in Hawaii—who depend on the program for long-term nursing care. It imposes an age tax on people 50 to 64 that allows insurance companies to charge them five times more for insurance. It fulfills the Republican Party's cherished goal of defunding Planned Parenthood. It undermines protections for Americans living with serious and chronic diseases who could face the reimposition of yearly and lifetime caps on their care.

For millions of people in our country, TrumpCare is not some abstract proposal that has no relevance to their lives. Last week, Senator MURRAY, Senator VAN HOLLEN, and I joined three advocates—Ian, Marques, and Jill—who told us their stories about how TrumpCare would impact them.

Ian grew up in Fond du Lac, WI. During his sophomore year in high school, Ian discovered he had bone cancer after suffering an injury playing football. He has been cancer-free for 6 years and is now pursuing a career in medical research, in large part, because of his experience in fighting this cancer. Although Ian has been cancer-free for some time now, he is very concerned about what TrumpCare could mean for him if his disease comes back. He has a preexisting condition.

Marques lives in Richmond, VA. He was diagnosed with multiple sclerosis when he was only 27 years old. He has three young daughters and faces a lifetime of extensive treatment for his disease. Because of the Affordable Care Act and the guarantee of coverage it affords every American, Marques did what he never thought he would be able to do with MS, he started his own business.

Jill is from Hillard, OH. Her daughter Alison was born with cystic fibrosis. Alison endured a lot at a very young age. When she was only 7, Alison had part of her lung removed because of the damage her disease caused. Because she has health insurance, which makes paying for expensive CF drugs more affordable, Alison is a happy teenager planning eagerly for her future. Jill made clear what would happen if TrumpCare passes: Alison's CF medication would become prohibitively expensive. Under TrumpCare, Jill would have to make decisions about which drugs she could afford for Alison, not which would work best to fight her disease.

Annual or lifetime limits on healthcare coverage will mean constant worry about paying for the lifesaving care that Ian, Marques, Jill, and their families need—not starting a business, not living like a normal teenager or young adult with dreams for the future. They will spend practically every waking moment just worrying about how they are going to pay for the care they need to live.

TrumpCare would be a disaster for the American people, and we are going to fight against it tooth and nail, but I also want to be clear about what we are fighting for. We are fighting for universal healthcare that is a right, and not a privilege, for every American.

Tomorrow, I am going in for surgery to remove the lesion I have on my rib, but I am going to be back as quickly as I can to keep up the fight against this mean, ugly bill. The stakes are too high to stay silent. We need everyone in this fight because we are all in it together.

Millions of people across the country are mobilizing against TrumpCare because healthcare is personal. I am encouraged that so many people have been calling all of us and making their voices heard. The majority leader and Donald Trump can try to jam this bill down our throats, but we aren't going to let them succeed, and we are going to hold them accountable.

The fight continues.

I yield the floor.

The PRESIDING OFFICER. The Democratic leader.

WISHING THE SENATOR FROM HAWAII WELL

Mr. SCHUMER. Mr. President, I just want to salute, on behalf of all of us in the Senate, our great, great Senator from Hawaii. Her courage, her strength, her conviction to help people who need help is just inspiring—that is the only word I could think of, ''inspiring''—to every one of us.

We love you, MAZIE. We wish you well, and we can't wait for you to come back and rejoin the fight doubly invigorated.

I yield the floor.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. MERKLEY. Mr. President, I extend to my colleague from Hawaii every blessing for her successful health treatment. I know the thoughts and prayers of every Member of the Senate are with her tomorrow and beyond as she undertakes that healing path.

HEALTHCARE LEGISLATION

Mr. MERKLEY. Mr. President, I appreciate the comments of the Senator from Hawaii tonight. They are certainly very relevant to the issue of healthcare here in America because each of us hopes that if a loved one gets ill, they will have the peace of mind that they know they will be able to get the healthcare they need and they will not go bankrupt in the process. Yet here we are tonight debating a bill titled ''Better Care Act.''

Better Care, has ever there been a bill in the history of the United States of America so more perversely named than this Better Care Act which strips care from 22 million Americans?

I was very struck by one equation of this bill; that is, that it provides to the richest 400 Americans $33 billion over a 10-year period. That is enough to pay for healthcare under Medicaid for 700,000 individuals—700,000 individuals. It rips the healthcare away from them to give $33 billion to the richest 400 families. That is obscene. That is certainly not better care.

It is hard for me to imagine that a single Member of this body would vote to proceed to this bill, but here we are. Until we get agreement that we are not going to proceed, we have to continue to carry on this fight.

We know that 15 million people, CBO estimates, will lose healthcare in the next 12 months. That is even worse than the House bill. Last week, I came to this floor to call the Senate draft mean and meaner. The House bill was mean. The Senate's is meaner. Now we have the CBO estimate that says, yes, it is worse. One million more people would lose healthcare in a short period of time.

Furthermore, the rate at which standard Medicaid is compressed—Medicaid, as it existed before ObamaCare, that rate has increased to further diminish healthcare, having nothing to do with ObamaCare, just to add to the cruelty of this bill. So millions lose, but we deliver billions of dollars to the richest Americans.

In my home State of Oregon, just the elimination of the expansion of Medicaid, the Oregon health plan—just that would eliminate 400,000 Oregonians off healthcare.

Imagine those individuals holding hands, 400,000 Oregonians, stretching from the Pacific Ocean to the State of Idaho. Anyone who has driven across Oregon would realize it is 400 miles across Oregon. If you are driving it, it is 7 hours of driving. For 7 hours, at 50 miles an hour, 60 miles an hour, you are passing a stream of people who would lose their healthcare just from the elimination of the expansion of Medicaid.

My colleagues across the aisle have crafted this so as to put it beyond the next Presidential election, beyond the 2018 election and beyond the 2020 election. Why? They are so terrified of the impact of this on the election they decided to postpone it until after 2018 and 2020, as if that makes it acceptable to rip healthcare from millions of people. That type of cynical, cynical act, purely political, is not going to be viewed well by the American public.

If you are so ashamed of this bill, if someone is so ashamed that they want to postpone the effects beyond the next Presidential election 3½ years from now, then maybe you should be so ashamed as not to vote to move to the bill here in the short term.

One of our colleagues across the aisle noted today: I can't imagine—not quite the exact word-for-word, but it is close. I can't imagine that anyone in America would have a chance to review this bill and truly understand it in time to proceed to it this week, including myself.

Well, that is certainly true. Has there ever been a case where a bill profoundly affecting so many has not had the benefit of committee deliberation here in the Senate? Are we a legislative body or are we a dictatorship where everything is done behind closed doors

and then rammed through? That is not the American way, and that is not the constitutional vision for how the Senate should work. There is supposed to be time to consult healthcare experts and time to go home to consult our constituents and find out how they feel.

If one is so terrified of this bill that you are afraid of your constituents, then you shouldn't vote to proceed to the bill. If one is so terrified you don't want to consult the experts, you shouldn't proceed to this bill. If you are so terrified that the reaction from the public will be so strong that it will put you in an awkward spot, then you shouldn't proceed to this bill—because you have the responsibility to consult with your folks back home, a responsibility to consult with healthcare experts, to understand every nuance of this bill.

One of those facts is going to have a devastating impact on those who would go to nursing homes. Folks who are under Medicaid and in a nursing home have given up their entire income and assets before they can get Medicaid support.

I was in Klamath Falls the weekend before this last weekend, went to a nursing home, and they said: Senator, almost 100 percent of the folks here on long-term care are paid for by Medicaid. I thought they were going to say 60 percent or two-thirds, because that is the national statistic. No, in rural Oregon, in Klamath Falls, almost 100 percent.

Then we had the CEO of the Oregon Health Association reach out and address this issue of how it is going to affect seniors. Here are his exact words:

> I was on a call early today looking at some projections of how hard Oregon and Medicaid-funded long-term care service would be hit. If this bill passes, it literally could force the closure of the majority of nursing facilities in Oregon by 2025.

One thing I can't get out of my mind. At another nursing home I went to is a woman named Deborah. I explained I was coming by to talk to people because I wanted to understand better the impact of this bill on long-term care.

She said: Senator, I am paid for by Medicaid. If Medicaid disappears, I am on the street, and that is a problem because I can't walk.

That is exactly what Deborah said. And, of course, it is a problem, not only because she can't walk but because she needs extensive care, which is why she is in long-term care to begin with.

The anxiety was palpable among the nursing home residents, among the long-term care residents, because they have no backup plan, because they had to spend down their assets before they qualified for Medicare. Don't think of this just as ripping healthcare away from millions of working families, millions of struggling families, millions of children, but also from our seniors who are in long-term care, who need extensive care, and who have given up their assets in order to qualify for Medicaid. They used those assets to pay for it as long as they could, and now they are on Medicaid. We are prepared to take those folks, many of them in wheelchairs—like Deborah, unable to walk—and throw them into the street and say: too bad.

The President called the House bill mean and indicated he wanted a bill with more heart. This is not a bill with more heart. We should not move to proceed to this bill.

The PRESIDING OFFICER. The Senator from Minnesota.

Ms. KLOBUCHAR. Mr. President, I thank my colleague from Oregon for his words.

I rise today to give voice to the concerns I am hearing from so many people in my State and across the country about this repeal bill.

First, I want to recognize my colleague from Hawaii, Senator HIRONO, who spoke earlier tonight about her personal battle with kidney cancer, as she is an example to all of us of determination and grit when the going gets tough. She not only is going to the hospital for surgery tomorrow—which isn't an easy surgery—but she decided she wanted to spend the night before she went into the hospital here because she is so passionate about this issue.

