Unfortunately, Senate Republicans are less interested in solving problems than they are in creating them. The day before this floor debate began, the assistant Republican leader—the junior Senator from Arizona—said: ''There is no way to fix this bill.'' Of course, that is absolutely totally wrong.

All Senators know there is a reliable way to improve legislation—to improve this bill. It has been in use for 220 years. It is called the legislative process. It is called doing our job.

As this bill continues to improve, I, once again, remind my colleagues not to lose sight of the bigger picture. As we delve into the details and debate the fine print, let us not forget why we are here. Our goal remains the same it was the day we began this debate many months ago. It remains the same as it was a year and a half ago, when Senate Finance Committee chairman MAX BAUCUS first held a series of hearings that led to the legislation that is now before us.

Our goal remains the same as it was last November when the American people called in a loud and clear voice for change. It remains the same as it did 31 years ago, when Senator Ted Kennedy called it shameful that ''in our unbelievably rich land, the quality of health care available to many of our people is unbelievably poor, and the cost is unbelievably high.''

It remains the same as it did the day President Truman sounded a call to action to ensure that American families are protected from what he called ''the economic effects of sickness.'' That was more than 64 years ago, and more than half of today's Senators weren't even born then. That constant goal has been and remains this: We must make it possible for every American—each and every American—to afford to live a healthy life.

Each moment in this fight is historic. No bill to put health care decisions in the hands of the people has ever come this far. But the most historic days of the journey lie ahead. We can only seize that opportunity if this debate is about facts, not about fear.

I remind my colleagues that if we are to truly help the American people and the American economy, if we are to sincerely do the work our neighbors sent us to do, if we are to leave our children and grandchildren a better inheritance than a deep deficit and a broken health care system—if we are to do any of these things—we must work together and not against each other. We must work as partners, not as partisans.

This is not the first time I have asked my Republican friends to think of the real families across this Nation who face real problems—families with real diseases, real sicknesses, real medical bills, and real fears. It is not the first time I have warned that America has no place for those who hope for failure.

This is not the first time I have extended my hand across the aisle and asked my Republican friends to abandon their shortsighted strategy to bring the Senate to a screeching halt; for example, issuing an informational guide on how to stop and slow things. That doesn't work. We need a strategy that says we can win because that will mean the American people do not lose.

So I hope that, for the first time, we will have people of good will on the Republican side of this Chamber who will walk over and say: Let's work together to get some things done. I have had a couple good conversations the last few days with some of my colleagues on the other side of the aisle. I hope we can move forward. This is a bill that doesn't look at a person who is sick or hurt or afraid as being a Democrat or a Republican or an Independent. They are Americans. They are from Virginia, Montana, Nevada and from all over America and they are people who are calling upon us to do the right thing.

RECOGNITION OF THE MINORITY LEADER

The ACTING PRESIDENT pro tempore. The Republican leader is recognized

HEALTH CARE REFORM

Mr. MCCONNELL. Mr. President, we had a very clarifying vote on the Senate floor about the direction of our friends on the other side with regard to our health care system. Yesterday, all but two of them voted to preserve nearly $½ trillion in cuts to Medicare, the health program for our seniors. In the runup to that vote, they said these cuts were not cuts and that Medicare Advantage in particular is not a part of Medicare, arguments plainly contradicted by the text of the bill itself, by the Department of Health and Human Services, by the independent Congressional Budget Office, and by the experience of seniors themselves.

Seniors do not want Senators fooling with Medicare. Let me say that again. Seniors do not want Senators fooling with Medicare. They want us to fix it, to strengthen it, to preserve it for future generations—not raid it like a giant piggy bank in order to create some entirely new government program.

Yesterday's vote was particularly distressing for the nearly 11 million seniors on Medicare Advantage. So today Members will have an opportunity to undo the damage they voted to do to this program. With yesterday's vote, proponents of this measure authorized $120 billion in cuts to Medicare Advantage and in the process they expressly voted to violate the President's pledge that seniors who like the plans they have can keep them. The President has said seniors who like the plans they have can keep them—because you can't cut $120 billion from a benefits program, obviously, without cutting benefits.

The Congressional Budget Office has been crystal clear on this matter. When asked about the effect these cuts would have on Medicare Advantage, the Director of CBO was unequivocal. He said that approximately half of Medicare Advantage benefits will be cut for nearly 11 million seniors enrolled in this program under this bill.

This is the Director of the Congressional Budget Office being unequivocal. He said that approximately half of Medicare Advantage benefits will be cut for nearly 11 million seniors enrolled in this program under this bill. That is what our friends on the other side voted for yesterday and they know it.

One Democrat last night was explicit. He admitted that after yesterday's votes, Democrats will not be able to say that ''if you like what you have you can keep it.'' This is one of our Democrat colleagues yesterday saying: ''If you like what you have you can keep it'' can no longer be said.

He went on to say ''that basic commitment that a lot of us around here have made will be called into question.'' I think that is highly likely.

Our friends have a couple of choices here today. They can reaffirm their plan to cut benefits for nearly one-fourth of all seniors enrolled in Medicare, they can admit that the President's pledge about keeping the plan you like no longer applies, or they can reverse part of yesterday's vote later today by voting with Republicans to restore those cuts to Medicare Advantage.

I yield the floor.

RESERVATION OF LEADER TIME

The ACTING PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

SERVICE MEMBERS HOME OWNERSHIP TAX ACT OF 2009

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate will resume consideration of H.R. 3590, which the clerk will report.

The assistant legislative clerk read as follows:

A bill (H.R. 3590) to amend the Internal Revenue Code of 1986 to modify the first-time home buyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

Pending:

Reid amendment No. 2786, in the nature of a substitute.

Whitehouse amendment No. 2870 (to amendment No. 2786), to promote fiscal responsibility by protecting the Social Security surplus and CLASS program savings in this act.

Hatch motion to commit the bill to the Committee on Finance, with instructions.

The ACTING PRESIDENT pro tempore. The Senator from Montana.

Mr. BAUCUS. Mr. President, we are beginning our fifth day of consideration on the health reform bill. We will be in a period of debate only until about 11:30 a.m. Pending now is the

amendment by the Senator from Rhode Island, Mr. WHITEHOUSE, on fiscal responsibility. Also pending is a motion to commit by the Senator from Utah on Medicare Advantage. It would be my hope that the Senate will vote on these matters today.

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

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

The assistant legislative clerk proceeded to call the roll.

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

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

Under the previous order, the time until 11:30 a.m. will be for debate only with the time equally divided and controlled between the two leaders or their designees, with the majority controlling the first portion of time.

The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, experts and economists of every political stripe agree that preserving America's long-term economic security means reforming the way we provide and pay for health care. Health care spending makes up one-sixth of the U.S. economy. Future generations can expect the burden of insurmountable debt if we fail to act.

The fiscal challenges we may face in years to come pale in comparison to the threat of uncontrolled Federal health care spending. The chart behind me essentially shows that. The chart shows the percentage annual growth rates beginning in 2004. The red is the economy, the blue is health care costs. Clearly, over time, especially as the economy dipped during this great recession, the gap between economic growth and health care spending has widened. Projections are that in future years they will widen more and more. As you can see out to 2018, the total economy is projected. Near 2018 the economy is above 4 percent and health care spending is 7 or 8 percent.

Doing nothing means health care spending continues to grow faster than our economy. That is what that chart shows quite dramatically. Doing nothing means entitlement spending more than doubles by the year 2050. That is taking one-fifth of our gross domestic product.

But it is not simply the Federal budget on the line, it is the family budget too. Incredibly, in total we are spending 80 times as much on health care today as we did five decades ago—80 times more on health care today than we did five decades ago. Now family budgets are breaking under the strain—already. That is going to get worse if we do nothing. The cost of the average family health care plan will reach $24,000 in the year 2016. That is not too many years away from now. This represents an 84-percent increase over 2008 premium levels. That means, if we do nothing, in fewer than 10 years most families would have to dedicate half of their household budget to health insurance. For years we have heard the warnings from Federal budget experts. Now we are hearing every day from folks back home who simply cannot afford the care they need.

We have an obligation to act. Now we have an opportunity to act. The country's leading economists and Federal budget experts laid out strategies and options for getting costs under control. We have taken their recommendations to heart. There is a lot of agreement among those who study these issues of what we must do. Now we have a bill that does what they suggest. It also passes the test of fiscal responsibility.

We have many reasons to vote for this bill. It protects and even increases Medicare benefits for seniors. It achieves near universal coverage in less than 10 years. That means it achieves the goal of virtually everybody having health insurance in that period of time. It slows the growth of Federal health care spending. It stops insurance industry discrimination and, based on independent, nonpartisan analysis, makes a serious dent in our Federal deficit.

This chart behind me represents what 2 weeks ago the Congressional Budget Office and Joint Committee on Taxation confirmed in no uncertain terms, that deficits go down under this plan. The official cost estimate reads as follows:

> The Congressional Budget Office and the Joint Committee on Tax estimates that on balance the direct spending and revenue effects of enacting this Patient Protection and Affordable Care Act legislation would yield a net reduction in Federal deficits of $130 billion over the years 2010 to 2019. That is represented by the green bar on the left. It is a net $130 billion reduction during the first 10 years of this bill.

In addition to reducing the Federal deficit, in the first decade, the CBO also tells us that the bill decreases the deficit by a much greater amount, by $650 billion, in the second decade.

According to the CBO, this bill also slows the growth of Medicare costs, which has been a principal goal in our Medicare debate since day one. Medicare spending would grow 6 percent annually instead of 8 percent annually. In other words, Medicare would continue to grow but, unlike today, it will grow at a sustainable rate.

Of course, no projections, even from the Congressional Budget Office, can be certain. We can safely say this bill will put us on the right track. We can safely say this bill is better than doing nothing. No honest assessment challenges the case for acting now to slow the growth of Federal spending. No honest assessment challenges the case. And no honest assessment of this bill challenges the CBO analysis. I have not heard one. I have not heard an honest challenge to the CBO analysis, nor have I heard of a good, honest case for not acting now to slow the growth of Federal spending, which means we have many reasons to pass health care reform, not the least of which is the long-term financial health of the economy and our Nation. But the reasons for passing this are much more than simply facts and figures. This is about Americans from every corner of this great country, struggling to make ends meet, forced into bankruptcy by medical tragedy. This is about stopping insurance industry discrimination; this is about saving Medicare for our seniors and reducing the deficit for our grandchildren.

I don't know which other Senators wish to speak. Senator BINGAMAN wishes to gain recognition in the time we have.

Let me ascertain how much time we have and how many speakers we have.

The ACTING PRESIDENT pro tempore. The Senator has 40 minutes.

Mr. BAUCUS. I yield 15 minutes to the Senator from New Mexico.

The ACTING PRESIDENT pro tempore. The Senator from New Mexico.

Mr. BINGAMAN. Mr. President, let me thank Senator BAUCUS for his leadership on this issue. I have mentioned to him many times that I strongly believe without his leadership, we would not be where we are today in our effort to reform health care. I congratulate him on the superb effort he has made.

I want to spend a few minutes talking about health care reform both as it affects the country but also as it affects my home State of New Mexico. First, I would like to discuss the context for this health reform bill, and that is the very serious problem we face in the country with the growing cost of health care, if the Congress fails to act. We have a chart I will put up, since everyone has charts. This is a chart that shows what is happening to all health care costs and has been happening since 1960. We can see that as a percent of the gross domestic product, back in 1960 we were spending right at 5 percent of GDP on all health care. Today we are spending much more like 16 percent of the gross domestic product on health care. The projections for the future, if we do not act to reform the health care system, are very serious indeed.

Let me allude to an article in the morning New York Times. This is by Nobel award-winning economist Paul Krugman of Princeton University. He talks about this issue of fiscal responsibility and the impact of health care reform on the deficit. It talks about how some Senators have concerns about going ahead with this health care reform bill because of what it might cost. He makes the point:

> But if they're really concerned with fiscal responsibility, they shouldn't be worried about what would happen if health reform passes. They should, instead, be worried about what would happen if it doesn't pass. For America can't get control of its budget without controlling health care costs—and this is our last, best chance to deal with these costs in a rational way.

I ask unanimous consent that the full column from the New York Times

of this morning be printed in the RECORD following my remarks.

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

(See exhibit 1.)

Mr. BINGAMAN. As this chart demonstrates, according to the Congressional Budget Office, if we don't act to deal with the growth in health care costs, Federal spending on Medicare and Medicaid combined will grow from 5 percent of GDP today to almost 10 percent by 2035. By 2080, the government would be spending almost as much as a share of the economy on just its two major health care programs as it has spent on all of its programs and services in recent years.

Let me put up another chart that demonstrates that most of this increase in cost is not the result of our aging population. We do have an aging population; that does add to the cost of health care because as people get older they tend to need more health care. The dark blue shows the increase expected in health care costs by virtue of aging. But the lighter blue talks about the effect of excess cost growth that is not related to aging; that is, the growth in health care cost is out of control in our current system. Such spending is unsustainable. It has led the Congressional Budget Office to say:

Slowing the growth rate of outlays for Medicare and Medicaid is the central long-term challenge for fiscal policy.

Moreover, across the country, premiums continue to increase. They are becoming more and more unaffordable for individuals and for businesses. I hear on a regular basis when I go around New Mexico—and I am sure all my colleagues hear from their constituents as they travel in their States—that people cannot continue to pay more and more each year for their health care coverage. According to an August report by the Commonwealth Fund, nationally, family premiums for employer-sponsored health insurance increased 119 percent between 1999 and 2008. If cost growth continues on its current course, those premiums could increase another 94 percent to an average of $23,842 per family by 2020. I am not sure what the circumstance is in many States, but I know in New Mexico there are many families who cannot afford to pay $23,800 in health care premiums.

Nowhere is the unsustainable growth felt more acutely than in my home State. Without health reform, in my State we are projected to experience the greatest increase in health insurance premiums of any State in the Union. For example, the average employer-sponsored insurance premium for a family in New Mexico was about $6,000 in the year 2000. By 2006, this rate had almost doubled, or the cost had almost doubled to $11,000. By 2016, the amount is expected to rise to an astonishing $28,000. In addition, health insurance premiums in New Mexico make up a larger percentage of New Mexico's income, the income of the average New Mexico family, than almost all other States. We are paying 31.18 percent. Over 31 percent of the average income of a family in New Mexico is going to pay for health care. This is expected to grow to 56 percent if we do not reform our health care system.

It is important to highlight that the higher spending on health care in the United States does not necessarily prolong lives. I hear a lot of speeches about how we have the greatest health care system in the world. We are the envy of the world. People would just love to have access to our health care system. This chart illustrates that in 2000, the United States spent more on health care than any other country in the world, an average of $4,500 per person. That was in 2000. Switzerland was the second highest at $3,300, substantially less. Essentially, its cost per person was 71 percent of what it was in the United States during that year. Nevertheless, the average U.S. life expectancy comes out at 27th in the world. Our life expectancy average is 77 years. Many countries, 26 to be exact, achieve higher life expectancy rates with significantly lower spending on health care.

Data from the McKinsey Global Institute clearly indicates there is a considerable level of waste in our current system. McKinsey estimates that the United States spends nearly $½ trillion annually in excess of other similarly situated nations. Of this, about $224 billion in excess costs are found in hospital care. About $178 billion are found in outpatient care. Together these account for more than 80 percent of U.S. spending above the levels of other nations.

Here is one other chart. This is one I have used before on the Senate floor. Not surprisingly, as costs and inefficiencies continue to build, access to health care is becoming more and more difficult for middle- and lower-income Americans. This chart indicates the rate of uninsurance throughout the country. First, on the left-hand side is the year 2000; on the right-hand side is 2008. We can see the dark blue States are States where 23 percent or more of the population ages 18 to 64 are uninsured. Back in the year 2000, New Mexico and Texas were the only two States where the rate of uninsurance exceeded 23 percent. Now we can see the rate of uninsurance exceeds 23 percent for many of the States, particularly across the southern part of the country.

We have a very serious problem that needs addressing. It is clear that the U.S. health care system is failing many Americans. The situation is becoming more and more urgent. According to a study published by the Harvard Medical School in August, medical costs have led to almost two-thirds of the bankruptcies in this country. More than 26 percent of bankruptcies are attributable to health care problems. The study found that most medical debtors were well educated, owned their own homes, had middle-class occupations and, shockingly, three quarters had health insurance. So these were people who had coverage, but the coverage was not adequate to meet the needs. Unfortunately, for many individuals, the very high cost of medical care leads them to delay or to avoid receiving medical care altogether.

The Urban Institute reports that 137,000 people in this country died between 2000 and 2006 because they lacked health insurance. That includes 22,000 people in 2006. Clearly, the need for national health reform has never been so great.

The Patient Protection and Affordable Care Act, the legislation we are debating, introduced by Senator REID and others a few weeks ago, includes the key reforms we have come up with and that the experts have come up with, aimed at addressing these very serious problems, while protecting the aspects of our health system that are working today.

First, this bill includes long-overdue reforms to increase the efficiency and quality of the health care system while reducing overall cost. For example, the legislation includes payment reforms that I have championed to shift from a fee-for-service payment system to a bundled payment system. This will reshape our health care reimbursement system to reward better care and not simply more care as it currently does today.

Second, it includes a broad new framework to ensure that all Americans have access to quality and affordable health care. This includes creation of a new health insurance exchange in each State which will provide Americans a centralized source of meaningful private insurance as well as refundable tax credits to ensure that coverage is affordable.

Finally, these new health insurance exchanges will help improve choices by allowing families and businesses to compare insurance plans on the basis of price and performance. This puts families, rather than the insurance companies or the government bureaucrats, in charge of health care. It helps people to decide which quality, affordable insurance option is right for them.

The Congressional Budget Office, which is cited here—quite frankly, I notice that the Congressional Budget Office is cited by both Democrats and the Republicans in this debate, and that is a credit to the CBO. They are seen as nonpartisan, and they are nonpartisan. I congratulate Doug Elmendorf for the good work CBO has been doing in support of our efforts to come to the right answer on health care reform—the CBO forecasts that this legislation would not add to the deficit.

As the chart Senator BAUCUS had a few minutes ago clearly indicates, the deficit would be reduced in the first 10 years by $130 billion. It would be reduced in the second 10 years, going up to 2029, by something over $600 billion.

Let me also point out the contrast. We are talking about a bill which the

Congressional Budget Office says will reduce the size of the deficit in future decades. I can remember a couple Congresses ago when we had a debate on adding subpart D to Medicare, Part D to Medicare. There are many on the floor who are concerned about cost today—at least they say so in their speeches—who were very anxious to add that legislation to Medicare, adding another $500 billion. That was estimated by the CBO at that time: another $500 billion over a 10-year period to the cost that Medicare was bearing.

The efforts we are making in this legislation to bring under control the cost growth in Medicare is essential if we are going to keep Medicare solvent in the future, and part of the solvency problem Medicare has in the future, frankly, is related to what we did in subpart D.

On the subject of premium cost, CBO has also found that in the individual market, the amount that subsidized enrollees would pay for non coverage would be roughly 56 percent to 59 percent lower, on average, than the premiums charged in the individual market under current law. Among enrollees in the individual market who would not receive new subsidies, average premiums would increase by less than 10 to 13 percent. The legislation would have smaller effects on premiums for employment-based coverage. Its greatest impact would be on smaller employers qualifying for new health insurance tax credits. For these businesses and their employees, CBO predicts premiums would decrease by about 8 percent to 11 percent compared with their costs under current law.

This is consistent with estimates of the impact in my home State of New Mexico, where average families may see a decrease in premiums of as much as 60 percent. In addition, about two-thirds of New Mexicans could potentially qualify for subsidies or Medicaid and nearly a quarter would qualify for near full subsidies or Medicaid.

An overall decrease in premium costs also is consistent with the experience in Massachusetts where there has been an enormous reduction in the cost of nongroup insurance in the State after they enacted similar reform to what we are considering now in the Senate. After reform the average individual premium in Massachusetts fell from $8537 at the end of 2006 to $5143 in mid-2009, a 40 percent reduction while the rest of the Nation was seeing a 14 percent increase.

Finally, much of the debate on health care reform has focused on insurance coverage but it is important to recognize that as we expand coverage to include more Americans, the demand for health care services will also increase. A strong health care workforce is therefore essential for successful health reform. Within the United States, approximately 25 percent of counties are designated health professions shortage areas—a measure indicating that there is insufficient medical staff to properly serve that geographic area. The problem is even more apparent in rural States such as New Mexico. For example, 32 out of 33 counties in my State has this shortage designation. As a result, New Mexico ranks last compared to all other states with regard to both access to health care and utilization of preventative medicine.

The Patient Protection and Affordable Care Act we are debating contains key provisions to improve access and delivery of health care services throughout the Nation. These provisions include increasing the supply of physicians, nurses, and other health care providers; enhancing workforce education and training; and providing support to the existing workforce.

I applaud Senators REID, BAUCUS, DODD, HARKIN, and many other colleagues who have worked so hard on this bill. This legislation represents true healthcare reform. It is time for the Senate to put partisanship aside and enact this critical and long overdue legislation.

I see my time is up and there are others waiting to speak. I yield the floor.

EXHIBIT 1

[From the New York Times, Dec. 4, 2009]

REFORM OR ELSE

(By Paul Krugman)

Health care reform hangs in the balance. Its fate rests with a handful of ''centrist'' senators—senators who claim to be mainly worried about whether the proposed legislation is fiscally responsible.

But if they're really concerned with fiscal responsibility, they shouldn't be worried about what would happen if health reform passes. They should, instead, be worried about what would happen if it doesn't pass. For America can't get control of its budget without controlling health care costs—and this is our last, best chance to deal with these costs in a rational way.

Some background: Long-term fiscal projections for the United States, paint a grim picture. Unless there are major policy changes, expenditure will consistently grow faster than revenue, eventually leading to a debt crisis.

What's behind these projections? An aging population, which will raise the cost of Social Security, is part of the story. But the main driver of future deficits is the ever-rising cost of Medicare and Medicaid. If health care costs rise in the future as they have in the past, fiscal catastrophe awaits.

You might think, given this picture, that extending coverage to those who would otherwise be uninsured would exacerbate the problem. But you'd be wrong, for two reasons.

First, the uninsured in America are, on average, relatively young and healthy; covering them wouldn't raise overall health care costs very much.

Second, the proposed health care reform links the expansion of coverage to serious cost-control measures for Medicare. Think of it as a grand bargain: coverage for (almost) everyone, tied to an effort to ensure that health care dollars are well spent.

Are we talking about real savings, or just window dressing? Well, the health care economists I respect are seriously impressed by the cost-control measures in the Senate bill, which include efforts to improve incentives for cost-effective care, the use of medical research to guide doctors toward treatments that actually work, and more. This is ''the best effort anyone has made,'' says Jonathan Gruber of the Massachusetts Institute of Technology. A letter signed by 23 prominent health care experts—including Mark McClellan, who headed Medicare under the Bush administration—declares that the bill's cost-control measures ''will reduce long-term deficits.''

The fact that we're seeing the first really serious attempt to control health care costs as part of a bill that tries to cover the uninsured seems to confirm what would-be reformers have been saying for years: The path to cost control runs through universality. We can only tackle out-of-control costs as part of a deal that also provides Americans with the security of guaranteed health care.

That observation in itself should make anyone concerned with fiscal responsibility support this reform. Over the next decade, the Congressional Budget Office has concluded, the proposed legislation would reduce, not increase, the budget deficit. And by giving us a chance, finally, to rein in the ever-growing spending of Medicare, it would greatly improve our long-run fiscal prospects.

But there's another reason failure to pass reform would be devastating—namely, the nature of the opposition.

The Republican campaign against health care reform has rested in part on the traditional arguments, arguments that go back to the days when Ronald Reagan was trying to scare Americans into opposing Medicare—denunciations of ''socialized medicine,'' claims that universal health coverage is the road to tyranny, etc.

But in the closing rounds of the health care fight, the G.O.P. has focused more and more on an effort to demonize cost-control efforts. The Senate bill would impose ''draconian cuts'' on Medicare, says Senator John McCain, who proposed much deeper cuts just last year as part of his presidential campaign. ''If you're a senior and you're on Medicare, you better be afraid of this bill,'' says Senator Tom Coburn.

If these tactics work, and health reform fails, think of the message this would convey: It would signal that any effort to deal with the biggest budget problem we face will be successfully played by political opponents as an attack on older Americans. It would be a long time before anyone was willing to take on the challenge again; remember that after the failure of the Clinton effort, it was 16 years before the next try at health reform.

That's why anyone who is truly concerned about fiscal policy should be anxious to see health reform succeed. If it fails, the demagogues will have soon, and we probably won't deal with our biggest fiscal problem until we're forced into action by a nasty debt crisis.

So to the centrists still sitting on the fence over health reform: If you care about fiscal responsibility, you better be afraid of what will happen if reform fails.

The ACTING PRESIDENT pro tempore. The Senator from Montana.

Mr. BAUCUS. Mr. President, how much time remains under the control of the majority?

The ACTING PRESIDENT pro tempore. Twenty-four minutes.

Mr. BAUCUS. Mr. President, I yield 10 minutes to the Senator from Massachusetts.

Mr. KIRK. Mr. President, I thank the Senator.

Mr. BAUCUS. We might be able to find extra time, too, if the Senator is looking for extra time. Right now, according to the number of Senators who

want to speak, that is all we have in this first block. But sometimes we can work things out—if the Senator wants to talk a little longer. But right now it is 10 minutes.

The ACTING PRESIDENT pro tempore. The Senator from Massachusetts.

Mr. KIRK. Mr. President, I thank Senator BAUCUS.

AMENDMENT NO. 2870

Mr. President, today in the United States of America, approximately 200 million of our citizens are elderly or disabled. These are not mere statistics. They are family members and loved ones—vulnerable, challenged, and often forgotten. But they were not forgotten by their friend and advocate, Senator Ted Kennedy. He understood a fair and civilized society should be judged on how it treats its most vulnerable citizens.

Sadly, millions of seniors and persons living with disabilities struggle to obtain the services and supports they need to live fulfilling lives and to remain in their communities among their friends and families—in what they hoped would be their productive golden years.

As Senator Kennedy understood, it is morally wrong for so many disabled men and women who need assistance to be forced to face the heartbreaking choices: Do I abandon my job, spend down my savings, move out of my home, give up my American dream in order to qualify for Medicaid, the only government program that can provide me with the supports I need, or do I forgo my independence and resign myself to living the rest of my life confined to a facility?

Senator Kennedy also understood it is morally wrong when that infirm or elderly individual's friends or loved ones must also face heartbreaking choices: Do I give up my job and commit my time to care for my infirm parent at the expense of my own family and children or do I resign myself to confining my aging mother or father to a facility?

Families across this country understand this heart-wrenching crisis all too well. A recent SCAN poll found that nearly 60 percent of those surveyed had a personal experience with long-term care. As this chart demonstrates, nearly 80 percent would be more likely to support health care reform if—if—it included a long-term care program. These families know the current long-term care industry is not meeting their current needs and that change must come.

As always, Senator Kennedy cared how our society would be judged. He did not just sit by. He acted. He drafted the Community Living Assistance Services and Supports Act, known as the CLASS Act, which we are debating this morning. This program was at the heart of his effort to help people with functional limitations and their families to obtain the services and supports they need. It gives them the chance to maintain their independence and remain active, productive members of their communities.

Under the CLASS Act, a worker in Massachusetts, or any other State, can choose to pay a premium into this voluntary insurance program through affordable payroll deductions. After contributing for 5 years, they become eligible for a cash benefit of at least $50 a day if they become disabled. That cash benefit can make the difference in allowing a disabled person to live with independence, self-respect, and dignity.

For example, it can pay for having a ramp installed to their home or to pay for needed transportation or to purchase a computer to work from home and remain self-sufficient. It can also pay for a caregiver to come to their home, help them bathe, get dressed, and cook meals—services that otherwise often fall to family and friends who are forced to work reduced hours on their own jobs or quit those jobs altogether to provide that needed care.

Currently, long-term care, as we know it, is paid for through a fragmented combination of sources, including family budgets, Medicaid, Medicare, and private insurance. Without a prior and voluntary insurance investment, which the CLASS Act offers, paying for long-term care can be financially catastrophic for many individuals and families, since home care and nursing homes can cost over $70,000 a year.

Only one in five individuals can afford private long-term care insurance, and many are excluded because of preexisting conditions. Medicare's role in providing long-term services is extremely limited, covering only short-term skilled nursing care and home health. This lack of options forces many people to turn to Medicaid, which is our Nation's primary payer and only safety net program providing comprehensive long-term care services and supports.

But who is eligible for Medicaid? People only qualify for Medicaid if they are or become poor. This criterion forces many families to impoverish themselves to obtain the Medicaid support they need. We have all heard the stories: The family member works hard all his or her life, and then due to an accident they cannot afford to pay for needed services and supports out of their pocket. So they now must give up their savings to become eligible to turn to the government and to Medicaid to provide the proper care they need to survive. No one wins—not the disabled or elderly parent, not the family caregiver, not the government, and not Medicaid.

I have a letter from a woman who lives on Cape Cod in Massachusetts. She knows firsthand how powerful the CLASS Act could be for families. Jerilyn has been caring for her sister who is brain damaged, legally blind, paralyzed, and incontinent. Jerilyn writes:

Caring for my sister at home has saved the state thousands and thousands of dollars every year and we have done this care for 38 years. We fight every year to get sufficient hours for PCA care with Mass Health. We are holding down full time jobs which also supplement my sister's care. This is so wrong. Instead of encouraging families who want to keep their loved ones at home and save the state money, they work against us so I believe we will give up and just place them in nursing homes . . . which in turn cost the state more money . . . is this not totally crazy?

She is asking the right question. The CLASS Act will help turn this serious, no-win situation into an everyone-wins result. It gives individuals with disabilities and their families the funds they need to obtain some of the services they need without having to resort to Medicaid.

The current reliance on Medicaid is not only a strain on our families, it is also a strain on our already overburdened Medicaid system. Today, Medicaid spends nearly $50 billion a year on long-term services and supports. Estimates indicate that by 2045 that spending could exceed $200 billion. Obviously, this current course is unsustainable.

In addition, the private insurance industry is not doing enough to meet the growing demand for such care. Aging baby boomers and longer lifespans will increase the demand for long-term care dramatically for decades to come. Yet 95 percent of people over age 45 do not have private long-term care insurance, and fewer and fewer people are able to buy such coverage.

Make no mistake, as it stands today, if someone without adequate long-term care coverage becomes disabled, they will more than likely have to turn to the already overburdened Medicaid system to get the help they need. The CLASS Act is designed to specifically remedy this looming crisis by giving people an affordable option other than Medicaid. The act will save the system over $1.6 billion over the first 4 years that people start receiving benefits.

Some opponents of the CLASS Act argue that the program will not be sustainable over time and that it will become insolvent and end up costing taxpayers large amounts. That argument could not be further from the truth.

Let's give proper credit where it is due. With the help of our friends on the other side of the aisle, we have taken real steps to ensure that the program remains solvent for years to come. The act establishes a strong work requirement to make sure the funds continue to come into the program from the payroll tax deduction or from an individual's voluntarily paid premium. It requires the Secretary of HHS to review and set the premiums annually to ensure that the program will remain solvent for the next 75 years. It directs the Secretary, in addition, to review the cost projections 20 years into the future. Finally, it mandates that no taxpayer funds will be used to pay benefits.

Let me repeat that final point, since I have often heard it misrepresented.

No taxpayer funds will be used to pay benefits. Benefits will be paid through self-funded and voluntary premiums.

During the markup in the HELP Committee this summer, Senator DODD led a main discussion about this program. With the help of the Republicans on the committee, especially Senator GREGG of New Hampshire, additional safeguards were included to ensure that the act will stand on strong financial footing for years to come. After the committee adopted Senator GREGG's 75-year solvency amendment, the program won strong words of support from both parties. We credit Senator GREGG for that constructive contribution.

This CLASS Act will do all the things it should do. It will provide financial and health security to elderly and infirm Americans. It will strengthen Medicare. It will make health reform the exact thing the American people need.

With that, I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Montana.

Mr. BAUCUS. Mr. President, I yield 8 minutes to the Senator from Wisconsin, the chairman of the Special Committee on Aging.

The ACTING PRESIDENT pro tempore. The Senator from Wisconsin.

Mr. KOHL. Mr. President, I thank very much Senator BAUCUS.

I come to the floor to talk about the many ways in which this bill will have a positive impact for seniors.

Over the past year, we have seen confusion about what health care reform will mean for Americans and particularly for seniors. I had hoped that once the Senate voted to move forward with debate on one merged bill, we could offer some definitive answers on how health reform will help them. Unfortunately, here we are on the floor, continuing to send mixed messages about some very concrete provisions. As chairman of the Aging Committee, I wish to help set the record straight for older Americans.

This health reform bill is not going to cut Medicare benefits. Independent groups such as the AARP and the National Committee to Preserve Social Security and Medicare have said this bill will strengthen Medicare and not harm it. AARP believes this bill will transition Medicare to a more efficient system, where quality health care outcomes are rewarded and waste, which experts believe accounts for up to 30 percent of Medicare spending, is reduced.

In terms of the cuts to Medicare Advantage, this bill will only cut back on overpayments to these private Medicare plans. Benefits will not be affected. AARP also supports these cuts because they understand that most of the overpayments are going to insurance company profits, not to seniors' benefits, and that this overspending is putting Medicare on a faster path to insolvency. Experts say by making these cuts, health reform will extend the solvency of the Medicare trust fund by 5 years, without making one cut to guaranteed benefits.

I understand people complain that this bill is too long. But any bill that seeks to offer choice and meet the needs of so many Americans is, by necessity, complex. We cannot gloss over these vital issues. So I would like to take a minute to share with you some of the provisions that have not received as much attention but are, nevertheless, crucial to improving America's health care system. There is a lot in this bill for older Americans, retirees, and those planning ahead for a healthy and happy long life. The Aging Committee has worked closely with the leadership of the HELP and Finance Committees to improve several of our provisions, most of which have bipartisan support. I wish to particularly thank Senator BAUCUS, Senator DODD, Senator HARKIN, and Majority Leader REID for being so willing to work with us on these important issues.

We have enlisted help from seniors groups of every stripe to ensure health reform makes commonsense improvements that, in some cases, are desperately needed.

This bill will significantly improve the standard of care in nursing homes nationwide for the first time in 22 years. I thank my colleague, Senator GRASSLEY, for working together to make sure this important issue was not overlooked as part of health reform. In and of itself, this is a huge undertaking, but it is just one piece of the puzzle to comprehensively reform our health care system.

This bill will also train and expand the health care workforce so they are prepared to care for the growing elderly population. By implementing recommendations from the Institutes of Medicine, we will begin to address the severe shortage we face of direct care workers.

This bill will protect vulnerable patients by creating a nationwide system of background checks for long-term care workers. This policy is more than just a good idea in theory. We have implemented it in seven States and seen its results. Comprehensive background checks are routine for those who work with young children, and we should be protecting vulnerable seniors and disabled Americans in the same way.

This bill will make it easier for seniors to get the care they need in their own homes because when it comes to long-term care, one size does not fit all. The goal of long-term care should be to allow older or disabled Americans to live as independently as possible.

This bill will help update our current long-term care system in order to offer choices tailored to an individual's needs. It will also help to alleviate the huge financial and emotional burden on married couples who need long-term care. I worked with my colleague, Senator CANTWELL, to ensure that married couples who receive care in their home and community are not required to spend the vast majority of their assets to receive assistance.

The committee has also helped to include a provision that will benefit all Americans regardless of age by helping to lower the costs of prescription drugs and medical devices.

Our policy aims to make transparent the influence of industry gifts and payments to doctors.

Although these are only a few of the Aging Committee's priorities, this bill makes many other improvements to our current health care system for older Americans.

The Senate bill will reduce the cost of preventive services and add a new focus on paying doctors to keep patients well and not just paying them for when their patients get sick.

Today, seniors pay 20 percent of the cost of many preventive services. By eliminating the copayment and deductibles through Medicare for important services such as immunizations, cholesterol screenings, bone calcium-level screenings, and colonoscopies, we will help save lives as well as lower health care costs.

The bill will also provide for the first time an annual wellness visit at no cost to the beneficiary. Patients will be able to receive a personalized health risk assessment for chronic disease, have a complete review of their personal and family medical history, and receive a plan for their care.

This bill will remove the ability of insurance companies to deny access to consumers based on preexisting conditions. We know having health care is essential throughout one's life from beginning to end, but many older Americans count the days until they become eligible for Medicare because they are not able to find insurance coverage at any cost due to a health condition in their past.

I could go on about the many other improvements, small and large, that will benefit our Nation's seniors, but I will stop here and simply urge my colleagues to work to educate seniors and not scare them about the important changes this bill will make to provide them with better health care at lower cost.

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

Mr. BAUCUS. Mr. President, how much time remains for the majority?

The ACTING PRESIDENT pro tempore. Five minutes.

Mr. BAUCUS. I ask unanimous consent that there be an additional 5 minutes on each side.

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

Mr. BAUCUS. Mr. President, I yield the remaining time to the Senator from Oregon, which should be 10 minutes.

The ACTING PRESIDENT pro tempore. The Senator from Oregon is recognized.

Mr. WYDEN. Mr. President, I wish to spend a few minutes this morning talking about Medicare Advantage and particularly to highlight the fact that I

think it is important to support the language put together by the chairman of the Finance Committee on Medicare Advantage and to reject the amendment offered by our friend from Utah, Senator HATCH.

I wish to begin my comments with respect to Medicare Advantage by pointing out that it is clear that not all Medicare Advantage is created equal. Some of Medicare Advantage is a model of efficiency, and some of it is pretty much a rip-off of both taxpayers and seniors. I would refer, as it relates to the abusive plans, to the very important hearings chaired by Senator BAUCUS in the Finance Committee. I recall on one occasion sitting next to our friend from Arkansas, Senator LINCOLN. We had witnesses describe how Medicare Advantage was being sold door-to-door in her part of the country by individuals dressed up in scrubs as physicians and health care providers. In the discussion of how to handle it, we looked at various kinds of reforms to rein in abusive practices. I came to the conclusion that when you do something such as that, the CEOs ought to be put in jail. That is what is documented on the record as it relates to the hearings held in the Senate Finance Committee and why I come to the floor to make it clear that I think it is important to distinguish between the good-quality Medicare Advantage plans and those that have been living high on the hog through some of the overpayments we have documented on this floor.

My State has the highest percentage of older people in Medicare Advantage in the country. I had an opportunity to work closely with Chairman BAUCUS in terms of addressing Medicare Advantage, and I think that with the chairman's leadership, it has been possible to show you can find savings in the Medicare Program without harming older people, without reducing their guaranteed benefits, their essential benefits, as we have learned, with Medicare Advantage. The way Chairman BAUCUS goes about doing that is by forcing the inefficient Medicare Advantage plans to follow the model of the efficient ones. The way we have been able to do that is essentially through a two-part strategy: first, encourage competitive bidding and, second, provide incentives for quality, which is done through the bonus payment provisions that are in the legislation.

First, on competitive bidding, you have plan bids, and you use the plan bids to set Medicare Advantage benchmarks which would encourage the plans to compete more directly on the basis of price and quality rather than on the level of extra benefits offered to those who are enrolling. With the competitive bidding, plans compete to be the most efficient and hold down costs. I commend Chairman BAUCUS for making this a central part of the way Medicare Advantage would be handled. Certainly our part of the country has shown this as a path to get more value for the Medicare Advantage dollar in the days ahead.

In addition, in the Finance Committee I offered an amendment with several colleagues that would boost the payments to those plans that, according to the government—and the government uses a system of stars, in effect, to reward quality—our amendment would boost the payments to those Medicare Advantage plans with four- and five-star quality ratings.

So, in effect, with our legislation there are both carrots and sticks. Competitive bidding plus bonus payments offers both, so the plans compete to provide the best value for seniors. By encouraging the plans to be more efficient, it is possible to achieve significant savings for older people, help shore up the solvency of the Medicare trust fund, and meet the cost-saving goals of the legislation.

One point that has been discussed by colleagues on the floor of the Senate is this matter of individuals being able to keep what they have. I have heard that is not the case with Medicare Advantage plans; that somehow, under the legislation that has been offered by the Finance Committee, older people would not be able to keep what they have, according to some on the floor. That is simply inaccurate. Seniors who have Medicare Advantage plans under the Baucus legislation will be able to keep those plans. They will be able to stay with what they have, keep their guaranteed, essential benefits, and through the language that has been authored now in the legislation before us, there will be lower costs for taxpayers.

Last point. I have heard a lot of talk about grandma on the floor of the Senate. I spent the bulk of my professional life in effect working with grandma. I was the cofounder of the Oregon Gray Panthers and ran the legal aid program for older people in our home State for a number of years. I want it understood that I think with the Baucus legislation on Medicare Advantage, that proves it is possible to make savings in the Medicare Program without cutting essential benefits. Using commonsense principles of competitive bidding, No. 1, and incentives for quality, I think grandma is going to be just fine under our language for Medicare Advantage.

Mr. President, with that, I yield the floor.

Mr. BAUCUS. Mr. President, how much time is remaining on the majority side?

The ACTING PRESIDENT pro tempore. Three minutes.

Mr. BAUCUS. And on the minority side?

The ACTING PRESIDENT pro tempore. Fifty-five minutes.

Mr. BAUCUS. Mr. President, I reserve the remainder of the majority time.

The ACTING PRESIDENT pro tempore. The Senator from Tennessee.

Mr. ALEXANDER. Mr. President, during the next 55 minutes, we will have several Republican Senators come to the floor. I ask unanimous consent that during that time, Senator MCCAIN be allowed to be the manager of a colloquy among the Republican Senators.

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

Mr. ALEXANDER. Mr. President, before Senator MCCAIN begins, if I may, I wish to take a moment to establish where we are today and what happened yesterday as a lead-in to what he is about to discuss.

Yesterday, Senator MCCAIN offered an amendment on the floor of the Senate that would do two things: It would send this 2,074-page Democratic health care bill back to the Finance Committee and say to them, No. 1, take out the cuts in Medicare, and No. 2, any savings in Medicare must go to make Medicare more solvent. That is what the McCain amendment would have accomplished. That was defeated. Fifty-eight Democrats said yes to the cuts in Medicare. They said yes to using the money that comes from these cuts to create a new entitlement program. Forty Republicans and two Democrats said, no, we don't want cuts to Medicare and we do not want a new entitlement program.

So yesterday we made it clear that the central core of this bill includes nearly $½ trillion in cuts to Medicare. There is no question about that. Everyone concedes that. The President said that when he addressed us. The Congressional Budget Office says that. The question is whether it is a good idea or a bad idea, and yesterday, by 58 votes, the Democrats said yes to these cuts in Medicare.

Today, we want to talk about one aspect of those cuts which is Medicare Advantage. We are going to talk about these cuts in a careful, accurate way so the 11 million seniors who have Medicare Advantage understand exactly what the risk is to their Medicare Advantage policies.

We can see that a portion of the overall Medicare cuts that the Democrats approved yesterday is a $120 billion cut over the next 10 years to the Medicare Advantage program. Now, what is Medicare Advantage? Medicare Advantage is an option seniors have. If you choose this option, Medicare pays a fixed amount every year for your care, to companies that might come to you and offer a Medicare Advantage plan which you can choose instead of the original Medicare plan.

