stimulate business—and we also had in that bill a provision to stimulate the economy by extending the Build America Bonds that were so successful in our Recovery Act and those funds expired.

One can have all the excuses one wants. The fact is, my friends on the other side of the aisle are opposing extending unemployment benefits for people who are out of work.

I would also say this: Pay-go is very interesting. I am glad my friend brought that up. I am glad he brought up the big deficit because it is very big. But where was my friend from Kentucky when we had two wars that were unpaid for during the Bush administration, tax cuts that cost more than $1 trillion unpaid for? Where were my friend and the Republicans objecting to that?

Pay-go is important, and we passed pay-go here—we, the Democrats, passed it. My friend did not vote for it. It passed because Democrats voted for it. Not a single Republican voted for it. We had these in effect during the Clinton years, and it worked. We paid down the debt in the last Clinton years.

We also understand how important the debt of this country is. It started to build up so strong during the 8 years of the Bush administration. We brought to this floor—no one worked harder than the Acting President pro tempore to come up with something to address the debt with the chairman of our Budget Committee and others.

We wanted a debt commission, and we brought to this floor a debt commission, a good one. It was based upon what we did with military base closings. We tried for decades to close bases that were unnecessary in the country anymore, after World War II was over, the Korean war was over, Vietnam. We did not need all those bases. But because of what happens when trying to close a base because of local politics, we could not do it. So we passed a bill that said we are going to have a base closing commission. They will come back with recommendations, and the House and the Senate have a choice: either vote no or yes on their recommendations. And they voted yes, both the House and the Senate, and we closed numerous bases all over the country.

The debt commission we established was based upon that—the same thing—and we voted, we Democrats voted. It would have passed. Why did it not pass? Because seven Republicans who cosponsored the legislation voted against it.

So we do not need lectures here on debt. What we need is to recognize there are poor people all over America who are desperate today, and people who are working, making good money on these road projects all over America today who are being told to go home because we do not have inspectors to take care of their work.

Therefore, Mr. President, I object.

The ACTING PRESIDENT pro tempore. Objection is heard.

Mr. REID. Mr. President, unless my friend has more to say, 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. ALEXANDER. 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. ALEXANDER. Mr. President, I ask unanimous consent to speak in morning business for up to 15 minutes.

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

Mr. ALEXANDER. Thank you. Mr. President, will the Acting President pro tempore please let me know when I have consumed 12 of the 15 minutes.

The ACTING PRESIDENT pro tempore. Yes.

Mr. ALEXANDER. Thank you very much, Mr. President.

HEALTH CARE

Mr. ALEXANDER. Mr. President, it was my privilege last Thursday, along with some other Members of the Senate, to attend a health care summit at the invitation of President Obama. It went on a long time. We learned one thing we already knew, that our President is smart and knows a lot about health care. So he stayed the whole time.

But it gave those of us on the Republican side a chance we do not have the opportunity to have as often, which is, to be on center stage and let the American people know, A, who we are, and, B, what our ideas are. So it was a terrific way for us to show, for example, that our goal is to reduce health care costs, that we wish to move step by step toward that goal.

We identified a number of areas, such as being able to buy health insurance across State lines, allowing small business health plans to pool together, reducing junk lawsuits—all of which will tend to bring down the cost of premiums, which is what most Americans want.

During the discussion, early on, actually, the President and I had a little disagreement about whether his plan, which is based upon the Senate bill, which passed on Christmas Eve, would raise premiums. What I had said in my opening remarks on behalf of Republicans was that millions of Americans, under the Democratic plan, would pay higher insurance premiums in the individual market because of government mandates and taxes. The President says that is wrong. I cited a Congressional Budget Office report to show I was right. And rather than dispute the President of the United States in public—I thought I had enough time to make my case—I said I would send him a letter, which I did that same day. So I ask unanimous consent, Mr. President, to have printed in the RECORD the letter I gave to President Obama on Thursday.

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

U.S. SENATE,
Washington, DC, February 25, 2010.

Hon. BARACK OBAMA,
President, The White House, Pennsylvania Avenue, Washington, DC.

DEAR MR. PRESIDENT: During today's discussion on health care, you and I disagreed about whether the health care bill that passed the Senate on a party-line vote on December 24 would cause health insurance premiums to rise even faster than if Congress did not act. I believe premiums will rise because of independent analysis of the bill:

On November 30, the non-partisan Congressional Budget Office (CBO) wrote in a letter to Senator Bayh that ''CBO and JCT estimate that the average premium per person covered (including dependents) for new nongroup policies would be about 10 percent to 13 percent higher in 2016 than the average premium for nongroup coverage in that same year under current law.''

When you asserted that CBO says premiums will decline by 14 to 20 percent under the Senate bill, you are leaving out an important part of CBO's calculations. These reductions are overwhelmed by a 27 to 30 percent increase in premiums due to the mandated coverage requirements in the legislation. CBO added those figures together to arrive at a net increase of 10 to 13 percent—as shown in their chart in that same letter.

In that same letter, CBO wrote, ''The legislation would impose several new fees on firms in the health sector. New fees would be imposed on providers of health insurance and on manufacturers and importers of medical devices. Both of those fees would be largely passed through to consumers in the form of higher premiums for private coverage.''

On December 10, the chief actuary for the Centers for Medicare and Medicaid Services—who works for your administration—concurred with the CBO. In his analysis, the actuary said, ''We anticipate such fees would generally be passed through to health consumers in the form of higher drug and device prices and higher insurance premiums.'' He also said, ''The additional demand for health services could be difficult to meet initially with existing health provider resources and could lead to price increases, cost-shifting, and/or changes in providers' willingness to treat patients with low-reimbursement health coverage.''

For these reasons, the Senate-passed bill will, indeed, cause Americans' insurance premiums to rise, which is the opposite of the goal I believe we should pursue.

Sincerely,

LAMAR ALEXANDER.

Mr. ALEXANDER. But today what I wish to do in the next few minutes is explain why I believe I am correct, that under the President's health insurance plan, which is based upon the Senate plan, for millions of Americans in the individual market, premiums would go up because of one-size-fits-all government mandates, because of taxes that are passed on to consumers; but for other reasons as well—by shifting costs.

When you dump 15 million people or 18 million people into a program called Medicaid, what happens is, we do not pay the doctors and the hospitals well enough to take care of those folks. So

those providers shift the costs to people who are paying with private insurance, and premiums go up.

Costs for young people in the individual market will go up under this plan because if you put in a rule that says my insurance at my age cannot go up more than a certain amount compared with my son's insurance, then his insurance goes up, and because a scheme like the Democratic plan depends upon requiring everybody to buy insurance. There is a weak provision for that, and I suspect many young people will rather pay the $750 fine rather than buy a $2,500 insurance policy, which they think they cannot afford.