I know she is going to fight this disease and win and come out stronger than ever. I have been so moved by how she has taken on her personal fight against cancer at the same time that she has kept this fight going in the Senate. She is doing it not just for herself or for her State but for people all over the country.

As Senator HIRONO has said, her experience shows how quickly a routine visit to the doctor can turn into a serious diagnosis—a diagnosis that becomes a preexisting condition.

Everyone who faces a serious illness, no matter who they are, should be able to focus all of their energy on getting better, not on how they are going to pay their medical bills. Unfortunately, the bill we are considering doesn't allow everyone to do that.

As the nonpartisan Congressional Budget Office noted earlier today, this bill could mean the return of annual or lifetime limits on what insurance would cover for people with expensive conditions like cancer or Alzheimer's, and some key healthcare benefits might be excluded from insurance coverage altogether.

It is no surprise that the Minnesota Hospital Association has said that this proposal ''creates a lot of chaos.''

I was just at Northfield Hospital this weekend. It is a college town, but it is in the middle of a very rural part of our State, with a lot of farms surrounding it. In fact, they call the town ''Cows, Colleges, and Contentment.'' In that town and in that hospital, there wasn't a lot of contentment during my visit.

The CEO of the hospital told me that he was worried that this bill could drive more of his patients to bankruptcy. I met with a number of people who were on the board and work at the hospital, and they were all very concerned about what the bill would mean.

This did not mean that they didn't want to see changes to the Affordable Care Act. They do. They see the issues with premiums in our State. That is why our Republican legislature worked with our Democratic Governor to pass a bill for reinsurance, to try to use something to leverage the risk for the people in the exchange. We could do something similar on the Federal level, and we should, but that is not what this bill is about.

The head of another hospital in my State said: ''They are shortening up the money, but they're not giving us the ability to manage the care.''

A Minnesota seniors organization said that this bill ''feels like we're pulling the rug out from underneath families and seniors.'' That is why AARP strongly opposes the bill as well.

According to the CBO report that we got today, this bill would cause 22 million people to lose their coverage over the next 10 years—22 million people. On Friday, my Republican colleague Senator HELLER said that he ''cannot support a piece of legislation that takes insurance away from tens of millions of Americans.'' I agree.

I hope our Republican colleagues will come to the negotiating table in a bipartisan way. I hope this administration will not sabotage the bill that we have now and will work with States like mine that want a waiver to be able to do the kind of cost sharing and the reinsurance that I just described. During that time, we can work together to actually make healthcare in America better and more affordable.

We need to think about the real and devastating impacts on people's lives that this piece of legislation would have because that is what this debate is about. It is not about all of us going back and forth and citing facts and figures. In the end, it is about how this will affect people.

It is about the lives of people like the mom in Minnesota who has a child with Down syndrome. She told me how she has seen Medicaid help parents of kids with disabilities avoid bankruptcy and how it helps school districts pay for the therapy children like hers need. She said that this bill is ''unconscionable''—that is her word—because of what it would do to adults and kids who have disabilities.

We have more than half a million children in Minnesota who rely on Medicaid and the Children's Health Insurance Program. This includes kids like the students of a retired teacher from Northwestern Minnesota, right across from the North Dakota border. The teacher wrote in, saying that the bill is ''cruel and mean,'' especially for the families of special needs students.

A lot of us have talked about how the President called the House bill mean and how we hoped to avoid a bill like

this in the Senate. In fact, this last weekend, he did admit that he had called the House bill mean after he had celebrated its passage. That is behind us.

The President is the one who is known for speaking his mind and speaking directly. He didn't need a poll or a focus group or an accountant to look at the House bill. He just called it what it was—mean.

In Minnesota, people don't mince words either, and that is why that teacher told me exactly what the impact of this Senate bill would be. In fact, today the Congressional Budget Office—the nonpartisan Congressional Budget Office—confirmed it earlier today with its estimate that millions of people, 22 million people, would lose their Medicaid coverage because of the bill.

Our debate today is about the lives of people like the retiree with Parkinson's in Minneapolis, who told me she is ''scared and worried.'' She is not just worried about the cuts to Medicaid but also about depleting the Medicare trust fund to pay for tax cuts for the very wealthy. As she told me, the future of these vital programs that so many Americans depend on is on the line.

This healthcare bill is also about the people who are worried about taking care of their baby boomer parents at the same time that they are caring for their children. One woman told me about her mom, who died 2 years ago at 95 after suffering from dementia for more than 20 years. She had worked her whole life, but as she got older, she couldn't afford the nursing care she needed so much. Luckily, she was able to rely on Medicaid to pay for it.

More than half—54 percent—of nursing facility residents in Minnesota rely on Medicaid. I think when this House bill first came out, people thought, well, Medicaid—what does that have to do with my life? Then they started talking to their parents, their grandparents or they started talking to their neighbors, and that is when they realized, whoa, over 50 percent of people who go into assisted living and nursing homes end up relying on Medicaid.

This woman's daughter told me she is worried that this bill's cuts would put those vital services for seniors at risk for so many other parents and their kids. And even for older people who don't use Medicare or Medicaid, this bill could put health coverage out of reach. That is because it has an age tax for seniors, allowing older people to be charged five times as much as younger people for insurance. As AARP has said, that is just not right.

These are the concerns I have heard from seniors and their families in Minnesota. They are shared by people across the country, especially by people in our rural areas, where they tend to have a little older population. One reason for that is because the Senate bill, actually more than the House bill when it comes to Medicaid, makes even deeper cuts over the long term that will hurt seniors and rural hospitals along with children, people with disabilities, and people suffering from opioid addiction.

We actually have a strong bipartisan group working on the opioid addiction problem. Four of us—two Democrats, two Republicans—were the chief authors of the bill that passed last year, which set the framework for the Nation. We then put billions of dollars into treatment last year, and we shouldn't blow it up now by passing a bill that, because of the Medicaid cuts, would—in my State, one-third of the people who get opioid addiction treatment get it from Medicaid. Actually, it would be moving ourselves backward.

I know my colleagues Senator COLLINS and Senator MURKOWSKI have expressed real concerns about these kinds of Medicaid cuts in their States of Maine and Alaska, which also have big rural populations.

In my State, Medicaid covers one-fifth of our total rural population, about 20 percent of our rural population. These cuts could cause the rural hospitals that serve this population to close. This doesn't just threaten healthcare coverage; it threatens the entire local economy. That is a big deal for rural hospitals, which often have operating margins of less than 1 percent. These rural hospitals are on the frontlines of the opioid epidemic that is hitting communities across the country.

In my State, deaths from prescription drugs now claim more lives than homicides. They claim more lives than car crashes. While there is more work to do to combat the epidemic, I want to recognize our progress. Yes, we passed the blueprint bill, which I just mentioned, with the help of Senators PORTMAN, WHITEHOUSE, and Ayotte. Unfortunately, we are moving ourselves backward.

Medicaid expansion has helped 1.3 million people receive treatment for mental and substance abuse across the country. I know this bill's cuts to these important services for people struggling with addiction have real concerns in States like West Virginia and States like Ohio.

The problems with this bill, of course, go beyond Medicaid cuts, as a mom from Belgrade, MN, told me when she wrote about her daughter who died way too young from cancer. She asked me to oppose this bill in honor of her daughter and the thousands of other children diagnosed with cancer each year. She is worried that the waivers in this legislation would undercut protections for people with preexisting conditions, threatening to make health insurance unaffordable for families like hers who have children or children with cancer.

One man from Minneapolis told me that what this does is ''downright scary.'' Those were his words. He is scared because he is self-employed. He has a preexisting condition, and he gets his insurance on the individual market. He is worried that under this bill, his costs—which are already high—would skyrocket.

I am the first to say that we need to fix the individual market. In fact, I started out by talking about the fact that we have done some work in our State, and I would like to bring that out nationally. This bill is not the way to do it because—as the CBO said earlier today—it would actually cut assistance and increase deductibles for many people on the individual market. Based on CBO's projections, the Joint Economic Committee estimates that average premiums in Minnesota would go up substantially next year, even more than they have gone up already.

People across the country are making their voices heard about these types of problems. According to the Kaiser Family Foundation poll that came out just last week, only 30 percent of Americans had a favorable view of the House bill, and these concerns go across party lines. Only about half of Republicans—56 percent—supported the House bill.

I know this bill has some differences from the House version, but as Speaker RYAN said last week, the two are very similar. I hope that hearing from Americans on both sides of the aisle prompts my colleagues to start working together to make our system better in a bipartisan way.

Here are some ideas. I would love to include, if we worked on a bipartisan basis together, not only the work that needs to be done on the individual market, but on the exchanges, on the rates, and for small businesses. But I would also like to work on prescription drugs. I have a bill that would harness the negotiating power of 41 million seniors on Medicare to bring drug prices down. We have a number of Senators on the bill. Right now, Medicare is absolutely banned from negotiating with 41 million seniors. That is just wrong. Our seniors should be able to use their market power to negotiate.

I would also love to see more competition in this market. There are several ways we can do it. One is by bringing in less expensive drugs from other countries when we have drug shortages now in this country. Senator COLLINS and I worked on this, and the bill passed this Senate and got signed into law. Now the Secretary of Human Services can actually bring in drugs that are safe from other countries when we have a drug shortage. We refined some of the language where the rules already allowed the Secretary to do that. They could do the same thing right now, but we can make it even more clear if this Congress got behind it.