Many seniors choose these plans—11 million seniors. Nearly one out of four seniors in America who are part of Medicare chooses the Medicare Advantage plan. In my home State of Tennessee, the number is about 230,000 Tennesseans.

Why do they choose it? Well, it includes some benefits they may not have in the original Medicare plan. These benefits include dental care, vision care, hearing coverage, reduced hospital deductibles, lower co-payments, lower premiums, coordinated

chronic care management, and physical fitness programs.

The distinguished Senator from Oregon was on the floor and he mentioned grandma. I have mentioned grandma a few times—no disrespect to grandpa; he is in the same boat. He said grandma didn't need to worry about her Medicare Advantage plan because none of the benefits would be cut. That is not what the Director of the CBO, who is often cited by the chairman of the Finance Committee, has said. He said that half of the benefits currently provided to seniors under Medicare Advantage would disappear under the Finance Committee plan, which is much like the plan we are considering. The benefits that would disappear would include those I mentioned.

Today, with Senator MCCAIN leading the discussion, we wish to talk about the Medicare Advantage plan, and why cuts to Medicare Advantage play a central part of this $2.5 trillion bill. Cuts to Medicare pay for about half of that $2.5 trillion cost, and the ones we are talking about today are the Medicare Advantage plans. I understand there will be an amendment by Senator HATCH, who has joined us, and I am sure he will talk about his own amendment. He was present on the Finance Committee when Medicare Advantage was created. I understand there will be an amendment to send this back to the Finance Committee saying don't cut Medicare Advantage.

Mr. MCCAIN. Yes. For those who missed Senator HATCH's important statement last night, which he will add to today, I point out that he was able to take a trip down memory lane. In June 2003, when the Medicare Modernization Act was before the Senate, several of our colleagues, including Senators SCHUMER and KERRY, offered a bipartisan amendment on the floor to provide additional funding for benefits under the Medicare Advantage Program.

But amnesia is not confined to one side of the aisle around here. I ask my friend from Tennessee—you know this discussion about Medicare Advantage—we have to better understand what is this program and why is it so popular. Is it because it offers seniors a chance to get additional benefits? Maybe the Senator can give a short definition of that. I think the American people may not be totally clear on what we are discussing here and why 11 million Americans—over 300,000 citizens in my own State—have chosen Medicare Advantage, and that has prompted, according to Bloomberg, Senator CASEY of Pennsylvania, to say, ''We are not going to be able to say 'if you like what you have, you can keep it.''' ''That basic commitment that a lot of us around here have made will be called into question.''

The title of that is ''Dem Senator Says Medicare Advantage Cuts Break President's Pledge.''

Maybe the Senator from Tennessee can give me a brief outline of what seniors get under Medicare Advantage and why it is so popular with 330,000 senior citizens in my State and 11 million in the country.

Mr. ALEXANDER. I can do that. The Senator is correct. If the Senator from Pennsylvania, Senator CASEY, said that, he is merely repeating what the Director of the CBO stated, when he said that fully half of the benefits of Medicare Advantage will be lost.

To answer the Senator's question, Medicare Advantage is an option that 11 million of the 40 million seniors who are on Medicare have chosen. The reason they choose it is because it is a plan offered by private companies, often to people in rural areas, often to minorities——

Mr. MCCAIN. Lower income seniors.

Mr. ALEXANDER. Yes, lower income Americans also choose these. They often choose it because the plans generally offer these benefits: dental care, vision care, hearing coverage, reduced hospital deductibles, lower co-payments, lower premiums, coordinated chronic care management, and physical fitness programs.

Mr. MCCAIN. I thank my friend. The reason I ask this, he mentioned that Medicare Advantage would allow seniors to have dental care, vision care, hearing care, physical fitness—it is fascinating. This allows our senior citizens to have dental, vision, hearing, and physical fitness care, and that is a little strange because, as was pointed out to me, that is exactly what we have here in the Senate. About 100 paces from here, if I need some doctor care immediately, if I need some vision care, if I need some dental care, I can get it. Next to my office in the Russell Senate Office Building, for the last several months—and I don't know at what cost, but I would like to get entered into the RECORD how many tens of millions of dollars it is. But they are renovating a gym. So my colleagues yesterday voted against keeping the Medicare Advantage Program, when we have, right here, the best Medicare Advantage Program ever heard of in the world—free hearing, free vision, free dental—and they are expanding a gymnasium in a many-months-long project. I will get the cost of that, although that may be hard to do.

Let me get this straight. Again, the American people should understand this. We voted to cut drastically a program that seniors have taken advantage of, which gives them additional hearing, vision, dental, and physical fitness care, while we practice it here every single day. Every day, there is a physician on duty—more than one—not very far from where I speak, who is ready to give us instant care. If hospitalization is needed, we can get instant transportation to the Bethesda Naval Hospital, where we will get free care. Incredibly, the Senate, on largely partisan lines, yesterday voted against senior citizens in this country, most of whom have paid a lot more into the program than we have. We are going to deprive them of what we have every single day we are members of the Senate.

That is an exercise in hypocrisy. The Senator from Pennsylvania has it right, because the President, time after time, said to the American people: If you like the insurance policy you have today, you can keep it. How many hundreds of times have we heard him say that at townhall meetings? And his administration mouthpieces say the same thing. The Senator from Pennsylvania is right when he says, ''We are not going to be able to say if you like what you have, you can keep it. That basic commitment that a lot of us around here have made will be called into question.''

I will say a couple words, and I will talk more about this later. Every time the Senator from Montana and others are on the floor, they talk about the fact that AARP now supports this blatant transfer of funding from the Medicare Program, which the seniors have earned, into a brandnew entitlement—a $2.5 trillion entitlement program. That is what this bill is all about.

For your information, AARP has received $18 million in stimulus money. There is a job creator for you. AARP, which has given its full-throated support to the Democratic health care legislation, even though seniors remain largely opposed, received an $18 million grant in the economic stimulus package for a job training program that has not created any jobs, according to the Obama administration's recovery.gov Web site. That is astonishing to me because from everything I have ever seen, they have created millions of jobs, including in the ninth congressional district of Arizona, where they said they created thousands of jobs. Unfortunately, we only have eight congressional districts, but that is OK.

In February, Politico reported that AARP was putting pressure on Republican Members of Congress to support the stimulus package. Since then, AARP has moved on to lobbying for passage of health care legislation, even though Democratic proposals have called for several hundred billion dollars in cuts to Medicare—a program that the group typically defends tooth and nail when Republicans propose cutting it. It turns out that AARP is also in a position to benefit financially if the health care legislation passes, because seniors losing benefits as a result of cuts to Medicare Advantage will be forced to buy Medigap policies, which is the main source of AARP revenue. Barry Rand, chief executive of AARP, was a big donor to the Obama campaign and has retained a cozy relationship with the administration. That is shocking news.

So, my friends, also I might add that in 2006, AARP received $18 million from the Federal Government, and we are reserving additional Federal moneys that they get.

The most important thing is this, and let's make it clear: AARP will receive direct benefits because seniors

who have cuts in their Medicare Advantage and other Medicare programs can buy—guess what—a Medigap insurance policy from AARP—in other words, to cover the things being cut back under this legislation, and it costs $175 a month. The Medicare Advantage premiums are zero for most seniors or $35 a month. Again, if the Medicare Advantage plans go away, people would have to buy a Medigap plan sold by—you got it—AARP. And some low-income seniors could not afford $175 a month.

That is why the Senator from Tennessee stated that if we drive people out of Medicare Advantage, we are harming low-income seniors all over this country. We are harming them. We are doing them a great disservice. If you think with 17 percent real unemployment in my State that seniors who are unemployed and down on their luck are going to be able to afford the AARP Medigap policy for $175 a month, come and visit my State and I will tell you they can't.

It is interesting, the conversation about high-income seniors, and how we are going to tax people with Cadillac plans and all of those things, when what we are doing is harming the lowest income seniors in rural areas of America.

Mr. KYL. Will my colleague yield for a quick point?

Mr. MCCAIN. Yes.

Mr. KYL. The Senator was making the point that you cannot take $120 billion out of the program without hurting folks. Those on the other side of the aisle said we can do that—we can cut it by $120 billion and it still won't hurt anybody. My colleague asked the Senator from Tennessee exactly what some of the benefits were and he repeated them. I went to get the actual statistical number of how much it will actually reduce benefits in terms of actuarial value. According to the Congressional Budget Office, in the year 2019, when fully implemented, here is the statistic: The actuarial value of the reduction in benefits under Medicare Advantage is 64 percent; in dollar terms, it goes from $135 a month down to $49 a month. In other words, the very things my colleague talks about—vision care, dental, all of those things——

Mr. MCCAIN. All of the things we routinely use in the Senate. I hope those who voted to harm the seniors in this country and not allow them to have dental, vision, and other health care would unilaterally disavow the use of the physician care and vision care and hearing care available to all of us 24 hours a day right here in the Senate.

Mr. KYL. The last point. I want to say that I hear my colleague loudly and clearly. I hope the American people do too because you cannot call a $120 billion cut something that doesn't hurt people, and especially when the Congressional Budget Office itself says, yes, that reduces these very benefits from a value of $135 a month down to $49 a month. That is a huge cut in the value of the services they receive under Medicare Advantage. That is what we are trying to prevent by this amendment.

Mr. MCCAIN. Could I mention one other thing? I will not spend that much more time on AARP. But the reason I do is because every time the Senator from Montana stands up, he talks about AARP endorsing this rip-off of the American people.

Let me quote again from a Bloomberg article entitled ''AARP's Stealth Fees Often Sting Seniors With Costlier Insurance.'' I quote from the Bloomberg article just briefly:

> Arthur Laupus joined AARP because he thought the nonprofit senior-citizen-advocacy group would make his retirement years easier. He signed up for an auto insurance policy endorsed by AARP, believing the advertising that said he would save money.
>
> He didn't. When Laupus, 71, compared his car insurance rate with a dozen other companies, he found he was paying twice the average. Why? One reason, he learned, was because AARP was taking a cut out of his premium before sending the money to Hartford Financial Services Group, the provider of the coverage. . . .
>
> AARP uses the royalties and fees to fund about half the expenses that pay for activities such as publishing brochures about health care and consumer fraud—as well as for paying down the $200 million bond debt that funded the association's marble and brassstudded Washington headquarters.
>
> In addition, AARP holds clients' insurance premiums for as long as a month and invests the money, which added $40.4 million to its revenue in 2007. . . .
>
> During the past decade, royalties and fees have made up an increasing percentage of AARP's income, rising to 43 percent of its $1.17 billion in revenue in 2007 from 11 percent in 1999, according to AARP data.

This is a Bloomberg article. This is not from the Republican Policy Committee.

The point is, who gains? Who gains from this legislation? Who is going to make hundreds of millions of dollars more because they provide the Medigap policies people will be deprived of when we kill off Medicare Advantage? AARP.

Mr. ALEXANDER. Mr. President, I see the Senator from Texas, the Senator from Idaho, and the Senator from Wyoming have all come to the floor, in addition to the sponsor of the motion, Senator HATCH. I am sure they are prepared to reflect on who is hurt by these cuts.

The only thing I would emphasize is what the Senator from Arizona has said is that disproportionately low-income Americans in Texas, Idaho, Tennessee, Wyoming, and Utah are hurt. Only one-third of eligible White seniors who do not have Medicaid or employer-based insurance are enrolled in Medicare Advantage. But the number increases to 40 percent for African Americans and 53 percent for Hispanics.

Mr. MCCAIN. May I ask the Senator again, he described the benefits that are provided under the Medicare Advantage program that seniors can have if they want, right? Are those same benefits—dental, vision, hearing, and fitness care—available under regular Medicare today?

Mr. ALEXANDER. My understanding is the answer is no. That it is the reason 11 million Americans choose Medicare Advantage because these benefits are not available under the original Medicare plan.

Mr. MCCAIN. In Montana, there are 27,000 enrollees who will see a 24-percent decrease. In Connecticut, there are 94,000 enrollees who will see a 14-percent decrease. By the way, some special deals have been cut for three States I understand—Oregon, New York, and Florida. We are going to try to fix that. There is no reason one State should be shielded any more than another from these draconian measures. We are going to try to fix that situation.

The reason I bring up this issue, present-day Medicare beneficiaries do not have vision, they do not have dental care, they do not have fitness. Yet we in the Senate enjoy it every single day. So yesterday we voted to deprive seniors from the ability to have the same privileges that we enjoy every single day in the Senate. I would argue that is an exercise in hypocrisy.

Mr. ALEXANDER. I might say we are operating under a colloquy managed by Senator MCCAIN. So Republican Senators are free to engage in discussion.

Mrs. HUTCHISON. Mr. President, I very much appreciate what the Senators have been talking about because what Senator MCCAIN is saying is that these seniors who are low income have an affordable option, and it is less expensive than the AARP option that would give them this extra care—the eye care, the dental care, the hearing aids. It is an affordable extra option.

In Texas, we have over 500,000 seniors enrolled in Medicare Advantage. One of the great things about Medicare Advantage is that it is available in rural areas, and it gives them choices that they might not be able to afford with other programs that are Medigap. This one is affordable. That is why we are fighting so hard to restore the cuts to Medicare Advantage.

Medicare Advantage costs about 14 percent more than traditional Medicare because it provides a wide range of these extra benefits we have discussed—dental, eye care, hearing aids and, in many cases, it pays providers more. Republicans, of course, are open to discussing how to improve the Medicare Advantage payment formula. We want to be more efficient with taxpayer dollars, but do we want to do that in the context of creating a massive new entitlement program and ask Medicare to pay for it or to cut lifesaving benefits for seniors? Is that what we want to do, I ask Senator CRAPO?

Mr. CRAPO. That is absolutely the case. I would like to point out, when we had the Finance Committee markup, I asked CBO Director Elmendorf directly whether provisions in the bill,

which are still in the bill, would reduce the benefits that Medicare recipients received. His response was:

For those who would be enrolled otherwise under current law, yes.

There has been a lot of talk here about we are not cutting Medicare benefits or we are or it is this or that. The bottom line is, the CBO Director said it: Yes, we are cutting benefits.

I would like to ask the sponsor of this motion a question because I know there are some who are saying the reason we are cutting Medicare Advantage is that it is so expensive, and we should be cutting Medicare and controlling its costs; that it is about 14 percent more expensive than fee-for-service Medicare.

Some people say if you are defending Medicare Advantage, you are defending overpayments in health care plans. Would the Senator from Utah like to respond to that criticism some are making?

Mr. HATCH. I would be delighted to. To be clear, so-called overpayments to Medicare Advantage plans do not go to the plans. As a matter of fact, they go to the seniors in the form of extra benefits. That is a pretty important point a lot of people miss. Seventy-five percent of the additional payments to Medicare Advantage plans are used to provide seniors with extra benefits, including chronic care management—you would think you would want to do that—hearing aids, eyeglasses. The other 25 percent of any extra payments are returned to the Federal Government. I cannot imagine why anybody would not want to do that.

Mrs. HUTCHISON. Mr. President, I ask the distinguished Senator from Utah to also respond to the arguments that claim that the government cannot afford now to continue overpaying these private plans and that the Medicare trust fund is going broke. Of course, we tried actually several years ago to shore up the Medicare Program, trying to do it in a responsible way, not cutting out the Medicare benefits these seniors can receive as an affordable option. What does the Senator say to that?

Mr. HATCH. The Senator from Texas pointed out the Medicare trust fund is going broke. Yet what do we have on the other side? They take almost $500 billion out of Medicare. Trust me, I am deeply concerned about the solvency of the Medicare trust fund.

Mr. MCCAIN. May I say it is my understanding that Dr. BARRASSO has actually seen Medicare Advantage patients. He and Dr. COBURN are probably the only two. Maybe we could let him give us the benefit of his experience and also not only the benefit of his experience, but I am sure he is going to tell us what the impact is going to be on the low-income seniors from his State.

Mr. BARRASSO. I agree with the Senator from Arizona that people choose to be on Medicare Advantage. Mr. President, 11 million people have chosen to be on Medicare Advantage because it is a wise choice to make because they get better benefits. They get dental care, they get the vision care, they get the hearing aids, they get the fitness thing.

Mr. MCCAIN. Just as we do.

Mr. BARRASSO. Just as we do. It works in preventive care and coordinated care.

Mr. MCCAIN. I don't think they have as nice a gym, though, as we are going to get.

Mr. BARRASSO. It is also no surprise when people read about this and learn about it that they would want to be on Medicare Advantage. What the Senator from Utah has said, the sponsor of this motion, is that the money that goes into this program is for the benefit of the seniors. It is for services for the seniors on Medicare. To me, this whole bill basically guts Medicare, raids Medicare to start a whole new program.

Today, as the Senator from Arizona has mentioned in these articles, the Associated Press and USA Today said:

Senate Democrats closed ranks Thursday behind $460 billion in politically risky Medicare cuts at the heart of health care legislation. . . .

It goes on to say:

Approval would have stripped out money to pay for expanding coverage to tens of millions of uninsured Americans.

So they are going to take $460 billion, it says, away from our seniors who depend on it for their Medicare and start a whole new government program. The Washington Times, front-page story headline, reads: ''Democrats Win $400B in Medicare Cuts. McCain Pushed for Another Way to Pay for It.''

I look at this and say this is not fair to our seniors, not fair to the patients I have taken care of for 25 years in Wyoming, taken care of folks—taken care of folks—when grandmom breaks her hip, what we need to do for our patients. These are choices people have made.

Mr. President, 11 million Americans have chosen Medicare Advantage because there is an advantage to them for the health care they get—the additional services, the coordinated care, the preventive care. Anyone who looks at this and studies it says: I want to sign up.

It has been wonderful in rural areas and big cities. This has helped a lot of people in the country. It is not surprising that one out of four people in the country on Medicare have chosen Medicare Advantage, but yet what we are seeing here is Democrats want to get rid of Medicare Advantage.

Mr. MCCAIN. Let me get this straight. Basically, by removing the choices that seniors have as a part of Medicare Advantage—dental, vision, hearing, fitness—we are taking away from them what we ourselves enjoy every single day in the Senate?

Mr. BARRASSO. We are taking it away from seniors and using all that money to start a new government program when we know Medicare is going to go broke by 2017.

Mr. HATCH. We are listening to only one of the two doctors in the Senate who knows, who has been on the ground, has met with the people, who understands what this means to senior citizens. One-quarter of them are on Medicare Advantage.

In the end, I believe we not only actually help seniors be more healthy but save a lot of money in the end. Trust me, I am deeply concerned about the solvency of the Medicare trust fund. We have been sounding that alarm for years. That is why it is so shocking we are debating a $2.5 trillion health reform bill that does almost nothing to make sure Medicare is sound and, in fact, does a lot of things to make it unsound, or almost nothing to make sure Medicare is around for future generations.

Instead, we are just creating another Federal entitlement program that we cannot afford while Medicare has $38 trillion in unfunded liabilities.

Mr. CRAPO. The Senator is absolutely right. A lot of people trying to defend these cuts are saying these extra costs in the Medicare Advantage Programs are just going to make insurance companies' profits bigger and help pay for large CEO salaries. Nothing could be further from the truth. The reality is, as the Senator from Utah already indicated, 75 percent of this 14 percent extra payment in these plans go to provide the seniors with the extra benefits we are talking about, and then 25 percent is returned to the Federal Government, not to insurance companies, not to CEOs.

I have a chart. We are going to make it into a bigger one. But those who support this program say we are not cutting Medicare benefits. This chart—I apologize it is a little bit small—but this is a chart of the United States. It shows what is happening to the benefits of Medicare Advantage beneficiaries. As you might guess, the dark red is more than 50 percent reduction in the benefits of the people in those dark red States. In the medium red color, it is between a 25- and 50-percent reduction in coverage. The only States that do not have a reduction in coverage are the white ones. There are three or four States that are not seeing deep cuts in Medicare Advantage benefits.

Those who say—like the President who said it was one of his goals—if you like what you have, you can keep it—not if you live in one of the States that is not in white on this chart because your benefits will be cut.

Mr. ALEXANDER. I wonder if I might ask the Senator from Idaho to go back over a point he made a moment ago because he went over it quickly and it is such an important point and one reflected by the chart behind him about what he just said. Repeatedly we are told that seniors won't lose benefits if you cut nearly $½ trillion in Medicare. So if you could take

a moment—I believe you were in the Finance Committee markup where the bill was being written that was offered by the distinguished Finance Committee chairman, and I believe you were talking to the head of the Congressional Budget Office, who is often cited by our friends on the other side as the nonpartisan authority for exactly what the bill does, and you asked him whether the benefits of Medicare Advantage recipients would be cut. Would you describe that in a little more detail so people understand exactly the scenario?

Mr. CRAPO. Yes, I would. This chart shows the last two sentences of our colloquy when we were in the Finance Committee, but it went on for some time. But the bottom line is that I was asking the Director of CBO whether the cuts to Medicare Advantage that are in the bill would reduce benefits to senior citizens, and he said yes. And the reason he used this phrase here, which says ''for those who would be enrolled otherwise under current law,'' the reason he prefaced it that way—which we don't have on the chart—is that for future seniors it will not be a viable option. So in the future, those who are not on it now won't have a significant viable option to get on it because it is going to be gutted.

So he was saying that for those 75 percent—and by the way, Medicare Advantage is the most popular part of Medicare today. It is the fastest growing part of Medicare. It is popular because it provides these additional benefits that seniors have to pay so significantly for to get in supplemental insurance that AARP is going to provide. So what the CBO Director said was that for the future, those who aren't already on it won't get it.

Mr. MCCAIN. Could the Senator from Texas and I go back to one of the things I mentioned earlier, because in Texas, how many are under Medicare Advantage?

Mrs. HUTCHISON. Five hundred thousand of my constituents are on Medicare Advantage.

Mr. MCCAIN. Five hundred thousand in your State, and there is no ''shielding.'' According to this Bloomberg article and according to our knowledge, it says:

Senators Charles Schumer of New York, Bill Nelson of Florida, and Ron Wyden of Oregon are among those who secured special provisions shielding constituents from cuts. Casey—

Referring to Senator CASEY of Pennsylvania—

says he wants ''very comparable'' protections for his State—surprisingly enough—where more than one-third of Medicare beneficiaries participate in Medicare Advantage. ''It's the kind of thing that will likely be addressed on the floor,'' he said.

Well, I eagerly look forward to working, on the other side of the aisle, with all the Members from those States, with the exception of New York, Florida, and Oregon, who have earned special shielding from these cuts. I look forward to working with them, and let's fix it for all of us; right, Senator HATCH?

Mr. HATCH. That is right. Go ahead.

Mrs. HUTCHISON. Yes, I would say to the Senator from Arizona, I was wondering if every State could have the same treatment. Why not have every State get this shielding for their Medicare Advantage? That is 11 million people in this country who would then be helped by a fair assessment of this all over the country.

But let me just point out one other provision. The way they have been shielded is through grandfathering. What about people who——

Mr. MCCAIN. And was that shielding done on the floor of the Senate, in open debate and in discussion of the issue?

Mrs. HUTCHISON. Oh, no. Now, amazingly——

Mr. MCCAIN. It was done in an office over here, where we still await the white smoke.

Mrs. HUTCHISON. The white smoke, that is correct. But then the question arises: What about the future, where people will say: That is what I can afford and what I want to have. But grandfathering doesn't include anyone who might want to join in the future; it is only the people already in the system. And for how long they live, that is great, but what about the future?

So this is a great program. It is affordable for the lower income people. This shielding is only for three States now, but I would like to see us all have the same capabilities for our constituents. And what about our future constituents?

Mr. GREGG. Would the Senator yield on that point, because the Senator from Arizona has raised an important point. If this is such a good program for these four States, why isn't it a good program for everybody?

But more importantly, the Senator is the expert around here on earmarks. Is this not a classic earmark? And didn't we hear from the other side of the aisle that we were going to have open government; that we were not going to have this type of exercise occur within major bills; that bills weren't going to be loaded up with special earmarks assisting one Member or another? As the expert on the issue of earmarks, would the Senator comment?

Mr. MCCAIN. I would say this is probably the classic hometown protectionism that we see in earmarking and benefits that we see in the earmarking process.

But also, I would remind the Senator from New Hampshire, as we have all discussed several times, a year ago last October, our then-candidate for President said: It is all going to be on C–SPAN. Well, the C–SPAN cameras are still waiting outside Senator REID's offices to go in and film these negotiations so that, as President Obama said, all Americans can see who is on the side of the pharmaceutical companies and who is on the side of the American people.

C–SPAN, keep waiting. We are going to try to get you in.

Mr. GREGG. If I could ask one more question because I have been listening to this debate, and I came over because I wanted to participate a little. I think it has been an excellent and informative debate.

I have been looking at the numbers here, and I know the numbers are big—big—in this first 10-year period—almost $500 billion in reductions in Medicare spending. But I think the point we need to make is that it doesn't end there. It doesn't end there. Those Medicare spending reductions go on into the next decade, too, and over the first two decades of this bill, Medicare spending reductions will account for $3 trillion—$3 trillion. How can anybody argue against what the Senator from Idaho said, which is that this translates into real reductions in Medicare benefits?

Mr. MCCAIN. Isn't the vitally important point in this discussion that this massive mountain being carved out of Medicare is not being used to save Medicare? It is creating a huge new entitlement program. So here we are with Medicare going broke in 7 years, and we are taking money out of it in order to create a new program. That is the crime that is being committed here.

Mr. GREGG. The Senator is absolutely right. And the new program, by the way, will not be solvent either. So we are compounding the insolvency of the future, and we are passing that on to our children.

Mr. HATCH. We are taking $½ trillion out of a program that is going to be insolvent before the end of this decade and we are giving it to another program that is already insolvent.

Mr. GREGG. That will be insolvent.

Mr. HATCH. That will be insolvent. It is almost insane what they are doing. And they wonder why the American people are having such a difficult time, why we have 10 percent unemployed, why the underemployment is 17 percent in this country. Those are people who are trying to get part-time jobs because they can't get full-time jobs. So 17 percent is the real number.

This whole program is about helping low-income people and minorities, when you stop and think about it. That is what Medicare Advantage does. As the distinguished Senator from Arizona has said, they can't afford these supplemental policies on which AARP will make a lot of money if they can kill this program. There are a lot of gaps in traditional Medicare benefits, including high cost sharing and no out-of-pocket limits. That is why 89 percent of seniors have some form of supplemental coverage on top of Medicare. For many low-income Americans and minorities, Medicare Advantage is the only way they can afford the supplemental coverage.

I compliment all of my colleagues here on the floor—the distinguished Senator from Arizona; the distinguished Senator from Idaho; the distinguished Senator from Texas; our only

doctor on the floor right now and one of only two in the Senate, Senator BARRASSO from Wyoming; and, of course, our leader in the Senate, both on the Budget Committee, Senator GREGG and, of course, Senator ALEXANDER. You guys have really summed this up.

Mr. MCCAIN. Could I say again that we have had spirited debate and discussion on this floor, but it is clear the majority of the American people do not support the proposal that is before us, and they do not support meeting in private, mostly in secret, closed negotiations.

Again, I renew our offer to the Democrats and to the administration: Let's get together in a room with the C–SPAN cameras and any other outlet, and let's sit down and do some serious negotiations on the areas we can agree on, which there are many, and let's save Medicare, let's fix this system, and let's do it together in the way the American people want us to—in a bipartisan fashion, not behind closed doors, so the American people can see us work together for a change.

I thank all of my colleagues for their many contributions. We are ready to talk. We are ready to talk, but we won't be driven.

Mrs. HUTCHISON. Mr. President, I would like to return to a point that was made earlier about the President promising, and it being understood by everyone, that if you like what you have, you can keep it. On Medicare Advantage, once again, the CMS has estimated—and I would ask the distinguished Senator from Utah to verify this—that enrollment in Medicare Advantage will decrease by 64 percent under this bill.

Mr. HATCH. A lot of seniors are going to be badly hurt by these cuts, no question, and the poor.

Mrs. HUTCHISON. And 8.5 million seniors would be deprived.

Mr. HATCH. And a lot of them are minorities, by the way. This is amazing to me, how we go through all kinds of demagoguing about low-income people and minorities, and yet they are going to take one of the most important benefits away from them. That benefit is mentioned in the Medicare handbook for 2010, yet they act as if it is not part of Medicare. I can't believe some of the arguments that have come from the other side.

Mr. MCCAIN. Could I ask the Senator from New Hampshire, the senior member on the Budget Committee, a person who is well-known for his knowledge of the economy, of the budgetary situation in America, what happens if we pass this massive bill? What happens to America's economy?

Mr. GREGG. Well, my view is this: First off, we know a couple of facts—that we grow the government by $2.5 trillion over a 10-year period when this bill is fully implemented. We also know the tax increases during that period will be approximately $1.2 trillion, tax increases and fees, and they are not going to fall on the wealthy, they are going to fall on the small businessperson trying to create the extra job. We also know there will be an entire sea change in the way people get their health care, that the government will be stepping in between you and your doctor and basically making a decision as to what your doctor can tell you you can have for health care, what the provider will tell you you can have for health care.

There is something that hasn't been discussed much. We know the innovations in health care which have done so much to make America the best place to get health care in the world and which have put us on the cutting edge of drugs that have improved the lives of millions of people, not only in the United States but across the world, will be significantly chilled because there will not be an interest in investing capital in a market that is so controlled by the government.

In the end, it is fairly obvious to anybody who has been around this place that there isn't going to be $3 trillion in reductions of Medicare spending over the next 20 years and there isn't going to be $500 billion in Medicare spending cuts in the next 10 years. So all that spending is going to fall on the backs of our children in the form of debt.

We already have a nation that is on an unsustainable path under the present budget scenario without this health care bill. Our deficits are $1 trillion a year, on average, for the next 10 years. That is without this bill. Our public debt goes from 35 percent of the gross national product to 80 percent of the gross national product. We become insolvent at the end of this decade—not this decade but the decade starting today, 10 years from today. That is aggravated dramatically by exploding the size of the government under this bill rather than taking the step-by-step approach that has been proposed by our side to reform health care, to make it more effective and make it deliver more services to more people at a better cost.

A number of times I have heard people on the other side of the aisle get up and say that CBO says this bill reduces the cost of health care spending to the Federal Government. It is just the opposite—just the opposite. The CBO letter specifically said that the cost to the Federal Government of health care goes up—goes up—under this bill in the 10-year period. So this bill does not turn down the cost of health care, it does explode the size of government, it does put the government into the business of managing your health care, and as a result, I think it is going to reduce the quality of life of our children.

Mr. HATCH. Will the Senator yield on that point?

Mr. GREGG. I do not have the floor.

Mr. MCCAIN. Go ahead.

Mr. HATCH. The Senator has pointed out he does not believe they can afford all these programs. The Senator is not suggesting this is a game, is he?

Mr. GREGG. I am suggesting it is very difficult, under any scenario, to believe this Congress is going to do anything other than spend the money that is put in this bill. It is certainly not going to end up making the reductions in Medicare it proposes in this bill. If it does make those reductions, though, I think the Senator from Utah has been absolutely right in saying those reductions should go to making the Medicare system solvent. They should not go to creating a brand new entitlement.

Mr. MCCAIN. On that point I think Senator CRAPO wishes to exactly emphasize the point of Senator GREGG.

Mr. CRAPO. I wish to make a comment or two and then engage with the ranking member of the Budget Committee.

Often people talk about driving the cost curve down. Frankly, when you talk to Americans about what they want in health care reform, the vast majority of them say the reason we need health care reform is because of the skyrocketing cost of health care and health care insurance. Those who are promoting this bill say they are bending that cost curve down. My question is which cost curve are they talking about? Is it the size of government? Are they bending the size of government growth down? No, as the Senator from New Hampshire said, they are growing government by $2.5 trillion for the first true 10-year period of the bill.

Are they driving personal health care costs down? No, the CBO report we recently got said 30 percent of Americans will see their health insurance go up, and the other 70 percent will, at best, see it stay about what it is today, rising at the same levels it is today.

Are they talking about the Federal deficit? The chairman of the Budget Committee has indicated to us we are going to see skyrocketing deficits. Those who claim this bill is going to reduce the deficit can say so only if they take into account all of their budget gimmicks, such as not counting the first 4 years of the spending, or the hundreds of billions of dollar of taxes that are going to be imposed on the American people, or the Medicare cuts we have been talking about. Take any one of those three out of this bill and it drives the deficit up in a skyrocketing fashion, is that not correct, Senator?

Mr. GREGG. Absolutely.

Mr. MCCAIN. Has the Senator from New Hampshire ever heard of legislation where you pay in the first 4 years before a single benefit comes about? Nowadays I see these advertisements that you can buy a car and you don't have to make a payment for a year and then you can start making payments. In this deal it is the reverse; you make payments and then perhaps you get the benefits after some years.

The Senator from Tennessee, I think, wishes to comment, too.

Mr. ALEXANDER. I would direct my comment to the Senator from New

Hampshire, too. The President of the United States said something a few weeks ago that I thought was profound and that I agreed with, he said this debate is not just about health care; it is about the role of the Federal Government in the everyday lives of the American people. I believe he is exactly right about that, which is why so many Americans are turning against this bill.

Would the Senator from New Hampshire agree the President was correct, that this debate is about, in my words now, Washington takeovers, more taxes, more spending, and more debt? It is not just about health care. The enormous interest across the country in these votes comes from a much larger picture than this health care bill.

Mr. GREGG. I think the Senator from Tennessee has once again hit the nail on the head. I respect the President's forthrightness. The President has said very simply he believes that prosperity comes from growing the government. When this bill passes, we will see the largest growth in government in the history of our country. This is going to be 16 percent of our economy basically managed by the Federal Government. You are going to see the Government explode in size. Does that lead to prosperity? I don't happen to think it does. It certainly doesn't lead to prosperity if along with that massive expansion in the size of the government you are going to see your deficit go up significantly, your debt go up significantly, or the tax burden go up significantly, which reduces productivity, or if you take a large segment of our society, our seniors, 35 million today, 70 million by the year 2019, and say to them they are not going to have the ability to have a solvent Medicare system because the way that system might have been made more solvent is now being used to create a brandnew entitlement, a massive new entitlement for a whole group of people who never paid for an insurance policy and never paid into the Medicare insurance fund.

I think the Senator has touched the base. We have seen automobiles, we have seen financial institutions, we have seen the student loans, and now we are seeing health care all taken over by the government or partially taken over by the government. Clearly the goal is, as the President said, expand the size of the government, create prosperity, use the European model. I don't happen to be attracted to the European model. I think the American model works better where you have a government you can afford and give entrepreneurs a chance to go out and take risks and create jobs.

Mr. MCCAIN. Senator HUTCHISON will conclude.

Mrs. HUTCHISON. We have been talking about Medicare Advantage and losing this great option for lower income seniors, which is so important. I was reminded that we have not even talked about the $135 billion that would be taken out of hospitals in this bill. These are the care providers. We are talking about taking away benefit options in eye care and dental care and hearing aids, sort of basic things seniors need, but also undercutting the hospitals that treat them, so the care provided in the hospitals themselves would also have to be cut back.

It does not pass common sense to cut Medicare in order to create a new big entitlement program. We have all said that Medicare is on life support anyway, everyone understands that. So you take almost a $½ trillion out of a program that is working for seniors, that gives options to seniors such as Medicare Advantage, and you take away their care to pay for another entitlement program that is not specifically designed for them.

I thank the Senator from Arizona and ask him to finish the comments on what is happening to this bill, this country, and our seniors. We need to stop it.

Mr. MCCAIN. I thank my colleagues. It has been a lot of fun. I yield the floor.

Mr. BAUCUS. Mr. President, if I may, I ask unanimous consent that we extend for an additional hour the period for debate only with no further amendments or motions in order during the hour; and that the time be equally divided between the two sides, with the Republicans controlling the first 30 minutes and the majority controlling the second 30 minutes.

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

Mr. BAUCUS. I believe there is 3 minutes remaining on the first block, on the majority side?

The ACTING PRESIDENT pro tempore. There is 2 minutes 20 seconds.

The Senator from Ohio is recognized.

Mr. BROWN. Mr. President, I ask unanimous consent to be added as a cosponsor to the Coburn amendment No. 2789 requiring all Members of Congress to enroll in the new public health insurance option. I wish to add my name to Senator COBURN's amendment. Seventeen years ago when I first ran for Congress I promised I would pay my own health insurance until Congress paid health insurance for everyone. I have paid out of my pocket since then. I look forward with great eagerness to joining the public option as soon as it is available.

Mr. BAUCUS. Mr. President, I think I will use my 2 minutes 20 seconds.

The ACTING PRESIDENT pro tempore. And 15 seconds.

Mr. BAUCUS. OK. I want to make three basic points. The Senator from Arizona talks about, gee, all these Medicare Advantage plans have dental and vision coverage. He goes on to say, so do Members of Congress.

The fact is that is not automatically true. The fact is Members of Congress choose among various private plans. Some plans offer dental and vision, some do not. Aetna is a company that Members of Congress could choose from under FEHBP and others that Members of Congress can choose from. Those do provide dental and vision coverage. But there are others—I think Blue Cross and Blue Shield does not provide dental and vision coverage.

I make that point because this is exactly what we are trying to set up in these exchanges. People could participate in the exchanges, where they would buy private coverage and they could choose among various private plans which coverage they want. Do they want a plan that covers dental and vision, or not? That is exactly what we are trying to do in the exchange, as is the case for Members of Congress. Medicare Advantage plans do provide dental and vision. I think that is great.

I see my time has expired. At the appropriate time I wish to go into greater detail and explain why what we do in this bill I think makes eminent sense.

The ACTING PRESIDENT pro tempore. The Senator from Iowa is recognized.

Mr. GRASSLEY. Mr. President, I yield myself such time as I might take. I don't think I am going to speak more than 6 or 7 minutes, for the benefit of my colleagues who may want some of this time.

I want to tell my colleagues why I am supporting the Hatch amendment. In my home State of Iowa there are 64,000 seniors enrolled in Medicare Advantage. These are seniors who have come to rely on lower cost and particularly additional benefits that Medicare Advantage provides, as opposed to traditional Medicare. Yesterday I came to the floor to point out that my colleagues on the other side of the aisle are playing word games to cover up the fact that they are raiding Medicare, cutting benefits by 64 percent for these 11 million seniors who have chosen voluntarily to go on Medicare Advantage as opposed to traditional Medicare. Let me repeat: This bill cuts Medicare benefits, or let's say raids Medicare, by 64 percent for 11 million Medicare beneficiaries.

My friends on the other side of the aisle keep saying they are not cutting and they use these words, ''they are not cutting guaranteed benefits.'' But this is not even the case. Because we have this new independent Medicare advisory board that is set up in this legislation, it is given very specific authority to cut payments to Medicare Part D. This will result in higher costs and less guaranteed benefits for Medicare beneficiaries enrolled in Medicare Part D.

But I want to leave that debate for later. I want to visit with my colleagues now about Medicare Advantage. Mr. President, 64,000 seniors in Iowa and 11 million seniors nationwide do not care about the gobbledy-gook type words we use here in town, as legal as they are—''guaranteed benefits'' on the one hand and the words ''additional benefit'' on the other hand. In other words, guaranteed benefits or,

as the other side wants us to believe, somehow additional benefits provided under Medicare.

I say that is Washington nonsense. I want to bring a little bit of Midwestern common sense to this debate. Our constituents want to know that Congress is not cutting Medicare benefits they have come to rely upon and that would include, under Medicare Advantage, dental care, eyeglasses, hearing aids, and other additional benefits provided by this program that they voluntarily chose, Medicare Advantage.

I know that to be the case. I have at least 1,000 letters I have received since last summer on this point. But I want to read one from Miss Purificacion S. Gallardo of Iowa City, IA.

> I am writing to urge you to oppose cuts to Medicare Advantage. . . . This plan was a great help to me when my late husband, who passed away in May, was hospitalized. . . . I was able to afford to pay the hospital without going bankrupt. We seniors who live on a fixed income depend on our benefits from Medicare Advantage. I am retired and don't know how I would have managed without [Medicare Advantage].

Some of my colleagues on the other side of the aisle don't want seniors, even people such as my constituent from Iowa City, Ms. Gallardo, to know that this 2,074-page bill is cutting their benefits. Because the other side will say they are simply cutting so-called overpayments to Medicare Advantage plans. That doesn't make any difference to Ms. Gallardo. They fail to mention, 75 percent of these so-called overpayments must be spent for additional benefits—not only free money for a company to use or free money that benefits a Medicare Advantage recipient without any concern about what it costs—75 percent of these payments must be spent for additional benefits. Then where does the rest of it go? The rest of it comes back to the Federal Treasury. Cuts to these Medicare Advantage payments are, in fact, cuts in Medicare benefits.

I am more than happy to have a debate on how to reform Medicare Advantage payments. We should always be looking for ways to make payments more efficient. But the solution is not to cut benefits by 64 percent, on which seniors have come to rely, to fund an entirely new entitlement program this country can't afford. At a time when seniors are in the midst of the biggest economic crisis since the Great Depression, we should not be debating a bill that forces them to spend more money on health care, and that is exactly what this 2,074-page bill will do. Seniors who lose their Medicare Advantage as a result of this bill may be forced to buy a Medigap plan to fill in all the holes in traditional Medicare. That is why more low-income seniors enroll in Medicare Advantage. The so-called overpayments my colleagues on the other side of the aisle keep decrying help fill in the significant cost sharing and premiums that exist in traditional Medicare.

This bill will force low-income seniors, who pay little to nothing under Medicare Advantage, to come up with $175 per month to buy a Medigap plan. That doesn't sound like that is a very good way to help seniors. That sounds like this bill is paying for an entirely new entitlement program and paying for it, quite frankly, on the backs of 11 million Medicare beneficiaries.

I support the Hatch amendment. Let's take the $120 billion in Medicare Advantage cuts back to the Finance Committee and find a way to improve the program without hurting 11 million seniors.

I yield 5 minutes, as the manager on this side, to Senator HUTCHISON.

The ACTING PRESIDENT pro tempore. The Senator from Texas.

Mrs. HUTCHISON. Mr. President, I appreciate what the distinguished Senator from Iowa has discussed. I specifically liked the fact that he is relating this to where we are today. Sometimes it seems as though we are in a vacuum, not realizing how stretched people are right now. We are in a time of joblessness, people are worried about keeping their jobs, worried about having lost their jobs, where they are going to get their health care. We have seniors who are stretched because they are not able to earn income. We are in a distressed time. There is no doubt about it. To talk about cutting Medicare by almost $500 billion is astounding. I am concerned about hospitals. We talked for the last 45 minutes about the cuts to benefits—the hearing aids, the dental work seniors need, the eye care seniors need.

What about the cuts to care provided in a hospital? Hospitals that treat a large share of low-income seniors get an extra payment from Medicare. Medicare already makes reduced payments to providers, to doctors but also to hospitals, to hospice, to nursing homes, and home health agencies for senior services. And yet proposed is a cut of almost $500 billion. All of these serve our seniors in such great ways. Look at the cuts, almost a $½ trillion over 10 years. This is not sustainable. We cannot take away from Medicare, cut services, cut reimbursements to providers. What is going to happen to a hospital? What is going to happen to a hospital in a rural area, especially that is barely hanging on right now because they are trying to make ends meet in a more expensive treatment area and they lose the added payment that would make them whole in the treatment of low-income seniors?

