directing the actuarial program for CMS and directing the development and analysis of health care financing issues.

On April 9, Mr. Spitalnic released a review of the estimated financial effects of this legislation. Analysis conducted by the Heritage Foundation actuaries indicates that the drafters of the bill actually double-counted funds. While the bill anticipates higher premiums for Medicare Parts B and D and cuts to Medicare Part A, those savings would be $55 billion and $32 billion, respectively.

Medicare Part A is the trust fund American working people's money goes into off their paychecks every week. So most Americans believe they pay for Medicare. And they do, for the most part, although we are now taking in less money than is going out to a significant degree.

So what did this bill do? This bill cuts the expenditures for Medicare Part A, the trust fund part, and it claims that money—$32 billion and $55 billion, respectively—is now available to spend on the physicians to pay for their fix. But the physicians' Medicare part—when you go to a doctor and Medicare pays for that—that is not trust fund money. That is general revenue Treasury money.

So what has happened? They are cutting the reimbursements of hospitals and doctors. They claim it won't affect the benefits accrued to people who need health care, but it probably will. To cut the cost of providers of health care services, in effect, reduces the benefits that actually go to the patient.

So how does that money get from the trustees of Medicare—who are supposed to manage this program and take the money in that comes off our paychecks and goes to Medicare—to paying for something outside of Medicare Part A?

They take an oath to be responsible and faithful to the trust as trustees of Medicare. They don't give it to the U.S. Treasury. They loan it. There is a debt instrument. The money is loaned to them and the Federal Government pays interest. That is where we get the 30-some odd billion dollars in interest over 10 years—part of it.

The money that is being used to fund the portion that they claim is actually paid for I say is not paid for. The Congressional Budget Office has told us this technique is double counting. The money cannot be used to benefit Medicare and, at the same time, fund a new expenditure. We really have to watch this. It is something I have come to realize is one of the biggest gimmicks the Senate uses.

When ObamaCare was passed—on December 23, the night before it passed, we got a letter from the Congressional Budget Office at my request. I read it on the floor on December 24, the day the bill passed. It said, I think, there was $400 billion, $500 billion in double-counted money they said was available to fund the Affordable Care Act.

Colleagues, we have got to be careful. A country goes broke by managing money this way—huge sums of money.

Beyond this gimmick, CMS Actuary Spitalnic goes on to say that H.R. 2 raises ''important long-range concerns that would almost certainly need to be addressed by future legislation.''

When the bill's 5 percent annual bonuses in physician payments expire as scheduled in 2024—9 years from today—a major payment cut from most physicians would follow the next year, according to his report. The payment structure would also be troublesome in years with high inflation. So, in essence, by 2024, another round of doc fixes would be needed. In other words, not only does this bill add massively to the debt and engage in—I hate to say this—improper accounting, but it also fails to even provide the long-term solution it promises. It promises we are going to have a permanent fix of the payments of physicians. But this bill is not a permanent fix, and within 9 years we are going to be back in a situation that is unacceptable and has to be dealt with again by spending more money. By making these cuts in the outyears, the real costs are hidden.

We have a proposal that provides increases for doctors for the next 9 years and then begins to show reductions, and it claims, somehow, that this is going to pay for it. But Congress is not going to allow those reductions to take place either, because we are not going to be cutting doctors 5 percent a year for any 1 year, most likely.

It is not too late to make things right. The bill needs to go through regular order. It hasn't gone through our committee in the Senate. The House said the bill was going through the regular order. It hasn't gone through the regular order. It hasn't been through a committee where members have the chance to offer amendments. It is coming up on the floor. We are hardly having any amendments. I understand maybe we will have three amendments on each side. That is a pretty minuscule discussion when it supposedly has to be passed in a day. So the discussions will take place at midnight tonight.

Colleagues, we have to understand the importance of what we are doing. This legislation adds almost $200 billion to the debt in the next 10 years. It breaks our past commitment and the precedent we have established to pay for these doc fixes. In fact, I have been most insistent that before we put the extra money for the physicians, we find a pay-for—some responsible reduction in spending elsewhere—so we can set priorities and pay for the doctors. This is substantially abandoned in this legislation. I think it disregards Congress's commitment to honest accounting, the principles that we have established about how to accurately calculate the cost of legislation. It breaks the budget we had agreed to in 2011—the spending reductions in the Budget Control Act—and it violates the budget the Senate just passed a couple of weeks ago.

