

Some of my colleagues have said an “independent board,” such as the Medicare advisory board, would insulate health care payment decisions from politics. But the very charter of the Medicare advisory board was the result of a deal cut behind closed doors with the White House, a political deal, and it has a lot of reasons why, as we can tell, I don't think it is going to work well.

According to Congress Daily:

Hospitals would be exempt from the [board's] ax, according to the committee staff and hospital representatives, because they already negotiated a cost-cutting agreement with [the chairman of the Finance Committee] and the White House. “It's something that we worked out with the committee, which considered our sacrifices,” said Richard Coorsh, spokesman for the Federation of American Hospitals. A committee aide and a spokeswoman for the American Hospital Association reiterated that hospitals received a pass—

They were protected from 4 years of cuts—

based on the \$155 billion cost-cutting deal already in place.

Is that the kind of politics we want to encourage behind closed doors—deals cut to protect one sector of the health care industry and sacrifice another while denying people access to health care? That is the kind of politics I would think we would want to avoid.

The truth is, the Reid bill gives more control over personal health decisions

to Washington, DC, where politics will always play a role in determining winners and losers when the government is in control because people are going to come to see their Members of Congress and say: Will you help us? We are your constituents. And Members of Congress are always going to try to be responsive, if they can, within the bounds of ethics to their constituents.

This needs to be not a process that is dictated by politics but on the merits and on the basis of preserving the sacred doctor-patient relationship. If we really want to insulate health care from politics, we need to give more control to patients—to patients, to families, to mothers and fathers, sons and daughters—to make health care decisions in consultation with their physician, not nameless, faceless, unaccountable bureaucrats.

I filed an amendment to completely strike the Medicare advisory board from the Reid bill. I urge my colleagues to support it at the appropriate time. The Medicare advisory board empowers bureaucrats to make personal medical decisions instead of patients, whose power to determine their own future, in consultation with their doctor, we ought to be preserving.

The Medicare advisory board is an attempt to justify the \$½ trillion pilaging of Medicare from America's seniors to create a new entitlement program. We should fix Medicare's nearly \$38 trillion in unfunded liabilities, not steal from a program that is already scheduled to go insolvent in 2017.

At a time of insolvent entitlement programs, record budget deficits, and unsustainable national debt, this country simply cannot afford a \$2.5 trillion spending binge on an ill-conceived Washington health care takeover.

I yield the floor.

Mr. GREGG addressed the Chair.

The PRESIDING OFFICER. The Senator from New Hampshire.

Mr. GREGG. Madam President, it is the tradition in this body that a person seeking recognition gets recognized, is it not?

The PRESIDING OFFICER. It is, and I say the Senator from California was here earlier.

Mrs. FEINSTEIN. If I might, Madam President, my understanding was we alternate, go from side to side. I have been sitting here waiting.

Mr. GREGG. Madam President, I believe I have the floor.

The PRESIDING OFFICER. The Senator from New Hampshire.

Mr. GREGG. Madam President, I ask unanimous consent that at the conclusion of remarks of the Senator from California, I be recognized.

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

The Senator from California.

AMENDMENT NO. 2791

Mrs. FEINSTEIN. Madam President, I admire the Senator's gentility. I thank him very much.

I rise to say a few words on behalf of the Mikulski amendment, but before I do, I wish to make a generic statement.

Those of us who are women have essentially had to fight for virtually everything we have received. When this Nation was founded, women could not inherit property and women could not receive a higher education. In fact, for over half this Nation's life, women could not vote. It was not until 1920, after perseverance and demonstrating, that women achieved the right to vote. Women could not serve in battle in the military, and today we now have the first female general. So it has all been a fight.

Senator MIKULSKI and Senator BOXER in the House in the 1980s carried this fight. Those of us in the 1990s who came here added to it. You, Madam President, have added to it in your remarks earlier. The battle is over whether women have adequate prevention services provided by this bill. I thank Senator MIKULSKI and Senator BOXER for their leadership and for their perseverance and their willingness to discuss the importance of preventive health care for women. Also, I thank Senator SHAHEEN, Senator MURRAY, and Senator GILLIBRAND, joined by Senators HARKIN, CARDIN, DODD, and others, for coming to the floor and helping women with this battle.

The fact is, women have different health needs than men, and these needs often generate additional costs. Women of childbearing age spend 68 percent more in out-of-pocket health care costs than men. Most people don't know that, but it is actually true. So we believe all women—all women—should have access to the same affordable preventive health care services as women who serve in Congress, no question. The amendment offered by Senator MIKULSKI—and she is a champion for us—will ensure that is, in fact, the case. It will require insurance plans to cover at no cost basic preventive services and screenings for women. This may include mammograms, Pap smears, family planning, screenings to detect postpartum depression, and other annual women's health screenings. In other words, the amendment increases access to the basic services that are a part of every woman's health care needs at some point in her life.

Let me address one point because there is a side-by-side amendment submitted by the Senator from Alaska. Nothing in our bill would address abortion coverage. Abortion has never been defined as a preventive service. The amendment could expand access to family planning services—the type of care women need to avoid abortions in the first place.

As I mentioned, the Senator from Alaska has offered an alternative version of this proposal. But regardless of the merits or problems with her proposal, it remains a kind of budget buster. According to the CBO, the amendment would cost \$30.6 billion over 10 years. Adopting this amendment would require us to spend some of the surplus raised by the CLASS Act or some of the budget surpluses in the bill. The

underlying bill, as written, reduces the budget deficit by \$130 billion in the first 10 years and as much as \$650 billion in the second 10 years. This is a very important thing, in my view, and we need to maintain these savings. The Mikulski amendment would do that. It costs \$940 million over 10 years as opposed to the \$24 billion to \$30 billion in the Murkowski amendment.

The Mikulski amendment is, I believe, the best way to expand access to preventive care for women, while keeping this bill fiscally responsible.

We often like to think of the United States as a world leader in health care, with the best and the most efficient system. But the facts actually do not bear this out. The United States spends more per capita on health care than other industrialized nations but in fact has worse results. According to the Commonwealth Fund, the United States ranks No. 15 in avoidable mortality. That means avoidable death. This analysis measures how many people in each country survive a potentially fatal yet treatable medical condition. The United States lags behind France, Japan, Spain, Sweden, Italy, Australia, Canada, and several other nations.

According to the World Health Organization, the United States ranks No. 24 in the world in healthy life expectancy. This term measures how many years a person can expect to live at full health—robust health. The United States again trails Japan, Australia, France, Sweden, and many other countries.

These statistics show we are not spending our health care resources wisely. The system is failing to identify and treat people with conditions early on that can be controlled. Part of the answer, without question, is expanding coverage. Too many Americans cannot afford basic health care because they lack basic health insurance. But another piece of the puzzle is ensuring this coverage provides affordable access to preventive care—the ability to be screened early—and that is what the Mikulski amendment will accomplish.

Women need preventive care—screenings and tests—so that potentially serious or fatal illnesses can be found early and treated effectively. We all know individuals who have benefited from this type of care—a mammogram that suddenly identifies an early cancer before it has spread or before it has metastasized; a Pap smear that finds precancerous cells that can be removed before they progress to cancer and cause serious health problems; cholesterol testing or a blood pressure reading that suggests a person might have cardiovascular disease which can be controlled with medication or lifestyle changes. This is how health care should work—a problem found early and addressed early. The Mikulski amendment will give women more access to this type of preventive care.

Statistics about life expectancy and avoidable mortality can make it easy to forget that we are talking about real patients and real people who die too young because they lack access to health care. Physicians for Reproductive Choice and Health shared the following story, which comes from Dr. William Leininger in California, and here is what he says:

In my last year of residency, I cared for a mother of two who had been treated for cervical cancer when she was 23. At that time, she was covered by her husband's insurance, but it was an abusive relationship and she lost her health insurance when they divorced. For the next 5 years, she had no health insurance and never received follow-up care, which would have revealed that her cancer had returned. She eventually remarried and regained health insurance, but by the time she came back to see me, her cancer had spread. She had two children from her previous marriage, and her driving motivation during her last rounds of palliative care was to survive long enough to ensure that her abusive ex-husband wouldn't gain custody of her children after her death. She succeeded. She was 28 years old when she died.

Cases like these explain why the United States trails behind much of the industrialized world in life expectancy. For this woman, divorce meant the loss of her health coverage, which meant she could not afford followup care to address her cancer—a type of cancer that is often curable if found early. And that is where prevention comes in. So this tragic story illustrates the need to improve our system so women can still afford health insurance after they divorce or lose their jobs. And it shows why health reform must adequately cover all the preventive services women need to stay healthy.

The Mikulski amendment is a fight—I am surprised, but it is a fight—but it will help expand access to preventive care while keeping the bill fiscally responsible. To me, it is a no-brainer. If you can prevent illness, you should. In and of itself it will end up being a cost savings. So I have a very difficult time understanding why the other side of the aisle won't accept a measure that is more fiscally responsible by far than their measure, will do the job, and will give women preventive care and begin to change that statistic which shows that, among other nations, we do so badly.

I thank the Presiding Officer for coming to the floor and speaking out on this, and I hope there are enough people in this body who recognize that virtually everything women have gotten in history has been the product of a fight, and this is one of those.

I yield the floor.

The PRESIDING OFFICER (Mr. CARDIN). The Senator from New Hampshire.

Mr. GREGG. Mr. President, I ask unanimous consent that the next Republican speaker be the Senator from Louisiana, Senator VITTER.

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

Mr. GREGG. Mr. President, at this point I rise to speak generally about

the bill and specifically about this Medicare proposal—the proposal in the bill and the motion that has been offered by Senator McCain, which I think is an excellent idea.

Let's start with the size of this bill. It is unusual that we would be considering a bill of this size and not have had more time to take a look at it, but the bill itself—and I am glad that the chairman of the Finance Committee has essentially agreed with this earlier today—costs \$2.5 trillion when it is fully implemented—\$2.5 trillion. When my budget staff took a look at this bill—and we only had a brief time to do it, obviously, last week—and came up with that number, people on the other side of the aisle said, regrettably: No, that is a bogus number. The number is \$840 billion, it is not a \$2.5 trillion bill. However, it is \$2.5 trillion when it is fully implemented. When the programmatic activity of this bill is under full steam, over a 10-year period, it will cost over \$2.5 trillion. That is huge—huge.

In an earlier colloquy, I heard the chairman of the Finance Committee—who does such a good job as chairman—make the point: Well, it is fully paid for. It is fully paid for in each 10-year period. That is true, literally. I give him credit for that. But two questions are raised by that fact. The first is this: Why would you expand the Federal Government by \$2.5 trillion when we can't afford the government we have?

The resources that are being used to pay for this, should they ever come to fruition, are resources which should probably be used to make Medicare solvent or more solvent or, alternatively, to reduce our debt and deficit situation, as we confront it as a nation. We know for a fact that every year for the next 10 years—even before this bill is put in place—we are going to run a \$1 trillion deficit every year, because that is what President Obama has suggested. We know for a fact that our public debt is going to go from 35 percent of our gross national product up to 80 percent of our gross national product within the next 6 years without this bill being passed. We know we are in a position where we are headed down a road which is basically going to hand to our children a nation that is fiscally insolvent because of the amount of debt put on their back by our generation through spending and not paying for it.

So why would we increase the government now by another \$2.5 trillion when we can't afford the government we have? That is the question I think we have to ask ourselves. Isn't there a better way to try to address the issue of health care reform without this massive expansion of a new entitlement—creating a brandnew entitlement which is going to cost such an extraordinary amount of money and dramatically expand Medicaid, which is where most of the spending comes from in this bill—a massive expansion of Medicaid and a

massive new entitlement created that we don't have today?

This bill, when it is fully implemented, will take the size of the Federal Government from about 20 percent of GDP or a little less—where it has historically been ever since the post-World War II period—up to about 24 or 25 percent of GDP. To accomplish that, and claim you are not going to increase the deficit, requires a real leap of faith. Because it means that to pay for this—and this is why the McCain motion is so important—you are going to have to reduce Medicare spending by \$1 trillion, when this bill is fully implemented—\$1 trillion over a 10-year window. In fact, during the period from 2010 to 2029, Medicare spending will be reduced in this bill by \$3 trillion.

Those dollars will not be used to make Medicare more solvent. And we know we have serious problems with Medicare. Those dollars will be used to create a brandnew entitlement and to dramatically increase the size of government for people who do not pay into the hospital insurance fund; for people who have not paid Medicare taxes, for the most part but, rather, for a whole new population of people going under expanded Medicaid and people getting this new entitlement under the public plan. So if you are going to reduce Medicare spending in the first 10 years by \$450 billion, and the second 10 years fully implemented—there is some overlap there, but fully implemented \$1 trillion, and then over a 19-year period, the two decades, by \$3 trillion, instead of using those monies—those seniors' dollars—to try to make Medicare more solvent, they are going to be used for the purposes of expanding and creating a new entitlement and expanding Medicaid.

This is hard to accept as either being fair to our senior population or being good policy from a fiscal standpoint. Why is that? Because if we look at the Medicare situation, we know Medicare as it is structured today has an unfunded liability of \$55 trillion—\$55 trillion. That means in the Medicare system we do not know how we are going to pay \$55 trillion worth of benefits we know we are now obligated for.

The answer we get from the other side of the aisle is: Well, this \$55 trillion number goes down, because this bill cuts Medicare and, therefore, the benefit structure reduces. But do the revenues, or the reduction in that, go toward the purpose of making Medicare more solvent? No. Those monies are taken and spent. Those monies are taken and used to create a larger government. They aren't used to reduce the deficit or to reduce the debt, all of which is being driven, in large part, by this \$55 trillion worth of unfunded liability as we go forward. No, they are being used to create a brandnew entitlement which has nothing to do with seniors, and a brandnew entitlement which is going to be paid for, in large part, by seniors, or by a reduction in their benefit structure.

That makes very little sense, because essentially you are taking money out of the Medicare system and using it to expand the government, when in fact what we should be doing, if you are going to take money out of the Medicare system, is you should be using it to reduce the obligations of the government—the debt obligation—so the Medicare system becomes more affordable. That is not the goal here, however.

Then, of course, there is the practical aspect of this. We know these types of proposals are plug numbers to a great degree, because we know this Congress is not going to stand up to a \$½ trillion cut in Medicare over the next 10 years and a \$3 trillion cut in Medicare over the next 20 years. Why do we know that? I know it from personal experience. I was chairman of the Budget Committee the last time we tried to address the fact that we have an out-year liability in Medicare that is not affordable—this \$55 trillion number. We know it is not affordable. We know we have to do something about it. So I suggested, when I was chairman of the Budget Committee, that we reduce Medicare spending, or its rate of growth—not actual spending, its rate of growth—by \$10 billion over a 5-year period, less than 1 percent of Medicare spending. My suggestion was that we do that by requiring—primarily we get most of that money by requiring senior citizens who are wealthy to pay a reasonable proportion of their Part D premium and then take those moneys and basically try to make Medicare a little more solvent with it. We got no votes from the other side of the aisle—none, zero—on that proposal.

Now they come forward with a representation that they are going to reduce Medicare spending and benefits to seniors by \$3 trillion over the next 20 years and \$400-some-odd billion over the next 10 years, and they expect this to be taken seriously? Of course not. This is all going to end up being unpaid-for expenditures in expansion of these programs.

These brandnew entitlements that are being put in this bill and this expansion of other entitlements that do not deal with Medicare, by the way, are going to end up being in large part paid for by creating more debt and passing it on to our children. As I mentioned earlier, that is a fairly big problem for our kids. They are going to get a country, as it is today, that has about \$70 trillion in unfunded liability just in the Medicare and Medicaid accounts, to say nothing of the other deficits we are running up around here. Now we are going to throw another huge amount on their backs.

Some percentage of this \$2.5 trillion—probably a majority of it—will end up being added to the deficit and debt as we move out into the outyears even though it is represented that it is not going to be. The only way you can claim you are going to pay for this, of course, is with these Medicare cuts and

these tax increases that are in this bill, and these fee increases. We are going to spend a little time on the tax increases and fee increases and the speciousness of those proposals, but right now we are focusing on Medicare.

In any event, what we have is a bill that takes government and explodes its size. We already have a government that is pretty big—20 percent of our economy. You are exploding it to 24 percent of our economy, and then you are saying you are going to pay for that by dramatically reducing Medicare spending? It does not make any philosophical sense, and it certainly does not pass the test of what happens around here politically.

In addition, there is the issue of how this bill got to a score in the first 10 years that made it look as if it was more fiscally responsible. I have heard people from the other side. Again, I respect the chairman of the Finance Committee for acknowledging that this bill, when fully implemented, is a \$2.5 trillion bill. But a lot of folks are claiming this is just an \$843 billion bill, that is all it is in the first 10 years, that is all it costs. There are so many major budget gimmicks in this bill that accomplish that score that Bernie Madoff would be embarrassed—embarrassed by what this bill does in the area of gamesmanship.

Let's start with the fact that it begins most of the fees, most of the taxes, and most of the Medicare cuts in the first year of the 10 years, but it does not begin the spending on the new program, the new entitlements, until the fourth and fifth year. So they are matching 4 and 5 years of spending against 10 years of income and Medicare cuts and claiming that therefore there is a balance.

Ironically, it is represented and rumored—and I admit this is a rumor—that originally they were going to start the spending in the third year under this bill. Of course, nobody knew what the bill was because it was written in private and nobody got to see it. But then they got a score from CBO that said it didn't work that way, so they simply moved the spending back a year and started it in the fourth year. They sent it back to CBO, and CBO said: If you take a year of spending out in the 10 years and you still have the 10 years of income from the taxes, fees, and cuts in Medicare, you get a better score. We will give you a better score. You will get closer to balance. It is a pretty outrageous little game of hide the pea under the shell.

This is probably the single biggest—in my experience, and I have been on the Budget Committee for quite a while—in my experience, it is the single biggest gaming of the budget system I have ever seen around here. But it is not the only one; there is something here called the CLASS Act.

Mr. HATCH. Will the Senator yield?

Mr. GREGG. I will be happy to yield to the Senator from Utah for purposes of a question.

Mr. HATCH. What is the current cost of our health care across the board in this country, without this bill?

Mr. GREGG. It is about 16 to 17 percent of our gross national product.

Mr. HATCH. That is \$2.5 trillion?

Mr. GREGG. That is correct.

Mr. HATCH. The Senator is saying they are going to add, if you extrapolate it out over another 10 years, \$2.5 trillion.

Mr. GREGG. It takes the spending from 16 to 17 percent to about 20 percent of GDP.

Mr. HATCH. If I understand my colleague correctly, he is saying, to reach this outlandish figure of \$843 billion, literally they do not implement the program until 2014 and even beyond that to a degree, but they do implement the tax increases?

Mr. GREGG. The Senator from Utah, of course, being a senior member of the Finance Committee, is very familiar with those numbers, and that is absolutely correct.

Mr. HATCH. Is that one of the budget gimmicks my colleague is talking about?

Mr. GREGG. I think that is the biggest in the context of what it generates in the way of Pyrrhic, nonexistent savings because it basically says we are really not spending—because it doesn't fully implement the plan in the first year, it says we are not spending that much money. In fact, we know that when the plan is fully implemented, it is a \$2.45 trillion not a \$840 billion bill.

Mr. HATCH. Am I correct that the Democrats have said—and they seem to be unified on this bill—that literally this bill is budget neutral? But as I understand it, in order to get to the budget neutrality, they are socking it to a program that has about \$38 trillion in unfunded liabilities called Medicare—to the tune of almost \$500 billion or \$½ trillion in order to pay for this? Am I correct on that? No. 2, who is going to lose out when they start taking \$500 billion out of Medicare? And what are they going to do with that \$500 billion? Are they going to put it into something else? Are they using this just as a budgetary gimmick? What is happening here? As the ranking member on the Budget Committee today, you really could help all of us understand this better.

Mr. BAUCUS. Will the Senator yield for a question?

Mr. GREGG. If I can first answer the question of the Senator from Utah, and then I will be happy to answer the chairman of the Finance Committee.

The Senator from Utah basically is correct in his assumption. Essentially, they are claiming an approximately \$400-some-odd billion savings in Medicare over 10 years which they are then using to finance the spending in this bill over the last 5 years, 5 to 6 years of the 10-year window. In the end, after you fully implement this bill and you fully implement the Medicare cuts, it represents \$3 trillion of Medicare reductions over a 20-year period.

Where does it come from? It comes from two different accounts, primarily. One is, just about anybody who is on Medicare Advantage today—about 25 percent of those people will probably completely lose their Medicare Advantage insurance, and it is 12,000 people in New Hampshire, so say 4,000 people.

Mr. HATCH. How many people on Medicare are on Medicare Advantage?

Mr. GREGG. I believe 11 million people.

Mr. HATCH. That will be what percentage of people on Medicare?

Mr. GREGG. About 25 percent of those people will lose their Medicare insurance under this proposal, mostly in rural areas. And second, because there is \$160 billion of savings scored. You can't save that type of money in Medicare Advantage unless people don't get the Medicare Advantage advantage.

Second, it comes in significant reductions in provider payments. How do provider payments get paid for when they are cut, I ask the Senator from Utah. I suspect it is because less health care is provided.

Mr. HATCH. How does that affect the doctors?

Mr. GREGG. It certainly affects the hospitals, and it probably affects the doctors. I have heard the Senator from Montana say they are going to straighten out the doctor problem down the road, but that is another \$250 billion of spending which we don't know where they are going to get the money from. But, yes, it would affect, in my opinion, all providers—doctors, hospitals, and other people who provide health care to seniors. You cannot take \$450 billion out of the Medicare system and not affect people's Medicare.

Mr. HATCH. Am I wrong in saying Medicare is already headed toward insolvency and that it has up to almost \$38 trillion in unfunded liability over the years for our young people to have to pay for?

Mr. GREGG. The Senator from Utah is correct again. The Medicare system is headed toward insolvency, and it goes cash-negative in 2013, I believe—maybe it is 2012—in the sense that it is paying out less than it takes in, and it has an unfunded liability that exceeds, actually, \$38 trillion now. I think it is up around—

Mr. HATCH. Then how can our friends on the other side take \$½ trillion out of Medicare, which is headed toward insolvency, to use for some programs they want to now institute anew?

Mr. GREGG. I think the Senator from Utah has asked one of the core questions about this bill. Why would you use Medicare savings, reductions in Medicare benefits, which will definitely affect recipients, for the purposes of creating a new program rather than for the purposes of making health care more solvent if you are going to do that in the first place? And are these savings ever going to really come about? One wonders about that also.

Mr. HATCH. I heard someone say today on the floor—I don't know who it was, I can't remember—that Medicare Advantage really isn't part of Medicare. Is that true?

Mr. GREGG. Actually, I would yield to the Senator from Utah on that issue—not the floor but yield on that question because I think the Senator from Utah was there when Medicare Advantage was drafted as a law.

Mr. HATCH. I was there in the Medicare modernization conference, along with the distinguished chairman of the committee, Senator BAUCUS, and others, when we did that because we were not getting health care to rural America. The Medicare+Choice plan didn't work. Doctors would not take patients. Hospitals could not pay; they could not take patients. There were all kinds of difficulties in rural America. So we did Medicare Advantage, and all of a sudden we were able to take care of those people. Yes, it costs a little more, but that is because we went into the rural areas to do it.

But this would basically decimate Medicare Advantage, wouldn't it, what is being proposed here? And that is part of Medicare.

Mr. GREGG. I believe it is a legal part of Medicare, Medicare Advantage.

Mr. HATCH. No question about it.

Mr. GREGG. And this would have a massively disruptive effect on people who get Medicare Advantage because you are going to reduce it—the scoring is there will be a reduction in Medicare Advantage payments of approximately \$162 billion, I believe it is, and there is no way you are going to keep getting the advantages of Medicare Advantage if you have that type of reduction in payments.

Mr. HATCH. How can they take \$½ trillion out of Medicare? That is not all Medicare Advantage. Medicare Advantage is only part of that, the deductions they will make there. But how can they do that and still run Medicare in a solvent, constructive, decent, and honorable fashion?

Mr. GREGG. If the Senator will allow me to respond, the problem here is we have rolled the Medicare issue into this major health reform bill—or the other side has—and they have used Medicare as a piggy bank for the purposes of trying to create a brandnew entitlement which has nothing to do with senior citizens. Yes, Medicare needs to be addressed. It needs to be reformed. The benefit structure probably has to be reformed. But we should not use those dollars for the purposes of expanding the government with a brandnew entitlement. We should use those dollars to shore up Medicare so we don't have this massive insolvency.

Mr. HATCH. You mean they are not using this \$500 billion to shore up Medicare and to help it during this period of possible insolvency with a \$38 trillion unfunded liability? They are not using it for that purpose?

Mr. GREGG. That is correct.

Mr. HATCH. For what purpose are they using it?

Mr. GREGG. They are using to fund the underlying bill, and the underlying bill expands a variety of initiatives in the area of Medicaid and in the area of a brandnew entitlement for people who are uninsured to subsidize the government plan.

Mr. HATCH. You were going to talk about the CLASS Act.

Mr. GREGG. The CLASS Act is another classic gimmick of budgetary shenanigans which I would like to speak to, briefly. I know the Senator from Montana had a question or maybe he has gone past that point and we have answered all his questions. I can move on to the CLASS Act.

Mr. BAUCUS. I would like to hear you talk about the CLASS Act. I am no fan of the CLASS Act myself so why don't you proceed.

Mr. GREGG. I thank the Senator for his forthrightness on that. The CLASS Act needs to be explained. It is a great title. We come up with these wonderful “motherhood of titles.” We attach them to things and then suddenly they take on a persona that has no relationship to what they actually do. The CLASS Act is a long-term care insurance program which will be government run. It is another takeover of private sector activity by the Federal Government. But what is extraordinarily irresponsible in this bill is, we all know in long-term care insurance that you buy it when you are in your thirties and your forties. You probably don't buy it when you are in your twenties. You buy it in your thirties, forties, and fifties. You start paying in premiums then. But you don't take the benefits. The cost of those insurance products don't incur to the insurer until people actually go into the retirement home situation, which is in their late sixties and seventies, most likely eighties in our culture today, where many people are working well into their seventies. So there is a large period of people paying in, and then 30 or 40 years later, they start to take out.

What has happened in this bill, which is a classic Ponzi scheme—in fact, ironically, the chairman of the Budget Committee did call it a Ponzi scheme, the Senator from North Dakota, Mr. CONRAD—they are scoring these years when people are paying into this new program and, because the program doesn't exist, everybody who pays into it, starting with day one, the beneficiaries of that program aren't going to occur until probably 30 or 40 years later. They are taking all the money that is paid in when people are in their thirties, forties, fifties, and sixties as premiums. They are taking that money and they are scoring it as revenue under this bill and they are spending it on other programmatic initiatives for the purposes of claiming the bill is balanced. It adds up to about \$212 billion over that 20-year period, 2010 to 2029.

OK. So you spend all the premium money. What happens when these people do go into the nursing home, do require long-term care when they become

75, 80, 90 years old? There is no money. It has been spent. It has been spent on something else, on a new entitlement, on expanding care to people under Medicaid, on whatever the bill has in it. So we are going to have this huge bill that is going to come due to our kids one more time. We already are sticking them with \$12 trillion of debt right now, and we are going to raise the debt ceiling, sometime in the next month, to, I don't know what it is going to be, but I have heard rumors it may be as high as 13 more trillion. We know we have another \$9 trillion of debt coming at us just by the budgets projected for the next 10 years. Now we are going to, 30 years from now, have this huge bill come in as the people who decided to buy into the CLASS Act suddenly go into the retirement home. There will not be any money there for them. It is gone. It will have been spent by a prior generation to make this bill balanced.

The CLASS Act has been described as a Ponzi scheme relative to its effect on the budget. It is using dollars which should be segregated and protected under an insurance program. If this were an insurance company, for example, they would actually have to invest those dollars in something that would be an asset which would be available to pay for the person when they go into the nursing home so they are actuarially sound. But that is not what happens under this bill. Under this bill, those dollars go out the door as soon as they come in for the purposes of representing that this bill is in fiscal balance. It is not. It is not in fiscal balance, obviously.

Even if you were to accept these incredible activities of budgetary gimmickry, the fundamental problem with this bill is it grows the government by \$2.5 trillion, and we can't afford that when we already have a government that well exceeds our capacity to pay for it. Inevitably, we will pass on to these young pages, as they go into their earning careers and raise their families, a government that is so expensive, they will be unable to buy a home, send their kids to college or do the things they wish to do that give one a quality of life.

I have certainly taken more than my fair share of time at this point. The Senator from Louisiana was going to go next.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, it has been a very interesting discussion, listening to the Senator from New Hampshire. Several points. One, the underlying bill is clearly not a net increase in government spending on health care. The numbers are bandied about by those on the other side—\$1 trillion, \$2.5 trillion, et cetera. I do acknowledge and thank the Senator from New Hampshire for saying, yes, it is all paid for. He did say that. He did agree this is all paid for. So I just hope when other Senators on that side of the aisle

start talking about this big cost, \$1 trillion, \$2 trillion, whatever, that they do admit it is paid for. The ranking member of the Senate Budget Committee flatly said: Yes, it is all paid for. I would hope other Members on that side of the aisle heed the statement of the Senator from New Hampshire, ranking member of the Senate Budget Committee, for saying it is all paid for.

But don't take my word for it or his word. It is what the CBO says. In fact, let me quote from a letter to Senator REID not too long ago:

The CBO expects that during the decade following the 10-year budget window, the increases and decreases in Federal budgetary commitment to health care stemming from this legislation would roughly balance out so that there would be no significant change in that commitment.

That is, a commitment to health care, to government health care spending, no change basically. It is flat. Although it is a little better than flat because the subsequent CBO letter has said the underlying bill achieves about \$130 billion in deficit reduction over 10 years and one-quarter of a percent of GDP reduction in the next 10 years. The Senator from New Hampshire talks about large deficits this country is facing. That is true. Frankly, all of us in the Senate have a responsibility to try to reduce that budget deficit as best and as reasonably as we possibly can. Bear in mind, this underlying health care bill helps reduce the budget deficit. Sometimes people on the other side like to suggest that \$1 trillion over 10 years will add to the budget deficit. Again, we have definitely established it does not add to the budget deficit at all, not one thin dime.

