about 900 or 1,000—the biggest town in the county—and its future rests in large part upon what happens in agriculture.

There are lots of great ranch families in our State. One of those is the Gardiners. The Gardiner Ranch is in Clark County. Their story is told a bit in today's edition of the Wichita Eagle. They are known as some of the best ranchers in the country. For more than 50 years, they have provided the best Angus cattle. They have customers across the country. It is a family ranch. This is multigenerational, and three brothers now ranch together. It is not an unusual way that we do business in Kansas.

In addition to the economic circumstances that agriculture presents in our State, it is one of the reasons I appreciate the opportunity to advocate on behalf of farmers and ranchers. It is one of the last few places in which sons and daughters work side by side with moms and dads, and grandparents are involved in the operation. Grandkids grow up knowing their grandparents. There is a way of life here that is important to our country. Our values, our integrity, and our character are often transmitted from one generation to the next in this circumstance because we are still able to keep the family together, working generation to generation. The Gardiners are an example of that, but there are hundreds of Kansans who exemplify this.

I would like to tell the story of Mr. Gardiner, as reported by the Wichita Eagle. Mr. Gardiner said that he was slowly driving by some of his estimated 500 cattle that had died in this massive wildfire, and he complained on their behalf that they never had a chance. The fire was so fast. His ranch, as I said, is one of the most respected. The quality of the family's Angus cattle has been a source of pride and national attention for more than 50 years.

Like others, the Gardiners have endured plenty of bumps—and this is him telling their story—over five generations of ranching. The drought and dust of the 1930s was tough, he said, and there were even drier times in the 1950s. About 5 years ago, there was another drought in our State that was so devastating. He said his family lost 2,000 acres when they couldn't make a payment to the bank. Blizzards in 1992 killed a lot of cattle.

My point is that nothing is easy about this life, but there is something so special about it. The point I want to make is that people are responding to help, and I thank Kansans and others from across the country who are responding to the disasters that are occurring across our State throughout this week and into the future. This isn't expected to go away anytime soon.

Mr. Gardiner said that more hay is on the way, and the process of rebuilding fences will begin, hopefully, within a few weeks. He said he was sent word that Mennonite relief teams were coming from two Eastern States to work on his fences and to do so without pay. Truckloads of hay are already en route and rolling in. This story indicates that many of those truckloads of hay are coming from ranchers who in the past have bought livestock from the Gardiners.

Mr. Gardiner's veterinarian, Randall Spare, said that the Gardiners have long been known for taking exceptional care of their customers. The veterinarian says, ''Now it's their turn'' for the customers to repay them. ''The Gardiners are the cream of the crop, like their cattle. I'm not surprised so many people [from so many places] are wanting to help them.''

The reporter says that while he was talking to Mr. Gardiner for this interview, Mr. Gardiner answered his cell phone as his pickup slowly rolled across a landscape that now looked so barren. The reporter said that many of the calls were from clients who just called to send their best or to be brought up to date and to ask the Gardiners how they could help and how the Gardiners were holding up.

Mr. Gardiner said:

It's really something [special], when you hear a pause on the other end of the line and you know it's because [the person who called is] crying because they care that much. It gets like that with ranching. It's like we're all family.

That is a great thing about our State. It is like that with Kansas. We are all a family. But the fact is that his family is still alive. He tells the story of not knowing whether his brother and his wife were alive. The fire swept around them, but they found a place that avoided the fire, a wheat field where the wheat was still green and so short that the fire didn't intrude. But he stopped his truck to think a bit and, the story indicates, to sob a bit.

He watched as his brother Mark and his wife Eva disappeared behind a wall of fire as they tried to save their horses and dogs at their home. Ultimately, the house was destroyed. Mr. Gardiner, the one the reporter was talking to, said:

I had no choice but to turn around and drive away, with the fire all around me. For a half-hour I didn't know if my brother and his wife were dead or alive. I really didn't.

He said that then his brother and his wife and some firefighters gathered in the middle of that wheat field. It was so short and so green, it wouldn't burn. He said:

It was so smoky I didn't even know exactly where we were at. But then a firefighter came driving by and told us everybody made it out. That's when I knew Mark and his wife were alive. That's when I knew everything would eventually be all right. I am telling you, that's when you learn what's really important.

So today I come to the Senate floor to express my gratitude for the opportunity to represent Kansans like the Gardiners, farmers and ranchers across our State but city folks, as well, who know the importance of family, who know that living or dying is an important aspect of life but that how they live is more important, and to thank those people—not just from Kansas but from across the country—who have rallied to the cause to make sure there is a future for these families and for the farming and ranching operations.

It is a great country in which we care so much for each other, and that is exemplified in this time of disaster that is occurring across my State. I am grateful to see these examples, and I would encourage my colleagues that we behave the way Kansas farmers and ranchers do—live life for the things that are really meaningful and make sure we take care of each other.