The President made the point in his usual very persuasive way that, wait a minute, actually you would be getting better insurance. But that is comparing apples and oranges. As George Will said on ABC's ''This Week'' yesterday—he asked this question: If the government required you to buy a better, more expensive car, even if it was better than the car you have, it would still be more expensive, would it not?

That is the case with the President's health care plan. In fact, premiums will go up for millions of Americans in the individual market, up more than they otherwise would over the next several years—and we all know how rapidly they are rising—and the whole exercise we have been going through over the last year is to bring premiums down, not help drive premiums up.

What I said to the President, with respect, was that the Congressional Budget Office, on November 30, said this about the Senate bill:

The Congressional Budget Office and the Joint Committee on Taxation estimate that the average premium per person covered for new nongroup—

That means individual policies—

would be about 10 to 13 percent higher in 2016 than the average premium for nongroup—

That is individual coverage—

in the same year under current law.

In other words, if you buy an individual policy—that means not a policy with your employer—by 2016 it will be at an average of 10 to 13 percent higher than it otherwise would.

I ask unanimous consent to have printed in the RECORD the relevant parts of the Congressional Budget Office letter of November 30 to Senator EVAN BAYH on this point.

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

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, November 30, 2009.

Hon. EVAN BAYH,
U.S. Senate, Washington, DC.

DEAR SENATOR: The attachment to this letter responds to your request—and the interest expressed by many other Members—for an analysis of how proposals being considered by the Congress to change the health care and health insurance systems would affect premiums paid for health insurance in various markets. Specifically, the Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation have analyzed how health insurance premiums might be affected by enactment of the Patient Protection and Affordable Care Act, as proposed by Senator Reid on November 18, 2009.

I hope this information is helpful to you. If you have any further questions, please contact me or the CBO staff. The primary staff contact for this analysis is Philip Ellis.

Sincerely,

DOUGLAS W. ELMENDORF,
Director.

Attachment.

SUMMARY OF FINDINGS

The effects of the proposal on premiums would differ across insurance markets (see Table 1). The largest effects would be seen in the nongroup market, which would grow in size under the proposal but would still account for only 17 percent of the overall insurance market in 2016. The effects on premiums would be much smaller in the small group and large group markets, which would make up 13 percent and 70 percent of the total insurance market, respectively.

NONGROUP POLICIES

CBO and JCT estimate that the average premium per person covered (including dependents) for new nongroup policies would be about 10 percent to 13 percent higher in 2016 than the average premium for nongroup coverage in that same year under current law. About half of those enrollees would receive government subsidies that would reduce their costs well below the premiums that would be charged for such policies under current law.

Table 1.

Effect of Senate Proposal on Average Premiums for Health Insurance in 2016

	Percentage, by Market		
	Nongroup[a]	Small Group[b]	Large Group[c]
Distribution of Nonelderly Population Insured in These Markets Under Proposal	17	13	70
Differences in Average Premiums Relative to Current Law Due to:			
Difference in Amount of Insurance Coverage	+27 to +30	0 to +3	Negligible
Difference in Price of a Given Amount of Insurance Coverage for a Given Group of Enrollees	-7 to -10	-1 to -4	Negligible
Difference in Types of People with Insurance Coverage	-7 to -10	-1 to +2	0 to -3
Total Difference Before Accounting for Subsidies	+10 to +13	+1 to -2	0 to -3
Effect of Subsidies in Nongroup and Small Group Markets			
Share of People Receiving Subsidies[d]	57	12	n.a.
For People Receiving Subsidies, Difference in Average Premiums Paid After Accounting for Subsidies	-56 to -59	-8 to -11	n.a.
Effect of Excise Tax on High-Premium Plans Sponsored by Employers			
Share of People Who Would Have High-Premium Plans Under Current Law	n.a.	19	
For People Who Would Have High-Premium Plans Under Current Law, Difference in Average Premiums Paid[e]	n.a.	-9 to -12	
Memorandum			
Number of People Covered Under Proposal (Millions)	32	25	134

Source: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Notes: n.a. = not applicable.

a. The nongroup market includes people purchasing coverage individually either in the proposed insurance exchanges or in the individual insurance market outside the insurance exchanges.

b. The small group market includes people covered in plans sponsored by firms with 50 or fewer employees.

c. The large group market includes people covered in plans sponsored by firms with more than 50 employees.

d. Premium subsidies in the nongroup market are those available through the exchanges. Premium subsidies in the small group market are those stemming from the small business tax credit.

e. The effect of the tax includes both the increase in premiums for policies with premiums remaining above the excise tax threshold and the reduction in premiums for those choosing plans with lower premiums.

Mr. ALEXANDER. Now, the President said: Wait a minute. The premiums in the individual market will go down 14 to 20 percent. That is also in the same letter. Of course, he is right about that. They go down because of administrative efficiencies and new enrollment, but he left out that there are other factors involved so that the government mandates will drive them up 27 to 30 percent or, in the end, the average, as the CBO said, premium per person covered in an individual policy would be up 10 to 13 percent.

The bill has subsidies in it for some Americans. The same letter says about half of Americans who buy in the individual market will get a subsidy. Well, we are paying for that subsidy, but let's concede that point. Still, that leaves half of the people in the individual market for whom premiums will go up on an average of 10 to 13 percent.

Why is that? One reason is because the Senate bill says people will have to buy a richer policy than they have today. That means it has a higher actuarial value. They call it in the bill ''minimum creditable coverage.'' It means this is the amount of insurance I think you should have before you buy a policy. That might be a good decision. It undoubtedly would be good to have the insurance. It just costs 27 to 30 percent more than today's average.

The National Federation of Independent Businesses wrote a December 12 letter in opposition to the Senate bill saying the benefit mandates will put small business owners ''at risk of having to drop coverage due to cost increases that outpace their health budgets.''

I ask unanimous consent to have printed in the RECORD the letter from NFIB to Senator MCCONNELL and Senator REID, dated December 8.

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

NATIONAL FEDERATION OF INDEPENDENT BUSINESS,
December 8, 2009.

Sen. HARRY REID,
Majority Leader, Hart Senate Office Building, Washington, DC.
Sen. MITCH MCCONNELL,
Minority Leader, Russell Senate Office Building, Washington, DC.

DEAR SENATORS REID AND MCCONNELL: As the Senate continues to debate the future of comprehensive healthcare reform, the National Federation of Independent Business, the nation's leading small business association, is writing in opposition to the Patient Protection and Affordable Care Act (H.R. 3590).

When evaluating healthcare reform options, small business owners ask themselves two specific questions. First, will the bill lower insurance costs? Second, will the bill increase the overall cost of doing business? If a bill increases the cost of doing business or fails to reduce insurance costs, then the bill fails to achieve their No. 1 goal—lower costs.