In addition, we actually reduce the budget deficit through health care reform, through this underlying legislation. We all know the Medicare trust fund is in jeopardy, in part, because baby boomers are retiring more but also because health care costs are going up at such a rapid rate. That is health care costs for everybody. It is health care costs for me, for every Senator, for every senior, for businesses. Let's not forget, we spend in America about 60 percent more per person on health care than the next most expensive country, about 50 to 60 percent more per person. The trend is going in the wrong direction. We are going to spend about \$33 trillion in America on health care over the next 10 years. That is going to be somewhat evenly divided between public expenditures and private. Every other country in the world has figured out ways to limit the rate of growth of increase in health care spending. We haven't. We are the only industrialized country—in fact, developing country—that hasn't figured out how to get some handle on the rate of growth of increase in health care spending.

One could say: Gee, let's forget about it. Just let the present trend continue. We all bandy about different figures.

One I am fond of at least remembering is the average health care insurance policy in America today costs about \$13,000. If we do nothing over 8 years, it will be \$30,000. That is a much higher rate of increase than income for Americans. It means the disparity between wages of the average American and what they are paying on health care will widen all the more if we do nothing. We have to do something. This legislation is a good-faith effort to begin to get a handle on the rate of growth of spending in this country.

The Senator from New Hampshire was being honest, frankly. Some on the other side are being not quite so honest. He is basically saying: Yes, it is true we are not cutting beneficiary cuts, although he talks about Medicare Advantage. Let me point out that there is nothing in this legislation that requires any reductions in any beneficiary cuts. In fact, guaranteed benefits under Medicare are expressly not to be cut under the express language of this bill. The portion we are talking about is Medicare Advantage. The fact is, there is nothing in this bill that requires any cuts at all in Medicare Advantage payments. Those Medicare Advantage payments are in addition to the guaranteed Medicare payments, such as gym memberships, things such as that which are not part of traditional Medicare.

Why do I say there is nothing in there that requires cuts for those extras? That is because the decision on what benefits or what extras Medicare Advantage plans have to give the guaranteed benefits, that is by law. But the decision as to what extras should go to their members is a decision based not upon us in the government, in Congress, not upon the HHS Secretary; it is based on the corporate officers of these companies. They are overpaid, Medicare Advantage plans, right now. Everybody knows they are overpaid. Even they, privately, will tell you they are overpaid. They are overpaid based upon legislation that Congress passed in 2003, the Medicare Part D, by setting these high benchmarks. They are overpaid. The MedPAC commission also said they are overpaid to the tune of about between 14 and 18 percent. So the reductions that are provided for in this bill, in Medicare Advantage plans, the effect of those reductions is up to the officers of those plans.

They could cut premiums people otherwise pay. They could cut benefits to help themselves, help their salaries. They could cut stockholders. They could cut administrative costs.

They can decide what they want to do. That is solely a decision of the executives of Medicare Advantage plans. Private insurance plans is what they are. They are private insurance plans, so there is nothing here that says the fringes, the extras, have to be cut at all. Those executives could keep those fringes and maybe have a little less return to their stockholders or maybe make some savings in their adminis-

trative costs, maybe not increase their salaries. There is nothing here that requires those fringes, those extras, to be cut, nothing whatsoever.

The Senator from New Hampshire says: Oh, it is about \$400 billion to \$500 billion of reduced payments to providers in this legislation. That is true. Well, let's look and see what the consequences of that are. First of all, that means the Medicare trust fund's solvency is extended. It is more flush with cash. I would think all Senators here would like to extend the life of the Medicare trust fund. A good way to do that is by what we are doing in this bill, saving about \$450 billion over 10 years that otherwise would be paid to Medicare providers is not being paid, and those benefits inure to the trust fund.

There is no dispute—none whatsoever—that this legislation extends the life of the Medicare trust fund by another 5 years. That is because of those changes in the structure and also because there are no cuts in benefits. There are no cuts in benefits, I say to Senators. Although sometimes Senators on that side of the aisle like to either say or strongly imply there are cuts in benefits, there are no cuts in benefits. There are no cuts in the guaranteed benefits with the basic benefits, and there are no required cuts for the fringes or the extras because the officers can make that decision not to cut, if they want to. That is their choice, as I have explained a few minutes ago.

Let's look to see what the other side proposed not too many years ago back in 1997. They proposed cutting the Medicare benefit structure, cutting payments to providers, big time—big time. They proposed a 12.4-percent cut to providers back in 1997, when they were in charge. They did that in part to save the Medicare trust fund, to extend the life of the Medicare trust fund.

I have a hard time understanding why back then it was a good thing to do, which was about three times more of a cut—let's see, twice as heavy a cut to Medicare providers back then, in 1997, than it is today. Nobody over there has explained why it was the right thing to do back then but not the right thing to do today, when the goal is the same. The goal is the same; that is, to extend the solvency of the trust fund.

One could say—I think the Senator from New Hampshire did say—well, let's take those savings, which do extend the solvency of the trust fund, but not—he said—provide another program. I think he wants to use that to cut the deficit. That is what I think he wants to do.

That is a very basic, fundamental, values question I think this country should face; that is, do we want to set up a system where virtually all Americans have health insurance? We are the only industrialized country in the world that does not have a system where its citizens have health insurance—the only industrialized country

in the world. It is a very basic question. I think we should ask ourselves as Americans: In every other industrialized country, health insurance, health care is a right. That is the starting point. In every other country that has a health care system, health care is a right—that everybody should have health care.

Of course, it is true, people are different. Some are tall, some are short. Some are very athletically endowed, some are not. Some are smart, some are not so smart. But health care does not care—that is a way to put it—whether you are dumb, smart, tall, skinny. It affects everybody; that is, diseases affect everybody, and everybody needs health care regardless of your station in life, regardless of your income, regardless of whether you are an egghead, you are brilliant, or an athlete. It makes no difference whatsoever. We are Americans.

I frankly believe other countries on that point have it right; that is, that they treat all their citizens basically equally because disease is indiscriminate—who is going to get disease—accidents are indiscriminate—who is going to get in an accident—and so forth. So we could take this \$400 billion, \$500 billion and reduce the deficit with it and forget any health insurance coverage. That would be an option. That is a legitimate question we could ask ourselves. I frankly think the better choice is to take that \$400 billion, \$500 billion, which does extend the solvency of the trust fund, and help set up a way, help set up a system so all Americans have health insurance. We do it in a way that reduces the budget deficit. We do it in a way that reduces the budget deficit in the first 10 years and also in the next 10 years.

I again repeat, if trimming the rate of growth of provider payments was OK back in 1997—that was twice as much as today back then to extend the solvency of the Medicare trust fund—why isn't it OK today to do half as much to extend the life of the trust fund, in this case for 5 more years, and at the same time help provide health insurance benefits for people who deserve it?

Let's not forget, hospitals want us to do this. They want everyone to have health insurance. Doctors want us to have a system where everybody has health insurance, whether it is Medicaid or it is private health insurance. All the providers want it. The pharmaceutical industry does, the home health industry does, the hospice industry does. The durable medical equipment manufacturers want it. They all want it because they know it is the right thing to do. They also know they are not going to get hurt.

I heard some reference here that some HHS actuary, commenting on the House bill, said, oh, gee, it might scare providers and whatnot, but we actually got subsequent information which showed that letter—that actuary admitted it is extremely variable, what he came up with. There are lots of fac-

tors he did not take into consideration. I also have statements from hospital administrators saying no way are they going to be allowed.

In fact, let's remind ourselves of this: It was not too many weeks ago, a couple months ago—remember that meeting—when all the health care providers and the insurance industry went to the White House? They were all over there. What did they pledge to President Obama to help get health care reform passed? That they would cut their reimbursements by \$2 trillion over 10 years. They would cut. They agreed to cut their payments that Uncle Sam makes to them in the health care system by \$2 trillion over 10 years. It was widely reported in the papers.

What did we do in this bill? We reduced the rate of increase in payments to providers, not by \$2 trillion, not by \$1 trillion, less than  $\frac{1}{2}$  trillion over that same 10-year period. So if they could commit back then to \$2 trillion, you would think, my gosh, this is a quarter of that. That is not too bad and not going to hurt anybody, and providers are not going to be leaving.

I might add too, I have a letter from AARP to the majority leader dated today. It has been handed to me. In part it says:

The legislation before the Senate properly focuses on provider reimbursement reforms. . . . Most importantly, the legislation does not reduce any guaranteed Medicare benefits.

This is a letter today from the American Association of Retired People. I will re-read that portion. It is addressed to Senator REID:

The legislation before the Senate properly focuses on provider reimbursement reforms. . . .

And, man, we need about a week or so to talk about all the reforms in this bill that are so important so we have a better health care system focusing more on quality than we currently do in the United States system. Again:

Most importantly, the legislation does not reduce any guaranteed Medicare benefits.

In the letter they also say:

AARP believes that savings can be found in Medicare through smart, targeted changes aimed at improving health care delivery, eliminating waste and inefficiency, and aggressively weeding out fraud and abuse.

That is important. It is very important. I might add, too, that every person today who pays a Part B premium—every American today—every senior today who pays that quarter, that 25 percent of Part B today, pays also for the waste that is in the system today, especially under Part B. So if we get the waste out, we also will be able to reduce that Part B premium payment that seniors have to pay too. I think that is a good thing.

So the more you dig into this bill, the more you see the good features. I do not think all the good features have been pointed out in this bill. One of our jobs here is to point out what they are, so when this legislation passes—mark my words, this legislation is going to

be enacted. It is going to be enacted, I will not say exactly when, but certainly, if not this month, it will be signed by the President either this month or next month—then Americans are going to start to see: Oh, gee, there is a lot in there that is good. I didn't know about that. That is good. I like that. It may not be perfect, but they started in the right direction. That is pretty good. They are going to like it.

I hear all these references to polls around here, and that is because of all the confusion, in part. But once it is passed and people look to see what is in it—they will look to see what is in it because that is the law. They are forced to look to see what is in it because that is the law.

I know some of my colleagues on the other side of the aisle may say: Yes, when they look to see what is in it, they will see how bad it is. I disagree. That is not my view. My view is, the more this legislation is subjected to the light of day, the disinfectant of sunshine, which shows what is in this bill, the more people are going to say: Hey, that was a good thing they did back then in December or January.

I yield the floor.

The PRESIDING OFFICER. The Senator from Louisiana.

Mr. VITTER. Mr. President, I rise to talk about a very important topic on the floor right now, along with the Medicare issue; that is, preventive screenings and services, particularly for women. I want to focus on a very specific and important example of that, which is breast cancer screening through mammography, and also through the practice of self-examination.

This is very timely because 2 weeks ago, a U.S. government-endorsed panel issued new recommendations on this topic, which I believe, along with tens of millions of Americans, is a major step in the wrong direction. I think we need to focus on this recent action and talk about this and fix it in the context of this health care reform debate.

What am I talking about? Well, on Tuesday, November 17—literally just a couple weeks ago—the U.S. Preventive Services Task Force, which is an official government-sanctioned body—a task force about preventive medicine—issued new recommendations regarding breast cancer screening for women, including the use of mammography.

These new recommendations they came out with a couple weeks ago are a big step backward, a big retrenchment in terms of what the current state of knowledge is and what their previous recommendations were. Their new recommendations, just out 2 weeks ago, do four things that take a big step back on breast cancer screening.

No. 1, for women between the ages of 40 and 49, rather than get a routine mammogram every 2 years to screen for breast cancer, the task force said: Forget about that. We do not recommend that anymore. We step back from that recommendation.

No. 2, for women aged 50 to 74, the previous recommendation was to get a routine mammogram to screen against breast cancer every year. The task force, 2 weeks ago, stepped back from that and said: No, every other year is probably good enough. So not every year: every other year.

No. 3, for women over the age of 75, the previous recommendation was to have routine screening at least every 2 years. The new recommendation from the task force steps back from that and says: No, we do not recommend routine screening over the age of 75.

And, No. 4, the task force 2 weeks ago said: We no longer recommend breast self-examination by women to detect lumps to get treatment early. We do not believe in that. We do not think the science is clear on that. We step back from that.

Those are four huge changes in their previous recommendations. Those are four huge, new recommendations completely at odds with what I believe is the clear consensus in the medical community and the treatment community.

When I first read about these new U.S. Preventive Services Task Force recommendations, around November 17, I had the immediate reaction I just enunciated, but I said: I am not an expert. I am not a doctor. I am not a medical expert. I want to hear from folks who are much closer to this crucial issue than me. So my wife and I convened a roundtable discussion in Baton Rouge, LA. We had it on Monday, November 23. It was at the Mary Bird Perkins Cancer Center. They were very kind to host it. It was coshosted by Women's Hospital in Baton Rouge. We had a great roundtable discussion featuring a lot of different people, including oncologists, other MDs, other medical experts, and including, maybe most importantly, several breast cancer survivors who literally lived through this issue themselves. Those breast cancer survivors were all women who got breast cancer and had it detected relatively early, in their forties. So they are exactly the group of people these new recommendations would work against because the new recommendations say don't get regular mammography screening in your forties.

Again, I was interested in hearing from the real experts, both medical experts and the survivors, what they thought about it. I wasn't very surprised, quite frankly, when they all had exactly the same reaction I did to these new U.S. Preventive Service Task Force recommendations. Everybody to a person said this is a big step backward. This will make us move in the wrong direction. Increased screening, early detection is a leading reason we are winning increasingly the fight against breast cancer. It is a leading reason we are doing so much better in this fight.

In that one room at the Mary Bird Perkins Cancer Center, in a sense we

had a snapshot through history and proof of the great gains we have made, including through early screening because, as I said, we had these survivors, all a supercause for celebration: Folks who had detected their cancer, most of them relatively early; all of them first got it and detected it either in their forties or some in their thirties. Unfortunately, in the same room, we had a life experience on the other end of the spectrum going back 40-plus years. That is my wife Wendy who lost her mother to breast cancer when she was 6 years old. One of the reasons is simple and straightforward and directly related to what we are talking about.

Back in the late 1960s when Wendy lost her mom to breast cancer there wasn't this same routine. There wasn't this emphasis on screening. There wasn't the recommendation for annual mammograms. There wasn't the educational push for self-examination. There wasn't that focus, and because of that, far more women, tragically, including Wendy's mother, died.

We have made huge progress since then. Again, the very life experiences in that one room in Baton Rouge proved that. The medical doctors and the oncologists, the other experts, as well as the breast cancer survivors, all made that point.

So I am standing on the Senate floor to urge us to take focused, specific action to legislatively repeal any impact of these new recommendations by the U.S. Preventive Services Task Force issued in November.

This topic is on the Senate floor. It is on the floor through the Mikulski amendment. There is probably going to be a Republican alternative to that Mikulski amendment. My concern is, in terms of everything on the floor now, none of it directly, specifically takes back the impact of those new recommendations. I think that is the first matter we should all come together on, 100 to nothing, on this topic.

We can have a broader debate. We can have differences about the best approach to prevention and screening. But the first concrete, focused thing we should do right now on the Senate floor today is come together, 100 to nothing, to legislatively overrule any impact of those new recommendations. That is, again, what I have been hearing from experts not just in Baton Rouge, not just in that one room, but across the country; experts in terms of oncologists, other medical doctors, leaders of the cancer associations across the country and, perhaps most importantly, breast cancer survivors. I daresay that is what every Member of this body has heard from their States since those new recommendations came out around November 17.

So, again, whatever we do in this broader debate, I have a very simple, basic, focused suggestion. Let's show the American people we can come together around something on which I believe we all agree.

There is an expression: It is mom and apple pie. Well, this should be consid-

ered mom and apple pie because it is literally about mom and our wives and our daughters and, obviously, half the population. So let's come together around this issue, and let's legislatively overrule any legal impact, any legal consequence of these new task force recommendations of the U.S. Preventive Service Task Force.

That is what my Vitter amendment, No. 2808, does. I had hoped the amendments on the Senate floor on this general topic would do that already. Unfortunately, the one that is pending now, at least the Mikulski amendment, does not do that. In fact, in some ways it points to the new recommendations of the task force and holds up those new recommendations. Our current law holds up the current recommendations. I think because the new recommendations they promulgated around November 17 are so egregious, such a bad idea, because the consensus around the country starting with experts and oncologists is so clear that we should negate any impact of them. So, again, my Vitter amendment No. 2808, which is currently filed as a second-degree amendment to the Mikulski amendment, would do that.

Let me be perfectly clear and read my text because it is very short:

For the purposes of this Act, and for the purposes of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

So what it does is simple. It says we are erasing, we are canceling out, any effect of those new recommendations made by the task force in and around November 2009. We are saying that never happened because the consensus is so clear against it.

Again, I expected the Mikulski amendment to do that directly. It doesn't do that. It does other things about prevention, which is fine. We can debate those points. We can have a discussion about that. But I think we need to all come together to absolutely, categorically, specifically, legislatively take back, overrule these new recommendations.

I am certainly eager to work with everyone in this body starting with Senator MIKULSKI, starting with Senator MURKOWSKI, whom I believe may offer a Republican alternative to include this language. I hope this language, which seems to me is a no-brainer given the consensus on the topic, can be included in both of those amendments. It should be just accepted and included in the Mikulski amendment. It should be accepted and included in the Murkowski amendment. That would be my goal so that whatever happens on these votes, we come together in a unified way. Literally, it would in essence be 100 to nothing, to say: No, time out. These new recommendations of the U.S. Preventive Services Task Force from November of

this year are a huge step backwards, a huge mistake. That is what the experts are saying. That is what oncologists are saying. That is what cancer specialists are saying. That is what leaders of cancer associations are saying. That is what, perhaps most importantly, breast cancer survivors are saying.

We can look at history in this country in the last several decades and happily point to real progress in this fight. One of the causes of that good news, that improvement since the late 1960s when my wife Wendy's mom passed away from breast cancer, clearly one of the underlying reasons, clearly one of the leading causes is dramatic improvement in this prevention and screening, using mammography, also educating about self-examination.

So, again, I have this second-degree amendment. My hope and my goal would be that this language, which should be noncontroversial, would be accepted on it, as well as any Republican alternative, and that whatever happens in terms of those votes, we come together and make crystal-clear that this task force of unelected bureaucrats—didn't include a single oncologist, by the way—made a big mistake and we are going to make sure those new recommendations don't have any impact in terms of law, in terms of government programs, in terms of legal impact on insurance companies.

Again, I look forward to working with everyone on the floor, including Senator MIKULSKI, including Senator MURKOWSKI and others to pass this language. It should be a no-brainer. It is mom and apple pie. Let's pass it and at least in this focused way come together and do the right thing in direct reaction to something that just happened 2 weeks ago.

Thank you, Mr. President. I yield the floor.

The PRESIDING OFFICER. The Senator from Ohio is recognized.

Mr. BROWN. Mr. President, I certainly appreciate Senator VITTER's empathy for victims of breast cancer, for people who obviously should be tested for breast cancer, in many cases more frequently than they are. I am sorry about Wendy's mother's death from breast cancer.

I think, though, that Senator VITTER missed the larger point. While most of us in this Chamber disagree with the finding of that Bush-appointed commission—committee, commission, task force—I think the bigger question is that a whole lot of the status quo which Senator VITTER has defended, sort of ad hominem, the bigger question is under the status quo so many women aren't getting tested for breast cancer. It is estimated that 4,000 breast cancer deaths could be prevented just by increasing the percentage of women who receive breast cancer screening.

That is why the Mikulski amendment is so important. It is important because in this country today, if you take a group of 1,000 women who have

breast cancer and who have insurance, and 1,000 women who have breast cancer who don't have insurance, those who don't have insurance are 40 percent more likely to die. So the issue is that committee—I think that commission made a mistake. We pretty much, most of us here, think that commission made a mistake. I am not sure why those people whom President Bush put on the commission made the decision they did. It should have been oncologists sitting; Senator VITTER is right about that.

The larger point is that women without insurance don't get tested, and women without insurance are 40 percent more likely to die of breast cancer than those with insurance. At the same time, as the Presiding Officer knows, in the State of Maryland, women typically pay more for their insurance than men do on the average.

So if we are going to do this right, it means we need insurance reform, which is what this legislation does. No more preexisting conditions, no more men and women who have their insurance canceled because they got too sick last year and had too many expenses and the insurance companies practiced rescission and they cut them off. No more if I have insurance and if I have a child born with a preexisting condition do I lose my insurance.

I come to the floor pretty much every day reading letters from people in Ohio—from Galion and Girard and Gallipolis and Lima, all over my State. Typically, people were pretty happy with their insurance if they had written me a year ago, these people. But today these people writing found out their insurance doesn't cover what they thought it did. They end up losing their insurance because of a preexisting condition. They can't get insurance because they once had breast cancer. They have had this discrimination against them because of gender or geography or disability. That is what is important about the bill and what is important about the Mikulski amendment.

That is why I would hope Senator VITTER, as he is pushing for assistance for women with breast cancer—I applaud him for that—would go deeper than just dismissing the recommendations of one government commission and that, in fact, he would advocate for better testing, more frequent testing for women who are not getting tested often enough today, and that the rates for women would be comparable to the rates for men. That is, again, why the Mikulski amendment is so important.

I will repeat: The health reform legislation as is will finally put an end to discrimination, discrimination that charges women significantly higher premiums because they have had children.

It is considered a preexisting condition by some insurance companies if a woman had a C-section because she might get pregnant again and she is going to have another C-section and

that costs more. A woman with a C-section has a preexisting condition. A woman who has been—in some cases, with some insurance companies' policies—victimized by domestic violence has a preexisting condition because the boyfriend, the husband or whoever hit her the one time, the insurance companies would suggest, is going to do it again. So she has a preexisting condition. What kind of health care system is that?

That is why I suggest Senator VITTER support the Mikulski amendment and support this legislation. In fact, it will put rules on insurance policies so people will be treated in a different way than they have been in the past.

Let me talk, for a moment, specifically about the Mikulski amendment and why it is so important. It will ensure that women are able to access needed preventive care and screenings at no additional cost. One of the things, in spite of the McCain amendment—and I appreciated Senator BAUCUS's comments a minute ago about how ironic it is. I was in the House of Representatives for 14 years and in the Senate now for the last 3 or so. I have heard so many colleagues eviscerate Medicare. They have tried to cut Medicare, privatize it, and come at it from all different directions repeatedly over these last 15 years. Now they want to tell us they are the ones who want to protect Medicare. In fact, this legislation saves money and saves lives, and this legislation saves Medicare.

One of the things this legislation does for Medicare beneficiaries is it will begin to provide these preventive care screenings so seniors will pay no copay. It is not cutting Medicare and services, as my friends on the other side say—all those who are opposed to every part of the bill, most of whom have tried to slow this legislation down. We cannot even vote on the McCain amendment. We are ready to do it, but the Republicans don't seem to want to move forward on this legislation.

Let me go back to why the Mikulski amendment makes so much sense. All health care plans would cover comprehensive women's preventive care and screenings, requiring that recommended services be covered at no cost to women. We know that to get preventive screenings and care—if we make them at no cost, the chances of people getting them are significantly higher. More than half of women delay or avoid preventive care because of the costs. One in five women at age 50 has not received a mammogram in the past 2 years.

That isn't because the Commission, appointed by the former President Bush, made this decision; it is not because of their bureaucratic decision that Senator VITTER rails about, and many of us agree with; it is not because 1 in 5 women age 50 has not received a mammogram; it is that they don't have insurance, in most cases, and they cannot afford the mammogram.

In 2009, some 40,000 women will lose their lives to breast cancer; 4,000 breast cancer deaths, one-tenth of those could have been prevented by increasing these preventive screenings. These kinds of mammograms, this preventive care, and these doctor visits will be covered for free for women.

This amendment would broaden the comprehensive set of women's health services that health insurance companies must cover and pay for.

For instance, it would ensure that women of all ages are able to receive annual mammograms, covered by their insurer. It would encourage coverage of pregnancy and postpartum depression screenings, Pap smears, screenings for domestic violence, and annual women's health screenings. It makes so much sense. It would save the lives of women, and it means women would suffer from a lot less illnesses. It will save money for the health care system because these illnesses will be detected much earlier, and women will get the kind of care they should. That is what this whole legislation is about and what the Mikulski amendment will add to.

This amendment will remove any and all financial barriers to preventive care so we can diagnose diseases and illnesses early—when we have the best chance at being able to save lives, obviously.

Understand again, this legislation and the Mikulski amendment are supported by the National Organization for Women, the National Partnership of Women and Families, the American Cancer Society Cancer Action Network, and all kinds of women's organizations. They understand this is the best thing for women in this country.

I hope the Senate can proceed to a vote on this amendment. I hope my Republican colleagues will not just talk about the bad decision of this Commission—and most of us think it was a bad decision—but actually do something about it, something substantive, and give women in this country a fairer shake from health care insurance companies and cover these preventive services and cancer screenings. It will make a big difference if we can move forward and expand preventive health care services to women.

I yield the floor.

The PRESIDING OFFICER (Mr. MERKLEY). The Senator from Oklahoma is recognized.

Mr. COBURN. Mr. President, I wish to pick up where Senator BROWN left off. I will describe one of my real patients, but I will not use her real name. I will call her "Sheila." Sheila was 32 years old. She came in with a breast mass. I examined it and thought it was a cyst. I sent her to get an ultrasound, which confirmed a cyst. OK. We did a mammogram to make sure. The mammogram said it looks like a cyst. The standard of care for somebody with a cyst is to watch it expectantly, unless it is painful, because 99 percent of them are benign cysts. I had the good for-

tune to do a needle drainage on her cyst 3 days after she had her mammogram. There were highly malignant cells within the cyst. She has since died.

The reason I wanted to tell the story about Sheila is because what the Senator from Ohio, in supporting the Mikulski amendment, doesn't recognize is, we don't allow the Preventive Services Task Force to set the rules and guidelines. We do something worse: We let the Secretary of HHS set the guidelines.

The people who ought to be setting the guidelines are not the government; they are the professional societies that know the literature, know the standards of care, know the best practices; and, in fact, the Mikulski amendment doesn't mandate mammograms for women. It leaves it to HRSA, the Health Resources Services Administration, which has no guidelines on it today whatsoever.

So what you are saying with the Mikulski amendment is, we want the government to, once again, decide—all of us are rejecting what the Preventive Services Task Force has said, but instead we are going to shift and pivot and say we will let the HRSA decide what your care should be.

The other aspect of the Mikulski amendment I fully agree with. I don't think there ought to be a copay on any preventive services. I agree 100 percent. But the last place we ought to be making decisions about care and process and procedure is in a government agency that, No. 1, is going to look at cost as much as at preventive effectiveness.

If the truth be known, the Preventive Services Task Force, from a cost standpoint—as a practicing physician, I know how to read what they put out—from a cost standpoint, it is exactly right. From a clinical standpoint, they are exactly wrong, because if you happen to be under 50 and didn't have a screening mammogram and your cancer was missed, to you, they are 100 percent wrong. You see, the government cannot practice medicine effectively. What we are trying to do in this bill throughout is have the government practice medicine, whether it is the comparative effectiveness panel or the Medicare Payment Advisory Commission.

What we have asked is for the government to make decisions.

Let me tell you what that is. That is the government standing between me and my patient. It is denying me the ability to use my knowledge, my training, my 25 years of well-earned gray hair, and combine that with family history, social history, psychological history, where it might be important, and clinical science, and me putting my hand on a patient such as I did Sheila. Most physicians would never have stuck a needle in that cyst, and she would not have lived the 12 years that she lived. She would have lived 1 or 2 years. But she got 12 years of life because clinical judgment wasn't de-

ferred or denied by a government agency.

There is a wonderful member of the British Parliament who happens to be a physician. When we were debating the issue of the comparative effectiveness panel, which will be applied to whatever HRSA or the Secretary does, I asked him: What about the national institute of comparative effectiveness in England? Here is what he said: As a physician, it ruins my relationship with my patient because no longer is my patient 100 percent my concern. Now my patient is 80 percent my concern and the government is 20 percent of my concern. So what I do is I take my eye off my patient 20 percent of the time to make sure I am complying with what the national institute of comparative effectiveness says—even if it is not in my patient's best interest.

When we pass a bill that is going to subterfuge or undermine the advocacy of physicians for their patients, the wonderful health care we have in this country will decline. There are a lot of other things about the bill I don't agree with. But the No. 1 thing, as a practicing physician, that I disagree with is the very fact—the thing I am most opposed to as a practicing physician—I like best practices. I use Vanderbilt in my practice. I like them. They make me more efficient and make me a better doctor. But they are not mandated for me when I see something that in my judgment and in the art of medicine I get to go the other way because I know what is best for my patient.

What we have in this bill is what we passed with the stimulus bill, the comparative effectiveness panel—which is utilized in this bill—and we have the Medicare Payment Advisory Commission saying you have to cut. Where do we cut? Whose breast cancer screening do we cut next year? When we have the Commission saying we have to, unless we act affirmatively in another way, we are dividing the loyalty of every physician in this country away from their patients. They are no longer a 100-percent advocate for their patients. This is a government-centered bill. It is not a patient-centered bill.

Going back to the Mikulski amendment and what will come with the Murkowski amendment, the Murkowski amendment is far better. It does everything Mikulski does but doesn't divide the loyalty or advocacy of the physician. Here is what it does. The Murkowski amendment says nobody steps between you and your doctor—nobody, not an insurance company, not Medicare or Medicaid. We use as a reference the professional societies in this country who do know best, whether it be for mammograms and the American College of Surgeons, the American College of OB/GYNs, the American College of Oncology, the American Academy of Internal Medicine or the American College of Physicians, which have come to a consensus in terms of what best practices are but

don't mandate what will or will not be paid for when, in fact, the art of medicine is applied to save somebody's life, such as Sheila's.

For you see, if this bill passed, Sheila would have lived 2 years instead of 12. Ten years was really important to her family. She got to see the children I delivered for her grow up. One of them she got to see married.

If we decide the government is going to practice medicine, which is what this bill does—the government steps between the patient and their caregiver, deciding in Washington what we will do—what you will have is good outcomes 80 percent of the time and disasters 20 percent of the time. That is not what we want.

I do not deny that there are plenty of problems in my profession in terms of not being as good as we should be, of not having our eye on the ball some of the time, of making mistakes some of the time. I do not deny that. But what I do embrace is most people who go into the field of medicine go in for exactly the right reason; that is, to help people. It is so ironic to me that we have a bill before us that limits and discourages and takes away the most altruistic of all efforts, which is to do 100 percent the best right thing for your patient.

The reason having HRSA or the Secretary set guidelines is bad is because most patients do not fit the textbook. Here is what the textbook says, but this patient has this condition, this history, and this finding that are different. What we have done in this bill is, multiple times, take the learned judgment of caregivers and say: You will bow to what the Federal Government says; you will bow to what HRSA says; you will bow to what the Secretary of HHS says. Seventy-five times in this bill, there are new programs created; 6,950 times in this bill are requirements for the Secretary to set up new rules and regulations. If you do not think that will put the government between you and your care, you have no understanding of health care in this country and you have no understanding of the problems we face today because of Medicare and Medicaid rules that interrupt and limit the ability for us to care in the best way for our patients.