Mr. President, I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

CLOTURE MOTION

The PRESIDING OFFICER. Pursuant to rule XXII, the Chair lays before the Senate the pending cloture motion, which the clerk will state.

The bill clerk read as follows:

CLOTURE MOTION

We, the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, do hereby move to bring to a close debate on the nomination of Seema Verma, of Indiana, to be Administrator of the Centers for Medicare and Medicaid Services, Department of Health and Human Services.

Mitch McConnell, Steve Daines, John Cornyn, Tom Cotton, Bob Corker, John Boozman, John Hoeven, James Lankford, Roger F. Wicker, John Barrasso, Lamar Alexander, Orrin G. Hatch, David Perdue, James M. Inhofe, Mike Rounds, Bill Cassidy, Thom Tillis.

The PRESIDING OFFICER. By unanimous consent, the mandatory quorum call has been waived.

The question is, Is it the sense of the Senate that debate on the nomination of Seema Verma, of Indiana, to be Administrator of the Centers for Medicare and Medicaid Services, shall be brought to a close?

The yeas and nays are mandatory under the rule.

The clerk will call the roll.

The bill clerk called the roll.

Mr. CORNYN. The following Senators are necessarily absent: the Senator from Georgia (Mr. ISAKSON), and the Senator from Florida (Mr. RUBIO).

Further, if present and voting, the Senator from Florida (Mr. RUBIO) would have voted ''yea.''

The PRESIDING OFFICER. (Mr. PERDUE). Are there any other Senators in the Chamber desiring to vote?

The yeas and nays resulted—yeas 54, nays 44, as follows:

[Rollcall Vote No. 85 Ex.]

YEAS—54

Alexander	Fischer	Moran
Barrasso	Flake	Murkowski
Blunt	Gardner	Paul
Boozman	Graham	Perdue
Burr	Grassley	Portman
Capito	Hatch	Risch
Cassidy	Heitkamp	Roberts
Cochran	Heller	Rounds
Collins	Hoeven	Sasse
Corker	Inhofe	Scott
Cornyn	Johnson	Shelby
Cotton	Kennedy	Strange
Crapo	King	Sullivan
Cruz	Lankford	Thune
Daines	Lee	Tillis
Donnelly	Manchin	Toomey
Enzi	McCain	Wicker
Ernst	McConnell	Young

NAYS—44

Baldwin	Gillibrand	Peters
Bennet	Harris	Reed
Blumenthal	Hassan	Sanders
Booker	Heinrich	Schatz
Brown	Hirono	Schumer
Cantwell	Kaine	Shaheen
Cardin	Klobuchar	Stabenow
Carper	Leahy	Tester
Casey	Markey	Udall
Coons	McCaskill	Van Hollen
Cortez Masto	Menendez	Warner
Duckworth	Merkley	Warren
Durbin	Murphy	Whitehouse
Feinstein	Murray	Wyden
Franken	Nelson	

NOT VOTING—2

Isakson	Rubio

The PRESIDING OFFICER. On this vote, the yeas are 54, the nays are 44.

The motion is agreed to.

The Senator from Kansas.

Mr. MORAN. Mr. President, I ask unanimous consent that notwithstanding the provisions of rule XXII, following leader remarks on Monday, March 13, the Senate resume executive session for the consideration of Executive Calendar No. 18, and that the vote on confirmation occur at 5:30 p.m.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. MORAN. Mr. President, on behalf of the majority leader, there will be no further votes this week in the U.S. Senate.

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

The PRESIDING OFFICER. The clerk will call the roll.

The assistant bill clerk proceeded to call the roll.

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

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

Mr. WYDEN. Mr. President and colleagues, today the Senate turns to consider the nomination of Seema Verma to be the Administrator of the Centers for Medicare and Medicaid Services.

I would be the first to say that in coffee shops across the land, people are not exactly buzzing about the office known as CMS, but the fact is, this is an agency that controls more than a trillion dollars in healthcare spending every year. Even more important and more relevant right now, if confirmed, and if TrumpCare somehow gets rammed through the Congress over loud and growing opposition, this is going to be a major issue on her plate right at the get-go.

I thought it would be useful to just give one example of the connection involved in this legislation. TrumpCare cuts taxes for the special interests and the fortunate few by $275 billion, stealing a chunk of it from the Medicare trust fund that pays for critical services to the Nation's older people.

If TrumpCare passes and Ms. Verma is confirmed, under section 132 of the bill, she would be able to give States a green light to push the very frail and sick into the high-risk pools that have historically failed at offering good coverage to vulnerable people at a price they can afford. Under section 134 of TrumpCare, Ms. Verma would be in charge of deciding exactly how skimpy TrumpCare plans would be and how much more vulnerable people would be forced to pay out of their pockets for the care they need.

Under section 135 of the bill, if confirmed, Ms. Verma could be paving the way for health insurers to make coverage more expensive for older people approaching retirement age.

Given all that, I want Members to understand there is a real link between this nomination and the debate about TrumpCare, and this is, in effect, the first discussion we have had about TrumpCare since these bills started to get moving without any hearings and getting advanced in the middle of the night.