We need to think this through. I hate to object because I truly believe we need to take care of physicians' payments. It is absolutely wrong, and Congress has been negligent in failing to address this for years. It has been over a decade that we haven't dealt responsibly with this.

So I salute the House colleagues for saying we are going to develop a bill that fixes this over time. Unfortunately, it is not a permanent fix, as I originally thought it would be, but, it is also not a responsible fix, a grownup fix. The kind of action for which the American people depend on Congress, and hope to see, is not occurring because this bill adds to the debt.

We want to do something. We want to fix the doctors' problem, but we don't want to cut spending anywhere else.

Faced with that difficult choice, this legislation—at least to a two-thirds degree—does what we too often do: We just spend the money, commit to spending the money, and then add it to our credit card. We add it to the debt that is $18 trillion now and growing dramatically, producing for us an annual interest payment of $220 billion and putting us on a path—according to the Congressional Budget Office—of an almost $900 billion interest payment in 10 years. I believe that is not good management of the people's business.

I appreciate the opportunity to share these grim remarks and to lament the difficult situation in which we find ourselves. I do believe the Lee amendment will fix this. Maybe other amendments will, too. But we certainly need to step forward and make sure we don't continue down this path.

I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

The PRESIDING OFFICER (Ms. AYOTTE). Without objection, it is so ordered.

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

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

MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT

Mr. WYDEN. Madam President, it is my hope that soon the Senate will be about to start voting on legislation that in one fell swoop will improve health care for millions of Americans. This discussion should start with a Medicare milestone. That milestone is abolishing once and for all the outdated, inefficiency-rewarding, commonsense-defying system of paying physicians under the Medicare Program.

As my colleague from New Hampshire knows, what I am talking about in the technical lingo of health care is the SGR, the sustainable growth rate. It is a horrendously flawed formula for paying doctors and providers who treat our Medicare patients. Yet despite this very sour pedigree, it has dominated much of the discussion about Medicare since 1997.

I wish we had put this flawed reimbursement system in the dustbin of history last year. As some of my colleagues know, I had sought to do that, along with the support of others. But I think now we have reached the point, on a bipartisan basis, where we have a chance for seniors and their providers to cross the victory line and be better off and have a better system for all Americans.

I thought I would take a minute or two before discussing some of the other health care efforts that I hope will go forward today to describe how this happens. A little over a year ago, there was not much reason to think we would not just keep passing this leaky boat. That is essentially what the Senate had been doing for years and years with this flawed program.

In fact, I remember one of our younger Members of this body was where the Presiding Officer of the Senate is sitting. I said: At this rate, we are probably going to be on patch No. 70 or 80 by the time we get around to really fixing this. So people were not very optimistic a little over a year ago. Since then, however, since that 17th patch, we saw Members on both sides of the aisle saying: It is time to start getting serious and getting traction for a permanent repeal-and-replace of this flawed reimbursement system.

In January of this year, momentum finally began to grow. In other words, we used that period in 2014 as a springboard. Discussions began with Speaker BOEHNER and Leader PELOSI. Their discussions were really based on the bipartisan, bicameral framework that was developed in 2014 when leaders in the other body and the Senate got together: Finance Members, Ways and Means Members, the Energy and Commerce Members. The combination of that work and Speaker BOEHNER and Leader PELOSI coming together leads us to where I hope we will be here before long, and that is, once and for all abolishing this flawed reimbursement system.

If we did not take this action—and in effect it really has to be done now—without taking people through the root canal work of how the reimbursement system works at the Medicare center, what is called CMS, we do know that if Congress does not intervene, we would see physicians cut 21 percent. That would, in my view, cast a very strong shadow over our ability to serve America's older people. I mean, particularly in the rural areas of this country, we have a lot of those practices that serve older people walking on an economic tightrope right now. They are trying to figure out how to pay the staff and pay for equipment and lighting and everything else. A 21-percent cut would be enough, in my view, to really put some of those small rural practices out of business. So it was the judgment of this bicameral group that worked through 2014, that Leader PELOSI and Speaker BOEHNER picked up on this year, to come up with a very different kind of model to replace the Medicare reimbursement system that was so flawed, the SGR, with a merit-based incentive payment that rewards those who provide high-quality, high-value care. That, in my view, is how we get the best value for America's seniors who, of course, want to get the right amount of care at the right time. They want it to be of high quality.