The Texas Hospital Association estimates that $2 billion will cut in payments to hospitals for treating a large volume of low-income Medicare patients, $2 billion out of our economy. Mr. President, 254 counties in Texas, more than one-fourth, do not even have an acute care hospital within their boundaries. With these kinds of cuts to rural hospitals, we are talking about losing more hospitals. There is no doubt about it. They are already struggling. Why would we pay for health care reform on the backs of our senior citizens? Why would we take away a program they have that is tailored for their needs in order to pay for another big government program that is going to cost $2.5 trillion, most of which is going to be added to the deficit, added to the debt, and we are already hitting the ceiling of the debt at $12 trillion? We are in a very tough financial time. We are in a time that is hard for people who have lost jobs, hard for seniors stretched to make ends meet, hard for hospitals serving seniors and not getting paid the full cost of the treatment. Yet we are talking about cutting these services.

Of the $135 billion in Medicare cuts to hospitals, $2 billion is for the reimbursement rates that will no longer be making hospitals whole. I went to the major medical centers in Texas—in Dallas, Houston. Then I went to rural areas. It is the topic of conversation. Anyone who is dealing with a hospital in a rural area, they are all saying: What are you doing?

Of course, we are not doing anything. We are fighting these health care cuts. But we have to make sure they know what is happening so we can achieve that result.

I understand my time has expired. I think the Senator from Oklahoma has the rest of the time on our side.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Oklahoma.

Mr. INHOFE. Mr. President, I thank the Senator from Texas. I yield myself the remainder of our time, which I understand is until 10 after the hour.

I wish to talk about taxes, which is our subject, and in a different way than others did. The stated purpose of the Democrats' health care proposal is to do two things: lower cost and increase coverage. This bill is a miserable failure on both counts. Under the plan, premiums are expected to increase, as a result of new taxes, new regulations, and restrictions. In general, you are going to pay more for your health insurance thanks to the Democrats' 2,000-page bill. This is in direct contradiction to the stated goals of the bill itself. I will be specific about that in a moment.

The second issue is coverage. Again, we find a miserable failure. The most often cited number of uninsured Americans is 47 million Americans. I saw some interesting numbers in a Washington Post opinion piece the other day which kind of ranks out the uninsured and how they are broken down. This is very significant. Of the 47 million, 39 percent reside in the five States of California, Florida, New Mexico, Arizona, and Texas. Those are our border States. Indeed, it is estimated that 9.1 million of the 47 million are illegal immigrants, people in this country illegally. Secondly, of the 47 million, 9.7 million have incomes above $75,000 and choose not to purchase health insurance. This bill would solve that issue by using the coercive power of the Federal Government to force citizens to allocate their resources in a manner that

meets the approval of bureaucrats in Washington and of politicians. The bill makes it a crime not to have health insurance. If you don't get it, you get taxed.

Lastly, a total of 14 million of the 47 million are currently eligible for current government programs—Medicaid, Medicare, SCHIP, and so forth—and choose not to sign up. If you do the math, that reduces that 47 million down, if you take out the illegals and the others for the reasons I stated, to about 14 million. So this, by and large, is what people are talking about when they mention the 47 million uninsured Americans. These numbers shed some interesting light on the composition of the number of uninsured Americans that gets thrown around. President Obama, interestingly, uses a different number. He doesn't use 47 million. He uses 30 million. I think he wants to avoid the immigration issue, and it is probably wise of him to do so. He doesn't want to be accused of giving rich benefits to people who are here illegally. I noted, with great interest, the CBO's estimate of the number of Americans who will not have health insurance, even if this bill were to be enacted over the wishes of the majority of the American people, 24 million. This bill still leaves 24 million Americans uninsured, after spending $2.5 trillion to do just that, while at the same time making health care more expensive for the rest of us.

I hear the other side often throwing numbers around without any documentation. I use the CBO and other nonpartisan, credible sources so we can avoid doing that. President Obama wants to spend $2.5 trillion in new health care promises at a time when the country can't afford the promises we have already made, and we have a record 1-year budget deficit which, by the way, means that 47 cents out of every dollar the Federal Government spends this year is borrowed. In 10 years, 16 percent or nearly $1 out of every $5 the government spends will be spent solely on interest payments on the debt. President Obama's budget doubles the Federal debt in 5 years and triples it in 10 years. We have talked about this on the floor. I don't think there is disagreement.

On top of this, we face $67 trillion in unfunded liabilities from our current entitlements of Social Security, Medicare, and Medicaid. This health care plan layers yet another unaffordable entitlement on top of Medicare and Medicaid and Social Security and the other entitlements we have, all in a system that is already crumbling. It seems to me this bill is exactly what the American people do not need. That is why most Americans are reporting that this bill is something they do not want at this time or ever. I think it is common sense.

Reading through the legislation, one is struck by the myriad of ways this bill raises taxes on America's citizens—from job-creating small businesses, to middle-class families. I count about a dozen of them, adding up to about $500 billion in tax increases over the next few years—$½ trillion in new taxes. So everyone should get ready to pay a higher health care bill and a higher tax bill should this measure become law.

Some might be inclined to say: But President Obama promised he would not raise taxes. That was, indeed, a campaign promise of the current administration, that no one making under $250,000 per year would see their taxes go up.

Let me just go ahead and quote that. This is what President Obama said during the campaign:

> I can make a firm pledge . . . no family making less than $250,000 will see their taxes increase—not your income taxes, not your payroll taxes, not your capital gains taxes, not any of your taxes.

So we started analyzing this bill, and guess what we found out. When the bill is fully enacted, the nonpartisan Joint Committee on Taxation—keep in mind, I am quoting sources here that are credible sources and nonpartisan sources—the Joint Committee on Taxation found that, on average, individuals making over $50,000 and families making over $75,000 would see their taxes go up. Let me repeat that. Individuals making over $50,000 and families making over $75,000 would have their taxes go up under this bill. Indeed, according to the Joint Committee on Taxation, 42 million middle-class families and individuals—those making less than $200,000, on average, will pay higher taxes in this bill. President Obama's health care reform bill currently under consideration in the Senate raises revenues to a large extent on the backs of middle-class Americans despite Candidate Obama's pledge not to do that.

So let's look at some of these instances where we get taxed. I am getting this, again, from the Joint Tax Committee and from CBO. If you have health insurance, you get taxed. According to the nonpartisan Congressional Budget Office, new excise taxes applied to health insurance providers will end up taxing the beneficiaries. This tax also has the effect of increasing premiums as well. So you are double-taxed on this deal.

Now, that is if you do have health insurance. What if you do not have health insurance? You still get taxed. Under this bill, you get taxed if you do not carry health insurance, as a penalty. Where does this burden fall? You guessed it: middle-class Americans. CBO has said that half of the Americans affected by this provision make between $22,800 and $68,000 for a family of four. That is middle-class America.

If you take prescription drugs, you get taxed. That is another area. According to the JTC and CBO, new taxes in the bill applied to the provision of prescription drugs will end up raising the cost of those drugs. So you are taxed again.

If you happen to need a medical device—this is something I am really sensitive to, and I have not heard much discussion of this issue on the floor so far. It is a difficult thing. I was talking to Senator ENZI. He said people do not really know what medical devices are. The stents—these are things that are available here in America. You cannot find them in many of the other countries. So if you need a medical device, you get taxed. If you have high out-of-pocket medical bills, you get taxed.

My son-in-law, Brad Swan, installs pacemakers and defibrillators. This morning, I was talking to him, and he told me what happened last night. He said that at 1 o'clock in the morning, they got a call to go out to the emergency room of St. Francis Hospital in my city of Tulsa, OK, and they had an 8-year-old boy who had no heartbeat. He was born with congenital heart disease. He put in a pacemaker at that time, and he was perfectly healthy in the morning. I think most doctors would agree that without it, that child would not have lived. My older sister Marilyn faced a similar situation 9 years ago. She is alive today. She is healthy today. She would not be alive today without it. That is how serious this is.

Dr. Stanley DeFehr is from Bartlesville, OK. I talked to him this morning about this, about the significance of the medical devices. I am going to quote his answer. I wrote it down. He said:

> The decision of who needs a pacemaker could be complicated, particularly the decision to put in a pacemaker on someone we might consider quite elderly. But it's a false economy to deny putting one in because of their risk of falling (breaking a hip or shoulder). In the case where they fall, the costs become quite high. The cost of a pacemaker pales in comparison to the cost of a stroke or multiple fractures.

A pacemaker, by the way, costs about $5,000 and lasts about 10 years. That is $500 a year—not a bad deal. So I think this is a quality-of-life issue that we could lose with the Democrats' government-run health care schemes.

So those are some examples of what we can do to pay higher taxes under this bill. If you have health insurance, you pay higher taxes. If you do not have it, you pay higher taxes. If you purchase a medical device, you have higher taxes. If you pay your own medical bills out of your pocket, you have higher taxes. If you take prescription drugs, you have higher taxes. All of these activities are taxed mercilessly under this legislation.

I want to turn now to examine one tax provision in particular that I find strikingly dishonest, damaging, and expensive to the taxpayer. It is an additional Medicare payroll tax that is in this legislation, and it is a perfect example of how this bill is going to tax you. You have to go into the bill to find these things. There are clandestine taxes in the bill that will hit you when you do not expect them to.

Basically, the bill says that people making $200,000 a year are going to pay an additional payroll tax called the

hospital insurance payroll tax that raises over $53 billion. Keep in mind, this is above the taxes we are already paying. They are getting these people at $200,000. You might think that is a lot of money. But there is a catch to this. They did not index it. So if you do not index the $200,000, then a period of time goes by, and it is far less than the amount it sounds like today. In fact, I would say in 10 years from now that $200,000 would pretty much fit a lot of the middle-income people in America. So there is this increase with an additional Medicare payroll tax in this bill that raises $50 billion. It is not indexed, and we know how that is going to extend to other people now.

I remember Candidate Obama making a firm pledge not to raise taxes on middle-class Americans. However, this health care reform bill before us breaks that pledge on numerous occasions. But it is not unlike the new taxes which will be imposed on other measures the Democratic Congress and President Obama would like to enact. I just mentioned the $500 billion in new taxes this health bill raises.

There is another tax in another program going on, which I have talked about on this floor many times; that is, the cap and trade. That is still on the floor. That could come up at any time. Of course, that is not something that would be $500 billion over a 10-year period; that would tax the American people in excess of $300 billion every year.

I have quoted as my sources the Wharton School of Economics, MIT, CRA, and others that have done evaluations. So it is not just this bill, even though this bill is what we are talking about today; we still have the problem of other legislation being promoted by the President and by the Democrats here.

The Obama administration's own Treasury Department estimated that cap-and-trade legislation would cost each family in America $1,761 a year. It is much more than that in heartland America. In Oklahoma, it would be closer to $3,300 a year. So we are talking about some very large tax increases.

But, again, back to the health care bill, I noted earlier that the government-run health care system, as proposed by the President and by the Democrats, is expected to cost $2.5 trillion on top of the already exploding record deficits. This bill will increase payments we make on our country's ever-exploding Federal debt. This Democratic Congress's agenda clearly includes more tax on Americans. They may be hidden, but they are there. It is disingenuous. It is costly. It is another reason this bill should not be passed by the Senate. I say ''another.'' The other and the main reason is that a government-run health system does not work.

I yield the floor.

The PRESIDING OFFICER (Mr. BURRIS). The Senator from Montana.

Mr. BAUCUS. Mr. President, I understand we are now under the order where there is a half hour allocated to the majority side; is that correct?

The PRESIDING OFFICER. That is correct. The Senator has 30 minutes.

Mr. BAUCUS. Mr. President, I yield myself 10 minutes.

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

Mr. BAUCUS. Mr. President, I just want to help people understand this legislation. I am sure many do, but I am sure there are some who do not with respect to the choices people will have.

We have a uniquely American system of health care in America. It is roughly half public, half private. The goal of this legislation is to retain what we have; that is, basically have that same balance of public and private. It has worked pretty well for America. It is uniquely American. We are not Canada. We are not Great Britain. We are not Switzerland. We are the United States of America. I think it is good to build on our current system and make our current system work better.

I am prompted to explain the choices, in part by the statements by the senior Senator from Arizona, who said Medicare Advantage plans enable people to get eyeglasses and dental care. And that is true. But he went on to say that, gee, shouldn't Members of Congress, who like all that and want to keep all that—that Members of Congress get free dental and free eyeglasses. Well, that is really not true. Members of Congress do not get that. But it is true Members of Congress participate in—all Federal employees, Members of Congress, people in the Forest Service, people all around the country—all Federal employees participate in the same system. It is called FEHBP. It is the Federal Employees Health Benefits Plan, where Federal employees and Members of Congress, all together, the same, can choose among many different private health insurance plans. There is an open enrollment season—in fact, we are in the midst of it right now—where Members of Congress and all Federal employees can look to see if they want to choose a different insurance company or not. Some of those companies do provide dental and vision coverage. Some do not. So if a Federal employee wants to choose a plan that covers dental and vision, he or she can do so. Just pay the premium, and you are covered with dental and vision.

We are setting up under this legislation an exchange that is very similar—almost identical—to the FEHBP, where people who do not have health insurance can go look on the exchange and choose, among private companies, which one makes the most sense for them. Some may have dental, some may have eyeglass coverage, some may not. That is just a choice people can make.

In addition to that, there is even more choice, because currently a Federal employee does not have to join FEHBP. A Federal employee can choose not to get health insurance if he or she does not want to or maybe they get it through their spouse someplace else. The same can be true with the exchange set up in this legislation. The person could buy among different competing private plans that offer health insurance on the exchange or a person can go outside the exchange because he or she thinks they can get a better deal, if that person wants to.

So I just want to make it clear that we are encouraging choice. We are encouraging competition. And I might say that under the legislation, Members of Congress who fully participate in this will be coequal with others. If there is a private option, Members of Congress can participate in that as well. In fact, we are requiring Senators and their staffs—they do not have to participate in the exchange, but it is certainly available to them, and they can opt out if they want to.

Let me just say a little bit about Medicare Advantage. What does MedPAC say about Medicare Advantage? Several years ago, Congress established an advisory board that is now called MedPAC to advise them on how Medicare should pay providers in traditional fee for service and private health insurers in Medicare Advantage. Again, Medicare Advantage is with private companies. They have executives. They have stockholders. They are private companies. MedPAC advises us how much Congress should pay MedPAC and other Medicare providers in traditional fee for service. It is an independent agency. Its experts are nonpartisan, highly respected.

Each year, they send a report to Congress that examines issues in Medicare. Here is what MedPAC had to say about the current state of Medicare Advantage in its 2009 June report. I am going to quote now from this independent advisory panel:

> First, we estimate that in 2009 Medicare pays about $12 billion more for enrollees in Medicare Advantage plans than it would if it were fee-for-service Medicare.

Second:

> Current high payments have resulted in some plans that bring no innovation but simply mimic fee-for-service Medicare at a much higher cost to the program.

In other words, they are saying that Medicare Advantage plans get paid for a lot more but with no innovation compared to the fee-for-service Medicare.

MedPAC says:

> This situation is unfair to taxpayers and beneficiaries not enrolled in Medicare Advantage who subsidize the higher costs.

Well, that is pretty obvious.

In addition, MedPAC goes on to say:

> The excessive payments encourage inefficient plans to enter the program, further raising costs to Medicare.

There are so many dollars currently given to Medicare Advantage plans, according to MedPAC, that encourages inefficient plans to enter the program. Why not? They are getting all of this extra money.

Further quoting:

The cost of Medicare Advantage subsidies is borne by taxpayers who finance the Medicare program and by all Medicare beneficiaries via Part B premiums.

Or to say it differently, about 78 percent of Americans who are not in Medicare Advantage plans are paying, in effect, a $90-per-year tax for which they get no benefit which goes into the Medicare Advantage plans.

In addition:

The Part B premium for all beneficiaries is increased by about $3 a month, regardless of whether you receive the benefit.

A couple of more quotes from MedPAC:

The additional Medicare Advantage payments hasten the insolvency of the Medicare Part A trust fund by 18 months.

That is an interesting statement. The additional payments hasten the insolvency of the Medicare Part A trust fund by 18 months.

Going with quotes from MedPAC:

Although many plans are available, only some are of high quality.

In addition, continuing the quote:

Only about half of the beneficiaries nationwide have access to a plan that CMS rates as above average in overall plan quality.

This is what MedPAC says. That is the nonpartisan expert that helps advise Congress on what reimbursement levels should be.

We have heard day after day that this bill is cutting Medicare benefits for our seniors. When my colleagues on the other side of the aisle realized this bill does not cut, reduce, ration, or eliminate a single guaranteed benefit, they turned their argument to Medicare Advantage. I think they finally recognize there are no guaranteed benefits cut in this legislation, so they turn to Medicare Advantage. They argue that the efficiencies and savings achieved by ending billions of dollars of overpayments to these private plans will either end the program or dramatically cut services to beneficiaries.

But let's just look at the numbers. I have a chart behind me. This chart shows the yearly spending for Medicare Advantage in billions of dollars. So you can see from the chart that in the year 2009, $110 billion will be spent on Medicare Advantage plans. That is the far left. Moving to the right, 10 years later, in the year 2019, about $204 billion is spent. So if we total it all up, about $1.7 trillion will be spent on Medicare Advantage plans over the next 10 years.

You see that little—what color is that? It is kind of orange, it is kind of an interesting sort of red—whatever it is, at the top of that chart. That represents the reduction in Medicare Advantage plan payments under this legislation. It is not very much, as you can tell by looking at the chart. It averages out, I think, to around a 10-percent reduction in Medicare Advantage payments.

So when we see these big crocodile tears, and we hear Medicare Advantage is being cut; when we hear all of these dramatic statements that so much is going to be taken away from seniors because Congress is cutting Medicare Advantage, the fact is, we are reducing the rate of increase in Medicare Advantage payments by only about 10 percent, and under this legislation about $1.7 trillion will be spent on Medicare Advantage plans. Remember, MedPAC says these are overpayments. MedPAC says this 10 percent reduction is what they should be paid.

Remember, too, these are private plans. These are private companies. It is not Medicare. These are private companies receiving these payments, and they are insurance companies. It is interesting to me that a lot of Members of Congress aren't too wild about insurance companies. Well, Medicare Advantage companies are insurance companies. That is what they are. They are private insurance companies. They are private insurance companies. They have their private insurance company chief executive. They have their private insurance company officer. They have their private insurance company stockholders. They have their private insurance company administrative costs and marketing expenses. They are private insurance companies. That is what they are. So we should not lose sight of all of that.

I wish to also point out that as private insurance companies, these Medicare Advantage plans are doing pretty well. Let me quote from an Oppenheimer Capital analyst in a November 12 report about Medicare Advantage plans. He said:

Between 2006 and 2009, we estimate that Medicare Advantage accounted for nearly 75 percent of the increase in gross profits among the larger plans in the industry, highlighted by an estimated gross profit increase of $1.9 billion in 2009, relative to commercial risk earnings gains of nearly $600 million.

Commercial risk earnings gains are the ordinary health insurance companies, but 75 percent of the gross profit increase was under Medicare Advantage plans, not traditional health insurance.

I might say, too—I don't have the papers; maybe I can find them. It is worth noting, it underlines the point that these are private companies. It is not traditional Medicare.

Here it is. Because it is interesting, let's look at the compensation of these insurance company executives of these Medicare Advantage plans, the CEOs. The total compensation of a CEO at Aetna is $24 million a year. The total compensation of the CEO at Coventry is $9 million a year; at Wellcare, $8 million; at Humana, $4.7 million a year; and at United Health Care, $3 million. Now, people should be able to make some money and officers of companies should be able to do OK, but here we are talking about very high salaries that these insurance companies pay to their top executives. Frankly, if there is a 10-percent reduction in the $1.7 trillion over 10 years, they could, you would think, take some of that 10 percent maybe in salary reduction or dividends to stockholders, make other cost savings. It doesn't have to come out of the beneficiaries. It is they, the executives, who are making these decisions of where the 10-percent reduction is allocated.

Bottom line, I just wish to say I am not opposed to Medicare Advantage plans. Frankly, I think it is good we have Medicare Advantage plans. Medicare Advantage plans provide the competition to Medicare. They help keep the system on its toes. But we have an obligation as Members of this Senate to the taxpayers and to seniors to cut waste and to cut overpayments in a way that does not harm beneficiaries. These are reductions recommended to Congress by the best advisory board of experts we could find. They didn't just come out of thin air and Members of Congress thought this up. This was recommended to us by the MedPAC advisory board.

Second, there is no reduction in guaranteed benefits to seniors. That is absolute. There is no reduction in guaranteed benefits to Medicare Advantage participants. So A, we are being fair. This chart shows it. We are trying to find the right level of reimbursement set up in a way so there is no reduction in beneficiaries' benefits. In fact, in this legislation, we add more benefits for Medicare participants, Medicare Advantage, as well as traditional fee-for-service Medicare. I might add in this legislation we give an increase to Medicare Advantage plans that show demonstrated improvement in quality.

As I mentioned, MedPAC said a lot of these plans are totally inefficient. A lot of these plans have no coordinated care. A lot of these plans don't have any quality, but they get the extra money. So we are saying let's get to a compensation level that is fair. We do it on a competitive bidding basis, take the average bid for an area, and we also say let's make sure there is no reduction in guaranteed benefits at the same time. I think that is a responsible thing to do.

So all of these arguments, these sound bites, frankly, that you hear from the other side of the aisle are just that, they are sound bites. They are not the honest analysis of what is going on.

So I encourage us to keep in mind, keep in perspective what we are doing so we can help provide a better health care system for our country. This is only one part of it. There are many other parts, but this is just this one part.

How much time do we have remaining, Mr. President?

The PRESIDING OFFICER. There are 13½ minutes.

Mr. BAUCUS. I see Senator DODD is on the floor. At this time I yield to the Senator from Michigan.

The PRESIDING OFFICER. The Senator from Michigan is recognized.

Ms. STABENOW. Mr. President, first, I wish to thank our distinguished chairman of the Finance Committee

for debunking what has just been said on the Senate floor by our colleagues on the other side of the aisle, laying out the facts of what is and is not happening with Medicare Advantage. I wish to build on that as well.

I would encourage anyone who is interested to go to the Web site of AARP, one of the organizations we know to be champions for seniors, and take a look at what they say about the myth that health care reform will hurt Medicare. They lay out several things. One is:

None of the health care reform proposals being considered by Congress would cut Medicare benefits or increase your out-of-pocket costs for Medicare services.

Then, just this week, in supporting our efforts, they have put out a statement, a letter, and at the end, again, they reiterated:

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

I find it interesting that a few years ago our colleagues quoted AARP all the time when we were debating the Medicare prescription drug bill—I would guess that every single one of our Republican colleagues used their support in putting forward their bill—and now they are trying to disparage AARP, which is a very credible organization, because they don't agree with what AARP is saying. But I think the millions of people who belong to AARP will be listening to what they are saying about the fact that we are not, in fact, cutting the guaranteed Medicare benefits.

In addition to that, we have the Alliance for Retired Americans and the National Committee to Preserve Social Security and Medicare all saying they support what we are doing and they have debunked the Republicans' scare tactics point by point.

So what is happening here? The reality is that colleagues on the other side of the aisle, since the inception of Medicare, have been fighting even the existence of Medicare. It was Democrats and a Democratic President in 1965 who passed Medicare over their objections. The same arguments we are hearing today, we heard then. Now everyone sees that Medicare is a great American success story. But we have seen so many efforts.

In the 1990s, when I was a Member of the House, Speaker Gingrich said in his Contract With America in 1994 that they wanted to come in and change Medicare, they couldn't directly do it so they would do it through the back door and let it ''wither on the vine''—those famous words that we heard at that time in terms of trying to privatize Medicare, which is what I believe Medicare Advantage really is.

Then, recently, in the debate on the floor of the House of Representatives, we had 80 percent of the House Republicans support an effort to do away with Medicare at all, as we know it, as a guaranteed benefit. Instead, give vouchers to seniors to buy from private for-profit insurance companies. We know the reality of this. This is about the for-profit insurance industry that right now is receiving overpayments. Whether it is the CBO or MedPAC—any analysis will say they are receiving overpayments right now, and we are trying to ratchet that back.

What is happening? Why should folks care? Of course, taxpayers care about overpayments. We have maybe 15 to 20 percent of seniors right now who are in the Medicare Advantage Program. We have been told by the Budget Office that 80 to 85 percent will see their premiums go up to pay for overpayments to for-profit insurance companies. That is not fair. The vast majority of seniors and people with disabilities would see their premiums go up under Medicare to pay for for-profit insurance companies that try to get a piece of the action under Medicare.

Secondly, we know the Medicare Advantage Program, as the chairman has said, and in reading the report, has actually made the solvency of the Medicare trust fund worse. It is going to run out of money sooner if we don't stop these overpayments. Our legislation, rather than having it run out of money 18 months earlier, will increase the solvency by 5 years. We are committed to increasing and continuing the solvency of the trust fund and protecting Medicare for the future. We believe it is a great American success story. We are proud that Democrats were the ones who created Medicare, with a Democratic President. We are proud that it is Democrats now who are coming forward to be able to make sure we protect Medicare for the future.

What is happening here is that we are seeing a variety of stalling tactics, a variety of efforts on the other side not only to stop us from moving forward on health insurance reform, but efforts time and time again to protect the for-profit insurance companies.

For the record, I want to read to you the list of Medicare benefits everyone receives now, which will continue regardless of this—whether we cut back on some of the profits of the for-profit insurance companies: inpatient hospital care and nurses; doctor office visits; laboratory tests and preventive screenings; skilled nursing; hospice care; home health care; prescription drugs; ambulance services; durable medical equipment, such as wheelchairs; emergency room care; kidney dialysis; outpatient mental health care; occupational physical therapy; imaging, such as x rays, CT scans, and so forth; organ transplants, and a ''welcome to Medicare'' physical.

They are all covered now and will be covered under this legislation. The difference is we are going to take the overpayment to the for-profit insurance companies and put it back into Medicare to reduce the cost of prescription drugs, which has become the infamous doughnut hole, the gap in coverage. We will begin to close that by taking the excess profit for the for-profit companies and putting it back into Medicare. We are going to reduce the premiums seniors pay for drugs and medical care and eliminate copays so that people can get preventive care without a fee, and we are going to strengthen Medicare for the future.

I will wrap up by saying this: This legislation, in total, is about saving lives, about saving money, and about saving Medicare. We admit our goal is not to save the profits of the for-profit insurance companies. We are guilty of that. We are focused on making sure Medicare is strong, vibrant, and solvent for our future generations, as well as our seniors today. By the way, we are going to make sure we are saving lives and money in the process.

I strongly urge us to oppose any effort that is put forward that would be done in the interest of the insurance industry and at the expense of seniors in America. That is what these efforts to commit are all about. I hope we will reject them.

The PRESIDING OFFICER. The Senator from Connecticut is recognized.

Mr. DODD. Mr. President, let me, first of all, commend our colleague from Michigan, who is a member of the Finance Committee and has been a stalwart defender of the traditional Medicare Program and of our elderly not only in her State but around the country. She has offered, I think, some very cogent and worthwhile information this morning once again on this subject matter.

We keep going around and around in this debate. It is a little frustrating because we are talking about basically whether we are going to limit to some degree the profits of some private insurance companies that are under the rubric of something called Medicare Advantage. Again, these are private companies that are receiving subsidies, supported by Medicare beneficiaries and the taxpayers of this country. We are not talking about eliminating Medicare Advantage but rather—we had a big chart a few minutes ago. We will get it in a few minutes. It shows we are not eliminating the program, we are restraining profit growth in the program.

We are rewarding Medicare Advantage in the bill, as the chairman pointed out. Based on performance and quality, we actually give bonuses in Medicare Advantage—contrary to the arguments you have heard by those who are heralding Medicare Advantage, despite the fact that the very companies who argued for it to begin with, promised they were going to prove how they could reduce costs and be more efficient. In fact, today, it is quite the opposite. Right now the government pays these Medicare Advantage insurance companies $1.14 to do the same thing for seniors that Medicare does for $1. That is basically, on average, what it amounts to.

The question is, can we reduce the cost of the overpayments, which are basically ending up in the pockets of insurance companies? There is nothing wrong with profits in private companies, but let's declare them what they

are. This is not traditional Medicare. They are private companies that are anxious not only, I presume, to provide benefits to their beneficiaries, but they are also looking to make a profit. There is nothing wrong with that, but since the premiums were set by statute, and we have an obligation to try to keep our costs down, we are trying to do so because the promises that were made have not been kept. The costs are vastly exceeding the promises made.

The amendment we are going to hear about from our friends on the other side is nothing more than a recycled compilation of some of the ''greatest hits'' we have heard: stalling with arcane obstruction tactics, while standing up for some of the private companies—and I have no objection to standing up for private companies that do a good job, but when you do so at the expense of scaring seniors with baseless claims, then I do object. That is what is going on here because, quite frankly, today almost 80 percent of our elderly are paying $90 a year in additional premium costs, without getting any benefit from it whatsoever, to provide benefits under the Medicare Advantage Program. That is not equitable. The 80 percent of our elderly need to know that they are being disadvantaged by this.

What the Finance Committee, under the leadership of MAX BAUCUS, is trying to do is bring some equity back into this. He pointed out—and it deserves being repeated—that nothing in the bill does away with Medicare Advantage. We are trying to get it back to a sense of reality and not, again, disadvantage 80 percent of our seniors.

Right now, there is Medicare ''disadvantage''—that is what it ought to be called, because that is what it does—disadvantages. Why should 80 percent of the elderly in this country pay higher premiums, with no benefits, at the expense of the 20 percent who are going to get some small advantage under this—but very little, because most of it ends up in profits. I will tell you why that happens in a minute.

To make my point, according to the Oppenheimer Capital analyst Carl McDonald, in a report issued a month ago:

> Between 2006 and 2009, we estimate that Medicare Advantage accounted for nearly 75 percent of the increase in gross profits among the larger plans in the industry, highlighted by an estimated gross profit increase of $1.9 billion in 2009, relative to commercial risk earnings gains of nearly $600 million.

I know the chairman of the Finance Committee made that point. Seventy-five percent of the increase in gross profits came from the Medicare Advantage plans. These profits come out of the pockets of the American taxpayer because of the subsidies and, of course, the Medicare beneficiaries who are paying those extra dollars every year, without receiving any of the benefits at all. Our bill will protect and strengthen Medicare and extend the life of the trust fund, as you have heard over and over again. That is not a fact to dispute. That is a fact. We extend the life of the Medicare Program. Part of the way our bill adds to the use of Medicare is to eliminate wasteful overpayments. These are overpayments far beyond what was anticipated when the program was written.

As I mentioned a moment ago, the government pays insurance companies in the Medicare Advantage Program $1.14 to do the very same things for seniors that traditional Medicare does for $1. So those are the overpayments we are trying to rein in. There is no evidence these wasteful overpayments do anything to improve the care of our seniors. At the same time, they speed Medicare's descent into bankruptcy and raise premiums for all Medicare beneficiaries.

Our bill would end that waste and use the money we save to help seniors pay for prescription drugs by closing the doughnut hole. For the second time in less than a week, our friends on the other side are using these tactics to halt progress completely, fighting for these profits and overpayments that, again, come out of the hide of taxpayers and our elderly.

If you look at this chart, if you extend to 2019, almost 10 years from now, what is the difference between what our bill does and what those who want no change do? The difference is $20 billion. In the post-reform period, in 2019, it is $183 billion going to Medicare Advantage. What the opposition wants is to hold it at $204 billion in 2019. That is $20 billion. That is the savings we are looking for in order to reduce overpayments and provide those resources to the elderly so they can afford prescription drugs.

If you want to side with these companies—they are still going to make a profit. This will not deprive them of that. The profit margins will be far more realistic and it will reduce subsidies, as well as overpayments being made by the elderly who receive nothing from this program at all.

Let me make my case on this point. Senator STABENOW listed the guaranteed benefits under Medicare. The chairman did it as well. Also, we add benefits as a result of our bill. In addition to the inpatient hospital care, doctor office visits, lab tests, kidney dialysis, emergency care, occupational therapy, organ transplants—all of these issues—we also do things in our bill that are not available presently. We reduce the size of the Medicare doughnut hole. That is an added benefit that does not exist today. We reduce premiums to pay for drugs and medical care. We eliminate the copays. What an advantage that is here. Ask yourself whether you would like to eliminate copays or watch private companies make an additional $20 billion in 10 years. Which is the better choice? Ask the overwhelming majority of seniors which they would rather have—an elimination of the copays they are paying today, or continue to provide excess profits for the companies here that have made so much under the Medicare Advantage Program.

Lastly, of course, and most important, we help keep Medicare solvent. People say: Give me some examples on why the differences exist between Medicare and Medicare Advantage. I have a couple of examples from my home State that I think highlight the point. These come from the Center for Medicare Advocacy, or CMA, which is a nonprofit organization, as my colleagues know, that does casework on behalf of individuals who need assistance dealing with Medicare Advantage plans. They provided two cases from my State. I presume most of my colleagues could find cases in their own States.

A woman living in Madison, CT, a shoreline community in Connecticut, had Lou Gehrig's disease, ALS. We are all familiar with ALS. We know the stories people go through with that disease. She was in a Medicare Advantage plan. She was denied coverage for home health care because she was said to be ''stable.'' That was the quote, ''she was stable.'' That is not a valid reason for denial, and she was hardly stable with ALS. CMA, the Center for Medicare Advocacy, had to go to Federal court to get her care covered despite firm written support regarding her medical condition from her doctors.

Here is a woman under Medicare Advantage with ALS being declared by Medicare Advantage ''she was stable.'' Her doctors said anything but the case.

When my friends talk about rationing of care under the present system, here is Medicare Advantage, a private firm, making a medical decision that should have been made between her and her doctor. They eventually got it overturned, but they had to go to Federal court to get it overturned. That would not have happened under Medicare. If she had been under Medicare, she would have gotten that help, no questions asked.

When people say there is no distinction, this is a live case.

Let me give the second one. A woman from Vernon, CT, and her husband traveled to Florida to visit their daughter living there. When she got to Florida, she fell down and sustained some physical injuries. While being treated at a Florida hospital for her injuries, it was discovered that she had a brain tumor, the reason she had the fall. She had no idea of this beforehand.

The Medicare Advantage plan covered treatment for the fall as an emergency—which Medicare Advantage plans must cover, even out of network, by the way—but not any diagnosis or treatment for the brain tumor.

The woman had another daughter who was a nurse who lived in Utah. So they traveled from Florida to Utah where she went for the cancer treatment for the brain tumor. While undergoing chemotherapy, this woman had a

life-threatening reaction to one of the medications from which she almost died. The Medicare Advantage plan denied coverage for all of this care because it was out of network. She was in Utah. They said no, leaving the client and her husband with $100,000 in bills.

Again, the Center for Medicare Advocacy went to court and battled against this decision. They were successful in recovering $90,000 out of the $100,000. This woman is now deceased, but she and her family were left with over $10,000 in bills, all of which would have been covered under traditional Medicare, but she had gone into a Medicare Advantage plan. In both instances, they would have avoided having to go to Federal court, having to fight as hard as they did, going through the trauma and turmoil. It is bad enough you have to wrestle with cancer or wrestle with a brain tumor, but then you get saddled with $100,000 in bills and Medicare would have taken care of them. This Medicare Advantage Program disadvantaged her in the process.

These are examples of how private Medicare Advantage does not always operate in good faith. They are not always there when you need them.

There are significant differences between Medicare Advantage and Medicare. With traditional Medicare, you know what services you get.

I ask unanimous consent to have printed in the RECORD a list of services so people can read about it, if people have not already done that.

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

No one is removing Medicare benefits. Every senior in America will still get these benefits: Inpatient Hospital Care and Nurses; Doctor's Office Visits; Laboratory Tests and Preventive Screenings; Prescription Drugs; Ambulance Services; Durable Medical Equipment—i.e., Wheelchairs; Emergency Room Care; Kidney Dialysis; Outpatient Mental Health Care; Occupational and Physical Therapy; Imaging (X-rays, CTs, and EKGs); Organ Transplants; and ''Welcome to Medicare'' Physical.

And under our legislation: Reduces the Size of the Medicare ''Donut Hole''; Reduces premiums seniors pay for drugs and medical care; Eliminates copays; and Helps keep Medicare solvent.

Mr. DODD. Mr. President, all medically necessary hospital care and doctor office visits are covered under Medicare. You know you can get these services from any Medicare provider anywhere in the country. Out of network you get this kind of help, whether you are in Utah, Florida, or Vernon, CT, where one woman was from. Medicare would have provided that care. Here she was bouncing around the country and denied one place after another under Medicare Advantage. With traditional Medicare, she would not have had to worry about a private insurance plan playing games with her coverage.

The Medicare Advantage plans run the show. They change the benefits. Cost sharing goes on. This is why Medicare Advantage is not like traditional Medicare. So when people say it is just like Medicare, no, it is not just like Medicare. If you doubt me, then call that family in Madison, CT, or call that woman's family from Vernon, CT. Ask them whether Medicare Advantage is just like Medicare. You will get an earful from them on what they went through.

We should be clear that we are not eliminating Medicare Advantage. Again, I appreciate Senator BAUCUS making this point. It needs to be made over and over again. We are not eliminating it at all. We are reducing payments to private plans and making the system work more uniformly. We actually give bonus payments for care coordination and quality improvements. These plans can use those payments to improve benefits for beneficiaries. So we are hardly eliminating it. We are making it work better.

I have serious reservations about how this plan operates, I will say that, but I would not advocate on the floor of the Senate the elimination of Medicare Advantage. I do want to make it work better, and I do want to cut back when we have overpayments occurring. I don't think it is fair that 80 percent of the seniors in my State or elsewhere are paying $90 a year extra to cover this program and get none of the help from it and people under Medicare Advantage, who could have been protected, are not because they opted to be in that plan and then found out it is anything but what they thought it was.

We are going to hear these arguments over and over about Medicare Advantage. A little truth in advertising is necessary here. So people understand, it is not Medicare and it is not an advantage, not under the present system, not at all. That is what we have been trying to say over and over again here so people understand.

This is a good bill. This is a solid bill. This took a tremendous amount of work in the Finance Committee, which had the responsibility of crafting these provisions which are highly complicated and very delicate in what they do. What we have done is preserve and strengthen our Medicare system, expanding benefits for people, eliminating copays, allowing those preventive and screening services to be available to our elderly, seeing to it they will have prescription drugs at lower costs. That is all in this bill. That is a great advantage.

What a tragedy it would be if in these next few days, after all the debate, that we lose all the work that has been done to make these improvements in our health care system.

I commend my colleague from Montana and my colleagues on the committee who worked so hard to put this bill together, this balance together that can make a great difference in people's lives.

I also thank our colleague from Rhode Island for offering his amendment, which we are going to be considering at some point when we get to vote occasionally on some matters here. I hope at some point we get to do that. We have done it a couple of times. There has been over a year of debate and discussion. I think the American people want to see some action.

We think we have a good bill. It is going to take on important market insurance reforms that ensure Americans can get access to health care promised by their insurance plans. It is going to make sure if someone loses his or her job, they can get insurance. It is going to improve the quality of health care and focus our system more on prevention and wellness.

On top of all these things, it is going to reduce the deficit. As we have heard over and over again, CBO is talking about saving $130 billion in the first 10 years and $650 billion in the second.

I have to say something. The other day we got the news that CBO said the premiums on the individual plans, the small business plans and the large business plans, are actually going to reduce premiums costs by as much as 20 percent in one area, and 3 percent in another. I would have thought there would be wild applause. Even those who oppose the bill would have said: Isn't this great news? What we got was almost a deep disappointment that CBO gave us a report that people are actually going to save money under this bill. All of a sudden they attack CBO because they did not like the results coming out of CBO. I guarantee had they come back and said they are going to increase premiums, we all would be talking about that. Here we get a report that actually we are going to save premium costs, reduce the costs to the Federal budget as has been pointed out.

Senator WHITEHOUSE is going to offer an amendment that makes clear these savings we are talking about are used to strengthen Social Security, reduce the deficit, and contribute to the long-term solvency of the CLASS Act, that it will be for that purpose and that purpose alone.

The third part of his amendment is particularly important. Many of our colleagues have come to the floor in the last few days to claim the CLASS Act will be a long-term drain on the budget. It is not true. Thanks to our colleague from New Hampshire, Senator GREGG, the CLASS Act will be required by law to be solvent for 75 years. This was not in our original proposal. It was added in the HELP Committee markup by Senator GREGG, and I thank him for it.

The Gregg amendment was unanimously adopted in our markup. CBO says it produces $72 billion in savings for the Federal Government over the first 10 years of its existence and it will save nearly $2 billion for Medicaid.

We further added language to the bill to require the Secretary to maintain enough reserves after the first 10 years to pay off any claims that may emerge. We have included language to prevent

Federal appropriations from being used to pay benefits to ensure the program is self-funded.

Finally, at the request of several Senators, the distinguished majority leader made sure we did not use any of the savings in the CLASS Act for any other purpose than to pay for the CLASS Act itself. This amendment offered by Senator WHITEHOUSE will give Senators a chance to commit themselves to that purpose. Senators who claim the CLASS Act will hurt the Federal budget, of course, should vote for this amendment because statutorily it will prohibit any of those funds from being used for any other purpose other than for the CLASS Act and the recipients who want to use them. I commend him for that move and thank him. When that vote occurs, I urge colleagues to vote for the Whitehouse amendment.

Lastly, I ask unanimous consent to be included as a cosponsor, along with my colleague from Maryland, Senator MIKULSKI, of Senator COBURN's amendment No. 2789 which adds Members of Congress to the public option.

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

Mr. DODD. Mr. President, we added that provision to the HELP Committee bill. Senator COBURN offered that amendment. Senator Kennedy, myself, and others voted for that Coburn amendment. I think it may have shocked the Senator from Oklahoma at the time that we actually voted for his amendment. I know Senator BROWN has been added as a cosponsor. I have no objection to that amendment. That is how much I think the public option would be worth. If we have a public option in this plan—and my hope is we will—there is nothing wrong with insisting Members of Congress be included in that public option proposal. His amendment suggests that. We supported it in committee, and I am prepared to support it again on the floor of the Senate.

I point out, I wish we could get Members as well who are reluctant to support this bill to recognize that as Members of Congress today, we all have pretty good health care plans under the Federal employees benefits package, some 23 options every year that are available to us, along with the 8 million Federal employees in this country under those plans. I wish we could get others to recognize how valuable that is to all of us and our fellow Federal employees. Unfortunately, that does not seem to be the case.

I hope before this is concluded we will have far more support for this effort we have crafted and provided to our colleagues for their consideration.

Again I compliment the Finance Committee and my friend from Montana for the work he has done on this issue. It is very well thought out, very balanced and fair.

I said this over and over: I challenge any Member to come to the floor and identify a single guaranteed benefit under Medicare that is cut out under this bill. There is not one. Three days have gone by since I made the charge that not a single guaranteed benefit under Medicare is cut. You will not find one; not one.