The odds were against Republicans writing a single piece of legislation that would make healthcare more expensive, kick millions off their coverage, weaken Medicare and Medicaid, and produce this Robin Hood in reverse, this huge transfer of wealth from working people to the fortunate. Nobody thought you could do all of that at the same time, but somehow the majority found a way to do it. Republicans are rushing to get it passed before the American people catch on.

As part of this debate about Seema Verma, we are going to make sure people understand this nomination is intertwined with what happens in the discussion about TrumpCare and how these particularly punitive provisions with respect to Medicare and Medicaid would affect our people.

For 7 years, my colleagues on the other side have pointed to the Affordable Care Act as pretty much something that would bring about the end of Western civilization and, at a minimum, would basically continue a system responsible for every ill in our healthcare system. That was the argument. The Affordable Care Act is responsible for just about every ill and will practically be the end of life as we know it.

Their slogan was to ''repeal and replace,'' and it was a slogan they rode through four elections to very significant success. The only problem was, it was really repeal and run, and that replacement was nowhere in sight. Now the curtain has been lifted. The lights are shining on TrumpCare, and it sure looks to me like there are a lot of people not enjoying the movie. TrumpCare goes back to the days when healthcare in America mostly worked for the healthy and the wealthy.

We have a lot of debate ahead, so we are not going to just lay it all out here in one shot.

I do want to mention some key points on the roll that Ms. Verma, if confirmed, would play. I want to start by addressing what this means in terms of dollars and cents.

If you look at the fact that the Medicare tax, which everybody pays every single time they get a paycheck, and that money is used to preserve this program that is the promise of fairness to older people—the Medicare tax would be cut for only one group of Americans in this bill. I find this a staggering proposition. The people who need it the least, couples with incomes of over $250,000, people who need it the least would be given relief from the Medicare tax—not working families, just the wealthy.

As I indicated, we are talking all told about $275 billion worth of tax cuts to the special interests and the fortunate few, and it is largely paid for by taking away assistance to working people to help, for example, pay for their premiums.

I brought up the ACA Medicare payroll tax for a reason because I think when Americans look at their next paycheck—if you are a cop or a nurse and you get paid once or twice a month and you live, say, in Coos Bay, OR, or in Medford, another Oregon community, you will see it on your paycheck. If you are a cop or a nurse, no tax relief for you, but if you make over $250,000—on a tax that is used to help strengthen Medicare's finances, at a time when we are having this demographic revolution—the relief goes to people right at the top, and you reduce the life expectancy of the trust fund for 3 years.

The first thing I will say with respect to what this means, the provision I have just outlined breaks a clear promise made by then-Candidate Trump not to harm Medicare.

I remember these commercials—we all saw scores and scores of them—Candidate Trump said to America's older people—many of whom voted for him, I think, to a great extent because they heard this promise—he said: You know, you have worked hard for your Medicare. We are not going to touch it. We are not going to mess with it.

When the President was asked about cutting Medicare, here is what he said: Medicare is a program that works. People love Medicare, and it is unfair to them. I am going to fix it and make it better, but I am not going to cut it.

The President of the United States said he is not going to cut it.

Well, that promise not to harm Medicare lasted 6½ weeks into the Trump administration so the wealthy—the wealthy—could get a tax reduction, the fortunate few who need it least, and

the effect would be to cut by 3 years the life of the Medicare trust fund.

I think that ought to be pretty infuriating and concerning for people who work hard—cops and nurses and people who are 50, 55, 60 today. They are counting on Medicare to be around when they retire, but because TrumpCare made it a focus to give tax relief to the fortunate few, that tax relief cuts 3 years off the life of the Medicare trust fund.

If that wasn't enough, people who are 50, 55, 60, before Medicare, they are going to get another gut punch. This one is in the form of higher costs.

In parts of my home State—particularly in rural areas like Grant County, Union County, and Lake County—I am sure I am going to hear about this. I have townhall meetings in each one of my counties. A 60-year-old who makes $30,000 a year—now those are the people we have long been concerned about, particularly people between 55 and 65 because they are not yet eligible for Medicare.

A 60-year-old, in communities like I just mentioned, who makes $30,000 a year, could see their costs go up $8,000 or more. The reason that is the case is a big part of TrumpCare. It is based on something we call an age tax.

Back in the day when I was the director of the Oregon Gray Panthers—and I was really so fortunate at a young age to be the director of the group for close to 7 years—we couldn't imagine something like the hit on vulnerable older people that this age tax levies. Republicans want to give the insurance companies the green light to charge older Americans five times as much as they charge younger Americans. The reality is that older people are going to pay a lot more under TrumpCare. That is what we were trying to prevent all those years with the Gray Panthers. We didn't want to see older people pay more for their healthcare, the way they are going to under TrumpCare if they are 50 or 55 or 60.

