Fund, with about $1.6 billion coming in the first 2 years.

Then, we replenished the general fund for the amounts we moved into the Highway Trust Fund. We did this by clamping down on tax cheats and unscrupulous Medicare providers, as examples.

Finally, after accommodating Republican Senators' concerns at markup to rework some elements of our proposal, we accepted a widely supported idea to stabilize required contributions into pension plans.

The pension plan beneficiaries will still be able to rely on the plans getting funded, but employers will have a more predictable and realistic schedule for how much to contribute.

This provision raised sufficient revenue to enable us to then transfer another $4.5 billion into the Highway Trust Fund in the first 2 years, bringing the 2-year total to about $9.2 billion, well more than the $5.6 billion needed to just pay for the bill.

This pension stabilization provision raised more than $9 billion in total, which also enabled us to accept a Republican amendment to put additional money into the Highway Trust Fund in future years. This brought the 10-year total to approximately $14 billion, as I stated earlier.

My understanding is that this increase in general fund revenue to plus up the Highway Trust Fund would be considered acceptable under the House Republicans' proposed budget with its ''Reserve Fund.''

It is also my understanding that the House's proposed 5-year bill will leave the Highway Trust Fund at the brink of insolvency by the bill's proposed conclusion, unlike the Senate's carefully crafted compromise that I have just described.

The House leadership should not make inaccurate claims about the Senate's bill to camouflage their own inability to pass a long-term bill and unwillingness to work out compromises.

We just passed yet another short-term extension to provide funding for only 90 days. We can't keep kicking the can down the road. Pretty soon there will be no road left to kick the can down.

The easiest way to work together and forge a solution to create jobs and fund our Nation's highway system is for the House to take up the Senate's bill. It's a good bill. It provides certainty so businesses and communities can plan construction projects and create jobs.

It is fully paid for. In fact, it ensures the Highway Trust Fund will remain solvent even after the end of the bill. It gives us time to address the longer-term needs of our national program, and how we are going to pay for it.

The House Republican leadership should set partisanship aside. They should realize there are no Republican or Democratic roads or bridges. There are only American ones. It is time to work together and not leave the Highway Trust Fund insolvent.

Thank you. I yield the floor.

The PRESIDING OFFICER. The Senator from Maine.

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

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

HEALTH CARE REFORM

Ms. COLLINS. Mr. President, during the past week, the Supreme Court heard arguments on the constitutionality of President Obama's health care law. This week also marks the 2-year anniversary of the President's signing that law.

There is no question that our health care system required and still requires significant reform. In passing this law, however, Congress failed to follow the Hippocratic oath of ''first, do no harm.'' The new law increases health care costs, hurts our seniors and health care providers, and imposes billions of dollars in new taxes, fees, and penalties. This, in turn, will lead to fewer choices and higher insurance costs for many middle-income American families and most small businesses—the opposite of what real health care reform should do.

I find it particularly disturbing that President Obama's health care law does not do enough to rein in the cost of health care and to provide consumers with more affordable choices. In fact, Medicare's Chief Actuary estimates the law will increase health care spending across the economy by more than $300 billion. The nonpartisan Congressional Budget Office says the law will actually increase premiums for the average family plan by $2,100. Moreover, a recent report issued by the CBO found that the new law will cost $1.76 trillion between now and the year 2022. That is twice as much as the bill's original 10-year pricetag of $940 million.

The new law will also mean fewer choices for many middle-income Americans and small businesses. All individual and small group policies sold in our country will soon have to fit into one of four categories. One size does not fit all.

In Maine, almost 90 percent of those purchasing coverage in the individual market have a policy that is different from the standards in the new law.

I am also very concerned about the impact of the law on Maine's small businesses, which are our State's job creation engine. The new law discourages small companies from hiring new employees and from paying them more. It could also lead to onerous financial penalties even for those small businesses that are struggling to provide health insurance for their employees.

According to a Gallup survey taken earlier this year, 48 percent of small businesses are not hiring because of the potential cost of health insurance under the new law. The Director of the Congressional Budget Office has testified that the new health care law will mean 800,000 fewer American jobs over the next decade.