In both cases, the Patient Protection and Affordable Care Act (H.R. 3590) fails the small business test and, therefore, fails small business. The most recent CBO study detailing the effect that H.R. 3590 will have on insurance premiums reinforces that, despite claims by its supporters, the bill will not deliver the widely-promised help to the small business community. Instead, CBO findings report that the bill will increase non-group premiums by 10 to 13 percent and result in, at best, a 2 percent decrease for small group coverage by 2016. These findings tell small business all it needs to know—that the current bill does not do enough to reduce costs for small business owners and their employees.

Despite the inclusion of insurance market reforms in the small-group and individual marketplaces, the savings that may materialize are too small for too few and the increase in premium costs are too great for too many. Those costs, along with greater government involvement, higher taxes and new mandates that are disproportionately targeted at small business and are being used to finance H.R. 3590, create a reality that is worse than the status quo for small business. The shortcomings of the Patient Protection and Affordable Care Act include:

A NEW SMALL BUSINESS HEALTH INSURANCE TAX

Unlike large businesses, which self-insure and find security under the blanket of ERISA, most small businesses are only able to find and purchase insurance in the fully-insured marketplace. The Senate bill includes a new $6.7 billion annual tax ($60.7 billion over 10 years) that falls almost exclusively on small business because the fee is assessed on the insurance companies. CBO's most recent study reinforces those costs will ultimately be passed on to their consumers, leaving the cost to be disproportionately borne by small business consumers in the individual and small-group marketplace whose only choice is to purchase those products or forgo insurance altogether.

A NEW MANDATE THAT PUNISHES EMPLOYERS, EMPLOYEES AND HINDERS JOB CREATION

Employer mandates fail employers and employees in two ways. First, mandates do nothing to address the core issue facing small business—high healthcare costs. Second, mandates destroy job creation opportunities for employees. The job loss, whether through lost hiring or greater reliance on part-time employees, harms low-wage or entry-level workers the most. The employer mandate in H.R. 3590 sets up potentially troubling outcomes for this sector of the workforce. The multiple penalties assessed on full-time workers will most certainly result in a reduction of full-time workers to part-time workers and discourage the hiring of those entrants into the workforce who might qualify for a government subsidy, hardly an outcome that contributes to a greater insured population.

A POORLY-STRUCTURED SMALL BUSINESS TAX CREDIT

As structured, the small business tax credit will do little, if nothing, to propel either more firms to take up coverage or produce greater overall affordability. Due to its short-term temporary nature and the limitations based on the business' average wage, its benefit is, at best, a temporary solution to the long-term cost and affordability problem. A tax credit that is poorly structured is not going to provide sustainable and long-term relief from high healthcare costs, and the recent CBO finding that the tax credit would benefit only 12 percent of the small business population illustrates its lack of effectiveness.

A BENEFIT PACKAGE THAT IS TOO HIGH A HURDLE FOR SMALL BUSINESS

NFIB has voiced concern over establishing a benefit threshold that is too high a price tag for small businesses to meet. Small businesses are especially price sensitive. They need purchasing choices that provide the flexibility in coverage options that reflect their marketplace and business needs. If Congress doesn't adjust the actuarial value standards in the legislation, what may be affordable this year may be unaffordable next year. As a result, small business owners will be at risk of having to drop coverage due to cost increases that outpace their healthcare budgets.

DESTRUCTIVE RATING REFORMS AND PHASE-IN TIMELINES THAT THREATEN AFFORDABILITY FOR ALL

NFIB supports balanced federal rating reforms that protect access and affordability, regardless of an individual or group's health status. However, the excessively tight age rating (3:1) in H.R. 3590 will increase more costs than it will decrease, and make coverage unaffordable for the very populations that are most beneficial to the insurance pool—the young and the healthy. Independent actuaries have analyzed the negative impact of such tight bands and have indicated that there will be devastating effects to the long-term viability of a pool without action to correct this rating imbalance.

Additionally, to prevent volatile spikes in insurance premiums, also known as ''rate shock,'' federal rating reforms must be appropriately applied to all marketplaces and phased in over a responsible period of time. If this is not done, then certain plans, including ''grandfathered plans,'' will utilize different rating practices when underwriting risk, which can create adverse selection issues. Those selection problems will have a striking negative impact on the new exchanges—exchanges that are meant to improve, rather than decrease, affordability for small business and individuals.

NATIONAL PLANS THAT PROVIDE LIMITED PROMISE FOR SUCCESS

Leveling the playing field for small business starts with allowing uniform benefit packages to be purchased across state lines. If done right, this can provide a greater security that, as people change jobs and move from state to state, they can keep the benefit plan that meets their healthcare needs. National plans would be particularly helpful for states with smaller populations and where consumers lack a robust marketplace with choice and competition for private plans. Specifically, the state ''opt-out'' language in the Patient Protection and Affordable Care Act would create more disincentives than incentives for carriers to embark on these new opportunities. If the national plan section is not significantly restructured to make national plans a viable option, then these new opportunities will never materialize for small business.

THREATENS FLEXIBILITY AND CHOICE FOR EMPLOYERS AND EMPLOYEES

Small employers need more affordable health insurance options and new alternatives for employers to voluntarily contribute to individually-owned plans. Provisions also need to be structured to insure that options are widely available to both employers and employees. The simple cafeteria plan language in H.R. 3590 excludes the owners of many ''pass-through'' business entities from participating in these arrangements. If owners are unable to participate in the plan, they will be less likely to provide insurance to their workforce. Finally, small business needs the freedom and flexibility to preserve options that are already proven to work. Prohibiting the use of HSA, FSA and HRA funds to purchase over-the-counter medications, along with the $2,500 limit on FSA contributions, diminishes that flexibility and threatens to further limit the options employers have to provide meaningful healthcare to their employees.

NEW PAPERWORK COSTS ON SMALL BUSINESSES

The cost associated with tax paperwork is the most expensive paperwork burden that the federal government imposes on small business owners. The Senate bill dramatically increases that cost with a new reporting requirement that is levied on business transactions of more than $600 annually, leaving small business buried in paperwork and increasing their paperwork compliance expenses.

AN UNPRECEDENTED NEW PAYROLL TAX ON SMALL EMPLOYERS

Since its creation the payroll taxes that fund the Medicare programs have not been wage-based and are dedicated specifically to funding Medicare. The Senate bill changes the nature of the tax and creates a precedent to use payroll taxes to pay for non-Medicare programs.