I see my friend from Wyoming has come to the floor. I know I have probably gone over my time.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, we are playing things by ear. I ask unanimous consent that the Senator from Wyoming be recognized to speak for debate only, and at a later point, we will figure out allocation of time on both sides, if he wishes to speak now.

Mr. ENZI. Yes, Mr. President, I wish to speak.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. ENZI. Mr. President, it is my understanding that I would be in charge of the next 30 minutes and then it would revert to the other side for 30 minutes after that.

Mr. BAUCUS. I might modify that so this side gets the next 30 minutes after that.

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

Mr. ENZI. It is also my understanding that at any time there is an agreement to vote, we will cancel out what we are doing. But there is no agreement yet.

I thank the Senator from Connecticut for setting up my speech so well. He said there was not anyplace that anybody can show any decline in guaranteed benefits. With what I am about to say, I will try to do that. Of course, the words ''guaranteed benefits'' do not show up anywhere in what we are doing. ''Benefits'' does but not ''guaranteed benefits.'' In my opinion, getting to be in a nursing home or being able to see a doctor, some of those ought to be considered guaranteed benefits. I will get into that a little bit in my speech and cover some of these areas that I think are very important to seniors. I am opposed to the $½ trillion of Medicare cuts in the Reid bill that are not going only to solve Medicare.

Some of my Democratic colleagues have attempted to argue this bill does not cut the Medicare Program. They further said that such cuts are justified and will not harm the program. They have also argued that no beneficiaries will lose their benefits—their guaranteed benefits. They are very careful on that, and I understand why they are careful on that because there are other benefits that are being cut that will be considered by those people who will lose that benefit to be a guaranteed benefit.

Unfortunately, all of those statements are false. It does not matter how many times my colleagues repeat these claims, they do not become any more accurate. This bill cuts $464 billion from the Medicare Program. It slashes payments to hospitals, nursing homes, home health agencies, and hospices. These are cuts to the Medicare Program, and I even have the page numbers on those.

The moneys from these cuts do not go to shore up Medicare. The money goes to new programs for others. These cuts will affect the care provided to Medicare beneficiaries.

The American Health Care Association, which represents nursing homes, said the cuts in the Reid bill would force layoffs, lower salaries, reduce benefits, and ultimately would hurt patients' quality of care. A commission was set up to make even more cuts to save Medicare. It is in the bill. There is a commission in there.

So with the side deals that have been made with lobbyists, the only place these cuts can come from is from seniors. I will cover that in a little more detail later. I have heard similar statements from home health providers, that is more than $40 billion in cuts; hospice providers, which is $8 billion in cuts; and hospitals, which is $130 billion in cuts. If these Medicare cuts go into effect, it could drive many providers out of the Medicare Program. That will mean patients do not have the care they expect and they need.

Some of my Democratic colleagues have accused us of trying to scare Medicare beneficiaries. If seniors are scared by our statements, they should be terrified by what the administration has to say about the Democrats' health reform bill. The administration's own chief actuary, Richard Foster, recently wrote that the steep Medicare cuts in the House-passed health reform bill would make it difficult for many providers to remain profitable and cause them to end their participation in Medicare. He went on to note this could jeopardize Medicare beneficiaries' access to care.

As the senior Senator from Tennessee noted yesterday, it is the Medicare cuts in the Reid bill that are actually scaring seniors. Medicare beneficiaries understand that if providers are no longer able to take Medicare patients, they—the seniors—will not get care. A lot of grandmas and grandpas have figured it out, and they are not going to stand for it.

The chairman of the Finance Committee has repeatedly said this bill will not cut or reduce any guaranteed Medicare benefit. That statement seems to ignore what this bill will do to providers. If a Medicare patient cannot get into a nursing home, they do not have nursing home benefits. If they can't find a home health aide willing to take Medicare patients, they do not have home health benefits. So the promise for coverage, when you can't get a doctor to see you, is not health care. You don't have benefits if you can't get a provider to treat you. Unfortunately, that is exactly what this bill will do.

Some of my Democratic colleagues have also attempted to justify the Medicare cuts in the Reid bill by arguing that many of the trade associations

representing health care providers have endorsed this bill. They are correct that several Washington-based trade associations and their lobbyists have endorsed the Reid bill. It is probably worth exploring why some of the groups have chosen to endorse this legislation.

In some cases, motivation is obvious. Some drug manufacturers are clearly motivated by self-interest and greed. They negotiated a secret deal with the White House that will actually increase what Medicare spends on brand-name drugs—brand-name drugs. They didn't touch the generics. They are interested in the brand-name drugs.

Under the terms of their deal, the drug manufacturers will provide discounts on brand-name prescription drugs when the seniors are in the Medicare coverage gap—known as the doughnut hole. They make the payments directly to the customer. It doesn't go through Medicare but directly to the customer. That way they can maintain the customer contact and keep them addicted to the brand name.

Generics are cheaper. A lot of people, when they go to the doughnut hole, switch to generics because that saves them money, and it saves us money. When they get through the doughnut hole, they will stay with whatever they are on while in the doughnut hole. So if they are forced to stay on a brand name to get a little extra discount as they go through the doughnut hole, they will stay with the brand name when the taxpayers are paying for it when it goes above the doughnut hole, which is the rest of the year. That could be a huge number. So while it looks generous by the drug companies, beware; their generosity is suspect with what they will make when it gets through the doughnut hole.

Under the terms of the sweetheart deal between the White House and the drugmakers, discounts are provided for these brand-name drugs. This will encourage seniors to continue to get those more expensive drugs, and it will actually cost the taxpayers $15 billion because the deal will actually increase Medicare costs.

In other cases, provider groups were promised special deals if they agreed to support the Reid bill—or whatever bill we were working on at that time. For instance, recent press reports have described how the American Medical Association was promised a permanent fix to the Medicare payment formula for doctors if they agreed to support this bill or a 1-year fix if there was an end to junk lawsuits. Under current law, doctors' Medicare payments are scheduled to be cut by more than 40 percent over the next decade. That is already in place. That is not a part of the bill. The cost of fixing the flawed government-mandated formula will be more than $250 billion. We know that because we have debated it on the Senate floor, and we decided we were going to have to pay for that if we were going to do it.

So let's see, $464 billion in Medicare money we are using on other things. That is why I keep saying Medicare money only ought to go to Medicare benefits, and that $250 billion for the doctors' fix might make it possible for people to see the doctors.

I can understand why doctors want to fix this flawed government price-control system—and that is what it is because they are telling the doctors what they can charge a customer, regardless of how long a time it is going to take them to take care of that patient. For a lot of them, they have discovered it costs more than what they are able to get. If they continue to do that, they have to go out of business. That is kind of the small business philosophy: You take in less money than what it costs to be in business, and you are out of business. So I don't think they like that kind of a government price-control system.

As a result, 40 percent of the doctors will not take a patient on Medicaid, and it is growing in percentage now on Medicare in the same way. When you fix the price, some people can't afford to provide it for that, so they can't take those patients.

I was talking to a friend of mine from Florida who said: Every time you call a doctor now, they say: Are you on Medicare? If you say yes, they say: We are not taking any new patients.

If you can't see a doctor, you don't have a benefit. It shows the exact problems that result from letting government bureaucrats use price controls to set payment rates. What I don't understand is why the AMA continues to support the bill when they got nothing for their deal. We didn't fix the $250 billion problem, and we haven't fixed the junk lawsuit problem.

I remember the President appearing at the National Convention of the American Medical Association and promising that there would be tort reform; that there would be an end to these junk lawsuits. All of our attempts, either in the HELP Committee or in the Finance Committee, to even bring that up have been either voted down or denied. As a result, there is nothing in this bill that is going to solve that problem. The bill does nothing to fix the Medicare payment formula for the doctors. Instead, it cuts $464 billion from Medicare and uses that money to cover the uninsured.

Even if these cuts can be made without hurting seniors, the Republicans are saying: Use the money only for Medicare. Medicare money for Medicare. Medicare funds should be used to fix Medicare's problems, such as this flawed payment formula that keeps doctors from taking seniors. Taking hundreds of billions of dollars out of the Medicare Program now will only guarantee that it will be much harder to permanently fix the doctor payment issue in the future.

I cannot understand why the AMA continues to support this terrible deal for doctors. If you can't see a doctor, your benefits—your guaranteed benefits—have been cut. Apparently, the members of the AMA don't like the deal either. At a recent convention, up to 40 percent of the current membership of the AMA voted to reject this deal. I know that is not a majority, but most associations survive by consensus agreements. That means almost all of their membership agrees with the tack they are taking, not just slightly more than half. Their membership is less than 20 percent of all doctors. It is a dwindling association.

Let's see, less than 20 percent of the doctors had 40 percent that opposed it. We are getting down to some pretty small percentages of those who supported what the AMA did in their deal.

Finally, many provider groups have been reluctant to speak out against this bill because they have received threats from the White House and congressional Democrats. Nursing homes, home health agencies, and hospice providers have all reportedly been threatened with further cuts—further cuts—if they speak out against the bill. Is that freedom of speech, or is it just bad ethics? They have reportedly been told that any public statements of opposition to the Reid bill will lead to even more severe cuts.

These providers have had to make the choice to silently accept devastating cuts rather than oppose them and risk being utterly destroyed. One of the Medicare Advantage providers is Humana, and I will use them as an example. CMS said they couldn't let their customers know what was about to happen, and chastised them for sending out a letter. I thought the customer deserved to know and that we were in a new era of transparency. That doesn't sound very transparent to me. So how can that happen in America?

At any rate, I hope my colleagues and the American people will take these facts into account when they hear Senators talk about provider groups supporting this bill. Unfortunately, health care provider support for this bill is being driven primarily by greed or stupidity or fear. We know this bill will not fix the problems in the American health care system. It will not lower health care costs. It will not lower insurance premiums. It will still leave 25 million people uninsured.

What this bill will do is spend $2.5 trillion and guarantee a much bigger role for the government in dictating how health care will be provided in this country. If you are not under Medicare, yes, your government is going to tell you what is adequate coverage, and they are going to force you to buy it or pay a penalty.

Given the recent experiences that doctors have had with Medicare price controls, this is not an outcome that bodes well for America's health care providers or their patients. I remind everybody that in August there was an uproar, and that uproar continues. We don't notice it as much because we are not going to get to go home this weekend to talk to our constituents. That

might be by design because we already know what our constituents are saying.

They are saying: This bill is a bad deal for us. Where is the promise that you were going to cut costs for us? Where are the other promises that were made with this health care reform?

I would mention that the CBO found that premiums in the individual market will rise by 10 to 13 percent more than if Congress did nothing. That is CBO. Family policies under the status quo are projected to cost $13,100 on the average, but under this health care bill it should jump to $15,200. That is not very good news for the people in my State or any other State. No big cost rise in U.S. premiums is seen in the study, said the New York Times.

The Washington Post declared: Senate health bill gets a boost. The White House crowed that the CBO report was more good news about what reform will mean for families struggling to keep up with skyrocketing premiums under the broken status quo. The Finance chairman, the Senator from Montana, chimed in from the Senate floor that health care reform was fundamentally about lowering health care costs.

Yes, lowering costs is what health care reform is designed to do—lowering costs.

But then he said: And it will achieve this objective. Except that it won't.

CBO says it expects employer-sponsored insurance costs to remain roughly in line with the status quo. That is the failure of this bill. Meanwhile, fixing the individual market is expensive and unstable, largely because it does not enjoy the favorable tax treatment given to job-based coverage. You know, if you are buying insurance on your own, you are not getting a tax break on it. If companies buy insurance for the people working for them, they are getting a tax break.

In my 10 steps to solving health care, I mentioned and worked on making that fair. You have to be fair for both sides.

The Wyden-Bennett bill concentrates on making it fair for both sides. That is one of the issues people in this country are concerned about, making it fair for both sides. This bill doesn't make it fair for both sides.

Talking about fixing the individual market, that is expensive and it is largely unstable, I will say again, due to the favorable tax treatment given to job-based coverage which was supposed to be the purpose of reform. But CBO is confirming that new coverage mandates will drive premiums higher.

Democrats are declaring victory, claiming these high insurance prices don't count because they will be offset by new government subsidies. About 57 percent of the people who buy insurance through the bill's new exchanges that will supplant today's individual market will qualify for subsidies that cover about two-thirds of the total premium so the bill will increase cost but then disguise those costs by transferring them to taxpayers from individuals. Higher costs can be conjured away because they are suddenly on the government balance sheet.

The Reid bill has $371.9 billion in new health taxes that are apparently not a new cost because they would be passed along to consumers. Or perhaps they will be hidden in lost wages. This is the paleoliberal school of brute force wealth, redistribution and a very long way from the repeated White House claims that reform is all about bending the cost curve. The only thing being bent here is the budget truth.

Moreover, CBO is almost certainly underestimating the cost increases. Based on its county-by-county actuarial data, the insurer WellPoint has calculated that this bill will cause some premiums to triple in the individual market. I don't go by WellPoint, I go by what I found out in Wyoming itself and that is an accurate picture, particularly for the young people in our State. Those who are young and healthy will see a 300-percent increase. I think they are going to notice that. I don't think they are going to be happy with it. Other associations have come to similar conclusions. The reason for that is the community rating, which forces insurers to charge nearly uniform rates regardless of customer health status or habits. Habits is an important one on that. CBO does not think this will have much of an effect, but costs inevitably rise when insurers are not allowed to price based on risk. That is why today some 35 States impose no limits on premium variation and 6 allow wide differences among consumers.

That is not just WellPoint that is saying that. I have some peer-reviewed documents that also show that same thing from people from different colleges. They have found that the State community rating laws raise premiums in the individual market by 21 percent to 33 percent for families and 10 to 17 percent for singles. In New Jersey, which also requires the insurers to accept all comers, so-called guaranteed issue, premiums increased by as much as 227 percent.

Let's see, we just had some elections in New Jersey and things didn't go well there. It probably wasn't just tied to insurance costs.

The political tragedy is that there are plenty of reform alternatives that would reduce the cost of insurance. According to CBO, according to the Congressional Budget Office which we quote a lot, they did an evaluation on the relatively modest House GOP bill. The Republicans in the House were limited to one amendment. There were three amendments total in a 1-day debate and passage of the health care bill over there. That roused a lot of people in America, too. If you only get one amendment, they had to do what we have avoided doing. We have four different bills out there that solve what the President said he wanted solved. That is not counting the Wyden-Bennett bill that also solves what the President said, that is not included in this bill.

What the House put together—it is relatively modest, but it would actually reduce premiums by 5 percent to 8 percent in the individual market in 2016 and by 7 to 10 percent for small businesses. It would not increase the premiums, it would decrease the premiums.

The GOP reforms would also do so without imposing huge new taxes. We have concentrated in the last few days about talking about the Medicare money that is being stolen to provide for the changes. We have not talked yet about the extra taxes that are going to be put into place. That is the other half of the package. But the Democrats do not care because this bill, they say, is about lowering costs. No, it is about putting Washington in charge of health insurance at any cost.

I see the Senator from Wyoming is here. We have 10 minutes remaining on our time. If the Senator wishes to make some additional comments? He and I have been traveling in Wyoming.

The PRESIDING OFFICER. The Senator has 7½ minutes remaining.

Mr. ENZI. I yield the time to my colleague.

The PRESIDING OFFICER. The Senator from Wyoming is recognized.

Mr. BARRASSO. Mr. President, I ask my colleague from Wyoming, with whom I have the privilege of serving, I saw a large story in USA Today. This story says ''Senate Keeps Medicare Cuts in the Bill.''

What it says is:

> Senate Democrats closed ranks Thursday behind $460 billion in politically risky Medicare cuts at the heart of health care legislation.

It goes on to say:

> Approval would have stripped out money to pay for expanded coverage to tens of millions of uninsured Americans.

As I read this, it says the Republicans tried to keep the Medicare money for people on Medicare, but the Democrats want to take $460 billion away from seniors who depended upon Medicare and use it to start a whole new government program. Am I reading this correctly?

Mr. ENZI. That is the way I read it. That is the way the people in Wyoming are reading it and that is apparently the way people all over the country are reading it, particularly seniors. Seniors are the ones upset about what is happening and it is easy to see why. Even though the AARP says this is a good bill, they are saying: Wait a minute. I know people in the nursing home. I know people—some of them are saying I am in the nursing home. I am hearing what is going to happen at my nursing home if these cuts go into place.

As I said continually, we can call them anything we want but the seniors are saying those are cuts. Those are cuts in my benefits. Those are cuts in what I expect. Those are cuts in what I have been getting. Whether you call it guaranteed benefit or just plain old

benefits or whatever it is, they are saying, yes, we are being cut.

Mr. BARRASSO. Mr. President, I would say when my colleague from Wyoming and I held townhall meetings around the State of Wyoming, people have said don't cut our Medicare. Yet what I see this bill doing is cutting our Medicare and specifically, right now, there are thousands of people in Wyoming who are on a program called Medicare Advantage. There is an advantage to this program. That is why so many Americans have signed up for the program.

As a matter of fact, about one in four Americans who depend upon Medicare for their health care in this country has chosen Medicare Advantage, because there are some advantages being in this program called Medicare Advantage: dental, vision, hearing, fitness. Also, as a practicing doctor for 25 years, taking care of families in Wyoming, what I saw, the reason they liked this, if they were on Medicare, is because it dealt with prevention and it actually helped coordinate care.

One of the things Medicare does not do as well is coordinate care and work with prevention. We know how important prevention is in helping people keep down the cost of their care—how good it is in terms of giving people opportunities to stay healthy. That is why they call it prevention.

The bill in front of us, as I see it—I ask the Senator from Wyoming—is a bill that is going to cut $120 billion from Medicare Advantage, the program the people in our State like?

Mr. ENZI. The Senator from Wyoming is absolutely correct. We are getting a lot of calls and mail, letters about that. Another thing the President promised, of course, is that everybody would have catastrophic coverage. It fascinates me that the Wyoming people and the people across America have figured out that Medicare doesn't have catastrophic coverage. But Medicare Advantage provides catastrophic coverage as well as a number of other things that Medicare does not cover. I think they realize, too, that if Medicare Advantage goes away, yes, they can get Medigap but Medigap is more expensive. It is also interesting that the AARP sells Medigap.

Mr. BARRASSO. I actually heard somebody say Medicare Advantage is not Medicare. But if you turn to the Centers for Medicare Services' 2010 Official Government Handbook—we are going to go into 2010 next month. If you go to the official handbook for 2010, and the handbook is called ''Medicare And You,'' it says a Medicare Advantage plan is ''another health coverage choice you may have as part of Medicare.'' People who actually look at this choose this. They make the choice because they say this is a good deal for me. That is what Americans want. They want to get value for their money.

A recent poll said, in terms of Americans, when they send money to Congress, how much of that do they get back in value? They think about 50 cents on the dollar. That is a national Gallop Poll. They have been polling on this for a long time and it is the highest number ever of what Americans think, in terms of the fact that they are getting very little value for their tax dollars. They see games being played. That is what I hear when I have telephone townhall meetings in Wyoming. They know Senator REID's bill steals $464 billion from Medicare. They know it raids the health care program they depend upon, not to make Medicare stronger, not to make Medicare more solvent, but as my colleague from Wyoming tells me, to create a brandnew entitlement program. They are raiding Medicare to start another government program that is itself going to be insolvent.

I ask my colleague from Wyoming, are you seeing what I am seeing?

Mr. ENZI. I am seeing what you are seeing. I am noticing some people do not know what an entitlement actually is. That is a bill that goes on forever, that the Secretary of Health and Human Services has to make sure that it is paid in perpetuity unless there is some other major Congressional action that happens. We keep paying that bill over and over again. I think the Senator from Wyoming recognizes entitlements and some of the difficulties involved with that.

Mr. BARRASSO. Mr. President, an article in Bloomberg yesterday said the Kaiser Family Foundation poll released this past month found that 60 percent of seniors said they would be better off if Congress did not change the health care system.

We know we need to do some changes. But this massive bill, this 2,000-page bill that weighs 20 pounds, is not the right change we need. For our seniors, people who rely on Medicare for their health care, to absolutely raid $464 billion from Medicare, almost $½ trillion, there is a point where more people—the baby boomers, more and more people are added to the rolls every day. To raid this program to start a whole new government program is not the right prescription for America. It is not what our seniors want. It is not what they signed up for. It is not why they are choosing Medicare Advantage. It is because it is a choice they make and that is why we right now have 11 million Americans who are on Medicare Advantage. We have 11 million seniors—that represents almost one-quarter of all Medicare patients in this country.

Mr. ENZI. We are being notified our time is up. We will continue. I have several letters from Wyoming organizations that I want to have printed in the RECORD, and I will do that at a later time.

I thank the Chair and yield the floor.

The PRESIDING OFFICER. The Senator from Connecticut.

Mr. DODD. Mr. President, a few moment ago I started to describe an amendment that will be offered by our colleague from Rhode Island, Senator WHITEHOUSE, regarding the CLASS Act.

As a bit of background, the CLASS Act is a proposal that was originally conceived by a former colleague and dear friend, Ted Kennedy of Massachusetts, years ago, the idea behind it being that we ought to try to figure out a way to support people in this country who end up with disabilities. Their disabilities are not so dramatic that they would deprive them of the opportunity to continue with work but serious enough that they would require some additional help in order to provide a basic standard-of-living, either a driver, some help on food assistance, whatever it may be.

Under present disability formulas, which are basically income-replacement bills, in order to get some help if you are disabled, you almost have to impoverish yourself to qualify and then be restrained about how much you can actually earn, if you want to continue to work. So while it has been a good program and certainly has helped a lot of people, in a sense there are catch-22s in it, that to qualify for it, you have to divest whatever you have acquired or earned and impoverish yourself. Then, even though you may be capable of continuing to work, you are limited on how much you can actually earn under those programs.

It was the vision of Senator Kennedy years ago to try to come up with a different idea, not to replace that but an idea that might allow for people who are disabled to get some help during that period of disability, however long it might last, without necessarily having to then impoverish themselves or to limit their outside earnings, given the fact that they may be able to continue to perform and, in fact, would like to continue to work.

The question was, how could we do this, particularly in light of the fact that we don't want to necessarily be adding a cost to taxpayers. It was his idea to come up with a totally voluntary program that individuals would have to contribute to out of their own pocketbooks, not out of taxpayers pocketbooks, by putting aside resources on a monthly basis over a period of years—5 in the case of this bill—where the plan would become vested and then to contribute that amount thereafter. Then, in such case if you found yourself disabled—and there are criteria that would determine whether you met those thresholds—you would then qualify, based on the fact that you have paid your own money into this program continuously, without exception, to receive at least about $75 a day, providing assistance to you so that you might get along and be able to continue to operate without having to impoverish yourself and put limitations on your work. At $75 a day, that would provide over $27,000 a year for those individuals who meet it. Again, entirely voluntary, your money, not public money—no taxpayer money goes into the plan.

Five million people under the age of 65 living in the community have long-term care needs, and there are over 70,000 workers with severe disabilities in the Nation today who need daily assistance to maintain their jobs and their independence. Long-term care supports and services are an area that is not currently affordable or accessible for millions of our fellow citizens. It is estimated that 65 percent of all those who are 65 or over today will spend some time at home in need of long-term care services, for which average costs run at least $18,000 a year.

Mr. President, 1½ million people today are in nursing homes, and roughly 9 million of our fellow elderly Americans will need help with activities of daily living during the current year. By the year 2030, that number will increase to 14 million, as we watch the baby boom population age. And while those lives will be extended and hopefully the quality improved, we all accept the notion that as we get older, we have greater needs physically. That certainly is something anyone over the age of 65 can tell you. So as the years progress, the quality of care, longevity tables increase, the number of people who will need some form of services or another will jump from 9 million today to roughly 14 million. Those numbers are apt to increase.

Many people who need long-term services and supports rely on unpaid family and friends to provide that care. They have children or grandchildren who are around to provide that kind of assistance. A lot can't, of course. But ultimately many of these individuals have to impoverish themselves to qualify for Medicaid. We know what happens. They transfer the house, their assets. They shove everything over to their children or someplace else so that they qualify for that title XIX window. They become desperately poor, so they can then qualify for Medicaid, which remains the primary payer for these services. The CLASS Act is designed to avoid that, if we can, in as many cases as possible by providing a lifetime cash benefit—voluntary, totally paid for by the beneficiaries—that offers seniors and people with disabilities some protection against the cost of paying for long-term care services and supports and helps them obtain services and supports that will enable them to remain in their homes, reside in their communities, and, in many cases, continue to work.

Let me tell you how the program works. The program is a totally voluntary, self-funded insurance program with enrollment for people who are currently employed. Affordable premiums will be paid through payroll deduction, if the individual's employer decides to participate. It is totally voluntary, nothing required whatsoever. If the employer does not want to participate, the employee would have to find some other way. If the employer decides to allow a payroll deduction, they can do that. Participation by workers, again, is entirely voluntary. Self-employed people or those whose employers do not offer the benefit will also be able to join this program through a government payment mechanism.

Individuals qualify to receive benefits when they need help with certain activities of daily living and they have paid premiums for at least 5 years and have worked for at least 3 of those 5 years. Beneficiaries receive lifetime cash benefits based on the degree of impairment, expected to average roughly $75 a day or roughly $27,000 a year. Benefits can be used to maintain independence at home or in the community and should be sufficient to cover typical costs of home care services or adult daycare. Benefits can also be used to offset the cost of assisted living and nursing home care.

Let me tell you how the improved version of this act protects the taxpayer. There have been issues raised about how they are going to be protected under this program. All CLASS Act benefits are paid by voluntary participants, not taxpayers. The CLASS Act actually would save taxpayer dollars by reducing Medicaid costs—according to CBO, almost $2 billion. CLASS Act premiums must be set at a level sufficient to guarantee actuarial soundness of the program.

We thank Senator GREGG for his amendment in the debate on the CLASS Act bill when it came up in committee.

The current CLASS Act includes significant improvements over earlier versions, such as tighter eligibility standards, a new reserve requirement, and an absolute prohibition on the use of taxpayer dollars to pay benefits. The Congressional Budget Office determined that the improved program is totally actuarially sound.

This bill, the Patient Protection and Affordable Care Act, creates a voluntary insurance program. Under the program, working people pay premiums for at least 5 years before it would vest. After that point, if the individual has paid in for 5 years and worked for at least 3 of those 5 years and develops a disability, they can receive a cash benefit of no less than $50 a day for as long as that disability persists. Contrary to popular belief, Medicare and most private health insurance only pay for long-term care for a short period, meaning that most people pay out of their own income or assets or their family's assets to provide this kind of benefit. Those with the most intense needs will frequently exhaust these assets and have to rely on Medicaid, thus impoverishing themselves in order to qualify.

The CLASS Act provides essential options for 65 percent of those age 65 and older who will need long-term care services at some point in their lives and for the 70,000 workers with severe disabilities in the Nation today who need daily assistance to maintain their jobs and their independence.

It has been said that this program is not financially stable and amounts to nothing more than a Ponzi scheme. This program, they say, will create a new government entitlement program. It is not a government entitlement program—anything but. The CLASS Act does not confer rights or an obligation on the government funding, nor does it affect receipt of or eligibility for other benefits. The program stands on its own financial feet.

CBO has estimated the program to be actuarially sound for the next 75 years. The CLASS Act is solvent, according to the CBO. The program would run only on its own cashflows. CBO estimates an average monthly premium of $123 for an average daily cash benefit of $75 for those who qualify. It may not seem like much, but over a year that would provide needed assistance for those who suffer under disabilities.

CBO uses very conservative participation rates. CBO assumes participation rates that do not consider that CLASS would offer a lifetime cash benefit, be endorsed by the government, and provide a convenient way for employees to auto-enroll through their employers with a voluntary opt-out. All of these features would increase participation rates, which will result in lower premiums, encourage enrollment, and make the program even stronger financially.

Solvency of the program is bolstered by flexibility to adjust the program. In their November 25 letter to the Congress, the CBO acknowledges that the legislation gives flexibility to the Health and Human Services Secretary to adjust premiums and benefits where or if ever needed. This provides a lever to ensure that the program stays solvent even if real life does not perfectly mirror the models of the CBO, as good as they are.

As the Congressional Budget Office discusses, the CLASS Act would function just like any other private long-term care insurance program which finances benefit payments from a premium reserve and interest income off that reserve. Due to budget scorekeeping, the CBO finds that premium revenue exceeds benefit payments in the third decade but does not take into consideration accumulated reserves and income off those reserves that keep the program fiscally independent.

Beyond being self-supporting and voluntary, this program can actually generate savings in Medicaid. Direct offset of the $75 daily benefit is applied toward any Medicaid long-term care costs. Beyond that, the CLASS Act program will help people live independently at home or in the community. When people with disabilities get the services they need, they are less likely to spend down to get Medicaid and less likely to enter a nursing home or hospital, all of which generates additional Medicaid savings.

Of course, what we don't calculate here, because I don't know how one would calculate it, is that notion of independence. I suspect maybe all of us

know people who are on Medicaid and know the frustration particularly of someone who is otherwise healthy but suffers from disabilities who would like to work and wants to keep independent. Yet if you go into the Medicaid Program, there are huge restraints on your ability to do so. So by this program, aside from financially reducing Medicaid costs, we are actually providing that additional sense of human dignity and decency that just because you have a disability and you need help doesn't mean you don't want to be self-sufficient and keep working. There is the gratification of knowing you are contributing in some way other than being shuttered away, having impoverished yourself, relying on others' assets to take care of you because you do not have those resources.

Senator Kennedy generated this idea years ago, and now I think it is improved because of the amendments and ideas that have been suggested by a number of our colleagues here, as well as others, and we have actually strengthened the concept to give it the kind of financial independence Members want it to have, sheltering these dollars against being used for other purposes, such as going off to some other program that people may have a great desire to fund by tapping into these resources. We prohibit that from happening.

If employers do not want to have a payroll deduction, they do not have to have that. No one is required to join the program. We believe, though, when members of our society and country see the benefits of this, they will gravitate to it as a wonderful way to ensure against that dreaded possibility all of us face; that is, becoming disabled, being unable to work as much as we would like to, needing additional assistance and help, and, of course, having very few places to turn to get it.

The disability groups and others that support this, 275 organizations, aging, religious groups, disability organizations across the country—I am not going to read all of them here because 275 names is a lot, but I have here the list of all 275 organizations that have strongly supported this proposal. I cannot think of any finer way to celebrate the memory of our former colleague, who cared so much about this bill we are now engaged in debating, who brought this idea to the table years ago, and who championed it for so many years.

Today, we have a chance to include this wonderful concept, this creative, innovative idea. It saves money. It provides independence for people. It gives them a chance to lead good lives. It provides support to their families who otherwise have to bear a lot of that burden. None of us want our children or our grandchildren to have to bear burdens as they are trying to raise their own families. So here is a little idea that has generated support, totally by voluntary contributions. There is no government money involved at all. And it is to give people a chance to live out the remaining time of their lives with decency and dignity, having the sense of making a contribution and making a difference.

All of those facts I cannot put a dollar amount on. I cannot tell you what the financial benefit is of someone getting up in the morning, getting a little help but going off to a job and knowing they are needed and have worth and value as a human being. What is the dollar amount on that? I cannot tell you, except I know it has value in our country. Or the alternative? Getting rid of all your assets, impoverishing yourself, relying on your family or friends to take care of you in order to try to survive, when you could be doing more.

So I hope my colleagues will support the Whitehouse amendment when it is offered to strengthen this program and that they will resoundingly defeat the effort to cut this program out of the bill altogether. I cannot think of a worse thing we could do with a piece of legislation that is designed to be creative, innovative, reduce costs, and make a difference for millions of our fellow citizens. And a growing number—as was pointed out, by the year 2030, 14 million Americans in our country, and I suspect more—will be in need of services such as these.

I see my colleague and friend from Iowa on the floor, who has been as strong a champion as this Congress has ever had when it comes to the disabled in our country, having been the author of the Americans with Disabilities Act, along with others but nonetheless the principal architect of that effort, and he can speak more eloquently than any other human being I have ever known about why this program is important and what it means.

Mr. President, I ask unanimous consent that the list of 275 organizations that strongly endorse and support Senator Kennedy's CLASS Act be printed in the RECORD.

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

HEALTH CARE REFORM/CLASS ACT OF 2009
NATIONAL SUPPORT LIST

DISABILITY GROUPS

ADAPT, America Psychological Association, American Association on Health and Disability, American Association on Intellectual and Developmental Disabilities, American Association of People with Disabilities, American Association on Mental Retardation, American Congress of Community Supports and Employment Services, American Foundation for the Blind, American Medical Rehabilitation Providers Association (AMRPA), American Music Therapy Association, American Physical Therapy Association, American Network of Community Options and Resources, Anxiety Disorders Association of America, The ALS Association, Assisted Living Federation of America, Association of Assistive Technology Act Programs, Association of Programs for Rural Independent Living, Association of University Centers of Disabilities, Autism Society, ACCSES.

Bazelon Center for Mental Health Law, Brain Injury Association of America, Center for Disability Issues and the Health Professions at Western University of Health Sciences, CSAVR (Council of State Administrators of Vocational Rehabilitation), Consortium of Citizens with Disabilities (umbrella organization for 114 advocacy groups), Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD), Council for Learning Disabilities, Center for Accessible Living, Depression and Bipolar Support Alliance, Disability Policy Collaboration, Disability Rights Education and Defense Fund, Easter Seals, Epilepsy Foundation, Higher Education Consortium for Special Education Teacher Education, Helen Keller National Center, Division of the Council for Exceptional Children, Justice for All, Mental Health America, National Academy of Elder Law Attorneys, National Alliance on Mental Illness, National Association for Anorexia Nervosa and Associated Eating Disorders.

National Association of Councils on Developmental Disabilities, National Association of County Behavioral Health and Developmental Disability Directors, National Association of State Directors of Developmental Disabilities Services, National Association of State Head Injury Administrators, National Center on Learning Disabilities, National Coalition on Deaf-Blindness, National Council on Independent Living, National Disability Rights Network, National Down Syndrome Society, National Down Syndrome Congress, National Multiple Sclerosis Society, National Organization on Disability, National PACE Association, National Rehabilitation Association, National Spinal Cord Injury Association, Paralyzed Veterans of America, Rehabilitation Engineering and Assistive Technology Society of North America, Research Institute for Independent Living, Self-Advocates Becoming Empowered, Special Olympics, Inc.

TASH, The Arc of the United States, The Autistic Self Advocacy Network, Tourette Syndrome Association, United Cerebral Palsy, United Spinal Association, US Psychiatric Rehabilitation Association.

AGING GROUPS

AARP, Alliance for Retired Americans, Alliance for Quality Long Term Care, Alzheimer's Association, Alzheimer's Foundation of America, American Association for Geriatric Psychiatry, American Association for Homecare, American Association for Homes and Services for the Aging, American Health Care Association, Association of BellTel Retirees, Association of Retired Americans, ATAP (Assistive Technology Programs), Burton Blatt Institute, National Alliance for Caregivers, National Association for Homecare and Hospice, National Association of Area Agencies on Aging, National Association of Nutrition and Aging Services Programs, National Association of Professional Geriatric Care Managers, National Association of State Units on Aging, National Council on Aging, National Family Care Givers Association.

National Indian Council on Aging, National Respite Coalition, Notre Dame du Lac Assisted Living, OWL—The Voice of Midlife and Older Women, Prima Council on Aging, ProtectSeniors.org, The National Consumer Voice for Quality Long-Term, The National Voice for Quality Long-Term Care, Therapeutic Communities of America, United Neighborhood Centers of America, Volunteers of America, Wider Opportunities for Women.

HEALTHCARE GROUPS

American Academy of Pediatrics (AAP), Ambulatory Behavioral Healthcare, American Association for Marriage and Family Therapy, American Congress of Rehabilitative Medicine, American Counseling Association, American Diabetes Association, American Group Psychotherapy Association,

American Hospital Association (AHA), American Mental Health Counselors Association, American Occupational Therapy Association, American Society on Consultant Pharmacists, American Therapeutic Recreation Association, Association for Ambulatory Behavioral Healthcare, Assoc. of the Advancement of Psychology, Bazelon Center for Mental Health Law, Center for Medicare Advocacy, Families USA, Family Voices, Gay Men of African Descent, Medicare Rights Center.

Mujeres Unidas Contra el SIDA, National Alliance to End Homelessness, National Partnership for Women and Families, National Association of Children's Behavioral Health, National Association of Mental Health Planning Councils, National Association of School Psychologists, National Coalition of Mental Health Consumer/Survivor Organizations, National Committee to Preserve Social Security and Medicare, National Council for Community Behavioral Health Care, National Foundation for Mental Health, National Health Council, National Minority AIDS Council, The Center for Medical Advocacy, Visiting Nurses Association of America.

UNIONS

American Federation of Labor-Congress of Industrial Organizations (AFL–CIO), American Federation of State, Country, and Municipal Employees (AFSCME), Service Employees International Union (SEIU), American Federation of Teachers (AFT), National Association of Active and Retired Federal Employees (NARFE).

RELIGIOUS ORGANIZATIONS

American Association of Pastoral Counselors, American Baptist Home Mission Societies, Association of Jewish Aging Services of North America, Association of Jewish Family and Children's Agencies, B'nai B'rith International, Catholic Health Association of the United States, Council of Health and Human Service Ministries of the United Church of Christ, Episcopal Community Services in America, Evangelical Lutheran Good Samaritan Society, Evangelical Lutheran Church in America, Friends Committee on National Legislation, Hindu American Foundation, Islamic Society of North America, Jewish Council for Public Affairs, Lutheran Services in America, L'Arche USA, Mary Immaculate Health/Care Services, Masonic Communities and Services Association, National Council of Jewish Women, Presbyterian Church (U.S.A.).

Presbyterian Association of Homes and Services for the Aging, Sisters of Charity, United Jewish Communities, The Jewish Federations of North America, The Union for Reform Judaism, Unitarian Universalist Association of Congregations, United Methodist Church.

HIV/AIDS ORGANIZATIONS

ActionAIDS, Philadelphia, PA; African Services Committee, New York, NY; AIDS Action Baltimore, Baltimore, MD; AIDS Action Council, Washington, DC; AIDS Action Committee of Massachusetts, Boston, MA; AIDS Alabama, Birmingham, AL; AIDS Alliance for Children, Youth & Families, Washington, DC; AIDS Coalition of Southern New Jersey, Bellmawr, NJ; AIDS Foundation of Chicago, Chicago, IL; AIDS Housing Alliance/SF, San Francisco, CA; AIDS Law Project of Pennsylvania, Philadelphia, PA; AIDS Legal Council of Chicago, Chicago, IL; AIDS Legal Referral Panel, San Francisco, CA; AIDS Partnership Michigan, Detroit, MI; AIDS Project Los Angeles, Los Angeles, CA; AIDS Services Foundation Orange County, Irvine, CA; AIDS Task Force, Wheeling, WV; AIDS Treatment Data Network, New York, NY; AIDSNET, Bethlehem, PA; American Dental Education Association, Washington, DC.

Asian & Pacific Islander Wellness Center, San Francisco, CA; Association of Nurses in AIDS Care, Akron, OH; Association of Nutrition Services Agencies (ANSA), Washington, DC; Better Existence with HIV (BEHIV), Chicago, IL; Black Coalition on AIDS, San Francisco, CA; CAEAR Foundation, Washington, DC; Catholic Charities CYO, San Francisco, CA; Colorado AIDS Project, Denver, CO; Center on Halsted, Chicago, IL; The COLOURS Organization, Inc., Philadelphia, PA; Common Ground—the Westside HIV Community Center, Santa Monica, CA; Community Care Management Corporation, Ukiah, CA; Community Healthcare Network, New York, NY; Community HIV/AIDS Mobilization Project (CHAMP), New York, NY & Providence, RI; Community Research Initiative of New England (CRI), Boston, MA; Face to Face/Sonoma County AIDS Network, Santa Rosa, CA; Fenway Community Health, Boston, MA; Gay Men's Health Crisis (GMHC), New York, NY; Harlem United Community AIDS Center, New York, NY; Hawaii Island HIV/AIDS Foundation, Keaau & Kailua-Kona, HI; Health and Home Support Services, Inc., Newport News, VA.

Health Imperatives, Brockton, MA; HIV ACCESS, Alameda County, CA; HIV/AIDS Services for African Americans in Alaska, Anchorage, AK; HIV/AIDS Services/Greater Love Tabernacle Church, Dorchester, MA; HIV Dental Alliance, Atlanta, GA; HIV Health and Human Services Planning Council of New York, New York, NY; HIV Health Services Planning Council, Sacramento, CA; HIV Health Services Planning Council—San Francisco EMA, San Francisco, CA; HIVictorious, Inc., Madison, WI; HIV Medicine Association, Arlington, VA; Housing Works, New York, NY; Hyacinth AIDS Foundation, New Brunswick, NJ; Inova Juniper Program, Springfield, VA; JRI Health/Sidney Borum Health Center, Boston, MA; Lansing Area AIDS Network, Lansing, MI; L.A. Gay & Lesbian Center, Los Angeles, CA; Legacy Community Health Services, Inc., Houston, TX; LifeLinc, Baltimore, MD; Lifelong AIDS Alliance, Seattle, WA.

Lower East Side Harm Reduction Center, New York, NY; Michigan Positive Action Coalition (MI-POZ), Detroit, MI; Minnesota AIDS Project, Minneapolis, MN; Nashville CARES, Nashville, TN; National Alliance of State and Territorial AIDS Directors, Washington, DC; National Association of AIDS Education and Training Centers, Detroit, MI; National Association of People with AIDS, Washington, DC; The National Coalition for LGBT Health, Washington, DC; National Minority AIDS Council, Washington, DC; National Pediatric AIDS Network, Boulder, CO; National Women and AIDS Collective, Brooklyn, NY; New York City Health and Hospitals Corporation, New York, NY; NYC AIDS Housing Network (NYCAHN), New York, NY; The New York State Nurses Association, Latham, NY; New York State Wide Senior Action Council, Inc., Albany, NY; Okaloosa AIDS Support and Informational Services, Inc. (OASIS), Ft. Walton Beach, FL; Open Arms of Minnesota, Minneapolis, MN; Partnership Project, Portland, OR; Paterson Counseling Center, Inc., Paterson, NJ; People Living With HIV/AIDS Committee of the Baltimore Planning Council, Baltimore, MD.

Positive East Tennesseans, Knoxville, TN; Project Open Hand, San Francisco, CA; Project Inform, San Francisco, CA; Ryan White Medical Providers Coalition, Arlington, VA; San Francisco AIDS Foundation, San Francisco, CA; Sisters Together And Reaching, Inc. (STAR), Baltimore, MD; Southern NH HIV/AIDS Task Force, Nashua, NH; Strong Consulting, Crescent City, CA; Test Positive Aware Network, Chicago, IL; The AIDS Institute, Washington, DC & Tampa, FL; The Albany Damien Center, Albany, NY; The International Community of Women Living with HIV/AIDS (ICW), Washington, DC; The Sexuality Information and Education Council of the United States (SIECUS), Washington, DC; Treatment Action Group (TAG), New York, NY; Triad Health Project, Greensboro, NC; United Methodist Mexican-American Ministries, Garden City, KS; Victory Programs, Inc., Boston, MA; Village Care of New York, New York, NY; Wilson Resource Center (WRC), Arnolds Park, IA; Women Together for Change, St. Croix, U.S. Virgin Islands.