I am for the prevention aspects of the Mikulski amendment. I think it is a great idea. As a matter of fact, it should not be just about women. It should be about screening for prostate cancer for men as well. It should be about treadmills for people with high cholesterol. It should be about true preventive measures. Why were they not included? Because what we have done under the Mikulski amendment is \$892 million over 10 years. We want to do this for one group but we will not do it for the other.

If you think the government will not get in between, let me give three examples right now which violate Federal law today. The Center for Medicare and Medicaid Services today violates Fed-

eral law. They ration the following three things:

If, in fact, you are elderly and you have a complication with your colon and you are a high-risk patient to have a perforation if you were to have a colonoscopy—that is when we go in with a fiber optic light to look at the colon—Medicare denies the ability for you to have a CT automated, camera-centered, swallowed-pill colonoscopy, which is available. The technology is proven and is being used outside of Medicare. You cannot have a video colonoscopy by way of a remote-control camera. Why did CMS eliminate that? They eliminated it because it costs too much. So if you are 87 years old and you have a mass in your colon and you cannot have a regular colonoscopy, you cannot even buy this procedure; it is against the law because Medicare forbids it.

No. 2—and this has happened to me numerous times—women with severe osteoporosis—a loss of calcium in their bones at 50 years of age—diagnosed with a DEXA scan in a screening prevention so they do not get a collapsed vertebra or break a hip, you put them on a medicine. The medicines are expensive, there is no question, but they really do work. Some medicines work for some people; other medicines work for others. Once you do a DEXA scan, under Medicare rules, you cannot do another one for 2 years. So you cannot check to see if the medicine is working after 6 months, to see if you see an improvement in the calcification of a woman's bones, because Medicare said it is too expensive and we are doing too many of them. Rather than go after the fraud in DEXA scans, what they did was ration the care.

Here we have a woman and you have diagnosed her properly. You have started her on the medicine, but you have to wait 2 years. What happens during that period of time if you are given a medicine that is not working effectively? Because it did not work in her case, you have to wait 2 years and her osteoporosis advances and she falls and breaks her hip because Medicare said we were doing too many of them?

Take what CMS did to all the oncologists in this country. They said we are paying too much money for EPOGEN. EPOGEN is an acronym for erythropoietin, which is a chemical that is kicked out by your kidneys to cause you to make red blood cells. When you get chemotherapy for breast cancer or colon cancer, like I have had, sometimes that chemotherapy not only kills your cancer but it kills your blood cells. Because we were using too much EPOGEN, Medicare put out a rule rationing EPOGEN and said: Unless you have a hemoglobin of X amount, you cannot get a shot of EPOGEN, and by the way, you cannot take your own money and buy it either. The doctor will get fined if he gives it to you if you don't meet the guideline. What happens? For 80 percent of the patients, it worked fine.

But for those patients who have other comorbid—other conditions, such as congestive heart failure or chronic obstructive pulmonary disease—emphysema—where significant drops in hemoglobin can cause organ failures in other parts of the body, there was no exception made by CMS for a physician to make a judgment and say: This rule should not apply here because this patient is going to end up in the hospital.

My oncologist told me a story of one of his patients who could not get EPOGEN. It ended up that their heart failure was exacerbated because they got anemic from the chemotherapy, ended up on a ventilator in ICU, and died. Why did they die? Because they got heart failure. Why did they get heart failure? Because they got too anemic. Why did they get too anemic? Because Medicare would not allow the doctors to give them the medicine.

What is wrong with the bill, what is wrong with the Mikulski amendment is we rely on government bureaucracies to make the decisions about care rather than the trained, learned, experienced, truly caring caregivers in this country to make those decisions. Instead of going after the fraud in Medicare, which is well in excess of \$90 billion a year, we decided we will ration care.

The authors of this bill are going to say: No, that is not true. But when I offered amendments in committee to prohibit rationing of Medicare services—to prohibit it—it was voted down. Every person who voted for moving on this bill voted against the rationing. Why would they do that? Because ultimately the feeling is: We know better. Washington knows better. We know your patients better. We know how to practice medicine better. We are going to take ivory tower doctors who do not have real practices anymore, we are going to take retired researchers, and we are going to tell you how to practice. And we are going to save money by limiting what you can get.

The chairman of the Finance Committee has said we do not truly cut Medicare Advantage, that the services are not reduced. The chairman's own bill, on page 869, subtitle C, part C—I won't go through reading it—reduces Medicare Advantage payments. The differential from \$135 to—I will read it to the chairman. The chairman is shaking his head. Let me read it to him. Let me also reference what CBO has said. I will be happy to yield to the chairman if he wants to talk now.

Mr. BAUCUS. As soon as I get the page number, I guess I would like to ask the Senator from Oklahoma a question.

Mr. COBURN. I will be happy to yield for a question.

Mr. BAUCUS. What page?

Mr. COBURN. Page 869, subtitle C, part C.

Mr. BAUCUS. I don't have it with me right now, but there are no required reductions in fringes or extras—

Mr. COBURN. No required reductions in what?

Mr. BAUCUS. Fringes, such as gym memberships, and extras such as that. The bill basically provides that there be no reductions in guaranteed Medicare payments. There is a long list of what guaranteed Medicare payments are.

Even the Medicare Advantage companies, which are private companies with officers and they have stockholders—they have to report to their board of

directors, and they have all these administrative costs, very huge administrative costs. The reductions to Medicare Advantage—the application of reductions to Medicare Advantage plans are at the discretion of the officers. The officers can decide they are not going to cut the fringes; that is, the fringes and the extras that are beyond, in addition to the guaranteed Medicare benefits.

If an officer wants to, it is his discretion, I am assuming—

Mr. COBURN. Reclaiming my time, I ask unanimous consent to have printed in the RECORD CBO 11/21/2009, which shows an average from \$135 down to \$51 per month on the average Medicare Advantage beneficiary.

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

ESTIMATED EFFECTS OF THE MEDICARE ADVANTAGE (MA) PROVISIONS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT ON ENROLLMENT IN MA PLANS AND ON FEDERAL SUBSIDIES FOR ENROLLEES IN MA PLANS OF BENEFITS NOT COVERED BY MEDICARE

	Enrollment in MA Plans (millions)		Average Subsidy of Extra Benefits Not Covered by Medicare (dollars per month)	
	2009	2019	2009	2019
All Areas	10.6	13.9	87	135
Areas with Bids that Average Less than 100 Percent of Spending Per Beneficiary in the Fee-for-Service Sector	4.7	6.9	120	172
Areas with Bids that Average More than 100 Percent of Spending Per Beneficiary in the Fee-for-Service Sector	5.9	7.0	61	98

	Reduction in enrollment in MA plans, 2019		Net reduction in Medicare spending 2010–2019 Billions of dollars	Average subsidy of extra benefits not covered by Medicare, 2019 Dollars per month
	Percent	Millions		
All Areas	–18	–2.6	105	49
Areas with Bids that Average Less than 100 Percent of Spending Per Beneficiary in the Fee-for-Service Sector	–29	–2.0	<sup>a</sup> –62	51
Areas with Bids that Average More than 100 Percent of Spending Per Beneficiary in the Fee-for-Service Sector	–9	–0.6	–43	47

<sup>a</sup> The estimate of a \$105 billion net reduction in Medicare spending over the 2010–2019 period reflects a \$118 billion reduction in Medicare payments that would be offset, in part, by a \$13 billion reduction in Part B premium receipts. Note: Under current law, extra benefits include health care services not covered by Medicare, such as vision care and dental care, and subsidies of beneficiaries' out-of-pocket costs for Part B or Part D premiums or cost sharing for Medicare-covered benefits. Under the Patient Protection and Affordable Care Act, extra benefits would include health care services not covered by Medicare and subsidies of beneficiaries' out-of-pocket costs for cost sharing for Medicare-covered benefits.

Mr. COBURN. The fact is, if you like what you have, you cannot keep it, for 2.6 million Americans. You can say that is not true. That is what CBO says. Here are their numbers. They sent the report to the chairman.

Mr. BAUCUS. Will the Senator yield? Mr. COBURN. I will be happy to yield.

Mr. BAUCUS. It is true—first of all, we need to back up. Isn't it true that the MedPAC commission came to the conclusion that the Medicare Advantage plans are overpaid?

Mr. COBURN. Absolutely. I agree with the chairman.

Mr. BAUCUS. It is also true that it is their recommendation that the Medicare plans overpaid by the amount of 14 percent.

Mr. COBURN. I don't know the actual amount. I agree with the chairman that they are overpaid.

Mr. BAUCUS. That is true. They are overpaid.

Mr. COBURN. Yes.

Mr. BAUCUS. If they are overpaid, doesn't that necessarily mean there are reductions in payments attributable to each beneficiary by definition?

Mr. COBURN. I disagree with that.

Mr. BAUCUS. If they are overpaid—

Mr. COBURN. Here is what I would say. This morning, the claim made by the chairman and Senator DODD is that Medicare Advantage is not Medicare. Medicare Advantage is Medicare law. It was signed into law. It is a part of Medicare. The chairman would agree with that?

Mr. BAUCUS. Absolutely. In 2003, I made the mistake and agreed to give the Medicare Advantage plans way more money than they deserved. And

as the Senator from Oklahoma has said, they are overpaid.

Mr. COBURN. I agree with the chairman. You won't hear that from me. How did we get there? How did we get there? How did we get there, to where they are overpaid? We have an organization called the Center for Medicare and Medicaid Services. They are the ones who let the contract, are they not? They, in fact, are. Twenty-five percent of the overpayment has to be rebated to CMS today; the Senator would agree with that? Seventy-five percent for extra benefits, 25 percent rebate. How did we get to where they are overpaid? Because we have a government-centered organization that is incompetent in terms of how they accomplished the implementation of that bill.

What was said by Senator DODD this morning—and I confronted him already on it, but it bears repeating—is that the Patients' Choice Act eliminates the dollars without eliminating the services because it mandates competitive bidding with no elimination in services for Medicare Advantage. So if you want to save money, competitively bid rather than go through eight pages of reductions year by year in the payments that go back to Medicare Advantage.

We have this complicated formula that nobody who listens to this debate would understand. I know the chairman understands it because he helped write it. But the fact is 2.6 million Americans, according to CBO, will see a significant change in their Medicare benefits. Medicare Advantage is Medicare Part C. We have had a kind of a differential made that it isn't really

Medicare. It is Medicare. And 20 percent of the people in this country who are on Medicare are on Medicare Part C—Medicare Advantage—and they like it. And why do they like it? Because most of them don't have enough money to buy a supplemental Medicare policy to cover the costs that are associated with deductibles and copays and outliers. So I agree with the chairman that Medicare Advantage is overpaid, but I disagree with the way you are going about getting there.

I also disagree with taking any of the money that is now being spent on Medicare Part C and creating another program. I think all that money ought to be put back into the longevity of Medicare.

In case you don't understand how impactful that is, we now owe, in the next 75 years—actually, we don't owe it, because none of the Senators sitting here will be around. Our kids are going to get to pay back \$44 trillion in money for Medicare we will have spent, that we allowed to grow, in fraud, close to \$100 billion a year and then did nothing about it. This bill does essentially nothing about that \$100 billion a year, or \$1 trillion every 10 years. If we were to eliminate that—which this bill does not—we would markedly extend the life and lower the debt that is going to come to our children.

That leads me to the other important aspect of the health care debate. We know when you take out the funny accounting—the Enron accounting—in this bill, and you match up revenues with expenses, you are talking about a \$2.5 trillion bill. The chairman of the

Finance Committee readily admits he has it paid for, and CBO says you have it paid for. But how does he pay for it? He pays for it with the 2.6 million people who like what they have today and who are going to lose what they have today. He pays for it by raising Medicare taxes. Then the Medicare taxes he raises he doesn't spend on Medicare, he spends that on a new entitlement program. Think about what we are doing. Is there a better way to accomplish what we are doing?

I thank the chairman for indulging me and allowing me to continue this long. I will wind up with a couple of statements and then share the floor with him.

You know, after practicing medicine for 25 years, I know we have a lot of problems in health care, and I appreciate the efforts of the chairman of the Finance Committee to try to find a solution for them. It is not a bipartisan solution, but it is a solution. And it is a solution that grows the government. It puts the government in charge of health care and creates blind bureaucracies that step between you and your doctor. That is one way of doing it. But wouldn't a better way be to do the following: Let's incentivize people to do the right thing, rather than building bureaucracies and mandating how they will do it. Wouldn't it be better to incentivize tort reform in the States? Wouldn't it be better to incentivize physicians based on outcomes? Wouldn't it be better to incentivize good behavior by medical supply companies, DME, drug companies, hospitals, physicians, through accountable care organizations, through transparency for both quality and price?

We don't have any of that in here. What we have is a government-centered bureaucracy that, according to CBO figures, will add 25,000 Federal employees to implement this program—25,000. If you call the Federal Government, how long does it take you now to get an answer? Yet we are going to add 25,000 employees just in health care. That is an extrapolation of the amount of agencies, dividing what CBO says per agency and per cost they will come up with. Wouldn't it be better to fix the things that are broken, rather than to try to fix all of health care?

I heard one of my colleagues today say on the floor, and I think it is true, that people in America are upset with us, and I think rightly so. I apologize to the American people for my arrogance. I apologize to the American people for the arrogance of this bill; the thinking that we got it right; that we can fix it in Washington; that we don't have to listen to the people out there; that we don't have to listen to the people who are actually experiencing the consequences of what we are going to do. I apologize for the arrogance of saying we can create a \$2.5 trillion program and that we know best. Well, you know what, we don't know what is best.

As Senator ALEXANDER has said so many times, what needs to happen is

we need to start over. We need to protect the best of American medicine. And what is the best? Well, if you get sick anywhere in the world, this is the best place in the world to get sick, whether you have insurance or not. If you have heart disease or atherosclerotic disease, this is the best place in the world. It costs too much, there is no question, but it is the best place. If you have cancer, you are one-third more likely to live and be cured of that cancer living in this country than anywhere else in the world—for any cancer. It just costs too much.

This bill doesn't address the true causes of the cost. What are the true causes of the cost? Well, No. 1, we know Medicare and Medicaid underpay and so we get a cost shift that is \$1,700 per year per family in this country. So you get to pay three taxes in this country on health care: You pay your regular income tax, which goes to pay for Medicaid, and it also now starting to pay for Medicare as well; you have to pay 1.45 percent, plus your employer gets to pay 1.45 percent of every dollar you earn for Medicare; and then your health insurance costs \$1,700 more per year because Medicaid and Medicare don't compensate for the actual cost of the care because of the government-centered role that is played in terms of the mandates, the rules, and regulations.

We have a tort system in this country that costs upward of \$200 billion in waste a year, which is 8 percent of the cost. Ninety percent of all cases are settled with no wrong found at all on the part of caregivers, and of the remaining 10 percent only 3 percent find anything wrong. Of 97 percent of all the cases, only 10 percent go to trial, and 73 percent of that 10 percent are found in favor of the providers. So we spend all this money practicing defensive medicine and there is not one thing in this bill to fix that problem. That is 8 percent.

Take your health care premium, or your percentage of your health care premium, and apply 8 percent, and that is going down the drain because I am ordering tests you don't need but I need to protect myself in case somebody tries to extort money from me with a lawsuit that I know is going to get thrown out, but I have to have it there to prove it. And then we have inefficiencies.

Ultimately, what we need to do is to protect what is good, incentivize the correct behavior in what is wrong, and go after the fraud in health care with a vengeance—put doctors in jail, hospital administrators in jail. Don't slap them with a fine and ban them from Medicare. Put them in jail. The people who are stealing our grandkids' money, up to \$100 billion a year, need to go to jail. We play pay and chase. We pay everybody and then we try to figure out whether they deserve to get paid. Nobody else does that, but the government does, and that is who we are getting ready to put in charge of another \$2.5 trillion worth of health care?

One of the reasons health care is in trouble in this country is that 61 percent of all the health care is run through the government today. Look at TRICARE for our military, look at VA care, look at Indian health care, at SCHIP and Medicaid. There is an estimate of \$15 billion a year in fraud in New York City alone on Medicaid. That is one estimate, per year, in one city on Medicaid. And then Medicare. And we are going to say those are running so good that we ought to move another \$2.5 trillion, or 15 percent of health care, to where we are at 76 percent of all health care is run by the government? I reject that out of hand until we can demonstrate we are good at what we do.

What we ought to be doing is turning it back. The private sector isn't the answer to everything. I agree with that. I can't stand 80 percent of the insurance bureaucrats I deal with. But at least I have a fighting chance, because they will call me back when I need to do something for a patient. I never get a call back from Medicare. They do not call me back. The State doesn't call me back on Medicaid when I need to do something. So I go on and do it and find somebody else to pay for it. That is the kind of system we have today.

Think about the mothers in this country in a Medicaid system where 40 percent of the primary care doctors in this country won't see their children. That is Medicaid. That is realistic Medicaid today in our country. So they have a sick kid, but they can't get in to a doctor, even though they have insurance. They have Medicaid, but they can't get in. Why can't they get in? Because only 1 in 50 doctors last year who graduated from medical school goes into primary care. We have created an abrupt shortage in primary care. And, No. 2, the payment is not enough to pay for the overhead to see the child. So you have a weepy woman who is worried about her sick kid, and care is delayed if you can't get in. It doesn't matter if you have Medicaid if you can't be seen. So what happens? She goes to the emergency room. What happens in the emergency room? We spend three or four times as much as we should, because that is an emergency department. The doctor has no knowledge of the child or the mother. He doesn't want to get sued, so we have a 40-percent defensive medicine cost in the emergency room.

The answer is not more government health care. The answer is creating the incentives for people to do the right thing. The only way we get things under control in health care in this country and the only way we create access for people in this country is to decrease the cost of health care. This bill doesn't decrease the cost of health care. If we want to make sure we do what is best for American medicine while we fix what is wrong, we will do it one significant part at a time. I can't imagine dealing with thousands, tens of thousands of more bureaucrats in

health care, and I can't imagine the impact it is going to have between me and my patients. It is going to severely impact them. Do I want everybody in this country to have available care? Yes; 15 percent of my practice was gratis, for people who had no care, who had no money. That is true with a lot of physicians out there in this country. It is true with a lot of labs. It is true with a lot of hospitals. It is true with a lot of the providers in this country. They are caring people.

We are going to tie them up. We are going to put regulations and ropes around them. We are going to mandate rules and regulations, and we, in our arrogant wisdom, are going to tell Americans how they are going to get their health care. I certainly hope not. But I am not thinking about me. I am thinking about our kids and our grandkids.

I will end with one last comment. Thomson-Reuters, in a study put out October 9 of this year—it is a very well-respected firm—their estimate of the \$2.4 trillion that we spend on health care per year in this country is that between \$600 and \$850 billion of it is pure waste. Defensive medicine costs and malpractice is between \$250 billion to \$325 billion by their estimate. Not one thing in this bill to address that—not one thing.

Fraud, there is between \$125 and \$175 billion per year—insignificant in this bill, \$2 billion to \$3 billion.

Administrative inefficiency, 17 percent—between \$100 and \$150 billion wasted on paperwork in health care every year.

Provider errors—that is me—between \$75 and \$100 billion; that is either wrong diagnosis or failure to treat appropriately. It is the smallest of all.

What are we doing? We are going to tell the providers—the hospitals, the medical device companies, the drug companies, the doctors, the radiologists, the labs, the physical therapists—we are going to tell them how to do it. That is not where the problem is.

My hope is that the American people will come to their senses and say: Wait a minute. Slow down. Stop. Fix the important things. Fix the worst thing first, the next thing second, the next thing third, the next thing fourth. The unintended consequences of this bill are going to be unbelievable. Nobody is smart enough to figure all this out—nobody. Nobody on my staff, nobody on the Finance Committee, nobody in Majority Leader REID's office can predict all the unintended consequences that are going to come about because of this bill.

The chairman has been awfully patient, and I see my colleague here to offer an amendment. With that, I yield the floor.

**THE PRESIDING OFFICER** (Mr. BURRIS). The Senator from Oregon is recognized.

Mr. MERKLEY. Mr. President, I rise today to share a few thoughts about our health care proposal and also to ad-

dress the amendment of my good friend from Maryland, Senator MIKULSKI. We have heard the word "arrogant" echo in this Chamber. "The bill before us is arrogant."

I come to it with a somewhat different perspective. For 10 years, as a representative of a working class neighborhood back in Oregon, as a State legislator, I have heard a lot of stories from America's working families—from the working families in my House district back home, a lot of stories regarding health care. There is a lot of concern that they can't afford health care. There is a lot of concern that their children do not have appropriate coverage. There is a lot of concern that their health care is tied to their job, and if they lose their job they are going to lose their health care.

There is a huge amount of stress for America's families who understand if you have health care you have to worry about losing it, and if you don't have it you have to worry about getting sick. That is why we are here today in this Chamber debating health care, because so many of us have heard from our constituents, so many of us know from our personal experience what a dysfunctional, broken health care system we have in America.

Sometimes, listening to this conversation on the Senate floor, you would think this is a rather complicated debate. But the heart of this bill is not that complicated. The heart of this bill is that every single American should have access to affordable, quality health care, and that we can take a model that has worked very well for the Federal employees of our Nation, a model that encourages competition, a model that says let's create a marketplace where every individual, every small business that currently struggles to get health care and has to pay a huge premium for health care—enable them to join a health care pool that will negotiate a good deal on their behalf.

I think every American who has tried to get health care on their own, every small business that is paying a 15- to 20-percent premium because they don't have the clout of a large business, understands if they could join with other businesses, if they could join with other individuals, they would get a lot better deal.

Americans understand if there is a large pool of citizens who are seeking health insurance that insurers are going to be attracted to market their goods. We have seen that in the Federal employees system, where insurers come and compete. It turns the tables. It takes the power away from the insurance companies and it gives the power to the American citizen because now the citizen is in charge. Now the citizen gets to choose between health care providers instead of having to search for anyone from whom they can possibly get a policy.

I do not find that it is arrogant to try to create a system in which individuals

and small businesses get health care that is more affordable. I don't find that a bill that says we are going to invest in prevention is arrogant, that is smart. I don't find a bill that says we are going to create incentives to do disease management arrogant, so someone suffering from diabetes has the disease managed rather than ending up with an expensive amputation of their foot. That is intelligent, that is not arrogant.

I don't find that having a bill that says every single American is going to find affordable health care, and if they are too poor to afford it we will provide a subsidy to assist them, to get everyone in the door, that is not arrogant. That is saying we are all in this together as citizens and that health care is a fundamental factor in the quality of life. It is a fundamental factor in the pursuit of happiness. It is not arrogant to find for fundamental access to health care.

I rise specifically to address the amendment offered by my good friend from Maryland, Senator MIKULSKI. The legislation we are considering has many parts that make health care more affordable and available, that expand access; many parts to hold insurance companies accountable. But a big part of health care reform also deals with helping people avoid illness or injury in the first place. That is what Senator MIKULSKI's amendment does and why it is so important that it be included in this package.

Preventive screening saves lives. That is a fact. Early detection saves lives. That is a fact. Too many women forgo both because of the cost.

I want to share a story from a physician in Oregon. The physician is Dr. Linda Harris. I am going to quote her story in full. It is not that long. She says:

I work one day a week at our county's public health department. There I met Sue, a 31-year-old woman who came in with pelvic pain and bleeding. She proved to have extremely aggressive cervical cancer that was stage IV when I diagnosed it.

She continues:

When Sue was 18 she had a tubal ligation after she gave birth to her only child. As a single mom she did not have the financial resources to have more children. She concentrated on raising her daughter. Sue always worked, sometimes 2 jobs at once, but never the kind of job that offered health insurance. But because she had a tubal ligation she did not qualify for our State's family planning expansion project that provides free annual exams, Pap smears and contraceptive services to many of our clients.

The doctor continues:

Cervical cancer is an entirely preventable disease. Pap smears almost always find it in its preinvasive form, but Sue never came in for a Pap smear or an annual exam. Her lack of affordable access to basic health care proved fatal. When Sue died of cervical cancer her daughter was 13.

That is the completion of the story that the doctor shared. Sue should not be viewed as a statistic in a broken health care system. But, instead, we

should take her story to heart, about the importance of preventive services. Sue is one of 44,000 Americans who die each year because they lack insurance, according to a recent Harvard Medical School study.

Let me repeat that statistic because I think it is hard to get your hands around—44,000 Americans die each year because they lack insurance. I don't think it is arrogant to say we should build a health care system that gives every single American access to affordable, quality care so that 44,000 of our mothers and fathers, our sons and brothers, our daughters, our wives, our sisters—so that 44,000 of them do not die each year because they lack insurance.

Senator MIKULSKI's amendment will help keep this tragedy from happening to our families. To put it plainly, it will save lives. It does this by allowing the Health Resources and Services Administration to develop evidence-based guidelines to help bridge critical gaps in coverage and access to affordable preventive health services—the same approach the bill takes to address gaps in preventive services for children. This will guarantee women access to the kinds of screenings and tests that can prevent illnesses or stop them early.

As the American Cancer Society Cancer Action Network notes:

Transforming our broken "sick care" system depends on an increased emphasis on detection and early prevention, enabling us to find diseases when they are easier to survive and less expensive to treat.

That last point is also important. Treating illnesses also saves money. With so much emphasis on the cost of health care, we should all agree that it is common sense to include reforms that lower health care costs for all Americans.

I was noticing that her amendment has a long list of organizations stating how important this is—the National Organization for Women, the National Partnership for Women and Families, the Religious Coalition for Reproductive Choice, the American Cancer Society-Cancer Action Network, the National Family Planning and Reproductive Health Association.

I applaud Senator MIKULSKI for offering this amendment. I urge my colleagues to remember the 44,000 Americans who die every year because they do not have access to insurance, because they do not have access to preventive services, and vote to include this important reform.

The PRESIDING OFFICER. The Senator from Alaska is recognized.

Ms. MURKOWSKI. Mr. President, I ask unanimous consent I be permitted to engage in colloquy with my Republican colleagues on an amendment I will be discussing.

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

Ms. MURKOWSKI. Mr. President, there has been a great deal of discussion this week certainly, and last

week, with the announcement from the U.S. Preventive Services Task Force, the USPSTF, of their recommendations as they relate to mammograms and recommendation that women under the age of 50 do not need to be screened until they reach age 50, and then on attaining the age 50, every other year after that.

When these recommendations came out on November 16, it is fair to say they generated a level of controversy, a level of discussion and a level of confusion around the country by women from all walks of life. For many years now, women have operated under what we knew to be the standards, the protocols. If you had a history of breast cancer in your family, you took certain steps earlier, but the general recommendation was out there. Certainly, the guidelines we had been following, the assurances we were seeking as women were that we would be encouraged to engage in these screenings on an annual basis. They gave us all a level of confidence. When these new recommendations, these new guidelines came out just a couple weeks ago, I do think the level of confusion, the level of anxiety that was raised because of this announcement brought a focus to some of what we are talking about when we discuss health care reforms and should the government be involved in our health care.

I know I have received e-mails from friends, from relatives, girlfriends I haven't heard from in a while, talking with women, generally, about what do they think about this. I would hear story after story of the woman who discovered, at age 39, a lump, something that was off, something that was not right, and then the stories subsequent to that, the steps she took as an individual with her doctor. Again, the announcement that we now have these guidelines that this preventative screening task force has put in place and everything we thought we knew and understood about what we should be doing with our health has been unsettled brings us to the discussion today.

We have an amendment offered by the Senator from Maryland. I would like to offer a little bit later an amendment, but I would like to speak to the amendment now, if I may. I am proposing this as a side-by-side to the Mikulski amendment. This is designed to allow for an openness, a transparency on preventative services, not just mammograms. I don't want to limit it to only mammograms, because we know that preventive services in so many other aspects of our health are also equally key and also equally important. What I am looking to do with my amendment is to rely on the expertise, not of a government-appointed task force but to rely on the expertise of medical organizations and the experts, whether they are within the college of OB/GYNs or surgeons or oncologists, rely on them and their expertise to determine what services,

what preventive services should be covered.

What we are seeking to do is allow for a level of information so an individual can select insurance coverage based on recommendations by these major professional medical organizations on preventative health services, whether it is mammography or for cervical cancer screening.

I think we learned from the announcement from the USPSTF, the Preventive Services Task Force, that when we have government engaging in the decisions as to our health care and what role they actually play, there is a great deal of concern and consternation. I have heard from many colleagues on both sides of the aisle: That task force was wrong. We think they have made a mistake in their recommendations.

What we are intending to do with this amendment is keep the government out of health care decision-making and allow the spotlight to be shown on the level of prevention coverage that patients will get under their health care plan, rather than relying on unelected individuals, basically individuals who are appointed by an administration to serve as part of this panel of 16, on the Preventive Services Task Force. My amendment specifies that all health plans must consult the recommendations and the guidelines of the professional medical organizations in determining what prevention benefits should be covered by all health insurance plans.

I know at least those of us who are on the Federal employees health benefits have an opportunity to subscribe to the Blue Cross/Blue Shield plan. This is their booklet that is out for 2010. This is under their standard basic option plan. Turn to preventative care for adults that is covered. They provide, under this particular plan, for cancer diagnostic tests and screening procedures for colorectal cancer tests, for prostate cancer, cervical cancer, mammograms, ultrasound, abdominal aneurysm. There is a list we can look to.

What we don't see laid out in this booklet or any of the other pamphlets that outline given plans out there is, OK, for instance, the breast cancer test, is there an age restriction. I am told under Blue Cross there is not. But it doesn't indicate that there. What do the experts recommend? It is not clear from what we receive. So what my amendment would do, in part, is to allow for this information to be directly made available to patients, to individuals who are looking at the plans, to make a determination as to what they will select.

If you go to the Web sites of these professional medical organizations, for instance, the American Congress of Obstetricians and Gynecologists, they recommend that cervical cancer screening should begin at age 21 years, regardless of sexual history. Cervical cytology screening is recommended

every 2 years for women between the ages of 21 and 29. The American Society of Clinical Oncology, as to the recommendations for mammography, urges all women beginning at age 40 to speak with their doctors about mammography, to understand the benefits and potential risks. By age 50, at the latest, they should be receiving mammograms. The American College of Surgeons, in their recommendations, recommend that women get a mammogram every year starting at age 40.