Senator MCCAIN and I have a bill to bring in less expensive drugs from Canada, which is very similar to the American market. We have a provision in the bill so they would be safe. Many people in my State are doing this now. We once had bus rides of seniors going up there to get less expensive drugs. We could do it with other countries, as

well, as long as they were certified as safe. For one of the ways you could do it, Senator LEE and I have a bill that looks at this. Again, this a bipartisan bill. If you have less competition in the market and you have less competitors, that would trigger the ability to bring in more drugs. You could do it based on the price. If it goes up high and the Secretary or someone else that we could put in that place finds that it is not because of input costs, you could allow this competition to come in from other countries. It would be a trigger. I would bet you right now that if you did that, it would create incentives on American drug companies not to jack up the prices like they have been doing.

The top 10 selling drugs in America have gone up over 100 percent. Things like insulin are up three times. Things like naloxone, which we rely on for overdoses from opiates, have gone up astronomically. It feels like when these drug companies get a monopoly in their lap, they go for it. That is what is happening.

A second way to bring in competition is by encouraging more generics. Senator GRASSLEY and I have a bill to stop something called ''pay for delay.'' This is unbelievable to me, when I describe this to people—that big pharmaceutical companies are actually paying generic companies to keep their products off the market. The nonpartisan Congressional Budget Office has found that this would save something like $3 billion over a number of years if we passed our bill. That is for the government and taxpayers, but you could save an equal amount of money for consumers who are paying for this in premiums. How could you ever explain that pharmaceuticals are actually paying generics to keep their products off the market? That is a vote I would like this Senate to take. I would like to challenge anyone to explain why they would vote against that.

We also have another bill called the CREATES Act, with Senators GRASSLEY, LEAHY, LEE, and me, which makes it easier to get generics to market by sampling and other things.

These are just a few of the examples of bills that I think would be very good if we would consider them, but so far, we have done nothing. We banned seniors from negotiating. There is nothing in the House or the Senate repeal bills that does anything about these pharma issues. Again, that is one reason alone to be concerned about these bills.

I was at that baseball game a few weeks ago and saw firsthand that incredible bipartisan spirit, and at the women's softball game, as well. At the men's baseball game, the players played together, and, at the end of the game, when one team won—the Democratic team—they took their trophy and they gave it to the Republican team, and they asked them to put it in Representative SCALISE's office. That is what we need to see more of—not just two teams but one team. Certainly, on an issue as complex as healthcare, we just can't be playing in our separate ballparks. This is the time to come together. We have changes that we must make to the Affordable Care Act. I said that the day it passed—that it was a beginning and not an end.

I always thought it was unfortunate that it was more of a Democratic bill than it was a bipartisan bill. So we have an opportunity now to fix that, to make fixes to the bill, and to work together. But this bill is not the answer—this bill that we were not allowed to take part in, where the doors were closed, not only to Democratic Senators but to Americans themselves.

So I hope, as we go forward, that our colleagues on the other side will work with us on a truly bipartisan bill that would make some of the changes we need to bring down healthcare costs, instead of moving forward with this bill.

I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. MARKEY. Mr. President, I would like to thank my friend and colleague Senator HIRONO for her words and her willingness to share how this bill could impact the millions of Americans with preexisting conditions. I, along with everyone else in this Chamber, wish her the best and a speedy recovery so she can continue to fight for the people of Hawaii and the people of the United States.

After weeks of secret meetings, Senate Republicans released their healthcare legislation last week. In many ways, it is even worse than expected. It is no wonder that the Senate Republicans kept this legislative malpractice hidden behind closed doors. For working families and the elderly, for the disabled and for those suffering from opioid addiction, this legislation is a death sentence. This bill takes a machete to Medicaid. It abandons people with preexisting conditions. It punishes Grandma and Grandpa, who live in a nursing home, and 25,000 seniors in Massachusetts' nursing homes who are on Medicaid.

It causes the single greatest rollback of civil rights for people with disabilities in a generation, by taking away the funding for those with disabilities. It creates an age tax for those over the age of 50. It shreds a critical healthcare program for the disabled, working families, and children just to bestow billions in tax breaks for the wealthiest in our country.

This is an amazing number. The richest 400 billionaires in the United States will get a tax break of more than $33 billion, which is roughly equivalent to the cuts from ending Medicaid expansion in four States. That is more than 700,000 people in just those four States who could be kicked off of their health insurance coverage to benefit just 400 billionaires in America who do not have to worry about their healthcare or their family's welfare. But for those who are going to lose the coverage—people with cancer, people with Alzheimer's, people who need opioid addiction treatment, people with diabetes—they will have their healthcare coverage slashed so that 400 billionaires can get a tax break, which they don't need and they don't deserve. That is at the heart of this Republican healthcare bill. It is what it is all about. This legislation is of the rich, by the rich, and for the rich.

It is a ''wealth care'' bill for the upper 1 percent in our country, and it says to everyone else: Your healthcare is going to suffer in order to take care of that 1 percent with their tax breaks. It is a more than $500 billion tax break to corporations and individuals making $200,000 or more. It is no wonder that President Trump has kept his tax returns secret, because he knew he was about to get a massive tax break through this legislation from slashing healthcare for people with cancer, diabetes, Alzheimer's, heart disease, and substance use disorders. This selfish Senate Republican legislation will increase premiums and out-of-pocket costs, while decreasing the quality of health insurance coverage for most Americans.

This bill would result in many Americans—especially those over the age of 50—paying thousands more in premiums for skimpier health plans. It will put insurance companies back in charge of our healthcare by allowing them to waive coverage of the essential health benefits like emergency care, prescription drugs, maternity care, or mental health treatment.

That means that someone with a preexisting condition, like a cancer survivor or a child with asthma, might have insurance but not actually be covered for the treatment they need, because under this bill, the anxiety of suffering from an illness or the constant fear of relapse will once again be exacerbated by financial insecurity.

Yet some of the most damaging provisions of this legislation are the brutal cuts to Medicaid, which already serves more than 70 million Americans, including, very importantly, two-thirds of all seniors in nursing homes in America, who are on Medicaid. Let me say that again: Two-thirds of all seniors in America are on Medicaid. Half of all seniors over the age of 85 have Alzheimer's, and 15 million baby boomers are going to have Alzheimer's. They are going to need some help. People have a hard time paying $60,000, $80,000, $100,000 a year for a nursing home bed. What are the Republicans planning on doing over the next 15 years? Slashing that funding in Medicaid for seniors in our country who will need that help just to stay in a nursing home, or else they are going to have to go home to their families who will be responsible for providing the care for them.

The Senate Republicans doubled down and opted for even steeper cuts in their bill than in the House version. In

3 years, the Senate bill will start the process of kicking millions off of their Medicaid coverage by ending Medicaid expansion in States around the country. It will mean 22 million Americans are kicked off of coverage.

Then, as if that wasn't enough, starting in 2025, the plan will institute even more drastic Medicaid cuts that every year become a deeper cut than the year before, and it will literally mean death by a billion cuts for millions of Americans who will lose their healthcare coverage, especially those suffering from substance use disorders. Medicaid covers about one-third of Americans with an opioid use disorder and pays for nearly half of the medication-assisted treatments in Massachusetts. Taking away this treatment would be a death sentence for thousands of Americans.

A vision without funding is a hallucination. The Republicans are saying: We will find the will to take care of these people with opioid treatments. Well, you can't will your way to dealing with an opioid crisis. It is a disease. You need funding. You need treatment. And right now, there are millions of Americans who don't have the treatment they need. Medicaid is the way in which it will be provided, but the Republicans are just going to slash it, and the consequences are going to be catastrophic.

Now, here is what the Republicans are saying: To make up for the cuts to Medicaid, the Senate Republican healthcare legislation creates an opioid fund of $2 billion for 2018. Compare that to the $91 billion in funding for opioid use disorder treatment that would be provided by the Affordable Care Act over the next 10 years. A $2 billion opioid fund is pocket change for a crisis that took 2,000 lives just last year in Massachusetts and 33,000 lives across the country. And if people were dying from opioid addiction at the rate they are dying in Massachusetts, that would be a 100,000 people a year—two Vietnam wars a year dying from opioid addiction. They are going to slash the funding for treatment for these families. It will be a death sentence for these individuals if they do not have access to the funding.

So the formula of this bill is simple: First, increase the cost of care, so working families pay more. Second, decrease the quality of care for seniors and the sick. Finally, hand over the hundreds of billions of dollars in tax breaks to the wealthiest people in our country—billions in tax breaks to people who don't need them, who don't deserve them, paid for by people who can't afford it. It is healthcare heartlessness.

To add insult to injury, it will devastate the budgets of already strapped States, which may be forced to raise taxes or cut other benefits, such as education or housing assistance, to make up for the billions of dollars States will lose because of this bill.

It is cruel. It is inhumane. It is immoral. It is just plain wrong to cut healthcare benefits for those who need them to give tax breaks to those who do not need them. That is the Republican plan.

The Republican leadership is trying to catch a political unicorn with this bill—to make moderate Republicans happy while satisfying the most conservative elements of the Republican Party. But there is no treatment for TrumpCare. It is dangerous for healthcare, and there is no reviving Medicaid if this bill passes.

This Republican proposal has never been about policy. It isn't about covering more people or decreasing costs of healthcare or making it more patient-centered. The Republican proposal has always been about slashing healthcare for ordinary Americans to give a massive tax break to the wealthy in our country. That is the Republican policy agenda, not patient-centered care, because this will hand back over the power to insurance companies in our country, not to patients.

If Republicans were really concerned about reducing the deficit, then every single dollar in this bill would go to reducing the deficit—the crocodile tears which they shed about the deficit. No, ladies and gentlemen, they are shoving this money straight to the biggest number of billionaire beneficiaries than any tax bill in our country's history. They are, in fact, the party of the wealthy. They are the party trying to make sure that those who are in charge of funding the Republican Party now receive their pay back in the form of tax cuts at the expense of the healthcare of the ordinary people in our country. That is selfish, that is unconscionable, and that is why the Democrats are going to fight this every step of the way this week in order to protect healthcare for every American.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Vermont.