I think the real question is whether they are going to be able to afford insurance at all. The reality is that a lot of those older people whom I have just described—and I have met them at my townhall meetings—every single week they are walking on an economic tightrope. They balance their food costs against their fuel costs and their fuel costs against their rent costs. Along comes TrumpCare and pushes them off the economic tightrope where they just won't be able to pay the bills, particularly older people in rural areas.

So the reality is that it is expensive to get older in America, and we ought to be providing tools to help older people. But what TrumpCare does is, instead of giving tools to older people to try to hold down the costs, TrumpCare basically empties the toolbox of assistance and basically makes older people pay more.

Next, I want to turn to the Medicaid nursing home benefit. Working with senior citizens, I have seen so many older people—the people who are on an economic tightrope, who are scrimping and saving—even as they forego anything that wouldn't be essential, burn through their savings. So when it is time to pay for nursing home care, they have to turn to Medicaid. The Medicaid Program picks up the bill for two out of every three seniors in nursing homes.

Now, today the Medicaid nursing home benefit comes with a guarantee. I want to emphasize that it is a guarantee that our country's older people will be taken care of. All of those folks—the grandparents whom we started working for in those Gray Panther days—had an assurance that grandparents wouldn't be kicked out on the street. TrumpCare ends that guarantee.

You could have State programs forced into slashing nursing home budgets. You could see nursing homes shut down and the lives of older people uprooted. We could, in my view, have our grandparents that are depending on this kind of benefit get nickeled and dimed for the basics in home care that they have relied on.

When it comes to Medicaid, TrumpCare effectively ends the program as it exists today, shredding the healthcare safety net in America. It doesn't only affect older people in nursing homes. It puts an expiration date—a time stamp—on the Medicaid coverage that millions of Americans got through the Affordable Care Act. For many of those vulnerable persons, it was the first time they had health insurance. So what TrumpCare is going to come along and do is to put a cap on that Medicaid budget and just squeeze them down until vulnerable persons' healthcare is at risk.

If low-income Americans lose their coverage through Medicaid, it is a good bet that the only TrumpCare plans they will be able to afford are going to be worth less than a Trump University degree.

I want to move next to the effects of the bill on opioid abuse. Clearly, by these huge cuts to Medicaid, TrumpCare is going to make America's epidemic of prescription drug abuse-related deaths even worse. Medicaid is a major source of coverage for mental health and substance use disorder treatment, particularly after the Affordable Care Act, but this bill takes away coverage from millions who need it. We have had Republican State lawmakers speaking out about this issue as well as several Members of the majority in the Congress.

Colleagues, just about every major healthcare organization is telling the Congress not to go forward with the TrumpCare bill—physicians, hospitals, AARP—that is just the beginning. But the majority is just charging forward, rushing to get this done as quickly as possible.

We are going to have more to say about these issues.

I see my colleagues here.

To close, just by intertwining, how this appointment is going to be a key part of the discussion of TrumpCare revolves around the questions we asked Ms. Verma.

For example, I was trying to see if this bill would do anything to help older people hold down the cost of medicine. Now we have heard the new President talk about how he has all kinds of ideas about controlling the cost of medicine. Here was a bill that could have done something about it.

I see my colleagues, Senator STABENOW and Senator CANTWELL.

I said to the nominee: I would be interested in any idea you have—any idea you have—to hold down the cost of medicine. On this side we have plenty of ideas. We want to make sure that Medicare could bargain to hold down the cost of medicine. We have been interested in policy to allow for the importation of medicine. We said: Let's lift the veil of secrecy on pharmaceutical prices.

I asked Ms. Verma: How about one idea—just one—that you would be interested in that would help older people with their medicine costs. She wouldn't give us one example.

I am going to go through more of those kinds of questions, because the reality is—and I see Senators STABENOW and CANTWELL here—that what we got in the committee was essentially healthcare happy talk. Every time we would ask a question, she would say: I am for the patients; I want to make sure everybody gets good care.

So I thank my colleagues, and I yield for Senator CANTWELL.

The PRESIDING OFFICER. The Senator from Washington.

Ms. CANTWELL. Mr. President, will the Senator yield for a question?

Mr. WYDEN. Of course.

Ms. CANTWELL. Mr. President, I ask this of my colleague, the Senator from Oregon, because Washington, Oregon, and so many other States spend so much time innovating. The proposal we are seeing coming out of the House of Representatives really isn't innovation. I like to say that if you are looking at this, just at the specifics, the per capita cap is really just a budget mechanism. It doesn't have anything to do with innovation. It just has to do with basically triggering a cut to Medicaid and shifting that cost to the States. My concern is that we already do a lot with a lot less, and we know how to innovate. We would prefer that the rest of the country follow that same model. I would ask the Senator from Oregon: Do you see any innovation in this model, in capping and cutting the amount of Medicaid and shifting that to the States?

Mr. WYDEN. My colleague from Washington is ever logical.