As an individual who is looking to make a determination as to what the experts are saying out there, what is being recommended, I would like to know that this information is made available to me to help me make these decisions. What our amendment would require is the plans would be required to provide this information directly to the individuals through the publications they produce on an annual basis. What we are talking about now is the doctors. It is the specialists who will be recommending what preventative services to cover, not those of us here in Washington, DC, in Congress, not the Secretary of Health and Social Services, who may or may not be a doctor or a medical professional, not a task force that has been appointed by an administration. We are trying to take the politics out of this and put it on the backs of the medical professionals who know and understand this. This is where I think we want to be putting the emphasis. This is where we want to be relying on the professionals, not the political folks.

Additionally, my amendment ensures that the Secretary of Health and Human Services shall not use any recommendations made by the U.S. Preventive Services Task Force to deny coverage of any items or services. This is the crux of so much of what we are discussing right now with these latest recommendations that came out by USPSTF. The big concern by both Republicans and Democrats and everyone is the insurance companies are going to be using these recommendations now to deny coverage to women under 50 or to a woman who is over 50, if she wants to have a mammogram every year; that she would only be allowed coverage for those mammograms every other year rather than on an annual basis. We want to take that away from the auspices, if you will, of the government. To suggest that we will deny coverage based on the recommendations of this government task force is not something I think most of us in this country are comfortable with.

We specify very clearly that the Secretary cannot use any recommendations from the USPSTF to deny coverage of any items or services. We also include in the amendment broad protections to prevent, again, the bureaucrats, the government folks at the Department of Health and Human Services, from denying care to patients based on the use of comparative effectiveness research.

Finally, we include a provision that ensures that the Secretary of Health and Human Services may not define or classify abortion or abortion services as preventative care or as preventative services.

This amendment is relatively straightforward. It relies, essentially, on the recommendation of practicing doctors, as opposed to the bureaucrats, to the politicians, to those in office. My amendment addresses the concern that the government will make coverage determinations for your health care decisions. What we are doing here, quite simply, is making it transparent, making clear that the preventive services recommended by the professional medical organizations are visible, are transparent. We require the insurance companies to disclose that information that is recommended and, again, recommended by the professionals.

This is a good compromise. It basically keeps the government out, and it keeps the doctors in. It requires the insurance companies to disclose the information to potential enrollees and allows for, again, a transparency that, to this point in time, has been lacking.

It has been suggested by at least one other Member on the floor earlier that my amendment would cost somewhere in the range of \$30 billion. I would like to note for the record, we have not yet received a score on this. We fully believe it will be much less than has been suggested. When the statement was made, it was not with a full view of the amendment we have before us and is not consistent with that. I did wish to acknowledge that as we begin the discussion on my amendment.

Mr. ENZI. Mr. President, first, I wish to thank the Senator from Alaska for the tremendous work she has done on this issue and for the dozens of people she has talked to over the last couple days to try to come up with an amendment that would actually solve the problem everybody has been talking about.

I appreciate the Senator from Maryland recognizing this major flaw in the bill, and it is in the bill. The U.S. Preventive Services Task Force is in the bill. That is exactly the group that specified this new policy on mammograms that has upset people all across the country. It upset everybody so much that we have an amendment on the floor by the Senator from Maryland reacting to that and reacting to the fact that it is in the bill at the current time.

So I appreciate the Senator from Alaska coming up with a plan that actually is more comprehensive than the amendment from the Senator from Maryland because the Senator has had a little bit longer to work on it. I appreciate the words the Senator has in there that "you cannot deny." The Senator is on the Health, Education, Labor, and Pensions Committee with me, and I know we have worked on this issue in committee. I hoped this kind of a realization would have been made

at that time. We had some amendments where you could not deny based on this or the comparative effectiveness or could not prohibit based on it. We know all those amendments failed, meaning there was probably some intention to deny or to prohibit based on these groups.

So I appreciate the Senator bringing up the fact that it is the caregivers who will have some say in this so Washington cannot come between you and your doctor. I wish the Senator would go into a little bit of some of her background from Alaska because the Senator and Alaska have been very involved in breast cancer for a long time, and people ought to be aware of the kind of services that are available out there and what the costs of those services are.

Ms. MURKOWSKI. I appreciate the question from my colleague from Wyoming. The Senator knows, coming from a rural State, that our health care costs are typically higher, and it is not just an issue of cost, but it is an issue of access, and particularly in my State, where most of our communities are not connected by roads, it is very difficult to gain access to a provider. It is even more difficult to gain access, for instance, to mammography units.

I have been involved in this issue, in terms of women's health and cancer screening, for many decades now, primarily because my mother got started in it back when I was still in high school and saw a need to provide for breast cancer screening for women in rural areas, where they could not afford to fly into town, as we would call it, for the screenings. So she engaged in an effort—and continues to this day—to raise money for not only mobile mammography units but to figure out how we move those units from village to village.

Essentially, what they have been able to do, over the years, is you put that mobile mammography unit on the back of a barge and you take it up and down the river and you stop in every village and offer free screenings for women. You fly it into a village, where you are not on a river. We have been making this effort, again, for decades, working, chipping away slowly at the issue of breast cancer. We recognize it in our State. Particularly with our Alaska Native populations, we see higher levels of breast cancer than we would like. We are trying to reduce that.

But when these recommendations came out several weeks ago from the USPSTF, I will tell you, there was a buzz around my State amongst women about: Well, now what do I do? Where do I go? Do I need to go in for my screening? What should I do?

There is an article that was actually in the news just, I guess, a couple weeks ago, and it cites a comment from a doctor. Her comment was, the new recommendations were confusing patients who usually come in for their annual screenings. She said: My schedulers have called to schedule patients

to come in for their followup mammogram, and they have been told: Well, I don't have to do that now. This government group says I don't have to do that.

Mr. President and my colleague from Wyoming, maybe some do not. But what about those who are at risk? These are the ones whom I think we are continuing to hear from who say: Please, add some clarity to this.

Mr. ENZI. Mr. President, I know there is not any word that probably turns a family upside down as much as the word "cancer," and it does not matter which form of cancer it is. It is just drastic because we do not know all the implications of it. Maybe someday we will. Maybe someday we will know how people get it, and we will be able to cure it with a vaccine. But, so far, what we have are some mechanisms for putting it into remission.

One of the reasons I know how upsetting that is and how it turns the world upside down is, 3½, 3¾ years ago my wife was diagnosed with colon cancer. She had screenings, but she listened to her body. She said: Something is the matter here. She kept going to doctors. So even if they do not recommend the screenings, if your body is saying something is the matter, pursue it until you are either convinced nothing is the matter or a doctor finds what is the matter. That is the advice she gives to everybody. These are things that need to be between the patient and the doctor.

Now that she is in remission, one of the things the doctor recommended was that she take Celebrex. That is something normally for arthritic pain, but what they found was in some patients that will keep polyps from growing that will turn into cancer in the colon, and we definitely do not want that to recur again. So she is taking that. But it is a constant fight with making sure that is an approved medication and that it can be done and that it will be paid for.

If that were just a task force recommendation—first of all, since she had the screening, they would say she does not have a problem and, later, she would die from it. But she was able to listen to her body, get the treatment she needed, and now is continuing to get the treatment without a task force saying: No, 99 percent of the people do not need that. Her doctor and she are able to determine what she needs.

On other screenings, once you have cancer, there are other times you need to have MRIs, other kinds of tests run. That, again, has to be up to the doctor and the patient to determine how often those are needed. Again, I know from talking to a number of people whom I know—not just ladies either—who have had cancer, once you have had cancer and you are in remission, you would actually prefer to have your screening a little bit earlier for the mental reassurance you get with it.

Again, from talking to people—and we have talked to more now because we

are trying to give some reassurances to them when this terrible word comes up—when they go to the doctor, one of the first things that happens is they weigh in, they take your blood pressure. When you are waiting for a decision on how the blood test you got turned out or the MRI you got turned out or whatever it was, that blood pressure goes through the roof. Quite frequently, you cannot leave the doctor's office until you have—you went there for the information, so, of course, you stay for the information, but they will not let you leave until they do the blood pressure test again, to make sure it goes down below the critical stage. That is how much impact this has on people.

So I am glad the Senator did something that goes a little bit further, covers a few more things, and makes sure people have access to their doctor, to the tests they need, and not to be relying on some government bureaucracy to say: Well, in 99 percent of the cases or 85 percent of the cases—who knows how far down they will take it, depending on what the costs are. We do not want that to happen.

I think the Senator's amendment allows patients to get these preventive benefits and stops government bureaucrats and outside experts from ever blocking patients' access to those types of services.

I appreciate the Senator from Maryland who put up an amendment. I do not think it meets that standard. They still rely on government experts called the U.S. Preventive Services Task Force to decide what preventive benefits should be covered under private health insurance. This is the same Preventive Services Task Force that made this decision that women under the age of 50 should not receive annual mammograms.

In fact, I think I even remember in there that they were not necessarily recommending self-examination. Most people I know who are very young discovered it with self-examination. I certainly would not want them to quit doing that because there is a recommendation from somebody who does not understand them or their body.

Patients do want to receive preventive screenings. Sometimes they are a little reluctant to do it because nobody wants the possibility of hearing that word given to them.

Americans should be able to get screened for high blood pressure and diabetes when a doctor recommends they get these tests. I think the Senator and I agree they should be able to get colonoscopies, prostate exams, and mammograms, so they can prevent deadly cancers from progressing to the point where they are no longer curable. Many of these diseases are preventable or curable or can be put into remission if they are discovered early enough.

I think we agree with Senator MIKULSKI's goal that all Americans should be able to get preventive benefits, but we disagree that her amendment achieves

that stated goal. Her amendment does not ensure access to mammograms for women who are under the age of 50. Part of that I am taking from an Associated Press article.

As most Americans know, last month the U.S. Preventive Services Task Force revised the recommendations for screening for breast cancer, advising women between the ages of 40 and 49 against receiving routine mammograms and women ages 50 and over to receive a mammogram just once every 2 years. The U.S. Preventive Services Task Force lowered its grade for these screenings to a C.

That sparked the political firestorm, as many women became confused about what services they could get and when they could get them. The health care bills before Congress further confused the issue because they rely heavily on the recommendations of the task force. That is what is in the bill. The underlying Reid bill says—and the Mikulski amendment restates—that all health plans must cover preventive services that receive an A or B grade from the task force. Let's see, we just said that was a C grade.

Because breast cancer screenings for women under the age of 50 are no longer classified by the task force as an A or B, plans would not have to cover those services. So Senator MIKULSKI drafted an amendment to try to fix this problem, but I think it confuses the matter some more.

I say to the Senator, I appreciate the effort you have gone to, to try to clarify that and expand it to some other areas—and to not add another layer of bureaucracy—by saying that all services and screenings must be covered by health plans.

However, the previous amendment does not have any guidelines that are specifically for women or prevention.

Ms. MURKOWSKI. If I may comment on the Senator's last statement, this is very important for people to understand. There has been much said about the Mikulski amendment and what it does or does not do. But it is very important for women to understand the Mikulski amendment will not provide for those mammograms for women who are younger than age 50. Her amendment specifically provides that it is "evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force."

So you go to the task force report, and as the Senator has noted, women who fall between the ages of 40 and 49 receive a grade of a C, and the recommendation is, specifically: Do not screen routinely. Individualized decision to begin biannual screening, according to the patient's context and values. But they have received a C designation by USPSTF.

According to the Mikulski amendment, those women who are younger than 50 years of age will not be eligible

or will not be covered under the mandatory screening requirement she has set forth in her amendment.

I think where she was trying to go was to ensure that these recommendations would not be used to deny coverage. She adds a paragraph stating that nothing shall preclude health plans from covering additional services recommended by the task force that are either not an A or a B recommendation. But the amendment does not require plans to cover services that are not an A or a B. In other words, if you are 45 years of age, you are in this C category, and the amendment does not require, then, that your preventive screening services be covered. So for those women who are in this age group—Congresswoman DEBBIE WASSERMAN SCHULTZ just went through a recent bout of cancer, and I think that was diagnosed at age 41. For those women who fall into this category, this amendment the Senator from Maryland has introduced does not address the concerns that have been raised by these recommendations coming out of this preventive task force. Again, I think we need to understand that what this amendment specifically allows for is first-dollar coverage for immunizations for children, children's health services as outlined with the HRSA—Human Resources Services Administration—guideline. But, in fact, the requirement to provide for screening coverage for women who are not in this A or B category—in other words, anybody younger than 50—we need to understand is not covered through this.

Our amendment, through allowing for a level of transparency, ensures that when you go to obtain your insurance, you can see very clearly what the professional medical organizations recommended are the guidelines and then what your insurer is proposing to offer you for your coverage. If it is not coverage you like, then shop around. This is what this insurance exchange is supposed to be all about.

Mr. ENZI. Mr. President, I congratulate the Senator from Alaska also.

Isn't it true that the Senator's amendment ensures that the Secretary of Health and Human Services won't be able to deny any of these services based on any recommendation? That is one of the things we have been concerned about. Again, that is an unelected bureaucrat who could come between you and your doctor and your health care. I know the Senator has covered that in her amendment, too, and I do appreciate it.

Ms. MURKOWSKI. It states very clearly on the second page that the Secretary shall not use any recommendation made by the U.S. Preventive Services Task Force to deny coverage and items serviced by a group health plan or a health insurance issuer. So, yes, we make it very clear that these recommendations from the USPSTF cannot be used to deny coverage.

I think the opportunity to have medical professionals, as this USPSTF is

comprised of—we should have an entity that is kind of looking out and seeing what best practices are. But then that entity should not be the one that causes a determination as to whether coverage is going to be offered. You can use that as a resource, most certainly, just as we use as a resource the recommendation from, say, for instance, the American Congress of Obstetricians and Gynecologists, the American College of Surgeons, the American Society of Clinical Oncology, but it is not going to be the determining factor. I think that is where we need to make that separation, where my amendment separates from Senator MIKULSKI's.

Mr. ENZI. Mr. President, I also appreciate that the Senator from Alaska makes sure they can't deny care based on comparative effectiveness research, which actually was part of the stimulus bill that was run through at that point in time, and finally that the Senator's amendment includes a common-sense provision that would prohibit the Secretary from ever determining that abortion is a preventive service.

So I hope all of my colleagues, whether they are pro-life or pro-choice, would support this change to ensure that the controversial issues don't sidetrack the debate on the preventive issues because what we are talking about is the preventive issues, and I appreciate the Senator covering that.

Ms. MURKOWSKI. I am glad the Senator mentioned the issue of the abortion services. I think there is a vagueness in the amendment Senator MIKULSKI has offered. Some have suggested that it would allow those in the Human Resources Services Administration, HRSA, to define abortions as a preventive test, which could provide that health insurance plans then be mandated to cover it. That has generated some concern, obviously. Some have opposed the amendment, saying that if Congress were to grant any executive branch entity sweeping authority to define services that private plans must then cover, merely by declaring a given service to constitute preventive care, then that authority could be employed in the future to require all health plans to cover abortions.

So all we are doing with my amendment is just making very clear there are no vagaries, there is no second-guessing. It just makes very clear that the Secretary cannot make that determination that preventive services are to include abortion services.

Mr. ENZI. Mr. President, as I said before, my wife says that she had probably never mentioned the word "colon" twice in her whole life, and since then she has become an encyclopedia for people who have a very similar problem. She had a colonoscopy a short time before. She was still having problems, and they had said there is no problem, but she kept getting it checked until she found that there was a problem. So people need to listen to their bodies, and they need to listen to their doctors, and they shouldn't have

a bureaucrat coming in between that. So I thank the Senator.

Ms. MURKOWSKI. I thank the Senator for the dialog here today. I think this is an important part of our discussion as we debate health care reform on the floor. We have had good conversations already yesterday and today about the cuts to Medicare, the impact we will feel as a nation if these substantive cuts advance. But I think this discussion—and we are narrowing it so much on what the recommendations have been from this task force, but I think it is a good preview of what the American people can expect if we move in the direction of government-run health care, of bureaucrats, whether it is the Secretary of Health and Human Services or whether it is task forces that have been appointed by those in the administration, who are then able to make that determination as to what is best for you and your health care and your family's health care.

I think the discussion we have had today about ensuring that it is not best left to these entities, these appointed entities to make these determinations, but let's leave it to—or let's allow the information to come to us from the medical professionals. Senator COBURN has spoken so eloquently on the floor about relying on those who really know and understand, who live this and who practice this, rather than us as politicians who want to be doctors. I don't want to be a doctor. I want to be able to rely on the good judgment of a provider I trust, and I want him or her to be able to make those decisions based on their understanding of me and my health care needs and what is best for me and what the best practices are that are out there, rather than having a task force telling them: That is the protocol for Lisa. She is 52. She is able to get a mammogram every other year now. I want to know that it is me and my doctor who are making these decisions.

I hope Members will take a look at the amendment I will offer and consider how it allows for truly that kind of openness, that kind of transparency, and gives individuals the freedom of choice in their health care that I think we all want.

With that, I thank my colleague from Wyoming, and I yield the floor.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, I ask unanimous consent that Senator WHITEHOUSE, Senator STABENOW, Senator DODD, and I be allowed to engage in a colloquy.

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

The Senator from Rhode Island is recognized.

Mr. WHITEHOUSE. I thank the Presiding Officer. I am delighted to be on the floor, along with the distinguished chairman of the Finance Committee and the distinguished Senator from Michigan, who has worked so hard on these issues.

I am sure I am not going to be the only person to say this, but I would like to respond briefly to the colloquy that just took place between the Senator from Wyoming and the Senator from Alaska because, as I understand it, the Mikulski amendment provides for preventive services that are in the A and B category as a floor, not a ceiling, at a minimum, and it instructs the Health Resources and Services Administration to provide recommendations and guidelines for comprehensive women's preventive care and screenings. Once that is done, then all plans would be required to be totally apart from the A or the B.

In terms of the Health Resources and Services Administration being an entity that wants to get between you and your doctor, these are actually scientists, not bureaucrats. It is an independent panel.

I think it comes with some irony to hear the concern expressed on the other side of the aisle repeatedly about bureaucrats coming between Americans and their doctors and telling them what care they can and cannot have when my experience in Rhode Island leading up to this debate, the Presiding Officer's experience in Illinois leading up to this debate, Senator STABENOW's experience in Michigan leading up to this debate—all of our experience in our home States leading up to this debate—has been that the problem has been that the private for-profit insurance industry is out there denying care every chance it gets.

I think the distinguished Senator from Illinois was presiding when I told the story of a family member of mine who died recently who was diagnosed with a very serious condition. He went to the National Institutes of Health to get the best possible treatment. He got the best specialist on his particular diagnosis in the country, and when he took that back to New York, his insurance company said: I am sorry, that is not the indicated care. That is just one experience I have had. Hundreds of Rhode Islanders have been in touch with me about their nightmare stories over and over again, whether it is because you have a preexisting condition and they won't insure you; or once you get diagnosed, they won't authorize your doctor to proceed with the care you need; or even if you go ahead and get the care, they will do everything they can to avoid paying the doctor and create every kind of administrative, bureaucratic headache for the doctor. The private insurance industry is standing between you and the care you need.

I have not once—not once since I have been here—heard anybody on the other side of the aisle express any concern about the bureaucrat between you and your doctor as long as it is an insurance company bureaucrat. It seems to me they actually approve of bureaucrats getting between you and your doctor as long as it is a bureaucrat who is an insurance company bureaucrat

who has a profit motive to deny you health care. Then it is OK. Then they don't complain. But when it is independent scientists working hard to generate the best science that can be done so that people get the best information to make decisions, then suddenly we hear about bureaucrats.

I think the people listening to this should have that history in mind as they evaluate this claim that we are trying to put bureaucrats between Americans and their doctors. By stripping the abuses away from the insurance company, this bill does more to relieve that problem than any other piece of legislation I can think of.

I yield to the distinguished Senator from Michigan.

The PRESIDING OFFICER. The Senator from Michigan is recognized.

Ms. STABENOW. I thank my colleague from Rhode Island because I couldn't agree more with what he just said in terms of who is standing between, in this case, a woman and her doctor or any patient and their doctor.

Right now, I assume the Senator would agree with me that the first person, unfortunately, the doctor may have to call is the insurance company to see whether he can treat somebody, to see what it is going to cost, is it covered. Right now, we know that half the women in this country, in fact, postpone, delay getting the preventive care they need because they can't afford it. So the amendment from the distinguished Senator from Maryland is all about making sure women can get the preventive care we need, whether it is the mammogram, whether it is the cervical cancer screenings, whether it is focused on pregnancy.

Would the Senator from Rhode Island agree that right now in the marketplace, I understand that about 60 percent of the insurance companies in the individual market don't cover maternity care?

They don't cover prenatal care. They don't cover maternity care, labor and delivery, and health care through the first year of a child's life. That is standing between a woman, her child, and her doctor. That is the ultimate standing between a woman and her doctor, since they were not going to cover that.

I think one of the most important things we are doing in this legislation is to have as basic coverage—something as basic as maternity care. When we are 29th in the world in the number of babies that make it through the first year of life, that live through the first year of life, that is something we should all be extremely outraged about, concerned about.

This legislation is about expanding health care coverage, preventive care, making sure babies and moms can get prenatal care, that babies have every chance in the world to make it through the first year of life because we have adequate care there. Yet the ultimate standing between a woman and her doctor is the insurance company say-

ing: We don't think maternity coverage is basic care.

Mr. WHITEHOUSE. If the Senator will yield.

Ms. STABENOW. Yes.

Mr. WHITEHOUSE. That is the business model of the private health insurance industry now. They want to cherry-pick out anybody who might be sick, and that is why we have the pre-existing condition exclusion.

Then they have an absolute army of insurance company officials whose job it is to deny care. I went to the Cranston, RI, community health center a few months ago. It is a small community health center providing health care in the Cranston, RI, area. It doesn't have a great big budget. I asked them how difficult it is to deal with the insurance companies in order to get approval and get claims paid. They said: Well, Senator, 50 percent of our personnel are engaged not in providing health care but in fighting with the insurance industry to get permission for care and to get claims paid.

Ms. STABENOW. Will the Senator repeat that to me? That is astounding. He said 50 percent?

Mr. WHITEHOUSE. Yes. Half of the staff of the community health center was dedicated to fighting with the insurance industry, and the other half was actually providing the health care.

In addition, they had to have a contract for experts, consultants, to help fight against the insurance industry. That was another \$200,000—\$200,000 for a little community health center, plus half of their staff.

What we have seen in the past 8 years is that the administrative expense of the insurance industry has doubled. That is what they are doing. It is like an arms race. They put on more people to try to prevent you from getting care because it saves them money when they do. They have a profit motive to deny people.

In the case of a member of my family whom they tried to deny, he had the fortitude to fight back and eventually they caved. But for every person like him who fights and gets the coverage they paid for and are entitled to, some will be too ill, too frightened, too old, too weak, too confused, or some simply don't have the resources, when they are burdened with a terrible diagnosis like that, to fight on two fronts. So they give up and the insurance company makes money.

It is systematized. Not once have I heard anybody on the other side of the aisle in the Senate complain about that. It is a scandal across this country. It is the way they do business. I don't think there is a person on the Senate floor who hasn't heard a story of a friend or a loved one or somebody they know and care about who has been through that process. It is not hypothetical. It is happening now, and it is happening to all of us. But it is only when we come in and try to fight that suddenly this concern is raised, this "oh my gosh, you are going to get bureaucrats." But they happen to have no

profit motive. They will work for the government and will be trying to do the right thing and be experts. But suddenly it is no good.

Ms. STABENOW. As the Senator has said eloquently, we have all had situations like this happen in our families. Everybody listening and everybody involved in the Senate family has certainly had that happen to us. I have found it very interesting; every Tuesday morning we invite people from Michigan who are in town, to come by and we do something called "Good Morning, Michigan."

Not long ago, a woman came in and said:

I'm finally excited. I am 65 and now I can choose my own doctor because I am going to be on Medicare.

Medicare is a single-payer, government-run health care system. I could not get my mother's Medicare card away from her if I had to wrestle her to the ground because, in fact, it has worked. It is focused on providing health care. That is their mission.

One of the things I think is indicative of the whole for-profit health care system—by the way, we are the only ones in the world who have a for-profit health care system—is when they talk as an industry, they talk about the "medical loss ratio." The medical loss ratio is how much they have to pay out on your health care. So the language of the insurance industry—now, it is different if there is a car accident or if your home is on fire. We understand you don't want to pay out for a car accident or for a home fire. But in this case, we have an institution set up, through which most of us—we have over 82 percent of us in the private for-profit insurance market through our employers. We are in a system where the provider, the insurance company, calls it a "medical loss" if they have to pay out on your insurance. I think that alone is something that, to me, sends a very big red flag, if they are trying to keep their medical loss ratio down.

We have in this legislation been doing things to keep that up. We want them to be paying out for most of the dollars paid on a premium in health care so the people are getting the health care they are paying for. That is what this legislation is all about. But as my friend from Rhode Island has indicated, point by point, when we look at every amendment in the Finance Committee—I would say virtually every amendment from our colleagues on the Republican side—and when we look at the amendments so far on the floor of the Senate, the first two being offered are about protecting the for-profit insurance companies, making sure excessive payments that are currently going out for for-profit companies under Medicare continue; making sure we are protecting the industry's ability—not the doctor's ability to decide what care you need, when you need it, and so on, but the insurance company's ability to decide what they

will pay for, what is covered, when you will get it—and, by the way, if you get too sick, they will find a technicality and they will drop you.

All of those things we are addressing are to protect patients, protect taxpayers, consumers, in this legislation. Would the Senator not agree?

Mr. WHITEHOUSE. I do.

Ms. STABENOW. The sign behind the Senator is right. It is about saving lives, money, and Medicare.

Mr. WHITEHOUSE. As the Senator noted, there is an astonishing similarity between the interests of the private health insurance industry and the arguments made by our friends on the other side on the floor. It is amazing. They are identical, virtually, to one another. I have yet to hear an argument about health care coming from the other side of the aisle that does not reflect the interests and the welfare of the private insurance industry, about which for years I never heard them complain while they were denying care.

We have another example beyond Medicare. I am struck that today is the first day since the President's speech in which he announced another 30,000 men and women will be going over to Afghanistan in addition to the ones there. All of us in the Senate and in America are proud of our soldiers. We wish them well. Those of us who have visited Afghanistan know how challenging an environment it is and how difficult it is to be away from one's family. There can be no doubt in our minds that we want the best for our men and women in the service. Everybody agrees we want the best for them. Our friends on the other side also want the best for them.

When we give them health care, what do we give them that we think is the best? We give them government health care through TRICARE and through the Veterans' Administration. I have not heard a lot of complaining about that, about stripping our veterans out of the Veterans' Administration and letting them go to the tender mercies of the private health insurance industry because when there is not an issue that involves the essential interests of the private health insurance industry, then they will do the right thing and recognize that is best for our service men and women. That is best for our veterans and, of course, we all support that. It makes perfect sense. It belies the arguments we are hearing today.

Ms. STABENOW. I totally agree with the Senator. I thank him for his comments. What I find even more perplexing is that what we have on the floor is not a single-payer system, even though some of us would support that. It is not. It is, in fact, building on the private system but creating more accountability. We are not saying there would not be a private insurance industry. What we are doing is saying that small businesses and individuals who cannot find affordable insurance today should be able to pool together in a larger risk pool. That has been, in fact,

a Republican and Democratic idea going back years.

We are saying if they want to be able to ask us to cover these folks, we are saying to the insurance companies they have to stop the insurance abuses. We are not saying they can't offer insurance. In fact, this is a model like the Federal employee health care model, where people who don't have insurance today can get a better deal in a group pool, like a big business and a small business and individuals will purchase from private insurance companies. Many of us believe there ought to be a public option in there as well. But we are talking about private insurance companies participating.

All we are saying is, wait a minute. If you are going to have access to the individuals that now will have the opportunity to buy insurance, we want those rates to be down, and we want them to be affordable. We want to make sure there are no preexisting conditions. We want to know that if somebody pays a premium every month, and then somebody gets sick, that they don't get dropped on some technicality. We want to make sure that women aren't charged twice as much as men, which in many cases is happening today. Sometimes there is less coverage. We want to make sure maternity care is considered basic, that women's health is considered a basic part of a health insurance policy. We are not saying we are eliminating the private sector. We are not going to the VA model or even the Medicare model.

This is reasonable, modest, and should be widely supported on a bipartisan basis. These ideas have come from both Democrats and Republicans over the years, and yet we still get arguments that are wholly and completely protecting the interests of an industry that we are, in fact, trying to engage and provide affordable health care insurance.

Mr. BAUCUS. Mr. President, who has the floor? We are all talking.

The PRESIDING OFFICER. The Senator from Montana is recognized. A colloquy was going on and it was terrific.

Mr. BAUCUS. I ask my colleagues, is it not true that basically in America, although all of America spends about \$2.5 trillion on health care, basically it is 50/50. It is 41 or 42 percent public and about 60 percent private. We in America have roughly a 50-50 system today; is that right?

Ms. STABENOW. I say to our colleague that I believe that is the case. In my State, we have 60 percent in the private market through employers.

Mr. BAUCUS. This legislation before us basically retains that current division. What we are doing is coming up with uniquely American ideas. We are not Great Britain, France, or Canada. We are roughly 50-50—a little more private in fact. In 2007, it was 46 percent public and about 54 percent private. Roughly, that is where we are. It might change ever so slightly. But we are not those other countries, we are America.

This legislation before us maintains that philosophy; is that correct?

Ms. STABENOW. Absolutely. In fact, I think it invites the private sector to participate in a new marketplace.

Mr. WHITEHOUSE. If I may interject, I add that it is a relatively familiar American principle to put public and private agencies side by side in competition, in fair competition, and let the best for the consumer win. We see it in public universities. Many of us have States with public universities that we are very proud of. They compete with private universities. I think every one of us has a public university in our State, and it is a model that works very well in education. Many of us—unfortunately not in Rhode Island—have public power authorities that compete with the private power industry.

In fact, some of the most ardent opponents of a public option go home and buy their electricity from a public electric cooperative or a public power authority. We see it in workers compensation insurance. A lot of health care is delivered through workers compensation insurance.

Mr. BAUCUS. But isn't that a pretty good system—don't put too many eggs in one basket? Doesn't each keep the others on their toes a little bit?

Mr. WHITEHOUSE. I think it is the oldest principle of competition, as the distinguished chairman of the Finance Committee pointed out.

Mr. BAUCUS. Doesn't this legislation provide for more competition than currently exists?

Mr. WHITEHOUSE. I think it does.

Mr. BAUCUS. For example, with exchanges, with health insurance market reform and with the ratings reform.

