HEALTH CARE

Mr. KYL. Mr. President, that brings me to the final point. In yesterday's Wall Street Journal, an article is entitled ''ObamaCare's Real Price Tag.'' It goes through all the different expenses of the proposed health care legislation, with the creation of a government insurance company. They talk about the funding gap that is created by the commitments of funding to this entire program. One of the things they notice is people need to be aware of the long-term consequences. We all know that Medicare, for example, is not financially sound. We can go out through the 5-year projections, 10-year, 15-year, 20-year, and so on, and know what the obligations of our children and grandchildren will be.

When we pass regular legislation in Congress, we have a set of blinders that says: What is the 10-year cost? We get it, and then we assume there are no more costs beyond that. What this oped points out is, we can calculate a 10-year cost. Maybe it is $1 trillion or $2 trillion or maybe it is more than that. We can at least estimate it. That is what the CBO and the Joint Tax Committee are charged with doing. Then there is an assumption that there is no cost beyond that.

What the people who write the legislation frequently do is to build in benefits in the early years and then phase in the ways of paying or not paying for it, so the real costs come in the so-called outyears—the outyears are beyond the 10-year window—so that it doesn't score as a big loser. What they point out is, in effect, what this legislation does is gone out for 10 years and creates a cliff. When you fall off the cliff, that is when you are in trouble because the commitments to the people for health care have been already made.

Can you imagine Congress pulling back on those commitments? Once there is an expectation from government, that is not lightly withdrawn. The American people come to expect it, and there is a big lobby against it, if you try to withdraw the benefit. But if you haven't provided for how you are going to pay for it, there is a very rude and sudden awakening when you come to the cliff and realize you haven't folded into your calculations how you are going to pay for this benefit.

We did that with the so-called SCHIP legislation. We created a benefit, and the benefit kicked in early. The funding ostensibly stopped after a certain period of years. But everybody knew the funding would not stop. That required the suspension of belief. I guess it is called cognitive dissonance. The notion that somehow or another Congress is going to, at the end of that period of time—I believe it was 5 years—pull back all the benefits we had been giving to people for 5 years, that was not going to happen.

So you had the commitment to provide benefits, but no way to pay for them. As this article points out, that is what is happening with this health care legislation as well.

Let me quote from the third paragraph:

In the July 26 letter, CBO Director Douglas Elmendorf notes that the net costs of new spending will increase at a more than 8 percent per year between 2019 and 2029—

There we are talking about the next 10 years, not the first 10 years.

—while new revenue would only grow at about 5 percent. ''In sum,'' he writes, ''relative to current law, the proposal would probably generate substantial increases in federal budget deficits during the decade beyond the current 10-year budget window.''

The point is, we should not look at these things during the first period of time that we analyze them, but rather the continuing commitment of the American taxpayer. When we do that, as the Director of the CBO points out, we find that we have a continuing, growing deficit; in other words, piling up more and more debt and, if anything, my guess is that these estimates are conservative and that the amount of deficit would be even more.

The editorialist in the Wall Street Journal had complained about this, talking about the ''Grand Canyon'' between spending and revenue, pointing to the CBO's long-term projections, and then said:

That's not our outlook. That's what White House Budget Director Peter Orszag told the House Budget Committee in June. He added that ''If you're not falling off a cliff at the end of your projection window, that is your best assurance that the long-term trajectory is also stable.''

As the editorial points out: ''The House bill falls off a cliff.''

So the precise thing we are trying to avoid in intelligent legislating is not avoided in the Democratic health care proposals: benefits promised now, ostensibly paid for in the first 10 years, not paid for after that. That is not me talking, as I said, that is the nonpartisan Congressional Budget Office.

There are other examples of this pointed out, but as the editorial notes in conclusion:

ObamaCare's deficit hole will eventually have to be filled one way or another—along with Medicare's unfunded liability of some $37 trillion.

I read that last night, and I had to go back and reread it—unfunded deficit of $37 trillion. It is impossible for us to imagine how much money that is—$37 trillion just for current obligations, not counting what would be added by the ObamaCare.

We cannot afford this, and I think the American people are beginning to appreciate we cannot afford it. There is no free lunch. The Federal Government cannot simply keep promising things and not worry about the costs in the future. We can only print money for so long before we have rampant inflation that destroys the wealth of everyone, primarily the people who have saved in the country, which starts with our senior citizens.