Mr. DODD. I yield the floor.

The PRESIDING OFFICER (Mr. KAUFMAN). The Senator from Iowa.

Mr. HARKIN. Mr. President, I wish to thank our friend and leader on this issue, Senator DODD, for his eloquence in supporting what so many of our elderly in this country want more desperately than just about anything else; that is, the peace of mind of knowing that if they should become disabled, they will not be forced to go into a nursing home, they will have some support, and they will be able to live in their homes in their communities. Talk to anyone with a disability—not just the elderly, anyone with a disability—and they will tell you how important it is that you have that kind of assurance that if, God forbid, you become disabled, your only hope will not be to go into a nursing home for the rest of your natural life.

Senator Kennedy worked on this for years. The couple times I talked to him this summer and this spring, this is what he wanted to talk to me about: making sure we included this in the bill. This was his cause, to make sure we had a program people could contribute to that would afford them some support if, in fact, they became disabled.

I do not understand the move by my Republican friends to strike this. This is not a mandatory program. This does not force anyone to pay a dime. It is all voluntary. We say, if you want to, you can put some money aside during your working years in a fund that will vest so that if you become disabled, you can get some support to stay at home, maybe with your own family, maybe with just enough support so you can get another job and work even though you have a disability. This is voluntary.

I ask my friends on the other side of the aisle, why are you against a voluntary program that will enable people to have that kind of peace of mind? Well, I have heard it said: Well, maybe the taxpayers will have to pay for this and everything.

I will tell you this: In the committee, Senator GREGG—Senator GREGG from New Hampshire, Republican Senator GREGG, my good friend—offered an amendment to make sure the contributions were the only things that would sustain this program, that it would not become an entitlement. Here is what he said, his own words:

I offered an amendment, which was ultimately accepted, that would require that

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.

The CBO has scored this. This is completely paid for over 75 years—over 75 years. I do not understand why anyone would want to strike it.

What Senator WHITEHOUSE has said—again, I think this is very appropriate for us—is that any savings we get from this be reinvested either in the CLASS Act—so when people do get disabled, maybe they will get a little bit more money. So we have some savings in the CLASS Act. What Senator WHITEHOUSE has said is, put those savings back in the CLASS Act or Social Security. It makes sense to me. So again, I think it is an improvement on the bill, what Senator WHITEHOUSE is suggesting.

I plead—I plead—with my fellow Senators, do not kill this program aborning. We stood here on this floor 19 years ago, on July 20, 1990. We stood on this floor to pass the Americans with Disabilities Act. There were a few votes against it. In fact, there are one or two people still here who voted against it. I think if you asked them now, they would say it has been a pretty darn good bill. It has broken down a lot of barriers, opened a lot of doors for people with disabilities in our country, changed our environment in this country, not only in terms of physical access, but I think, more importantly, it has changed how we view people with disabilities, no longer looking at people with a disability to say, what is their disability, we now look at those people and say, what are your abilities, what can you do—not just looking at someone's disability. So we have come a long way.

The one thing we have never been able to really do is to set up a functioning system so people could put some money aside to protect themselves in case they got disabled. Well, this is it. This is our chance. This is a big part of this health care bill, a big part.

Well, maybe, I suppose, if you are trying to kill the bill, you would want to kill the CLASS Act. But this is vitally important for our country. It is really the next logical step after the Americans with Disabilities Act. It is going to provide for so many people in this country that security and that peace of mind of knowing they will not have to go into a nursing home or an institution if they become disabled. And it can happen to any one of us here on the Senate floor, our families, our staff, our loved ones. No one knows what might happen to us either from an accident or a physical ailment. No one knows. But shouldn't we at least have some part of this health care bill that provides that kind of voluntary program? No one is forced into anything. I guess that is what perplexes me more than anything else—why my Republican friends want to prevent something like a voluntary program—a voluntary program—from going into existence that would do this, that is fiscally sound for 75 years. I just do not get it.

So I hope we will support the Whitehouse amendment and make sure this fund is totally solvent. I think he is on the right track, that if there are savings, to put the money back in there, so maybe that $75 a day could be maybe $80 a day, or something like that, to help people.

I see, Mr. President, we now have a statement from the AARP about the CLASS program. Here is what they said. They said:

Decades of talking to our members tell us that older Americans want to live in their homes as they age. That's why AARP strongly supports the Community Living Assistance Services and Supports (CLASS) program, which recognizes that older individuals and people with disabilities should have the right to live independently in their own homes and communities, and to receive the help they need without having to spend down to poverty.

Mr. President, I ask unanimous consent to have that statement from the AARP printed in the RECORD.

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

AARP STATEMENT ON THE COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS PROGRAM

WASHINGTON.—AARP Executive Vice President Nancy LeaMond released this statement today in support of the Community Living Assistance Services and Supports (CLASS) program:

''Decades of talking to our members tell us that older Americans want to live in their homes as they age. That's why AARP strongly supports the Community Living Assistance Services and Supports (CLASS) program, which recognizes that older individuals and people with disabilities should have the right to live independently in their own homes and communities, and to receive the help they need without having to spend down to poverty.

''With nearly 40 million members age 50-plus, AARP has fought to strengthen long-term services and supports. We thank the House and Senate for including the CLASS program in their health care reform bills. The voluntary CLASS insurance program will promote independence, choice, dignity and personal responsibility. It is self-funded and fiscally responsible. AARP believes the CLASS program has been strengthened throughout the legislative process. We look forward to working with Senate, House, and the Administration to enact this critical program. America's seniors and persons with disabilities deserve nothing less.''

Mr. HARKIN. Mr. President, I am going to put this in personal terms—personal terms. I have told this story before, and I am going to tell it again because I think it indicates why we need a program such as this.

I have a nephew, Kelly; my sister's boy. He got injured at a very young age; he was only 19 years old. It made him a severe paraplegic, almost a quadriplegic. My sister and her husband did not have any money at all. Yet Kelly was able to go to college—go to school. He was able to get a job, able to live in a house by himself. He had his own little home. He had his own van he drove that had a lift on it, and he could get his wheelchair in there and drive it to work. He actually started a small business and employed some people. He has lived a full life. He is now a man of about 50. He has had a great life. Even with that disability, he has been able to get around and do things. He is a taxpayer. He has paid taxes. He has employed people. Every night when he goes home, he has to have a nurse come in the home and get him ready for bed and for him to do his exercises and things such as that. Then, in the morning, he has to have another nurse to get him out of bed and take care of his needs, get him ready to go. Actually, Kelly gets his own meals and stuff. Then he goes off to work and comes back. This happens every day.

How was he able to afford to do that? He did not have any money. He did not have any insurance. How was he able to afford to do that? He got injured in the military. He got injured in the military. So for all these years, the Veterans' Administration has been paying for this. It has been wonderful. It has kept him out of an institution, kept him out of a nursing home, and it has allowed him to live by himself, to go to school, to go to work, to be with his family, to be with his friends.

I have often thought, this is wonderful, but why should that just be for people who are injured in the military? What about so many other people who get injured like my nephew Kelly who are not in the military, maybe even injured before they could go into the military? He was only 19 when it happened to him. So for all these years, I have thought we should have some system in this country that would allow people like my nephew—who were not in the military but who, through an unfortunate accident, became disabled—that they could have that same kind of life, where they could live in their own homes in their own communities with their own families, have their own friends. That is why this is so important. This is perhaps one of the most important things we have done since the passage of the Americans with Disabilities Act to make sure people with disabilities have a full, enjoyable, productive, quality life.

I hope Senators will decisively defeat the amendment that wants to strike this. Say yes. Say yes to so many people with disabilities and young people today and working people today. Say yes that we are going to have a system whereby you will have the peace of mind of knowing that if you want to contribute the money, you will be able to do so. Say no to the amendment that would strike that, and say yes to the Whitehouse amendment that actually supports the CLASS Act, makes sure that any savings from it are reinvested in that program.

I thank the President and I yield the floor.

The PRESIDING OFFICER. The Senator from Connecticut.

Mr. DODD. Before we go to our next speaker, I wish to ask if I could request that the next half hour be equally divided; is that OK?

The PRESIDING OFFICER. The Republican deputy leader.

Mr. KYL. I had hoped to take the next half hour, but if we could do 40 minutes, equally divided, I could take 20.

Mr. DODD. Forty minutes, equally divided.

Mr. KYL. Would I be able to take the first 20 minutes then?

Mr. DODD. Yes. That would be under the same order as we had before, I would ask the Chair.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from Arizona is recognized.

Mr. KYL. Mr. President, we are discussing the Hatch motion to preserve Medicare Advantage. I wish to give a little bit of background about the Medicare Advantage Program. It was established with the goal of ensuring that beneficiaries all across the country would actually have Medicare choices. Under the program, private health plans receive government payments in order to serve Medicare beneficiaries. In addition to offering comparable coverage to Part A, which is for hospitals, and Part B, physician services, Medicare Advantage plans can also offer Part D coverage, prescription drug benefits.

The central goal of the Medicare Advantage provisions was to ensure that beneficiaries across the Nation, not just those in populous areas, would have access to health plan options. Under the law, Medicare Advantage plans must provide all physician and hospital Medicare benefits.

Here is the key. I hope my colleagues will think about this for a moment because this has been a little bit perhaps distorted in the conversation we have had. If a plan's costs to provide all the Medicare benefits is less than the government payment, then by law, the plan must apply the difference to provide additional benefits to the beneficiary or to reduce premiums.

It seems to me that is what this whole reform was about in the first instance, to try to ensure quality care and reduce the cost of insurance to beneficiaries.

But what are these extra benefits? We have heard them discussed. They include, first of all, lower cost sharing, including out-of-pocket limits on beneficiary cost sharing, as well as specific health benefits such as vision, dental care, hearing services, routine physical, cancer screenings, and so on. Plans can also offer management services, which can be particularly important to beneficiaries with chronic illnesses, and that is a protection, by the way, that does not exist in regular fee-for-service Medicare.

Today, every beneficiary has health plan choices. Since 2003, the number of Medicare beneficiaries enrolled in private plans has nearly doubled from 5.3 million to 10.2 million in the year 2009, according to the Kaiser Family Foundation. So these are very popular plans and growing in popularity.

Let's go back in time just a little bit to consider the history, back to 1972, because in past years my colleagues on the other side of the aisle were all for Medicare Advantage. Over the years, Congress has tried to control spending by reducing payments to private Medicare plans. One problem was, severe payment reductions resulted in the elimination of plan options. For example, in 1997, the Balanced Budget Act reduced plan payments by $74.5 billion over 10 years. What happened? Well, about three-quarters of a million beneficiaries, from 1999 to 2003, had to change plans or else lose their health plan altogether. This included not only less populous and more rural areas of the country but also areas such as Long Island, NY.

Well, Congress heard from these seniors loudly and clearly. They were angry about losing their coverage. Many remember that the Medicare Modernization Act was a landmark achievement which provided seniors with prescription drug coverage, but it was necessary for another reason as well and that was to respond to the call of the seniors who wanted their private options back.

So, in 2003, the Medicare Modernization Act expanded plan options to include regional PPOs and restore plan payments. It was a deliberate, bipartisan decision to increase the plan's payments so they could enter rural areas of the country and even some of the urban areas—as I mentioned, Long Island. If my colleagues don't remember, let me remind them.

Former Senator Clinton from New York, for example, said that these Medicare+Choice plans—that is now what we call the Medicare Advantage plans, and I am quoting:

> . . . are feeling the squeeze in a system caught between rapidly exploding costs and rapidly imploding finances. While we debate the future of Medicare, we need to recognize that there are people right now in our States who depend on these plans today.

The current senior Senator from Massachusetts said at the time, and I quote:

> I urge my colleagues to support the additional funding that is urgently needed to strengthen the Medicare+Choice program for seniors. This should be among our highest priorities in this year's Medicare debate.

It was, and we did. So this is not something bad that we provided this money to these plans. We provided it so the plans could provide the benefits to seniors, particularly in areas where otherwise they wouldn't have those choices.

So why has this all of a sudden become unpopular with our friends on the other side of the aisle? Well, obviously, first and foremost, they need trillions of dollars to fund their bill, so they look around for where they can get some money and decide: Well, we can get $120 billion from here; this is one way we can help pay for the new entitlements under their bill. But to them, there has to be some kind of justification to take that money, so the idea is: Well, it is not fair that the government would pay money into this program for extra benefits for seniors when that money could be spent on regular fee-for-service Medicare. Of course, that argument presupposes that government health care is always superior to the plans offered in the private market, which these seniors have made clear, by doubling the enrollment in the private plans, is not the case. As I said, they have made their preference clear.

They asked us for choices, as Members of Congress enjoy. They want access to private plans and these additional benefits, and we delivered as promised. We gave them the choices, Republicans and Democrats alike. Now they need the money, so they decide this is a way to get some money to pay for their new entitlement.

Our friends on the other side of the aisle have been talking about overpayments. There is no such thing as an overpayment in this program under the law. No money goes to the plans. It is not as if the insurance companies get the money from the government. The insurance companies, if their bid is under what the traditional Medicare bid is, have to return 25 percent of it to the U.S. Government and the other 75 percent, by law, must go to their beneficiaries, either in the form of lower premiums or additional benefits. So these aren't overpayments to the plans, as has been represented. As I said, 75 percent of the additional payments must be used to provide seniors with extra benefits, which could include lowering premiums, including chronic care management, and so on. The other 25 percent is returned to the government, so there is no overpayment.

Some on the other side argue that they are protecting guaranteed benefits. Well, this is semantics. Nobody is going after the benefits Medicare has traditionally supplied. What we are pointing out and what this amendment would prevent from happening is, the benefits under Medicare Advantage would not be cut, and there is no question—nobody can deny—that those benefits would be cut. In fact, according to the CBO, by the year 2019, they will have been cut by 64 percent, a huge—almost $90—over $90 in actuarial value. So my point is, seniors, of course, would like to keep what they have.

What about this promise if you like what you have, you get to keep it. Sorry. Not if you are on Medicare Advantage. As I said, according to the Congressional Budget Office, the legislation would cut benefits from $135 a month actuarial value to $49 actuarial

value. That is a real cut. It may not sound like much to some people, but to our seniors, it is a huge hit. They are asking what happened to this promise to let them keep what they have.

There is an interesting memo by James Capretta and Robert Book, who write for the Heritage Foundation, on the Medicare Advantage cuts, and here is what they say:

Reform should mean more patient choice and health plan accountability. But these current proposals would lead in the opposite direction—toward a system of less choice, less accountability, and eventually lower-quality health care.

That is what the Hatch motion is attempting to prevent, to preserve these benefits for seniors.

I have gotten tons of calls, about 500 calls just in the last several days, opposing cuts to Medicare Advantage. I haven't, by the way, received a single call from a senior citizen asking us to make these cuts. I have been reading from these letters. I have read about a dozen of these letters. Let me read a few from constituents who tell us the real effect these cuts would have on them. Bear in mind, in my State we have about 329,000 seniors who are enrolled in Medicare Advantage plans.

One constituent from Phoenix says:

For the past month I have heard a lot about proposed Medicare cuts. Finally, after years of being self-employed and being able to afford only high deductible insurance, I am now in Medicare and have a Medicare Advantage plan. Please tell me you are not cutting Medicare Advantage. Have a heart. Leave Medicare and Medicare Advantage alone.

We are trying.

A constituent from Peoria, AZ, says:

I oppose cuts to Medicare Advantage. I have two family members receiving health care under this program. The care has consistently been outstanding due to the efforts of our case manager in coordinating patient care between providers and patients. We have a voice in determining type and scope of our care. Please do not cut Medicare Advantage!

Here is a note from a constituent from Apache Junction:

I have heard reports that if passed, the new government health care plan would do away with or cut Medicare Advantage. If so, it would nearly double my health care costs with my present health care provider. I do not want any legislation passed that would take away the Medicare Advantage option for seniors.

Another constituent from Peoria:

President Obama has said we can keep the insurance we have if we like it, but has said he wants to cut or eliminate Medicare Advantage. What happens to the millions of people who have Medicare Advantage? These are all seniors, many of whom cannot afford to pay more. Why should so many seniors have to sacrifice in order to help pay for universal coverage? Why do we not hear more debate on this issue?

Well, to my constituent from Peoria, that is what this debate is all about. We are trying to prevent these cuts.

Here is a constituent from Prescott Valley:

I have Medicare Advantage. My husband wants to retire from his job where he has excellent health coverage for some serious health concerns. So long as he has good medical coverage, he does well. Should Medicare Advantage be cut, his health would necessarily suffer after his retirement. We cannot afford higher supplemental coverage. I don't want to lose my husband. I have spent many a sleepless night wondering how to keep my husband healthy once he retires. I have several friends currently undergoing chemotherapy and they are wondering if their health would be in jeopardy if Medicare Advantage were cut. Are we not worth saving? Clearly, there are many who want to spend our money on their own priorities. God bless you, sir, for advocating on our behalf!

These are real concerns from real people. They don't want us to cut Medicare Advantage.

The final point I wish to make is one of our colleagues was saying: Well, there are bad Medicare Advantage plans and good Medicare Advantage plans. How do we know which ones are good and bad? It turns out the senior Senator from Florida devised a formula which protects a lot of folks in his State, especially in Broward County, Miami Dade County, and Palm Beach but doesn't protect very many other folks.

Maybe this is the definition of good versus bad. There are a few that are protected in Colorado, Maryland, Mississippi, Oklahoma, and Texas. In my State of Arizona, with a lot of retirees, very few are exempted from the cuts. This is not going to go over well—to exempt only a few in certain key areas, and none of the others.

Again, what happened to the promise that everyone gets to keep what they have?

My bottom line in supporting the Hatch amendment is that we should not punish seniors who signed up to have the choice of Medicare Advantage. There are better ways to reform health care. We have talked about those ways. Our senior citizens have paid into the program. They have asked us for this program. Democrats and Republicans have supported it in the past. Now, simply because somehow or other we have to scrape up money for the new entitlements in this legislation, we are going to attack the very program all of us have supported in the past.

It is unfair, it is not right, and we need to defeat those cuts in Medicare, and that is why the Hatch motion to preserve Medicare Advantage should be supported by my colleagues.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. GRASSLEY. Mr. President, before the Senator from Arizona leaves, on the point he made and the efforts by the members of the other party to strike Medicare Advantage, I have a letter that was sent to members of the Medicare conference on September 30, 2003, with more Democratic signers who are still in the Senate than Republican signers who were in the Senate, which set out all of the reasons Medicare Advantage was so very important and why it needed to have more money put into the year 2003.

For instance, I will read from the letter:

For nearly 5 million Medicare beneficiaries across America, Medicare Plus Choice—

That is what it was called before Medicare Advantage—

is an essential program that provides high quality, comprehensive, affordable health coverage. These seniors and disabled Americans have voluntarily chosen to receive their health coverage through Medicare HMOs and other private sector plans because they have excellent value. To preserve this important option for seniors across the country, bipartisan legislation was introduced in the Senate as S. 590, the ''Medicare Plus Choice Equity and Access Act.''

Cosponsored by Senators Schumer and Santorum, S. 590 sought to increase reimbursement rates and add new reimbursement options. . . .

Et cetera, et cetera. We have plenty of history in the Senate that is bipartisan that we ought to maintain—Medicare Advantage—rather than do an injustice to it, as this legislation before the Senate is trying to do.

I ask unanimous consent to have this letter printed in the RECORD.

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

U.S. SENATE,
Washington, DC, September 30, 2003.

DEAR MEDICARE CONFEREE: We are writing to ask you, as a member of the Medicare conference committee, to ensure that the final Medicare bill includes a meaningful increase in Medicare+Choice funding in fiscal years 2004 and 2005. While the Senate bill makes a modest step toward this goal, we hope that the stronger provisions in the House bill will be preserved in conference.

For nearly 5 million Medicare beneficiaries across America, Medicare+Choice is an essential program that provides high quality, comprehensive, affordable health coverage. These seniors and disabled Americans have voluntarily chosen to receive their health coverage through Medicare HMOs and other private sector plans because of their excellent value. To preserve this important option for seniors across the country, bipartisan legislation was introduced in the Senate as S. 590, the ''Medicare+Choice Equity and Access Act.''

Co-sponsored by Senators Schumer and Santorum, S. 590 sought to increase reimbursement rates and add new reimbursement options for Medicare+Choice programs. Although the Senate version of the Medicare bill does include a modest increase in reimbursement rates in FY 2005, we were pleased to see that the House version contains a more comprehensive commitment to strengthening Medicare+Choice beginning in 2004.

Medicare+Choice uses private sector innovations to offer all of the traditional Medicare benefits in addition to extra benefits such as prescription drug coverage, vision benefits, and hearing aids. These added services are particularly important to low-income seniors who cannot afford the high out-of-pocket costs they would incur under the Medicare fee-for-service program. In many cases, this program is the only option for low-income seniors to receive comprehensive, affordable health coverage.

But in recent years, lack of adequate government funding for the Medicare+Choice program has steadily reduced the health plan choices and benefits of seniors across the nation. As funding increases have continually fallen short of rising health care costs, seniors have watched the quality of their health

care decline. Each year, health plans deprived of essential funding have been forced to eliminate benefits, increase seniors' out-of-pocket costs, or even withdraw completely from certain areas.

We strongly support additional Medicare+Choice funding for two very important reasons: (1) to protect the health care choices and benefits of the nearly 5 million Medicare beneficiaries who are currently enrolled in private sector health plans; and (2) to strengthen the foundation for future health plan choices.

We believe that the Medicare+Choice funding provisions in H.R. 1 are critically important to preserving choice and quality for America's seniors. We urge you to include these provisions in the final bill reported out of the Medicare conference committee.

Sincerely,

Rick Santorum, John F. Kerry, Arlen Specter, Jon Corzine, Gordon Smith, Jim Bunning, Dianne Feinstein, Joseph I. Lieberman, Patty Murray, Charles E. Schumer, Frank R. Lautenberg, Hillary Rodham Clinton, Ron Wyden, Mark Dayton, Norm Coleman, Mary L. Landrieu, Maria Cantwell, Christopher J. Dodd.

Mr. GRASSLEY. Mr. President, does the Senator from Wyoming want the remainder of our 20 minutes?

Mr. BARRASSO. Yes.

The PRESIDING OFFICER. The Senator from Wyoming is recognized.

Mr. BARRASSO. Mr. President, to correct something I heard on the floor today, when the senior Senator from Connecticut had some concerns about this, he said how private health plans deny claims. He said Medicare doesn't deny claims.

In the United States of America, the No. 1 denier of claims for health care is Medicare. The study that is out from a full year, from March 2007 to March 2008, Medicare rejected 475,000 claims of its 6.9 million claims filed, at the rate of 6.85 percent. When you compare that to private insurance companies, the industry average for the claims that are rejected is about 4.05 percent.

So Medicare rejects, by number, 10 times more than the largest private insurance company. A lot of these claims—I have followed this closely because I have been the medical director of something called the Wyoming Health Fairs, where people can get their blood tested at a low cost. It is a preventive or prevention-designed program. Yet Medicare refuses to pay for prevention. It refuses to pay for these blood tests because they are preventive as opposed to diagnosing a specific problem in a specific patient with a specific symptom.

What do our seniors in America do? They turn to a program called Medicare Advantage because it gives them the advantage to choose this program. It is one of the choices they have under Medicare. At this point, 11 million Americans have chosen to participate in Medicare Advantage and receive their health care through Medicare Advantage. We are talking about seniors who depend on Medicare for their health care.

The number of people signing up for Medicare Advantage has continued to increase, and now there are 11 million people—or one out of every four seniors—on Medicare in this country. They know who they are and they like the program. The reason they like the program is because they get additional services—services beyond what someone on the traditional Medicare Program receives, such as dental care, hearing care, eye care, preventive care, and coordinated care.

We hear a lot about the failings of the health care system, and there are many in this country, and one of them is that care is not coordinated. People go from specialist to specialist. We need coordinated care. Medicare Advantage does a much better job at coordinating care than traditional Medicare.

It is baffling to me that the plan in front of us in the Senate today is trying to eliminate Medicare Advantage to the tune of over $100 billion. When one looks at the cuts that are in this plan—it is $464 billion in Medicare cuts, $135 billion for hospitals, $42 billion for home health agencies, $15 billion for nursing homes, and $8 billion for hospice providers. But it is $120 billion for Medicare Advantage—the program that more seniors, as they learn about it, want to sign up for, because it is an advantage to them to have their health care through a program which focuses on preventive care, coordinated care, and helps them stay healthy and live longer. Yet this Senate and this bill that Senator REID has brought to the floor is trying to completely gut that program and deny our seniors who rely upon it from receiving the care they have earned.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, I yield 5 minutes to the Senator from Wisconsin.

The PRESIDING OFFICER. The Senator from Wisconsin is recognized.

Mr. FEINGOLD. Mr. President, I rise in strong support of the Community Living Assistance Services and Supports Act, or CLASS Act, which was introduced by the late Senator Ted Kennedy. The CLASS Act would create an optional insurance program to help pay for home care and other assistance for adults who become disabled. Those choosing to participate would pay monthly premiums into an insurance trust, and after 5 years, could access a cash benefit if they become disabled and need assistance.

Over 10 million Americans are currently in need of long-term care, and that number is expected to rise to 15 million in the next 10 years. These individuals struggle to remain independent with limited assistance, and many turn to Medicaid as an insurer of last resort. In order to qualify, however, people need to go through a substantial ''spend down'' of their assets and commit to unemployment to remain eligible. Mr. President, this is totally inefficient. Instead of ensuring that an individual can remain an independent and functional member of society, the current policy requires that to receive assistance, a person basically becomes a ward of the State. Medicaid pays for half of long-term care costs and increased expenditures are expected to add $44 billion each year to Medicaid over the next decade. Not only is this unsustainable it is nonsensical.

This is as much about protecting people's dignity as it is about fiscal responsibility. Too many Americans fall on hard times, becoming disabled from an accident or illness, with no safety net to help them stay independent. Ensuring that these people have an alternative to Medicaid, so that they can remain active and independent, will reduce the Federal deficit by $73.4 billion over 10 years and save Medicaid $1.6 billion in the first 4 years benefits are available. Medicaid savings will continue to grow over time as more beneficiaries utilize CLASS Act benefits instead of Medicaid.

And thanks to amendments accepted in the Senate Health, Education, Labor, and Pensions Committee, the bill language is stronger than ever. Senator GREGG, my colleague on the Budget Committee, amended the bill to require the Secretary of Health and Human Services to set premiums that are actuarially sound for a 75-year window, and maintain sustainable enrollment and benefit structure. While some have suggested that the CLASS Act is fiscally not sound, the Gregg amendment should put those concerns to rest.

Long-term care reform has been a cornerstone of my work in public office since my days in the Wisconsin State Senate. I have seen how important it is to give people options so that they can match the level of care and assistance to their personal needs. Pushing anyone and everyone into Medicaid, or into a nursing home, is a waste of potential, a waste of opportunity, and a waste of money. Medicaid and our Nation's nursing homes have a critical role to play for some Americans. But for many Americans, it is simply not the right fit. The CLASS Act will ensure that taxpayer dollars are spent enrolling only those who truly need Medicaid into the program, and help others save for a time when they might need some assistance to remain independent. The CLASS Act is a critical part of this health reform bill, and I urge my colleagues to oppose any effort to weaken or strike this program from the bill.

I yield the floor.

Mr. DODD. Mr. President, the Senator from Rhode Island wants to be heard.

The PRESIDING OFFICER. The Senator from Rhode Island is recognized.

Mr. WHITEHOUSE. Mr. President, I will speak for just a moment because I know the Senator from Pennsylvania wishes to speak. When he comes to the floor, I will quickly yield to him. While there is a moment in between, I want

to speak to some of the arguments we have heard.

There is always the question of the substance of an argument. There is also the question of the credibility of an argument. I think as people watch this debate and discuss the credibility of the concern expressed by our friends on the other side of the aisle about the deficit impact of the CLASS Act, it is worth considering a few facts just to evaluate that.

First is that the CLASS Act is required to be actuarially self-sustaining. People pay into it and, from those funds, under the insurance principle, funds come back out. It is required to be self-sustaining that way.

Second, it is voluntary. Nobody has to contribute. If you want to contribute, then you can become eligible for the benefit once you have vested. But nobody is forced into this; it is entirely voluntary. The CBO, on which we rely in a nonpartisan fashion, has said this is solvent for 75 years.

Finally, because we think—at least on this side—this matters. It will help the disabled and elderly at that critical point of decision, when their ability to stay home, their ability to stay independent, or their ability to stay at work depends on just a little bit of help to accommodate their age or disability, it is then that this will make a difference. What a difference it will make in human lives.

I know the Senator from Connecticut wishes to use an example. I will yield to him on his signal. We have seen this before. We saw this not long ago on the public option, which would compete with insurers head to head on a fair and level playing field. It was completely voluntary, and it had to be actuarially self-sustaining. It had to meet the solvency laws of the State in which it operated. In both cases, our colleagues on the other side have rushed to the floor to talk about deficits and how these will contribute to the deficit.

These are both actuarially self-sustaining programs required to stay solvent. Yet here they come to raise the specter of deficits. But this is the same party that pays for 14-percent subsidies to private insurers to compete with Medicare. As my son would say, duh, if you are getting 14 percent extra, it is pretty easy to compete.

When they asked for that deal, they promised they would drive costs down. In fact, they have driven costs up, and they put it in their pockets. It is not fair to the insurers that are not in the program. It is greedy on their part. All we want to do is hold them to their promises.

Do we hear any concerns about the deficit problem on the 14-percent subsidy for the Medicare Advantage Program? No, dead silence—guess what—because it helps the insurance industry.

When the Part D program came in, our friends on the other side forced through a provision—a unique provision—that gave the pharmaceutical industry a special privilege that the U.S. Government could not negotiate with it over price—could not negotiate with it. Lord knows how much that has added to our deficit. But have they ever come to complain? No, because the beneficiary is the pharmaceutical industry. But when things help regular people, when things help competition in the insurance market, even where they are required to be actuarially self-sustaining and solvent, then suddenly they turn up. They can detect the threat of deficit in parts per billion when it helps somebody. But a patent, actual living, breathing, deficit-enhancing subsidy that is on the books right now, they don't care about if it helps the pharmaceutical industry or the insurance industry.

As we have this discussion, that is a point worth bearing in mind because it is not just the substance of the amendment, it is the credibility of the argument that counts.

I said I would yield to the distinguished Senator from Pennsylvania when he arrived, and he has arrived. Without further ado, I yield the floor.

Mr. CASEY. Mr. President, I thank my colleague from Rhode Island, Senator WHITEHOUSE, who has been among the more forthright and capable advocates of what we are talking about today, not only with regard to health care generally, but in particular what brings us to the floor at this moment, among several issues, but principally his work and the work over many years that Senator Kennedy did for the so-called CLASS Act, the Community Living Assistance Services and Supports Act.

What is this all about? I wish to talk for a couple of minutes about how it works. I think sometimes we get lost in the discussion about the finer points of a policy or program and we tend to forget what it means. Here is what it means. Here is what it means for an American who is working and wants to continue working to support his or her family or to support themselves, contribute to our economy, demonstrate that people who happen to live with a disability of one kind or another can be so significant in our economy, can contribute so much with their ability and their brain power and their ability to contribute in a very positive way.

We are talking about the dignity of work, whether the Senate is going to stand up and say: With this act, with this program for someone who happens to have a disability and wants to work and wants to voluntarily contribute premiums so they have some security, some peace of mind down the road if they should need this help, we are talking about the dignity of that work.

This is a test of the Senate, whether we are going to stand up for people who have a disability and their opportunity to work. It is a very simple question. You either stand with them or you do not.

It is also about one important word, I think—independence, whether we are going to say to someone who wants to work and has a disability, are they going to have the independence, the freedom to work and live the life they choose?

Here is how it works. This is not complicated. This is not some mysterious program. Here is how it works. Here is how they qualify to get these benefits. They qualify to receive benefits when they do three things. First, they need help with certain activities of daily living. We all know what those are. There are so many people out there who can work and can contribute if we give them a little help, just a little bit of help that we are talking about today to do the basic things in life—to be able to wake up in the morning and, if you have a disability, maybe have someone help you get ready for work, whether that is getting in the shower, shaving, whatever you have to do to get ready for work in the morning—activities of daily living, things that people who do not have disabilities take for granted. That is the first thing you have to have is that need that we can all understand.

Secondly, this person would have to pay premiums for at least 5 years before they could benefit from the program. I said ''premiums.'' I did not say a ''government subsidy.'' We are talking about premiums here, and this is a program that certainly has its origin in government, but this is not exactly similar to the Children's Health Insurance Program, for example, or Medicaid, where it is a government program that helps a particular person, a person who happens to have a disability or is a child. In this case, people are paying premiums, and they have to pay those premiums for 5 years.

In addition to the need and paying premiums, the third requirement is they have to work at least 3 of those 5 years. We are talking about people who are employed, working people who happen to have a disability. This is a creative program to help them do that.

Why do we get the opposition we do from across the aisle? I think it is pretty simple. We have a lot of folks across the aisle who want to kill this bill. So they are going to try to strike the CLASS Act, which is outrageous and insulting. They are going to try to strike whatever they can, if they can, to kill the bill. So this is a bill-killing exercise. This is not a debate about the finer points of the CLASS Act. This is a bill-killer exercise. It is very simple, and I think it will tell a lot about where people stand.

Let me go into a couple more details. I know we are almost out of time. Here is what happens to that beneficiary—a person working, a person who has a need, and a person who has paid premiums. That beneficiary receives a lifetime cash benefit based on the degree of impairment, not just any old formula. We want to make sure the benefit corresponds to someone's impairment, their inability to do their job or live their life the way they hope

to. It is expected to average about $75 a day or more in the case of an individual. That is what we are talking about here.

We are not talking about, in this case, a government entitlement program. Few people are as passionately supportive of the Children's Health Insurance Program or Medicaid as I am. I believe there are programs that are funded by the government, run by the government, that work very well. But in this case, we are not talking about that kind of a program. We are talking about a program that does not confer rights or an obligation on government funding, nor does it affect the receipt or eligibility for other benefits. The program stands on its own financial feet because people are paying premiums out of their own pocket for 5 years to save for that day when they have a need because they have some kind of disability. And it is solvent—solvent. It is a program that people sign up for voluntarily. It is a voluntary program.

When you line up all of the reasons to support this program that Senator DODD, as the chairman of our committee, the Health, Education, Labor, and Pensions Committee, this summer when we were debating this bill—he carried the ball for Senator Kennedy in the chairmanship of our committee and in our hearings and also for this program. I am grateful for his leadership and also grateful for Senator HARKIN's leadership to support this voluntary program. I am also grateful that Senator WHITEHOUSE has lent his voice and his expertise and his focus on getting this program as part of our health care reform bill.

It makes a lot of sense. It is solvent, and it will help those who have a disability who want to work, who want to go to work every day and live a full life.

Mr. President, I yield the floor.

Mr. DODD. Mr. President, I yield whatever time we may have remaining to Senator KIRK of Massachusetts, who has done an incredible job in very difficult circumstances—replacing our beloved former colleague Ted Kennedy from Massachusetts. He has been a valuable contribution over these days he has been here. I know he wishes to say a few words as well.

The PRESIDING OFFICER. The Senator from Massachusetts.

There is 3 minutes remaining.

Mr. KIRK. Mr. President, I thank Senator DODD and Senator BAUCUS for their tireless leadership on this entire health care bill.

I wish to say a word about the CLASS Act. We have heard Senator DODD and others say this is the core element of this health reform bill championed by Senator Edward Kennedy. I say if he were here today, he would say this is not about politics; this is about the content of the character of our Nation. He believed, as I do, and I know Senator DODD does, this Nation is judged or should be judged on how we treat the infirm and the weakest among us. This CLASS Act, as was eloquently pointed out by Senator CASEY of Pennsylvania, involves no taxpayer funds, is fiscally solvent, and does what everyone says we must do: provide independence, self-respect, and dignity to the infirm in our society.

Second, it keeps the caregivers and the loved ones from carrying that burden all by themselves and not having to sacrifice their jobs and their time and their heartache to share their children with perhaps one of their parents and dividing a family in that way.

This is at the heart of what our country should be about. It is not who wins—the Republicans or the Democrats. It is not a government program. It is self-funded. It is voluntary. There is no taxpayer money involved. So what other reason could there be but politics to keep people from coming together on this issue?

I urge my colleagues—all on this side and my Republican colleagues on the other side—to think about those families who are facing this plight. They are Republicans, they are Independents, and they are Democratic families as well. This is an American program for some veterans and others who have sacrificed.

I think the only thing we can do, the only right thing we can do, if this is going to be a reflection of the character of this Nation, is to support the CLASS Act.

I thank Senator DODD once again. I am proud to be standing at the desk of Senator Edward Kennedy who believed deeply in this issue, who started a long time ago and wanted to see it fulfilled this afternoon.

I yield the floor.

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

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

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

Mr. DODD. Mr. President, I am about to, on behalf of the majority leader, propound a unanimous consent request.

Mr. President, I ask unanimous consent that at 3:30 p.m. today, the Senate proceed to vote in relation to the following amendments and motion to commit, as listed in this agreement, with no other amendments, motions to commit, or any other motion except a motion to reconsider and table upon the conclusion of any vote, being in order during the pendency of this agreement; further, that prior to the second and succeeding votes, there be 2 minutes of debate, with all time equally divided and controlled in the usual form; that any amendment or motion covered under this agreement be subject to an affirmative 60-vote threshold, and that if any achieve that threshold, then it be agreed to and the motion to reconsider be considered made and laid upon the table; that if it does not achieve that 60-vote threshold, then it be withdrawn; that after the first vote in this sequence, the succeeding votes be 10 minutes in duration:

A Senator WHITEHOUSE amendment re: Social Security fiscal responsibility; the Republican leader's designee amendment re: fiscal responsibility; Senator STABENOW's side-by-side amendment re: Medicare Advantage; and Senator HATCH's motion to commit re: Medicare Advantage.

Further, that once this agreement is entered, the Republican leader's designee be recognized to call up the fiscal responsibility amendment; and that once it has been reported by number, Senator STABENOW be recognized to call up the Medicare Advantage side-by-side amendment; that upon disposition of the amendments and the motion in this agreement, the next two matters for consideration will be a Senator LINCOLN amendment regarding insurance executive compensation, and Republican leader's designee motion to commit regarding home health agencies; that for the remainder of today's session, no further amendments or motions to commit be in order, with the time until then being equally divided between the leaders or their designees, with Members permitted to speak up to 10 minutes each.

The PRESIDING OFFICER. Is there objection?

Mr. MCCONNELL. Mr. President, reserving the right to object, and I will not be objecting, I see the assistant majority leader on the Senate floor. I think it would be helpful, as soon as the majority leader or someone on that side can do so, to indicate at what point during the day tomorrow and at what point during the day on Sunday we might be having additional votes. It might be helpful to our colleagues on both sides of the aisle in terms of planning for the weekend.

The PRESIDING OFFICER. The majority leader.

Mr. REID. Mr. President, I would say through the Chair to my distinguished colleague, the senior Senator from Kentucky, that we are going to come in at 10 in the morning. At this time, it appears Senator LINCOLN will be offering an amendment, and I would hope we can be ready at that time to have whatever the minority wants to do in regard to that amendment. Then we are going to have an amendment offered by the Republicans. I would hope that we can dispose of those two amendments tomorrow, maybe in the early afternoon—maybe 2:30 or 3 o'clock start voting on them.

Mr. MCCONNELL. So am I correct in assuming that the votes are most likely going to be in the afternoon tomorrow, or both morning and afternoon?

Mr. REID. In the afternoon. I think we will need some debate in the morning.

Then Sunday morning, at the request of the Republican leader, we are not going to come in until noon, or thereabouts.

Mr. MCCONNELL. I think we are going to need some debate time. Oh, we will have that in the afternoon.

Then on Sunday, obviously, we would not go in until noon on Sunday, and the votes will be——

Mr. REID. There is an event in Washington that a number of Senators are obligated to go to that is in the evening, so we will get everybody out of here by 6, 6:30 that night, at the latest.

I would also say, Mr. President, through the Chair to my friend, that we Democrats are going to have a caucus—tentatively scheduled to have one Sunday afternoon.

The PRESIDING OFFICER. Is there objection to the request?

Hearing no objection, it is so ordered.

The Senator from South Dakota.

AMENDMENT NO. 2901 TO AMENDMENT NO. 2786

Mr. THUNE. Mr. President, I would like to call up amendment No. 2901 and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report the amendment.

The bill clerk read as follows:

The Senator from South Dakota [Mr. THUNE] proposes an amendment numbered 2901 to amendment No. 2786.

The amendment is as follows:

(Purpose: To eliminate new entitlement programs and limit the government control over the health care of American families)

Beginning on page 1925, strike line 15 and all that follows through line 15 on page 1979.

Mr. THUNE. Mr. President, I want to speak to the amendment that we just filed at the desk. This amendment is very straightforward and very simple. It does what a number of my colleagues on the other side have asked to do, and that is to strike the CLASS Act from the underlying health care reform bill that is being debated on the floor of the Senate right now.

I want to read some excerpts from a letter that seven Democratic Senators, including the chairman of the Senate Budget Committee, Senator CONRAD, put together asking that this CLASS Act not be included as part of this legislation.

Mr. President, I ask unanimous consent to have printed in the RECORD the letter from which I will be quoting.

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

U.S. SENATE,
Washington DC, October 23, 2009.

Hon. HARRY REID,
Majority Leader, The Capitol, Washington, DC.

DEAR LEADER REID: We write regarding the merger of the Finance and HELP Committee health reform bills. We know you face a great many difficult decisions now, one of which is whether to include provisions from the HELP Committee bill known as the CLASS Act in the merged bill.

We urge you not to include these provisions in the Senate's merged bill, nor to use the savings as an offset for other health items in the merger.

While the goals of the CLASS Act are laudable—finding a way to provide long term care insurance to individuals—the effect of including this legislation in the merged Senate bill would not be fiscally responsible for several reasons.

CBO currently estimates the CLASS Act would reduce the deficit by $73 billion over ten years. But nearly all the savings result from the fact that the initial payout of benefits wouldn't begin until 2016 even though the program begins collecting premiums in 2011. It is also clear that the legislation increases the deficit in decades following the first ten years. CBO has confirmed that the legislation stand-alone would face a long-term deficit point of order in the Senate.

Some have argued that the program is actuarially sound. But this is the case because premiums are collected and placed in a trust fund, which begins earning interest, and because the HHS Secretary is instructed to increase premiums to maintain actuarial solvency. We have grave concerns that the real effect of the provisions would be to create a new federal entitlement program with large, long-term spending increases that far exceed revenues. This is especially the case if savings from the first decade of the program are spent on other health reform priorities.