Mr. WHITEHOUSE. All of those, and a public option. All of that adds to a better environment. One of the interesting things about this is you only have a good and fair market. America is founded on market principles. We all believe in market principles. One of the things about the market is that people will cheat on it if there are not rules around the market. If you don't make sure that the bread is good, honest, healthy bread, some rascal will come and will sell cheap, lousy, contaminated bread in the market. You have to have discipline and walls to protect the integrity of the market.

That is what the health insurance market has lacked. That is overdue. I think it will enliven the market in health insurance and animate the market principle.

Mr. BAUCUS. I ask my colleagues, is there anything in this legislation which will interfere with the doctor-patient relationship; that is, to date people choose their own doctors, whichever doctor they want. They can, by and large, go to the hospital they want, although the doctor may send them to another hospital. Is there anything in this legislation that diminishes that freedom of choice patients would have to choose their doctor?

Mr. WHITEHOUSE. Nothing.

Ms. STABENOW. If I may add, I think one of the most telling ways to approach that is the fact that the American Medical Association, the physicians in this country, support what we are doing. They are the last ones who would support putting somebody—somebody else, I should say, because I believe we have insurance company bureaucrats frequently between our doctors and patients—but they would not be supporting us if it were doing what we have been hearing it is doing.

Mr. BAUCUS. What about the procedures doctors might want to choose for their patients? Is there anything in this legislation which interferes with the decision a physician might make as to which procedure to prescribe, in consultation with his or her patient?

Ms. STABENOW. As a member of the Finance Committee with the distinguished chairman, we have heard nothing. We have written nothing that would in any way interfere with procedures. In fact, I believe through the fact we are making insurance more affordable, we are going to make more procedures available because more people will be able to afford to get the care they need.

Mr. WHITEHOUSE. The American Academy of Family Physicians and the American Nurses Association support this legislation because they know that instead of interfering between the doctor and the patient, we are actually lifting out the interference that presently exists at the hands of the private insurance for-profit industry between the patient and the doctor. They want to see this, and that is one of the important reasons.

Another important reason, something the distinguished chairman of the Finance Committee is very responsible for, beginning all the way back at the start of this year when the Finance Committee, under his leadership, had the "prepare to launch" full-day effort on delivery system reform.

What you will see is doctors empowered in new ways to provide better care, to have better information.

Mr. BAUCUS. I might ask my friend—that is very true—Could he explain maybe how doctors may be, in this legislation, empowered to have better information to help them provide even better care? What are some of the provisions?

Mr. WHITEHOUSE. There are a great number of ways and much of it is thanks to the chairman's leadership and Chairman DODD on the HELP Committee. We put together a strong package melded by Leader REID. The main ingredients are taking advantage of electronic health records so you are not running around with a paper record, you are not having to fill out that clipboard again, they are not having to do another expensive MRI because they cannot access the one you had last week. If you have drugs you are taking, the drug interactions that

might harm you will be caught by the computer and signal the doctor so they can be aware of it and make a decision whether to change the medication. The electronic health record is a part of that.

Investment in quality reform is a huge issue. Hospital-acquired infections are prevalent throughout this country. They cost about \$60,000 each on average. They are completely preventable. Nobody knows this better than Senator STABENOW from Michigan because it was in her home State that the Keystone Project began, which has since migrated around the country. It has gone statewide in my home State through the Rhode Island Quality Institute. It has been written up by the health care writer Dr. Atul Gawande in the New Yorker magazine. What the information from Senator STABENOW's home State of Michigan shows is that in 15 months, they saved 1,500 lives in intensive care units and over \$150 million by better procedures to prevent hospital-acquired infections.

Ms. STABENOW. If I may add to that—and I thank the chairman for putting in language on the Keystone initiative in the bill—in this bill, we are, in fact, expanding what has been learned about saving lives and saving money by focusing on cutting down on infections in the intensive care units, by focusing on surgical procedures, things that actually will save dollars, don't cost a lot, and save lives. But they involve thinking a little differently, working a little bit differently as a team. Our physicians, hospitals, and nurses have found that if they made quality a priority, it became a priority.

There are so many things in this legislation that will save money, save lives, increase quality, and that is what this is all about, which is why so broadly we see the health care community, all the providers, nurses, doctors, and so on, supporting what we are doing.

Mr. BAUCUS. I think it is important not to overpromise because some of these initiatives, some of these programs will take a little time to take effect. In fact, some of the provisions do not take effect for a couple, 3 years. But still, wouldn't my colleagues agree that some of these are going to probably yield tremendous dividends in the future, especially generally the focus on quality, not outcomes, reimbursing physicians and hospitals based on quality, not outcomes, the pilot projects, the bundling, the counter care organizations and other similar efforts in this legislation. One of the two or both may want to comment on that point. I think it is a point worth making.

Mr. WHITEHOUSE. It is a very important point. Again, this is not something that emerged suddenly or overnight. The distinguished Senator from the Finance Committee has been working hard on this a long time, back even before "prepare to launch," which is an early reflection of the work he has been doing.

As we look at this bill, and as people who have been watching this debate have seen, this legislation saves lives, saves money, and saves medicine. We can vouch for that through the findings of the Congressional Budget Office. But the Congressional Budget Office has been very conservative in its scoring.

Mr. BAUCUS. Very.

Mr. WHITEHOUSE. There is a letter the CBO wrote to Senator CONRAD. There is testimony and a colloquy he engaged in with me in the Budget Committee that makes clear that beyond the savings that are clear from this legislation, there is a promise of immense further savings. What he said is:

Changes in government policy—

Such as these—

have the potential to yield large reductions in both national health expenditures and Federal health care spending without harming health. Moreover, many experts agree on some general directions in which the government's health policies could move.

The chairman of the Finance Committee has developed those general directions through those hearings and it is now in the legislation. But the conclusion he reaches is:

The specific changes that might ultimately prove most important cannot be foreseen today and could be developed only over time through experimentation and learning.

The MIT report that came out the other day, Professor Gerber, Dr. Gerber said the toolbox to achieve these savings through experimentation and learning is in this bill. I think his phrase was everything you could ask for is in this bill.

As the distinguished chairman of the Finance Committee knows better than I do, there are big numbers at stake here. If you look at what President Obama's Council on Economic Advisers has estimated, there is \$700 billion a year—when we talk numbers, we usually multiply by 10 because it is a 10-year window. So when people say there is this much in the bill, it is over 10 years. This is 1 year, \$700 billion in waste.

The New England Health Care Institute estimated \$850 billion annually in excess costs and waste. The Lewin Group, which has a relatively good opinion around here, and George Bush's former Treasury Secretary, Secretary O'Neill, have estimated it is over \$1 trillion a year. So whether it is \$700 billion or \$850 billion or \$1 trillion, even if these tools in the toolbox that we will refine through learning and experimentation achieve only a third, it is \$200 billion or \$300 billion a year.

Mr. BAUCUS. Right. Some people are worried, perhaps, gee, there they go back there in Congress. They talk about waste—which is good; we want to get rid of waste. But then when they talk about waste, they talk about cutting out the waste, some think: Gee, if they are cutting out the waste and they are cutting health care reimbursements, gee, won't that hurt health care in America? Won't that harm health care in America? Won't that reduce

quality? If they are cutting so much, \$600 billion, \$700 billion, \$800 billion—that is a lot of money—aren't they going to start cutting quality health care in America?

I see my good friend, the chairman of the HELP Committee, on the floor. He may want to join in this discussion as well, adding different points as to why the legislation we are putting together increases quality, does not cut quality, but it increases quality at the same time it reduces waste. I wonder if my colleagues might comment on all of that because it is an extremely, I think, important point to drive home our legislation improves quality health care.

Mr. DODD. I was going to raise the point, I say to my colleague and chairman of the Finance Committee, that there are a lot of good things about our health care system. We want to start off acknowledging that our providers, doctors do a magnificent, wonderful job. But we also know the system is fundamentally broken because it is based on quantity rather than quality.

That is my question. There is a question mark at the end of it. It is my opinion that is what it is. In other words, doctors and hospitals—the system—are rewarded based on how many patients you see, how many hospital beds are filled, how many tests get done, how many screenings are provided along the way. So it is all based on quantity. The more quantity you have, the system survives. Inherent in that is the question, if that is what drives the system, only quantity, then obviously what you are going to end up doing is have a sick care system, not a health care system.

If we asked, what are you trying to do over all—to fundamentally shift from a quantity-based system to a quality-based system where we try to keep people out of doctors' offices, out of hospitals, out of situations where they need to be there. That is what we are trying to achieve. To do that, we need to incentivize the system in reverse. The incentives today are to fill all these places. We are trying to incentivize by keeping people healthier, living a better health style, stopping smoking, losing weight, eating better food—all of these things that are not only good for you but overall save money. Am I wrong?

Mr. BAUCUS. I think my colleague is exactly right. As he was speaking, I was thinking of that article a lot of us have referred to often, the June 1 New Yorker article by Atul Gawande, comparing El Paso, TX, and McAllen, TX. They are both border towns. In El Paso, health care expenditures per person are about half what they are in McAllen. And yet the outcomes in El Paso are better than they are in McAllen.

One might ask: Why in the world is that happening? Why is there twice as much spent in McAllen than El Paso and the outcomes are different? The answer is we have a system which al-

lows the McAllens in the system, that allows payment in basic quantity and volume as opposed to quality.

I believe it depends on the community what the culture is. Some communities have a culture of patient-focused care. The current system allows that, but, unfortunately, if the culture in the community is more to make money, our reimbursement system today allows for that as well. So I think one of the things we are trying to do is to get more quality in the system—reimbursement to pay doctors and hospitals—more quality, as you have said—and that is going to even out a lot of the geographic disparities that have occurred in the country over time and so the quality will increase and the cost and the waste will decrease.

Mr. DODD. One last question I wished to raise, if I could, because our colleague from Montana said something yesterday that I think deserves being repeated, as I understood him, on the point he just made about the Gawande piece, which did that comparison between McAllen, TX, in Hidalgo County, which is the poorest county in the United States, and El Paso, and then I think you talked about Minnesota as well.

There is a fellow by the name of Don Berwick, a doctor who is an expert on integrated care, and one of the things he says—and I think you said this yesterday it deserves being repeated—it isn't just at the Cleveland Clinic or the Mayo Clinic where this happens—that kind of culture that exists at community hospitals and small hospitals all over the country where they have figured out integrated care; that is where doctors and hospitals have figured out how to provide services and reduce costs.

I have 31 hospitals in my State, and similar to all our colleagues, I have been visiting many of them and talking to people. Manchester Community Hospital is a very small hospital in Manchester, CT—a community hospital—and they have reduced costs and increased quality because they have figured out, between the provider physicians and the hospital, how to do that. My point is—and your point is—this is happening all across America in many places, and we need to be rewarding that when it occurs.

Mr. BAUCUS. There is no doubt about that. In fact, it is interesting the Senator mentioned his name because not too long ago I asked him that question. I said: Why, Dr. Berwick, is it that in some communities they get it and some they do not? His answer was that sometimes there is somebody—maybe it is a hospital or someone who is a pretty dominant player—who kind of starts it out and gets it right, and that is true.

He invited 10 integrated systems to Washington, DC, to kind of talk over what works and what doesn't work.

These are not the big-named institutions; they are the lesser named institutions. In fact, one of them I can probably say is the Billings Clinic, in Billings, MT—not too widely known, but they participated last year—the same process and integration with the docs, the acute care, and the postacute care. They have significantly cut costs, they have significantly improved the quality, and they are very proud of what they have done.

Mr. WHITEHOUSE. May I offer a specific example from the bill as an illustration of this?

One of the very few areas in which the Congressional Budget Office is prepared to document savings from these quality improvements is in the area of hospital readmissions. The chairman of the Finance Committee worked very hard to get hospital readmission language in his bill, I think we had it in the HELP bill as well, Chairman DODD, and it is in the bill Leader REID put together. What it does is it strips, over 10 years, \$7 billion—I think is the number—\$7 billion of money that hospitals would otherwise be paid when somebody gets out of the hospital and is readmitted within 30 days for the same condition.

The reason they are willing to apply those savings is because now you can demonstrate that if you have better prerelease planning, then people will go out and they will do better on their own. They will do better at home or they will do better in a nursing home, and therefore they will not come back. So you save lives because the health care is better, and you save money because they do not come back to the hospital. You improve on the front end. The hospital will do that. They will invest and improve on the front end because they don't want to pay on the back end if they are not recovering their costs with the readmission. It is a win-win for everyone. The individual American who has to be readmitted to the hospital and undergo, once again, all the procedures and all the risks that being in a hospital entails because he or she didn't get a proper discharge plan is not helped out by having to go back to the hospital.

Mr. BAUCUS. I have very direct experience in this. My mother was in the hospital 3 years ago—in another hospital, not the Billings Clinic—and there was no discharge plan. There was no way to help deliver health care for her when she left the hospital and went into a rehab center—sort of a nursing home. Sure enough, she didn't get the proper meds, she didn't get the proper attention, the doctor did not see her every day or after that, and, lo and behold, she had to be readmitted to the hospital. She had a gastrointestinal issue, and, sure enough, they took care of her back in the hospital. But once she was discharged, they did it right. They improved upon the mistakes they had made.

So I saw it firsthand, and it irritated the dickens out of me, frankly, in see-

ing how they did not pay sufficient attention to my mother. If this happens to my mother, my gosh, I bet it is even worse in lots of other situations.

Mr. DODD. If my colleagues will yield, I wished to thank Senator WHITEHOUSE, who was on our committee for the duration of our markup and he did a stunning job. He was a very valuable member of the committee and he made some wonderful suggestions to our bill all the way through the process.

I was told the other night by a friend of mine—Jack Conners, who is very involved in Boston and sits on the board and chairs the board of the hospitals in Boston—I think my colleague from Rhode Island may recognize the name—the average elderly person discharged from the hospital gets, on average, four medications—on average. Within 1 month, that individual, in most cases living alone, maybe with someone else, but on in years and so less capable of understanding it all, is basically not taking the four medications—or only taking parts of them—and finding themselves right back in the hospital as a readmission.

In our bill, we do a little bit to address that, and I think there is some effort in the Finance Committee bill through telemedicine—there are ways now through technology to provide some advice. This might not be a bad idea in terms of employment issues. It wouldn't take much to train people to be a home health care provider and to stop in. Your mother was in a nursing home, but most people end up in their apartment.

Mr. BAUCUS. Well, she is now home and getting great attention. I made sure of that.

Mr. DODD. We could help people who are being discharged, and the savings, by employing some people to do it, I think, would vastly be less than the cost of sending them back to the hospital.

Mr. BAUCUS. An example of that. I was talking to the head of Denver Health. It is an integrated system. I have forgotten the name, but she was so enthusiastic about the integration she performed with Denver Health. I will give you one small example, and it is one you just mentioned. She said: We have patients here—heart patients—and when they are discharged we ask them: Are you taking your meds? Are you controlling your blood pressure? Are you taking your medication to control your blood pressure?

They say: Oh, yeah, yeah, yeah, I am taking my meds.

She says: Well, why is your blood pressure so high?

The response is: Well, I, I, I. Because they are integrated, they check with their pharmacy, which is part of their system, to check the refill rate of the patients. Sure enough, they find their patient's refill history shows they were not taking their meds. So they get the patients back and they say: You are not taking your meds.

They say: Oh, I guess I wasn't.

They tell them: We are checking on you.

So, sure enough, they take their meds, and they have a much better outcome, generally, with their cardio patients because of that integration.

Mr. DODD. It works.

Mr. WHITEHOUSE. Part of what the distinguished chairman worked so hard on was to put in place the program so we will be able to begin to reimburse doctors for those kinds of discussions.

Mr. BAUCUS. Absolutely.

Mr. WHITEHOUSE. Right now, our payment system is driving them away from having that kind of simple discussion. It doesn't always support the electronic prescribing that would let you know they are not picking up their meds. But President Obama did a great job on that, with the electronic health record funding he put through.

But this question of doing what you are paid to do, if all you are paid for are procedures, then the hospital doing the discharge summary, if they couldn't get paid for that, but they did get paid when the person came back and was readmitted and maybe \$40,000, \$50,000 a day, it doesn't take too long to figure out where their effort is going to be. It is not going to be in those areas that save money for the system but hurt them financially because we have set up the payment system with all these perverse incentives.

Mr. BAUCUS. I don't know how much longer my colleague wanted to speak, but some time ago I know Senator HATCH wanted to speak at 5 o'clock, so I am trying to be traffic cop here.

Mr. DODD. If I could, Mr. Chairman, make the case—because I think it needs to be said and, unfortunately, over, over, and over again—because it is argued on the other side that we are cutting back on providers of the hospitals, for instance. That is accurate. We are doing that. If that is all we were doing, the complaint would have great legitimacy. But what we have done in this bill is to try to create a justification for that and provide the resources that make those savings reasonable. If you are having fewer readmissions in a hospital, which the hospitals support, if you are doing the kinds of things we are talking about to keep people healthy so they do not go back in, then these numbers become realistic numbers.

It is not just saying we are cutting out funding. We are improving systems in bill. People pick up the bill all the time and say: Look at all the pages. It is because a lot of thought has gone into this to do exactly what Senator WHITEHOUSE and the chairman of the committee talked about all day yesterday. This isn't just a bunch of language here. It goes to the heart of this and how we intend to accommodate the interests of the individual by improving their quality and simultaneously reducing the cost.

Everyone has made those claims that is what we need to do—increase quality, reduce cost, increase access. So

you can't just say it and not explain how you do it. What we have done in our bill is explain how we do that, how we increase access, how we improve quality for the individual and institutions and simultaneously bring down cost. That is what we spent the last year working on, to achieve exactly what is in these pages that people weigh and pick up all the time. If they would look into them, they would see the kind of achievements we have reached.

Those achievements have been recognized by the most important organizations affecting older Americans—AARP and the Commission to Preserve Social Security and Medicare. They have examined this. These are not friends of ours. These are people who objectively analyze what we are doing, and it is their analysis, their conclusion, reached independently, along with many others, that we have been able to reduce these costs, these savings, in this bill and simultaneously increase access and improve quality.

That has been the goal we have all talked about for years. This bill comes as close to achieving the reality of those three missions than has ever been done by this Congress, or any Congress for that matter. So when people talk about these cuts in Medicare, they need to be honest enough for people to realize what we have done is to stabilize Medicare, extend its solvency, and guarantee those benefits to people who rely on Medicare. That has all been achieved in this bill.

So when people start with these scare tactics and language to the contrary, listen to those organizations who don't bring any political brief to this, who don't have an R or a D at the end of their names. Their organizations are designed, supported, financed by, and applauded by the very individuals who count on having a solid, sound Medicare system. These organizations unanimously—unanimously—have said that guaranteed benefits in this bill remain intact. We stabilize Medicare, and we provide the kind of programs that will save lives and increase the quality of life for people. It is not only about staying alive but the quality of life and being able to live a quality life, independently, for as many years as possible.

At the end of the day, we all die one at a time in this country. No matter what else we do, that is the final analysis. But to the extent you can extend life and improve the quality of life and save the kind of money we ought to, that is the goal of this bill, and we largely achieve it.

I applaud, again, the Finance Committee, and the chairman, Max Baucus, who helped us get through and navigate these very difficult waters, and I thank our colleague from Rhode Island for his articulating these issues as well as his contributions during the HELP Committee proceedings on this bill. He brought many sound and very positive ideas to the table.

I wish to take a minute or two as well, if I could, to respond to our colleague and friend from New Hampshire, who, at some length, talked about his problems with what we call the CLASS Act that was part of our HELP Committee bill. I wish to briefly address those comments.

The CLASS Act was an issue Senator Kennedy championed for many years—the idea of providing an independent, privately funded source of assistance to people who become disabled but who want to continue working and earn a salary; who do not want to be limited by the constraints of a Medicaid system, which is very undesirable. Not a nickel of public moneys are used. Individuals make the contribution. If it vests for 5 years, and if you are faced with those kinds of disability issues, you can then collect approximately \$75 per day to provide for your needs—maybe a driver, maybe someone providing meals—but you then have the opportunity to continue working as an individual, without any limitations on what you can make or earn.

Again, no public money is involved. It builds up. Thanks to JUDD GREGG in our committee it is actuarially sound. He offered an amendment which insisted on the actuarial soundness of this program. The CLASS Act assists individuals who need long-term services and supports with such things as: assisted transportation, in-home meals, help with household chores, professional help getting ready for work, adult day care, and professional personal care. It also saves about \$2 billion in Medicaid savings. There are very few provisions which almost instantaneously do that.

Again, these dollars have to remain for just this purpose. You cannot raid this fund for any other purpose—which was a concern legitimately raised by some, that this \$75 billion may be used for other purposes. We have attempted to write into this legislation prohibitions to keep these moneys from being offered for any other purpose.

In fact, Senator GREGG, when he offered his amendment, said:

I offered an amendment, which was ultimately accepted, that would require the CLASS Act premiums be based on a 75-year actuarial analysis of the program's costs. My amendment ensures that instead of promising more than we can deliver, the program will be fiscally solvent and we won't be passing the buck—or really passing the debt—to future generations. I'm pleased the HELP Committee unanimously accepted this amendment.

Which we did. I hear some of my colleagues say this bill did not have anything but technical amendments of the 161 Republican amendments I took during committee markup—this was one of the amendments, Senator GREGG's amendment, which we accepted unanimously. My colleague from Utah was of course a member of the committee. He diligently paid attention to every amendment that was offered and I know remembers as we adopted one of his amendments dealing with biologics

in the committee that Senator Kennedy strongly supported in conjunction with Senator HATCH. But this CLASS Act is a unique and creative idea. We thank our colleague from Massachusetts, no longer with us, for coming up with and conceptualizing this idea that individuals, with their own money, contributing to a fund, could eventually draw down to provide these benefits should they become disabled. Individuals often want to continue working and being self-sufficient without getting into Medicaid, which limits your income, restrains you entirely.

Here is a totally privately funded program, no public money, just what you are willing to contribute over a period of years to protect against that eventuality that you might become disabled, so you can continue to function.

I have one case here, Sara Baker, a 33-year-old woman in my home State of Connecticut living in Norwalk. Two years ago Sara's mother, who was only 57 years old at the time, suddenly suffered a massive stroke. The stroke left the right side of her body completely paralyzed. She lost 100 percent of her speech. Sara recalls that fateful day when she got the call. I will quote her:

I was living out west in Arizona—working, dating—living and loving my life. Then . . . I got the phone call. . . . In seconds, literally, my entire world fell apart. I swear I can still feel that feeling through my whole body when I think about it. So there I was in a state of complete and total lunacy, getting on a plane with one suitcase—home to Connecticut. Guess what? I never went back.

Sara's mother was transferred to a rehab hospital. Sara went to the hospital every single day for 2 months to be at her mother's side as she went through therapy. Sara's mother had worked as an RN for 17 years. Her mom and the hospital social worker both agreed, her health insurance was “as good as they come.”

However, when it comes to long-term care, they don't come as good. Her mother was abruptly discharged from the rehab hospital after 60 days, when her insurance company decided she had made enough “progress.”

Sara went 9 months without working, dipped into what savings she had, and then went into debt to provide the long-term services and supports her mother needed.

As she recalled, and I will quote her again:

I made the whole house wheelchair accessible. I became a team of doctors, nurses, aides, and a homemaker. I helped her shower, get dressed, cut food, gave medicine, took her blood pressure. . . . What would have happened if I wasn't there? Basically, one of two things—I could have hired someone to come to the house, all out of pocket of course, or the State could have depleted her assets—her home, savings, everything—and she would have been put in a nursing home funded by Medicaid.

Stories like Sara's are not the exception, unfortunately. They happen every minute of every day, all across our country. They are common in my State

as well as any other State in the Nation. At any moment any one of us or someone we love can become disabled and need long-term services.

We also have an aging population. In my home State of Connecticut, the number of individuals 85 and over, the population most likely to need long-term care, will grow by more than 70 percent in the next 20 years.

Families such as Sara's are doing the right thing. They take care of each other, as most people understand we all would try and do. They do whatever they have to do. But the cost of long-term care can be devastating on middle-class working families. While 46 million Americans lack health insurance, more than 200 million lack any protection against the costs of long-term care. The CLASS Act will help fill that gap. It doesn't solve it all. It helps fill a gap. It is an essential part of health care reform. The CLASS Act will establish a voluntary—purely voluntary, there are no mandates on employers, no mandates on employees, no mandates on anyone—national insurance program.

If you decide, only you decide, voluntarily to contribute and participate in this, it happens. It is a long-term care insurance program financed by premium payments collected through payroll at the request of the individual, not a mandate on the employer. When individuals develop functional limitations, such as Sarah's mother, they can receive a cash benefit in the range of \$75 a day, which comes to over \$27,000 a year.

It is not intended to cover all the costs of long-term care but it could help many families like Sarah's. It could pay for respite care, allowing family caregivers to maintain employment. It could pay for home modifications. It could pay for assistive devices and equipment. It could pay for personal assistance services—allowing individuals with disabilities to maintain their independence, and community participation. It could allow individuals to stay in their homes versus having to go to a nursing home. It would prevent individuals from having to impoverish themselves by selling off everything they have, to then go through that title XIX window and become Medicaid recipients and then be constrained on what they could possibly earn.

Think about what if this young woman Sara had a family living out West, her own children instead of being single, how would she have done that? How would she have been able to pack up a whole family and move from the West to the East to take care of her mother in those days? Many families face these issues every day.

So while this proposal is not going to solve every problem, it is a very creative, innovative idea that does not involve a nickel of public money, not a nickel. It is all voluntary, depends upon the individual willing to make that contribution, to provide that level

of assistance, Lord forbid they should end up in a situation where they find themselves disabled and need some long-term services to allow them to survive and be part of their community life, including going back to work, without impoverishing themselves, selling off everything they have in order to make themselves qualified for Medicaid assistance.

I applaud my colleague from Massachusetts. There are a lot of great things he did over the years. He was a champion of so much when it came to working families and their needs in health care. But this idea, the Kennedy idea of the CLASS Act, is one that has a wonderful legacy to it. It is the heart of this bill. It has been endorsed and supported by over 275 major organizations in the country. I have never seen a proposal such as this receive a level of support across the spectrum that the CLASS Act is getting.

I know there will be those who try to take this out of the bill. I will stand here hour after hour and defend this very creative, innovative idea that can make a difference in the lives of millions of our fellow citizens, not only today but for years to come.

I again thank Senator Kennedy and his remarkable staff who did such a wonderful job on this as well, and I thank Senator GREGG, even though he is critical of the program. Senator GREGG's ideas were adopted unanimously in our markup of the bill and provided the actuarial soundness of this proposal for a long 75 years to come. For that we are grateful to him, for offering those amendments which were adopted by every Republican and every Democrat on the committee at the time of our markup last summer.

I see my colleague from Utah, and I have great respect for my friend from Utah. He and I have worked on so many issues together. Either he would get me in trouble politically or I would get him in trouble politically when we went to work on things. The very first major piece of legislation I ever worked on in the Chamber was to establish some Federal support for families who needed it for childcare. It was a long, drawn-out battle, but the person who stood with me almost a quarter of a century ago to make that happen—and today it has almost become commonplace for people to get that kind of assistance—but as long as I live, I will never forget I had a partner named ORRIN HATCH who made that possible. Whatever differences we have—and that is not the only thing we have worked on together, but it was the very first thing I worked on and he joined me in that effort—it became the law of the land and today millions of families manage to navigate that difficult time of making sure their families are going to get proper care and attention while they go out and work hard and try to provide for them as well. I thank him for that and many other things as well.

The PRESIDING OFFICER. The Senator from Utah is recognized.

Mr. HATCH. Mr. President, I thank my colleague. There is no question he is a great Senator. I have always enjoyed working with him and we have done an awful lot together. I want to compliment Senator WHITEHOUSE too, a terrific human being and great addition to this Senate and I have a lot of respect for him. He gives me heartburn from time to time, as does Senator DODD. On the other hand, they are great people and very sincere. Our chairman of the committee, Max Baucus, is a wonderful man. He is trying to do the best he can under the circumstances. I applaud him for it. Senator STABENOW from Michigan and I have not seen eye to eye on a lot of things, but we always enjoy being around each other.

This is a great place, there is no question about it. We have great people here. But that doesn't make us any less unhappy about what we consider to be an awful bill.

But right now, today, let me talk about a few specific things. Today the senior Senator from Illinois came to the floor and spoke about my efforts to reduce the costs associated with medical malpractice liability. I don't think his statement should go unanswered. Not only were a number of his statements simply incorrect as factual matters, but some of them even bordered on being offensive. I am not offended, I can live with it, I can take criticism, but some of them I think were a little bit over the top.

First of all, he referred to the recent letter I received from the CBO which indicated that the government would realize significant savings by enacting some simple tort reform measures. I don't know anybody in America who has any brains who doesn't realize we have to do something about tort reform when it comes to health care. According to the CBO, these measures would reduce the deficit by \$54 billion over 10 years. That is a lot of money. Private sector savings would be even more significant. According to the CBO, we would likely see a reduction of roughly \$125 billion in private health care spending over the same 10-year period, and that, in my view, is a low estimate. Democrats apparently want the American people to think these numbers are so insignificant that this issue should be ignored in this health care bill, and I have to respectfully disagree.

I may be one of the few Senators in this body who actually tried medical malpractice cases. I actually defended them. I defended doctors, hospitals, nurses, health care practitioners. I understand them.

There are cases where there should be huge recoveries. I would be the first to admit it. I saw the wrong eye taken out, the wrong leg taken off, the wrong kidney. You only have two of each of those. You bet your bottom dollar we settled those for significant amounts of money. But I also saw that the vast majority of the cases were frivolous,

brought to get the defense costs which then only ranged from \$50,000 to \$200,000, depending on the jurisdiction. If a lawyer can get a number of those cases they can make a pretty good living by bringing those cases just to get the defense costs, which of course adds to all the costs of health care. There is no use kidding about it.

Furthermore, Senator DURBIN, the distinguished Senator from Illinois, cited the same CBO letter in order to claim that the tort reform measures supported by many on my side of the aisle would cause more people to die.

Give me a break.

I can only assume he is referring to the one paragraph in the CBO letter that addresses the effect of tort reform on health outcomes. In that single paragraph the CBO referred to three studies. One of these studies indicated that a reduction in malpractice lawsuits would lead to an increase in mortality rates—one of the three.

The other two studies cited by the CBO found that there would be no effects on health outcomes and no negative effects could be expected. So, let's be clear, the CBO did not reach a conclusion in this case. These studies were cited only to show that there is disagreement in this area and, once again, the majority of the studies cited said there would be no negative effects on health outcomes. Apparently, omitting data and studies that disagree with your conclusions is becoming common practice among policy makers these days.