THE ABSENCE OF REAL MEDICAL LIABILITY REFORM

NFIB strongly supports medical liability reform as a means to both inject more fairness into the medical malpractice legal system, and to reduce unnecessary litigation and legal costs. Taking serious steps to adopt meaningful medical liability reform is a significant step toward restoring common sense to our medical liability litigation system. It also is especially critical to improving access to healthcare for those living in rural areas, where it is becoming increasingly difficult for those in need to locate specialists such as OB/GYNs and surgeons.

THE CREATION OF A NEW GOVERNMENT-RUN HEALTHCARE PROGRAM

A government-run plan will drive the private healthcare marketplace out of business. Private insurers will be unable to compete in a climate where the rules and practices are tilted in favor of a massive government-run plan. This means millions could lose their current coverage. This will decrease choice and increase costs. On both accounts, the government-run plan will leave small business with a single option the government-run plan, which is the exact opposite outcome small businesses want from healthcare reform.

There is near universal agreement that, if done right, small business has much to gain from healthcare reform. But if it is done wrong, then small business will have the most to lose. The Patient Protection and Affordable Care Act, which is short on savings and long on costs, is the wrong reform, at the wrong time and will increase healthcare costs and the cost of doing business. NFIB remains committed to healthcare reform, and urges the Senate to develop common sense solutions to lower healthcare costs while ensuring that policies empower small business with the ability to make the investments necessary to move our economy forward.

Sincerely,

SUSAN ECKERLY,
Senior Vice President,
Public Policy.

Mr. ALEXANDER. The one-size-fits-all provision in the Democratic bill says all individual and small group policies must have an actuarial value of 60 percent.

Senator SUSAN COLLINS of Maine, who was the insurance commissioner of Maine, made a speech on the Senate floor on December 18, and pointed out that 87 percent of the individual policies that are purchased in Maine today would cost more under the Reid bill.

I commend to my colleagues the Senator's testimony of December 18, 2010.

Senator COLLINS used the example that the most popular individual market policy sold in Maine costs a 40-year-old about $185 a month. Under the Senate bill that 40-year-old would have to pay at least $420 a month, more than twice as much for the policy that meets the new minimum standard, or face a $750 penalty. It is true Maine citizens, as is true for all Americans—about half of them—would receive subsidies to help them buy that policy, but the average premium for the other half of the 87 percent is going to go up under the Democratic bill.

We believe Americans ought to have more choices than that. That is a fundamental difference of opinion. Should Washington decide you need to buy a richer policy, or should you decide that for yourself based upon the other needs of your family?

The Congressional Budget Office does state, as I have mentioned, that there are a number of enrollees—about half—who would have the subsidies, and that is in the letter I have already introduced into the RECORD. But someone is paying for those subsidies: the taxpayers are paying for them, which brings up the second reason I said on Thursday that premiums for millions of Americans in the individual market will go up.

The commonsense idea is that if you tax an insurance company or a medical device company or a manufacturer of drugs, they will pass the taxes on to whom? To us, who are buying insurance policies or medical devices or drugs. So we end up paying. In fact, one part of the President's proposal deliberately does that. It is a 40-percent excise tax on insurance companies for what we call Cadillac plans, the high-cost private insurance plans.

A letter from the Joint Committee on Taxation, dated February 24, says the 40-percent excise tax will raise $32.7 billion, all of which will be passed along to consumers in the form of higher insurance premiums. That may be a good thing. In fact, I think it is because it helps to discourage the purchase of more expensive policies. But it does raise premiums in the individual market.

The Joint Committee on Taxation Memorandum on High Cost Plans, dated September 29, says:

> The excise tax would be mainly passed along through increases in premiums.

Because the new tax is indexed to regular inflation plus 1 percent instead of medical inflation, which goes up very much higher and quicker, the new tax, like the alternative minimum tax, will pretty soon start to hit Chevy and Buick insurance policies and not just Cadillac policies.

But there are other taxes in the President's proposal. There are up to $½ trillion in new taxes, which will be passed on to consumers: $20 billion in excise taxes on lifesaving medical devices, $33 billion on drugs, and $60 billion on health insurance companies. In the previously mentioned CBO letter and a JCT letter to Senator GRASSLEY in October of last year, both said these taxes will be passed on to patients, increasing health insurance premiums.

The Chief Actuary of the Center for Medicare and Medicaid Services, who is a part of the Obama administration said:

> We anticipate such fees would be generally passed through to health consumers in the form of higher drug and device prices and higher insurance premiums.

That was on December 10 of last year, about the Senate bill.

The Lewin Group, on October 30, said:

> Employer spending would increase steadily under the [Democratic] act, reflecting the cost of paying the various excise taxes under the act. Total employer health spending would increase by 2.1 percent by 2019.

I ask unanimous consent to have printed in the RECORD the executive summary of the Lewin Group letter.

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

EXECUTIVE SUMMARY

In this study we estimate the impact of The America's Healthy Future Act as adopted by the Senate Finance Committee. The Act would require most Americans to have health insurance. To assure access to affordable coverage, the Bill expands the Medicaid program to 133 percent of the Federal Poverty Level (FPL) for all adults. It also provides a new premium tax credit for people living between 133 percent and 400 percent of the FPL (e.g., $88,000 for a family of four).

In addition, the Act establishes an ''exchange'' that presents consumers with a selection of health coverage alternatives that is available to individuals and firms with fewer than 100 workers. States would have the option to extend eligibility to larger employers beginning in 2017. Only people participating in the exchange who do not have access to employer coverage would be eligible for the premium tax credit. The Act also reforms insurance markets by assuring guaranteed issue of coverage and prohibiting plans from varying premiums with health status.

Employers with more than 50 workers are required to pay a penalty for each uninsured worker receiving a premium tax credit through the exchange. The Act also provides an employer health insurance tax credit for up to two years for firms with fewer than 25 workers with an average employee earnings of less than $40,000. Workers offered coverage by an employer are not eligible for premium subsidies offered in the exchange unless the cost of employer coverage exceeds 10 percent of income.

The Act is funded with reductions in spending under Medicare and Medicaid, a new excise tax on high cost health plans (premiums over $8,000 for individuals and $21,000 for families). It also includes a second excise tax on insurance, new excise taxes on branded prescription drugs and device manufacturers, and other changes in revenues.

In this study we provide estimates of the program's impact on coverage and spending for the federal government, state and local governments, private employers and consumers. To demonstrate the long-term impact of the Act, we provide estimates for a 20-year period from 2010 through 2029.

Mr. ALEXANDER. The National Federation of Independent Business letter says the same. There are other reasons the premiums will go up.

Mr. President, seeing no one else here, I wonder if I might ask unanimous consent for 5 additional minutes.

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

Mr. ALEXANDER. I thank the President.

Here is a third reason, in addition to government mandates and taxes, that will cause premiums to rise. We call it cost-shift. Premiums will increase because the bill dumps 15 million to 18 million more Americans into the government program called Medicaid. This is the analysis of the Chief Actuary on January 8, 2010.