A major part of this legislation will, in my view, help to promote better coordination of care. American health care is so fragmented and so strewn, kind of hither and yon, very often a senior can be treated by a variety of providers. No one really rides point on it. The senior ends up in the hospital emergency room.

At that point, when providers say: Who should we be in contact with? The senior is not even sure of all of the people, particularly if that senior has multiple chronic conditions—perhaps diabetes and a heart problem—the senior will not even know the array of providers they have seen, let alone have someone coordinate their care.

The good thing about this reform is it promotes that kind of care coordination. Also, physicians, as part of this, will have clear incentives to enter alternative payment models that are going to promote team services, services where there is a team of health care providers. It will require more Medicare transparency, more information about various services that are provided to older people so that there is some sunlight on this incredibly complicated system, particularly the Medicare Program that takes over $500 billion a year and spends it in a way that has not been particularly transparent.

I want to thank Senator GRASSLEY for working with me closely on this for a number of years.

Finally, this legislation also makes permanent what is called the QI Program, again fancy health care lingo for an important program that pays the premiums, the outpatient premiums, for low-income older people. I think that is especially important, because it says for older people, particularly those of modest income, that there is going to be some assistance for the outpatient services, what is called Part B, which are so critical in terms of keeping older people out of long-term care facilities.

My guess would be in New Hampshire and Oregon—like in my home State of Oregon—having that kind of assistance for low-income people in the community is really key to avoiding institutional care.

I do want to note that I think all of us are going to say this bill does not meet the test of perfection. I happen to believe the bill would have been stronger had this body been involved in all of the negotiations. But clearly to have a milestone for Medicare—and that is what I think you get when you eliminate what really pretty much is a fraud. The Medicare reimbursement system has been honored more in the breach than in the observance. Every year it is waived, it is patched. I think to replace it with what I have described really is something that when the history of Medicare is written, people are going to look back and say: This was an important day. These were sensible changes. Improving care coordination, putting a new focus on quality, data transparency, coordination of health care teams, the kinds of things that this proposal does, are very much in the interests of seniors, providers, and taxpayers. I think this day will be remembered for making a very important contribution in the history of Medicare.

I do want to mention several other amendments that I hope will be offered. I also feel very strongly about the need for this legislation to reaffirm and strengthen health care in America for our most vulnerable children. There are more than 100,000 of these youngsters in my home State alone. I am talking about the Children's Health Care Insurance Program, what is known as CHIP. My hope is we will have a chance here to vote to expand on what the other body has done and have a children's health program that will be extended for 4 years and not just 2.

The CHIP program has the support of almost 40 Governors. They span the philosophical spectrum. They have achieved such strong support because these Governors who are right on the front lines with a program that involves very close coordination by the Federal Government and the State governments want some certainty and predictability. They don't want vulnerable kids and their families to be in limbo.

So I am very hopeful that amendment will be offered and that it will get the support of our colleagues.

Third, I hope there will be an amendment to improve health care for women. I believe we have all followed this debate that I think is needlessly divisive. There are so many Senators who want to find common ground to improve health care.

We have gotten bogged down and somehow virtually all the bills now seem to be a magnet for a debate about abortion. My colleague, Senator MURRAY, wishes to offer a very important amendment to expand health care services and the availability of reproductive health services for women, community-based care. I am very hopeful that will be offered as well.

Finally, on a bipartisan basis, Senators CARDIN and COLLINS wish to offer legislation to really set aside what are

very outdated approaches with respect to how Medicare provides services, therapy services, for our citizens. We are talking about physical therapy, occupational therapy, services with respect to speech.

Senators CARDIN and COLLINS want to get rid of these arbitrary therapy caps. I am very hopeful their amendment will be able to be offered as well.

One last point, on a matter that is not health care related, this legislation carries an additional program that is particularly important to the people whom I represent, and that is the Secure Rural Schools Program would be extended for 2 years.

I wrote this law in 2000 with our former colleague, the Senator from Idaho, Mr. Craig, because in most of our States—States where the Federal Government owns much of the lands, heavily forested—as a result of changes in environmental policy and other changes, a lot of these rural communities didn't have the money they needed for schools, roads, law enforcement, and basic services.

We have extended it since 2000. We have had testimony indicating we are going to need that safety net for some time, even as you try to get the harvest up in a sustainable way.