In his speech earlier today, the distinguished Senator from Illinois also discounted the prominence of defensive medicine in our health care system, saying only that "some doctors" perform unnecessary and inappropriate procedures in order to avoid lawsuits. Once again, the facts would contradict this generalization. A number of studies demonstrate this. For example, a 2005 study of 800 Pennsylvania physicians—where I used to practice law—in high-risk specialties found that 93 percent of these physicians had practiced some form of defensive medicine. That was published in the *Journal of the American Medical Association*, June 1, 2005.

In addition, a 2002 nationwide survey of 300 physicians—this is the Harris Interactive "Fear of Litigation Study"—found that 79 percent of physicians ordered more tests than are necessary. Think about that. If 79 percent are ordering more tests than are necessary, you can imagine the multibillions of dollars in unnecessary defensive medicine that comes from that. But that is not the end of that "Fear of Litigation Study." Seventy-four percent of physicians referred patients to specialists who, in their judgment, did not need any such referral. Think about it—referring people to specialists that they knew they didn't need. Think of the cost, the billions of dollars in cost. Fifty-two percent of physicians suggested unnecessary invasive proce-

dures. The word "invasive" is an important word. Fifty-two percent. Why? Because they are trying to protect themselves by making sure that everything could possibly be done. Forty-one percent of physicians prescribed unnecessary medications. This is a nationwide survey of 300 physicians.

The costs associated with defensive medicine are real—I would say unnecessary defensive medicine because I believe there are some defensive medicine approaches that we would want the doctors to do but not to the extent of these doctors ordering more tests than are necessary, ordering more specialists than are necessary, suggesting unnecessary invasive procedures, unnecessary medications. This is the medical profession itself that admits this.

In another study Pricewaterhouse found that defensive medicine accounts for approximately \$210 billion every year or 10 percent of the total U.S. health care cost. Here are some more facts from the Pricewaterhouse study. Of the \$2.2 trillion spent every year on health care in the United States, as much as \$1.2 trillion can be attributed to wasteful spending—\$1.2 trillion of \$2.2 trillion. Yet, the Democrats want to deny that unnecessary defensive medicine is being utilized to a significant extent. According to this study, defensive medicine is the largest single area of waste in the health care system. It is on par with inefficient claim processing and care spent on preventable conditions.

Yet, despite these overwhelming numbers—and I know some Democrats will say that is Pricewaterhouse and they must have been doing it at the expense of somebody who had an interest. Pricewaterhouse and other accounting firms generally try to get it right. They got it right here. Those of us who were in that business can attest to it.

Yet, despite these overwhelming numbers, my friends on the other side have opted to overlook them and instead relate horrific stories associated with doctors' malpractice, apparently trying to imply that Republicans simply don't care about these truly tragic occurrences. However, nothing could be further from the truth. In fact, in all the proposals that have been offered during this debate, there has not been a single suggestion to prevent plaintiffs from obtaining the compensation for actual losses they have incurred, not one suggestion that they should. Instead, we have sought to impose some limits on the noneconomic damages. All economic damages damages awarded for actual loss, past, present, and future—are fine, fair game. We've sought only impose some limits on the noneconomic damages in order to define the playing field, encourage settlement, and introduce some level of predictability to the system.

It is no secret that personal injury lawyers—some of them—are prolific political contributors to those politicians who fight against tort reform. With a Democratic majority and a

Democrat in the White House, their lobbying efforts during this Congress have reached unprecedented levels. Given this reality, it is obvious why trial lawyers have not been asked to give up anything in the current health care legislation.

Supporters of this health care bill will be asking the American people to pay higher health care premiums, for seniors to give up Medicare Advantage, which 25 percent of them have enlisted in, for businesses to pay higher taxes, for medical device manufacturers to pay more just to bring a device to the market that may save lives or make lives more worth living. The only group that has not been asked to sacrifice or change the way they do business happens to be the medical liability personal injury lawyers.

I would hope we would focus our efforts more on helping the American people than on preserving a fund-raising stream for politicians. Sadly, that doesn't appear to be happening in the current debate.

As I said, there are some very honest and decent attorneys out there who bring cases that are legitimate where there should be high rewards. But the vast majority, I can personally testify, are less than legitimate and the resulting costs are costing every American citizen an arm and a leg. It is something we ought to resolve. We ought to resolve it in a way that takes care of those who truly have injuries and get rid of these frivolous cases driving up the cost for every American.

Not too long ago, I talked to one of the leading heart specialists in Washington. He acknowledged, we all order a lot of tests and so forth that we don't need, that we know we don't need. But we do it so that the history we have of the patient shows we did everything possible to rule out everything that possibly could occur, even though we know we don't need to do it. To be honest, under the current system of lawsuits, I don't blame them. They are trying to protect themselves.

We should also discuss the shortage of doctors we have going into high-risk specialties. We have areas in this country where you can't get obstetricians and gynecologists to the people. Law schools will tell you, at least the ones I know, that there aren't that many young people going into obstetrics and gynecology today because they may not make as much money and the high cost of medical liability insurance is so high that they really can't afford to do it. And, of course, they don't want to get sued.

So much for that. I love my distinguished friend from Illinois, and he knows it. I care for him. But let me tell you, I think he knows better. He knows that I know better. I would be the first to come to bat for somebody who was truly injured because of the negligence of a physician. I don't have any problem with that at all.

I just thought I would make a few comments about this but, again, say

that I understand some of the excesses that go on on the floor. But that was an excess this morning, even though I know my dear friend is sincere and dedicated and one of the better lawyers in this body. Having said that, I will end on that particular subject.

Let me once again take a few minutes to talk about the Medicare provisions in this Democratic Party health care bill.

Throughout the health care debate, we have heard the President pledge not to “mess” with Medicare. Unfortunately, that is not the case with the bill before the Senate. To be clear, the Reid bill reduces Medicare by \$465 billion to fund a new government program. Unfortunately, seniors and the disabled in the United States are the ones who suffer the consequences as a result of these reductions. Everyone knows Medicare is extremely important to 43 million seniors and disabled Americans covered by the Medicare Program.

Throughout my Senate service, I have fought to preserve and protect Medicare for both beneficiaries and providers. Medicare is already in trouble today. The program faces tremendous challenges in the very near future. The Medicare trust fund will be insolvent by 2017, and the program has more than \$37 trillion in unfunded liabilities. This is going to be saddled onto our children and grandchildren.

The Reid bill will make the situation much worse. Why is that the case? Again, the Reid bill cuts Medicare to fund the creation of a new government entitlement program. More specifically, the Reid bill will cut nearly \$135 billion from hospitals—where are they going to get this money?—\$120 billion from Medicare Advantage, almost \$15 billion from nursing homes, more than \$40 billion from home health care agencies, and close to \$8 billion from hospice providers. These cuts will threaten beneficiary access to care as Medicare providers find it more and more challenging to provide health services to Medicare patients. Many doctors are not taking Medicare patients now because of low reimbursement rates.

Let me stress to my colleagues that cutting Medicare to pay for a new government entitlement program is irresponsible. Any reductions to Medicare should be used to preserve the program, not to create a new government bureaucracy.

As I just said, the President has consistently pledged: We are not going to mess with Medicare. Once again, this is another example of a straightforward pledge that has been broken over the last 11 months. Maybe you cannot blame the President because he is not sitting in this body. The body is breaking it.

This bill strips more than \$120 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 the so-called “additional benefits,” such as vision care and dental care, will decline from \$135 to \$42 by 2019. That is a reduction of more than 70 percent in benefits. You heard me right: 70 percent.

During the Finance Committee’s consideration of health care reform, I offered an amendment to protect these benefits for our seniors, many of whom are low-income Americans and reside in rural States and rural areas. However, the majority party would not support this important amendment. 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.”

Let me make the point as clearly as I can. When we promise American seniors we will not reduce their benefits, let’s be honest about that promise. So we are either going to protect benefits or not. It is that simple. Under this bill, if you are a senior who enjoys Medicare Advantage, the unfortunate answer is, no, they are not going to protect your benefits.

All day today, we had Members on the other side of the aisle claim that Medicare Advantage is not part of Medicare. This is absolutely—I have to tell you, it is absolutely unbelievable. I would invite every Member making this claim to turn to page 50 of the “2010 Medicare and You Handbook.” It says:

A Medicare Advantage is another health coverage choice you may have—

Get these words—as part of Medicare.

Let me repeat that:

A Medicare Advantage is another health coverage choice you may have as part of Medicare.

Hey, that is the Medicare “2010 Medicare and You Handbook.” Who is kidding whom about it not being part of Medicare?

So the bottom line is simple: If you are cutting Medicare Advantage benefits, you are cutting Medicare.

I also heard the distinguished Senator from Connecticut this morning mention that the bureaucrat-controlled Medicare Commission will not cut benefits in Part A and Part B. Well, once again, my friends on the other side are only telling you half the story. So much for transparency. On page 1,005 of this bill, it states in plain English:

Include recommendations to reduce Medicare payments under C and D.

I am just waiting for Members on the other side of the aisle to come down and now claim that Part D is also not a part of Medicare. We all know it is.

It is also important to note that the Director of the nonpartisan Congressional Budget Office has told us in clear terms that this unfettered authority given to the Medicare Commission would result in higher premiums.

It is important details such as these that the majority does not want us to discuss and debate in full view of the American people. They call it slow-walking. They call it obstructionism. Making sure we take enough time to discuss a 2,074-page bill that will affect every American life and every American business is the sacred duty of every Senator in this Chamber. We will take as long as it takes to fully discuss this bill, and you can talk for a month about various parts of this bill that are outrageous and some that are really good, too, in all fairness—not many, however.

I have heard several Members from the other side of the aisle characterize the Medicare Advantage Program as a giveaway to the insurance industry. You know, when you cannot win an argument, you start blaming somebody else. So they want a government insurance company to take the place of the insurance industry. Well, maybe that is too much. They want it to compete with the insurance industry. But how do you compete with a government-sponsored entity? And there are comments that the so-called government plan will cost more than the current insurance businesses they are so criticizing. I am not happy with the insurance industry either, but, by gosh, let’s be fair.

Let me give everyone watching at home a little history lesson on the creation of Medicare Advantage. I served as a member of the House-Senate conference committee which wrote the Medicare Modernization Act of 2003. The distinguished Senator from Montana would agree with me, it was months of hard, slogging work every day to try to come up with the Medicare Modernization Act of 2003. Among other things, this law created the Medicare Advantage Program. It gives people vision care, dental care, et cetera.

When conference committee members were negotiating the conference report back then, in 2003, several of us insisted that the Medicare Advantage Program was necessary in order to provide health care coverage choices to Medicare beneficiaries. At that time, there were many parts of the country where Medicare beneficiaries did not have adequate choices in coverage. In fact, the only choice offered to them was traditional fee-for-service Medicare, a one-size-fits-all, government-run health program.

By creating the Medicare Advantage Program, we were providing beneficiaries with choice in coverage and then empowering them to make their own health care decisions as opposed to the Federal Government making them for them. Today, every Medicare beneficiary may choose from several health plans.

We learned our lessons from Medicare+Choice, which was in effect at the time, and its predecessors. These plans collapsed, especially in rural areas, because Washington decided—

again, government got involved—to set artificially low payment rates. In fact, in my home State of Utah, all of the Medicare+Choice plans eventually ceased operations because they were all operating in the red. You cannot continue to do that. It was really stupid what we were expecting them to do. I fear history could repeat itself if we are not careful.

During the Medicare Modernization Act conference, we fixed the problem. We increased reimbursement rates so all Medicare beneficiaries, regardless of where they lived—be it Fillmore, UT, or New York City—had choice in coverage. Again, we did not want beneficiaries stuck with a one-size-fits-all, Washington-run government plan.

There were both Democrats and Republicans on that committee, by the way, and the leader was, of course, the distinguished Senator from Montana. I admire him for the way he led it, and I admire him for trying to present what I think is the most untenable case here on the floor during this debate. He is a loyal Democrat. He is doing the best he can, and he deserves a lot of credit for sitting through all those meetings and all of that markup and everything else and sitting day-in and day-out on the floor here.

Today, Medicare Advantage works. Every Medicare beneficiary has access to a Medicare Advantage plan, if they so choose, and close to 90 percent of Medicare beneficiaries participating in the program are satisfied with their health coverage. But that can all change should this health care reform legislation currently being considered become law.

In States such as Utah, Idaho, Colorado, New Mexico—just to mention some Western States—Wyoming, Montana—you can name every State—rural America was not well served, and we did Medicare Advantage.

Choice in coverage has made a difference in the lives of more than 10 million Americans nationwide—almost 11 million Americans. The so-called “extra benefits” I mentioned earlier are being portrayed as gym memberships as opposed to lower premiums, copayments, and deductibles.

To be clear, the Silver Sneakers Program is one that has made a difference in the lives of many seniors because it encourages them to get out of their homes and remain active. It is prevention at its best. It has been helpful to those with serious weight issues, and it has been invaluable to women suffering from osteoporosis and joint problems. In fact, I have received several hundred letters telling me how much Medicare Advantage beneficiaries appreciate this program. They benefit from it. Their lives are better. They use health care less. They do not milk the system. They basically have a better chance of living and living in greater health.

Throughout these debates, throughout these markups, throughout these hearings that have led us to this point, every health care bill I know of has a

prevention and wellness section in the bill that will encourage things such as the Silver Sneakers Program that has benefited senior citizens so much and was not one of the major costs of Medicare Advantage.

Additionally, these beneficiaries receive other services such as coordinated chronic care management, which is important, coordinated chronic care management for seniors; dental coverage—really important for low-income seniors; vision care—can you imagine how important that is to people over 60 years of age? How about those who are over 70 or 80 years of age? And hearing aids—can you imagine how important that is to our senior citizens? This program helps these seniors, and it helps them the right way.

Let me read some letters from my constituents. These are real lives being affected by the cuts contemplated in the bill.

Remember, there is almost \$500 billion cut by this bill from Medicare, which goes insolvent by 2017 and has an almost \$38 trillion unfunded liability.

Let me read this letter from a constituent from Layton, UT:

I recently received my healthcare updater for 2010. I am in a Med Advantage plan with Blue Cross/Blue Shield. Thanks to the cuts in this program by Medicare, my monthly premiums have risen by 49% and my office visit co-pay has increased 150%. Senator HATCH, I am on a fixed income and this has really presented a problem for me and many others I know on the same program. And, at my age I certainly can't find a job that would help cover the gap. I worked all my life to enjoy my retirement and thanks to the current economy I've lost a lot of those monies that were intended to help supplement my income.

This letter is from a constituent from Logan, UT, where the great Utah State University is:

Please stop the erosion of Medicare Advantage for seniors. Very many of us are already denied proper medical and dental care not to mention those who cannot afford needed medications. Hardest hit are ones on Social Security who are just over the limit for extra help but cannot keep up with the rising medical costs that go way beyond the so-called “cost of living increases” which we are not getting this year anyway. If those in government who make these decisions had to live as we do day to day, I think we would find better conditions for seniors. The difference in decision making changes when you are hungry and cold your own self.

Here is a constituent from Pleasant Grove, UT:

Please do not phase out the Medicare Advantage program, senior citizens need it. Our supplement insurance rates go up every year and our income does not keep pace with the cost of living.

Here is a constituent from Salt Lake City, UT:

We met with our insurance agent this morning about the increased costs of our Medicare Advantage plans due to the health care reform bill now before Congress.

Our premium costs have already been significantly increased with the coverage substantially decreased. We are in our 80s and cannot afford these increases and are hurt by the decreased coverage. We are writing to

you to have you stop the cuts and restore the coverage to Medicare Advantage plans. This is an issue that is very important and very real to us at this point in our lives. Please stop the cuts and restore coverage.

I can't support any bill that would jeopardize health care coverage for Medicare beneficiaries. I truly believe if this bill before the Senate becomes law, Medicare beneficiaries' health care coverage could be in serious trouble.

I have been in the Senate for over 30 years—33 to be exact. I pride myself on being bipartisan. I have coauthored many bipartisan health care bills since I first joined the Senate in 1977. Almost everyone in this Chamber wants a health care reform bill to be enacted this year. I don't know of anybody on either side who would not like to get a health care bill enacted.

On our side, we would like to do it in a bipartisan way, but this bill is certainly not bipartisan. It hasn't been from the beginning. We want it to be done right. History has shown that to be done right, it needs to be a bipartisan bill that passes the Senate with a minimum of 75 to 80 votes. We did it in 2003 when we considered the Medicare prescription drug legislation, and I believe we can do it again today if we have the will and if we get rid of the partisanship. I doubt there has ever been a bill of this magnitude affecting so many American lives that has passed this Chamber on an almost—or maybe in a complete—straight party-line vote. The Senate is not the House of Representatives. This body has a different constitutional mandate than the House. We are the deliberative body. We are the body that has in the past and should today be working through these difficult issues to find clear consensus. True bipartisanship is what is needed.

In the past, the Senate has approved many bipartisan health care bills that have eventually been signed into law. I know a lot of them have been mine, along with great colleagues on the other side who deserve the credit as well. The Balanced Budget Act in 1997 included the Hatch-Kennedy SCHIP program. How about the Ryan White Act. I stood right here on the Senate floor and called it the Ryan White bill. His mother was sitting in the audience at the time. How about the Orphan Drug Act. When I got here we found that there were only two or three orphan drugs being developed. These are drugs for population groups of less than 250,000 people. It is clear that the pharmaceutical companies could not afford to do the pharmaceutical work to come up with treatments or cures for orphan conditions. So we put some incentives in there; we put some tax benefits in there. We did some things that were unique. If I recall it correctly, it was about a \$14 million bill.

Today we have over 300 orphan drugs, some of which have become blockbuster drugs along the line. They wouldn't have been developed if it

hadn't been for that little, tiny orphan drug bill. That was a major bill when I was chairman of the Labor and Human Resources Committee. They now call it the Health, Education, Labor, and Pensions Committee.

How about the Americans With Disabilities Act. Tom Harkin stood there, I stood here, and we passed that bill through the Senate. It wasn't easy. There were people who thought it was too much Federal Government, too much this, too much that. But Senator HARKIN and I believed—as did a lot of Democrats and a lot of Republicans, as the final vote showed—that we should take care of persons with disabilities if they would meet certain qualifications.

How about the Hatch-Waxman Act. We passed that. Henry Waxman, a dear friend of mine, one of the most liberal people in all of the House of Representatives and who is currently the very powerful chairman of the Energy and Commerce Committee over there, we got together, put aside our differences, and we came up with Hatch-Waxman which basically almost everybody admits created the modern generic drug industry.

By the way, most people will admit that bill has saved at least \$10 billion to consumers and more today, by the way, every year since 1984.

I could go on and on, but let me just say I have worked hard to try and bring our sides together so we can in a bipartisan way do what is right for the American people.

Let me just tell my colleagues, if the Senate passes this bill in its current form with a razor thin margin of 60 votes, this will become one more example of the arrogance of power being exerted since the Democrats secured a 60-vote majority in the Senate and took over the House and the White House. There are essentially no checks or balances found in Washington today, just an arrogance of power, with one party ramming through unpopular and devastating proposals such as this, one after another.

Well, let me say there is a better way to handle health care reform. For months I have been pushing for a fiscally responsible and step-by-step proposal that recognizes our current need for spending restraint while starting us on a path to sustainable health care reform. There are several areas of consensus that can form the basis for sustainable, fiscally responsible, and bipartisan reform.

These include:

Reforming the health insurance market for every American by making sure no American is denied coverage simply based on a preexisting condition. Some of my colleagues on the other side have tried to blast the insurance industry, saying they are an evil, powerful industry. We need to reform them, no question about it, and we can do it if we work together.

Protecting the coverage for almost 85 percent of Americans who already have coverage they like by making that cov-

erage more affordable. This means reducing costs by rewarding quality and coordinated care, giving families more information on the cost and choices of their coverage and treatment options, and—I said it earlier—discouraging frivolous lawsuits that have permeated our society and made the lives of a high percentage of our doctors, especially in those very difficult fields of medicine, painful and those fields not very popular to go into today. And, of course, we could promote prevention and wellness measures.

We could give States flexibility to design their own unique approaches to health care reform. Utah is not New York, Colorado is not New Jersey, New York is not Utah, and New Jersey is not Colorado. Each State has its own demographics and its own needs and its own problems. Why don't we get the people who know those States best to make health care work? I know the legislators closer to the people are going to be very responsive to the people in their respective States. I admit some States might not do very well, but most of them would do much better than what we will do here with some big albatross of a bill that really does not have bipartisan support.

Actually, in talking about New York, what works in New York will most likely not work in Colorado, let alone Utah. As we move forward on health care reform, it is important to recognize that every State has its own unique mix of demographics. Each State has developed its own institutions to address its challenges, and each has its own successes. We can have 50 State laboratories determining how to do health care in this country in accordance with their own demographics, and we could learn from the States that are successful. We could learn from the States that make mistakes. We could learn from the States that cross-breed ideas. We could make insurance so that it crosses State lines.

Can you imagine what that would do to costs? We could do it. But there is no desire to do that today with this partisan bill.

There is an enormous reservoir of expertise, experience, and field-tested reform. We should take advantage of that by placing States at the center of health care reform efforts so they can use approaches that best reflect their needs and their challenges.

My home State of Utah has taken important and aggressive steps toward sustainable health care reform. They already have an exchange. They are trying some very innovative things. By anybody's measure the State of Utah has a pretty good health care system. Is it perfect? No. But we could help it to be, with a fraction of the Federal dollars that this bill is going to cost. This bill over 10 years is at least \$2.5 trillion, and I bet my bottom dollar it will be over \$3 trillion. That is on top of \$2.4 trillion we are already spending, half of which they claim may be not well spent. We know a large percentage of that is not well spent.

Like I say, my home State of Utah has taken important and aggressive steps toward sustainable health care reform. The current efforts to introduce the defined contribution health benefits system and implement the Utah health exchange are laudable accomplishments.

A vast majority of Americans—I believe this to be really true—agree a one-size-fits-all Washington government solution is not the right approach. That is why seniors and everybody else except a very few are up in arms about these bills. That is what this bill is bound to force on us: a one-size-fits-all, Washington-run, controlled government program. I am not just talking about the government option. That is a small part of the argument today. If we pass this bill, we will have Washington governing all of our lives with regard to health care. I can't think of a worse thing to do when I look at the mess they have made with some very good programs.

Unfortunately, the path we are taking in Washington right now is to simply spend another \$2.5 trillion of taxpayer money to further expand the role of the Federal Government. I just wish the majority would take a step back, keep their arrogance of power in check, and truly work on a real bipartisan bill that all of us can be proud of. They have the media with them selling this bill as less than \$1 trillion. Give me a break. Between now and 2014, yes, they will charge everybody the taxes they can get and the costs they can get, but the bill isn't implemented until 2014, and even some aspects not until 2015. That is the only way, with that budgetary gimmick, they could get the costs to allegedly be down below \$900 billion. But even the CBO—certainly the Senate Budget Committee—acknowledges that if you extrapolate—I think my colleagues on the other side acknowledge that if you extrapolate it out over a full 10 years, you have at least \$2.5 trillion and in some circumstances as much as \$3 trillion.

How can we justify that? With the problems we have today, a \$12 trillion national debt, going up to \$17 trillion if we do things like this? How can we justify it? How can we stick our kids and our grandkids and our great grandkids—my wife and I have all three, by the way, kids, grandkids, and great-grandkids. How can we stick them with the cost of this bill? This is just one bill. I hate to tell you some of the other things that are being put forth in not only this body but the other. How come we do it on bills that are totally partisan bills?

If we look at what has happened, the HELP Committee, the Health, Education, Labor and Pensions Committee, came up with a totally partisan bill. Not one Republican was asked to contribute to it. They just came up with what they wanted to do. It was led by one staff on Capitol Hill. It is a very partisan bill. Then the House came up with their bill. Not one Republican, to

my knowledge, had even been asked to help, and it is a tremendously partisan bill—both of which are tremendously costly too.

Then the distinguished Senator from Montana tried to come up with a bill that would be bipartisan in the Finance Committee, but in the end, even with the Gang of 6—and I was in the original Gang of 7, but I couldn't stay because I knew what the bottom bill was going to be, and I knew I couldn't—I couldn't support it. So I voluntarily left, not because I wanted to cause any problems but because I didn't want to cause any problems. I found myself coming out of those meetings and decrying some of the ideas that were being pushed in those meetings. I just thought it was the honorable thing to do to absent myself from the Gang of 7. It became a Gang of 6 and then the three Republicans finally concluded that they couldn't support it either.

But I will give the distinguished chairman from Montana a great deal of credit because he sat through all of that. He worked through all of it. He worked through it in the committee, but then it became a partisan exercise in committee by and large.

Yes, there were a couple of amendments accepted: My gosh, look at that. Then what happened? They went to the majority leader's office in the Senate, and they brought the HELP bill and the bill from the Finance Committee, and they molded this bill, this 2,074-page bill with the help of the White House. Not one Republican I know of had anything to do with it, although I know my dear friend, the distinguished majority leader, did from time to time talk with at least one Republican, but only on, as far as I could see, one or two very important issues in the bill. There are literally thousands of important issues in this bill, not just one or two. There are some that are more important than others, but they are all important.

I am not willing to saddle the American people with this costly, overly expensive, bureaucratic nightmare this bill will be. I hope my colleagues on the other side will listen, and I hope we can start over on a step-by-step approach that takes in the needs of the respective States that is not a one-size-fits-all solution, that both Republicans and Democrats can work on, which will literally follow the principles of federalism and get this done in a way that all of us can be proud of.

I don't have any illusions and, thus far, it doesn't look like that will happen. But it should happen. That is the way it should be done. I warn my friends on the other side, if they succeed in passing this bill without bipartisan support—if they get one or two Republicans, I don't consider that bipartisan support. You should at least get 75 to 80 votes on a bill this large, which is one-sixth of the American economy, 17 percent of the American economy. You should have to get 75 to

80 votes minimally. It would even be better if you can get more, as we did with CHIP and other bills. On some we have gotten unanimous votes—on bills that cost money, by the way. Republicans have voted for them, too. Republicans will vote for a good bill even if it costs some money. We are not about to vote for something costing \$2.5 trillion to \$3 trillion. I don't think the American people are going to stand for it.

Beware, my friends, of what you are doing. I can tell you right now this isn't going to work. I want to make that point as clear as I can.

With that, I yield the floor.

The PRESIDING OFFICER (Mr. BENNET). The Senator from Illinois is recognized.

Mr. BURRIS. Mr. President, as a lifelong public servant, I have always believed in the fundamental greatness of this country. I am sure this is a belief shared by every single one of my colleagues in this body. It is what drove us to serve in the first place, just as it has driven generations of Americans to serve in many capacities throughout our history. Democrat or Republican, liberal or conservative, we are united by our underlying faith in the democratic process and our respect for the people we have come here to represent. That is what makes this country great, the belief that together we can make progress. Together, we can shape our own destiny. That is why we gather here in this august Chamber, to bring the voices of the American people to Washington, to the very center of our democracy.

Earl Warren, the late Chief Justice of the Supreme Court, articulated this very well:

Legislators represent people, not trees or acres. Legislators are elected by voters, not farms or cities or economic interests.

He said this in reference to a court case about elected representatives at the State level, but his insight rings especially true here in the highest law-making body in the land.

I ask my colleagues to reflect upon this simple truth for a moment. We address one another as “the Senator from Illinois” or “the Senator from Texas” or “the Senator from Colorado” or “the Senator from Utah,” but we do not speak for towns, or companies, or lines on a map. Our solemn duty is to listen to the people we represent and give voice to their concerns and interests here in Washington. We strive to do this every day, but far too often partisan politics get in the way.

When it comes to difficult issues such as health care reform, the voices of the people sometimes get lost in all of the talk about Republicans versus Democrats, red States versus blue States. The media gets caught up in the horse race and, more often than we would wish, the atmosphere of partisanship follows us into this Chamber.

As our health care reform bill has cleared the first hurdle and moved to the Senate floor, I urge my colleagues to listen to the people—not just to the

party leadership—as they decide how to vote. If they shut out the health care insurance lobbyists, the special interests, and the partisan tug of war, they might be surprised at what they will hear from the American people.

In my home State of Illinois, the weight of consensus is hard to ignore. Folks stop me on the streets, stop me in hallways outside of my office, talk to me on airplanes; they call, write, and e-mail. They contact me every way possible. The message is always the same: We need real health care reform. They are telling me don't give up and don't back down. That is because the American people overwhelmingly support reform. They need health care reform now—not tomorrow or next year, they need it now.

I urge my colleagues to think of the uninsured people in their own States. Think about that. Who are the ones who are uninsured? These are the folks who need reform the most. We have all heard at least a few of the heart-breaking stories. Sadly, we will never be able to hear them all because there are too many. So it is time for us to listen and to take a stand on their behalf. It is time to bring comprehensive health care reform to every State in the Union, because in my home State of Illinois, 15 percent of the population is uninsured. In the most advanced country on Earth, this is simply unacceptable. We need to dramatically expand access to quality, affordable health care. But it is not just a blue States issue, it is an American issue. This is a problem that touches all of us. In fact, as we look across the map, we see that many of our States that need the most help are actually the red States.

Eighteen percent of the people in Tennessee and Utah don't have health insurance and cannot get the quality care they need. The number of uninsured stands at 20 percent in Alaska, and it is nearly 21 percent in Georgia, Florida, and Wyoming. In Oklahoma, Nevada, and Louisiana, more than 22 percent of the total population is uninsured, and 24 percent without health insurance in Mississippi. More than a quarter of the population in New Mexico can't get health insurance. In the great State of Texas, almost 27 percent of the population has no health coverage. These numbers speak for themselves. We need to expand coverage to include more of these people.

A recent study conducted by Harvard University shows that the uninsured are almost twice as likely to die in the hospital as similar patients who do have insurance. This human cost is unacceptable, and the financial cost is too much to bear.

While my friends on the other side seek to delay and derail health care reform at this crucial juncture, this bill seeks to save the health of our citizens, to save the lives of Americans, and to save money in the way coverage is offered and delivered. By extending coverage to these individuals and increasing access to preventive care, we can

catch illnesses before they become serious.

That is why I am proud to support provisions such as the amendment offered by my colleague from the great State of Maryland, Senator MIKULSKI. This measure would guarantee women access to preventive care and health screenings at no cost. If more women could get regular screenings and tests, such as mammograms, we can catch illnesses such as breast cancer, heart disease, and diabetes. We can keep more people out of the emergency rooms, we can save lives, and we can save money.