I ask unanimous consent that the relevant portions be printed in the RECORD.

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

DEPARTMENT OF HEALTH & HUMAN SERVICES, CENTERS FOR MEDICARE & MEDICAID SERVICES,

Baltimore, MD.

Date: January 8, 2010

From: Richard S. Foster, Chief Actuary

Subject: Estimated Financial Effects of the ''Patient Protection and Affordable Care Act,'' as Passed by the Senate on December 24, 2009.

The Office of the Actuary has prepared this memorandum in our longstanding capacity as an independent technical advisor to both the Administration and the Congress. The costs, savings, and coverage impacts shown herein represent our best estimates for the Patient Protection and Affordable Care Act. We offer this analysis in the hope that it will be of interest and value to policy makers as they develop and debate national health care reforms. The statements, estimates, and other information provided in this memorandum are those of the Office of the Actuary and do not represent an official position of the Department of Health & Human Services or the Administration.

This memorandum summarizes the Office of the Actuary's estimates of the financial and coverage effects through fiscal year 2019 of selected provisions of the ''Patient Protection and Affordable Care Act'' (PPACA) as passed by the Senate on December 24, 2009 (H.R. 3590, as amended). Included are the estimated net Federal expenditures in support of expanded health insurance coverage, the associated numbers of people by insured status, the changes in Medicare and Medicaid expenditures and revenues, and the overall impact on total national health expenditures. Except where noted, we have not estimated the impact of the various tax and fee proposals or the impact on income and payroll taxes due to economic effects of the legislation. Similarly, the impact on Federal administrative expenses is excluded. A summary of the data, assumptions, and methodology underlying our estimates of national health reform proposals is available in the appendix to our October 21 memorandum on H.R. 3200.

SUMMARY

The table shown on page 2 presents financial impacts of the selected PPACA provisions on the Federal Budget in fiscal years 2010–2019. We have grouped the provisions of the bill into six major categories:

(i) Coverage proposals, which include the mandated coverage for health insurance, the expansion of Medicaid eligibility to those with incomes at or under 133 percent of the Federal poverty level (FPL), and the additional funding for the Children's Health Insurance Program (CHIP);

(ii) Medicare provisions;

(iii) Medicaid and CHIP provisions other than the coverage expansion and CHIP funding;

(iv) Proposals aimed in part at changing the trend in health spending growth;

(v) The Community Living Assistance Services and Supports (CLASS) proposal; and

(vi) Immediate health insurance reforms.

The estimated costs and savings shown in the table are based on the effective dates specified in the bill as passed. Additionally, we assume that employers and individuals would take roughly 3 to 5 years to fully adapt to the insurance coverage provisions and that the enrollment of additional individuals under the Medicaid coverage expansion would be completed by the third year of implementation. Because of these transition effects and the fact that most of the coverage provisions would be in effect for only 6 of the 10 years of the budget period, the cost estimates shown in this memorandum do not represent a full 10-year cost for the proposed legislation.

ESTIMATED FEDERAL COSTS (+) OR SAVINGS (-) UNDER SELECTED PROVISIONS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT AS PASSED BY THE SENATE

[In billions]

Provisions	Fiscal year—										Total, 2010–19
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	
Total*	$11.6	$0.1	−$14.8	−$32.8	$14.7	$63.0	$71.4	$60.9	$55.8	$49.7	$279.5
Coverage†	4.7	6.6	1.7	.....	86.5	128.0	150.1	156.4	167.9	180.7	882.5
Medicare	2.2	−3.6	−12.1	−23.4	−62.6	−55.1	−70.2	−87.6	−104.6	−123.7	−540.7
Medicaid/CHIP	−0.4	−0.1	0.2	−3.8	−3.1	−3.8	−3.9	−4.1	−4.0	−3.9	−27.1
Cost trend‡	.....	.....	.....	.....	−0.0	−0.1	−0.2	−0.4	−0.6	−0.9	−2.3
CLASS program	.....	−2.8	−4.5	−5.6	−5.9	−6.0	−4.3	−3.4	−2.8	−2.4	−37.8
Immediate reforms	5.0	.....	.....	.....	.....	.....	.....	.....	.....	.....	5.0

* Excludes Title IX revenue provisions except for section 9015, certain provisions with limited impacts, and Federal administrative costs.

† Includes expansion of Medicaid eligibility and additional funding for CHIP.

‡ Includes estimated non-Medicare Federal savings from provisions for comparative effectiveness research, prevention and wellness, fraud and abuse, and administrative simplification. Excludes impacts of other provisions that would affect cost growth rates, such as the productivity adjustments to Medicare payment rates, which are reflected in the Medicare line.

As indicated in the table above, the provisions in support of expanding health insurance coverage (including the Medicaid eligibility changes and additional CHIP funding) are estimated to cost $882 billion through fiscal year 2019. The net savings from the Medicare, Medicaid, growth-trend, and CLASS proposals are estimated to total about $603 billion, leaving a net cost for this period of $279 billion before consideration of additional Federal administrative expenses and the increase in Federal revenues that would result from the excise tax on high-cost employer-sponsored health insurance coverage and other revenue provisions. (The additional Hospital Insurance payroll tax income under section 9015 of the PPACA is included in the estimated Medicare savings shown here.) The Congressional Budget Office and Joint Committee on Taxation have estimated that the total net amount of Medicare savings and additional tax and other revenues would somewhat more than offset the cost of the national coverage provisions, resulting in an overall reduction in the Federal deficit through 2019.

The chart shown below summarizes the estimated impacts of the PPACA on insurance coverage. The mandated coverage provisions, which include new responsibilities for both individuals and employers, and the creation of the Health Benefit Exchanges (hereafter referred to as the ''Exchanges''), would lead to shifts across coverage types and a substantial overall reduction in the number of uninsured, as many of these individuals become covered through their employers, Medicaid, or the Exchanges.

By calendar year 2019, the mandates, coupled with the Medicaid expansion, would reduce the number of uninsured from 57 million, as projected under current law, to an estimated 23 million under the PPACA. The additional 34 million people who would become insured by 2019 reflect the net effect of several shifts. First, an estimated 18 million would gain primary Medicaid coverage as a result of the expansion of eligibility to all legal resident adults under 133 percent of the FPL (In addition, roughly 2 million people with employer-sponsored health insurance would enroll in Medicaid for supplemental coverage.) Another 21 million persons (most of whom are currently uninsured) would receive individual insurance coverage through the newly created Exchanges, with the majority of these qualifying for Federal premium and cost-sharing subsidies. Finally, we estimate that the number of individuals with employer-sponsored health insurance would decrease overall by about 4 million, reflecting both gains and losses in such coverage under the PPACA.