When I looked at this, I thought of it as an innovation desert because I was looking for some new, fresh ideas. We have seen some of them from Senator CANTWELL's State, and I think the Senator from Washington makes a very

important point with that poster because the reality is that this is a cap. This is a limit on what States are going to get. As I touched on in my comments, I think what is going to happen is this cap is not going to be enough money for the needs. I think this is going to slash the help for nursing home care under Medicaid, which pays two-thirds of the bill, and I think the nursing home care under this flawed TrumpCare proposal is going to get nickeled and dimed.

My colleague from Washington is right. I tried to read section by section, and we have read it several times. But we wanted to make sure to look—to my colleague's point—for innovation, and this proposal is an innovation desert.

Ms. CANTWELL. I ask the Senator from Oregon this through the Presiding Officer. The innovation that was already in the Affordable Care Act really did address the Medicaid population, in which so much of that cost is for long-term care and nursing home care. So Medicaid equals long-term care for so many Americans. In the Affordable Care Act we accelerated the process of shifting the cost to community-based care because it is more convenient for patients and up to one-third of the cost of a nursing home. So if we keep more people in their homes, that is better innovation.

In the Affordable Care Act, we incentivized States. In fact, we had 21 States take us up on that—including Arkansas, Connecticut, Georgia, Iowa, Kentucky, Louisiana, New Hampshire, Texas, Ohio, Nevada, Nebraska. There are many States that are doing this innovation and basically trying to move the Medicaid population to community-based care so we can save money.

Savings from rebalancing could make up for a large portion of the money the House is trying to cut in this bill. Basically, they are not saving the money. They are shifting the burden to the States, instead of giving innovative solutions to people to have community-based care; that is, long-term care services and staying in their home longer. Who doesn't want to stay in their home longer? Then we support them through community-based delivery of long-term healthcare services, and we save the Nation billions of dollars.

In fact, our State did this over a 15-year period of time, and we saved $2.7 billion. That is the kind of innovation we would like to see. But instead of implementing the innovation we started in the Affordable Care Act, they are trying to cap the Medicaid funding, which basically is changing the relationship from a mutually supported State and Federal partnership to a capped federal block grant. They are just saying: We are going to cost-shift this burden to you the States.

I saw that the Center on Budget and Policy Priorities analyzed the current House proposal and found it would result in a $387 billion cost shift to the States. Does the Senator from Oregon think that Oregon has the kind of money to take its percentage of that $370 billion?

To my colleague from Michigan: Does the Senator think the State of Michigan has the dollars to take care of that Medicaid population with that level of a cut?

Ms. STABENOW. If I might lend my voice on this and thank both of my colleagues. Senator CANTWELL has been the leader in so many ways on innovation in the healthcare system as we debated next to each other in the Finance Committee on the Affordable Care Act.

I wanted to share that in Michigan, where we expanded Medicaid, because of changes that have been made and work that is being done in the budget going forward in the new year, there is now close to $500 million more in the State of Michigan budget than was there before because of Medicaid expansion and the ability to manage healthcare risk. People have more healthcare coverage. We actually have 97 percent of the children in Michigan who can see a doctor today, which is incredible. At the same time the State is going to save close to $500 million in the coming year's budget.

Mr. WYDEN. If I can add this, because I think my colleagues are making a very important point. If you look at the demographics, there are going to be 10,000 people turning 65 every day for years and years to come. Senators STABENOW and CANTWELL are making a point about flexibility. The reality is, if I look at the demographic picture, we are going to need more out of a lot of care options—institutional care, community-based coverage. But I think the point Senator CANTWELL started us on is that, at a time when we have a demographic where we are going to need more for a variety of care options—a continuum of care—what my State is basically saying is that we are going to get less of everything. There is going to be less money for the older people who have nursing home needs. I am looking at a new document from the Oregon Department of Human Services, and it indicates that we are going to lose substantial amounts—something like $150 million for community-based kinds of services. So I appreciate the point my two colleagues are making.

Ms. CANTWELL. Mr. President, if I could, I will ask the Senator from Oregon one more question, and maybe my other colleagues will join in.

When you do not realize the savings and you cost-shift to the States, some of the key populations that you hurt are pregnant women and children. We do not want to have less money. If you think about Medicaid, pregnant women and children are a big part of the population.

I know our colleague from Pennsylvania has joined us, and he has been a champion for the Children's Health Insurance Program—CHIP—and everything that we do for women and children. I don't know if he has seen this in his State. I don't know if the Senator from Oregon or the Senator from Michigan or the Senator from Pennsylvania wants to comment on this—on the notion that we are not realizing the savings from delivery innovations like rebalancing, and then figuring out how to best utilize those for the delivery of the services that so many people are counting on. With a per capita cap, you are really going to be starting in a very bad place with the people who need these resources the most, and when it comes to Medicaid, women and children are front and center in this debate.

I hate the fact that somebody is going to cost-shift to the States, that the States are not going to have enough money, and then the very people who would end up paying the price are the women and children. I don't know if the Senator from Oregon, the Senator from Michigan, or the Senator from Pennsylvania wants to comment on that.