Even when the law tries to help small businesses, it misses the mark. For example, I have long been a proponent of tax credits to help small businesses afford health insurance for their employees. The new credits for small businesses in the health care law, however, are so poorly structured and phased out in such a way that businesses will actually be penalized when they hire new workers or pay their employees more. Moreover, they are temporary. The tax credits are temporary and can only be claimed for 2 years in an insurance exchange.

I am also very concerned that the new law is paid for, in part, through more than a $500 billion cut in Medicare—a program which is already facing serious long-term financing problems. It simply does not make sense to rely on deep cuts in Medicare to finance a new entitlement program at a time when the number of seniors in this country is on the rise. We need to fix and save Medicare, not add to its financial strains.

Moreover, according to the administration's own Chief Actuary, those deep Medicare cuts could push one in five hospitals, nursing homes, and home health providers into the red. I am particularly concerned about the impact on rural States like Maine. Many of those providers could simply stop taking Medicare patients. That would jeopardize access to care for millions of our seniors.

It did not have to be that way. The bitter rhetoric and the partisan gridlock over the past few years have obscured the very important fact that there are many health care reforms that have overwhelming support in both parties.

For example, we should have been able to agree on generous tax credits for self-employed individuals and small businesses to help them afford health insurance. That would have reduced the number of uninsured Americans. We should have been able to agree on insurance market reforms that would prevent insurance companies from denying coverage to children who have preexisting conditions, that would permit children to remain on their parents' insurance policies until age 26, that would require standardized claim forms to reduce administrative costs, and that would allow consumers to purchase insurance across State lines. Those are just some examples of health care reforms that would enjoy and do enjoy widespread bipartisan support.

We also should be able to agree on delivery system reforms that reward value over volume and quality instead of quantity. We should be able to agree on reforms that increase transparency throughout the health care system so consumers can compare prices and quality more easily.

I know the Presiding Officer's State, and Dartmouth College in particular, has done a great deal of work in this

area, as have many health care providers and many hospitals in the State of Maine. They are experimenting with new delivery models that will help them better control chronic disease treatments, which, in turn, will not only improve the quality of health care but also help to lower costs.

We should be able to agree on ways to address the serious health care workforce shortages that plague rural and small-town America. Simply having an insurance card will do you little or no good if there is no one available to provide the health care.

In short, I believe we made—Congress made—a real error in passing ObamaCare. We should repeal the law so we can start over, to work together in a bipartisan way to draft a health care bill that achieves the consensus goals of providing more choice, containing health care costs, improving quality and access, and making health care coverage more affordable for all Americans.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

The PRESIDING OFFICER (Mrs. SHAHEEN). Without objection, it is so ordered.

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

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

Mr. SESSIONS. Madam President, I am here today to share a new and stunning revelation unearthed by my staff on the Senate Budget Committee. One of my responsibilities as the ranking member is to look at the long-term cost of legislation, so we wanted to ascertain the long-term cost of the President's health care bill—I mean the kind of long-term cost analysis that has been going on for a number of years with regard to Medicare, Social Security, and Medicaid, over a 75-year period. I was floored by what we discovered.

First, let's put in a little context. President Obama told the American people repeatedly that his health care bill would cost $900 billion over 10 years and that it would not add one dime to the public debt. But we have shown that the cost score for the first 10 years of implementation, when the bill is fully implemented, is actually $2.6 trillion—almost three times as much.

In addition, the offsets used to reduce the law's official cost were enormous and phony, as I have discussed before and will detail at another time. These are unacceptable offsets. You have heard the story of Mr. Mistoffelees, the Napoleon of Crime. I say that this bill is the Napoleon of criminal offsets. The more we learn about the bill, the more we discover it is even more unaffordable than was suspected.

Over a period of about 3 months, our staff worked diligently to estimate the new unfunded liability that would be imposed by the passage of this legislation. This is not the total cost of the bill but the unfunded mandatory coverage obligations incurred by the U.S. Government on behalf of the people of the United States over a period of time.

An unfunded obligation is basically the amount of money we will have to spend on a mandatory expense that the bill does not have a funding source to meet—money we don't have but money we are committed to spend. It is this kind of long-term unfunded obligation that will place this Nation's financial situation at such great risk. It is the thing that has called witness after witness before the Budget Committee, on which I am ranking member, who tell us we are on an unsustainable path. That means money we will either have to print, borrow, or tax to meet the obligations we would incur as a people as a result of the passage of this bill.