We cannot borrow our way out of it because the main people who continue to lend to us, such as the Chinese, have begun to lecture us on the fact they don't trust we are going to pay them back now, and they are going to start requiring more and more in the way of interest payments for them to continue to lend to us.

It is a little bit like the credit card company that says to a family: Look, you have borrowed a lot of money on your credit card. We are not sure that you are going to be able to pay that back to us. So if you are going to borrow more money on the credit card, we are going to double the interest rate to make it a high interest rate so at least it accounts for our risk in lending you more money. Borrowing more money from the Chinese at higher interest rates is not the answer.

The other alternative is to tax the American people. Everybody understands taxing the American people is the worst thing you can do for an economy, especially in a downturn. Americans believe they are already taxed enough. You cannot tax the rich and solve the problem because they already pay most of the taxes and it would only account for another few hundred billion dollars, even if you taxed them for everything they are worth.

You eventually get down to the middle class. The President has said over and over that he does not want to tax the middle class. The reality is that it is unavoidable if we continue to consider legislation such as this.

Mr. President, I ask unanimous consent to have printed in the RECORD this Wall Street Journal op-ed of August 6 called ''ObamaCare's Real Price Tag.''

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

[From the Wall Street Journal, August 6, 2009]

OBAMACARE'S REAL PRICE TAG

The funding gap is a canyon by year 10.

ObamaCare sinks in the polls, Democrats are complaining that the critics are distorting their proposals. But the truth is that the closer one inspects the actual details, the worse it all looks. Today's example is the vast debt canyon that would open just beyond the 10-year window under which the bill is officially ''scored'' for cost purposes.

The press corps has noticed the Congressional Budget Office's estimate that the House health bill increases the deficit by $239 billion over the next decade. But government-run health care won't turn into a pumpkin after a decade. The underreported news is the new spending that will continue to increase well beyond the 10-year period that CBO examines, and that this blowout will overwhelm even the House Democrats' huge tax increases, Medicare spending cuts and other ''pay fors.''

In a July 26 letter, CBO director Douglas Elmendorf notes that the net costs of new spending will increase at more than 8% per year between 2019 and 2029, while new revenue would only grow at about 5%. ''In sum,'' he writes, ''relative to current law, the proposal would probably generate substantial increases in federal budget deficits during the decade beyond the current 10-year budget window.'' (The House bill has changed somewhat in the meantime, but not enough to alter these numbers much.)

The nearby chart shows this Grand Canyon between spending and revenue, including CBO's long-term predictions. While these are obviously very coarse estimates, there's also a projection of a $65 billion deficit in the 10th year—and ''deficit neutrality in the 10th year is . . . the best proxy for what will happen in the second decade.''

That's not our outlook. That's what White House budget director Peter Orszag told the House Budget Committee in June. He added that ''If you're not falling off a cliff at the end of your projection window, that is your best assurance that the long-term trajectory is also stable.'' The House bill falls off a cliff.

And the CBO score almost surely understates this deficit chasm because CBO uses static revenue analysis—assuming that higher taxes won't change behavior. But long experience shows that higher rates rarely yield the revenues that they project.

As for the spending, when has a new entitlement ever come in under budget? True, the 2003 prescription drug benefit has, but those surprise savings derived from the private insurance design and competition that Democrats opposed and now want to kill. The better model for ObamaCare is the original estimate for Medicare spending when it was passed in 1965, and what has happened since.

That year, Congressional actuaries (CBO wasn't around then) expected Medicare to cost $3.1 billion in 1970. In 1969, that estimate was pushed to $5 billion, and it really came in at $6.8 billion. House Ways and Means analysts estimated in 1967 that Medicare would cost $12 billion in 1990. They were off by a factor of 10—actual spending was $110 billion—even as its benefits coverage failed to keep pace with standards in the private market. Medicare spending in the first nine months of this fiscal year is $314 billion and growing by 10%. Some of this historical error is due to 1970s-era inflation, as well as advancements in care and technology. But Democrats also clearly underestimated—or lowballed—the public's appetite for ''free'' health care.

ObamaCare's deficit hole will eventually have to be filled one way or another—along with Medicare's unfunded liability of some $37 trillion. That means either reaching ever-deeper into middle-class pockets with taxes, probably with a European-style value-added tax that will depress economic growth. Or with the very restrictions on care and reimbursement that have been imposed on Medicare itself as costs exploded.

