coming to the floor to recognize a special Alaskan, somebody who makes my great State a better place for all of us to live, someone we call the Alaskan of the Week, usually an unsung hero who has done great things but doesn't want anyone to tell you about it because they are humble people. Some of these people have been very well known throughout the State, and others, as I mentioned, are doing their jobs in different communities throughout the State, but they are all considered our Alaskans of the Week. Unsung, well known—they all share a love for Alaska for good reason: There is so much to love about our great State.

I know most of the people in this room and watching on TV and in the Gallery think of Alaska as a majestic place, majestic landscape. It is true. It is majestic, but it is truly the people of Alaska who make it such a special place, kind and generous people, patriots and pioneers who pave the way for the rest of us and leave a very indelible and important mark on my State and, in many cases, our country.

Today, I would like to recognize one of these very special Alaskans, a trailblazer, someone whose work has touched nearly every corner of the State, someone whom we recently lost, unfortunately, just this week, but his memory will last forever. I am talking about Gene Zerkel, who was a member of the ''greatest generation'' and an aviation legend in the great State of Alaska.

I don't have to remind you, but many others throughout our country don't know just how important aviation is to Alaska. In my State, our skies are the highways and the roads. We have about 8,000 general aviation pilots in Alaska, which is more than any other State per capita by far, and with good reason: There are no roads and ferry services to over 100 communities in Alaska, including regional centers like Bethel, Nome, Barrow, and Kotzebue. That means everything from mail services to baby diapers has to be flown in by plane, and if someone gets sick and needs to go to a hospital, the only way they get to see a doctor is by a plane.

Our pilots and our airline industry are essential to serving the people of Alaska, and Gene Zerkel has been a part of that service, a legendary part of Alaska aviation, for decades.

Let me tell you a little bit about Gene. He lived life on his own terms and defined it through love of God, family, country, and aviation. The latter—his passion for aviation—took hold when he was just 3 years old, then living in Indiana when he took his first airplane ride with a barnstormer. He was so taken with it, when he grew up, he continued to do some of those kinds of flights, traveling in airshows.

Like so many in the ''greatest generation'' in our Nation, he enlisted in the Army Air Corps during World War II and later joined the U.S. Air Force. He continued his passion for aviation after he left the military. Some of his favorite adventures were flying during the construction of the DEWLine throughout Alaska and Canada in the 1950s.

In 1973, he fulfilled a lifelong dream so many people in America have, which was to come to Alaska and start a family. He started to fly in the great skies above Alaska. We are a better State and a safer State for it.

In Alaska, he owned and operated Great Northern Airlines and became senior VP of operations and maintenance for the legendary MarkAir. He also started Alaska Aircraft Sales and Maintenance, which still operates to this day on Lake Hood in Anchorage, AK.

He was an innovator. He transformed the de Havilland DHC–2 Beaver into what was known as the Alaska Magnum Beaver, and he was known for always putting safety first.

In 2007, Gene was awarded the Wright Brothers Master Pilot Award from the U.S. Department of Transportation and the FAA in recognition of his more than 50 years—half a century—of promoting aviation safety within the aviation industry, particularly in Alaska.

Gene lived for 90 years. He saw so much and did so much for many of us. His name is written above the skies of Alaska. But most importantly, he was a devoted husband of 48 years to his wife Joyce and the faithful father of nine children.

I had the good fortune of calling Gene a friend and was able to visit with him a few weeks ago. At 90 years old, he was still full of life and spark and energy and passion and optimism. I have also been in touch recently with one of his sons, a young Alaskan hero, Keenan, who has his father's passion for serving our country, with many deployments to Afghanistan as part of the 210th Rescue Squadron of the Alaska Air National Guard. He is literally a true hero in my State. Keenan carries on his father's passion for aviation, Alaska, and serving in the military.

Gene's love of country, family, and aviation will always be with us. My wife Julie and I pray for his family and his friends during this time.

Mr. President, I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The senior assistant legislative clerk proceeded to call the roll.