For instance, it is widely agreed that Social Security has an unfunded liability of $7 trillion over 75 years. That is an enormous sum. It is double the entire amount of the U.S. budget today. My staff used the models that are used by the Centers for Medicare and Medicaid Services. They talked with the individual experts about these numbers and worked diligently to come up with a figure using appropriate methods. That figure, using the administration's own optimistic assumptions and claims about the cost of the law, is an incredible $17 trillion that would be added to the unfunded liabilities of the United States over the next 75 years. That is more than twice the unfunded liability of Social Security.

I wish to emphasize that this $17 trillion figure is not an estimate based on what we think the bill will really cost if all the administration's claims and promises were to be proven false—and certainly there have been matters proven false already. We used the administration's own figures. So the unfunded liability is almost certainly not going to be less than $17 trillion, but if any more of the administration's claims unravel—as so many already have—the cost of the program's unpaid-for obligation will rise radically higher than $17 trillion. For instance, former CBO Director Douglas Holtz-Eakin, an expert in these matters, says that millions more individuals may lose their current employer coverage and be placed into the government-supported exchanges than currently projected—than what the administration has projected. But we didn't follow Mr. Holtz-Eakin's arguments or concerns; we took the administration's assumptions.

Let me briefly explain some of what now comprises this additional $17 trillion in unfunded obligations.

Madam President, $12 trillion is for the health care law's premium subsidy program. You see, the law created new regulations that drive up the price of insurance for millions of Americans. The writers of the law knew it would inflate the cost of insurance premiums, so to cover that cost, they had to include new government subsidies so people could pay for their more expensive insurance.

On Medicaid, this new health care law has added another $5 trillion to its unfunded liabilities. This is on top of the substantial unfunded obligations the Federal and State governments have already had to take on in order to support Medicaid. They have protested vigorously to us, warning of these additional deep expenditure requirements that are falling on the States.

These figures don't even account for the dozens of new bureaucracies that will be created to implement the President's health care law or the expansion of the bureaucracies. Those costs are not included in the $17 trillion or the cost estimates the administration used for the bill. For instance, the IRS has requested 4,000 new IRS agents and $300 million in additional funds for their part in implementing the new law.

At a time when we should be trying—we have to—to shore up programs that are threatened by default—Medicare, Social Security, Medicaid—this health care law adds an entirely new obligation—one we cannot pay for—and puts the entire financing of the U.S. Government in jeopardy. We don't have the money. We don't have another $17 trillion in unfunded liabilities that we can add to our account. We have to reduce the ones we have. This has been obvious for several decades. People have talked about it repeatedly.

Instead of doing something about those programs that are headed to bankruptcy, we add—under this President's determined insistence and a straight party-line vote—one of the largest unfunded mandates in history on top of what we already have. How can we possibly justify this? It cannot be justified.

This bill has to be removed from the books because we don't have the money. There are a lot of other reasons, but that is one of them. It is inescapable. It would be absolutely irresponsible for this Congress to maintain a law that would run up this kind of debt—2½ times the unfunded obligations of Social Security—and we are worried about our children being able to have their Social Security checks on time.

This is not a little bitty matter, it is important. So I will be sending a letter to the GAO, the Government Accountability Office. They do these kinds of scorings over 75 years. We will ask them to construct their independent estimate of the unfunded health care law obligations. I believe they will be similar to the ones my staff has produced. I hope they are better, but I am afraid they are not. And even if they come close to what we have calculated, it is pretty clear that the money that

will be coming in could be far less and the obligations could be far more than what are being projected, as Mr. Holtz-Eakin and others have said. It is an urgent matter.

I plan to come to the floor in the coming days to continue to explain the true fiscal cost facts about this legislation. There are many other serious problems with it. It is unpopular, unaffordable, unconstitutional, and it has to be repealed.

I yield the floor.

The PRESIDING OFFICER. The Senator from Delaware.

Mr. CARPER. Madam President, I appreciate the opportunity to speak. I ask unanimous consent to speak as in morning business.