As described in more detail in a later section of this memorandum, we estimate that overall national health expenditures under this bill would increase by an estimated total of $222 billion (0.6 percent) during calendar years 2010–2019, principally reflecting the net impact of (i) greater utilization of health care services by individuals becoming newly covered (or having more complete coverage), (ii) lower prices paid to health providers for the subset of those individuals who become covered by Medicaid, and (iii) lower payments and payment updates for Medicare services, together with net Medicaid savings from provisions other than the coverage expansion. Although several provisions would help to reduce health care cost growth, their impact would be more than offset through 2019 by the higher health expenditures resulting from the coverage expansions.

The actual future impacts of the PPACA on health expenditures, insured status, individual decisions, and employer behavior are very uncertain. The legislation would result in numerous changes in the way that health care insurance is provided and paid for in the U.S., and the scope and magnitude of these changes are such that few precedents exist for use in estimation. Consequently, the estimates presented here are subject to a substantially greater degree of uncertainty than

is usually the case with more routine health care proposals.

The balance of this memorandum discusses these financial and coverage estimates—and their limitations—in greater detail.

Mr. ALEXANDER. The point is, Medicaid only pays doctors and hospitals about 60 percent of the cost of serving the 60 million patients who are now there. The Democratic bill would add 15 million to 18 million more patients. So what do the doctors and hospitals do? They see these patients, but then they shift the costs to the patients they see who have private insurance.

The President himself said that adds about $1,000 to every policy today, this cost-shifting. I have included that comment from the Chief Actuary.

The PriceWaterhouseCoopers report on the Senate Finance Committee bill in October of 2009 indicated that the net effect of the bills before Congress will make the Medicare and Medicaid cost-shift even more severe, raising the cost of private insurance premiums for large employers by $255 a year between 2015 and 2019.

I ask unanimous consent to have printed in the RECORD the relevant portions of the PriceWaterhouseCoopers report.

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

POTENTIAL IMPACT OF HEALTH REFORM ON THE COST OF PRIVATE HEALTH INSURANCE COVERAGE

ISSUE C—INCREASED COST SHIFTING

Today, certain costs (e.g., hospital expenses) are shifted to the private sector (employers and consumers) as some participants in the system pay less than their share of the cost of their care. Public programs such as Medicare and Medicaid reimburse less than the cost of care for hospitals' services. In addition, the uninsured or underinsured may not be able to cover the full cost of care, and this cost is then also transferred to the private market.

The initial hope of health reform was that by improving coverage of the currently uninsured, a significant percentage of uncompensated care would be eliminated. This is still anticipated to happen. However, the cost shift ''gains'' from decreasing the numbers of uninsured now appear to be more than offset by the losses from proposed cutbacks in Medicare and Medicaid spending allocated to the hospital sector.

It should also be noted that the impact of covering the uninsured may be different in communities constrained by limited hospital capacity. In those communities, covering the uninsured could actually increase cost-shifting if the newly insured increase demand for healthcare services and the overall mix of hospital patients migrates towards lower paying government programs.

The net impact is likely to result in an increase in cost shifting which translates into a 0.8 percent average annual increase in the private sector spending between 2010 and 2019, or $145 on average per year for family coverage in a large group plan (and $55 for single coverage). We note that this cost burden ramps up over the projection period, with an average annual increase in health costs of 1.2 percent over the second five-year period. We assume that this increased cost to the private sector will ultimately impact the cost of coverage for individuals and businesses in both the insured and self-insured market. As a result, premium costs for large group plans will be $37 higher each year between 2010 and 2014 for family coverage ($14 for single coverage), and $255 higher each year between 2015 and 2019 ($96 for single coverage).

Mr. ALEXANDER. Younger Americans in the individual market will pay higher premiums under the Democratic plan because, as I mentioned earlier, it will mandate for individual coverage that I can't pay more than three times as much as my son can pay for an insurance premium. That might help keep my premiums down, but it is going to send his up pretty far because 42 States, including Tennessee, allow more variance of that. So young people across America, who include about 30 percent of the uninsured, are in for a big surprise when their individual policies jump up 30 to 35 percent, which is what the Oliver Wyman report on September 28 said theirs might do, or when, since they are uninsured, they are required to buy insurance and they find the insurance they are required to buy is very expensive.

I ask unanimous consent to have printed in the RECORD the conclusion of the Oliver Wyman report.

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

CONCLUSION

As Congress considers approaches to maximize health insurance coverage in the United States, it is important to consider the impact of premium rate compression on current purchasers and the uninsured. Providing affordable premiums to young people is critical to encourage their participation and ensure the long-term sustainability of the insurance pool in the years following health insurance reform.

Requiring a young person to pay multiples of their expected medical expenses for health insurance is likely to cause these individuals to decline to purchase coverage. Maintaining adequate flexibility in rating will minimize the rate shock that many could see in the marketplace and encourage higher levels of coverage over time. Moreover, the elimination of health status as a rating factor will already provide significant benefit to older individuals, who are more likely to suffer from chronic health conditions.

In conclusion, our modeling demonstrates that the 5:1 age band, as originally included in the Senate Finance Committee's Chairman's Mark, will reduce disruption compared to tight age bands. Maintaining 5:1 age bands will encourage more young people to participate in the insurance market, thereby keeping average rates more affordable. This, in turn, will result in higher overall levels of participation in the insurance market and fewer uninsured.

Mr. ALEXANDER. Finally, the young and the healthy can skip out of this. That will drive up premiums. They may decide they would rather pay a $750 fine than $2,500 for a health insurance policy they think they don't need.

The American Academies of Actuaries wrote a letter on the Reid bill on November 20 that said: ''Any premium variations by age limited to a 3.1 ratio between the highest and lowest premiums,'' and then it goes on to say, ''would cause higher premiums on average relative to current premiums.''

I ask unanimous consent to have printed in the RECORD the letter from the American Academy of Actuaries of November 20, 2009.

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

NOVEMBER 20, 2009.

Re: Patient Protection and Affordable Care Act.

Hon. HARRY REID
Majority Leader, U.S. Senate, Hart Senate Office Building, Washington, DC.

Hon. MITCH MCCONNELL,
Minority Leader, U.S. Senate, Russell Senate Office Building, Washington, DC.