Ms. STABENOW. I thank the Senator very much. I will say this briefly and then turn to our colleague from Pennsylvania, who has been such a champion for children.

I would say first—again, as I said a moment ago—that, because of Medicaid, because of the healthcare expansion, 97 percent of the children in Michigan now can see a doctor. That means moms who are pregnant and babies, and moms and dads are less likely to be going to bed at night and saying: Please, God, do not let the kids get sick, because they can actually go to a doctor.

It reminds me, though, of the other thing happening on the floor and the larger question of the nominee for the Centers for Medicare and Medicaid Services. In the larger context, I asked her about whether or not maternity care and prenatal care should be covered as a basic healthcare requirement for women. I mean, it is pretty basic for us. She wouldn't answer the question. Essentially, she said women can buy extra if they want it. The new Secretary of Health and Human Services said that we, as women, can buy extra coverage for basic healthcare coverage for us. So it all comes together—Medicaid, the nominee on the floor, and what the House is doing to take away maternity care. It is really just bad news for moms and babies.

Mr. WYDEN. I would only add that what we learned in our hearings and in our discussion is that women, particularly the women served by the Medicaid Program, are really dealing with the consequences of opioid addiction as well.

In our part of the world, I would say to Senator STABENOW and Senator CASEY—in Oregon and Washington—we feel like we have been hit with a wrecking ball with this opioid problem. Again, when Senator CANTWELL talks about shifting the costs, she is not talking about something abstract. This

is going to take away money for opioid treatment.

So I am very pleased that my colleague is making these points, and I look forward to the presentation.

Mr. CASEY. Mr. President, I thank Senator CANTWELL for raising the issue about the impact of this decision that the Congress will make with regard to a particular healthcare bill and then also, particularly, the Medicaid consequences.

I was just looking at what is a 2-page report that was just produced today and that I was just handed from the Center on Budget and Policy Priorities. It is State specific.

In this case, looking at the data from Pennsylvania—I will not go through all of the data on Medicaid—just imagine that three different groups of Americans have benefited tremendously from the Medicaid Program every day. That is why what is happening in the House is of great concern to us.

We have in Pennsylvania, for example—just in the number of Pennsylvanians who have a disability—722,000 Pennsylvanians with disabilities who rely upon Medical Assistance for their medical care. Medical Assistance is our State program that is in partnership with Medicaid. There are 261,000 Pennsylvania seniors who get their healthcare through Medicaid. Hundreds and hundreds of thousands of people who happen to be over the age of 65 or who happen to have a disability of one kind or another are totally reliant, on most days, on Medicaid. The third group, of course, is the children, and 33 percent of all of the births in Pennsylvania are births that are paid for through Medicaid.

When we talk about this bill that is being considered in the House or when we talk about the confirmation vote for the Administrator for the Centers for Medicare and Medicaid Services, this is real life. What happens to this legislation and what happens on this nomination is about real life for people who have very little in the way of a bright future if we allow some here to do what they would like to do, apparently, to Medicaid.

It sounds very benign to say that you want to cap something or that you want to block-grant. They are fairly benign terms. They are devastating in their impact, and we cannot allow it to happen. That is why this debate is so critical.

I have more to say, but I do commend and salute the work by Senator CANTWELL, Senator STABENOW, and Senator WYDEN in fighting these battles.

I will read just portions of a letter that I received from a mom in Coatesville, in Southeast Pennsylvania, about her son, Rowan. The mom's name is Pam. She wrote to us about her son, who is on the autism spectrum. In this case, she is talking about the benefits of Medicaid—Medical Assistance we call it in Pennsylvania.

Here is what she wrote in talking about the benefits that he receives. After he was enrolled in the program, she said that Rowan had the benefit of having a behavioral specialist consultant. That is one expert who was helping Rowan, who was really struggling at one point. A second professional they had helping him was a therapeutic staff support worker. So there was real expertise to help a 5-year-old child get through life with autism.

Here is what his mom Pam wrote in talking about, since he was enrolled, how much he has benefited and how much he has grown and progressed:

He benefited immensely from the CREATE program by the Child Guidance Resource Centers, [which is a local program in Coatesville]. Thankfully, it is covered in full by Medicaid.

She goes on to write the following, and I will conclude with this:

Without Medicaid, I am confident I could not work full time to support our family. We would be bankrupt, and my son would go without the therapies he sincerely needs.

Here is how Pam concludes the letter. She asks me, as her representative—as her Senator—to think about her and her family when we are deliberating about a nomination like this and about healthcare legislation.

She writes:

Please think of us when you are making these decisions. Please think about my 9-month-old daughter, Luna, who smiles and laughs at her brother, Rowan, daily. She will have to care for Rowan later in life after we are gone. Overall, we are desperately in need of Rowan's Medical Assistance and would be devastated if we lost these benefits.