Mr. SANDERS. Mr. President, today's Congressional Budget Office analysis of the Trump-McConnell healthcare bill gives us 22 million reasons why this legislation should not see the light of day. What CBO tells us in truth is that this bill really has nothing to do with healthcare; rather, it is an enormous transfer of wealth from the sick, the elderly, the children, the disabled, and the poor into the pockets of the wealthiest people in this country.

According to CBO—and that report came out just a few hours ago—this bill would throw 22 million Americans off of health insurance, cut Medicaid by over $770 billion, defund Planned Parenthood, and substantially increase premiums for older Americans. Under this bill, a 64-year-old with an income of $56,000 could see his or her premiums increase from $4,400 under current law to $16,000—an increase of nearly 850 percent. How are older workers in this country going to deal with an 850-percent increase in their premiums? Meanwhile, the Trump-McConnell bill would provide a $231 billion tax break to the top 2 percent and hundreds of billions more in tax breaks to the big drug companies and insurance companies that are ripping off the American people every day.

At a time when the middle class of this country continues to shrink and when families all across America are struggling to make ends meet, to put food on the table, to pay their rent, to save a few bucks for retirement, we cannot take from working-class families and we cannot take from the sick and the elderly and the children in order to give even more to the very wealthiest people in this country—people who are at this moment doing phenomenally well.

Mr. President, this, in fact, is a barbaric and immoral piece of legislation. But let's be very clear. It is not just BERNIE SANDERS who opposes this bill. It is not just every Member in the Democratic caucus who opposes this bill. It is not just that the overwhelming majority of the American people oppose this legislation. According to a recent NBC/Wall Street Journal poll, only 16 percent of the American people thought this bill was a good idea. This bill is opposed by virtually every major healthcare organization in this country—the people on the frontlines, the people who today, yesterday, and tomorrow are dealing with healthcare issues, dealing with the sick, working in hospitals, working in community health centers. Almost without exception, every major healthcare organization in this country opposes this bill.

Maybe my Republican friends might want to get beyond the politics, get beyond Republicans and Democrats, and ask the people who really know about healthcare in America and ask yourself, how does it happen that virtually every major healthcare organization in this country opposes this legislation?

The AARP opposes this legislation—the largest senior group in America, which knows what high premiums for healthcare will do to their membership. The American Hospital Association knows a little bit about hospitals and what will happen to rural hospitals if this legislation is passed. The American Medical Association is a conservative organization. This is the doctors organization all over this country. This is not any progressive radical group; these are our doctors, the doctors we go to. They oppose this legislation because they know what will happen if there are massive cuts to Medicaid, if 22 million people are thrown off of health insurance. The American Academy of Family Physicians knows what this legislation will mean to the children of our country. The American Psychiatric Association, the Federation of American Hospitals, the Catholic Health Association, the American Lung Association, the Cystic Fibrosis Foundation, the March of Dimes, the National MS Society, the American Nurses Association—every one of these

organizations opposes the Republican legislation; not BERNIE SANDERS but every major healthcare organization says do not go forward with this disastrous bill.

This is what the AARP, the largest senior group in America, said recently:

This new Senate bill was crafted in secrecy behind closed doors without a single hearing or open debate—and it shows. The Senate bill would hit millions of Americans with higher costs and result in less coverage for them.

AARP is adamantly opposed to the Age Tax, which would allow insurance companies to charge older Americans five times more for coverage than every one else while reducing tax credits that help make insurance more affordable.

I ask all of my Republican friends to think for a moment about the implications of this bill and what it will mean to your constituents when they lose the healthcare they currently have. Put yourself in their place. Today you have health insurance, but tomorrow, next year, you might not. What does that mean? Think about it.

What does it mean if you are an individual today—and, sadly, there are too many of them. If you are a person today suffering with cancer and you are fighting for your life—maybe you are on radiation treatment. Maybe you are on chemotherapy. You are scared to death. You don't have a lot of money. You have cancer. You are struggling. And now you are reading in the papers that this Republican bill may take your health insurance away from you? How do you think they feel? I suspect scared to death. It is the same with people who have heart disease, who have asthma, who have diabetes or any other life-threatening illness. What happens to those millions of people when they cannot afford to go to the doctor when they are sick, cannot afford to buy the medicine they desperately need?

Mr. President, I know this is a sensitive issue, but I am going to raise it, and that is that the horrible and unspeakable truth is that if this legislation were to pass, and I am going to do everything I can to see that it doesn't, but if it were to pass, many thousands of our fellow Americans every single year will die, and many more will suffer and become much sicker than they should. That is not, again, BERNIE SANDERS talking; that is exactly what a number of studies have shown. Study after study, including one from the American Journal of Public Health to the New England Journal of Medicine, to the Harvard School of Public Health have told us. Again, this is not BERNIE SANDERS engaging in a rhetorical debate; this is what scientists and doctors who have studied the issue are telling us.

In fact, just this afternoon, a few hours ago, the Annals of Internal Medicine, a prestigious medical journal, published an article from researchers at the City University of New York School of Urban Public Health at Hunter College and Harvard Medical School entitled: ''The Relationship of Health Insurance and Mortality: Is Lack of Insurance Deadly?'' That is the title of the article appearing today.

According to a summary of this article, ''Insurance decreases the odds of dying among adults by at least 3 percent and as much as 29 percent and 'being uninsured substantially raises the risk of dying.' ''

The coauthor of this article, Dr. David Himmelstein, commented:

According to the CBO, the Senate Republicans' plan would strip coverage from 22 million Americans. The best estimate based on scientific studies is that about 29,000 Americans would die each year as a result.

I know no Republican wants to see anybody die—none of us do—but that is the reality we are dealing with, and you cannot ignore it. If somebody has cancer, if somebody has heart disease and you take away their health insurance, I don't need studies from Harvard University to tell me and to tell you what you know to be the case. This is the United States of America, and we can do better than that.

Mr. President, I ask unanimous consent that the article that appeared today in the ''Annals of Internal Medicine'' be printed in the RECORD.

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

[From Annals of Internal Medicine, June 27, 2017]

THE RELATIONSHIP OF HEALTH INSURANCE AND MORTALITY: IS LACK OF INSURANCE DEADLY?

(By Steffie Woolhandler, MD, MPH, and David U. Himmelstein, MD)

(About 28 million Americans are currently uninsured, and millions more could lose coverage under policy reforms proposed in Congress. At the same time, a growing number of policy leaders have called for going beyond the Affordable Care Act to a single-payer national health insurance system that would cover every American. These policy debates lend particular salience to studies evaluating the health effects of insurance coverage. In 2002, an Institute of Medicine review concluded that lack of insurance increases mortality, but several relevant studies have appeared since that time. This article summarizes current evidence concerning the relationship of insurance and mortality. The evidence strengthens confidence in the Institute of Medicine's conclusion that health insurance saves lives: The odds of dying among the insured relative to the uninsured is 0.71 to 0.97.)

This article was published at Annals.org on 27 June 2017.

At present, about 28 million Americans are uninsured. Repeal of the Affordable Care Act would probably increase this number, while enactment of proposed single-payer legislation would reduce it. The public spotlight on how policy changes affect the number of uninsured reflects a widespread assumption that insurance improves health.

A landmark 2002 Institute of Medicine (IOM) report on the effects of insurance coverage on the health status of nonelderly adults buttressed this assumption. The IOM committee responsible for the report found consistent evidence from 130 (mostly observational) studies that ''the uninsured have poorer health and shortened lives'' and that gaining coverage would decrease their all-cause mortality.

The IOM committee also reviewed evidence on the effects of health insurance in specific circumstances and medical conditions. It concluded that uninsured patients, even when acutely ill or seriously injured, cannot always obtain needed care and that coverage improves the uptake of essential preventive services and chronic disease management. The report found that uninsured patients with cancer presented with more advanced disease and experienced worse outcomes, including mortality; that uninsured patients with diabetes, cardiovascular disease, end-stage renal disease, HIV infection, and mental illness (the five other conditions reviewed in depth) had worse outcomes than did insured patients; and that uninsured inpatients received less and worse-quality care and had higher mortality both during their hospital stays and after discharge.

At the time of the IOM report, only one adequately controlled observational study had examined the effect of coverage on all-cause mortality. In this review, we summarize key evidence on this issue (Table 1), focusing on studies that have appeared since the IOM report and other previous reviews. Although not reviewed in detail here, more recent studies generally support the earlier reviews' conclusions that insurance coverage improves mortality in several specific conditions (such as trauma and breast cancer), augments the use of recommended care, and improves several measures of health status.

METHODS

We searched PubMed and Google Scholar on May 19, 2017, for English-language articles by using the following terms: ''[(uninsured) or (health insurance) or (un-insurance) or (insurance)] and [(mortality) or (life expectancy) or (death rates)].'' After identifying relevant articles, we searched their bibliographies and used Google Scholar's ''cited by'' feature to identify additional relevant articles. We limited our scope to articles reporting data on the United States, quasi-experimental studies of insurance expansions in other wealthy nations, and recent cross-national studies. We contacted the authors of 4 studies to clarify their published reports on mortality outcomes.