On the latter point, the 1965 Medicare statute explicitly stated that ''Nothing in this title shall be construed to authorize any Federal official or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided.'' Yet now such government management of doctors and hospitals is so pervasive in Medicare that Mr. Obama can casually wonder in a recent interview with Time magazine how anyone could oppose the ''benign changes'' that he supports, such as ''how the delivery system works.'' Oh, is that all?

Democrats will return in the fall with various budget tweaks that will claim to make ObamaCare ''deficit neutral'' over 10 years. But that won't begin to account for the budget abyss it will create in the decades to come.

Mr. KYL. Mr. President, I know I have talked about a lot of different issues today, but as we start this period of time when we go back home—we call it our work period back home—there are a lot of issues about which we want to talk to our constituents.

First on my list is going to be what do you think about the increased amount of debt this country is taking on, with all of the programs we have already passed and the programs that are on the horizon, including what was referred to here as ObamaCare, but the so-called health care reform? Do you believe your health care situation is in such a dire strait that we need to take on that kind of debt, or are there more targeted ways to resolve the problems that everybody acknowledges exists, particularly with some of the costs associated with health care.

We are also going to talk about whether the American people are comfortable with the degree of government involvement, the government takeover of all of these different elements of our society, including health care, including the mortgage business, as I talked about, and picking winners and losers in subsidizing the purchase of cars now.

I know we own two of the big car companies, but it seems a little self-serving then to try to help those car companies that the government owns by picking that as the place to put $3 billion to encourage people to buy new cars.

I know a lot of folks back home who are in other businesses who are hurting significantly. They could use this help just as much. I wonder if we took $3 billion and spread that to some of the other industries that are also hurting, I am sure they would say: This is great; why don't you help us out?

When government gets in the business of picking winners and losers, it is a sad day for our democratic Republic. I think we need to watch this. I am going to ask my constituents what they think about that. I already know. I got an earful last Sunday in church about a couple of these different ideas. I expect I am going to continue to hear about that.

It is important that our constituents talk to us about their concerns. We work for them, not the other way around. They pay our salaries. We need to listen to them about what they have to say.

Finally, we have all these domestic issues, but I wanted to refer to Senator LIEBERMAN's comments about we cannot forget we have brave men and women halfway around the globe right now in 120-degree temperatures representing us. They are the men and women in our military services and in our intelligence services working very hard to protect us.

We have to send the signal to them that we appreciate what they do, that we are not going to criticize them for simply doing their job. I think Senator LIEBERMAN was right when he said let's not send signals to those we have instructed to help us out in this war on terror that at the end of the day we are going to second-guess what they are doing, we are going to be Monday morning quarterbacks and even potentially find them criminally liable for activity they engaged in in good faith and belief they were protecting the American people.

I am going to be very interested to see what my constituents have to say about these issues. I know my colleagues will as well. I hope when we come back from the recess that we will not only be personally refreshed from having the opportunity to visit with our families and spend a little downtime but intellectually refreshed by having heard from our bosses—our constituents—on how they want to approach these problems in the future. Maybe in September, we will be a little more enlightened about how to carry out our responsibilities.

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

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

The legislative clerk proceeded to call the roll.

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

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

Mr. BROWN. Mr. President, I ask unanimous consent to speak as in morning business for up to 15 minutes.

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

HEALTH CARE REFORM

Mr. BROWN. Mr. President, I have come to the floor, much as I have every day for the last 3 weeks or so, to share letters from constituents in Ohio—from Findlay and Mansfield and Ravenna and Gallipolis and Bucyrus and Cleveland. These are letters from people who have often suffered because our health care system doesn't work for them.

We understand the health care system works for many; that many people are pleased with their health insurance. We understand—and the Chair certainly does, as a member of the Health, Education, Labor, and Pensions Committee—that we have made sure people who have insurance they are satisfied with can keep that insurance. As you know, we have built consumer protections around those health care plans that people now benefit from to make sure preexisting conditions are not banned from coverage; to stop discrimination based on gender or age; to make sure insurance companies cannot throw somebody off their rolls because they have an annual cap on the insurance. But as we throw these words around on this debate, words like ''exchange'' and ''market exclusivity'' and ''gateway'' and ''direct negotiations'' and all these terms, it is important to always bring it back to people whom we know, people who have written letters—from Eugene, OR, or from Toledo, OH—people who have written letters to us about the health insurance system. I would like to share a few of these letters today as I have for the last 2 or 3 weeks.