I am very pleased this program, an economic lifeline to rural communities across Oregon and other States, is going to be extended for 2 years. I think that provides us an opportunity to come up with fresh strategies, both with respect to the safety net.

I would like to—in the future, in the Senate Budget Committee—support it. I believe my colleague, the Presiding Officer, was interested to link Secure Rural Schools with the Land and Water Conservation Program and the PILT Program. We have bipartisan support for that.

I would like to see us use these 2 years to strengthen the safety net and get the harvest up in a sustainable way.

I wanted to make mention of that before I wrap up.

In closing, I think the health legislation—that I hope will be voted on shortly—represents one of those rare moments on a major issue.

I mean, I would go so far as to say—having worked with older people since my days with the Gray Panthers—I think what we are doing with the abolition of this outdated Medicare reimbursement system is laying the foundation for what will be the future of Medicare. The future of Medicare is not going to be what it was about in the 1960s when it began—a senior in New Hampshire might need the hospital for a serious injury, maybe they would see a physician, get Medicare Part B if they broke their ankle. The future of Medicare is going to be about dealing with chronic disease. It is going to be about diabetes, cancer, heart disease, and stroke.

The reality is that Medicare has not kept up with the times. I think it is worth noting that in the big debate about the Affordable Care Act, chronic disease was hardly mentioned at all, not by anybody. That is going to be the foundation of Medicare for the future. More than 90 percent of the Medicare dollars in the future, based on the challenge of dealing with older people with these chronic conditions, is going to be about chronic disease.

The reality is, when you abolish this flawed Medicare reimbursement system and start promoting coordinated care, what would happen in the State of New Hampshire is you would start seeing teams—perhaps a nurse, a physician, a pharmacist—a team in New Hampshire or in Oregon come together, particularly where there aren't the Medicare Advantage plans, and say we can give, as our colleague from Georgia noted not long ago, Senator ISAKSON, better care at lower cost and do it for what is likely to be the type of health care services that dominates Medicare in the future, which is chronic disease. We will be better able to tackle that with the abolition of SGR.

So my hope is shortly we will vote to take that action that I believe constitutes a Medicare milestone, reaffirms our commitment to America's youngsters, improves health care services for women—from one end of America to another—and gets rid of this outdated system of therapy caps that are restricting what those who need physical therapy, occupational therapy, and others could get.

This could finally be a punctuation mark in this, the 50th year of Medicare, and an opportunity for all Senators to see that they were part of adopting a fresh set of policies to provide a brighter and healthier future for all our people.

I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The senior assistant legislative clerk proceeded to call the roll.

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

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

Mr. HATCH. Madam President, I want to mention what Speaker BOEHNER said about this bill we are about to look into—the CHIP bill and the SGR, the physicians' payment bill. Speaker BOEHNER said:

> Unless the Senate passes the House-passed ''doc fix'' bill, significant cuts to physicians' payments will begin tomorrow. The House legislation passed with overwhelming bipartisan support, and we do not plan to act again, so we urge the Senate to approve the House-passed bill without delay.

He summed it up pretty well. The fact is this has been a long ordeal that a lot of us have worked on for a long time, a lot of people on Capitol Hill. If we can pass this bill tonight, it will be a major accomplishment and we can go back to the child health insurance bill.

I remember standing here on the floor with Ted Kennedy on the other side passing a bill that brought a lot of angst to a lot of people but which has helped millions of children who were deprived of good health care. So this is a very important bill and I hope we don't foul it up. I don't think we will.

Madam President, I stand today in support of H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015. If enacted, this legislation would repeal and replace the Medicare sustainable growth rate, or SGR. That is the formula called the sustainable growth rate. It will extend the CHIP program for an additional 2 years—a program that has worked very well—and will put in place much needed reforms to the Medicare Program—something that hasn't happened in a long time.

This bill represents more than 2 years of hard work on both sides of the Capitol. It passed overwhelmingly in the House of Representatives with 392 votes. I expect it will also get broad bipartisan support here in the Senate. It certainly has to.

We have all grown tired of the seemingly endless cycle of passing temporary SGR patches year after year after year. It is not a new problem. It is one we have been dealing with for a long time.