The best way to expand access is to create a strong public option that will lower costs, increase competition, and restore accountability to the insurance industry.

I am fighting for every single Illinoisan to make sure they have access to quality, affordable health care, and to make sure they have real choices. I am fighting for every Illinoisan, because every one of us will benefit from comprehensive reform. But I recognize that those who are uninsured need help the most, and they need it now.

I ask my colleagues to consider this need and to think about how many of their constituents stand to benefit from our reform package.

It is no secret that my Republican friends seek to block and delay this legislation. Many of them represent the so-called red States, where opposing health care reform is seen as a good political move. In the cynical course of politics as usual, most of those red States will be written off because they typically support the Republican Party. But not this time. Health reform isn't about politics. It is not about one party or the other. It is about the lives that are at stake here that we are trying to help. It is about the people who suffer every day under a health care system that fails to live up to the promises of this great Nation.

When it comes to our health care legislation, a vote against reform is a vote against the people who so desperately need our help. That is why I am asking my Republican friends to rise above politics as usual when they make this choice.

Recently, some of my colleagues across the aisle have said our bill would slash Medicare. This is simply not the case. There is no cut in Medicare—no \$465 billion cut. Our bill would do nothing of the kind. This is another cynical attempt to scare seniors into opposing health care reform. We have had enough of that.

The truth is this: According to the nonpartisan Congressional Budget Office, health care reform will lower seniors' Medicare premiums by \$30 billion over the next 10 years by focusing on prevention and wellness, increasing efficiency and making the program more cost effective.

Our Republican friends can choose to engage in partisan games and spread fear and disinformation about health

care reform, they can turn their backs on the people they swore to represent, or they can cast aside the tired constraints of partisanship and stand up for what is right. When they go home to the people who sent them to Washington, they can look those people in the eye and say: I fought for you. I stood up to the special interests, the campaign donors, and the political forces that tried to block reform. I didn't vote like a Senator who represents a red State or a blue State; I voted like a Senator who represented your State and all the good, hard-working people who desperately need this help.

That is the spirit that drove each of us to enter public service in the first place. That is what makes this country great, the belief that policy is decided by the interests of the people, not big corporations or political parties.

This country is more than just a set of lines on a map, and the more you cross those lines, the more you learn that ordinary Americans don't care who scores political points or who gets reelected. They care about results. They care about real costs and real health outcomes.

It is time for us to deliver. It is time to stand for the uninsured, the sick, the poor, and all those who cannot stand for themselves. I say to my colleagues, it is time to come together on the side of the American people and make health care reform a reality. This health care legislation that is being debated on this floor will save lives, it will save money, and it will save Medicare.

I yield the floor.

THE PRESIDING OFFICER. The Senator from Nevada.

MR. ENSIGN. Mr. President, I ask unanimous consent that I and my two colleagues be able to engage in a colloquy.

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

MR. ENSIGN. Mr. President, I would like to start by talking about the bill in general.

MR. DURBIN. Mr. President, will the Senator from Nevada yield for a question before he starts?

MR. ENSIGN. Yes.

MR. DURBIN. Can the Senator give us an indication of how long he expects the colloquy to last?

MR. ENSIGN. Maybe 40 minutes, somewhere in there.

MR. DURBIN. I thank the Senator.

MR. ENSIGN. Mr. President, there is a lot of talk about this bill. I wish to make some general comments about it. First, following the comments of my colleague from Illinois, he said there are not \$½ trillion in Medicare cuts. According to the Congressional Budget Office, there are \$464 billion to \$465 billion in Medicare cuts. So maybe not quite \$½ trillion, but we are certainly getting close.

There are, however, \$½ trillion in new taxes in this bill, 84 percent of which will be paid by those making less

than \$200,000 a year, a direct violation of the campaign pledge made by President Barack Obama, then-Candidate Obama.

This bill will result in increased premiums and health care costs for millions of Americans. This is a massive government takeover of our health care system. As a matter of fact, according to the National Center for Policy Analysis, in this 2,074 page bill—there are almost 1,700, 1,697 to be exact—references to the Secretary of Health and Human Services, giving her the authority to create, determine, or define things relating to health care policy in this bill. Basically, we are placing a bureaucrat in charge of health care policy instead of the patient and the doctor making the choices in health care.

I believe we cannot just be against this bill. What I do believe in is a step-by-step approach, an incremental approach, some good ideas on which we should be able to come together.

I think both sides agree we should eliminate preexisting conditions. Somebody who played by the rules, had insurance, happened to get a disease, they should not be penalized, charged outrageous prices, or have their insurance dropped. I think we can all agree on that.

We should be able to agree that if you can buy auto insurance across State lines, you should be able to buy health insurance in the State where it is the cheapest. Individuals should be able to find a State that has a policy that fits them and their family and be able to buy it there. If you can save money and you happen to be uninsured, especially today, it seems to make sense. Let's have that as one of our incremental steps.

I also believe this bill covers some of it, but I believe we need to incentivize people to engage in healthier behaviors. Seventy-five percent of all health care costs are caused by people's behaviors. Let me repeat that. Three-quarters of all health care costs are driven by people's poor choices in their behavior.

For instance, smoking. On average, it is around \$1,400 a year to insure a smoker versus a nonsmoker. For somebody who is obese versus somebody with the proper body weight, it is about the same, \$1,400 a year. For somebody who does not control their cholesterol versus somebody on regulating medication, it is several hundred dollars a year. For somebody who does not control their blood pressure versus somebody who does—let's give incentives through lower premiums to encourage people to engage in healthier behaviors. That will save money for the entire health care system and our Country will have healthier people with better quality lives.

Currently, big businesses, because of their number of employees, are allowed to take advantage of purchasing power. We ought to allow individuals and small businesses to join together in

groups to take advantage of that purchasing power. They are called small business health plans.

I believe my colleagues are going to talk about an idea they have, something I talked about for years, the idea of medical liability reform. There are several models out there. They are going to talk about a loser pays model, which other countries have engaged in and they do not have nearly the frivolous lawsuits nor the defensive medicine we practice in this country.

How many doctors order unnecessary tests in the United States because of fear of frivolous lawsuits? Talk to any doctor, and they will tell you every one of them orders unnecessary tests simply to protect themselves against the possibility that a jury may say: Gee, why didn't you order this test even though it was not indicated at the time?

That accounts for a large amount of medical costs. As a matter of fact, the Congressional Budget Office said \$100 billion between the private and public sector would be saved with a good medical liability reform bill.

I believe we need a patient-centered health care system, not an insurance company-centered health care system, not what this bill does, a government-centered health care system, where bureaucrats are in control of your health care. We need a patient-centered system.

Before us we have the Mikulski amendment. This is more of government-centered health care. There is a report out based on prevention that indicates that mammograms should not be paid for, basically, for women under 50 years of age, from 40 to 50 years of age, and women in the Medicare population age, the report indicates that they do not need annual mammograms. This was based mainly on cost. If you look at it from a cost standpoint, that is probably correct.

But think about it. If you are a woman and you get cancer and you could have had a mammogram diagnose it a lot earlier, you sure would rather have had that mammogram rather than have that mammogram denied.

The Senator from Maryland has proposed an amendment to try to fix the problem. The problem is, instead of one government entity determining whether somebody is going to get coverage, the amendment turns it over to the Secretary of Health and Human Services. Another government bureaucrat will determine whether something such as a mammogram will be paid for. According to the Associated Press, her amendment does not even mention mammograms.

Senator MURKOWSKI and Senator COBURN have come up with an alternative that actually puts the decision of whether to cover preventive services in the hands of experts in the field. Whether it be a mammogram for breast cancer, or an MRI, which most people think is going to be better than a

mammogram for diagnosing breast cancer, or whether it is a test for prostate cancer for men. Those kinds of things should be determined by experts in the field, not by government bureaucrats.

The various colleges—the American College of Obstetrics and Gynecology, for instance, has come out with certain recommendations, along with the American College of Surgeons. Those are the experts with peer-reviewed science. Those are the individuals who should determine what the recommendations are as to whether we pay for preventive services, not government bureaucrats.

Unfortunately, the Mikulski amendment just gives that determination to a government bureaucrat. That is why we should reject the Mikulski amendment, and adopt the amendment offered by the Senator from Alaska, the Murkowski amendment puts the decision making in the hands of the of the experts, where that decision should be made.

Let me close with this point. We have seen a lot of comparisons where are people saying that other countries have a better health care system than the United States. Let me give you the example of cancer survival rates.

This chart compares the average cancer survival rates in the European Union and the United States, it makes the point as to whether a government bureaucrat is making a health decision or the doctor and the patient are making the health treatment decision.

For kidney cancer, the European Union has a 56 percent 5 year survival rate; the United States, 63 percent survival rate after 5 years. On colorectal cancer, about the same difference between the United States and the European Union. Look at breast cancer, 79 percent after 5 years in the European Union; 90 percent in the United States. The most dramatic difference is on prostate cancer, 78 percent survival after 5 years in the European Union; 99 percent survival rate in the United States.

These are dramatic differences. Where would you rather get your health care if you had one of these cancers? The United States or Europe?

Canada, has even worse results than this. As a matter of fact, Belinda Stronach, a member of the Canadian Parliament, led the charge against a private system side by side with the government-run system in Canada. She did not want the private system.

Tragically, a couple years later, she developed breast cancer. Did she stay in Canada to get treatment, where there is a government-run health care system? No. Where did she go? She came to the United States. She was actually treated at UCLA. Why, because we have a superior system of quality in the United States.

We have a problem with cost. Some of the incremental steps I talked about will address costs.

I wish to turn it over now to my colleagues who are going to talk about

medical liability reform. Let's look out for the patient instead of the trial lawyers in the United States. Their idea on a loser pays system, I think, has a lot of merit, and it is something this body should consider very seriously.

I yield the floor to the Senator from Georgia, my good friend and colleague.

Mr. CHAMBLISS. Mr. President, I thank the Senator from Nevada for yielding. Senator GRAHAM and I do have an amendment we have filed today with respect to reforming the health care system in a real, meaningful way. It is an amendment that deals with tort reform, and it is a true loser pays system. We are going to talk about that in a few minutes.

Before I get to that, I wish to go back to some of the points the Senator from Nevada has talked about. I particularly appreciate his work on the mammogram issue, especially since this has been highlighted over the last couple weeks with regard to the recommendation that has come out of the independent board that advises HHS. I thank him for his work on that issue.

He is dead on. All of us know our wives are told every year, when they reach a certain age, they need to have a mammogram to make sure. Just like we do every year, go in and get a physical, they need to get their mammogram. The Senator talks about those kinds of checkups providing you with the kind of preventive health care that is going to hold down health care costs. I am a beneficiary of that. During a routine medical examination in 2004, it was determined I had prostate cancer. I was very fortunate it was picked up when it was, at an early stage. Instead of having to go through a lot of expensive procedures I might have had to go through, we were fortunate to be able to treat it. We are working on getting cured.

Senator ENSIGN is exactly right, this is the kind of test we need to make sure we encourage females to get and not put barriers in front of them.

Medicare is such a valuable insurance policy and program that 40 million Americans today take advantage of it. Mr. President, 1.2 million Georgians are Medicare beneficiaries. Again, I am one of those who is a Medicare beneficiary. So this is particularly important to me.

More importantly, in addition to these 40 million Medicare beneficiaries who are in the country today, there are another 80 million baby boomers who are headed toward Medicare coverage.

We have an independent Medicare Commission that was established by Congress years ago that is required to come to Congress every year and give Congress an update on the financial solvency of the Medicare Program. The purpose of that bipartisan Commission is to allow this body, along with our colleagues over in the House, the benefit of the work they do every year in looking at the amount of revenues that come in, in the form of the Medicare tax, and the outlays that go out, in the

form of payments to medical suppliers for our Medicare beneficiaries.

In the spring of this year, 2009, the independent Medicare Trustees Report reported back to Congress and said that unless real, meaningful reforms are made in the Medicare system, Medicare is going to start paying out more in benefits than it takes in in tax revenues in the year 2017.

Mr. President, what that means is that in 2017, Medicare is going to be insolvent, and it is just a matter of time before Medicare goes totally broke. And those individuals who are baby boomers, who have been paying into this program for 40 years, 50 years, or whatever it may be, are all of a sudden going to reach the Medicare age, where they expect to reap the benefits of the Medicare taxes they have been paying for all these years, and guess what. Not only are benefits going to be reduced, but unless something happens, unless there is meaningful reform and it is done in the right way, there is not going to be a Medicare Program.

I want to go back to something the junior Senator from Illinois said a few minutes ago. In talking about this issue of cuts in Medicare, he said this bill we have up for debate now that was filed by Senator REID does not have cuts in Medicare. He could not be more incorrect. And that is not a Republican statement. It is not a statement by anybody other than the Congressional Budget Office. I refer to a letter that has already been introduced during the course of this debate—a letter dated November 18—to the Honorable HARRY REID, the majority leader. I would refer the Senator to page 10 of that letter in which the Director of the Congressional Budget Office says this in reference to provisions affecting Medicare, Medicaid, and other programs:

Other components of the legislation would alter spending under Medicare, Medicaid and other Federal programs. In total, CBO estimates that enacting these provisions would reduce direct spending by \$491 billion over the 2010–2019 period.

Then the letter goes on, on this page alone, to delineate three areas where Medicare provisions are going to be reduced or cut, and I would specifically refer to them, but first is a fee-for-service sector, and this is other than physician services. It is going to be reduced by \$192 billion over 10 years. The Medicare Advantage Program—a program that literally thousands of Georgians take advantage of today and millions of Americans take advantage of—is going to be reduced by \$118 billion over 10 years, over the period 2010 to 2019. Medicaid and Medicare payments to hospitals—what we call disproportionate share payments, DSH payments—are going to be reduced or cut by \$43 billion over 10 years.

What does a reduction in these benefits mean to each individual community or each individual State? I can tell you what it means to the local hospital in the rural area of Georgia where I live. The reduction in DSH payments is

going to amount to a reduction in income at Colquitt Regional Medical Center in Moultrie, GA, by \$16.8 million over a 10-year period. These cuts in Medicare are going to result in a reduction in payments to Emory Hospital in Atlanta in the amount of \$367 million over a 10-year period.

So anybody who says these aren't cuts in Medicare spending simply has not read the bill and certainly has not read the letter from the Director of the Congressional Budget Office to Senator REID dated November 18, 2009.

I want to turn this over to my colleague from South Carolina after this final statement with reference to reductions in Medicare spending.

There is a specific reduction of \$8 billion in this bill over a 10-year period in hospice benefits.

Again, we have heard a number of personal stories around here, and I have a particular personal story myself. My father-in-law died when he was 99 years old. It was 3 years ago. The last 2 years of his life, he lived in an assisted-living home and he had hospice come in 2 or 3 or 4 days a week, for whatever he needed. Had he not had the benefit of hospice, he would have had to go in a hospital, and no telling how much in the way of Medicare medical expenses he would have incurred. But thank goodness we had hospice available, and he spent 2 days in the hospital. Otherwise, he was able to live in his assisted-living home, have my wife go by and spend quality time with him, which she will tell you today were the best 2 to 3 years of her life as far as her relationship with her father was concerned, because she had hospice there to take care of him. Yet here we are talking about reducing a benefit by \$8 billion that saved no telling how many thousands of dollars in the case of my family, and you can multiply that across America, and it is pretty easy to see we don't need to be reducing a benefit that is going to save us money in the long run.

I would like to turn it over to my friend from South Carolina, who also has some comments regarding Medicare, and then we will talk about our loser pays bill.

Mr. GRAHAM. I thank my friend from Georgia, and I will try to be brief.

I guess to say that we need to do health care reform is pretty obvious to a lot of people. The inflationary increases in the private sector, to businesses, particularly in the health care area, are unsustainable. A lot of individuals are having to pay for their own health care costs and are getting double-digit increases in premiums. In the public sector, the Medicare and Medicaid Programs are unsustainable. Medicare alone is \$38 trillion underfunded.

Over the next 75 years, we have promised benefits to the baby-boom generation and current retirees, and we are \$38 trillion short of being able to honor those benefits.

What has happened? We have created a government program that everyone

likes, respects, and is trying to save, and actuarially it is not going to make it unless we reform it. So what have we done? In the name of health care reform, we have taken a program many senior citizens rely upon—all senior citizens, practically—and we have reduced the amount of money we are going to spend on that program and then taken the money from Medicare to create another program the government will eventually run. It makes no sense.

We need to look at saving Medicare from impending bankruptcy. Why would we reduce Medicare by \$464 billion and take the money out of Medicare, which is already financially in trouble, to create a new program? It makes no sense to me. That is not what we should be trying to do, from my point of view, to reform health care.

The Medicare cuts Senator CHAMBLISS was talking about, they are real. The way our Democratic colleagues and friends try to get to revenue neutrality on the additional spending, to get it down to where it doesn't score in a deficit format, is they take \$464 billion out of Medicare to offset the spending that is required by their bill.

Here is the question for the country: How many people in America really believe this Congress or any other Congress is actually going to reduce Medicare spending by \$464 billion over 10 years? I would argue that if you believe that, you should not be driving. There is absolutely no history to justify that conclusion.

In the 111th Congress, there were 200 bills proposed—and I was probably on some of them—to increase the amount of payments to Medicare. In 1997, we passed a balanced budget agreement when President Clinton was President slowing down the growth rate of Medicare. That worked fine for a while, until doctors started complaining, along with hospitals, about the revenue reductions. Every year since about 1999, 2000, we have been forgiving the reductions that were due under the balanced budget agreement because none of us want to go back to our doctors and say we are going to honor those cuts that were created in 1997 because it is creating a burden on our doctors. Will that happen in the future? You better believe it will happen in the future. In 2007, Senators CORNYN and GREGG introduced an amendment to reduce Medicare spending by \$33.8 billion under the reconciliation instructions. It got 23 votes. I remember not long ago the Republican majority proposed reducing Medicare by \$10 billion. Not one Member of the Democratic Senate voted for that reduction. They had to fly the Vice President back from Pakistan to break a tie over \$10 billion.

So my argument to the American people is quite simple: We are not going to reduce Medicare by \$464 billion, and if we don't do that, the bill is not paid for, and that creates a problem of monumental proportions. If we

do reduce Medicare by \$464 billion and take the money out of Medicare to create another government program, we will do a very dishonest thing to seniors. We are damned if we do and damned if we don't. And during the whole campaign, I don't remember anybody suggesting that we needed to cut Medicare to create health care reform for non-Medicare services, but that is exactly what we are doing.

To my Democratic colleagues: There will come a day when Republicans and Democrats are going to have to sit down and seriously deal with the underfunding of Medicare and with the impending bankruptcy of Medicare. Everything we are doing in this bill may make sense to save Medicare from bankruptcy, but it doesn't make sense to pay for another government-run health care program outside of Medicare. It makes no sense to take the savings we are trying to find in Medicare and not use them to save Medicare from what I think is going to be a budget disaster.

So let it be said that this attempt to pay for health care, to make it revenue neutral, will require the Congress to do something with Medicare that it has never done before and is not going to do in the future. So the whole concept is going to fall like a house of cards.

The way we have tried to pay for this bill has so many gimmicks in it, it would make an Enron accountant blush.

Now, as to tort reform, quite frankly, I used to practice law and did mostly plaintiffs' work. I am not a big fan of Washington taking over State legal systems. I prefer to let States do what they are best at doing and let the Federal Government do a few things well—and we are doing a lot of things poorly. But if we are going to take over the entire health care system, if that is going to be the option available to us, then we also need to nationalize the way we deal with lawsuits.

And to the AMA: There will come a day, if we keep going down the road here, where the Federal Government will determine how you get to be a doctor. There will be no State medical societies, and we will have a national system to police doctors. That is what is coming if we continue to nationalize health care.

So, with Senator CHAMBLISS, I have tried to come up with a more reasoned approach when it comes to legal reform. I have always believed people deserve their day in court. There is no better way to resolve a dispute than to have a jury do it. I would rather have a jury of independent-minded citizens decide a case than a bunch of politicians or any special interest group. So the jury trial, to me, is a sacrosanct concept that has served this country well.

But one thing I have always been perplexed about in America is that the risk of suing somebody is very one-sided. Most developed nations have a loser pays rule. I think you should

have your day in court, but there ought to be a downside to bringing another person into the legal system. So I think a loser pays rule will do more to modify behavior than any attempt to cap damages. Let both wallets be on the table. You can have your day in court, but if you lose, you are going to have to pay some of the other side's legal cost, which will make you think twice.

As to the indigent person, most people who sue each other are not indigent. The judge would have the ability to modify the consequences of a loser pays rule, but we need to know going in that both wallets are on the table. Under our proposal, we have mandatory arbitration where the doctor and the patient will submit the case to an arbitration panel. If either side turns down the recommendation of the panel, they can go to court. But then the loser pay rule kicks in.

I think that will do more to weed out frivolous lawsuits than arbitrarily capping what the case may be worth in the eyes of a jury. I think it really does create a financial incentive not to bring frivolous lawsuits that does not exist today.

If there is a \$500,000 damage cap, most of the people I know would say: I will take the \$500,000. That is not much of a deterrent. But if we told someone they can bring this suit if the arbitration didn't go their way, but if they go into court after arbitration they risk some of their financial assets, people will think twice. I think that is why this is a good idea. The National Chamber of Commerce has endorsed it, and I am proud of the fact that they have endorsed it.

I would rather not go down this road, but if we are going to nationalize health care we also need to do something about the legal system that is going to be affected by the nationalization of health care.

A final comment I would like to make about what we are doing is that it is probably worrisome to people at home that we are about to change one-sixth of the economy and cannot find one Republican vote to help. I guess there are two ways to look at that: It is the problem of the Republican Party or maybe the bill is structured in a way that is so extreme there is no middle to it. I would argue that what we have done is abandon the middle for the extreme. It is pretty extreme, in my view, to take a program that is \$38 trillion underfunded, cut it, and take the money to create a new program rather than saving the one that is in trouble. It is pretty extreme, in my view, to take a country that is so far in debt you cannot see the future and add \$2.5 trillion of more debt onto a nation that is already debt laden in the name of reforming health care.

When you look at the second 10-year window of this bill, it adds \$2.5 trillion to the national debt. Is that necessary to reform health care? Do we need any more money spent on health care or

should we just take what we spend and spend it more wisely? The first 10 years is a complete gimmick. What we do in the first 10 years of this bill is collect the  $\frac{1}{2}$  trillion in taxes for the 10-year period, and we don't pay any benefits until the first 4 years are gone. That is not fair. That is a gimmick. That catches up with you in the second 10-year period.

So the reason we do not have any bipartisan support is because we have come up with a concept that has no middle to it. This is a power grab by the Federal Government. This is a chance to set in motion a single-payer health care plan that the most liberal Members of the House and the Senate have been dreaming of. This is a liberal bill written by and for liberals, and it is not going to get any moderate support on the Republican side—and there is some over here to be had—and they are going to have a hard time convincing those red State Democrats that this is good public policy. That is where we find ourselves, trying to change one-sixth of the economy in a way that you don't have any hope of bringing people together.

I would argue we should stop and start over.

I thank my good friend from Georgia for trying to find a way to change lawsuit abuse in a more reasoned fashion.

Mr. CHAMBLISS. I thank my colleague from South Carolina, Senator GRAHAM, for his thoughtful process that we went through in thinking through the loser pays bill and the amendment we have filed. Just like you, having practiced law for 26 years before I was elected to the House, the same year you were, and then we were elected over here, I tried plaintiffs cases as well as defendants cases. I never represented a defendant in a malpractice case. I was always on the other side.

I have great sympathy for individuals who are wronged by a physician who is negligent. You and I agree that anybody who is the victim of negligent action ought to have their day in court. That is what we provide for under our bill. There is absolutely no question about the fact that anybody who is subject to negligent acts on the part of a physician, they can have their day in court, and they should have their day in court if that is what they decide they want to do.

But under a loser pays provision like we have designed, we can eliminate, hopefully, the frivolous lawsuits that add significantly to the cost of health care delivery in this country. In 2003, direct tort litigation costs in America accounted for 2.2 percent of our GDP. That is double the percentage of Canada, Great Britain, Germany, France, and Australia—all of which have loser pays systems.

The State of Alaska has had a loser pays system since 1884 and tort claims in the State of Alaska constitute a smaller percentage of total litigation than the national average.

Florida, which applied a loser pays rule to medical malpractice suits from 1981 to 1985, saw 54 percent of their plaintiffs drop their suits voluntarily.

It does make a difference on frivolous suits. In the State of Florida during that same period of time, the jury awards for plaintiffs rose significantly. Just as in our situation, anybody who had a legitimate case in Florida during that period of time had the right to have their case adjudicated by a jury. Those who made the decision to do so received more significant awards. That is the way the system ought to work.

This is a win-win situation for the cost of health care delivery. It is a benefit to the physicians—sure, because they eliminate part of their significant cost of delivering health care services. But it also is a huge benefit to those individuals in America who are subject to negligent acts on the part of physicians.

I ask unanimous consent that a letter to Senator GRAHAM and myself from Bruce Josten at the U.S. Chamber of Commerce, dated November 3, 2009, be printed in the RECORD, and I yield the floor.

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

NOVEMBER 3, 2009.

Hon. LINDSEY GRAHAM,  
U.S. Senate,  
Washington, DC.

Hon. SAXBY CHAMBLISS,  
U.S. Senate,  
Washington, DC.

DEAR SENATORS GRAHAM AND CHAMBLISS: The U.S. Chamber of Commerce, the world's largest business federation representing more than three million businesses and organizations of every size, sector, and region, thanks you for introducing S. 2662, the "Fair Resolution of Medical Liability Disputes Act of 2009."

This legislation represents a positive and significant step toward providing a more reliable justice system for the victims of medical malpractice. Your bill encourages the states to establish alternative methods for resolving medical liability claims and provides them with the latitude to develop unique approaches that fit the needs of their diverse populations. The Chamber commends you for making this important and thoughtful effort to bring needed reforms to America's medical liability systems.

The issue of medical liability reform is central to any serious effort to overhaul America's healthcare system. The Congressional Budget Office recently determined that medical liability reform would reduce total national healthcare spending by \$11 billion in 2009 and reduce the federal budget deficit by \$54 billion over 10 years. The Chamber believes these estimates of healthcare savings may be too conservative. Yet nonetheless, the \$54 billion in deficit reduction is significant, representing over 10 percent of the net cost of the insurance coverage provisions agreed to in the Finance Committee's "America's Healthy Future Act of 2009." We are confident that you will be a forceful and effective advocate for medical liability improvements that will expand access to justice for injured patients and lower the cost of healthcare.

There is bipartisan agreement that for healthcare reform to be successful, it must "bend the growth curve," making healthcare

delivery more efficient and slowing healthcare inflation. Medical liability reform should play a critical role in any such effort. The Chamber appreciates your work on this legislation and looks forward to working with you and the Senate in the coming weeks and months to refine your legislation and advance commonsense changes to our system of resolving medical liability claims.

Sincerely,

R. BRUCE JOSTEN.

The PRESIDING OFFICER. The Senator from Illinois is recognized.

Mr. DURBIN. Could the Chair inform me how much time was used on the Republican side during the last group of speakers?

The PRESIDING OFFICER. That was 42 minutes 14 seconds.

Mr. DURBIN. I thank the Chair. I am going to proceed to speak in the same manner and yield to the Senator from Vermont. Our time will be less than that in total.

I see the Senator from Louisiana is here. We are going to be speaking less than 42 minutes. We guarantee him that much. We will follow the same process, if there is no objection, that was just followed with three Republican speakers who spoke in that 42-minute period of time.

I ask unanimous consent that Senator SANDERS be recognized after me to speak and that our total time be no more than 42 minutes.

Mr. VITTER. I object.

The PRESIDING OFFICER. Is there objection? Objection is heard.

Mr. DURBIN. Mr. President, I just offered that to the Republican side, and they asked me for permission and I gave permission, unanimous consent.

We will speak as long as we like. We will enter into a colloquy. I hope the Senator from Louisiana will reconsider.

Let me try to address a few of the issues that have been raised on the Senate floor. First, on the issue of medical malpractice, this is an issue often brought up on the other side of the aisle.

The first thing I would like to say is this is the bill we are debating. It is 2,074 pages, and one extra page makes it 2075 pages. It has taken us a year to put this together. There have been a series of committee hearings that have led to the creation of this legislation. It has been posted on the Web site for anyone interested. If they go to Google, for example, and put in "Senate Democrats," they will be led to a Web site which will let them read every word of this bill. It has now been out there for 12 days at least, and it will continue to be there for review by anyone interested.

If you then Google "Senate Republicans" and go to their Web site on health care and look for the Senate Republican health care reform bill, you will find—this bill, the Democratic bill, because there is no Senate Republican health care bill. For a year, and with an enormous number of speeches, they have come to the floor and talked

about health care but have never sat down and prepared a bill to deal with the health care system, which leads us to several conclusions.

This is hard work and they have not engaged in that hard work. It is easier to be critical of this work product. They have chosen that route. That is their right to do. This is the Senate. We are the majority party. We are trying to move through a bill. But all of the ideas they have talked about tonight and other evenings have not resulted in a bill.

Second, it may be that they do not want to see a change in the current system; they are happy with the health care system as it exists today. That is possible. In fact, I think it drives some of them to the point where they criticize our bill but do not want to change the system because they like it.

I guess there are some things to like about it. There are good hospitals and doctors in America. Some people are doing very well with the current system. But we also know there are some big problems. We know the current system is not affordable. We know the cost of health insurance has gone up 131 percent in the last 10 years; that 10 years ago a family of four paid about \$6,000 a year for health insurance. Now that is up to \$12,000 a year. We anticipate in 8 years or so it will be up to \$24,000 a year. Roughly 40 percent or more of a person's gross income will be paid in health insurance.

That is absolutely unsustainable. So businesses are unable to offer health insurance as well as individuals are unable to buy health insurance. The Republicans have not proposed anything, nothing that will make health insurance more affordable. This bill addresses that issue. They have nothing.

Second, we know there are about 50 million Americans without health insurance. These are people who work for businesses that cannot afford to offer a benefits package. They are people who are recently unemployed, and they are people in such low-income categories they cannot afford to buy their own health insurance, and their children—50 million. This bill we have before us will give coverage to 94 percent of the people in America, the largest percentage of people insured in the history of our country.

The Republicans have failed to produce a bill that expands coverage for anyone in America. Under the Republican approach, nothing would be done to help the 50 million uninsured.