DEAR MAJORITY LEADER REID AND MINORITY LEADER MCCONNELL: The American Academy of Actuaries' Health Practice Council commends members of the Senate as you prepare to debate and vote on the Patient Protection and Affordable Care Act. We share with you the goals of reducing the numbers of uninsured, increasing the availability of affordable coverage, controlling health spending growth, and improving the quality of care. On behalf of the council, I appreciate this opportunity to provide the following comments outlining the three key criteria that need to be considered when evaluating whether this legislation will lead to a viable health insurance system, and how the legislation can be improved to meet these goals. In particular:

For insurance markets to be viable, they must attract a broad section of risks. Implementing market reforms to prohibit insurers from denying coverage and to restrict how much premiums can vary will result in adverse selection and upward pressure on premiums unless lower-risk individuals have incentives to purchase coverage. An individual mandate can bring lower-risk individuals into the pool. To be effective, however, the penalties for not complying with the mandate must be meaningful relative to the premium faced. The penalties in the Patient Protection and Affordable Care Act are very low, which is especially problematic given the bill's limits on premium variations by age, which will raise premiums for younger individuals. Strengthening the bill's individual mandate through higher financial penalties is needed to reduce adverse selection that would arise due to the new issue and rating restrictions.

Market competition requires a level playing field. All plans, including any new public plans or health insurance cooperatives must operate under the same rules. As written, the public plan and cooperatives established under the legislation would be subject to the same market rules and benefit requirements that apply to public plans. They would also be required to negotiate rates with providers. The bill should retain these provisions and also ensure that start-up funds provided to these plans are adequate to meet not only pre-operational expenses but also solvency needs.

For long-term sustainability, health spending growth must be reduced. Provisions to control health care spending should include not only one-time improvements that will help address short-term goals, but also options that permanently reduce spending growth to address long-term goals. The Patient Protection and Affordable Care Act includes provisions that aim to reduce long-term spending growth by shifting the health care payment and delivery systems to focus on cost-effective and high-quality care. Many of these efforts take the form of studies and demonstration projects. Policymakers need to focus intently on finding ways to control spending and ensuring that

promising approaches and successful demonstration projects are adopted on a broad scale in a timely manner. . .

To this end, the Act also includes provisions that would help shift the health care payment and delivery systems from rewarding quantity of care to rewarding quality of care. The legislation includes many cost containment and quality improvement strategies focused on the Medicare program, including provider payment and delivery system reforms that provide incentives for coordinated and cost-effective care. Such a comprehensive and coordinated approach to addressing quality and costs is needed to fundamentally transform the health system to ensure its long-term sustainability. However, acknowledging that the impact on health spending and health outcomes of many potential programs is still unclear, the legislation directs many of these efforts in the form of studies and demonstration projects. Analyses from the Centers on Medicare and Medicaid Services and from the Congressional Budget Office suggest that at least in their current limited form, these provisions will have only a minimal impact on health spending growth. Policymakers need to focus intently on finding ways to control spending and ensuring that promising approaches and successful demonstration projects are adopted on a broad scale and in a timely manner.

SUMMARY

The American Academy of Actuaries' Health Practice Council strongly supports three key considerations for a sustainable health insurance system with increased access to affordable health insurance. In particular, for insurance markets to be viable they must attract a broad cross section of risks; market competition requires a level playing field; and for long-term sustainability, health spending growth must be reduced.

Outcomes of the reforms before you, because they involve so many complex interactions including market behavior, may not be fully known until implementation. Even actuaries must make certain assumptions in their projections, based on experience and expertise, as to what the exact effects will be. However, as the full Senate casts votes, we urge you to first and foremost examine these criteria as a litmus for determining the success of this reform effort. In particular, we believe that strengthening the individual mandate through higher financial penalties is needed to reduce the adverse selection that would arise due to the new issue and rating restrictions.

We welcome the opportunity to serve as an ongoing resource to you as health care reform legislation is considered in the Senate and through remainder of the legislative process. If you have any questions or would like to discuss these comments further, please contact Heather Jerbi, the Academy's senior health policy analyst (202.785.7869; Jerbi@actuary.org).

Sincerely,

CORI E. UCCELLO,
Senior Health Fellow.

Mr. ALEXANDER. All in all, these factors suggest why, when Senator COLLINS took a look at Maine, she found that 87 percent of people in Maine are paying less for their individual policies than the policies would cost under the Reid bill. It is true that half or more of them would receive some subsidy, which would reduce their costs, but around half of them will pay more. In Tennessee, Blue Cross Blue Shield, which covers about one-third of Tennessee's individual market, estimates the premiums for those individuals will increase by 30 to 45 percent under the Reid bill.

I ask unanimous consent to include a chart which demonstrates that.

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

Health Care Reform Analysis - CBO vs. BCBST Impact and Assumptions
Non-Group Analysis

	CBO Impact	BCBST Impact	CBO Assumptions	BCBST Assumptions
Difference in Amount of Insurance Coverage	**27% to 30%**	**17%**		
Increase in Actuarial Value*	18 to 21%	3%	Current non-group Actuarial Value is 60% & value under reform is 72%	Current non-group actuarial value is 69%; only impact is on policies below 60% moving up to minimum
Increase in Utilization and Scope of Benefits	9%	14%	Adding coverage of maternity, Rx, MH/SA, & pre-ex conditions as well as increased util from lower cost sharing	Adding coverage for maternity, pre-ex conditions and conditions currently ridered (Rx and MH/SA already covered)
Difference In Price of a Given Amount of Coverage	**-7% to -10%**	**3%**	CBO did not assign values to each element	After viewing CBO's analysis, appears that administrative cost savings may offset new fees. Seems that only way significant savings will be achieved is through a reduction in provider payments.
Reduced Administrative Costs				
Economies of Scale - More Enrollees	Decrease	Not considered		Expect minimal impact (less than 0.5%)
Benefit Standardization	Decrease	Not considered		Expect minimal impact (less than 0.5%)
Standard Electronic Transactions	Decrease	Not considered		Expect minimal impact (less than 0.5%)
Reduction in Underwriting Costs	Decrease	Not considered		Expect minimal impact (less than 0.5%)
Exchange Expenses Fee	Increase	0%		Assumed fees of 4% - 6% will be offset by reduction in sales expense
Increased Competition				
Increased Med Management	Decrease	Not considered		Expect minimal impact due to current high level of medical management
Reduced Provider Rates	Decrease	Not considered		
Prudent Purchasing by Exchange	Decrease	Not considered		Expect minimal impact
Higher Public Plan Costs	Decrease	Not considered		Expect minimal impact
Health Insurance Co Fee	Increase	2%		
Medical Device Fee	Increase	1%		
Cost Shifting	No Effect	Not considered		Differ with CBO's opinion that there is no historical evidence of cost shifting
Differences in Types of People Who Obtain Coverage **	**-7 to -10%**	**10% to 25%**	Adverse selection limited by policy provisions and will be offset by healthier uninsured population	Based on historical examples, adverse selection potential is significant, though mitigated somewhat by items below. Still believe cost impact will be greater than 10%.
Uninsured are Healthier on Average	Decrease			
Limited Amount of Adverse Selection Would Occur	Increase			
Open Enrollment		Not considered		
Premium Subsidies		Not considered		
Mandate				Mandate is weak and not likely to be effective
Total Difference Before Accounting for Subsidies	***10% to 13%***	***30% to 45%***		

** Reflects 60% minimum actuarial value requirement*

*** BCBST impact paper reflected 35% increase for the impact of guaranteed issue and no effective individual mandate.*
This can be split into the following components:
1) Impact of requiring coverage of pre-ex conditions and removing riders = 10%
2) Differences in types of people who obtain coverage = 25%

Note: Cases in BCBST paper also reflected the policy specific projected impact of limiting age band rating as well as eliminating rating based on gender and health status. Across book of business, average impact for all of these items is revenue neutral. CBO analysis is based on averages so their analysis has no associated impact.