A little over 2 years ago, a group of leaders from both the House and the Senate set out to fix this problem once and for all. As I mentioned yesterday, I was part of this group, as was former chairman of the Committee on Finance, Max Baucus. Together Senator Baucus and I worked with the leaders on the relevant House committees to craft legislation that would repeal and replace the SGR with an improved payment system that rewards quality, efficiency, and innovation. That legislation, which we reported out of the Committee on Finance by voice vote in late 2013, formed the basis of the legislation before us today.

I want to compliment the House for the great work they have done on this bill. I have to give a lot of credit to them. It is my hope we will act quickly to pass this bipartisan, bicameral legislation and send it to the President's desk as soon as possible.

This legislation demonstrates what Congress is truly capable of when Members work together. We all talk about the need for more bipartisanship in Washington. This bill can be a template for how things should work around here.

It also represents a step forward in the effort to reform our Nation's entitlement programs. As I mentioned, to go along with the permanent SGR fix, the bill includes a meaningful downpayment on Medicare reform. These reforms include a limitation on so-called Medigap first-dollar coverage, more robust means testing for Medicare Parts B and D, and program integrity provisions that will strengthen Medicare's ability to fight fraud.

Clearly, these reforms by themselves won't fix all of Medicare's fiscal problems. Indeed, much more work needs to

be done. But like many of my colleagues, I have been pushing for entitlement reform for years. During all that time I have seen politics and fear get in the way of progress. With this bill we have a chance to, at the very least, take a meaningful step forward—a bipartisan step, no less—in the effort to secure the safety net for future generations. Any Senator who, like me, supports entitlement reforms will welcome the changes we have made in this bill.

I am not here to say the bill is perfect. It is certainly not. But as the saying goes, we should not make the perfect the enemy of the good. This is a good bill. Once again, it passed in the House with a huge bipartisan majority and it is supported by groups across the health care spectrum. I ask unanimous consent to have printed in the RECORD a list of groups supporting this legislation at the conclusion of my remarks.

As it stands right now, in less than 12 hours doctors all over the country will face a 21-percent cut in Medicare reimbursements. In other words, we are out of time. We need to pass this legislation and we need to do it now. In fact, it is encouraging to see that even Members on the other side of the aisle support this good policy now, and I am proud of them for doing so.

Let's get this done. I hope all of my colleagues will join me in supporting H.R. 2.

I repeat what Speaker BOEHNER said today:

Unless the Senate passes the House-passed ''doc fix'' bill, significant cuts to physicians' payments will begin tomorrow. The House legislation passed with overwhelming bipartisan support, and we do not plan to act again, so we urge the Senate to approve the House-passed bill without delay.

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

H.R. 2, THE MEDICARE AND CHIP REAUTHORIZATION ACT (MACRA)

LETTERS OF SUPPORT

Alliance for Academic Internal Medicine (AAIM), Alliance of Specialty Medicine, AMDA The Society for Post-Acute and Long-Term Care Medicine American Academy of Allergy, Asthma, and Immunology (AAAAI), America's Essential Hospitals, American Action Forum, American Congress of Obstetricians and Gynecologists (ACOG), American Health Care Association, American Hospital Association, American Medical Association, American Academy of Dermatology Association, American Academy of Family Physicians, American Academy of Neurology (AAN), American Academy of Pediatrics, American Academy of Physician Assistants, American Association of Clinical Endocrinologists (AACE), American Association of Neurological Surgeons/Congress of Neurological Surgeons, American Association of Nurse Anesthetists, American Association of Nurse Practitioners (AANP) American Academy of Ophthalmology.

American Association of Orthopedic Surgeons, American Association for the Study of Liver Diseases (AASLD), American College of Allergy, Asthma and Immunology (ACAAI), American College of Cardiology (ACC), American College of Chest Physicians (CHEST), American College of Gastroenterology, American College of Physicians (ACP), American College of Radiology, American College of Rheumatology (ACR), American College of Surgeons, American Gastroenterological Association (AGA), American Geriatrics Society (AGS), American Health Care Association (AHCA), American Medical Society for Sports Medicine (AMSSM), American Medical Student Association, American Osteopathic Association (AOA).

American Psychological Association Practice Organization (APAPO), American Society for Blood and Marrow Transplantation (ASBMT), American Society of Clinical Oncology, American Society for Gastrointestinal Endoscopy (ASGE), American Society of Hematology (ASH), American Society of Nephrology (ASN), American Society for Radiation Oncology (ASTRO), American Thoracic Society (ATS), Americans for Tax Reform, Association of American Medical Colleges, Association of Departments of Family Medicine, Association of Family Medicine Residency Directors, Aurora Health Care, Billings Clinic, Bipartisan Policy Center, California Hospital Association, California Medical Association, Catholic Health Association of the United States, Center for American Progress (CAP).