We excluded most observational studies that compared uninsured persons with those insured by Medicaid, Medicare, or the Department of Veterans Affairs because preexisting disability or illness can make an individual eligible for these programs. Hence, relative to those who are uninsured, publicly insured Americans have, on average, worse baseline health, thereby confounding comparisons. Conversely, comparisons of the uninsured to persons with private insurance (which is often obtained through employment) may be confounded by a ''healthy worker'' effect: that is, that persons may lose coverage because they are ill and cannot maintain employment. Nonetheless, most analysts of the relationship between uninsurance and mortality have viewed the privately insured as the best available comparator, with statistical controls for employment, income, health status, and other potential confounders.

Finally, we focus primarily on nonelderly adults because most studies have been limited to this group, and this group is likely to experience large gains or losses of coverage from health reforms. Since the advent of Medicare in 1966, almost all elderly Americans have been covered, precluding studies of uninsured seniors. Although Medicare's implementation may not have accelerated the secular decline in seniors' mortality, the relevance of this experience, which predates many modern-day therapies, is unclear.

Children have also been excluded from most recent analyses of the relationship of

insurance to mortality. Deaths in this population beyond the neonatal period are so rare that studies would need to evaluate a huge number of uninsured children to reach firm conclusions, and high coverage rates make assembling such a cohort difficult. The few studies addressing the effect of insurance on child survival have found that coverage lowers mortality and few policy leaders contest the importance of covering children.

RANDOMIZED, CONTROLLED TRIALS

Only one well-conducted randomized, controlled trial (RCT)—the Oregon Health Insurance Experiment (OHIE)—has assessed the effect of uninsurance on health outcomes. In 2008, the state of Oregon opened a limited number of Medicaid slots to poor, able-bodied, uninsured adults aged 19 to 64 years. The state held a lottery among persons on a Medicaid waiting list, with winners allowed to apply for a slot. The OHIE researchers took advantage of this natural experiment to assess the effect of winning the lottery on the 74,922 lottery participants.

Many lottery winners did not enroll in Medicaid, and 14.1% of lottery losers obtained Medicaid through other routes (some also got private coverage). Hence, the difference in the ''dose'' of Medicaid coverage was modest, an absolute difference of about 25%; to adjust for this, the OHIE researchers multiplied outcome differences by about 4.

At 1 year of follow-up, the death rate among lottery losers was 0.8%, and the winners' death rate was 0.032% lower, a ''dose-adjusted'' difference of 0.13 percentage points annually. This difference was not statistically significant, an unsurprising finding given the OHIE's low power to detect mortality effects because of the cohort's low mortality rate, the low dose of insurance, and the short follow-up.

The findings on other health measures, obtained from in-person interviews and brief examinations on a subsample of 12,229 individuals in the Portland area, help inform the mortality results. Most physical health measures were similar among lottery winners and losers in the subsample. However, winners had better self-rated health, were more likely to have diabetes diagnosed and treated with medication, and were much less likely to screen positive for depression. Medicaid coverage was associated with a nonsignificant decrease of 0.52 (95% CI, 2.97 to −1.93) mm Hg in systolic blood pressure and 0.81 (95% CI, 2.65 to −1.04) mm Hg in diastolic blood pressure. In addition to the low dose of insurance, these wide CIs reflect the lack of baseline blood pressure data; this precludes analyses that take advantage of paired measures on each individual, which would reduce the variance of estimates.

In sum, the OHIE yields a (nonsignificant) point estimate that Medicaid coverage reduced mortality by 0.13 percentage points, equivalent to a (nonsignificant) odds ratio of 0.84.

Two older RCTs are also relevant to the effect of insurance and access to care on mortality, although neither directly compared insured and uninsured persons. In the RAND Health Insurance Experiment, random assignment to full (first-dollar) coverage reduced diastolic blood pressure by an average of 0.8 mm Hg ($P < 0.05$) relative to persons randomly assigned to plans that required cost sharing, an effect size similar to the blood pressure findings in the OHIE. Unlike the OHIE, the RAND Health Insurance Experiment obtained baseline blood pressure readings, allowing researchers to determine that for participants with hypertension at baseline, full coverage reduced diastolic blood pressure by 1.9 mm Hg, mostly because of better hypertension detection; the effect was larger among low-income (3.5 mm Hg) than high-income (1.1 mm Hg) participants.

The Hypertension Detection and Follow-up Program also suggests that removing financial barriers to primary care in populations with high rates of uninsurance may reduce

TABLE 1.—SUMMARY OF STUDIES ON RELATIONSHIP BETWEEN INSURANCE COVERAGE AND ALL-CAUSE MORTALITY

Study, Year (Reference)	Participants	Information on Baseline Health	Estimated Mortality Effect of Coverage vs. Uninsured	Comments
RCTs				
Oregon Health Insurance Experiment, 2013, 2011, 2012	74,922 nondisabled adults on waiting list for Medicaid.	Retrospective survey of a subsample; no baseline blood pressure or other measurements.	OR, 0.84 (NS)	Study was underpowered because of crossovers between insured and uninsured groups, low mortality rate, short follow-up. Coverage was associated with nonsignificantly lower (0.91 mm Hg) average diastolic blood pressure
Quasi-experimental studies, population-based				
Sommers et al., 2012, 2017	Nonelderly adults in states expanding Medicaid (Arizona, New York, Maine) and comparison states.	None at individual level; compared trends in death rates in expansion with those in neighboring states.	RR of death expansion/nonexpansion states, 0.939 (P = 0.001).	Study examined Medicaid expansions that preceded the ACA's expansions
Sommers et al., 2014	Nonelderly adults in Massachusetts and comparison counties.	None at individual level; compared trends in death rates in Massachusetts with those in matched control counties.	RR for death in Massachusetts counties/matched counties, 0.971 (P = 0.003).	The 2006 reform expanded Medicaid and implemented subsidized coverage for low-income persons
Hanratty, 1996	Newborns in Canadian provinces expanding coverage at different times.	None at individual level; compared infant mortality trends pre- vs. postreform.	RR for death, 0.95 or 0.96 (P < 0.05 for both).	Estimates varied slightly depending on how time trends were modeled
Quasi-experimental studies, clinic cohorts				
Lurie et al., 1984, 1986	186 clinic patients terminated from Medicaid vs. 109 who remained eligible.	Clinic-based data	OR at 1 y, 02.3 (NS)	Large effect probably reflects very high baseline risk. Among terminated patients with hypertension, average diastolic blood pressure increased 10 mm Hg at 6 mo vs. decrease of 5 mm Hg among controls (P = 0.003)
Fihn and Wicher, 1988	157 patients terminated from outpatient VA care vs. 74 controls.	Clinic-based data	OR not calculable from published data; per authors, ''at least 6% of terminated patients died''.	Marked deterioration in blood pressure control among terminated patients
Quasi-experimental studies using longitudinal data from the Health and Retirement Study.	Several cohorts followed for varying time periods from age ‡51 y.	Repeated questionnaires linked to Medicare records and National Death Index; no examination or laboratory data.	Conflicting results; some found lower deaths among insured, and others were null.	Studies compared mortality before age 65 y and relative changes in death rates after acquisition of Medicare eligibility. Different analytic strategies yielded different conclusions
Population-based cohort follow-up studies.				
Sorlie et al., 1994	CPS respondents 1982-1985	None other than being employed	HR for employed white women, 0.83 (NS); HR for employed white men, 0.77 (P = 0.05).	No data on smoking, health status or other nondemographic predictors of mortality at baseline
Franks et el, 1993	NHANES respondents 1971–1975	Surveys, physical examinations, and lab test results.	HR, 0.8 (P = 0.05)	Controls for baseline health status included physician-assessed morbidity
Kronic, 2009	NHIS respondents 1986–2000	Questionnaires only	HR, 0.91 (P < 0.05; without control for self-rated health) and 0.97 (NS; including self-rated health).	Control for self-rated health may bias findings because this variable is probably confounded by coverage
Wilper et al 2009	NHANES respondents 1988–1994	Surveys and physician-rated health after a physical examination.	HR, 0.71 (P < 0.05)	Controls for baseline health status included physician-assessed health status

mortality. That population-based RCT carried out in the 1970s screened almost all residents of 14 communities, with oversampling of predominantly black and poor locations. Persons with hypertension were randomly assigned to free stepped care in special clinics or referral to usual care. Although the clinics' staff treated only hypertension-related problems, they provided informal advice and ''friendly referrals'' for other medical issues. Strikingly, all-cause mortality was reduced by 17% in the intervention group, with similar reductions in deaths due to cardiovascular and noncardiovascular conditions.

Finally, a flawed RCT carried out by the Social Security Administration starting in 2006 bears brief mention. That study randomly assigned people who were receiving Social Security disability income and were in the waiting period for Medicare coverage to receive immediate or delayed coverage. Unfortunately, randomization apparently failed, with many more patients with cancer assigned to the immediate coverage than to the control group, precluding reliable interpretation of the mortality results. Interestingly, persons receiving immediate coverage had rapid and significant improvements in most measures of self-reported health.

MORTALITY FOLLOW-UP OF POPULATION-BASED HEALTH SURVEYS

Several routinely collected federal surveys that include information about health insurance coverage have been linked to the National Death Index, allowing researchers to compare the mortality rates over several years of respondents with and without coverage at the time of the initial survey. One weakness of these studies is their lack of information about the subsequent acquisition or loss of coverage, which many people cycle into and out of over time. This dilutes coverage differences and may lead to underestimation of the effects of insurance coverage.

Sorlie and colleagues analyzed mortality among respondents to the 1982–1985 Current Population Survey, with follow-up through 1987. In analyses limited to employed persons, the relative risk for death associated with being uninsured was 1.3 for white men and 1.2 for white women (neither overall figures nor those for minorities were reported).

The study's lack of data on important determinants of health, such as smoking, and its reliance on employment status as the only proxy for baseline health status weaken confidence in its conclusions.