Mr. ALEXANDER. At our summit on Thursday, there were a number of good ideas about reducing health care costs that the President seemed to share with Republican Members who were there. There was some obvious irritation on the part of the majority leader and others when we said things such as there is $½ trillion worth of cuts in Medicare, which there are. Our real objection to it is that the cuts are not used to save Medicare, which is going broke, but spent on a new program—$½ trillion in new taxes. There is $½ trillion in new taxes.

As I have just said, they tend to increase premiums for millions of Americans. There are premium increases. There is a deficit increase.

It is true the CBO has said that what was presented to them didn't increase the deficit, but what was not included in what was presented was paying doctors to serve patients in the government program we call Medicare. That is like having a horse race without the horses. How are you going to have a comprehensive health care bill and not include within its costs paying doctors to serve patients in the government program? When you put it in, the deficit goes up.

Then there is a problem of the passing off to States these expanded Medicaid costs without paying for them. I know as a former Governor—and I see the former Governor of Virginia in the chair—I struggled with that every single year. All the Governors are today in both parties. They don't want us sending them a bill for expanded health care. They can't pay the bills they have. We shouldn't do that. If we want to expand it, we should pay for it. That is another part of the bill.

So I came to the floor today to, No. 1, express my appreciation to the President for inviting us Thursday. It gave us a chance to show who we are and what we are for. I thought it was a good discussion. I believe there are 8 or 10, maybe a dozen different good ideas Senator COBURN and people on both sides of the aisle suggested. There are some differences between those ideas but, basically, they represent a way to move forward to reduce health care costs. That is what we ought to do. We don't do comprehensive very well in the Senate. Comprehensive immigration failed of its own weight. Comprehensive economy-wide cap and trade seems to be failing, again of its own weight. Comprehensive health care is very difficult to pass. That shouldn't be a surprise to any of us. This is a very big, difficult, complicated country with people of many different backgrounds and, in my judgment, we are just not wise enough for a few of us to rewrite the rules for 17 percent of our economy.

I think the American people have tuned into that. They want us to fix health care, but they want us to reduce costs. Again, we on the Republican side are ready to set that goal and, as we said 173 different times on the Senate floor the last six months of last year, we have offered 6 steps to move toward that goal. Maybe the President can think of six more. Maybe we can think of six more. We did that with the America COMPETES Act. We asked the national academies: What are the 10 steps that can help us become more competitive as a country? They gave us 20, and we passed most of them. In clean energy, we are coming together on nuclear power, offshore drilling, and energy development. Those are steps toward a goal that would be a more sensible way for us to work.

In the meantime, the unpleasant truth is, the current bill being considered—will cut Medicare, not spend it on Medicare—will raise taxes, and it will, as I have tried to demonstrate with respect to the President, raise individual premiums because of the one-size-fits-all government mandates and tax increases.

Finally, I commend to my colleagues today's editorial from the Wall Street Journal detailing how the Massachusetts health care plan has unexpectedly caused premiums to rise over the last couple years and what lesson there might be in that for us.

I yield the floor and 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. BAUCUS. 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.

CONCLUSION OF MORNING BUSINESS

The ACTING PRESIDENT pro tempore. Morning business is now closed.

TAX EXTENDERS ACT OF 2009

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate will proceed to the consideration of H.R. 4213, which the clerk will report.

The legislative clerk read as follows:

A bill (H.R. 4213) to amend the Internal Revenue Code of 1986 to extend certain expiring provisions, and for other purposes.

The ACTING PRESIDENT pro tempore. The Senator from Montana.

PRIVILEGES OF THE FLOOR

Mr. BAUCUS. Mr. President, I ask unanimous consent that the following staff be allowed the privilege of the floor during consideration of the pending bill: Randy Aussenberg, Aislinn Baker, Brittany Durell, Dustin Stevens, Greg Sullivan, Max Updike, and Ashley Zuelke.

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

AMENDMENT NO. 3336

(In the nature of a substitute)

Mr. BAUCUS. Mr. President, I now call up my amendment by number and urge its consideration.

The ACTING PRESIDENT pro tempore. The clerk will report the amendment by number.

The legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS] proposes an amendment numbered 3336.

(The amendment is printed in today's RECORD under ''Text of Amendments.'')

Mr. BAUCUS. Mr. President, Martin Luther King, Jr., once said:

Life's most urgent question is: What are you doing for others?

Pretty much all of us came here to the Senate to work on that urgent question. Pretty much all of us came here to help other Americans.

On a number of levels, the legislation before us today is urgent legislation. The legislation before us today is urgent because it would prevent millions of Americans from falling through the safety net.

The legislation before us is urgent because it would extend vital safety net programs that expired yesterday.

The legislation before us is urgent because it would put cash in the hands of Americans who could spend it quickly, boosting economic demand.

The legislation before us today is urgent because it would extend critical programs and tax incentives that create jobs.

The legislation before us today is urgent because it is important that we here can do this for other Americans.

Since the recession began, more than 7 million Americans have lost their jobs. The unemployment rate remains nearly 10 percent. For Americans without a job, this great recession is a great depression. If you do not have a job, it is a depression.

Last week, with a solid bipartisan vote, we passed legislation to help create jobs. We can and should do more, and by extending this package of vital provisions we can do just that.

The provisions in this bill are important to American families. They are important to communities that have suffered a natural disaster. They are important to businesses competing in the global economy. They are important to furthering America's commitment to energy independence.

The need is urgent. Yesterday many of these important provisions expired. Millions of Americans are being put at risk. The expiration of these provisions has left gaping holes in the safety net.

Among the provisions that expired yesterday are these: expanded unemployment insurance benefits; COBRA subsidies to help people keep their health insurance; a provision that keeps folks right at the poverty line from losing their benefits; the small business loan program; the temporary measure to prevent a 21-percent cut to doctors under Medicare; the Flood Insurance Program; the Satellite Home Viewer Act.