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

Mr. CARPER. Madam President, I feel compelled to say a word on the heels of our colleague from Alabama, whom I salute as he heads off into the setting Sun. I wish him well and to have a good break.

When I was in the Navy during the Vietnam war, when we weren't flying a lot of missions off the coast of Cambodia and Vietnam, we flew into a lot of other countries, including Japan. I have always had an interest in Japan in terms of the way they provide health care. One thing that intrigues me about that is that they spend half as much money for health care as we do. They spend 8 percent of gross domestic product. We spend 16 percent of gross domestic product. They get better outcomes—everything from longer life expectancy to lower rates of infant mortality—and they cover everybody. They cover everybody. It is not socialized medicine. They have a private health care delivery system and private health insurance companies as well as we do, but they get a better result for about half the money we do, and we have to compete with them.

It is not a fair competition. We have our businesses that are competing directly with the Japanese and, frankly, with other countries as well. But when they are spending half as much money for health care, and we are trying to compete our businesses against theirs, it is not a fair fight. It is like having one arm tied behind our back.

For years, Presidents, Members of Congress—Democrat and Republican—have talked about this challenge—the fact we spend so much more money for health care than the rest of the world, and we don't get better results and, in a lot of cases, we get worse results and we don't cover everybody. We have a lot of people uncovered. That is not smart.

For years, for decades, nobody took it on. They tried during the Clinton administration but gave up during that course. They didn't have the kind of bipartisan support that is needed. Frankly, we didn't have the bipartisan support I would like to have had on health care reform when we took it up during the earlier part of this current administration.

A lot of people have focused on the individual mandate as being constitutional or unconstitutional. I am not a lawyer. I don't pretend to be an expert on that stuff. I studied a little economics when I was a Navy ROTC midshipman at Ohio State. When I got out of the Navy and moved to Delaware to get an MBA under the GI bill, I studied some more economics and all, but I don't pretend to be a lawyer. But I do know this: Health insurance companies have said to all of us—Democrats, Republicans, Presidents, now and in the past—look, if you expect us to provide health insurance for folks with preexisting conditions, you have to make sure the pool of people we have to cover includes not just people who have preexisting conditions—not just people who are sick or have illnesses or conditions that are expensive to treat—you have to make sure we have a pool of people to insure that includes some healthy people.

The way some countries deal with this is they mandate for everybody to have coverage. We didn't want to do that. We didn't want to mandate that everybody have coverage, but we wanted to incentivize people, including healthier people—including healthier young people the ages of my sons who are in their early twenties—to make sure at least some of those young men and women end up in that pool, so healthy people end up in that pool.

So part of the request from the health insurance industry, in return for doing away with preexisting conditions and basically screening out sick people, saying they are not going to provide coverage for them, was to make sure a lot of healthier people ended up being in that health insurance pool.

The way we decided to do it in the health care bill, in the law rather than just mandate people get coverage, was to incentivize them. If they choose not to, that is their business. If they happen to be poor, we will help them pay down their cost for health care. But if they are not poor, and they have the financial means, we would like for them to get coverage. We are not going to mandate it, but the first year we have the means to be able to have coverage and they choose not to, there will be a fine or a penalty of some kind—maybe a couple hundred bucks, and that will increase not to $1,000 or $2,000, but it will go up several hundred dollars in order to encourage people to get the coverage.

At the end of the day, some people will say: I am paying $600—whatever it ends up being. Maybe instead of paying this fee I should just go ahead and get some health insurance coverage. The idea is to provide some plans that are reasonably affordable so folks can take advantage of them.

So that is the issue of the mandate. The Supreme Court will decide whether under the commerce clause of the Constitution that just as we compel people to pay into Social Security, it can be a similar kind of compunction to say we would like people to get covered for health care, but in this case not to mandate it, as we do with Social Security. So we will see how it works out in the Supreme Court.

They heard arguments this week, and I am sure the arguments will continue on the air waves, at townhall meetings, and on television for months to come and maybe beyond that. Who knows. But the heart and soul of the health care reform legislation has less to do with mandates for me than it does with how to get better health care outcomes for less money. For me, that is it—better health care outcomes for less money.