Center for Law and Social Policy (CLASP), Children's Hospital Association, College of American Pathologists, Council of Osteopathic Student Government Presidents (COSGP), Digestive Health Physicians Association, Endocrine Society (ES), Essentia Health, Families USA, Federation of American Hospitals, Fight Crime: Invest in Kids, Grace-Marie Turner for the Galen Institute, Greater New York Hospital Association (GNYHA), Gundersen Health System, HealthCare Association of New York State, Healthcare Leadership Council, Healthcare Quality Coalition, HealthPartners, HealthSouth, Hospital Sisters Health System, Iowa Medical Society.

Infectious Diseases Society of America (IDSA), Latino Medical Student Association Midwest, Let Freedom Ring, Louisiana Rural Health Association, LUGPA, March of Dimes, Marshfield Clinic Health System, Mayo Clinic, McFarland Clinic PC, Medical Group Management Association, Mercy Health, Military Officers Association of America (MOAA), Minnesota Hospital Association, Minnesota Medical Association, National Association of Community Health Centers, National Association of Psychiatric Health Systems, National Association of Spine Specialists, National Association of Urban Hospitals, National Coalition on Health Care, National Retail Federation, North American Primary Care Research Group, Novo Nordisk.

Oregon Association of Hospitals and Health Systems, Premier healthcare alliance, ReadyNation, Renal Physicians Association, Rural Wisconsin Health Cooperative, Society for Adolescent Health and Medicine (SAHM), Society of Critical Care Medicine (SCCM), Society of General Internal Medicine (SGIM), Society of Teachers of Family Medicine, Student National Medical Association, Student Osteopathic Medical Association, Tennessee Medical Association, Texas Medical Association, The 60 Plus Association, ThedaCare, The Hospital & Healthsystem Association of Pennsylvania, The National Committee for Quality Assurance (NCQA), The Society of Interventional Radiology, VHA Inc., Wisconsin Collaborative for Healthcare Quality, Wisconsin Health and Educational Facilities Authority, Wisconsin Hospital Association, Wisconsin Medical Society.

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

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

The PRESIDING OFFICER (Mr. GARDNER). Without objection, it is so ordered.

Mr. WHITEHOUSE. I ask unanimous consent to speak in morning business for up to 15 minutes.

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

CLIMATE CHANGE

Mr. WHITEHOUSE. Mr. President, the distinguished majority leader, the senior Senator from Kentucky, is resolutely opposed to any serious conversation about climate change. Under his leadership, the Republican Party in the Senate has exactly zero legislation for addressing carbon pollution in any serious way. The majority leader has even written to Governors around the country urging defiance of the climate change regulations of the U.S. Government, namely, the Environmental Protection Agency's forthcoming clean power plan to cut presently unregulated carbon pollution from our powerplants.

I thought I should take a look at what Kentucky is doing about climate change. It turns out that Kentucky is already crafting a plan for complying with President Obama's clean power plan. Why are they doing that? In a statement, the Kentucky Energy and Environment Cabinet said it was because ''the overwhelming majority of our stakeholders are telling us to make preparations to submit a plan.''

The overwhelming majority of Kentucky stakeholders are telling the State of Kentucky to submit a plan. Kentucky has an energy and environment secretary. His name is Dr. Len Peters. Dr. Peters does not mock or disparage the EPA. Indeed, he praised the EPA at a recent national climate change conference for the flexibility and openness of its rulemaking process. Dr. Peters began his talk by saying, ''I'm from Kentucky and I'm not a climate science denier.''

Setting aside compliance with the administration's clean power plan, Kentucky actually had its own climate action plan, written all the way back in 2011. The Kentucky climate action plan sets forth more than 40 actions to address climate change. It would reduce Kentucky's greenhouse gas emissions by 1.3 billion metric tons between 2011 and 2030.

The Kentucky Department of Fish and Wildlife within that climate action plan has its wildlife action plan. The wildlife action plan opens its chapter on climate change by quoting the Intergovernmental Panel on Climate Change. Around here a lot of fun is sometimes made of the Intergovernmental Panel on Climate Change, at