Slowing the growth of health care costs should be a top priority as we move forward with health reform. Inclusion of the CLASS Act would reduce the amount of long-term cost savings that would otherwise occur in the merged bill. The CLASS Act bends the health care cost curve in the wrong direction and should not be used to help pay for other health provisions that will become more expensive over time and increase deficits.

Thank you for your consideration. We hope that fiscally responsible measures to improve access to long-term care can be considered in the future.

Sincerely,

KENT CONRAD.
JOE LIEBERMAN.
MARY L. LANDRIEU.
EVAN BAYH.
BLANCHE L. LINCOLN.
E. BENJAMIN NELSON.
MARK R. WARNER.
U.S. Senators.

Mr. THUNE. Mr. President, the letter said:

We urge you not to include these provisions in the Senate's merged bill, nor to use the savings as an offset for other health items in the merger. While the goals of the CLASS Act are laudable—finding a way to provide long term care insurance to individuals—the effect of including this legislation in the merged Senate bill would not be fiscally responsible for several reasons.

The letter goes on to say:

[N]early all the savings result from the fact that the initial payout of benefits wouldn't begin until 2016 even though the program begins collecting premiums in 2011. It is also clear that the legislation increases the deficit in decades following the first 10 years.

They go on to say in this letter, Mr. President:

We have grave concerns that the real effect of the provisions would be to create a new Federal entitlement program with large, long-term spending increases that far exceed revenues. This is especially the case if savings from the first decade of the program are spent on other health reform priorities.

That, Mr. President, is a letter that was signed by the chairman of the Senate Budget Committee, Senator CONRAD of North Dakota, Senator LIEBERMAN, Senator LANDRIEU, Senator LINCOLN, Senator WARNER, Senator NELSON, and Senator BAYH. Seven Democratic Senators have gone on the record saying the CLASS Act shouldn't be included in this legislation because it is not fiscally responsible.

The fact is, the chairman of the Senate Budget Committee, Senator CONRAD, has described this as a Ponzi scheme of the first order—something that Bernie Madoff would be proud of.

Now, I have heard my colleagues get up and talk about how solvent this is and what a great program this is. Well, there are programs out there that are available for people to buy long-term care insurance. The problem with this one is that it takes all the money that comes in in the early years and spends it on other government programs—in this case health care reform—but who knows what other government programs are going to be created that will use the revenues that come in from this plan that supposedly a lot of people are going to sign up for, and CBO says it is going to be fewer than 4 percent that will sign up.

In fact, no senior today is going to benefit from it because you have to work for 5 years. If you are a senior who is retired, you will not see any benefit. This doesn't impact seniors, contrary to the assertion of some of my colleagues on the other side. It will impact future generations of Americans who are going to be stuck with the deficits and the debt that gets piled on them because of the outyears when this liability is incurred as people start getting paid out, from having paid in, and there is no money there. It is the classic definition of a Ponzi scheme: The money comes in today, it gets spent on other things, and then someday, when the liability comes in and people start saying: I paid into this program, and I should get some benefit, there will be no money there. So we will borrow for it or tax for it or something else.

They say, well, it is actuarially solvent over 75 years. Well, maybe, because you are running surpluses in the early years. But in the later years, you are running huge deficits. In the early years the surpluses are being spent. They are not being put into paying benefits for this program, when those benefits start being demanded by the people who have participated in the program.

Just look at what others have said about this program, Mr. President. I have quoted for you what the chairman of the Budget Committee, Senator CONRAD, said with regard to this program; that it is a Ponzi scheme of the first order, and that is being echoed by others. But this is what the administration's chief health actuary said about the CLASS Act. He said it would result ''in a net Federal cost in the longer term.'' The chief actuary also determined the program faces ''a significant risk of failure'' because the high cost will attract sicker people and lead to low participation.

The Congressional Budget Office agreed, saying:

The CLASS program included in the bill would generate net receipts for the program in the initial years when total premiums would exceed total benefit payments, but it would eventually lead to net outlays when benefits exceed premiums. . . . In the decade following 2029, the CLASS program would begin to increase budget deficits.

This particular quote could come as a bit of a surprise because this comes not from the CBO or the CMS actuary, but it comes from the Washington Post. The Washington Post called the CLASS Act a ''gimmick'' ''designed to pretend that health care is fully paid for.'' The Post goes on to say:

[T]he money that flows in during the 10 year budget window will flow back out again. These are not ''savings'' that can honestly be counted on the balance sheet of reform.

Even the Washington Post recognizes this for what it is. It is a sham. This is a budget gimmick, Mr. President, that is designed to obscure the cost of this program by generating surpluses in the early years. It is supposed to generate $72 billion in the first 10-year window, so that counts on the balance sheet of health care reform to make it look better. But this program is going to run deficits—deficits as far the eye can see—once the chickens come home to roost. Who will pay the bill for that? Future generations of Americans.

Mr. President, this is not good policy. Certainly, if you look at programs we already have on the books, Medicare is destined to be bankrupt in the year 2017. We have big problems down the road—unfunded liabilities in Social Security. This would create a huge new liability down the road that would be unfunded because all the money that comes in during the early years is going to be spent. This is more of the same old business as usual in Washington, DC, that the American people are fed up with. We can make people happy today by saying we are creating this new program that makes the majority's health care reform bill look better because it obscures the real cost of this bill by rolling in these revenues in the early years. But there is a long-term impact, according to the CBO, according to the actuary at Health and Human Services, and according to a lot of our colleagues on the other side—the seven Democrats who signed the letter, including the chairman of the Budget Committee, who, as I said, has called this program a Ponzi scheme of the first order; something that would make Bernie Madoff proud.

I don't know how my colleagues on the other side, with a straight face, can come to the Senate floor and say this is a great program, that it is actuarially sound. Sure, it may be a benefit to a few people, but I have to tell you, somewhere down the road, when the chickens come home to roost, there is going to be a huge liability that is going to be facing future taxpayers, future generations of Americans, as we start to pile up more deficits and more debt as a result of this Ponzi scheme.

This is a sham, Mr. President. I hope my colleagues will support this amendment. It would strike the CLASS Act from the underlying bill, not allow those revenues to be assumed in paying for or understating the cost of this bill, and not pile mountains of debt onto future generations.

Mr. President, I reserve the remainder of my time.

Mr. KYL. Mr. President, the Community Living Assistance and Services and Supports Act, known as the CLASS act, is a new, government-run, government-funded program for longterm care, intended to compete with long-term care plans provided by private insurers.

One of the oft-repeated arguments we have heard in favor of the CLASS act is that it would reduce budget deficits between 2010–2019.

First, when has a government program ever reduced budget deficits?

Second, the Congressional Budget Office tells us that this program will actually add to future Federal budget deficits. The CBO writes: ''The program would add to future federal budget deficits in large and growing fashion.''

Why would it do this?

The program offers returns that payments made into the system cannot cover—just like a Ponzi scheme, as Senator CONRAD said. Participants would have to pay into the system for five years before they start collecting benefits. Under the Senate proposal, only active workers could enroll in the program. So this would not be a program that would not benefit seniors or the currently disabled. So, if a worker began making payments in 2011, he or she could not collect benefits until 2016. So, for a time, the program would generate surplus receipts for the government while Americans are paying in and not collecting benefits. But eventually, we will reach a point when payments made into this program cannot sustain promised benefits.

As the CBO tells us, the program would ''lead to net outlays when benefits exceed premiums.'' (By the third decade of program operation—2030–2039—CBO assumes that CLASS begins to generate net increases in Federal outlays. The net increase in Federal outlays is estimated to be ''on the order of tens of billions of dollars for each (succeeding) ten-year period.''

CBO notes that the increase in net Federal outlays which will begin to occur after 2029 results despite the requirement that premiums be set to ensure the program's solvency over 75 years. The solvency requirement counts interest income paid to the program's trust fund as available to pay future benefits. However, CBO notes that those interest payments are an intra-governmental transfer within the Federal budget. Thus, CBO notes that from a budget scorekeeping perspective, the CLASS program would inevitably add to future deficits (on a cash basis) by more than it reduces deficits in the near term, even though the premiums would be set to ensure solvency of the program.

The administration's chief health actuary said the CLASS Act would result in ''a net federal cost in the longer term.''

Bottom line, this program is not sustainable outside the 10-year window.

That is why the Washington Post called it, ''a gimmick . . . designed to pretend that healthcare is fully paid for.''

The Post goes on:

Money that flows in during the 10–year budget window will flow back out again. These are not 'savings' that can honestly be counted on the balance sheet of reform.

Mr. DODD. Mr. President, how much time remains?

The PRESIDING OFFICER. There is 19 minutes remaining; on the Republican side, 10½.

Mr. DODD. Mr. President, I see my colleague from Minnesota. Does he wish to be heard? How much time does my colleague need?

Mr. FRANKEN. I thank the Senator. I need 3 minutes.

Mr. DODD. Take 4.

Mr. FRANKEN. I will use it.

The PRESIDING OFFICER. The Senator from Minnesota.

Mr. FRANKEN. Mr. President, I rise today to ask unanimous consent to be added as a cosponsor to the amendment of Senator COBURN, amendment No. 2789, to require all Members of Congress to enroll in the public option. I am pleased to cosponsor this amendment because I strongly support the public option and I will have no qualms at all enrolling in this plan.

There is a lot of misinformation about the public option, so I want to be clear about why we need a public option and why I would be proud to enroll in a public health insurance plan.

We need a public option because health insurance premiums for Minnesota residents have risen 90 percent since 2000 and because 444,000 Minnesotans went without health insurance in 2008. We need a public option because, while millions of Americans struggle to pay for health care, insurance executives continue to make bloated, obscene salaries. From 2000 to 2007, American families saw their premiums almost double. During that same time, we saw more than 6 million more Americans become uninsured. During that same period, insurance companies' profits rose 428 percent—428 percent in 8 years. They are making outrageous profits by gouging American families. That is why we need a public option.

The public option will offer affordable premiums and a comprehensive benefits package for Americans struggling with their health care costs. It is going to provide the kind of coverage Americans need to be healthy. The public option will foster competition among private health insurance companies and lower long-term costs for Minnesotans and for families all across the country. There is no cost for the public option to the Treasury. In fact, CBO estimates it saves $3 billion. It is a win-win situation.

It is important to remember that a public option doesn't mean private health insurance goes away. In fact, after health reform, 188 million Americans will have coverage through a private insurer. Only 2 percent of the overall insured population is projected to enroll in the public option. This is just another option you will have. It is an option because that is what the bill is about.

Mr. BROWN. Will the Senator from Minnesota yield?

Mr. FRANKEN. Absolutely.

Mr. BROWN. I know my colleague joined with Senator DODD, Senator MIKULSKI, and me to push this amendment that Members of the House and Senate actually go on the public option, partly to show we believe in it. It is a little curious that two of the sponsors, at least, Senator COBURN and Senator VITTER and some others, are so much against the public option that they want to pass this amendment. It sounds to me as if the Senator is serious about going on it, as I am, correct?

Mr. FRANKEN. I talked to my wife Franni. We have been married 34 years now. I talked to her a couple of weeks ago. I said if this passes, we should do the public option. She said, absolutely. Yes, I am perfectly serious about this.

The PRESIDING OFFICER (Mr. REED). The Senator from Minnesota has consumed 4 minutes allotted by the Senator from Connecticut.

Who yields time?

Mr. GRASSLEY. I yield 5 minutes to the Senator from Utah, Mr. HATCH.

The PRESIDING OFFICER. Without objection, the request of the Senator from Minnesota to be added as a cosponsor of the Coburn amendment is ordered.

The Senator from Utah is recognized.

Mr. HATCH. Mr. President, we are talking right now about a program that was well thought out, that was meant to help the poor and minorities. It was a bipartisan effort by Democrats and Republicans, and has worked amazingly well and is available to all recipients of Medicare.

Medicare Advantage came about in a bipartisan way to solve real problems. We were not getting health care to rural America. We were not getting health care, in many respects, to some of the poorer, some of the minority folks in our country.

I want to read a special letter here. Let me read this letter. I know it may have been read before, but I am going to read it again. It is dated September 30, 2003. ''Dear Medicare Conferees.'' I happened to be a member of that conference. I was one of those in there who led the fight for Medicare Advantage.

We are writing to ask you, as a member of the Medicare conference committee, to ensure the final Medicare bill includes a meaningful increase in Medicare+Choice—

That is the predecessor to Medicaid Advantage—

funding in fiscal years 2004 and 2005. While the Senate bill makes a modest step toward this goal, we hope the stronger provisions in the House bill will be preserved in conference.

For nearly 5 million Medicare beneficiaries across America, Medicare+Choice [the predecessor] is an essential program that provides high quality, comprehensive, affordable health coverage. These seniors and disabled Americans have voluntarily chosen to receive their health coverage through Medicare HMOs and other private plans because of their excellent value. To preserve this important option for seniors across the country, bipartisan legislation was introduced in the Senate as S. 590, the ''Medicare+Choice Equity and Access Act.''

That became Medicare Advantage.

Co-sponsored by Senators Schumer and Santorum, S. 590 sought to increase reimbursement rates and add new reimbursement options for Medicare+Choice programs.

It goes on to make a compelling case for what came from that conference as Medicare Advantage, and that was utterly pleasing to everybody who signed this letter.

By the way, let me just mention the Democrats who signed this letter, who wanted Medicare Advantage: JOHN KERRY, ARLEN SPECTER, DIANNE FEINSTEIN, JOE LIEBERMAN, PATTY MURRAY, CHARLES SCHUMER, FRANK LAUTENBERG, Hillary Rodham Clinton, RON WYDEN, Mark Dayton, MARY LANDRIEU, MARIA CANTWELL, and CHRISTOPHER DODD. Fourteen Democrats signed this letter, along with a number of bipartisan Republicans, who believed we really needed to include Medicare Advantage.

Now, to take advantage, our colleagues on the other side want to do away with Medicare Advantage, except in 3 States that are, for the most part, Democratic States, leaving all the other 46 States high and dry.

Let me just say that this letter is in response—it was a letter given to the Medicare modernization conference committee. This conference committee gave them everything they wanted for Medicare Advantage. This legislative grant of power gave the signatories the Medicare Advantage Program, which now 11 million senior citizens enjoy today.

Now those on the left want to do away with this important program that benefits seniors and minorities in an amazing set of ways. I am against that effort. I hope our colleagues on the other side will realize what they are doing. It just is not right. Vision care and dental care and so many other approaches that really work for this program will be taken away from these people. They are going to have to spend $175 to $200 a month to get what they got for an average of about $54 a month. These are people who need our help.

Let me change the subject for a minute because I understand my colleague from Oregon was discussing Medicare Advantage and talking about some Medicare Advantage companies living ''high off the hog'' and inferring that is a rationale for $120 billion in Medicare Advantage cuts. I have two responses to my colleague from Oregon. This is not about Medicare Advantage insurance companies, this is about preserving the choice of coverage for seniors.

The PRESIDING OFFICER. The Senator from Utah has used 5 minutes.

Mr. HATCH. I ask for another 2 minutes.

Mr. DODD. How much time remains for both sides?

The PRESIDING OFFICER. The Senator from Iowa controls 4 minutes 46 seconds; the Senator from Connecticut, 4 minutes 42 seconds.

Mr. DODD. The Senator has 4 minutes.

Mr. HATCH. He also said that under the Reid bill, Medicare Advantage beneficiaries will be able to keep what they have. You know, he is right about some Medicare Advantage beneficiaries being able to keep what they have due to the Nelson grandfathering amendment passed by the Senate Finance Committee this fall. But those protections primarily apply to Medicare Advantage beneficiaries in Florida, Oregon, and New York—beneficiaries living in other parts of the country. Rural areas will not be protected.

So let's be clear when we say Medicare Advantage beneficiaries' benefits will not be cut. These extra benefits include lower premiums, deductibles, and copayments, dental coverage, and hearing aids, to name only a few.

Bottom line: Most Medicare Advantage beneficiaries may not keep what they have, contrary to the President's promise to them.

The PRESIDING OFFICER. Who yields time?

Mr. DODD. Mr. President, I yield 4 minutes to the Senator from Michigan.

The PRESIDING OFFICER. The Senator from Michigan is recognized for 4 minutes.

AMENDMENT NO. 2899 TO AMENDMENT NO. 2786

Ms. STABENOW. Mr. President, I have an amendment that will be sent to the desk pursuant to the unanimous consent agreement. I now call up my amendment No. 2899.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Michigan [Ms. STABENOW] proposes an amendment numbered 2899 to amendment No. 2786.

Ms. STABENOW. I ask unanimous consent that the reading of the amendment be dispensed with.

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

The amendment is as follows.

(Purpose: To ensure that there is no reduction or elimination of any benefits guaranteed by law to participants in Medicare Advantage plans)

At the appropriate place, insert the following:

SEC. ___. NO CUTS IN GUARANTEED BENEFITS.

Nothing in this Act shall result in the reduction or elimination of any benefits guaranteed by law to participants in Medicare Advantage plans.

Ms. STABENOW. Mr. President, this is a very important amendment to

clarify, once again, that we are not cutting any Medicare benefits. We are not cutting any of the guaranteed Medicare benefits people receive right now. In fact, AARP, which has been saying this on its Web site for months, has released a letter now. It quotes this sentence:

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

Not only AARP but the Association for the Protection of Medicare and Social Security, the Alliance for Retired Americans, and other seniors organizations all agree.

What we are talking about is saving Medicare, cutting down on overpayments that have been in place. Right now, 80 to 85 percent of the seniors who get their benefits, their health care, through traditional Medicare are paying more in premiums, according to the Congressional Budget Office, than they otherwise would, because MedPAC estimates we are paying about $12 billion more for people in the private for-profit insurance system right now that is called Medicare Advantage. The majority of seniors are subsidizing high insurance company profits and overpayments. What we have done in this bill is take out the overpayments and, in fact, put in competition, competitive bidding. I thought that was something our colleagues on the other side of the aisle supported—competitive bidding for reimbursements so we are not continuing the overpayments in Medicare Advantage that are causing Medicare to go broke much sooner and causing the majority of seniors to subsidize high insurance company profits.

What we are seeing on the effort, unfortunately, of my friends on the other side of the aisle is an effort to support huge subsidies instead of supporting competitive bidding that is in the bill.

The reality is that the guaranteed benefits—inpatient care, doctor visits, lab tests, preventive screenings, skilled nursing facilities, hospice care, home health care, prescription drugs, ambulance services, durable medical equipment, emergency room care, kidney dialysis, outpatient mental health care, occupational and physical therapy, imaging such as x-ray, EKGs, organ transplants, and the ''Welcome to Medicare'' physical are all covered, as they have been, for all Medicare beneficiaries.

What we are doing is taking overpayments to for-profit insurance companies and putting that back into increased benefits for every senior. That is cutting down on prescription drug costs by closing the doughnut hole and strengthening preventive care. And the most important piece of all: lengthening the solvency of the Medicare trust fund.

I urge the adoption of my amendment at the appropriate time.

The PRESIDING OFFICER. Who yields time?

Mr. GRASSLEY. Mr. President, I yield 2 minutes to the Senator from Florida.

The PRESIDING OFFICER. The Senator from Florida.

Mr. LEMIEUX. Mr. President, I have been reviewing the amendment of the Senator from Michigan. This is very important to the people of Florida because it deals with Medicare Advantage. Medicare Advantage is a very important program. It is not just some extra frills. It is the idea that our folks in Florida can get eye care, dental care, hearing care, diabetic supplies, preventive medicine. Last week I went down to a Medicare Advantage clinic in Miami, the Leone Center. This is a place where seniors are getting holistic health care. The intention of this amendment is to guarantee the benefits in Medicare Advantage, but I am not sure it is phrased that way. I have been reading the bill. I have been reading Title XVIII of the Social Security Act. I cannot find the phrase ''guaranteed benefit.'' I ask unanimous consent that the ''guaranteed by law'' phrase in this amendment offered by my colleague from Michigan be eliminated so that we would ensure that benefits of eye care, dental care, preventative care, diabetic supplies, all the other things that are provided in Medicare Advantage, are actually preserved. No one is objecting to lower costs. No one is objecting to a competitive situation where we have companies providing more services for less cost. We want to make sure the services are still there.

I ask unanimous consent to have that phrase ''guaranteed by law'' be eliminated from the amendment.

The PRESIDING OFFICER. Is there objection?

Ms. STABENOW. Reserving the right to object, I ask that my colleague work with me. We will be happy to talk about how we might address what he is concerned about. Unfortunately, the reality is, the for-profit companies are objecting to competitive bidding. The language my colleague has suggested would include items that have been offered to the in people in for-profit plans such as gym memberships and other things that have been of great concern. Given that, I would have to object.

The PRESIDING OFFICER. Objection is heard.

The time of the Senator from Florida has expired.

Mr. HARKIN. Mr. President, I yield 3 minutes to the Senator from Ohio.

The PRESIDING OFFICER. The Senator from Ohio.

Mr. BROWN. I have watched from my office on C–SPAN and been on this floor countless times in the last 3 or 4 days as my friends on the other side continue to do the bidding of the insurance companies. I hear them talk about Medicare Advantage, how great it is. I was in the House of Representatives 10 years ago when Medicare Advantage began, when the insurance companies said: We can save Medicare 5 percent on all its costs by bringing forward Medicare Advantage. Then when the Republicans took control of everything, that savings of 5 percent, the insurance companies decided, no, we can't save 5 percent anymore. We need a 13-percent bonus. The chickens have come home to roost for the insurance companies, for good and bad.

I refer to a Dow Jones story entitled ''Humana 3rd Quarter Profits Up 65%, See Strong Medicare Advantage Gains.''

Let me excerpt from the first few paragraphs.

Humana Inc.'s third-quarter earnings rose 65% amid improved margins at its government (i.e. Medicare Advantage) segment. The company gave an initial 2010 forecast in which the health insurer projects ''substantial'' Medicare Advantage membership growth, resulting in revenue of $32 billion to $34 billion—well above analysts' average estimate of $29.63 billion. Humana's forecast takes into account reductions in Medicare Advantage over-payments.

As the Senator from Rhode Island knows and the Presiding Officer and my colleagues who have been strong supporters of Medicare, when we see people who have opposed Medicare, opposed the creation of Medicare 40 years ago, tried to privatize Medicare with Speaker Gingrich down the Hall in the House of Representatives a dozen years ago, now they are Medicare's biggest defenders? I don't think so. They have been the insurance industry's biggest defenders. That is what the debate the last 3 days was all about. What is important is we guarantee Medicare services, as we will. We quit subsidizing insurance companies, as we should. And then that $90 tax every Medicare beneficiary has to pay, that $90 that goes to insurance subsidies, will be taken away so Medicare fee-for-service, regular Medicare members, which is 81, 82, 83 percent of Medicare beneficiaries, won't be paying that insurance company Republican tax they have had to pay ever since Medicare Advantage subsidies to insurance companies were increased.

We need to get this bill moving. The stalling and delays should be over.

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

Mr. HARKIN. Parliamentary inquiry: How much time remains?

The PRESIDING OFFICER. The Senator from Iowa controls 6 minutes 45 seconds, and the Senator from Iowa controls 2 minutes 24 seconds.

Mr. GRASSLEY. I yield 1 minute to the Senator from Tennessee.

The PRESIDING OFFICER. The Senator from Tennessee.

Mr. CORKER. Mr. President, it was interesting to hear my friend from Ohio. I plan to support the Hatch amendment regarding Medicare Advantage, but it is not because I don't believe we need to do some things to cause Medicare to be more solvent. I do believe that Medicare Advantage does have some subsidies to insurance companies that are higher than they should be. The fact is, this bill is taking money from a program that is insolvent, Medicare, and using that to create an entitlement. I will support the Hatch amendment, even though I would love to work with my friends on the other side of the aisle to do those

things, to make Medicare more solvent, but I think what is so objectionable to all of us is to know that we have an insolvent Medicare Program that the trustees have said will be bankrupt in the year 2017, and my friends on the other side of the aisle are taking money from that program to leverage a new entitlement.

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

Who yields time?

Mr. HARKIN. I yield 2 minutes to the Senator from Illinois.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Mr. President, this is a basic choice. Will we continue to subsidize private health insurance companies that are overcharging the Medicare Program by 14 percent? Will we take that money out of Medicare to continue the subsidy for profitable private health insurance companies? It is that basic. I say to the Senator from Tennessee, the Congressional Budget Office tells us, yes, untouched, the Medicare program in 7 or 8 years faces insolvency. But this bill adds 5 years of solvency to Medicare right off the top—something he won't acknowledge but he should. Let me also add, if we are going to bring down the cost of Medicare so that recipients get quality care, we have to get rid of these outrageous subsidies to private health insurance companies, the Medicare Advantage Program. We also have to be honest about those providers overcharging Medicare. Why does it cost twice as much in Miami for the same service that is given to Medicare patients in Rochester, MN? It should not. Somebody is ripping off the system. If we can't ask those honest questions, then I am afraid we will not put Medicare on sound financial footing. We can do that. But we can't do that by saying: We have got to continue to subsidize private health insurance companies out of Medicare. That is the Hatch amendment. That is what we should vote against.

I yield the floor.

The PRESIDING OFFICER. Who yields time?

Mr. HARKIN. How much time do I have remaining?

The PRESIDING OFFICER. The Senator has 5 minutes.

Mr. HARKIN. I yield 2 minutes to the Senator from Rhode Island.

Mr. WHITEHOUSE. Mr. President, those of us who have been privileged to hear our friends on the other side debate the public option have seen a relentless insistence on the public option operating on a level playing field with the private insurance industry. I can't tell the number of times we have heard that. Indeed, even when we designed the public option so that it did operate on a level playing field with the private insurance industry, they still complained. But now we have a situation in which we have private industry operating at a 14-percent advantage and subsidy against Medicare. Suddenly, the other side's interest in a level playing field has evaporated. Suddenly their interest is in doing what is, once again—in the astonishing coincidence that characterizes debate—in the interest of the insurance industry.

I have yet to see an argument made from the other side of the aisle that doesn't happen to coincide with the interests of the insurance industry. It could not be more stark on this point. If it is a public option, they want it to compete on a level playing field. And even then they are against it. If it is privately subsidized coverage, getting an advantage against the public system, then they are for it.

I urge consistency and support of the effort to bring some discipline to Medicare Advantage, as the private insurance industry promised. We are doing no more than holding them to their word.

The PRESIDING OFFICER. Who yields time?

Mr. GRASSLEY. I yield the balance of my time to the Senator from Texas.

Mrs. HUTCHISON. I yield 30 seconds to Senator MCCAIN.

The PRESIDING OFFICER. The Senator from Arizona.

Mr. MCCAIN. Mr. President, I understand the Senator from Pennsylvania, Mr. CASEY, filed an amendment designed to spend $2.5 billion to protect Medicare Advantage benefits for Pennsylvanians. What is going on? What is going on here? Why can't we protect every citizen? That is five States that are ''protected'' and spending extra billions of dollars. Let's have an amendment that every State is treated the same. Let's do that. I tell my colleagues, I intend to introduce an amendment that will do so. That will take away the special exceptions that are taken for special States to have special influence around here.

Mrs. HUTCHISON. Mr. President, to put this in perspective, when I hear all of this debate, it is as though everything has to be more government, bigger government, government is better than the private sector. Medicare Advantage is an option. It is not a mandate. It is an option that allows seniors another choice to get eye care, hearing aids. Let's let seniors have this option. Let's not cut it away from them. We need more competition, not less.

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

Who yields time?

Mr. HARKIN. How much time do I have remaining?

The PRESIDING OFFICER. There is 2½ minutes.

Mr. HARKIN. Mr. President, it was interesting to hear the last speaker say: Don't take away the option for seniors in Medicare Advantage. Yet they have an amendment to take away the option for people who buy insurance against having a disability so they can stay in their own homes and have support. It is voluntary. It is not mandatory. No one is forcing them to do anything, I say to my friend from Texas. Yet there is an amendment on that side to take away that voluntary program, the CLASS Act, so that people can voluntarily put money into it to protect themselves against a future disability. Let's kind of keep our arguments a little bit straight.

A lot of people have talked about Medicare Advantage. I will not close the argument on that. I will close on the necessity of keeping the CLASS Act in this bill. I have spoken many times about that. It is not a partisan issue. It is like when we passed the Americans with Disabilities Act. It was not a partisan issue. This should not be a partisan issue too. We should not let politics get involved. Over 275 groups representing people with disabilities of all ages, from AARP to Paralyzed Veterans of America to the Interfaith Coalition, support the CLASS Act. It was unanimously adopted by the HELP Committee, unanimously adopted by Republicans and Democrats. Senator GREGG offered an amendment to insist that it be actuarially sound over 75 years, and it is actuarially sound over 75 years.

Secretary Sebelius said the administration supports it. President Obama supports it. There is broad-based support for the CLASS Act.

Today we received some letters from people around the country. I don't have time to read them all but just a couple. Here is one from Arkansas:

> My wife has a journalism degree, cerebral palsy and brings money to the state of Arkansas with her stay at home job with occasional travel. If her health worsens she could still earn money for the state under the CLASS Act working from home with the assistance from an attendant, [rather than having to go to a nursing home.]

Here is Virginia:

> I don't currently need the services under the CLASS Act, but having been born with a disability I've always been acutely aware of the possibility of serious issues down the road . . . it would be a good thing for me, a thirty-year-old working person, [to be able to put some money away.]

I beg my colleagues, for the sake of people with disabilities, let's not adopt the amendment of the Republicans to take away the CLASS Act. It was Senator Kennedy's premier goal.

Mr. GRASSLEY. Mr. President, I take a back seat to no one on issues associated with improving the lives of seniors and the disabled.

As ranking member on the Aging Committee, I oversaw critical hearings into deep and persistent problems in our Nation's nursing homes. I was the principal author of the Medicare Part D prescription drug bill which is currently providing our seniors and people with disabilities with affordable prescription medications.

On the disability front, one of my proudest achievements is the enactment of legislation I sponsored along with the late Senator Ted Kennedy, the Family Opportunity Act, which extends Medicaid coverage to disabled children.

In large part, through my efforts, the Money Follows the Person Rebalancing

Act, and the option for States to implement a home- and community-based services program were included in the Deficit Reduction Act of 2005.

Along with Senator KERRY, I have introduced the Empowered At Home Act which, among other things, revises the income eligibility level for home- and community-based services for elderly and disabled individuals.

If I thought that the CLASS Act would add to this list of improvements to the lives of seniors or the disabled, I would be first in line as a proud cosponsor of the CLASS Act.

But the CLASS Act does not strengthen the safety net for seniors and the disabled.

The CLASS Act compounds the long-term entitlement spending problems we already have by creating yet another new, unsustainable entitlement program.

The CLASS Act is just simply not viable in its current form.

It is almost certain to attract the people who are most likely to need it—this is known as adverse selection.

That will cause premiums to increase and healthier people to drop out of the program.

It is the classic ''insurance death spiral.''

On November 13, the administration's own Chief Actuary confirmed this. The Chief Actuary issued a dire warning in a report on the CLASS Act in the House bill which is virtually identical to the Senate version.

The Chief Actuary said:

There is a significant risk the problem of adverse selection would make the CLASS program unsustainable.

The CLASS Act has been characterized by the Washington Post editorial page as a ''gimmick.''

For the first 10 years, the CLASS Act saves money at the beginning because it collects premiums before benefits start getting paid out.

But sometime afterwards, it starts to lose money.

We all know what happens from there. It will become the taxpayers' responsibility to rescue the program as it fails.

Look at the financial struggles of Social Security. Look at Medicare. Look at Medicaid.

Now go home and look at your children and grandchildren.

Voting to protect the premiums of a program that you know will fail is irresponsible.

Creating the unsustainable CLASS Act is irresponsible.

Adding the ticking timebomb of yet another unfunded liability to our children and grandchildren through the CLASS Act is irresponsible.

The responsible vote is to strike the CLASS Act from the bill; I urge my colleagues to support this amendment.

Mr. President, I ask unanimous consent to have printed in the RECORD two items. First is an article from Fortune magazine on the CLASS Act. Second is a letter signed by seven of my Democratic colleagues objecting to the CLASS Act.

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

[From Fortune Magazine, Sept. 3, 2009]

THE CRAZY MATH OF HEALTH-CARE REFORM

(By Shawn Tully)

Embedded in the health-care plan moving forward is a truly gravity-defying new device: a costly entitlement program portrayed as a way to save money. So how can you raise billions with a program that can't even pay for itself? Only by using the crazy math that governs in the world of health-care reform.

The gimmick was hatched on July 15 when the Senate Committee on Health, Education, Labor & Pensions approved a federal insurance plan for long-term care called the Community Living Assistance Services and Supports Act, or CLASS Act.

The plan, which would provide modest benefits to people who can't perform such simple daily tasks as bathing or feeding themselves, was one of Sen. Ted Kennedy's last crusades. It quickly became a favorite among Democrats, who are now adding the CLASS Act to the leading proposal in the House, H.R. 3200, passed by the Energy & Commerce Committee.

While no one doubts the bill's humane intentions, its ardent champions have another motive as well. A budget gimmick allows them to claim that CLASS Act helps pay for health-care reform.

The Democrats are promising a ''deficit neutral'' plan, which means that according to rules set by the Congressional Budget Office, they need to find about $1 trillion in new taxes and savings over the next ten years. Right how, the House legislation stands around $250 billion short.

The CLASS Act looks like a gift: It brings in $58 billion in net tax revenues by 2019, lowering the deficit by an equivalent amount because only minor costs will be booked during that period. Under the CBO rules, the CLASS Act technically covers one-quarter of the $250 billion shortfall in funds needed to pay for health-care reform.

The gimmick lies in looking only at the CBO's ten-year budget window. The extra revenues are an illusion because of the disaster lurking just beyond that horizon.

In fact, none of the $58 billion is available to pay for the House bill. The CLASS Act is so poorly designed that the $58 billion reserve and all future premiums won't come close to covering the generous benefits it's promising.

Here's why the mechanics of the CLASS Act assure its eventual collapse.

Under the bill, all working Americans would have the option of contributing a payroll tax averaging $65 a month for long-term care. The eventual benefit for most recipients would be $75 a day or $27,000 a year.

It could be used towards nursing-home expenses, but the main goal is to allow infirm Americans to get the care they need from aides or therapists in their own homes so they're not forced into nursing homes.

But the CLASS Act's premiums aren't remotely high enough to cover a likely deluge of claims. ''It's a microcosm of many of the weaknesses in the health-care reform bills,'' says Steve Schoonveld of the American Academy of Actuaries (AAA), which did an excellent analysis of the CLASS Act.

The plan's main problem is that it encourages what's known as ''adverse selection''—it will attract an extremely high proportion of people who are sick and near retirement, and a relatively small share of the young and healthy needed to create a sound insurance plan.

One big weakness is that the CLASS Act doesn't screen for medical problems, or even require information about them. Hence, workers or their spouses can sign up even if they're already ill. By contrast, private plans require strict testing.

Participants in the CLASS program can also start collecting benefits after just five years, a period the AAA deems far too short. Workers and their spouses can also stop paying premiums, then rejoin when they get sick with no penalty.

As a result, the AAA expects that the plan will be swamped by people who know they have medical problems when they sign up, and demand benefits right after they've paid for five years.

The AAA says that the plan would become insolvent by 2021—just beyond the CBO's budget window—and would have to raise its premiums to $180 a month to meet its costs, a 177% increase.

That would put the CLASS Act into a death spiral, since virtually all younger and even moderately healthy participants would drop out. It would become a program exclusively for the old and sick, driving premiums still higher.

The most likely outcome is that we'll never get to the $180 premiums needed to fund the plan. Congress will be forced to pay enormous subsidies to keep the premiums low enough to encourage young and healthy people to sign up. Pressure will also be intense to raise the benefits to pay for more nursing-home expenses.

Instead of funding the shortfall in the House bill, the CLASS Act will create a giant budget shortfall of its own. Unfortunately, gimmickry like this is the kind of thing that has fanned public fears about health-care reform doing more harm than good.

U.S. SENATE,
Washington, DC, October 23, 2009.

Hon. HARRY REID,
Majority Leader, The Capitol,
Washington, DC.

DEAR LEADER REID: We write regarding the merger of the Finance and HELP Committee health reform bills. We know you face a great many difficult decisions now, one of which is whether to include provisions from the HELP Committee bill known as the CLASS Act in the merged bill.

We urge you not to include these provisions in the Senate's merged bill, nor to use the savings as an offset for other health items in the merger.

While the goals of the CLASS Act are laudable—finding a way to provide long term care insurance to individuals—the effect of including this legislation in the merged Senate bill would not be fiscally responsible for several reasons.

CBO currently estimates the CLASS Act would reduce the deficit by $73 billion over ten years. But nearly all the savings result from the fact that the initial payout of benefits wouldn't begin until 2016 even though the program begins collecting premiums in 2011. It is also clear that the legislation increases the deficit in decades following the first ten years. CBO has confirmed that the legislation stand-alone would face a long-term deficit point of order in the Senate.

Some have argued that the program is actuarially sound. But this is the case because premiums are collected and placed in a trust fund, which begins earning interest, and because the HHS Secretary is instructed to increase premiums to maintain actuarial solvency. We have grave concerns that the real effect of the provisions would be to create a new federal entitlement program with large, long-term spending increases that far exceed revenues. This is especially the case if savings from the first decade of the program are spent on other health reform priorities.

Slowing the growth of health care costs should be a top priority as we move forward with health reform. Inclusion of the CLASS Act would reduce the amount of long-term cost savings that would otherwise occur in the merged bill. The CLASS Act bends the health care cost curve in the wrong direction and should not be used to help pay for other health provisions that will become more expensive over time and increase deficits.

Thank you for your consideration. We hope that fiscally responsible measures to improve access to long-term care can be considered in the future.

Sincerely,

KENT CONRAD.
JOE LIEBERMAN.
MARY LANDRIEU.
EVAN BAYH.
BLANCHE L. LINCOLN.
E. BENJAMIN NELSON.
MARK R. WARNER.
U.S. Senators

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

All time has expired.

Under the previous order, the question is on agreeing to amendment No. 2870, offered by the Senator from Rhode Island, Mr. WHITEHOUSE.

Mr. HARKIN. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. DURBIN. I announce that the Senator from West Virginia (Mr. BYRD) is necessarily absent.

Mr. KYL. The following Senator is necessarily absent: the Senator from Kentucky (Mr. BUNNING).

Further, if present and voting, the Senator from Kentucky (Mr. BUNNING) would have voted ''yea.''

The PRESIDING OFFICER. Are there are any other Senators in the Chamber desiring to vote?

The result was announced—yeas 98, nays 0, as follows:

[Rollcall Vote No. 359 Leg.]

YEAS—98

Akaka	Ensign	Lugar
Alexander	Enzi	McCain
Barrasso	Feingold	McCaskill
Baucus	Feinstein	McConnell
Bayh	Franken	Menendez
Begich	Gillibrand	Merkley
Bennet	Graham	Mikulski
Bennett	Grassley	Murkowski
Bingaman	Gregg	Murray
Bond	Hagan	Nelson (NE)
Boxer	Harkin	Nelson (FL)
Brown	Hatch	Pryor
Brownback	Hutchison	Reed
Burr	Inhofe	Reid
Burris	Inouye	Risch
Cantwell	Isakson	Roberts
Cardin	Johanns	Rockefeller
Carper	Johnson	Sanders
Casey	Kaufman	Schumer
Chambliss	Kerry	Sessions
Coburn	Kirk	Shaheen
Cochran	Klobuchar	Shelby
Collins	Kohl	Snowe
Conrad	Kyl	Specter
Corker	Landrieu	Stabenow
Cornyn	Lautenberg	Tester
Crapo	Leahy	Thune
DeMint	LeMieux	Udall (CO)
Dodd	Levin	Udall (NM)
Dorgan	Lieberman	Vitter
Durbin	Lincoln	Voinovich
Warner	Webb	Wicker
	Whitehouse	Wyden

NOT VOTING—2

Bunning Byrd

The PRESIDING OFFICER. On this vote the yeas are 98, the nays are 0. Under the previous order requiring 60 votes for the adoption of this amendment, the amendment is agreed to.

Mrs. HUTCHISON. Mr. President, parliamentary inquiry: Are the next 3 votes 10-minute votes?

The PRESIDING OFFICER. The Senator from Texas is correct. The next 3 votes are 10-minute votes.

Mrs. HUTCHISON. Thank you, Mr. President.

Mr. LAUTENBERG. Mr. President, I move to reconsider the vote.

Mr. INOUYE. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 2901

The PRESIDING OFFICER. Under the previous order, there is 2 minutes equally divided.

Who yields time?

The Senator from Connecticut is recognized.

Mr. DODD. Mr. President, I urge my colleagues to support the CLASS Act and vote against the Thune amendment that would strike the CLASS Act from the bill.

As you have heard, I hope, this afternoon, this bill is totally voluntary. There are no requirements by employers or employees to be involved. This is a very creative idea using individuals' money to contribute to their own long-term financial security if they are faced with disabilities.

We have now, with the adoption of the Whitehouse amendment, secured that these funds can never be used for any other purpose than for the CLASS Act. That was the concern most of our colleagues had, if these funds would drift off. As a result of the Gregg amendment in our committee, it has now been determined that these programs will be actuarially sound for 75 years. We have fixed the problem CBO raised with it.

It is a very creative and solid program that can make a huge difference for millions of Americans to avoid going to Medicare, divesting themselves of their assets, and allowing them to lead independent lives with dignity. It is deserving of our support. I urge the approval of this program.

The PRESIDING OFFICER. Who yields time?

The Senator from South Dakota is recognized.

Mr. THUNE. Mr. President, the CLASS Act is the same old Washington, same old smoke and mirrors, same old games. I wish to read what the Congressional Budget Office and the chief actuary for the administration have said:

> The program would add to future Federal budget deficits in large and growing fashion.

If we don't take this out of this legislation, if we allow this to become law, we are locking in future generations to deficits and debt as far as the eye can see. This is, as has been described by the other side, a Ponzi scheme of the highest order. We need to take it out of this bill.

I urge my colleagues to adopt this amendment.

The PRESIDING OFFICER. Under the previous order, the question is on agreeing to amendment No. 2901 offered by the Senator from South Dakota, Mr. THUNE.

Mr. THUNE. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. The yeas and nays have been requested. Is there a sufficient second? There appears to be.

The clerk will call the roll.

The bill clerk called the roll.

Mr. DURBIN. I announce that the Senator from West Virginia (Mr. BYRD) is necessarily absent.

Mr. KYL. The following Senator is necessarily absent: the Senator from Kentucky (Mr. BUNNING).

Further, if present and voting, the Senator from Kentucky (Mr. BUNNING) would have voted ''yea.''

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 51, nays 47, as follows:

[Rollcall Vote No. 360 Leg.]