Kronick used data from the 1986–2000 National Health Interview Surveys, with mortality follow-up through 2002. The mortality hazard ratio for uninsured versus insured individuals was 1.10 (95% CI, 1.03 to 1.19) after adjustment for demographic variables, smoking, and body mass index. The hazard ratio fell to 1.03 (95% CI, 0.95 to 1.12) after additional adjustment for baseline health, defined by using self-reported disability and self-rated health. Although the self-rated health scale is known to be a valid predictor of mortality, it may introduce inaccuracies in comparisons of uninsured versus insured persons. Recent data indicate that gaining coverage improves self-rated health, before improvements in objective measures of physical health are detectable (or plausible). This suggests that uninsurance may cause people to underrate their health, perhaps because of anxiety or the inability to gain reassurance about minor symptoms. Analyses, such as Kronick's, that rely on self-rated health for risk adjustment therefore may inadvertently compare relatively sick insured persons to relatively healthy uninsured persons, obscuring outcome differences caused by coverage. Studies that include more objective measures of baseline health should be less subject to any such bias.

MORTALITY FOLLOW-UP OF POPULATION-BASED HEALTH EXAMINATION SURVEYS

Two studies have analyzed the effect of uninsurance on mortality using data from the National Health and Nutrition Examination Survey (NHANES), which obtains data from physical examination and laboratory tests among participants.

Franks and colleagues analyzed the 1971–1975 NHANES, with mortality follow-up through 1987. They compared mortality of uninsured and privately insured adults older than age 25 years, adjusted for demographic characteristics, self-rated health, smoking, obesity, leisure time exercise, and alcohol consumption. In addition, their models controlled for evidence of morbidity determined by laboratory testing and medical examinations performed by NHANES staff. By 1987, 9.6% of the insured and 18.4% of the uninsured had died. After adjustment for baseline characteristics and health status, the hazard ratio for uninsurance was 1.25 (95% CI, 1.00 to 1.55).

Wilper and colleagues' study (which we coauthored) used data from the 1988–1994 NHANES, with mortality follow-up through 2000. The study assessed mortality among uninsured and privately insured persons age 17 to 64 years, controlling for demographic characteristics, smoking, alcohol consumption, body mass index, leisure time activity, self-rated health, and physician-rated health after the NHANES physician completed the medical examination. The study also included sensitivity analyses adjusting for the number of hospitalizations and physician visits within the past year, limitations in work or activities, job or housework changes due to health problems, and number of self-reported chronic diseases, which yielded results similar to those of the main model. In the main model, being uninsured was associated with a mortality hazard ratio of 1.40 (95% CI, 1.06 to 1.84).

QUASI-EXPERIMENTAL STUDIES OF STATE AND PROVINCIAL COVERAGE EXPANSIONS

In two similar studies, Sommers and colleagues compared mortality trends in states that expanded coverage to low-income residents (before implementation of the Affordable Care Act) with trends in similar states without coverage expansions.

Their analysis of Medicaid expansions in Maine, New York, and Arizona during the early 2000s found that adult mortality rates fell faster in those states than in neighboring ones (a relative reduction of 6.1%, or 19.6 deaths per 100,000), coincident with a decline in the uninsurance rate of 3.2 percentage points. Mortality reductions were largest among nonwhites, adults age 35 to 64 years, and poorer counties. Sommers and colleagues' subsequent reanalysis using data that allowed better matching to control counties yielded a slightly lower estimate of the mortality effect. As the authors note, the large mortality effect from a relatively modest coverage expansion may reflect the fact that Medicaid enrollment often occurred ''at the point of care for patients with acute illnesses,'' leading to the selective enrollment of those most likely to benefit from coverage.

A study of the effect of Massachusetts' 2006 coverage expansion compared mortality trends in Massachusetts counties with those in propensity score-matched counties in other states. Mortality decreased by 2.9% in Massachusetts relative to the comparison counties, a difference of 8.2 deaths per 100,000 adults, with larger declines in poorer counties and those with lower coverage rates before the expansion.

OTHER QUASI-EXPERIMENTAL STUDIES

Several researchers have used data from the Health and Retirement Study (HRS)—a longitudinal study that has followed cohorts enrolled at age 51 years or older—to assess the effect of insurance coverage on mortality. The HRS periodically surveys respondents and their families and has been linked to Medicare and National Death Index data.

McWilliams and colleagues found significantly higher mortality rates among uninsured compared with insured HRS respondents, even after propensity score adjustment for multiple predictors of insurance coverage. Baker and colleagues found that respondents who were uninsured (compared with those who had private insurance) had higher long-term but not short-term mortality. After adjustment for multiple baseline characteristics, including instrumental variables associated with coverage (such as a spouse's union membership), Hadley and Waidmann found a strong positive association between insurance coverage and survival before age 65 years. Black and colleagues suggested, on the basis of a ''battery of causal inference methods,'' that others overestimated the survival benefits of insurance and that uninsured HRS respondents had only slightly higher (adjusted) mortality than those with private coverage. Finally, studies have reached conflicting conclusions as to whether the health of previously uninsured persons improves (relative to those who were previously insured) after they reach age 65 years and become eligible for Medicare. Overall, the preponderance of evidence from the HRS suggests that being uninsured is associated with some increase in mortality.

Some studies using other data sources suggest that death rates drop at age 65 years, coincident with the acquisition of Medicare eligibility, whereas others do not.

Finally, several studies have assessed the relationship between insurance coverage and hypertension control, a likely mediator of any relationship between coverage and all-cause mortality. Lurie and colleagues followed a cohort of 186 patients who lost Medicaid coverage because of a statewide policy change and a control group of 109 patients who remained eligible. Among those who lost coverage, 5 died within 6 months (compared with none in the control group; P = .16), and the average diastolic blood pressure of those with hypertension increased by 10 mm Hg (compared with a 5–mm Hg decrease in controls; P= 0.003). At 1 year, 7 patients who had lost Medicaid and 1 control had died; blood pressure differences were slightly less marked than seen at 6 months. A similar study of patients terminated from Veterans Affairs outpatient care because of a budget shortfall found marked deterioration in hypertension control among the terminated patients relative to controls who maintained access. These clinic-based findings accord with cross-sectional population-based analyses of data from NHANES, which have found worse blood pressure control among uninsured than insured patients with hypertension.

EVIDENCE FROM OTHER NATIONS AND FROM CROSS-NATIONAL STUDIES

The United States lags behind most other wealthy nations in life expectancy and is the only one with substantial numbers of uninsured residents. Although many factors confound cross-national comparisons, a recent study suggests that worse access to good-quality health care contributes to our nation's higher mortality from medically preventable causes (so-called amenable mortality). Similarly, a recent review of studies from many nations concluded that ''broader health coverage generally leads to better access to necessary care and improved population health''.

Quasi-experimental studies assessing newly implemented universal coverage in wealthy nations have reached similar conclusions. For instance, Taiwan's rollout of a single-payer system in 1995 was associated with an accelerated decline in amenable mortality, particularly in townships where coverage gains were larger. In Canada, a study exploiting the different dates on which provinces implemented universal coverage estimated that coverage expansion reduced infant mortality by about 5% (P < 0.03).

Finally, a recent study of cystic fibrosis cohorts also suggests that coverage improves mortality. Such patients live, on average, 10 years longer in Canada than in the United States. Among U.S. patients, those without known coverage have the shortest survival; among the privately insured, life expectancy is similar to that among patients in Canada.

TABLE 2.—WHY THE CAUSAL RELATIONSHIP OF HEALTH INSURANCE TO MORTALITY IS HARD TO STUDY

Deaths, especially from causes amenable to medical treatment, are rare among nonelderly adults, who account for most of the uninsured.

Because insurance might prevent death by slowing the decline in health over several years, short-term studies may underestimate its effects.

Many people cycle in and out of insurance diluting differences between groups.

Randomly assigning participants to no coverage is unethical in most circumstances.

Observational studies must address reverse causality. Illness sometimes causes people to acquire public insurance by qualifying them for Medicaid, Medicare, or Department of Veterans Affairs disability coverage. Conversely, illness may cause job loss and resultant loss of private coverage.

In cohort studies, adequate control for baseline health status is difficult, particularly in uninsured patients, whose lack of access lowers self-rated health and also causes less awareness of important risk factors, such as hypertension or hyperlipidemia.

TABLE 2.—WHY THE CAUSAL RELATIONSHIP OF HEALTH INSURANCE TO MORTALITY IS HARD TO STUDY—Continued

Quasi-experimental studies, which exploit factors associated with coverage (such as policy changes), rest on unverifiable assumptions (e.g., that without a coverage expansion, mortality trends in states expanding coverage would parallel those in comparator state).

DISCUSSION

The evidence accumulated since the publication of the IOM's report in 2002 supports and strengthens its conclusion that health insurance reduces mortality. Several newer observational and quasi-experimental studies have found that uninsurance shortens survival, and a few with null results used confounded or questionable adjustments for baseline health. The results of the only recent RCT, although far from definitive, are consistent with the positive findings from cohort and quasi-experimental analyses.

Several factors complicate efforts to determine whether uninsurance increases mortality (Table 2). Randomly assigning people to uninsurance is usually unethical, and quasi-experimental analyses rest on unverifiable assumptions. Deaths are rare and mortality effects may be delayed, mandating large studies with long follow-up. Many people cycle into and out of coverage, diluting the effects of insurance. And statistical adjustments for baseline health usually rely on participants' self-reports, which may be influenced by coverage. Hence, such adjustments may under- or overadjust for differences between insured and uninsured persons.