We don't have to look at Japan and other countries to figure that out. All we have to do is look at places such as Minnesota's Mayo Clinic, in Ohio the Cleveland Clinic, Pennsylvania's health care delivery system, which is called Geisinger, Utah's Intermountain Healthcare, and California's Kaiser Permanente. What do they have in common? They get better health care outcomes for tens of millions of people for less money than most other health care delivery systems in this country. Better results for less money.

How do they do it? Well, they have figured out what works, and they do more of that. They figured out what doesn't work to get better health care outcomes for less money, and they do less of that. They have moved away from what we call a fee-for-service approach to health care.

People get sick, they go see a doctor, they go see a nurse. They have visits and get shots or they get lab tests done or get x-rays or MRIs. We treat people when they get sick. For years, that is the way we have done health care in this country, including Medicare and Medicaid. Much smarter ideas have come out of Cleveland's clinic, and they have a huge health care clinic in northern Ohio, the Mayo Clinic, Geisinger in Pennsylvania, Intermountain in Utah, and Kaiser Permanente mostly in California.

Here is what they do. They do not just incentivize health care providers—doctors, nurses, and hospitals—to work on people when they are sick. Their incentive works entirely different. What they do in those places is focus on how to keep people healthy, not just how to incentivize the doctors, hospitals, and nurses to keep people healthy, but how do we incentivize the patient, the person whose health is at stake, how do we incentivize them to take personal responsibility for their own health care.

In my mind that is the heart and soul of the health care reform right there. Among the smart things that work are large purchasing pools. We have an 8-million-person pool for us that we are part of. Members of Congress, our staffs, all Federal employees, Federal retirees, and our dependents are part of a huge purchasing pool called the Federal Employees Health Benefits Plan. It is approximately 8 million people.

We don't have 8 million Federal employees, but we have 8 million people when we add in retirees and dependents and so forth. We are part of this big health care purchasing pool. We get lower prices.

It is not free. We pay about 28 percent of the cost of our premiums as Federal employees and servants, if you will, to people in our respective States, and our employers, the taxpayers, pay the other 72 percent or so.

But what we are going to do is provide the opportunity for individuals, for families, for businesses—small and midsize businesses—all over the country, in less than 24 months, to be able to join a similar kind of purchasing pool. We are going to start them, and every State—New Hampshire, Delaware, Alabama, and every other State—will have the opportunity to have their own large purchasing pool to be able to take advantage of lower administrative costs.

The administrative costs for our Federal Employees Health Benefits Plan is $3 out of every $100 of the cost of the premium. So $3 out of every $100 of premium costs goes for administration. In most plans for individuals, for families and small businesses, it is more like 20 or 30 percent. So 3 percent for our large purchasing pool, and we will have those available, in fact, in every State.

The other thing we have going for us in the Federal Employees Health Benefits Plan is we use private health insurance plans. We are not using socialized medicine or stuff like that. The private health insurance plans in the country can sign up and say they want to be able to offer their plans to the folks who are Federal employees with dependents, to Federal retirees, and so we can choose among them. So there is a lot of competition between those health insurance companies, and we get the benefit from that competition. It drives down cost. Competition helps drive down cost and improves the range of opportunities.

The other thing I like about the law is that, for the most part, insurance can't be sold across State lines. But we make an exception. I will use Delaware as an example. We are boundaried on the west by Maryland, to the north by Pennsylvania, and to the east by New Jersey. When we establish our own health insurance pool in 2014, we will have about 900,000 people. So we will have a huge health insurance pool, but we are sure not going to have 8 million people.

But what we will have under the law is the opportunity to create an interstate compact between Maryland or Delaware or Delaware and Pennsylvania or Delaware and New Jersey or maybe all of the above and have a multistate purchasing pool or exchange. The great thing about this approach is we, No. 1, will have a bigger pool, which will drive down administrative costs and increase the competition.

The health care that would be available in Delaware plans could be offered in Maryland, could be offered in Pennsylvania or offered in New Jersey. So we would have a larger purchasing pool, more competition, and a better deal for the consumer. I think that is another part of the heart and soul.