The third issue is one about health insurance companies. Everybody has an experience there. It is, unfortunately, not good for most, because when you pay premiums all your life and then need the health insurance, many times it is not there. What we do is give consumers bargaining power and a fighting chance with health insurance. That, to me, is a reasonable approach. It eliminates discrimination against people because of a preexisting condition and putting caps on the

amount of money that is being paid. We extend the coverage for children under family health plans from age 24 to age 26. We do things that give people peace of mind that when they need health insurance for themselves and their family it will be there.

The Republicans fail to offer anything that deals with health insurance reform. That is a fact. They have said a lot about Medicare.

I would like to tell you that tomorrow, or soon, I will be cosponsoring and Senator BENNET of Colorado will be offering an amendment which could not be clearer on the issue of this bill and the Medicare Program. The amendment is so short and brief and direct and understandable, I want to read a couple of highlights:

Nothing in the provisions of, or amendments made by, this Act shall result in the reduction of guaranteed benefits under title XVIII of the Social Security Act.

That is Medicare. What Senator BENNET is saying is that people will have their Medicare benefits guaranteed. Nothing in this bill will infringe on their Medicare benefits, despite everything that has been said.

The Bennet amendment goes on to say:

Savings generated for the Medicare program under title XVIII of the Social Security Act under the provisions of, and amendments made by, this Act shall extend the solvency of the Medicare trust funds, reduce Medicare premiums and other cost-sharing for beneficiaries, and improve or expand guaranteed Medicare benefits and protect access to Medicare providers.

All of the speeches made in the last 3 days about how this bill threatens Medicare—it does not—will be completely cleared up by the Bennet amendment. I hope some Republicans who have a newfound love of the Medicare Program, which was started many years ago, will join us in voting for this amendment. It would be great to see if their speeches to save Medicare will result in their votes for the Bennet amendment. This is a critically important amendment. I commend him for being so straightforward and showing real leadership on an issue of this magnitude.

I know the Senator from Vermont is interested in speaking. I am prepared to yield for comments and questions. Before I do, I wish to say by way of introduction that we heard one of our Republican colleagues say this is a single-payer bill, that at the end of the day we will have created a single-payer system. I think the Senator from Vermont is familiar with the concept of single payer, and I would invite his comments or questions through the Chair to me about his feelings on this issue.

Mr. SANDERS. I thank my friend from Illinois for asking that question because, coincidentally, we have just introduced and brought to the desk legislation for a single-payer national health care program. I suggest to my friend from Illinois and my Republican friends that it is a very different bill

than the legislation we are now looking at. In no way, shape, or form is the legislation being debated now a single-payer national health care program. As my friend from Illinois understands—and I ask his views on this—I have heard some of our Republican friends talk about how strong this current health care system is that we have right now. I ask my friend from Illinois, do you think we can do better than being the only major country in the industrialized world that does not guarantee health care to all of its people? Can we do better than that?

Mr. DURBIN. In response to the Senator from Vermont, we must do better. This is the only civilized, developed, industrialized country in the world where a person can literally die because they don't have health insurance. Forty-five thousand people a year die because they don't have health insurance. What does that mean? One illustration: If you had a \$5,000 copay on your health insurance policy—and people face that—and you go to the doctor and the doctor says: Durbin, we think you need a colonoscopy, and I realize I have to pay the first \$5,000 and the colonoscopy is going to cost \$3,000, and I say I am going to skip it—which people do, and bad things happen—I develop colon cancer and die, my insurance has failed me. Basic preventive care is not there. We are the only civilized, developed country where that is a fact.

Mr. SANDERS. I ask my friend from Illinois, has he talked to physicians who have, on that issue, told him that they have lost patients who walked into their office and they say: Why didn't you come in here 6 months ago or a year ago? And that patient says: I didn't have any money, and I thought maybe the pain in my stomach or my chest would get better.

I have had that conversation with physicians in Vermont. I wonder if the Senator has talked to physicians who have said the same thing.

Mr. DURBIN. A lady I met 2 weeks ago in southern Illinois, 60 years old, a hostess at a hotel who serves breakfast in the morning—they are there as we travel around our States—has never had health insurance in her life, is diabetic, and told me that her income is so low, \$12,000 a year, she could not afford to go to a physician to check out some lumps she had discovered. That is the reality of the current health care system in the wealthiest, greatest Nation on Earth.

Mr. SANDERS. We have heard discussions of death panels. I think the Senator might agree with me that when we talk about death panels, we are talking in reality about 45,000 people who die every single year because they don't get to a doctor on time. That seems to me to be what a death panel is.

In the midst of all this, with 46 million uninsured, with 45,000 people dying every year because they don't get to a doctor when they should, when pre-

miums have doubled in the last 9 years, when we have almost 1 million Americans going bankrupt because of medically related bills, I ask my friend from Illinois, isn't it time for a change? Isn't it time this country now moves forward and provides health care for all of our people in a comprehensive and cost-effective way?

Mr. DURBIN. Mr. President, I certainly agree with the Senator from Vermont. I would add one more statistic. Of the nearly 1 million people filing for bankruptcy in America each year because of health care costs, medical bills they can't pay, three-fourths of them have health insurance. Three-fourths of them were paying premiums. These were the people turned down when they needed coverage. These were the people who ran into caps on coverage on their policies. These are folks who had to battle it out and lost the battle with the insurance companies to try to get lifesaving drugs. That is the reality of the current system.

The fact is, the Republican side of the aisle has not produced an alternative. We have. We have worked long and hard to do it. They have not.

Mr. SANDERS. I ask my friend from Illinois if we are not only dealing with the personal health care issue of 46 million uninsured and people dying, but are we not dealing with a major economic issue? How are businesses going to compete with the rest of the world when every single year they are seeing huge increases in their health insurance premiums, and rather than investing in the business that they are supposed to be in, they are having to spend enormous sums of money as health care costs soar? I know small businesses in Vermont tell me that in some cases not only can they not provide health insurance to their workers, they cannot even provide it for themselves. I have to believe there is a similar situation in Illinois.

Mr. DURBIN. It is. We are sent many books and some of them I have a chance to glance at. This is the recent one I received, entitled "Bend the Health Care Trend." They have here information which says: American health care spending reached \$2.4 trillion in 2008 and will exceed \$4 trillion by 2018. We expect a doubling of basic health insurance premiums in 8 to 10 years, and we know what you just described is reality. Even businesses owned by a couple, a husband and wife, are finding themselves not only unable to provide health insurance for their employees, because of its cost, they can't cover themselves.

I had a friend of mine, one of my childhood friends, I grew up with him and his wife. His small business had one of their employees under the health insurance plan, and his wife had a baby with a serious illness. As a result, their premiums went through the roof. He had to cancel his group health insurance. He had to cancel the insurance he gave to his employees. He gave his employees the \$300 a month, whatever it

was they were paying, and said: We are all on our own now. We have to go in the private market. The couple with the sick baby couldn't find any health insurance. My friend, who was in his 60s, and his wife are in a pitched battle every year about how much they have to pay for health insurance and the company, the only one that will cover them, each year excludes whatever they turned a claim in for last year. So that is the reality of health insurance for small businesses.

I also want to tell my friend from Vermont, about one-third of all realtors in America are uninsured, have no health insurance. They are independent contractors, and they have no health insurance, one out of three.

Mr. SANDERS. While we are talking about the economics of health care, I wonder if my friend from Illinois has had the same experience I have had in Vermont where people tell me they are staying on the job, not because they want to stay on their job but because the job is providing decent health insurance. They can't go where they want to go because the new job may not provide insurance or they are afraid about the interval when they may not have any health insurance at all. I wonder if my friend from Illinois happened to see the piece in the paper, unbelievable, where a middle-aged fellow joined the U.S. military because his wife was suffering from cancer, and he couldn't find a way to get health care for her so he joined the military. Does the Senator think this is what should be going on in the greatest country in the world?

Mr. DURBIN. We can do better. I would say to those who call our plan a single-payer plan, what we are trying to do is to get fair treatment from private health insurance companies for consumers and families across America and to give them choices. The Senator from Vermont, I assume, is part of the Federal Employees Health Benefits Program. So am I. Most Members of Congress belong to the program. Eight million Federal employees and Members of Congress are part of this program. It may be the best health insurance in America. And we can shop. I just got a notice in the mail that says open enrollment is coming. If you don't like the way you were treated by your health insurance plan last year, you can change. You can pick a new one. If it is a generous plan, more money will be taken out of your check. If it is not, less money will be taken out. We can shop. What we do on the insurance exchanges in this bill is say to these Americans who wouldn't otherwise have options, go shopping. Find the best health insurance plan for your family. Exercise your choice.

I would say to Senator HARRY REID, who drafted this bill, I thank him for his hard work. He includes a public option, a not-for-profit health insurance plan with lower costs that people can choose, if they care to. Giving people that choice, giving them an option to

go shopping for the most affordable, best health insurance plan is what we enjoy as Members of Congress and what every American family should.

Mr. SANDERS. I ask my friend from Illinois, does he think some of our Republican friends feel so threatened and so upset by giving the American people the option to choose a public Medicare-type plan as opposed to a private insurance plan? Do you think that maybe, just maybe, some of our friends are more interested in representing the interests of the big private insurance companies rather than the needs of the American people?

Mr. DURBIN. I say to my colleague from Vermont, I am waiting for the first Republican Senator to offer an amendment to this bill to abolish Medicare. If they really believe that government health insurance is such a bad idea, they ought to step right up and show it.

Mr. SANDERS. I would say to my friend from Illinois that that is an interesting proposal and, in fact, I was almost thinking of offering an amendment at one point. We have a lot of people in this country who stand up and say: Get the government out of health care. Well, I think some of my Republican friends have kind of echoed that message. I do think that the Senator from Illinois is right. We may bring forth an amendment to allow our Republican friends to say: Let's abolish the Veterans' Administration. Because, as you know, that is a government-run program which most veterans in my State and I think around the country are very proud of. They think it is a good program. From what the statistics tell us, it is a very cost-effective way to provide quality health care to all of our veterans. Maybe we should bring forward an amendment to those who say get the government out of health care. If you want to abolish the Veterans' Administration, go for it. And what about TRICARE. Maybe you want to abolish TRICARE. Go for it. Maybe you want to abolish SCHIP which is providing high quality health insurance for millions of kids. Maybe we might work together and bring forth an amendment.

Let our Republican friends who say get the government out of health care, let them abolish the Veterans' Administration, Medicare, SCHIP, Medicaid, let them do that. We will see how many votes they might get.

Mr. DURBIN. There is another way that Senators who loathe the idea of government-run health insurance plans can show personally their commitment to that idea, by coming to the floor and publicly announcing they will not participate in the Federal Employees Health Benefit Program which provides health insurance for Members of Congress. I have yet to hear the first Member, critical of government health plans, come forward and say: So in a show of unity and personal commitment, I am going to opt out.

Mr. SANDERS. I suggest to my friend from Illinois that we could take

it a step further. I go to the Capitol physician's office. That is where I go. We pay extra money for it. I have Blue Cross/Blue Shield, but I go there. Do you know who runs the Capitol physician's office, which I suspect the vast majority of the Members of Congress go to and get very fine primary health care?

Well, it is that terrible government agency, the U.S. Navy. So maybe some of our friends who are busy denouncing government health care might want to say they do not want to take advantage of that very fine, high quality health care, and that speaks for the whole military as well. While we are at it, maybe you should abolish health care for the U.S. military, which is all government run and, by the way, generally regarded as pretty good quality health care.

I would ask my friend his views on that.

Mr. DURBIN. I do not think you will hear that. I think you will hear a lot of speeches about socialized medicine, socialism, and the big reach of government.

When it comes right down to it, there is not a single Member from the other side who stepped up and said: Therefore, I will offer an amendment to abolish it. They will have their chance in this bill, and if they want to, they can. I do not think the people who have this coverage today would like to see it gone.

Mr. SANDERS. It might be an interesting amendment, I would say to my friend. There is another area where it is a semigovernment nonprofit, which I know the Senator from Illinois feels very strongly about, and that is the Federally Qualified Community Health Centers begun by Senator Kennedy over 40 years ago, where we now have over 1,200 community health centers all over this country. In fact, I know this is widely supported in a bipartisan or tripartisan way, because the Federally Qualified Community Health Centers provide quality health care and dental care and low-cost prescription drugs and mental health counseling.

I might say to my friend from Illinois, one of the provisions in that 2,000-page bill he is holding up is legislation he and I and others have worked hard on, which is to substantially expand the Community Health Center Program into every underserved area in America. We talk about 46 million people being uninsured in this country. We have 60 million people who do not have access to a doctor on a regular basis.

If we expand the Community Health Center Program, if we expand to a significant degree the National Health Service Corps so we can help young people become primary health care physicians by paying off their very substantial medical debts, would my friend agree with me that this would be a major step forward in improving primary health care in America?

Mr. DURBIN. The Senator from Vermont has been a leader on this

issue. I can recall when President Obama came forward with his stimulus bill, the recovery and reinvestment bill, that the Senator from Vermont was one of the leaders to put additional funds in the bill to build clinics all across America—in rural areas we represent, in the towns and cities we represent as well—for the very reason the Senator mentioned: Because for a lot of people who I represent in downstate, southern Illinois, in some of the rural regions, it is a long drive to a doctors clinic for primary care. So these community health clinics, FHQA clinics, are going to offer people primary care.

I think as a result of this bill, when we enact it—and I feel very good about the enactment of this because I think we sense this is a moment in history we should not miss—we are going to see this network grow across America. And it has proven itself to be so good.

In the city of Chicago, I have visited these community health clinics. I will bet the Senator does in Vermont. What I find there—many times I will walk in the door. The administrator will be there. We will start talking. I will meet the doctors. I will meet the nurses. When I finally get a chance to drink a cup of coffee and talk to them for a few minutes, I say—and I mean it—if I were sick, I would feel confident walking into the front door of this clinic, that I would be in the best of hands—better than the most expensive clinic in my State.

Mr. SANDERS. My friend from Illinois makes the point. And I have visited virtually all of them in the State of Vermont. We have gone from 2 to 8, with 40 satellites. We have over 100,000 people in the State of Vermont who now use these Federally Qualified Health Centers.

I know my friend from Illinois is also aware that when you talk about health care, you have to talk about dental care.

Mr. DURBIN. Yes.

Mr. SANDERS. Because what is true in Vermont is true in Illinois. You have a whole lot of people who do not have access to a dentist, which these Federally Qualified Health Centers now provide, and mental health counseling, and low-cost prescription drugs.

So I thank my friend from Illinois. I am sure the Senator and I are going to work together to make sure we, in fact, are successful in keeping people out of the emergency room, keeping them out of the hospital, by enabling them to get the medical care they need when they need it. I look forward to working with my friend on that.

Mr. DURBIN. I might say, the Senator from Vermont has also raised an important issue. We know we are going to need more primary care physicians, so there are provisions in this bill to encourage young people to pursue primary care—internists, family practitioners—because those are the front-line people who are needed more frequently for preventive care and basic checkups, so people have a chance to

see a good doctor before they get sick or become seriously ill and it is much more expensive.

Mr. SANDERS. Right.

Mr. DURBIN. So we are pushing forward for more and more health care professionals. Again, the Republican critics of this legislation have offered nothing—nothing—when it comes to encouraging the growth in the number of our health care workers in America. This ought to be something that is nonpartisan. I would think that at some point they would agree that many things in here are essential for the future of our country. I think that is one of them.

Mr. SANDERS. Would my friend from Illinois agree, it does not make a whole lot of sense for people who do not have health insurance today to go into an emergency room and run up a huge cost or to get terribly ill because they do not go to a doctor when they should and end up in the hospital? Wouldn't it make a lot more sense, both for the personal health of the individual and saving money for the system, to provide health care to people when they need it?

Mr. DURBIN. I agree with the Senator from Vermont. I would say we have some of the best health care in America but also the most expensive health care in America. We spend more per person than any other nation on Earth, and a lot of it has to do with money not being well spent. People who do not have access to a medical home, which we establish in this bill, people who do not have access to a community health care clinic, in desperation, will take a baby with a high fever in to an emergency room.

Mr. SANDERS. Right.

Mr. DURBIN. They will wait for hours to finally see a doctor. Once there, they will have the most expensive care they could ever face, when they could have gone for a doctor's appointment.

Mr. SANDERS. Exactly.

Mr. DURBIN. And taken care of it for a fraction of the cost. That is not good for the hospitals because many of them are giving charity care they do not get compensated for, and they pass that cost along to other patients, and it certainly is not good for the families involved.

Mr. SANDERS. At this point, let me thank my friend from Illinois for allowing me to engage in this colloquy with him. I am going to yield back the floor to him and thank him for his very good work.

Mr. DURBIN. I thank the Senator from Vermont.

I say, at this point in time, we have three or four amendments before the Senate on health care reform. We started the debate on Monday. We are now wrapping up Wednesday. We are about to go into the 4th day of the debate on one of the most important bills in the history of the U.S. Senate, and we have yet to reach an agreement with the Republican side of the aisle to have the amendments voted on.

If we are only doing four amendments or three amendments in 4 days, this is not going to be the kind of debate the American people expected. They expected us to bring issues before the floor here, debate them, with a reasonable period of time, and then vote and move to another issue. Certainly, there are a lot of things to talk about.

So I hope the Republican side of the aisle will have a change of heart and will start to join us in this dialog, will offer their amendments in a timely fashion—we will give them their opportunity to debate them—and then bring them to a vote. But the fact is, we have not had a single vote this week on health care reform amendments because of objections from the other side. That is not in the interest of moving forward this important legislation and giving Members an opportunity to present their amendments and have them voted on in a timely fashion.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Mr. President, I ask unanimous consent that after any leader time on Thursday, December 3, and the Senate resumes consideration of H.R. 3590, it be in order for any of the majority or Republican bill managers to be recognized for a total period of time not to extend beyond 10 minutes, equally divided and controlled; that the time until 11:45 a.m. be for debate with respect to the Mikulski amendment No. 2791 and the McCain motion to commit; and during this time it be in order for Senator MURKOWSKI to call up her amendment with respect to mammography, a copy of which is at the desk; and that it also be in order for Senator BENNET of Colorado to call up amendment No. 2826, a side-by-side amendment with respect to the McCain motion to commit; that no other amendments or motions to commit be in order during the pendency of these amendments and motion; that at 11:45 a.m., the Senate proceed to vote in relation to the Mikulski amendment No. 2791; that upon disposition of the Mikulski amendment, the Senate then proceed to vote in relation to the Murkowski amendment; that upon disposition of these two amendments, the Senate continue to debate until 2:45 p.m. the Bennet of Colorado amendment No. 2826 and the McCain motion to commit, with the time equally divided and controlled between Senators BAUCUS and MCCAIN or their designees; that at 2:45 p.m., the Senate proceed to vote in relation to the Bennet of Colorado amendment No. 2826; that upon disposition of that amendment, the Senate then proceed to vote in relation to the McCain motion to commit; that prior to the second vote in each sequence, there be 2 minutes of debate, equally divided and controlled in the

usual form; that each of the above referenced amendments or motion be subject to an affirmative 60-vote threshold, and that if the amendments or motion do not achieve that threshold, then they be withdrawn; further, that if any of the above listed achieve the 60-vote threshold, then the amendment or motion be agreed to, and the motion to reconsider be laid upon the table; further, that it be in order if there is a request for the yeas and nays to be ordered with respect to that amendment or motion, regardless of achieving the 60-vote threshold, that if the yeas and nays are ordered, the vote would occur immediately with no further debate in order with respect to this particular consent.

The PRESIDING OFFICER. Is there objection?

Mr. VITTER. Mr. President, reserving my right to object.

The PRESIDING OFFICER. The Republican leader.

Mr. McCONNELL. Mr. President, reserving the right to object, and I will not object, I would just like to point out we have had some difficulty actually on both sides getting to the two votes that are designated in this consent agreement.

Our side of the aisle, the Republican side of the aisle, was prepared to vote on both of those amendments tonight. Then a problem developed on the other side, which I understand because we had had a problem on our side earlier. But I do just want to make it clear that Republicans were prepared and fully ready and willing to vote on the two amendments in the consent agreement tonight.

Mr. President, I do not object.

Mr. VITTER. Mr. President, reserving the right to object.

The PRESIDING OFFICER. The Senator from Louisiana.

Mr. VITTER. Thank you, Mr. President.

Mr. President, I certainly concur with the distinguished majority whip's goal of more amendments and more votes.

With regard to this very important screening and mammography issue, my goal has been a very focused one. I have a filed second-degree amendment that has a very simple, focused objective, which I believe is extremely non-controversial. I believe it would be supported by everyone in this body, and that is simply to ensure that there is no legal force and effect to the recent recommendations issued in November of 2009 by the U.S. Preventative Services Task Force with regard to breast cancer screening, use of mammography, and self-examination.

As everyone knows, those new recommendations were shocking in that they took a giant step back from the previous recommendations and took a giant step back in terms of recommended screening, which virtually every expert I know of strongly disagrees with.

So this filed, simple second-degree amendment simply says that those new

recommendations of November of this year have no force and effect. I will read the amendment. It is very short. To be clear, it does nothing more than that.

[F]or the purposes of this Act, and for the purposes of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

So we are simply ensuring that those new recommendations—which I strongly disagree with, experts strongly disagree with, I believe all of my colleagues do—have no legal force and effect. So I would simply ask that the unanimous consent proposed be modified so that the Mikulski amendment incorporates this language. I would propose that as an alternative unanimous consent request.

The PRESIDING OFFICER. Is there objection to the request, as modified?

Mr. DURBIN. I object.

The PRESIDING OFFICER. Objection is heard.

Is there objection to the original request from the Senator from Illinois?

Mr. VITTER. Yes, I continue to reserve my right to object. I am very disappointed about objecting to this important and what should be non-controversial provision. I would suggest another solution, which is to take the unanimous consent request on the floor and modify it so there is simply a vote on this second-degree amendment, amendment No. 2808, immediately before the vote on the Mikulski amendment.

The PRESIDING OFFICER. Is there objection to the request, as modified?

Mr. DURBIN. Mr. President, reserving the right to object.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. I am not sure I would support or oppose the amendment offered by the Senator from Louisiana, but this matter has been on the floor now for 3 days. I say to the Senator, there is a pending amendment here on your side of the aisle from Senator MURKOWSKI on this issue, and I would hope that the Senator has approached her to incorporate his language. I do not know if the Senator approached Senator MIKULSKI. But at this point we think we have some effort being made at fairness on both sides, that there will be Democratic amendments and Republican amendments both offered—Mikulski and Murkowski and McCain and Bennet—and so I would object because I believe we have the basis for a fair agreement at this point.

The PRESIDING OFFICER. Objection is heard. Is there objection to the original request of the Senator from Illinois?

Mr. VITTER. Mr. President, reserving my right to object, again, I am very disappointed to hear that. I have approached both sides. Senator MURKOWSKI has incorporated similar lan-

guage, and I was hoping we could come together, 100 to nothing, to actually pass this on to the bill, whichever alternative tomorrow is voted up—and maybe they both will be—but whichever is voted up or whichever is voted down, I think it is very important to come together and state that we don't want these new task force recommendations to have any force and effect.

So let me propose a third and final alternative unanimous consent request: that at any point after these votes, but before cloture is filed on the pending matter, this amendment No. 2808 receive a vote on the Senate floor as a first-degree amendment to the underlying bill.

Mr. DURBIN. Mr. President, reserving the right to object, may I suggest to my friend from Louisiana, would you consider approaching Senators MIKULSKI and/or MURKOWSKI the first thing tomorrow and see if they are prepared to work with you on this? This Mikulski amendment has been pending for 3 days.

Mr. VITTER. Mr. President, if I could—

Mr. DURBIN. Well, then, I object.

The PRESIDING OFFICER. Objection is heard.

Is there objection to the original request?

Mr. VITTER. Mr. President, reserving my right to object, just so I can respond directly, I didn't mean to cut the Senator off. If he has any further statement, I will be happy to listen to it. But just so I can respond directly, the first thing today, I approached both those Members and everyone involved in this debate about this language and certainly the majority side has had this language for at least 7½ hours. The equivalent of this language has been incorporated into the Murkowski amendment, but my hope is that the same thing be accepted in the Mikulski amendment because it is not clear which is going to be adopted. I don't see the great controversy here. So that was my hope. And that is why I approached those two Senators and the majority side 7½ hours ago about it with specific language.

So I renew my last unanimous consent request I made in that spirit.

Mr. DURBIN. Reserving the right to object, the staff advises me that they are reaching out to Senator MIKULSKI at this moment. I don't know if we can be in contact with her this evening, but I would ask the Senator from Louisiana if he would consider allowing us to go forward with this unanimous consent request and hope we can still modify it tomorrow, if there is an agreement with Senator MIKULSKI at that point. I don't think that jeopardizes the right of the Senator from Louisiana to offer this at a later time during the course of this debate.

Based on that, I would continue to object.

The PRESIDING OFFICER. Objection is heard.

Is there objection to the original unanimous consent of the Senator from Illinois?

Mr. VITTER. Mr. President, reserving the right to object, merely to respond through the Chair, I would say I have been working in that spirit. I have given the language to the majority side. I have been working both at the staff level and Member level with many folks. This should be non-controversial. I don't know of any Senator who disagrees with this. So I will accept that offer. I will not object to this pending unanimous consent, but I truly hope the offer is made in good faith because I believe, when anyone reads this language, they will agree with it.

Again, it simply says these latest recommendations by the U.S. Preventive Services Task Force, made 2 weeks ago, will not have any legal force and effect. I believe all of us—certainly, it is my impression and, I guess, we will find out tomorrow morning—I believe all of us want to stop them from having force and effect because it is a great step backward in terms of breast cancer screening and mammography and even education about self-examination.

So I certainly take that offer and look forward to the majority side re-reading this language and hopefully accepting it tomorrow morning because I can't imagine, on substantive grounds, objecting to the language.

Thank you. With that, I will not object.

The PRESIDING OFFICER. Without objection, the request from the Senator from Illinois is agreed to.

Mr. DURBIN. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

AMENDMENT NO. 2808 TO AMENDMENT NO. 2791

Mr. DURBIN. Mr. President, I ask unanimous consent that the previous order with respect to H.R. 3590 be modified to provide that the Vitter amendment No. 2808 to the Mikulski amendment No. 2791 be agreed to and the motion to reconsider be laid upon the table; that the order be further modified to provide that the vote with respect to the Mikulski amendment should now reflect the Mikulski amendment, as amended.

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

The amendment (No. 2808) was agreed to, as follows:

(Purpose: To prevent the United States Preventive Service Task Force recommendations from restricting mammograms for women)

On page 2 of the amendment, after line 15 insert the following:

“(5) for the purposes of this Act, and for the purposes of any other provision of law,

the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.”

#### MORNING BUSINESS

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

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

#### REMEMBERING MARY JOSEPHINE OBERST

Mr. McCONNELL. Mr. President, today I rise to honor the life of a Kentucky heroine, Ms. Mary Josephine Oberst of Owensboro. Ms. Oberst passed away on November 13, 2009, at the age of 95. A native Kentuckian, she proudly served her country as a member of the Army Nurse Corps beginning in 1937. In July 1941, Ms. Oberst was sent to the Philippines, and in early May the following year, when Bataan and Corregidor fell to the Japanese during the Battle of the Philippines, more than 60 nurses, including Ms. Oberst, were taken as prisoners of war, POWs, by the Japanese. These nurses, later christened the “Angels of Bataan,” were held as POWs for 33 months. During this time, Ms. Oberst continued her duties as a nurse, caring for fellow prisoners, even though she herself suffered from malaria and significant weight loss. In early February 1945, the 44th Tank Battalion rescued the POWs who were later brought back to the United States.

After overcoming the medical conditions which resulted from her imprisonment, Ms. Oberst was appointed captain and continued to serve as a member of the Army Nurse Corps. She worked in hospitals in Louisville, KY; Fort Knox, KY; and Ashford, WV, until her retirement from the Corps in 1947. Ms. Oberst was honored for her duty with several military service awards, including the Bronze Star Medal. Mary Josephine Oberst was a woman of high character, who faithfully served our country. Today, I wish to honor her life and her service, as well as give my condolences to her family for their loss.

#### AMINATOU HAIDAR

Mr. LEAHY. Mr. President, I want to bring to the attention of Senators who may not already be aware, a situation that has been unfolding in Morocco and the Canary Islands.

Last year, I had the privilege of meeting Ms. Aminatou Haidar, called by some the “Saharawi Gandhi,” who received the 2008 human rights award from the Robert F. Kennedy Center for Justice and Human Rights. Ms. Haidar is a focus of attention again today because she is on a hunger strike in the

Canary Islands after being summarily deported by the Moroccan Government on her way home to Western Sahara from the United States, where, coincidentally, she had been to receive the “Civil Courage Prize” from the Train Foundation.

Ms. Haidar is no newcomer to difficulties with the Moroccan authorities. She was first imprisoned in 1987 when she was a 20-year-old college student, after calling for a vote on independence for Western Sahara. When she was released after 4 years, during which she was badly mistreated, she continued her advocacy for the right of the Saharawi people to choose their own future.

Arrested again in 2005 and separated from her two daughters, she led a group of 37 other Saharawi prisoners on a 51-day hunger strike for better prison conditions, investigations into allegations of torture, and the release of political prisoners.

Since her 2006 release, she has continued her nonviolent struggle, which has brought widespread attention to the cause of the Saharawi people. The United Nations Security Council has repeatedly endorsed a referendum on self-determination for the people of Western Sahara.

On November 13, when Ms. Haidar arrived at the airport in El-Ayoun, she was detained by Moroccan authorities. She was told that by insisting on writing her place of residence as “Western Sahara” on her immigration form, she was in effect waiving her Moroccan citizenship. Her passport was taken, and she was forcibly put on a plane without travel documents to the Canary Islands, a Spanish archipelago located 60 miles west of the disputed border between Morocco and Western Sahara.

She remains there at the airport, separated from her daughters, in the 17th day of a hunger strike, and her health is reportedly rapidly deteriorating. She has refused an offer of a Spanish passport, insisting that she will not be a “foreigner in her own country,” and the Moroccan Government refuses to reinstate her passport. She is, in effect, a stateless person.

This is unacceptable. Article 12 of the International Covenant on Civil and Political Rights, which Morocco has ratified, states in part, “Everyone shall be free to leave any country, including his own. . . . No one shall be arbitrarily deprived of the right to enter his own country.”

The situation in Western Sahara is a difficult one for the Saharawi people and the Moroccan Government. It is a protracted dispute in which the international community has invested a great deal to try to help resolve, without success. I recall the time and energy former Secretary of State James Baker devoted to it. The solution he proposed was rejected by the Moroccan Government.

Morocco and the United States are friends and allies, and I have commended the Moroccan Government for