Inferences about mechanisms through which insurance affects mortality are subject to even greater uncertainty. In some circumstances, coverage might raise mortality by increasing access to dangerous drugs (such as oral opioids) or procedures (such as morcellation hysterectomy). On the other hand, coverage clearly reduces mortality in several serious conditions, although few are common enough to have a detectable effect on population-level mortality. The exception is hypertension, which is prevalent among the uninsured and seems a likely contributor to their higher death rates. Although uncontrolled hyperlipidemia is also more common among the uninsured, the OHIE—the only RCT performed in the statin era—found no effect of coverage on cholesterol levels.

Finally, our focus on mortality should not obscure other well-established benefits of health insurance: improved self-rated health, financial protection, and reduced likelihood of depression. Insurance is the gateway to medical care, whose aim is not just saving lives but also relieving human suffering.

Overall, the case for coverage is strong. Even skeptics who suggest that insurance doesn't improve outcomes seem to vote differently with their feet. As one prominent economist recently asked, ''How many of the people who write such things . . . choose to just not bother getting their healthcare?''

KEY SUMMARY POINTS

In several specific conditions, the uninsured have worse survival, and the lack of coverage is associated with lower use of recommended preventive services.

The Oregon Health Insurance Experiment, the only available randomized, controlled trial that has assessed the health effects of insurance, suggests that insurance may cause a clinically important decrease in mortality, but wide Cls preclude firm conclusions.

The 2 National Health and Nutrition Examination Study analyses that include physicians' assessments of baseline health show substantial mortality improvements associated with coverage. A cohort study that used only self-reported baseline health measures for risk adjustment found a nonsignificant coverage effect.

Most, but not all, analyses of data from the longitudinal Health and Retirement Study have found that coverage in the near-elderly slowed health decline and decreased mortality.

Two difference-in-difference studies in the United States and 1 in Canada compared mortality trends in matched locations with and without coverage expansions. All 3 found large reductions in mortality associated with increased coverage.

A mounting body of evidence indicates that lack of health insurance decreases survival, and it seems unlikely that definitive randomized, controlled trials can be done. Hence, policy debate must rely on the best evidence from observational and quasi-experimental studies.

Mr. SANDERS. Mr. President, this issue is really not just about healthcare. This is a profound moral debate defining who we are as a people today and whom we want to be as a people in the future.

A great nation is not simply one judged by how many millionaires and billionaires we have and by how many tax breaks we can give to billionaires. A great nation is judged by how we treat the weakest and the most vulnerable amongst us—those people who don't have fundraising dinners, those people who don't contribute hundreds of thousands of dollars into the political process. A great nation is judged by how we treat the children, the elderly, the sick, the poor, the people who have disabilities. This is what a great nation is. This legislation is not worthy of a great nation. This legislation must be defeated.

I yield the floor.

The PRESIDING OFFICER. The Senator from Washington.

Ms. CANTWELL. Mr. President, I come to the floor to join my colleagues. We can see there are numerous colleagues on this side of the aisle who are speaking, just as my colleague from Vermont just did with great passion or my colleague from Massachusetts did with great passion and as I am sure my colleague from Minnesota will. We have all been home for the weekend talking to our constituents. We are all back here now with the CBO news, and we are here because we are very concerned about the next steps the Senate might take in this healthcare debate.

When I was at home, I heard some unbelievably positive stories about healthcare. I was at a hospital in our State, Virginia Mason, which has been one of the leaders in reducing healthcare costs by utilizing new efficiencies. They have improved the return time of getting lab results to patients by 85 percent; they have increased productivity in some areas by 90 percent; they have reduced liability insurance premiums by 76 percent. They have innovated. They have innovated. They have innovated. They talked about the direction healthcare should go, and not once did they mention cutting or capping Medicaid as a solution.

I also talked to a community health center which, under the Affordable Care Act, was actually able to expand in a community. They literally cut in half the uninsured, and they are delivering great adult dental access to thousands of people in a county that didn't have good access to dental care. They are making great progress.

I talked to a veteran who served our country, who literally got out and is now going to school but without the help of Medicaid would not have been able to cover her healthcare expenses.

I met a woman on the street who told me her husband had lost his job. She never thought they would be on Medicaid, but when he lost his job, they went on Medicaid, and they depended on that to provide healthcare for themselves and their children.

I met a gentleman who also said he, too, lost his job, and after that came down with a serious, life-threatening illness, and it was only Medicaid that saved him.

So what do we know today that is different than last Friday? We now have some CBO numbers. We know the numbers. We know the numbers: that 22 more million Americans, as a result of this bill, if it is passed, would be uninsured; 15 million of them on Medicaid; and $772 billion in Medicaid cuts. We know we thought it was heartless. Now we see the numbers that say cutting that many people off of Medicaid is, in my opinion, as my colleagues have also said, not something we should be pursuing as a nation. It leaves us to ask about not just the impact of this on individuals, as I just mentioned—because I believe there is a much better way to go with innovation—but what it also does for the individual market. A lot of this debate started because people thought the individual market hadn't seen some of the benefits of the employer-sponsored system. Well, why not talk about the individual market?

If 7 percent of the way people access health insurance, the individual market, was having a problem, why not talk about ideas to improve the individual market? Instead, we have a bill from the House and the Senate that beats up on the Medicaid population as if they are the culprit. If you want to improve Medicaid and delivery services and help decrease costs, let's do that. There are so many innovative ideas, but just cutting people off Medicaid to solve the individual market problem doesn't even make sense to me.

We now have, as of last Friday, too, the Center on Budget Policy and Priorities' assessment, talking about how this would raise individual premiums in the individual market. They gave some examples. For example, in West Virginia and Nevada, a 60-year-old with an income of $36,000 would pay respectively, $5,000 and $4,000 more than what

they are paying now. In Alaska, a 60-year-old making $45,000 would pay $5,777 more than what they are paying now for premiums. So the notion that this bill is driving down costs is just a fallacy.

We have heard from Republican and Democratic Governors talking about this. They sent us a letter saying the first thing we should do is focus on improving our Nation's private health insurance system. Where did the Governors ask that you come and beat up on Medicaid? They didn't say that. They didn't say: Please beat up on Medicaid, have a big party covering people on Medicaid as a partner with us for 65 years and then leave us stuck with the bill. They didn't say that. They say:

> Medicaid provisions included in this bill are problematic. Instead, we recommend Congress address factors we can all agree need fixing.

That is a pretty clear message, I believe, from Republican Governors who are saying this is not the way to fix healthcare.

Also, last week, a nonpartisan study by the George Washington University found that the House-passed bill would have a huge economic impact on our country. States' economies would shrink by $93 billion, compared to what they would be without the bill. Business output would be cut $148 billion. The study notes that the bill, combined with normal economic cycles ''could contribute to a period of economic and medical hardship in the U.S.''

That report also talks about job loss throughout the country, saying that individual states would see more than $1 billion in lost gross State product, just because of the number of people who wouldn't be covered, the number of healthcare providers who would no longer be there, the loss of healthcare infrastructure and then the impact on the healthcare system overall for uncompensated care. These are costs we can't afford.

As my colleague Senator SANDERS mentioned, there are all these healthcare organizations that have now come out saying they don't support this Senate-drafted bill. The Academy of Family Physicians knows about caring for the Medicaid population. They are seeing so many patients, and they know what this challenge is. The American Psychological Association doesn't support this bill. Other healthcare associations, such as the Catholic Health Association, do not support this bill. I have a long list.

Mr. President, I ask unanimous consent to have printed in the RECORD the list of healthcare-related organizations and others that don't support this legislation.

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

ORGANIZATIONS OPPOSED TO SENATE HEALTH CARE BILL

Alliance for Retired Persons, America's Essential Hospitals, American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American Association of People with Disabilities (AAPD), American Association of Retired Persons (AARP), American Cancer Society Cancer Action Network (ACS CAN), American Civil Liberties Union (ACLU), American College of Physicians (ACP), American Congress of Obstetricians and Gynecologists (ACOG), American Diabetes Association, American Federation of State. Country and Municipal Employees (AFSCME), American Federation of Teachers (AFT), American Health Care Association (AHCA), American Heart Association (AHA), American Hospital Association (AHA), American Lung Association, American Muslim Health Professionals, American Nurses Association (ANA), American Osteopathic Association, American Psychiatric Association (APA).

American Psychological Association, American Public Health Association (APHA), Association of American Medical Colleges (AAMC), Big Cities Health Coalition, Bread for the World, California Public Interest Research Group (CPIRG), Catholic Health Association (CHA), Cato Institute, Center for American Progress, Center on Budget and Policy Priorities (CBPP), Center for Law and Social Policy (CLASP), Center for Reproductive Rights, Children's Hospital Association (CHA), The Chronic Illness & Disability Partnership, Coalition on Human Needs (CHN), Commission on Social Action of Reform Judaism, Community Catalyst, Consumers Union, Cystic Fibrosis Foundation, Ecumenical Poverty Initiative.

Environmental Organizations, Families USA, Federation of American Hospitals (FAH), First Focus, Friends Committee on National Legislation, Hispanic Federation, Human Rights Campaign (HRC), Indivisible, Leadership Conference on Civil and Human Rights, Lutheran Services in America, Medicare Rights Center, MomsRising, MoveOn.org, NARAL Pro Choice America, National Advocacy Center of the Sisters of the Good Shepherd, National Alliance on Mental Illness (NAMI), National Breast Cancer Coalition, National Center for Lesbian Rights, National Center for Transgender Equality, National Committee to Preserve Social Security & Medicare (NCPSSM).