This is real life for people. Sometimes it is far too easy here in Washington for people to debate as if these things are theoretical—that if you just cut a program or cap a program or block-grant a program, you are just kind of moving numbers around and moving policy around. This is of great consequence to these families, and we have to remember that when we are making decisions around here.

Everyone who works in this building as an employee of the Federal Government gets healthcare. We do not have someone else around the country who is debating whether or not we are going to have healthcare, like those families on Medicaid are having to endure.

I thank the Senator from Washington. I know that Senator STABENOW from Michigan may have more to add on this. We have a big battle ahead, but this is a battle that is not only worth fighting, but it is absolutely essential that we win the battle to protect and support Medicaid.

Ms. STABENOW. Mr. President, as Senator WYDEN's colloquy comes to an end, I will make a few comments in addition to those of my colleagues, and I very much appreciate all of their work.

There are so many different things to talk about as it relates to how healthcare impacts people. As Senator CASEY said, this is very personal; it is not political. There are a lot of politics around this, but it is very, very personal.

In Michigan, when we are talking about healthcare, in Medicaid alone we are talking about 650,000 people who have been able to get coverage now. Most of them are working in minimum wage jobs, and they now are able to get healthcare but couldn't before, as well as their children. That adds to the majority of seniors who are in nursing homes now, folks getting long-term care, folks getting help for Alzheimer's and other challenges and who are relying on Medicaid healthcare to be able to cover their costs.

I want to share a letter, as well, from Wendy, a pediatric nurse practitioner from Oakland County in Michigan. We have received so many letters—I am so grateful for that—and emails.

She writes:

As a pediatric nurse practitioner, I have seen so many of my patients benefit from the Affordable Care Act. Physical exams for the kids are now covered in full, with no co-pay. This means the kids are in to see us, which means we catch healthcare issues and early problems with growth or development that otherwise might be undetected and left untreated until it became a much bigger problem.

Isn't that what we all want for our children, to catch things early?

Immunizations are covered, which keeps everyone safer. Screening tests are covered, so potential problems are caught while they can still be managed. This better care keeps kids healthier and happier and prevents longer term care costs.

She goes on to write:

The Medicaid expansion means even more kids are covered, keeping not only those children healthier but keeping everyone around them healthier. Previously, parents of children who did not have insurance coverage would not seek care until the children were so ill that they could not see another option. Frequently, these children then utilized emergency room care—

Which, by the way, is the most expensive way to treat health problems—

[it was] not only a missed opportunity for complete and preventative healthcare but at a cost passed on to the community.

On a much more personal level, in 2015, our granddaughter, at age 3, was diagnosed with epilepsy related to a genetic condition . . . which made her brain form abnormally. On top of the epilepsy, she has developmental delays and autism, all related to her double cortex syndrome. Although our daughter and son-in-law are fully employed (teacher and paramedic), she qualifies for Children's Special Health Care (under Medicaid). This has been a huge blessing for us, and without it our family would have been financially devastated.

We are hopeful that my granddaughter will continue to have good seizure control and will develop to reach her full potential, but without the care that her private insurance and Children's Special Health Care provides, she would not have much of a chance of getting anywhere near her potential. I do not want to even consider how it will affect her future if insurance companies can refuse to cover her care due to her preexisting condition.

She concludes:

Please do not let partisan politics take precedence over doing what is right and what is best for the health of every U.S. citizen.

I know we are all getting hundreds of thousands of letters and emails and phone calls of very similar stories because healthcare is personal to each of

us—to our children, our grandchildren, our moms, and dads, and grandpas and grandmas. It is not political.

I am very grateful for my colleagues' being here today. I want to speak not only about the importance of expansion under Medicaid but also about the person who would be in charge of that very, very important set of services. That is the nomination in front of us, that of Seema Verma to be the Administrator of the Centers for Medicare and Medicaid Services.

This is a critical position, especially given the ongoing efforts that we are seeing right now to repeal healthcare—the Affordable Care Act—and replace it with legislation that would literally rip away coverage for millions of people and pull the thread that unravels our entire healthcare system. The decisions of the Administrator, both as an adviser to the President and as someone with the authority to make large changes in the implementation of existing law, will have far-ranging consequences for all of us—certainly, for the people whom we represent and especially for those who need healthcare, have begun receiving it, and now may very well see it taken away.

In the Finance Committee, when I asked Ms. Verma about Medicaid, I found that her positions would hurt families in Michigan, would hurt seniors in nursing homes, and would hurt children. And looking at her long record as a consultant on Medicaid, we know that Mrs. Verma's proposals limit healthcare coverage and make it harder to afford healthcare coverage, putting insurance companies ahead of patients and families once again.

I am also very concerned about her position on maternity coverage. During the hearing, I asked Ms. Verma whether women should get access to basic prenatal care and maternity care coverage as the law now allows—I am very proud of having authored that provision in the Finance Committee—or whether insurance companies should get to choose whether to provide basic healthcare coverage for women. I reminded her that before the Affordable Care Act, only 12 percent of healthcare plans available to somebody going out to buy private insurance offered maternity care—the vast majority did not—and that the plans that did often charged extra or required waiting periods. Her response indicated that coverage of prenatal and maternity care should be optional—optional. We as women cannot say our healthcare is optional.