YEAS—51

Alexander	DeMint	McCain
Barrasso	Ensign	McCaskill
Baucus	Enzi	McConnell
Bayh	Graham	Murkowski
Bennett	Grassley	Nelson (NE)
Bond	Gregg	Risch
Brownback	Hatch	Roberts
Burr	Hutchison	Sessions
Carper	Inhofe	Shelby
Chambliss	Isakson	Snowe
Coburn	Johanns	Thune
Cochran	Kyl	Udall (CO)
Collins	Landrieu	Vitter
Conrad	LeMieux	Voinovich
Corker	Lieberman	Warner
Cornyn	Lincoln	Webb
Crapo	Lugar	Wicker

NAYS—47

Akaka	Gillibrand	Murray
Begich	Hagan	Nelson (FL)
Bennet	Harkin	Pryor
Bingaman	Inouye	Reed
Boxer	Johnson	Reid
Brown	Kaufman	Rockefeller
Burris	Kerry	Sanders
Cantwell	Kirk	Schumer
Cardin	Klobuchar	Shaheen
Casey	Kohl	Specter
Dodd	Lautenberg	Stabenow
Dorgan	Leahy	Tester
Durbin	Levin	Udall (NM)
Feingold	Menendez	Whitehouse
Feinstein	Merkley	Wyden
Franken	Mikulski	

NOT VOTING—2

Bunning Byrd

The PRESIDING OFFICER. On this vote, the yeas are 51, the nays are 47. Under the previous order requiring 60 votes for the adoption of amendment No. 2901, the amendment is withdrawn.

Mr. DODD. Mr. President, I move to reconsider the vote and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 2899

The PRESIDING OFFICER. There will now be 2 minutes of debate, equally divided, on the Stabenow amendment.

Who yields time?

The Senator from Michigan is recognized.

Ms. STABENOW. Mr. President, this amendment is very clear. My amendment states that nothing in this act shall result in the reduction or elimination of any benefits guaranteed by law to participants in Medicare Advantage plans.

Right now, CBO tells us, and we understand from MedPAC that there is $12 billion in overpayments to for-profit insurance companies, which are additional costs that the Medicare recipients pay beyond what is traditional Medicare.

Eighty-five percent of our seniors in Medicare are in traditional Medicare and, right now, we are told that every single senior citizen or person with disability in Medicare pays $90 extra; every couple pays $90 extra to pay for the overpayments to private for-profit insurance companies.

As AARP has said, this legislation does not reduce any guaranteed Medicare benefits. We are asking for competitive bidding—for-profit company competitive bidding—to bring down the overpayments. I ask for support for the amendment.

The PRESIDING OFFICER. The Senator from Florida is recognized.

Mr. LEMIEUX. Mr. President, regarding this amendment, I had a conversation with my colleague from Michigan. The phrasing ''guaranteed by law'' doesn't guarantee anything. This isn't going to protect the benefits of Medicare Advantage. The benefits our senior citizens enjoy, such as eye care, hearing care, and dental care, are not protected by this. You can vote for it if you want to. It sounds good, but it is gift wrapping on an empty box.

The PRESIDING OFFICER. Under the previous order, the question is on agreeing to amendment No. 2899, offered by the Senator from Michigan, Ms. STABENOW.

Ms. STABENOW. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. DURBIN. I announce that the Senator from West Virginia (Mr. BYRD) is necessarily absent.

Mr. KYL. The following Senator is necessarily absent: the Senator from Kentucky (Mr. BUNNING).

Further, if present and voting, the Senator from Kentucky (Mr. BUNNING) would have voted ''yea.''

The PRESIDING OFFICER. Are there are any other Senators in the Chamber desiring to vote?

The result was announced—yeas 97, nays 1, as follows:

[Rollcall Vote No. 361 Leg.]

YEAS—97

Akaka	Feinstein	Merkley
Alexander	Franken	Mikulski
Barrasso	Gillibrand	Murkowski
Baucus	Graham	Murray
Bayh	Grassley	Nelson (NE)
Begich	Gregg	Nelson (FL)
Bennet	Hagan	Pryor
Bennett	Harkin	Reed
Bingaman	Hatch	Reid
Bond	Hutchison	Risch
Boxer	Inhofe	Roberts
Brown	Inouye	Rockefeller
Brownback	Isakson	Sanders
Burr	Johanns	Schumer
Burris	Johnson	Sessions
Cantwell	Kaufman	Shaheen
Cardin	Kerry	Shelby
Carper	Kirk	Snowe
Casey	Klobuchar	Specter
Chambliss	Kohl	Stabenow
Cochran	Kyl	Tester
Collins	Landrieu	Thune
Conrad	Lautenberg	Udall (CO)
Corker	Leahy	Udall (NM)
Cornyn	LeMieux	Vitter
Crapo	Levin	Voinovich
DeMint	Lieberman	Warner
Dodd	Lincoln	Webb
Dorgan	Lugar	Whitehouse
Durbin	McCain	Wicker
Ensign	McCaskill	Wyden
Enzi	McConnell	
Feingold	Menendez	

NAYS—1

Coburn

NOT VOTING—2

Bunning Byrd

The PRESIDING OFFICER. On this vote, the yeas are 97; the nays are 1. Under the previous order requiring 60 votes for the adoption of this amendment, the amendment is agreed to.

Mrs. MURRAY. Mr. President, I move to reconsider the vote.

Mr. BROWN. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

MOTION TO COMMIT

The PRESIDING OFFICER. Under the previous order, there is 2 minutes equally divided prior to a vote in relation to the motion to commit offered by the Senator from Utah, Mr. HATCH.

Who yields time?

Mr. BAUCUS. Mr. President, the pending motion would strike the savings the bill achieves from Medicare Advantage.

Why are we seeking savings from Medicare Advantage? Because MedPAC tells us that the government pays the private insurance companies that provide Medicare Advantage 14 percent more than we pay traditional Medicare; because these extra subsidies to Medicare Advantage cost the four-fifths of seniors in traditional Medicare $90 more a year in premiums even though they get no benefits from Medicare Advantage; because MedPAC says that ''the additional Medicare Advantage payments hasten the insolvency of the Medicare Part A trust fund by 18 months; because the private insurance companies that provide Medicare Advantage are making three-quarters of their profits from these government overpayments, and they can find some of the savings there; because private insurance companies that provide Medicare Advantage are paying their CEOs $24 million, $9 million, and $8 million a year, and they could find some of the savings there; and because nothing we do in our bill reduces benefits under Medicare.

Therefore, I urge my colleagues to oppose the motion.

The PRESIDING OFFICER. The Senator from Utah.

Mr. HATCH. Mr. President, I urge my colleagues to support my motion to commit.

Simply put, this motion protects Medicare beneficiaries participating in the Medicare Advantage Program by eliminating the $120 billion in cuts to the Medicare Advantage Program in the Reid bill.

Let me make this point as clearly as I can. A vote against my amendment is a vote for slashing benefits for 11 million seniors and low-income Americans, including vision benefits, dental benefits, home care for chronic illness, wellness programs, disease management programs, limits on cost sharing for primary care physician visits, reduced premiums for Part B, reduced premiums for Part D, reduced cost sharing for breast and prostrate cancer screening.

When we did this, 14 Democrats, many of whom are sitting here in the Senate right now, supported this development of Medicare Advantage.

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

Mr. HATCH. Have no doubt, when you vote against my amendment, you will be voting to cut these lifesaving and life-enhancing benefits. The choice is yours and the choice is clear. Our Nation's seniors are watching.

The PRESIDING OFFICER. The question is on agreeing to the motion.

Mr. BOND. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. DURBIN. I announce that the Senator from West Virginia (Mr. BYRD) is necessarily absent.

Mr. KYL. The following Senator is necessarily absent: the Senator from Kentucky (Mr. BUNNING).

Further, if present and voting, the Senator from Kentucky (Mr. BUNNING) would have voted ''yea.''

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 41, nays 57, as follows:

[Rollcall Vote No. 362 Leg.]

YEAS—41

Alexander	Cornyn	Isakson
Barrasso	Crapo	Johanns
Bennett	DeMint	Kyl
Bond	Ensign	LeMieux
Brownback	Enzi	Lugar
Burr	Graham	McCain
Chambliss	Grassley	McConnell
Coburn	Gregg	Murkowski
Cochran	Hatch	Nelson (NE)
Collins	Hutchison	Risch
Corker	Inhofe	Roberts

Sessions	Thune	Webb
Shelby	Vitter	Wicker
Snowe	Voinovich	

NAYS—57

Akaka	Franken	Merkley
Baucus	Gillibrand	Mikulski
Bayh	Hagan	Murray
Begich	Harkin	Nelson (FL)
Bennet	Inouye	Pryor
Bingaman	Johnson	Reed
Boxer	Kaufman	Reid
Brown	Kerry	Rockefeller
Burris	Kirk	Sanders
Cantwell	Klobuchar	Schumer
Cardin	Kohl	Shaheen
Carper	Landrieu	Specter
Casey	Lautenberg	Stabenow
Conrad	Leahy	Tester
Dodd	Levin	Udall (CO)
Dorgan	Lieberman	Udall (NM)
Durbin	Lincoln	Warner
Feingold	McCaskill	Whitehouse
Feinstein	Menendez	Wyden

NOT VOTING—2

Bunning	Byrd

The PRESIDING OFFICER. On this vote the yeas are 41, the nays are 57. Under the previous order requiring 60 votes for the adoption of this motion, the motion to commit by Mr. HATCH is withdrawn.

Mr. BAUCUS. Mr. President, I move to reconsider the vote.

Mr. UDALL of New Mexico. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, the Senator from Arkansas is to be recognized to offer an amendment.

AMENDMENT NO. 2905 TO AMENDMENT NO. 2786

Mrs. LINCOLN. Mr. President, I call up amendment No. 2905.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Arkansas [Mrs. LINCOLN], for herself, Mr. LAUTENBERG, Mr. MENENDEZ, Mr. FRANKEN, Mrs. BOXER, and Mr. REED proposes an amendment numbered 2905 to amendment No. 2786.

Mrs. LINCOLN. I ask unanimous consent the reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To modify the limit on excessive remuneration paid by certain health insurance providers to set the limit at the same level as the salary of the President of the United States)

On page 2040, strike line 14 and insert the following:

(b) DOLLAR LIMIT NOT TO EXCEED COMPENSATION OF THE PRESIDENT.—

(1) IN GENERAL.—Paragraph (6) of section 162(m) of the Internal Revenue Code of 1986, as added by subsection (a), is amended by adding at the end the following new subparagraph:

''(I) DOLLAR LIMIT NOT TO EXCEED COMPENSATION OF THE PRESIDENT.—In the case of a taxable year in which the $500,000 amount in clauses (i) and (ii) of subparagraph (A) exceeds the dollar amount of the compensation received by the President under section 102 of title 3, United States Code, for such taxable year, such clauses shall be applied by substituting the dollar amount provided in such section 102 for such $500,000 amount.''.

(2) REVENUE INCREASE TO BE TRANSFERRED TO MEDICARE TRUST FUND.—Section 1817(a) of the Social Security Act (42 U.S.C. 1395i(a)) is amended—

(A) by striking ''and'' at the end of paragraph (1),

(B) by striking the period at the end of paragraph (2) and inserting ''; and'', and

(C) by inserting after paragraph (2) the following new paragraph:

''(3) the revenues resulting from the application of section 162(m)(6) of the Internal Revenue Code of 1986, as determined by the Secretary of the Treasury or such Secretary's delegate.''.

(c) EFFECTIVE DATE.—The amendments made by

Mrs. LINCOLN. I yield the floor.

The PRESIDING OFFICER. The Senator from Nebraska is recognized.

Mr. JOHANNS. I have a motion at the desk.

The PRESIDING OFFICER. The clerk will report the motion.

The legislative clerk read as follows:

MOTION TO COMMIT

The Senator from Nebraska [Mr. JOHANNS] moves to commit H.R. 3590 to the Committee on Finance with instructions to report the same back to the Senate with changes that do not include cuts in payments to home health agencies totaling negative $42.1 billion.

Mr. JOHANNS. Mr. President, I rise to speak in favor of the motion that was just read. One of the things that I think is so very important about a debate on the Senate floor is we begin to understand what this legislation does to real people. We have come to understand that $466 billion in Medicare cuts that are shown over my left shoulder have real consequences to real people all across the United States. These cuts compromise care, they compromise access to services that real people need in their daily lives. Robbing these funds from Medicare to create a dramatic new entitlement program, in my judgment, is not sound policy and it is not sound government.

That is especially true in this case when the impact on seniors' health care is so profound. These cuts will reduce the quality of care many Americans are receiving today and reduce the care these Americans deserve.

I have to tell you, out of all these Medicare cuts, one of the largest headscratching cuts is the one to home health. The Senate bill cuts $42.1 billion for home health care. Home health is about 3.7 percent of the Medicare budget. It is an important program. Yet 9.1 percent of the Medicare cuts in the Senate bill are taken out of home health.

Medicare home health spends less today than it did over a decade ago, while serving a similar number of beneficiaries at less cost per patient. That is the kind of program we should celebrate. Yet this bill has them on the chopping block.

Maybe there is some misunderstanding about what home health provides, so let me clear up the confusion. Home health care agencies care for patients of all ages. They provide a broad range of essential health care in support services, real security in the comfort of a patient's home. Nine thousand Medicare-approved home health agencies existed in 2007. I am very pleased to report to you that 74 of those are in my home State of Nebraska. Nurses, therapists, home care aides, and others who serve elderly and disabled patients in their own homes drive nearly 5 billion miles a year to provide these much needed services. They care for about 12 million real people annually, with 428 million visits, each one providing that personal touch of care.

The services that are provided in this very essential program include rehabilitation therapies, telemedicine, wound care, pain management, and skilled nursing.

Who is eligible to receive Medicare home health services? We can answer that question by going to CMS. According to CMS, to qualify for Medicare home health benefits, a Medicare beneficiary must meet one of the following requirements: They must be confined to home, they must be under a doctor's care, they must need skilled nursing on a periodic basis, and they must have a continuing need for occupational therapy. These are truly some of the most vulnerable Americans. Yet in order to finance this new entitlement, this bill takes money out of that much needed program, and it places the cuts on the backs of these Americans, our most vulnerable Americans. Yet these cuts risk leaving them without care.

What kind of conditions do people who utilize home health agencies suffer from? I will turn to my own State to answer that question. In Nebraska, one of our agencies is in rural Cherry County. Cherry County is a very large county in western Nebraska—in fact, larger than some States. Who gets served in Cherry County? A gentleman with class III congestive heart failure. He is awaiting a heart transplant. A gentleman who lost a leg from complications from diabetes, they get home health care services. These folks are not striving to bilk the system. The payments that allow us to provide this much needed service to them are not excess payments. These are just average folks who are striving to do their best to recover from their condition and manage the best they can.

Keeping these folks out of the emergency room or the nursing home is a benefit to everybody. I don't see how anybody could argue this doesn't save tax dollars. In fact, there are statistics that support that statement. According to the National Association of Home Health Care and Hospice, an average per-visit Medicare charge for home health is $132. Let me compare that charge of $132 to 1 day at a hospital. That would cost 43 times as much, literally—$5,765 per day.

According to a study of Avalere Health:

Early use of home health care services following a hospital stay by patients with at least one chronic disease saved Medicare $1.71 billion in the 2-year period of 2005 to 2006.

Doesn't it seem like an enormous step backwards when we talk about reform, when really what we are doing is cutting a program that serves people so much in need and yet saves money in the Medicare Program? Home health agencies in Nebraska have been very successful in doing exactly what we want—keeping people at home and out of the hospitals and nursing homes. Of special interest are patients with congestive heart failure. One Nebraska woman turned to home health after facing a big stack of hospital bills for rehab. Since then, she has been able to remain at home safely at a fraction of the cost. This home health agency can see a person for 60 days at a cost of about $2,500. One hospital admission, by comparison, would cost Medicare conservatively $20,000 to treat a patient with chronic heart failure. Again, home health care costs a fraction of hospital care, about 10 times less.

There are so many stories from patients who are alive today who love home health care. This bill threatens them. Somewhere in the next hours, I am going to send to every Member of the Senate, all of my colleagues, a State-by-State analysis of what these cuts will do in their States because they need to know the impact. This bill threatens to take that all away. You can't cut $42 billion and just describe it as excess payments. You can't cut 42 billion and say: That is just fixing those who are bilking the system. When you cut $42 billion out of a program like home health care, it has real consequences.

Earlier this week, I did a video conference with Medicare providers in Nebraska. These Nebraska home health providers reported this legislation will cost them $120 million. What does that mean, $120 million? It may not sound like much around here, where we talk about trillion-dollar programs, but $120 million to the people of Nebraska in home health care, 68 percent of home health agencies in Nebraska will be in the red by 2016, 68 percent. In rural areas, as high as 80 percent will have negative margins. You lose those services in rural areas. They are lost. There is nothing that will step in for those people.

Home health providers already have to watch their bottom line, and they are already making very hard, painful decisions. During this video conference, a nurse in rural Nebraska explained the reality to me this way:

> I can give you a human story that just happened yesterday in our agency. We had a referral from a patient that lives 90 miles away. The drive time is three hours. To do the administration takes 1½ to 2 hours. Then you come back to the office and you do at least another hour of paperwork. It would take one person's entire day to serve one patient. Regretfully, we had to say no. We just could not see her. There is no other agency close enough to help this woman.

Can you imagine? We have a person who desperately needed these services, and we are debating whether we should cut $412 billion out of this program that will impact a State such as mine to the tune of $120 million? These agencies and the services they provide absolutely are reliant on Medicare.

According to the National Association of Home Care and Hospice:

> Medicare is the largest single payer of home health care services.

When we cut the payments in a program like this, we cut access to care. These access concerns are rooted in real life experiences. Between 1998 and 2000, Medicare home health spending fell from $14 billion to $9.2 billion or negative 34 percent, as a result of congressional action between 1998 and 2000. Those actions triggered the closure of 40 percent of home health agencies and reduced access for 1.5 million Medicare beneficiaries. Access becomes a real issue. If there is no home health agency, homebound patients end up with more expensive care at hospitals and nursing homes. That costs Medicare money. But, you see, we are also cutting hospitals and nursing homes in this bill.

If there is no home health provider near an area, not only are Medicare beneficiaries hurt but all citizens who need care. Any analysis is going to come to the same conclusion.

I will quote from one:

> Studies from MedPAC and the Government Accountability Office also suggest that access is a growing problem for patients who require intensive services. In June 2003, MedPAC issued a report indicating that skilled nursing facilities care is now substituting for home health care for some patients, most likely at a much higher cost for Medicare.

I don't think these are transformational reforms. These cuts are not transformational reform. They are just plain cuts, to start a new entitlement that will hurt real people, senior citizens who need our help. That is why I am offering this motion to recommit this legislation back to the Finance Committee to strike these ill-advised home health care cuts. I will follow up. I will make sure every Member sees the impact of these cuts in their State so they can make an assessment if these cuts should be put in place and cause the kind of damage I have described this evening.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. I yield Senator KLOBUCHAR 10 minutes.

Ms. KLOBUCHAR. I ask unanimous consent to speak for up to 12 minutes.

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

Ms. KLOBUCHAR. Mr. President, I rise to speak about a true health care reform. The way I look at this in my State, it is a matter of affordability and cost. We have one of the highest percentages of people covered in the country in Minnesota. The issue is, it is becoming more and more expensive for the people to afford health care. I always try to remember three simple numbers of all the ones we will hear in the next few weeks. Those are the numbers 6, 12, and 24. Ten years ago it cost $6,000 for an average family to pay for health care a year. Now it is $12,000, with a lot of people paying a lot more. Ten years from now, if we don't do anything, it will be somewhere between $24,000 and $36,000 a year, something regular people just can't afford. It is not going in the right direction.

If we don't act, costs will continue to skyrocket. The country spent $2.4 trillion on health care last year alone. That is $1 out of every $6 spent in the economy. By 2018, national health care spending is expected to reach $4.4 trillion, over 20 percent of our entire economy. Despite spending 1½ times more per person on health care than any other country, many of our people don't even have health care coverage. Many of them are losing their coverage because of preexisting conditions or because it simply is costing too much. These costs are breaking the backs of our families and businesses. We can see here, single coverage, 1999, $2,196. Now at 2008, the last figures we have available, $4,704, a doubling. Family cost, 1999, $5,791—that is the average family's premium—now they are paying $12,680.

Look what is happening to small businesses. A study by the Council of Economic Advisers found that small businesses pay up to 18 percent more than large businesses to provide health care coverage. In a recent national survey, nearly three-quarters of small businesses that did not offer benefits cited high premiums as the reason.

Look at it this way: Inflation usually raises the cost of most goods and services between 2 to 3 percent per year. Health care premium costs have been going up close to 8 percent a year. That is an increase Americans can't afford. Wages have not kept pace with the increase in premiums.

Look at this. Between 1999 and 2007, the average American worker saw his wages increase 29 percent. Obviously, the last few years it has not been that rosy. How much did his insurance premiums go up? One hundred twenty percent during the same time period. In other words, the health care premiums are taking out a bigger and bigger chunk of the average worker's paycheck. These costs are breaking the backs of the American taxpayer.

My colleague was talking about Medicare. The truth is, Medicare is projected to go into deficit by 2017, if we don't do anything about it.

Recent Congressional Budget Office estimates show that the majority of the projected $344 billion increase in Federal revenues are scheduled to automatically go to cover rising health care costs. Medicare—something that people who are 55 want to get when they are 65; people who are 65 want to keep until they live to the ripe old age of 95—if we don't do anything about it, is going in the red by 2017.

How do we do this? How do we get to the place where we want to go? We

must get our money's worth from our health care dollars. The problem now is, we are paying too much and we are not getting a good return on what we pay. The solution must be to get the best value for our health care dollars; otherwise costs are going to continue to wreak havoc on the backs of government, businesses, and individual families.

Medicare is 57 percent of all Federal health spending. If we want to sustain Medicare, which we all do, to provide that kind of high-quality health care our seniors deserve, we must do something to address the fiscal challenges.

The root of the problem is that most health care is purchased on a fee-for-service basis, so more tests, more surgery means more money. Quantity, not quality pays. According to researchers at Dartmouth Medical School, nearly $700 billion per year is wasted on unnecessary or ineffective care.

My favorite example is what Geisinger Clinic did in Pennsylvania. They were not happy with their diabetes treatment, so they decided we are going to have the routine patients see nurses. The more difficult cases will see doctors. Then those endocrinologists will review the records of the nurses and make sure this patient is progressing as we want. Guess what. Patient quality goes way up because they see nurses and they see them more regularly. Results go way up because endocrinologists are spending time on the most difficult cases and reviewing records of the other. Costs go down $200 per month per patient. Guess what. They get paid less—way, way, way less for that kind of good quality care.

This system is messed up, and we need to change it so we are rewarding based on results. We put the patient in the driver's seat so that when that patient gets better results, then we reward with payments. In Minnesota, we have several great examples of this coordinated outcome system.

At a place such as the Mayo Clinic, Park Nicollet, St. Mary's in Duluth, the priority is value not volume. As this chart shows, if the spending per patient with chronic diseases everywhere in the country mirrored the efficient level of spending in the Mayo Clinic's home region of Rochester, MN—this is Mayo Clinic quality health care.

For the last 4 years of chronically ill patients' lives, if we used that same system all over the country, how much would we save, if we used this system in Texas, if we used this system in Florida? We would save $50 billion every 5 years for the taxpayers of this country and get higher quality care.

This is not like a hotel right now in this country where if you pay more money, you get a better room with a better view. No. The opposite is true. In this country, the States where you pay more money, you get less quality care. That is what we need to change to bring all of the States up to that high-quality care, efficient care, that costs less but is a better value. That is what we need to do.

How do we do it? Well, linking rewards to the outcomes for an entire payment area creates the incentive for physicians and hospitals to work together to improve quality and efficiency; using bundling, to bill, so you look at the whole outcome of everyone working together, so you rely on nurses when you want to rely on nurses, so you rely on doctors when you want to rely on doctors; by reducing hospital readmissions. Who wants to go back in the hospital over and over again just because there are a bunch of infections hanging around? In fact, right now, if you go back to the hospital, the hospital gets rewarded for that. So we want to put in place protocols that make hospitals safer places to treat patients. In 1 year, hospital readmissions cost Medicare $17.4 billion, and a 2007 report by MedPAC found that Medicare paid an average of $7,200 per readmission that was likely preventable. We need to have integrated care, where you have a primary care provider, working with a team, instead of having 15 specialists running around the field, running over each other. You need a quarterback, well, let's just say like Brett Favre and the Minnesota Vikings. You have one quarterback who is your primary care doctor, who is in charge, with a team of doctors who look at all the medical records. That is integrated care. That is what we should be rewarding. That is what this bill does.

Looking at some of the other inefficiencies, the Presiding Officer has been a leader on Medicare fraud. Think about the money we can save. Medicare fraud alone costs taxpayers more than $60 billion every year. Instead of that money going to our seniors, do you know where that money is going? It is going to con men, people who are leeching off the system, people who are making up that they are providing services when they are not. The Presiding Officer and I have a bill we are working together on to bring that down so that money can actually go to our seniors instead of going out to a bunch of people who are ripping off the system, ripping off our seniors.

If you look at how you save money, if you look at how you reduce costs in Medicare, well, you reduce costs in Medicare by making changes to this system and making this work. We must look to the future. That is why health care reform this year is so crucial. This bill is not about today or even next year; it is about 5 years from now, it is about 10 years from now, and beyond. We cannot afford for the people of this country to hold off any longer. We can bring these costs down. We can bring the quality up. And we can reward the people of this country for the money they are putting into health care.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from South Carolina.

Mr. DEMINT. Mr. President, I appreciate the comments of the Senator from Minnesota, who brought out a lot of important issues as far as the rising costs of health insurance, and I certainly knew that as a small businessman. There is only one problem: The bill we are going to vote on does not solve those problems. In fact, as CBO basically tells us, insurance will continue to increase at the same rate it does now, and for those with individual insurance policies, it is very likely to go up.

Mr. President, we are here on a Friday evening being told we are going to work through the weekend, maybe next weekend, all the way up to Christmas Eve, with the intent to rush through a bill that many have called—and I agree—one of the worst pieces of legislation and one of the biggest threats to health care we have ever seen here in this country. Apparently, the majority wants to rush this through and hopefully intimidate the minority into allowing it to go through by keeping us here on weekends over the holidays. But I am proud Republicans are standing together against this bill and standing with the American people to stop the Democratic government takeover of health care in America and to stop them from paying for it by cutting nearly $500 billion from Medicare and raising taxes on millions of Americans.

I heard from one of our constituents, who was talking about Medicare and the cuts in Medicare, explaining very simply that Medicare is something he had paid for his entire 40 years of working out of his payroll taxes, and now he could not believe we were considering taking any money out of Medicare in order to pay for a new government program.

Americans work and pay for Medicare so that when they retire they will have benefits that give them the coverage they need. I think the majority must think Americans are not paying attention or maybe even they are not real smart, that you can take $500 billion out of a program that is already bankrupt and expect the benefits to stay the same, when already we know we are not paying doctors enough to see our seniors and more and more physicians are not even willing to see Medicare patients.

If there really is waste and fraud in Medicare—and we know there is some—we should find it and put that money back into the Medicare system so we can keep our promises to seniors.

Every Democrat in the Senate has already voted for a government takeover of health care, to cut Medicare to pay for it, and to raise taxes. Some of them said they were just moving the debate forward. But I ask you, what debate? Will there be any serious consideration to take this government-run plan out of this bill? There will not be.

We have already seen there is no serious consideration to stop taking money out of Medicare to pay for it. In fact, we have had a lot of debate about

what this is going to do: to cut from Medicare, what it is going to eventually do to benefits, cut Medicare Advantage. Now we are talking about cutting home health, which is so important, particularly in rural communities and for the more elderly constituents we serve.

There is no way you could take this money out of Medicare without hurting the programs. Instead, as we look ahead at more people retiring than ever in history and Medicare being bankrupt, we need to be looking at ways that we can shore up this program so it will be there for generations to come.

Every Republican voted no. Every Republican in this Senate has stood with the American people and said no to a health care bill that takes over the most personal and private part of our lives. I am proud of our party and our leadership.

Americans have been asking to see the differences between the Republican and the Democratic Parties. I think now more than ever on this issue they are going to see the Democrats standing with government-controlled health care, cuts in Medicare, increased taxes and on the other side Republicans who are going to stay here through Christmas and New Year's or whatever it takes to stop this bill and to sit down and really reform this system in a way that will lower costs and improve care to all Americans.

We need to continue to talk about these bigger issues, particularly how it affects Medicare, and we will be doing that over the weekend. But I think we owe it to the American people to begin to open this bill and explain what is in it. I can almost guarantee you, there is not one Member of the Senate who has read it yet. We are going to try to fit this in Santa's sleigh this year so it will be delivered to every American.

I have the first part here—1,000 pages, small print, front and back—and have started going through it, putting tabs on different pages, so we can talk about the different things because sometimes they sound so extraordinary, people do not really believe they are in there. I am not sure we will ever get through the whole thing, but I just want to take a couple parts tonight and just start talking about what is really in this bill.

On page 17, in section 2713 that is titled ''Coverage Of Preventive Health Services,'' which is really our jargon for rationing, it says:

> A group health plan and a health insurance issuer offering group or individual health insurance coverage shall provide coverage for . . .
>
> 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.

We heard from this task force a few weeks ago. This may sound harmless enough, as you look at it, but let's see what the really means: ''evidence-based . . . 'A' or 'B'.'' What is not A or B? Well, just 2 weeks ago, we found out something that was not A or B. Mammograms are a C rating. And the task force came out and said it should not be covered on anyone under 50 years old. That is in the bill, that it would not cover mammograms for folks under 50 years old because it is not A or B. Because of the outcry, we had an amendment from the other side to give themselves a little bit of cover on that one medical procedure, mammograms. We passed it with some fanfare yesterday. But the fact is, there are going to be many C ratings that are not covered.

What are we going to do here in Congress over the next several years when we find constituents are not covered for things they need in retirement from Medicare? Are we going to pass bills to try to cover those individual things? What we should really do is throw out the bill that is causing the problem. We should not be rationing care to our seniors.

Let's look at another page. And I know this is not as interesting as talking about theoretical stuff. But on page 33, section 2719 is called the ''Appeals Process'':

> A group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process . . .
>
> [to] provide notice to enrollees, in a culturally and linguistically appropriate manner. . . .

Now, what do we think that means? Well, in fact, in 2001—this term has been used before—the Department of Health and Human Services reported that the Department had spent $10 million to figure out what that phrase means. And we still do not know. It says: ''Health care services that are respectful of and responsive to cultural and linguistic needs.'' But what this really means to us, according to the 2000 census, is there are at least 20 languages spoken by at least 200,000 Americans in this country, and what we are putting out there is a liability for every insurance company that does not have every aspect of their plan in those 20 languages. It may sound like a simple thing, but every page of this bill, almost—as you read it, you realize it is increasing the complexity and the cost of the system here in America.

I will just cover one more of these because I hear my colleagues in the background urging me to finish. But I do think we owe it to the American people to begin to talk about what is really in this bill.

On page 39, it says, under a funding category:

> Out of all funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary $250,000,000 to be available for expenditure for grants under paragraph (1) and subparagraph (B).

Those subparagraphs are to track the trends in premium increases of health insurance once this bill goes into effect. Mr. President, $250 million to do what the Congressional Budget Office has already told us are going to be increases. But this kind of spending and this type of bureaucracy and complexity we are creating is not going to make health care more accessible and more affordable for Americans. It is creating a complex bureaucracy with tens of thousands of workers and bureaucrats to tell doctors what to do and hospitals what to do and for us, how to manage our health care.

The Congressional Budget Office has already released a report finding that those purchasing insurance through the health insurance exchanges that are in this bill could pay up to 16 percent more for health care than we do today. Yet we are moving ahead with the bill.

I will continue throughout this weekend, and every time I get a chance to speak, to talk about more of these things that are in this bill. But, folks, this is not a bill we should deliver to the American people for Christmas this year. This is a bill that we should throw out so we can start over and have a step-by-step approach to make health insurance more affordable and available to every American.

With that, Mr. President, I yield back.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I think we are going to go back and forth here.

Mr. ROBERTS. There is no ''forth.''

Mr. BAUCUS. Sorry?

Mr. ROBERTS. There is no ''forth,'' Mr. Chairman.

Mr. BAUCUS. Well, we are going to go back and forth. Here is Senator KAUFMAN.

Mr. ROBERTS. We could go back and back, sir—I do not care—and then forth and forth.

Mr. BAUCUS. Back and forth, and forth and forth, and to and fro, and this and that it works fine for me.

The PRESIDING OFFICER (Ms. KLOBUCHAR). The Senator from Delaware is recognized.

Mr. KAUFMAN. Madam President, I ask unanimous consent to speak in morning business for up to 5 minutes.

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

(The remarks of Mr. KAUFMAN are printed in Today's RECORD under ''Morning Business.'')

The PRESIDING OFFICER. The Senator from Kansas is recognized.

Mr. ROBERTS. Madam President, I rise today in support of the motion of my good friend from Nebraska, my colleague from Nebraska, Senator JOHANNS to—the official words say: to commit the bill back to the Senate Finance Committee with instructions to strike the cuts to the Medicare home health care benefit.

What the distinguished Senator is trying to do is bring some common sense to the cuts to a very vital source of health care, not only to rural areas but all over this country, and that is home health care. The bill we are considering, the bill sometimes called the

''behind closed doors'' bill, would cut home health care by $42 billion.

The Senator from Nebraska says that is a head-scratcher, and it certainly is. It is more than a head scratcher; it is a Lizzie Borden amputation in regard to a vital program.

Home health care is critical for our seniors. Obviously, that is the truth. As the cochair of the Senate Rural Health Care Caucus, I certainly understand that. So does the Senator from Nebraska. He was saying yesterday how many times he visits his rural hospitals, rural clinics, rural hospices, and you do that a lot if you are from Nebraska or Iowa or Texas or Kansas.

At any rate, in my home State of Kansas and other rural areas, many seniors live alone or out in the country miles away from a local hospital or a doctor's office. Even if they have a very good doctor, they can't get there because of their health condition. So home health care allows those seniors the freedom and the independence to stay in their home in the comfort of knowing somebody is there assisting their health care needs. More importantly, home health care is the cost-effective care, as the Senator from Nebraska has pointed out, that keeps the senior out of a nursing home or hospital and—guess what—saves the government money. Over the long term, if you cut home health care, you are going to increase the cost in regard to nursing homes, no question about it.

In my State I have had the pleasure of being able to see firsthand, as has the Senator from Nebraska, the great work our Kansas Home Health Care Association members do every day. Last year I was invited into the home of a lovely couple in Concordia, KS, America, not too far from Nebraska, and despite having multiple health issues, Duane and Phyllis were able to stay in their home with their little dog Josie, all thanks to the services provided by a home health care aide and a home nurse.

What is going to happen to seniors such as Duane and Phyllis if we slash $42 billion from home health care payments? Forty-two billion dollars is one of the largest Medicare cuts in the whole bill next to Medicare Advantage and the hospitals. The Senator from Nebraska had that chart showing serious cuts to all of our providers. Don't forget that this cut comes on the heels of several years of additional cuts to home health care—around $35 billion all told—that already have a large percentage of Kansas home health care agencies operating at very slim or negative Medicare margins. I know the same is true in Iowa, and the same is true in Texas, in Montana, in Nebraska, and all over the country.

I keep hearing my colleagues, however, on the other side of the aisle insisting that their $½ trillion cut to all Medicare—here is the quote—''won't affect the benefits guaranteed to seniors.'' Please stop that. Please stop that. That is the most disingenuous smokescreen in this whole debate. It may be true that this bill does not explicitly cut benefits. My friends across the aisle, however, cannot deny that their cuts in reimbursements to providers will affect those benefits, because when you cut the reimbursements to providers, guess who pays the price. The patients—Duane and Phyllis and their little dog Josie. I tell you what. You come to their house and you make that argument that if you close down or make cuts to home health care, Duane is not going to like it, Phyllis is not going to like it, and Josie will bite you on your leg.

As I said, many of my Kansas home health care agencies are already operating at negative margins. Their projected share of these cuts, as provided by the distinguished Senator from Nebraska, is almost $240 million. To the Senator from Montana, the distinguished chairman of the Finance Committee, my dear friend, that is $60 million in Montana; and Nevada, where the distinguished majority leader lives, the chart that has been provided to me by the Senator, $263 million.

We have Senator CORNYN sitting right behind me here. Senator CORNYN, you are in the $6.8 billion category for Texas. I might ask the Senator, What is going to happen if you get cut $6.8 billion in regard to home health care service?

Mr. CORNYN. If the Senator will yield for a response, $6.8 billion would cut not just into the muscle but into the bone and deny a lot of elderly people, particularly in rural areas, access to care entirely.

Mr. ROBERTS. I thank the Senator. The Senator from Nebraska has already pointed out what happens in Nebraska, and I know what will happen in Kansas. Nearly two-thirds of Kansas home health care agencies will have negative margins within only 5 years, probably 2 or 3, if these cuts are allowed to occur.

How are these agencies supposed to stay in business with these kinds of cuts? The home health care benefit will be worthless to a Kansas Medicare patient whose home health care agencies will go out of business. So, yes, in fact, this bill will effectively cut benefits. Again, get rid of the smokescreen.

This doesn't apply just to the home health care benefit. The same can be said for the effect of the cuts, as demonstrated by the Senator from Nebraska, for reimbursements to hospitals. This bill is going to cost the Kansas Hospital Association $1.5 billion. They have some outside experts who came in. I asked them: What is going to be the effect of the cuts? They already have cuts. They only get reimbursed 70 percent now, and $1.5 billion on top of that. We ought to have a chart—and I am sure we will have a chart—that would show Iowa or Nebraska or any State here, Texas especially, because of the number of folks there. So hospitals, hospices, skilled nursing facilities, and all of the rest.

I want every senior to know that while maybe it is technically accurate, again, for my friends across the aisle to claim this bill doesn't cut Medicare benefits, there is no way—no way—you can slash $½ trillion from payments to providers without affecting their ability to keep their door open, especially in rural and small town America. Seniors should know they will be left with a worthless benefit. To paraphrase my friend Senator ALEXANDER from Tennessee, it would be like having a bus ticket without a bus.

Thank you, Senator JOHANNS. Thank you for the work you are doing. Thank you for this motion. I hope we are successful. I hope people will wake up and understand the severity of what these cuts will do. I urge every Member of this Senate to support Senator JOHANNS when we come to a vote on this issue.

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

The PRESIDING OFFICER (Mr. KAUFMAN). The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, I have heard a lot here today about how this is going to hurt seniors and so on and so forth, words such as ''smokescreen.'' The fact is there is no smokescreen here whatsoever. This is a very well thought out, considered policy that I think strikes a very good balance between getting care to especially seniors at home, which is so important on the one hand, and making sure there is not waste on the other hand. That is our responsibility here, to make sure the program works and works well.

I have sort of a special interest in this. My mother was in the hospital. It happened about 2 weeks ago. She fortunately is doing much better. She is out of the hospital. She has spent some time with a home health caregiver with whom I was very, very impressed. This home health person is doing a great job with my mother. I have seen other instances too, but personally I was very happy to see my mother getting very good care from a home health care nurse.

I think it is also important to remind my colleagues that this amendment is generally a retread on the McCain amendment we debated over the last few days. That is, once again, the opponents of this bill are endorsing the status quo that leaves Medicare on the brink of going bankrupt and seniors facing higher costs.

Let me remind my colleagues again what will happen if we stick with the status quo. The status quo, meaning no bill, which the other side is advocating, means Medicare will go broke in 8 years. That is the status quo. In our legislation, that will be postponed for at least 5 more years. The status quo, as in no bill, which the other side is advocating, means seniors will continue to pay higher and higher premiums and cost sharing due to wasteful overpayments to health care providers.

There is so much waste in our system. We all know there is a lot of

waste. I am quite surprised not all of our colleagues want to cut out the waste. In effect, they want to keep the waste that, unfortunately, is in our system.

The status quo also means each year billions of Medicare dollars will continue to be wasted on lining the pockets of private insurance companies. That might be a bit of a strong statement, but the fact is, some chief executives of private insurance companies are paid tens of millions of dollars to manage Medicare Programs, especially Medicare Advantage, and the status quo means that will continue.

The status quo also means seniors will continue struggling to pay for prescription drugs. The stakes for seniors in the Medicare Program have never been higher.

We have a choice. It is a very simple choice: either endorse the status quo or strengthen Medicare.

Let's talk a little bit about home health care. Regarding Medicare changes for home health providers, let me describe what is in the Senate bill. I don't think our colleagues know specifically what is in the Senate bill. That may be a strong statement to make. But if they knew what was in the bill, I think some of the statements made tonight might be a little bit different.

As most of my colleagues would agree, home health care is an extremely important benefit in the Medicare Program. We are all very strong advocates of home health care. Across the country, there are more than 9,800 home health agencies providing care to seniors in their homes. This helps seniors get better and helps them to avoid expensive rehospitalizations.

We are all champions of home health care. We would like people not to be institutionalized. It is much more appropriate to have care in the home, and home health care agencies provide that.

In Montana, home health care providers go the extra mile—literally—to provide care to patients across vast distances. In some cases, in rural areas they have to drive 100 miles just to see one patient. They are dedicated people. They go great distances and travel a long way to see very few patients.

Home health providers make a real difference in improving seniors' health, and we should support their efforts. We all very much support their efforts.

While I have great respect for the services of home health providers, we also have a responsibility to protect the Medicare Program. Unfortunately, there is almost always waste somewhere. It is a matter of judgment as to how much is waste and how much is not.

We must make sure Medicare is paying appropriately; that is, that Medicare is not overpaying for Medicare services. We must take action to root out fraud and abuse in the Medicare Program generally and where it may occur in the home health industry as well.

I think the policies in the Senate bill achieve both goals. First, the Senate bill would ''rebase'' home health payments to ensure payments reflect actual costs of providing care. These changes are based on recommendations by MedPAC, which is the independent advisory commission that advises Congress on Medicare reimbursement. It is a nonpartisan group. MedPAC advises that we rebase. What do we mean by ''rebase''?

When the current home health payments were set, seniors received an average of 31 visits per episode. Today, they receive 22 visits; that is, they get paid about the same for doing less. We are trying to make sure the payment reflects the actual services provided. The Senate bill directs CMS to rebase payments to reflect this change. It is common sense. MedPAC recommended it and thinks it has to keep up with the times. Times have changed over the years, and the payment system should reflect that change.

There is something else I think is pretty important, and most of my colleagues would agree, the Senate bill roots out fraud that, unfortunately, exists in home health care as well as in other areas of Medicare spending. It tries to root out the fraud in Medicare payments for outlier cases.

Medicare provides an extra payment today for providers—home health folks—who treat sicker people, otherwise known as outlier patients—really sick, outliers. Unfortunately, the GAO found that some providers were gaming the system and getting much more outlier payments than they deserve.

For example, the GAO found that in one Florida county alone, home health providers were receiving 60 percent of all total outlier payments. That is nationwide. One county was getting 60 percent, even though they had less than 1 percent of the total Medicare population. I don't want to just single out Florida. Other counties in the southern part of the country clearly have a grossly disproportionate amount of high outlier payments.

The Senate addresses this problem by placing a cap on the amount any individual provider can receive in outlier payments.

Another change is the bill makes ''market basket'' changes in 2011 and 2012. That was recommended by MedPAC. Why is that important? MedPAC is actually much tougher. They wanted to start in 2010. We said we will hold off a bit. We wanted to be fair to the home health providers. In addition, the bill establishes a productivity adjustment for home health providers beginning not right away, not next year or the following year but in 2015.