National Council on Aging (NCOA), National Council for Behavioral Health, National Council of Jewish Women (NCJW), Planned Parenthood, Presbyterian Church (U.S.A.), Service Employees International Union (SEIU), Trust for America's Health (TFAH), National Multiple Sclerosis Society, National Organization for Rare Disorders, National Partnership for Women and Families, National Physicians Alliance, NETWORK Lobby for Catholic Social Justice, Pacific Institute for Community Organization (PICO) National Network, Physicians for Reproductive Health, Society of St. Vincent DePaul, Tennessee Justice Center, The Arc, Third Way, United Church of Christ Justice & Witness Ministries, U.S. Conference of Catholic Bishops, U.S. Public Interest Research Group (US PIRG), Young Invincibles.

Ms. CANTWELL. Mr. President, I hope my colleagues understand that there are those here who are very willing to talk about how we can improve our healthcare system, but we are not going to make poor Americans the scapegoat of our healthcare challenges.

A gentleman named Joe Baker, president of the Medicare Rights Center, I think, said it best. He said:

> You or someone you love is going to need Medicaid. You may not need the nursing home care . . . but you may rely on community-based services, like home care, that will allow you to stay in your home and out of a nursing facility. Medicaid is the lifeline that covers many of the benefits that Medicare does not provide.

Now why did I read that? Why did I pick a guy who is the head of a Medicare organization? Because he knows what his individual organization participants need in a healthcare delivery system. Everybody knows—everybody knows the people of America are living longer and as they age they need more healthcare. To our colleagues who want to reduce those costs, we are ready to come and talk about how we are going to reduce those costs.

I have talked about how I authored a community-based ''rebalancing'' program—the kind of rebalancing that helped our State save more than $2 billion. If we did that in every State, we would be saving billions of dollars, but the notion that we are going to proceed in the next 24 hours or so on a motion, after we have a CBO report that says this would have a devastating impact on millions of people with Medicaid, is not the right way to go.

Taking this out on the poor people of America who need Medicaid will make it worse for us as well. It will raise our rates, return the costs to where they were, and not help us solve this problem for the future. I hope our colleagues will understand that so many people are raising so many concerns about this. Yes, it is about economics, but there are also personal stories of people, such as our colleague from Hawaii who said: You never know. You never know when an individual situation is going to affect you, and you want to make sure there is healthcare to help you get through that crisis.

Thank you. I yield the floor.

The PRESIDING OFFICER. The Senator from Minnesota.

Mr. FRANKEN. Thank you, Mr. President.

I rise to talk about the effort to repeal and replace the Affordable Care Act. Before I begin, I thank Senator HIRONO for sharing her story and for leading us all here in the discussion tonight.

I thank the Presiding Officer who has been listening, and I appreciate that. I really do.

In recent days, we have finally gotten to see the plan that 13 Republican Senators have been working on in secret and behind closed doors. I really thought the Senate bill would be better. I thought it would be better than the House version that was passed. Even Senator BURR said of the House bill that it was ''dead on arrival'' in the Senate, but, unfortunately, the Senate plan is just as bad.

The nonpartisan Congressional Budget Office announced just today that, under the Senate plan, 22 million more Americans would be uninsured. That has consequences. Perhaps worst of all—and partly because this causes the reduction in the number of Americans who would be covered—the bill ends the Medicaid expansion and cuts the

funding for the Medicaid Program by nearly $800 billion—a program that has been a vital part of our social fabric since 1965.

This bill—and I do not like to say this—is mean. The President said that of the House bill. I do not like to characterize something that way, but it is mean and would have far-reaching effects for millions of Americans across the country.

This past weekend, I hosted a healthcare forum in Burnsville, MN. It is a suburb that is south of Minneapolis, of the Twin Cities. It was on the importance of Medicaid and how the Republican plan's devastating cuts would affect Minnesotans. Over 230 people showed up to share their stories about how Medicaid changed their lives, and it was very moving.

I think it is really important to tell this in terms of people, not in terms of numbers, although the numbers are pretty stark. Brandon and his mom spoke, Brandon and Sheri. They are both from Burnsville.

Brandon was born 15 weeks premature. He weighed just 1 pound 13½ ounces. He was so small that his parents' wedding rings could slide on his arm. He was also born with cerebral palsy and hydrocephalus, which is a condition that causes fluid to collect in Brandon's brain, which results in brain damage.

Brandon, who is now 17, got up with a walker at the event. He told me that he was taken immediately to the Mayo Clinic in Rochester. He was born in the Twin Cities, but Mayo said that his case was too complicated to handle, so they sent him back to the Twin Cities, to Gillette, which is a children's hospital. It is a great children's hospital, a great hospital. Within 24 hours of his birth, the hospital told Brandon's parents that his costs were already over $1 million—a terrifying addendum to what must have been a harrowing, harrowing experience.

Over the years, Brandon has needed 38 surgeries—surgery to reduce the fluid in his brain. He has a shunt. He has had surgeries to straighten out his legs. He has had eye surgeries and more. He has also needed extensive physical therapy, occupational therapy, speech therapy, and across his lifetime, he has needed other interventions to help him do basic tasks, like eat and now walk. He could not turn over. He could not do the things that babies do, that we parents and grandparents relish in every day.

But guess what. He is thriving. In fact, he just passed his first college course at Dakota County Technical College. He proudly told me and the rest of us that he received an A-minus, and he hopes someday to get a job at Gillette, the Gillette Children's Specialty Healthcare, which is the very place that provided him with the unique and high-quality care that he has needed over the years. All of this has been possible because Brandon and his family were able to get health insurance through Medicaid.

Sheri, Brandon's mom, said: ''If we didn't have Medicaid, Brandon probably wouldn't be here''—meaning at our forum—''and he wouldn't be doing as well as he's doing.''

Brandon similarly noted:

> Kids with special needs are referred to as ''special needs,'' and I like to think I'm pretty special. I also like to think our needs are also special depending on the kind of care we need and that's what Medicaid provides.

I really believe that all of us here tonight must do all we can to protect these kids and protect their families and everyone who relies on Medicaid, and I sincerely believe that means we have to defeat this bill.

My colleague Senator HIRONO stated last week: ''We are all one diagnosis away from a serious illness.'' That is the case. Do you know what else? We are also just one accident away from a life-changing injury.

Another Minnesotan, Deborah, shared her story with my office. She described for me a car crash and the subsequent traumatic brain injury that she survived in 2012.

She explained:

> It was just another day. I was on my way to work. I lost control of my SUV after sliding on a patch of ice and slammed into a concrete median.

Her whole life changed at that moment. She had to relearn basic tasks—reading, walking, talking, and eating—but all of it was possible because of the home- and community-based services she was able to receive through Medicaid.

She said:

> Without the services funded by Medicaid, my goal of returning to paid employment would be impossible. I honestly worry that proposed changes to the Medicaid program could significantly diminish my overall health outcomes and even leave me facing long-term homelessness.

As my colleagues and people at home who are watching this debate well know, this week could prove to be an extremely consequential week in the history of this country. The decisions we make—the 100 of us—over the next few days could literally mean life or death for many Americans. Lives are on the line.

Tomorrow, I will give a speech that is more about the data, and we have heard about some of that, but there is a study in the New England Journal of Medicine that came out this week that reads that Medicaid—having the insurance—improves people's lives and that—this is not precise—for every 300 to 800 who will lose healthcare, who would lose Medicaid, there will be a premature death.

This is a study that is going to be summarized in the New Yorker, in an article by Atul Gawande, that the effect of having insurance is not about dramatic emergencies. This is especially about things like diabetes and heart illness and cancer—the day-to-day. It is about having access. Because you have insurance for care, it improves the health of people, and it extends mortality. This is real stuff. What we are doing is really serious.

I strongly urge my Republican colleagues to talk with their constituents about the bill that was drafted. Again, it was behind closed doors, and many of my Republican colleagues did not see it until last week. I urge them to talk to their constituents about the consequences this bill would have for seniors, for children, and parents who have Medicaid coverage.

Talk to the people who would see their healthcare costs rise. Talk to the families who may lose their health insurance. People are afraid.

I am a cochair of the World Health Caucus. I go all around my State. I talk to roundtables at rural hospitals and nursing homes. These are the parts of my State that voted for Donald Trump. During the campaign, Donald Trump said that he would not cut Medicaid. These are people who are scared, whose elderly parents stay home because Medicaid pays for their home healthcare, and they are afraid because that will go away. Both she and her husband work—this was a woman in Herman, MN—and they do not know what they will do.

Please, listen to your constituents. You need to do the right thing and vote no on this bill for their sake—for the sake of your constituents.

I yield the floor.

ARMS SALES NOTIFICATION

Mr. CORKER. Mr. President, section 36(b) of the Arms Export Control Act requires that Congress receive prior notification of certain proposed arms sales as defined by that statute. Upon such notification, the Congress has 30 calendar days during which the sale may be reviewed. The provision stipulates that, in the Senate, the notification of proposed sales shall be sent to the chairman of the Senate Foreign Relations Committee.

In keeping with the committee's intention to see that relevant information is available to the full Senate, I ask unanimous consent to have printed in the RECORD the notifications which have been received. If the cover letter references a classified annex, then such annex is available to all Senators in the office of the Foreign Relations Committee, room SD–423.

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

DEFENSE SECURITY COOPERATION AGENCY,
Arlington, VA.

Hon. BOB CORKER,
Chairman, Committee on Foreign Relations, U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: Pursuant to the reporting requirements of Section 36(b)(1) of the Arms Export Control Act, as amended, we are forwarding herewith Transmittal No. 17–12, concerning the Air Force's proposed Letter(s) of Offer and Acceptance to the Government of Australia for defense articles and services estimated to cost $1.3 billion. After this letter is delivered to your office, we plan