The next CMS Administrator should be able to commit to enforcing the law requiring maternity care to be covered and commit to protecting the law going forward for women. Being a woman should not be a preexisting condition. Getting basic healthcare should not mean we have to buy riders or extra coverage because being a woman and the coverage we need is somehow not viewed as basic by the insurance company. We have had that fight. Women won that fight with the Affordable Care Act. We should not go backward.

I followed up with Ms. Verma, along with many colleagues, but have not received a response.

Over 100 million Americans count on Medicare and Medicaid. They need a qualified Administrator who puts their needs first, and I cannot vote for a nominee who does not guarantee that she will fight for the resources and the healthcare that the people of Michigan count on and need.

TRUMPCARE

Finally, I wish to take a moment to talk about the healthcare bill that has now come out of committees in the House and will be voted on in the House and then coming to us in the Senate. Frankly, let me start by saying that this is a mess—it is a mess on process, and it is a mess on substance.

As a member of the Finance Committee, I can tell my colleagues firsthand that this was not rammed through the Senate Finance Committee when we passed the Affordable Care Act. We had months and months and months of hearings, of which I attended every one, I think, and after that, the floor debate and that discussion and the discussion in the House. We knew what it would cost before we brought it up, by the way, which saved a lot of money by doing a better job of managing healthcare costs and creating innovation for our providers.

But the truth is that when we look closely at what is being debated in the House, for families in Michigan and across the country, it is really a triple whammy: higher costs, less healthcare coverage, and more taxes. Overall, it means more money out of your pocket as an American citizen, unless you are very wealthy, and it means less healthcare. This is not a good deal.

It cuts taxes for the very wealthy and for insurance companies. It gives an opportunity for insurance company execs to get pay increases and cuts taxes for pharmaceutical companies. Someone making more than $3.7 million a year would save almost $200,000. Let me say that again. Someone making more than $3.7 million a year would put $200,000 in their pocket as a result of this healthcare bill, TrumpCare. To put that in perspective, 96 percent of Michigan taxpayers would not qualify for this. Ninety-six percent of everybody in Michigan who gets up every day, goes to work, works hard—some take a shower before work, some take a shower after work—they are working hard every single day, and they would pay more, while the small percentage of those at the very top would get $200,000 back in their pockets.

As I indicated, it provides a tax break for insurance company CEOs to get a raise of up to $1 million but increases taxes and healthcare costs for the majority of Americans. Middle-class Americans and those working to get into the middle class would see tax increases and lose healthcare coverage at the same time—such a deal.

For seniors, this would allow insurance companies to hike rates on older Americans by changing the rating system. AARP, a nonpartisan organization, has indicated that premiums would increase up to $8,400 for somebody who is 64 years of age earning $15,000 a year. So they earn $15,000 a year, and their premiums could go up by more than half of what they are making. To put that in perspective—again, a comparison of who wins and loses under this plan—if you are 64 years old and earn $15,000 a year, you pay more—$8,400 more. If you are 65 years of age and earn over $3.5 million a year, you put $200,000 more back in your pocket. This is a rip-off for the majority of Americans and should not see the light of day.

On top of that, TrumpCare creates Medicaid vouchers. We have been talking with colleagues about the change in Medicaid. What does that mean? Well, instead of being a healthcare plan that covers nursing home care, whether that is someone who needs very little care or someone who has Alzheimer's or other extensive needs, your mom and dad or grandmom and granddad would get a voucher, and if it didn't cover the care in the nursing home, as it does now, then your family would have to figure out a way to make up the difference. We could very possibly have the situation we had before the passage of the Affordable Care Act where a lot of folks were going bankrupt trying to figure out—you use the equity in your home, except because of what happened in the financial crisis, you may not have much equity in your home anymore. So you try to figure out, how do I make up the difference to help my mom or dad or granddad and grandmom in the nursing home? That will be a very common discussion, I would guess, if this passes. So turning Medicaid into a voucher system would cut nursing home care and healthcare for families.

Let me also say that when there is a healthcare emergency like we had in Flint, MI, with 100,000 people being poisoned with lead and over 9,000 children under the age of 6 with extensive lead poisoning, and we had the President and the past administration step in to help those children because of the health problems from the lead exposure, that would not be possible under this new regime. It will not be possible to step in when there is a healthcare emergency for children or for a community.

In Michigan today, 150,000 seniors depend on healthcare through Medicaid for long-term care. Three out of five seniors in nursing homes in my State—three out of every five seniors—count on Medicaid for their long-term care. This radically changes and dismantles that healthcare system. We have nearly 1.2 million children in Michigan and 380,000 people with disabilities who use this system.

So we have a situation where we would see a radically different