These changes ask home health providers—like all other providers—to offer more efficient and higher quality care over time. We are being fair about it. Very importantly, in making these changes we worked closely with the home health industry to ensure these changes were reasonable and fair.

What do we do with respect to the agencies to make sure we are fair? On the rebasing policy, MedPAC recommended that we fully implement these changes in 2011. To ensure that providers can adapt to the new payment rates, we in the Senate decided we would phase in these changes over 4 years. The home health providers support this phase in. They think it is a good idea.

On the outlier policy and the fraud changes, these policies were actually suggested to us by—guess who—the home health industry. They came to us and suggested we make some changes in outliers because too many agencies are gaming the system. They asked us to make some outlier changes and stop that gaming, to make changes to stop the fraud. They came to us and gave us some ideas. Obviously, the home health industry fully supports the changes they recommended to us. They are in this bill.

On the market basket and productivity changes, the Senate bill holds off on applying these reductions while the rebasing policy is taking effect.

This bill gives home health agencies extra time—much more time than is recommended by the very aggressive proposed changes by MedPAC, the House bill, and the administration. We say those are too aggressive. We in the Senate decided to give agencies extra time to adapt to the payment changes in the bill rather than having all these implemented at the same time as MedPAC and the House and the administration all recommended.

Finally, with respect to rural home health providers, we are all very sensitive to the special needs of rural America. What did we do about that? From 2010 to 2015, rural providers will receive a 3-percent extra payment each year. This payment will ensure that rural providers are protected as we reform the home health system.

In total, the home health changes in the Senate bill, I believe, strike a fair balance between ensuring seniors have access to home care, while also rooting out inappropriate payments from the system.

I hear some of my good friends say: Gee, these changes are going to hurt seniors. They are not going to hurt them. In fact, most of the changes are suggested by the home health care industry. I think all of us want to root out fraud and waste. Also, it is claimed that Medicare beneficiaries will be harmed by this bill. This is a scare tactic.

Let me say what the American Association of Retired Persons says about these claims that these changes in Medicare reimbursement are going to harm seniors.

AARP says:

> Opponents of the health reform won't rest. [They are] using myths and misinformation to distort the truth and wrongly suggesting that Medicare will be harmed. After a lifetime of hard work, don't seniors deserve better?

That is AARP. I don't suggest tonight that any of our colleagues are using myths and misinformation to distort the truth. The point is, AARP claims that is not true. They support the bill strongly.

I will remind my colleagues of some of the positive changes in the legislation. This legislation improves the solvency of the Medicare Program by 5 years. It puts $30 billion back into the pockets of seniors in the form of lower Medicare premiums. It makes prescription drugs more affordable, which is an added benefit in this bill that would not be available if the legislation is not passed. The bill guarantees that seniors can continue to see a doctor of their choosing. The bill provides free wellness and prevention benefits. Those are new benefits. They don't currently exist. It will also include fair and appropriate changes for home health that protect access to care.

I don't question the motives of my colleagues. They believe they are standing up for seniors in opposing the home health changes. But in truth they will harm them because they are hurting the Medicare Program. I don't think we want to hurt the Medicare Program. We are trying to help the Medicare Program by making these changes.

There is one other point I want to make. This is kind of interesting. I thought when I saw it—if I still have it—it is kind of interesting. The growth rate in home health care spending will continue to be very high after this legislation passes. Currently, the growth rate of the home health care industry is almost 11 percent per year. After the legislation, it will be almost an 8-percent annual growth in the home health care industry. That is much faster than the national health expenditures.

I think most things in life are a judgment call. I think one fairly decides that the changes in this bill are good for seniors and home health care providers because they are sensitive to the needs of the industry, sensitive to patients, frankly, but also responsible to the American taxpayers by making sure we are rooting out waste.

The PRESIDING OFFICER. The Senator from Texas is recognized.

Mr. CORNYN. Mr. President, I think as the American people are listening to the debate we are having on health care reform, they are being asked to accept some pretty implausible claims. One claim is that we can take $½ trillion out of Medicare and it would not have any impact on the delivery of services to Medicare beneficiaries—$½ trillion.

I think the biggest mistake about the way this bill is paid for, with the huge tax increases and huge cuts in Medicare, is the proposal to take $½ trillion out of Medicare, including $40 billion out of home health care, in order to pay for a brandnew entitlement program, when we already know Medicare itself is on a fiscally unsustainable path.

I want to talk primarily about another aspect of these cuts, and that is the 11 million seniors, including 532,000 Texans, who will lose benefits under their Medicare Advantage Program because these are not inconsequential cuts in their benefits. They are serious. I want to talk about some real human beings, some real Texans, who are going to be affected in a negative way by these cuts.

First of all, I think it is absolutely critical for the American people to understand that Medicare itself does not provide complete coverage to seniors. That is why so many seniors end up buying supplemental insurance coverage—Medigap coverage, as it is sometimes called—in order to get their bills paid for. Medicare only pays, on average, about 80 percent to providers of what private health insurance does. That is the reason, without additional compensation, many doctors will not see a new Medicare patient. They simply cannot do it and keep their doors open to their other patients.

The truth is, Medicare Advantage was created to fix some of the flaws with Medicare fee for service to give seniors more affordable and better coordinated health care. None of us are standing up saying the proposed bill is all bad because some of the positive developments in the bill call for greater coordination of health care.

On balance, it makes things worse than it does better because of these cuts in things such as Medicare Advantage.

The President of the United States has said providing Americans with a choice of quality, affordable health care was a guiding principle for him. I agree with that statement of principle. Medicare Advantage was created for that very purpose because, as I said, Medicare itself does not always work well for patients.

Where I live in Austin, TX, which is Travis County, the last time I saw a report, only 17 percent of physicians will see a new Medicare patient because Medicare reimbursement rates are so low. Those problems are avoided in large part by Medicare Advantage because it pays physicians and providers better than Medicare fee for service.

According to the American Medical Association's 2008 national health insurance report card, Medicare—not private health insurance—but Medicare had the highest percentage and the largest number of denied medical claims. In fact, Medicare denied 10 times more medical claims than private health insurers. That is another reason why seniors deserve a choice between Medicare and private plans that will offer them better benefits.

As I mentioned, today, 11 million Americans made that choice of better benefits and better care coordination through the Medicare Advantage Program. The proposed bill, the Reid bill, will take away those choices and the benefits of those 11 million seniors by cutting about $120 billion from the program.

Many of our friends across the aisle will say we can cut $120 billion out of Medicare Advantage, and it will have no impact on delivery of services. But the Director of the Congressional Budget Office disagrees with them, who says their additional benefits will be cut roughly in half.

We need to set the record straight on these so-called overpayments allegedly going to insurance company profits. It is simply a false statement. It is not true. Our colleagues know the so-called overpayments to Medicare Advantage plans do not go into those plans. They go to seniors in the form of additional benefits. That is because, under Federal law, 75 percent of additional payments to Medicare Advantage plans are used to provide seniors with additional benefits—benefits which they would not get under Medicare fee for service, benefits such as chronic care management, hearing aids, eyeglasses, and the like. The other 25 percent of any extra payments is returned to the Federal Government.

Let's be clear. Cuts to Medicare Advantage would be taking away seniors' health care benefits for those 11 million seniors. As I mentioned, ½ million Texans are on Medicare Advantage, and the Reid bill would cut their benefits by well over half. You do not have to take my word for it. Listen to what the CBO Director, Dr. Elmendorf, said when Senator CRAPO asked him during a Finance Committee hearing. He said:

So approximately half of the additional benefit would be lost to those current Medicare Advantage policy holders?

Director Elmendorf:

For those who would be enrolled otherwise under current law, yes.

Nearly one out of every four seniors in Texas would lose about $122 a month in health care benefits to create a new $2.5 trillion entitlement that their grandchildren will ultimately have to end up paying for. And $122 a month may not sound like a lot for people inside the beltway, but a couple from my hometown of San Antonio recently wrote to me:

Please vote to leave our Medicare Advantage plans alone. We can't afford anything else as our portfolio was wiped out in the stock market collapse last year. My wife and I have had to go back to work, and we are in our seventies.

Yet this bill would impose another $122-per-month cut in their benefits.

Another constituent of mine from Conroe, TX, wrote:

Please do what you can to protect the Medicare Advantage plans. I'm on one and it has been beneficial to me. It has saved me an enormous amount of money and given me the benefits I've needed.

Some groups that support these cuts to Medicare Advantage have a conflict of interest, to say the least, because the benefits under traditional fee for service, as I mentioned, for Medicare is about 80 percent of what private insurance will pay. In order to get coverage, in order to pay the bills, many seniors have had to buy additional insurance

coverage. For 11 million seniors, Medicare Advantage provides those benefits.

For many seniors, former employers sometimes provide wraparound plans. For retired military, TRICARE provides a wraparound plan. For many low-income seniors, Medicaid helps with cost sharing and premiums. For many other seniors, they purchase a standalone Medigap policy.

We heard from our friends across the aisle about AARP's endorsement of the Medicare cuts in the Reid bill. If it sounds odd that a seniors' advocacy group would support taking nearly $½ trillion from an already near bankrupt program, it should.

The fact is, as the Washington Post noted on October 27:

. . . But not advertised in this lobbying campaign have been [AARP's] substantial earnings from insurance royalty and the potential benefits that could come its way from many of the reform proposals . . . Democratic proposals to slash reimbursements for another program, called Medicare Advantage, are widely expected to drive up demand for private Medigap policies, like the ones offered by AARP, according to health care experts, legislative aides, and documents.

So AARP, the so-called seniors' advocacy group, is advocating for a cut in benefits to 11 million beneficiaries of Medicare Advantage. The suggestion is one reason they would do so is because they will profit from this bill because these seniors will, if they can afford it, have to go out and buy Medigap coverage from, lo and behold, entities such as AARP.

The fact is, Medicare Advantage allows private plans to innovate better and provides better coordinated care for seniors. Groups such as the Kelsey-Seybold Clinic in Houston, TX, which is basically not seeing Medicare fee-for-service patients but is seeing Medicare Advantage patients because they can afford to coordinate care, the kinds of things we know they ought to be doing to provide better care, but they cannot afford to do it on the fee-for-service Medicare.

We have had the Medicare Program around for more than 40 years. The fact is, government bureaucrats are still trying to get the complex reimbursement formulas right. We know, as the distinguished chairman of the Finance Committee has said, that under the fee-for-service program, which is part of what needs to be reformed in this health care bill, Medicare pays for volume and not value.

Some of the positive things which I have complimented the bill on is, it includes some small steps to change our current pay-for-volume program to a pay-for-value approach through various delivery system reform demonstration programs.

The irony is, Medicare did not think of these delivery system reforms; rather, Washington is finally catching up on what private sector innovators have been doing for years. We heard the distinguished Senator from Minnesota talk about the Mayo Clinic. The Mayo Clinic has been doing that. I mentioned Kelsey-Seybold in Texas. But private sector innovators have been doing this through the Medicare Advantage Program already.

The delivery system reforms in the Reid bill would allow Medicare to experiment with different approaches to changing physician incentives, such as accountable care organizations or physician quality reporting initiatives.

Will they work? I happen to think they will. We do know private sector innovators have already figured out how to change physician incentives in the sorts of ways we ought to be doing more of and not punishing by cutting Medicare Advantage.

One Medicare Advantage plan, HealthSpring, serves 20,000 seniors in my State. They have been a leader for changing incentives for physicians to focus on quality rather than quantity. I met with their leadership and heard how they have done it. What they told me is they have a collaborative partnership with their physicians. They call it Partnership for Quality. Physicians are accountable for both cost and quality based on an evidence-based set of quality measures.

The results are a win-win: better quality care leading to healthier seniors and physicians who succeed in meeting evidence-based quality standards and ultimately lower health care costs, which I thought was supposed to be one of the goals of health care reform.

Participating physicians were paid financial incentives for meeting their goal, but as a result of coordination of care and evidence-based quality standards, they actually ended up charging less and patients experienced better results too. Members needed fewer hospitalizations and emergency room visits. Preventive measures increased mammograms by 80 percent, diabetic foot exams by 360 percent, and flu vaccinations by 246 percent.

I have heard about HealthSpring's success from a couple in Farmers Branch, TX, who recently wrote to me. They said:

We had a Medicare supplemental policy for several years until they priced themselves out of the market. We are now with a Medicare Advantage plan called HealthSpring. We have been very happy with this plan and the way they are saving us money. Please do not change or eliminate this program.

Let me tell you about one other Texas company called WellMed. While the Reid bill would finally give Medicare the ability to experiment with medical homes and care coordination, a San Antonio-based company, a Medicare Advantage company called WellMed, has been using a medical home model to coordinate patient care and emphasize prevention for nearly 20 years.

To quote from an article last month in ''Inside San Antonio:''

The health care delivery model at WellMed puts the patient at the center of a team directed by a primary care physician. The team may include a nurse, health coach, hospitalist, social service worker and physician assistant.

According to WellMed CEO Dr. George Rapier, ''We really do have to bring back the old-time primary care doctor who cared for you, who was concerned about you, who was part of your family, and you were part of their family. It's a primary care physician who knows all about you. So if you need a specialist, they know the best specialist to send you to. If you need to go in the hospital, they make sure you get the appropriate care in the hospital. They are your coordinator of care. And that's really the concept of a medical home.''

There is no question in my mind that the model has been saving lives in my State. Here is a story about one Texan whose life was saved by physicians caring for him at WellMed:

For years, Crohn's disease weakened—

We will call him Ed—

Ed's immune system and left him susceptible to infections. One morning in 2001, he lacked energy to even get out of bed. His breathing became labored. He developed a cough that sounded ''wet.''

His worried wife called his primary care physician at WellMed, Dr. Marlene Sanchez, who wanted Ed hospitalized immediately so she could order a nuclear scan of his lungs. He protested.

''She told me that if he refused to go, I should call 911 and have the paramedics come get him,'' [his wife] Annette recalled. ''He heard Dr. Sanchez talking to me, the urgency in her voice, and that convinced him to go.''

The scan confirmed Dr. Sanchez's suspicions: A potentially fatal blood clot had traveled from Ed's leg to his lungs. He was successfully treated and recovered. [Ed and his wife] recently celebrated Ed's 74th birthday.

Annette credits Dr. Sanchez for saving Ed's life and for acting as a catalyst that keeps him thriving in their golden years.

''We have seen an abundance of doctors, from the cancer doctors to the dermatologist, gastroenterologist, the blood doctor, the heart specialist—Ed has gone through it all . . . and they've all been coordinated by his primary care doctor. I've been to other doctors outside WellMed and you don't get the feeling that they are communicating like this.''

Well, many Texas seniors currently enjoy these extra benefits under Medicare Advantage, such as—another benefit—the Silver Sneakers program, the Nation's leading exercise program for older Americans. This past year, one of the Silver Sneakers members personally visited my office to deliver testimonials from other Silver Sneakers members. One Texan said:

At my age I need a program to strengthen me all over but primarily to help me with my balance and coordination. I need these skills to keep me from falling and breaking my bones.

Another participant in the Silver Sneakers program said:

I am 66, have been in the Silver Sneakers program a year. Prior to that I led a sedentary life, which included many health problems. I had hypertension, high cholesterol, chronic bladder condition, and mild depression. Since coming to classes and utilizing the weights and cardio machines, my life has improved immensely. My blood pressure has dropped, my cholesterol has been

lowered, my chronic bladder condition has improved and I just feel better all around. I am no longer depressed because I look better and look forward to going to class and visiting with my friends.

These cuts in Medicare Advantage are going to have a direct impact on the benefits my constituents in Texas are benefiting from—the 532,000 Texans who are currently on Medicare Advantage—and what they are asking me—which I can't answer—is why in the world would we want to cut Medicare Advantage, which actually works, as opposed to Medicare fee for service, which does not work well? Why would we take a fiscally unsustainable program, such as Medicare, which is going insolvent in 2017, and use that to create a $2.5 trillion new entitlement program?

My constituents, the seniors who have paid into Medicare all these years, are saying: It is not fair to take the money we have paid into Medicare and use it to create yet another entitlement program and not to fix Medicare itself. So I believe we need to fix Medicare's nearly $38 trillion in unfunded liabilities. We need to fix the improper payment rate of roughly 1 out of every 10 Medicare dollars which results in somewhere on the order of a minimum of $60 billion of fraudulent payments each year. We need to put it on a fiscally sustainable path, rather than taking $½ trillion from Medicare for another ill-conceived Washington health care takeover.

I don't believe my constituents believe you can take $½ trillion out of these programs, just as they do not believe you can take more than $100 billion out of Medicare Advantage, and it will have no impact on their benefits. They don't buy it. They don't believe it, and I don't either.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Mr. President, it is late in the evening. I was going to address three different issues tonight, but out of respect for Senator BAUCUS, the chairman of my committee, I am going to address just one of these issues and I will come back tomorrow morning, on Saturday, and speak on the rest of the issues.

The one issue I am going to address this evening is my support of the Senator from Nebraska and his motion to commit with instructions on the home health care aspect of this 2,074-page bill. That is Senator JOHANNS' motion. We are now considering a bill that cuts $½ trillion from a Medicare Program to fund yet another unsustainable health care entitlement program. Around $42 billion comes from cuts to home health care providers—hence the purpose of Senator JOHANNS' amendment that that not happen.

You have heard from Members on this side of the grave consequences of these cuts. Several Senators have already addressed these. These severe cuts pose a legitimate threat to beneficiaries' access to home health services. In my State of Iowa alone, there are around 160 home health agencies that provide valuable services to Medicare beneficiaries across the State. Thanks to these home health care providers, seniors in Iowa are able to live at home instead of institutional settings, such as nursing homes. These seniors place great value on being able to stay in their homes. I would have to say that in all the years I have been involved in senior issues, whether it has been chairman of the Aging Committee, or chairman and now ranking member of the Finance Committee, I haven't run into one single senior citizen in my State who said to me: I am just dying to get into a nursing home. They do not want to go there.

So that is the purpose of home health agencies, to save money, but it is to retain the quality of life, and maintain the quality of life for these citizens. I rarely hear Iowans say anything about living in a nursing home, except not to go there.

Since living at home has been found to be a more cost-effective alternative than institutional care, this results in Medicare spending less. These cuts that are in this 2,074-page Reid bill will make it even harder for Iowa home health care providers to care for Medicare beneficiaries. A good part of the Medicare home health cuts come from permanent productivity adjustments.

Let's look at the possibility—or I would say I have concluded the impossibility—of bringing greater productivity to nursing home care. You have heard this week about how Medicare's chief actuary found savings from these productivity adjustments to be very unrealistic. And just so you know that the letter I refer to from the chief actuary is real, observe this chart. You also heard this week how these permanent cuts would make it harder for providers to remain in the black. You also heard these providers might end their participation in Medicare and possibly then jeopardize access to care for beneficiaries, and probably then more people ending up in the more expensive environment of a nursing home.

The threat to access to home health care from these permanent productivity cuts isn't theoretical. It is real. Like many other Medicare providers, home health agencies provide labor-intensive services. It is because of these labor-intensive services that I raise the question and the possibility—and I say it ends up being an impossibility—for them to be more productive. There are few gadgets in home health that will increase productivity. And whatever available gadgets there are, they are unaffordable for many Iowa home health agencies because they are small operations with limited financial resources.

Home health care is about doctors, it is about nurses, and home health aides, and it is about all of these providing care to the most needy. So it is incorrect, in my judgment, to assume these providers will achieve the levels of productivity like the rest of the economy.

The HHS chief actuary's findings clearly apply to home health in my State of Iowa, as they do nationally. Just to remind you: ''The estimated savings may be unrealistic;'' and ''possibly jeopardizing access to care for beneficiaries for our seniors.'' More people in nursing homes.

Because of these cuts, the percent of Iowa home health agencies that have negative Medicare margins will increase to 75 percent. So over 120 of the 160 home health providers will have negative Medicare margins because of this 2,074-page Reid bill. Iowa providers are not alone. From ½ to 90 percent of home health agencies in States across the country would have negative Medicare margins.

I ask a unanimous consent to have printed in the RECORD three letters, which I wish to put in at various places in my remarks.

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

(See exhibits 1, 2, and 3.)

Mr. GRASSLEY. Mr. President, I have here a letter dated September 23 of this year from Val Halamadaris, the president of the National Association for Home Health and Hospice. This organization represents home health agencies across the country.

Mr. President, Mr. Halamadaris wrote this letter in response to the $43 billion in home health cuts in the Finance Committee package, which presumes to be the same number that is used in the Reid bill. In this letter, he stated:

> It is crucial to the survival of the home health services delivery system that you work to reduce the $43 billion in cuts currently contained in the Senate Finance Committee's health reform package. Our analysis indicates that by 2016, the proposed cuts in home health care services payment rates will lead to nearly 70 percent of providers nationwide at risk of closing because their costs will exceed Medicare payments. If that occurs, President Obama's promise that Medicare beneficiaries will not be adversely affected by health care reform will be broken.

I have yet to hear from a home health care provider in Iowa that these permanent cuts will make it easier for them to care for their Medicare beneficiaries. Instead, I hear these cuts would reduce access to home health services.

The second letter I asked to have inserted in the RECORD is from the Iowa Alliance in Home Care, and they wrote:

> Ensuring that Medicare home health payments are not reduced further is essential to avoid the resulting limited or no access to home health services for many Iowans who prefer to receive services in their home.

Not only is the chief actuary saying it, as the chart reflects, but people who are connected with the business of home health care are saying it: These permanent cuts will in fact jeopardize access to home health services in Iowa. So if the home health cuts in the Reid bill are allowed to go into effect, then

Iowa's seniors, who prefer to live full lives from their homes, will be forced to live in the more expensive settings of facilities such as nursing homes.

I believe many Members on both sides of the aisle share my concern about home health care cuts.

I have here a third letter, this one dated from July 27, 2007, and it is written to Senator BAUCUS and me.

Mr. President, I use this letter, even though it is 2 years old, because we were getting entreaties from 61 of our colleagues—of which 52 now still serve in the Senate—about a legislative proposal to cut Medicare home health payments in that year—2007—by $9.7 billion and hospice payments by more than $1.1 billion. They urged me and Senator BAUCUS, at that time, to ensure that home health and hospice providers receive full market basket inflation adjustments. They also urged us to oppose any cuts in payment rates through administrative actions.

In the letter, these Members stated that home health and hospice care ''have been demonstrated to be cost-effective alternatives to institutional care in both Medicare and Medicaid programs.'' They stated that ''reducing Medicare home health and hospice payments would place the quality of home health care and hospice and the home care delivery system at significant risk.''

Of these 61 Senators who signed this letter 2 years ago, 52 are currently here debating this bill in the Senate. Of those 52 Senators, 37 are from his side of the aisle who are now proposing $43 billion in cuts instead of $9.7 billion in home payment cuts and $1.1 billion in hospice payments cuts. I would think they would find these kinds of cuts three or four times—four times what we were talking about 2 years ago to be very unrealistic, and to keep home health as a viable organization going.

We also must look beyond health care when we look at the impact of these permanent cuts. I have also heard from providers in Iowa that permanent cuts such as these will make it even harder for them to keep their doors open. So around 3,500 Iowans who work at home health agencies are at risk of losing their jobs at a time when we have 10 percent unemployment, at a time when more of this country is concerned that Congress ought to be working on creating jobs, jobs, jobs as opposed to the health care issue and in some cases cutting jobs out. The Labor Department reported today that unemployment is 10 percent. Now is not the time to consider bills that increase unemployment rates.

About an hour ago, the Senator from Nebraska offered this motion I am speaking in favor of now, to send this bill to the Finance Committee with instructions to report a bill without these very enormous home health cuts that are in it. We should take this opportunity to fix the bill and then come back to the full Senate with a better bill. That is why I support the motion of the Senator from Nebraska to commit, and I urge my colleagues to do the same.

I yield the floor.

EXHIBIT 1

NATIONAL ASSOCIATION
FOR HOME CARE & HOSPICE,
Washington, DC, September 23, 2009.

Re Medicare Home Health Services.

Hon. CHARLES E. GRASSLEY,
U.S. Senate,
Washington, DC.

DEAR SENATOR GRASSLEY: I am writing to thank you for your continued support of home care patients nationwide and to enlist your help to ensure that access to home health services remains a reality for more than 3 million senior and disabled individuals that benefit from these important services.

It is crucial to the survival of the home health services delivery system that you work to reduce the $43 billion in cuts currently contained in the Senate Finance Committee's health reform package. Our analysis indicates that by 2016, the proposed cuts in home health services payment rates will lead to nearly 70% of providers nationwide at risk of closing because their costs will exceed Medicare payments. If that occurs, President Obama's promise that Medicare beneficiaries will not be adversely affected by health care reform efforts will be broken.

Invariably, providers of services facing rate cuts always cry out that care will be lost. However, history tells us that our warning should be heeded. The Balanced Budget Act of 1997 was expected to cut home health services spending by $16.1 billion in five years. Instead, the rate changes cut over $70 billion, leading to the loss of care to nearly 1.5 million Medicare beneficiaries. That change also led to higher outlays under state Medicaid programs, as well as greater use of nursing homes, hospitals, and other institutional settings. Still today, about $17 billion is spent on home health services, as compared with about $19 billion in home health outlays in 1997.

Several factors need to be understood about the current Finance Committee proposal. First, the proposal is not consistent with MedPAC advice. The proposal reduces rates to a point where Medicare margins will average zero. MedPAC, in its deliberations, clearly recognized the need for some level of margin in order to stay in business. In fact, we understand that MedPAC's executive director, Mark Miller, informed House Ways and Means members that MedPAC did not recommend a zero margin.

Second, there is a serious misunderstanding of Medicare margins. MedPAC estimates margins for 2009 will be 12.2%. However, this estimation does not include the impact of nearly 7% in rate reductions planned by way of regulation by 2011. Further, it does not include nearly 1,700 important providers of home health services, hospital-based agencies. Also, it does not reveal that the ''average'' is made up of a very wide range of individual agency margins with over 30% below zero already. Finally, reliance on Medicare margins does not convey that the total margin of agencies is estimated at 2% with Medicaid and Medicare Advantage losses driving the overall margin down.

Third, unlike other health care providers such as hospitals, the expansion of health insurance will not bring additional business of any material level. Home health patients average nearly 80 years of age and are already insured by Medicare or Medicaid. This means that the Medicare cuts to home health agencies are not offset by new revenues from newly insured patients. Instead, the proposed cuts of over 13.5% of spending on home health services will be as real as can be.

Fourth, the home health services community has put forward a credible and substantive alternative set of proposals for reforming the Medicare payment system. While the Chairman's Mark incorporates many of these proposals, the level of cuts is unsustainable. In fact, the level of cuts exceeds the $34 billion President Obama's budget recommended by nearly $10 billion. Still, the industry's proposal itself meets or exceeds the Obama budget target.

Fifth, the home health services cuts are far disproportionate to other provider sectors. The Chairman's Mark seeks 9.4% of all the Medicare cuts from home health care while home health makes up only 3% of the Medicare program currently. That disproportionate impact is further magnified by the fact that, unlike most other health care providers and insurers, expanding health insurance will have no meaningful increase in home health care business.

This is a historic time in this country, an opportunity to secure health care for all as a fundamental right. However, these reforms should not be done at the expense of our most vulnerable senior citizens, the homebound and infirm. Your leadership on this matter is greatly appreciated. Please let us know what we can do to help you succeed.

You have my great respect and admiration, now and always.

Sincerely,

VAL J. HALAMANDARIS,
President.

EXHIBIT 2

IOWA ALLIANCE IN HOME CARE,
Des Moines, IA, December 4, 2009.

Hon. CHARLES GRASSLEY,
Ranking Member, Committee On Finance, Dirksen Senate Office Building, Washington, DC.

SENATOR GRASSLEY: I'm contacting you today to urge your assistance concerning an issue of great significance to Iowa's dedicated home care nurses and other providers of valuable and needed in-home health care services to Iowans. The Iowa Alliance in Home Care respectfully requests your support to have the Senate Finance committee report back to the Senate, in response to a motion with instructions, a modified H.R. 3590 bill that does not include cuts in Medicare payments to home health agencies totaling $42.1 billion.

Your urgent action is critically important to ensure that access to quality health care services delivered in the home setting is not compromised. Proposed cuts in Medicare home health reimbursement would be devastating as most of Iowa's home care providers (i.e. public health departments, small businesses) rely largely or exclusively on Medicare and Medicaid payment to justify their operations which includes employment for thousands of Iowans. Insufficient Medicaid home health reimbursement, recently worsened by Governor Culver's ATB state budget cuts, has been reduced by an additional 5% effective 12/1/2009. In short, ensuring that Medicare home health payments are not reduced further is essential to avoid the resulting limited or no access to home health services access for many Iowans who prefer to receive services in their own home.

Senator, thank you for your past home health care support. We would greatly appreciate your immediate attention to this most critical of needs for our Iowa home health care community.

Regards,

MARK WHEELER,
Executive Director.

EXHIBIT 3

U.S. SENATE,
Washington, DC, July 27, 2007.

Hon. MAX BAUCUS, *Chairman,*
Hon. CHARLES GRASSLEY, *Ranking Member,*
Senate Finance Committee,
Washington, DC.

DEAR CHAIRMAN BAUCUS AND RANKING MEMBER GRASSLEY: Home health and hospice have become increasingly important parts of our health care system. The kinds of highly skilled and often technically complex services that our nation's home health and hospice agencies provide have enabled millions of our most frail and vulnerable seniors and disabled citizens avoid hospitals and nursing homes. By preventing such institutional care, home health and hospice services save Medicare millions of dollars each year. Most importantly, they enable individuals to stay just where they want to be—in the comfort and security of their own homes. We therefore urge you to ensure that Medicare beneficiaries continue to have access to important home health and hospice services by supporting full market basket inflation adjustments, as provided under current law, and opposing any cuts in payment rates through administrative actions.

The Administration's FY 2008 budget includes a legislative proposal to cut Medicare home health payments by $9.7 billion and hospice payments by more than $1.1 billion over five years. It also includes additional administrative cuts in payment rates. The Medicare home health benefit has already taken a larger hit in spending reductions over the past ten years than any other Medicare benefit. In fact, home health as a share of Medicare spending has dropped from 8.7 percent in 1997 to 3.2 percent today, and is projected to decline to 2.6 percent of Medicare spending by 2015. This downward spiral in home health spending began with provisions in the Balanced Budget Act of 1997 (BBA), which resulted in a 50 percent cut in Medicare home health spending by 2001—far more than the Congress intended or the Congressional Budget Office (CBO) projected.

We believe that further reductions in home health and hospice payments would be counterproductive to controlling overall health care costs. Home health and hospice care have been demonstrated to be a cost-effective alternative to institutional care in both the Medicare and Medicaid programs. In fact, the Medicare Payment Advisory Commission (MedPAC) has noted the results of a 2002 RAND study which showed ''in terms of Part A costs, episodes in an inpatient rehabilitation facility or skilled nursing facility are much more costly for Medicare than episodes of care among patients going home.'' (MedPAC's June 2005 Report to Congress).

Further reducing Medicare home health expenditures would also be in direct conflict with the Administration's desire to prioritize health care in the home as a cost-effective alternative to institutional care. During the World Health Congress in February of 2005, Secretary of Health and Human Services Michael Leavitt said: ''Providing the care that lets people live at home if they want is less expensive than providing nursing home care. It frees up resources that can help other people. And obviously, many people are happier living at home.''

Reducing Medicare home health and hospice payments would place the quality of home health care and hospice and the home care delivery system at significant risk. Several factors have contributed to the increased cost of providing care in the home over the past few years, including:

The cost of travel by clinicians to patients' homes;

The use of technology, like telehealth monitors, which is not covered by Medicare;

The need to pay significantly higher salaries for nurses, therapists, and home health aides to attract these individuals from the scarce supply of clinicians nationwide.

Many home health providers currently do not have a sufficient number of clinical staff to accept patient referrals from physicians and hospitals. As a consequence, hospital discharge planners have reported that they are finding it more difficult to refer patients for home health care. Additional cuts to the home health benefit could leave home health providers no alternative but to reduce the number of visits and/or patient admissions, which would ultimately affect access to care and clinical outcomes. In addition to these costs, hospices are also experiencing rising costs for pain management pharmaceuticals, and they are also finding that patients with shorter lengths of stay are requiring more intensive services.

In order to ensure that home health care and hospice remain a viable option for Medicare patients, we urge you to support full market basket updates for home health and hospice, as provided under current law, and to oppose any cuts in payment rates through administrative action. Thank you for your consideration of this important matter.

Sincerely,

Susan M. Collins; Russ Feingold; Christopher S. Bond; Jack Reed; Patrick J. Leahy; Arlen Specter; Norm Coleman; Sheldon Whitehouse; Robert Menendez; Ken Salaar; Barack Obama; Kent Conrad; Thomas R. Carper; Barbara Mikulski; Joe Lieberman; E. Benjamin Nelson; Daniel K. Inouye; Tom Harkin; Robert C. Byrd; Frank Lautenberg; Amy Klobuchar; Herbert Kohl; Byron L. Dorgan; Daniel K. Akaka; Barbara Boxer; Tim Johnson; Johnny Isakson; Evan Bayh; Jim Webb; Patty Murray; Chuck Hagel; Joseph R. Biden, Jr.; Robert P. Casey, Jr.; John F. Kerry; Hillary Rodham Clinton; Sherrod Brown; Christopher J. Dodd; John Thune; Carl Levin; John W. Warner; Saxby Chambliss; Ron Wyden; Mark L. Pryor; Maria Cantwell; Robert F. Bennett; Bernard Sanders; Charles E. Schumer; Richard G. Lugar; Dianne Feinstein; Larry E. Craig; John Cornyn; Benjamin L. Cardin; Edward M. Kennedy; Pete V. Domenici; Bill Nelson; Kay Bailey Hutchison; David Vitter; Pat Roberts; John E. Sununu; Mary Landrieu; Sam Brownback.

The PRESIDING OFFICER. The Senator from Alabama is recognized.

Mr. SESSIONS. Mr. President, before the Senator leaves, he is a man of great character and experience in these matters.

I have a letter from a constituent who writes to urge a vote against this health care bill. This is from Mr. Bill Eberle in Huntsville, AL. He says:

The worst part of this bill is that much of the cost will be paid for by cuts to Medicare.

I think the Senator has indicated he believes that is accurate.

He goes on to say:

I am 68 years old and I have paid into Medicare for 40 years, believing it would cover much of my health care costs when I became 65. Now I am being told that the Government has found people who need the coverage more than I do and they will cut the care for which I have paid for 40 years in order to cover people who have paid nothing into the program. It is not the Government's money. The money belongs to those of us who paid into it for so many years and are watching as it is being taken away from us.

My question to my colleague is, since the Senator has been so intimately involved with Medicare over the years, is it not true that every working American has money taken out of their paycheck to fund their Medicare and that they believe and we have a compact with them that when they reach 65, they will have the benefit of that?

Mr. GRASSLEY. When they reach age 65, they will have that benefit.

Mr. SESSIONS. Yes, 65. Yes.

Mr. GRASSLEY. To the tune of 2.9 percent of payroll. That is how much a self-employed person would pay. And an employee would pay 1.45 percent and the employer would pay 1.45 percent. Then, you know this 2074-page bill adds half a percentage point to those, so you are going to get it to a point where it is almost 2 percent for the employer, 2 percent for the employee, and it would be almost 4 percent for a self-employed person paying into this that is now going to be raided to finance a brandnew entitlement program.

Mr. SESSIONS. My constituent, then, is fundamentally correct in his concern?

Mr. GRASSLEY. I sense a great deal of resentment coming through in that letter, from the words of that letter from that person, that what he has paid into, for the probably 45 years of working before he retired—that now, with Medicare already being in jeopardy, based on the trustees' report which says that by 2017 there is not going to be any money in the trust fund, and then having $464 billion taken out of that trust fund to help finance a new entitlement program at a time when the present entitlement programs are in a great deal of financial jeopardy.

Mr. SESSIONS. I think you stated that so well. Just to reemphasize, this gentleman, Mr. Eberle, who paid into Medicare for 40 years, until he got to be 65, he got not a dime of Medicare benefit, did he?

Mr. GRASSLEY. No. The only way he would have gotten benefits is if he had become disabled before age 65.

Mr. SESSIONS. He pays into it all these years and just now gets to draw it, and people start taking it out.

I thank Senator GRASSLEY for his leadership on this issue. I think he and I come out of the soil of our States, out of the real world. My impression is that nothing comes from nothing. Would you agree? Somebody has to pay?

Mr. GRASSLEY. I say it this way. We are in a town where we are dealing with a lot of Washington nonsense, and I hope, from the rural areas of Alabama, like the State of Iowa, you bring a lot of common sense to this town where there is not a lot of it.

Mr. SESSIONS. I thank the Senator. I would say the matter is a very serious one we are dealing with. Today, I had the opportunity to talk to a very experienced person involved in health care issues for many years. I expressed my bafflement about some of the disagreements we have, about huge issues.

One of my staffers wrote down what he said. He said: ''In all my years I have never seen such transparent dishonesty in the Congress.''

He said ''it is the biggest fraud that has been perpetrated in the history of our country,'' in his opinion.

Here we have a situation. I want to say I am going to pursue this in a little more detail. I am not going to go into great length tonight. But we have an amendment—Senator BENNET offered an amendment yesterday that said we wouldn't cut guaranteed benefits for Medicare. But the way this deal is being done is they are cutting payments to providers of Medicare.

We are already reaching, as Senator GRASSLEY said, a national crisis because by 2017 we will not be able to have a surplus in Medicare, we are going into default in Medicare. Where are we going to get the money?

Could we have efficiencies? Could we save some money in Medicare? Could we do some things to keep the program afloat? Perhaps. But if we do so, should not we use it, should not we use any efficiencies in savings that we could scrape together without damaging the commitment we have to our seniors—should not we use those savings to save Medicare that is going into default? I suggest that is a moral and legal commitment.

Mr. Eberle has written to me. He has paid for 40 years. He has not been able to draw anything out of it for the 40 years he has paid into it. Now he gets ready to draw, and we are telling him we are going to cut $465 billion out of the Medicare payment. This is not a little bitty matter.

We seem to have amazing—we seem to have this dispute. One group, from the other side, says: Don't worry, we are not taking $465 billion from Medicare, and we wouldn't cut Medicare, and we don't believe in cutting Medicare, and we don't want to hurt Medicare in any way. Our side over here is saying: But you are. According to the numbers that are pretty plain in this legislation, hospitals will have a $135 billion reduction; hospices, you have $8 billion for life-ending care that has been so helpful to so many families; nursing homes have a $15 billion reduction; Medicare Advantage, $120 billion; home health agencies that Senator GRASSLEY talked about, a $42 billion reduction. Are we imagining this? Have we somehow formulated this? It all totals up to about $465 billion.

This matter, I suggest, is not going away. Either we have reality here or not. I believe the facts will show that we are raiding Medicare, we are weakening that program when it is already known to all of us in this body that Medicare is not actuarially sound.

I remember when President Bush determined, in a failed effort, to try to alter Social Security in a way that he believed would put it on a more sound footing. He got no help at all. We had many of our Senators on both sides of the aisle saying: If you really want to do something, as bad as Social Security is, Medicare is in a much worse financial fix. Why aren't you fixing it?

I remember a number of years ago, 10 or more, when Senator JUDD GREGG, then chairman of the Budget Committee, tried to come up with some legislation to contain a little of the growth in Medicare. Over 5 years, he had a plan that would contain the growth by $10 billion. Not a single Democrat voted for the Gregg proposal. Now they accuse the Republicans of trying to damage Medicare when, in fact, every penny of the $10 billion to be saved was going to be utilized to strengthen Medicare and try to keep it from going into default.

Now we are talking about taking $465 billion out of Medicare and starting a new entitlement program, a new entitlement program at the time that this Nation has just passed or just incurred the largest single deficit in the history of the American Republic, $1.4 trillion. Next year, we will be over $1 trillion, according to the Congressional Budget Office—not me.

Is this smart? To have a program that people have depended on, that we have a moral compact to support—to support our seniors who paid into this plan for 40 years, now taking money out of that to create a new program? It is, in fact, in quite a number of areas, going to cost far more than is being suggested by the people who are promoting the legislation. We are going to dig into this and try to analyze it with more clarity, but the truth is, the numbers just do not add up. They will not work. We just ought not to be establishing a new entitlement program of massive proportions in a way where we really have little concept of how it is going to play out at a time of the largest deficits this Nation has ever had, deficits that, according to our own Congressional Budget Office, will double the national debt in 5 years and triple it to $17 trillion in 10 years.

It is an unsustainable course, and one of the first things we have to do is watch how we spend our money. I talked to an individual today. He said: It is like your house is in serious need of repair. You really don't have the money to fix it. You finally decide you have to borrow money to fix the house, and instead you borrow money and add a wing onto the house.

We need to fix the house we have. We need to make sure we honor our commitment to Medicare recipients. They have already paid. That is the important point to remember. They have already paid their working life under a compact and a commitment that money would be in a fund that would be available. We ought not to be taking it away.

I urge colleagues to think about this. This is perhaps the most significant fatal flaw in the legislation. It just doesn't add up. There are others, but this one, to me, is the most dramatic, the most pernicious, the one that is most unwise. We simply need to slow down, ask ourselves how we can make our health care system better, how we can do it without breaking the bank. Aren't there some things we can do to improve health care without a huge cost? Yes, there are. Let's start with every single one of those we can agree on. If we do that, I think we could make a lot of progress.

Who knows, if this economy turns around—and we all hope it will—we would be in a better footing to consider a new benefit in the future.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

MORNING BUSINESS

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Senate proceed to a period of morning business, with Senators permitted to speak up to 10 minutes each.

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

REMEMBERING MAJOR GENERAL CHARLES BEACH, JR.

Mr. MCCONNELL. Mr. President, I am here today to remember the life of a dear friend, MG Charles Beach Jr., of Beattyville, KY. General Beach passed away this past Veterans Day, at the age of 90. He was a genuine servant to his country, his hometown, and the Commonwealth of Kentucky. While General Beach will be greatly missed, the contributions that he has made to Kentucky, and the sacrifices that he has made for this Nation, will surely live on as his legacy.

Charles Beach knew from a young age that he wanted to serve his country, and in 1940, he graduated from the Virginia Military Institute in Lexington, VA. Shortly after graduation, he completed his special training and began his active service. While in Italy in 1944, Charles became severely wounded during battle. He spent the next 8 months recovering in a military hospital and was awarded the Purple Heart.

Charles Beach joined the Army Reserves after he was released from active duty. After a short time in the Reserves, Beach was recommissioned into the U.S. Army, this time with the rank of major. In 1976, he was promoted to major general after becoming the 18th Commander of the 100th Division, where he commanded the Kentucky Army Reserve Training Division.

General Beach's contributions extended beyond his military service; he was an active member of his beloved hometown of Beattyville. The general served his community through many organizations including, as chairman of People Exchange Bank and Insurance, president of the Beattyville/Lee County Chamber of Commerce, president of September Place Retirement Village, and cofounder of a scholarship program to aid eastern Kentucky students wanting to pursue careers in medicine.