So two things, and I will close on this and then turn to what I came to the floor to talk about. But I was inspired by my friend from Alabama. In terms of the key reforms in the health care legislation, No. 1, move away from fee-for-service—just paying for treating people when they are sick. Migrate away from that. We still need to treat people when they are sick, but migrate to a system like we have at Mayo, Cleveland Clinic, Geisinger, Intermountain Health, and Kaiser Permanente where they focus on how we keep people well. Focus on prevention and wellness and focus on treating people in a coordinated fashion as a team, not as individual providers. Very smart.

The other key element is this idea of creating these large purchasing pools and trying to incentivize people to be part of the health care delivery system by taking better care of themselves. So those are the two keys.

GAS PRICES

Mr. CARPER. Madam President, I want to switch gears and talk a little about gas prices. Madam President, I don't know what kind of vehicle you drive most of your miles in while in New Hampshire. The vehicle I drive most of my miles in, and have been driving in Delaware for 11 years now, is a Town and Country Chrysler minivan. When I stepped down as Governor in 2001, my old Chevrolet Corsica was about 12 or 13 years old, and my wife said: Don't you think it is about time to get something new? So I took my oldest son Christopher, who was about 12 at the time, and I said: Let's go out and shop for a new car. I thought it would be a man thing, a dad and son thing.

So we went out and drove Porsches, we drove Ferraris, and we bought a 2001 Chrysler Town and Country minivan, which he laments to this day. Anyway, fast-forward 11 years, and we had a meeting yesterday morning, as you know, with the CEO of Chrysler-Fiat, and I mentioned at the meeting that we bought this vehicle when I stepped down as Governor, and 11 years later—later this week—the odometer will reflect the numbers 300,000 and counting. It will have over 300,000 miles. We are going to go over 300,000 miles. So it was built to last. What a great car, built in this country, a terrific vehicle. But when I stopped and got gas last weekend, we paid about $3.81, and the prices continue to go up—mostly up, sometimes down, and then back up again.

What I would like to do is talk a little about high gas prices and how it puts pressure on all budgets, including the budget of my own family. We drive that vehicle a whole lot and, hopefully, will drive it a few more miles before it is ready do sit more in the driveway and take a rest.

I want to begin by acknowledging that I go home just about every night and talk to people literally almost every day, morning or evening, in Delaware. I will cover the State this weekend and for the next week or two during our recess, so I hear a lot directly from the folks I am privileged to represent about their concerns about gas prices at the pump and the kind of pressure it puts on the budgets within their own families.

I understand gas prices are at their peak. Actually, they have been higher than this. I think they were a little over 4 bucks during part of the Bush administration, but this is as high as they have been for some time. It puts a strain on American families and American businesses, and it threatens to impede or slow down our economic recovery, which is actually moving at a pretty good pace. Unfortunately, the solution is not as simple as some would suggest. If it were, we would not be having this discussion every year or two around the same time.

I am asked sometimes: Why don't we just drill more in this country? Some assume high gas prices at the pump must mean we have slowed down or stopped drilling at home.

Many are surprised by the answer, and the answer is we are drilling more in America. In fact, I believe—correct me if I am wrong—but we are drilling more in this country than we have for at least the last 8 years. Because we are drilling more, the United States is now a net oil exporter, not a net oil importer. This country, which for years we said we are the Saudi Arabia of coal, is now on its way to becoming the Saudi Arabia of natural gas. As we have opened for drilling additional acres onshore, offshore, off Alaska, and the gulf, we are in a position to become a net oil exporter.

The Obama administration has made available millions of acres for oil and gas exploration in the last year or two, approving more than 400 drilling permits since the new safety standards were put in place. These safety standards, we may recall, were implemented to make sure we didn't have a repeat oilspill disaster such as the BP oilspill that occurred almost 2 years ago today.

We have been joined on the floor by Senator NELSON of Florida, who remembers all too well the oil that washed up in places such as Pensacola, where I did basic training on my way to becoming a naval flight officer. But since we got that straightened out and put in place tighter restrictions for drilling safeguards, 400 or so new drilling permits just since then have been put in place with stronger safety standards.

As a result, we have a record number of oil rigs operating right now, more working oil and gas rigs than the rest of the world combined. Let me say that