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

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

HEALTHCARE LEGISLATION

Mr. CASSIDY. Mr. President, I rise to speak to the repeal and replace effort that is before us, and the challenge has been how to do so. Senator MCCONNELL has recently introduced a bill, and as we pore over it, there is much to like, but quite likely, there will be some Senators who will still express reservations as to whether this amendment adequately fulfills President Trump's campaign pledges—those pledges specifically to continue coverage, care for those with preexisting conditions, eliminate mandates, and lower premiums.

If more is required, Senator LINDSEY GRAHAM and I have actually come up with an amendment that we will add to the bill being offered. It doesn't replace it but, rather, it adds to it. In it, we return to conservative solutions that devolve power back to States and rely upon the States to, in turn, devolve power to the patient.

So what does this bill do? What we do basically is take the dollars that the Federal Government would give to a State under ObamaCare and we give those same dollars in the form of a block grant. We allow the State to then administer the money in its best way to, one, give patients the power, and two, fulfill President Trump's pledges.

We think this works. It is a 10th Amendment solution in which that which is not specifically given to the Federal Government is, in turn, given to the State. Let the States decide what they want to do. Some object. They say: Oh my gosh. A conservative State may do something that we don't think—whoever is speaking—it should be allowed to do. Another might say: Well, I don't think a liberal State should be allowed to do that. Under our bill, we devolve to the State, so a blue State can do a blue thing and a red State can do a red thing. Let's let our States be the laboratories of democracy that teach each other the best way in which to insure others. But we say it will be the State that has the power and not the Federal Government.

If you oppose this approach, it means you would trust a Washington bureaucrat more to address the needs of your State than you would trust the people of your own State.

We would still have those protections which would allow folks to get the adequate coverage they need. There would still be—for example, preexisting conditions will be covered, fulfilling President Trump's pledge to that end. We would fulfill what I call the Jimmy Kimmel test—that everybody who is ill or has a loved one who is ill would have adequate resources to have that person's illness addressed.

We have a precedent as to how this is done. Congress, I am told, when it addressed the Temporary Assistance for Needy Families Program, gave the dollars necessary, with flexibility to the States. Although at the time the solution was criticized as giving too much money to the States, since, the Federal Government has not had to put in more money. Because of the flexibility, the States have been able to use the dollars allocated in such a way as to meet the needs of the population.

So what could a State do with these dollars?

It could help those patients who are at higher risk or higher cost purchase

the coverage they need, perhaps in a reinsurance or in an invisible high-risk pool that would allow premiums to be lowered for those individuals and for all.

It could maintain status quo. Those folks getting tax credits instead could have these dollars fund their purchase of insurance. It could be used together with Senator CRUZ's amendment, which would allow a health savings account to be used to purchase health insurance. The individual could set up such an account, the State could fund it, and then these dollars could then be used to purchase insurance. I like that, personally. That particular provision was in the Cassidy-Collins bill, the Patient Freedom Act, and it dovetails very nicely with block-granting these dollars back to the States to care for someone.

It could directly contract with providers to provide assistance to a specific population. So imagine you have an Indian reservation—or if not an Indian reservation, which might be covered under another source of funding, another fairly isolated population that does not have access to healthcare, the State could say: OK, we are going to come in and provide providers specifically for that population.

Alaska may adopt this because they have 700,000 people stretched over a land mass almost as big as the lower 48, and that might be a solution Alaska comes up with, but the point being, the solution would be specific for that State. Unlike ObamaCare, in which, out of Washington, DC, Washington bureaucrats dictate that the same approach be taken across the Nation no matter how different the States are, in this, the money is given to the State, and the State is asked to provide for their citizens in a way specific for the needs of that State.

We think the Graham-Cassidy amendment returning power to States and to patients is a conservative solution which ultimately gives the patient more power. I will repeat. This does not replace that bill which is being offered by Senator MCCONNELL. It would be an amendment to that. And if it turns out that some Senators feel as if that particular bill is not adequate to fulfill President Trump's campaign promises, we think this amendment could take the bill the rest of the way.

Mr. President, I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The senior assistant legislative clerk proceeded to call the roll.

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

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

Ms. CANTWELL. Thank you, Mr. President.

I know my Republican colleagues are working on versions of the healthcare bill they have been talking about today, and I know my colleagues are going to try to say they are protecting the sickest of Americans, and they are saying they do want to ensure that people with preexisting conditions don't have to pay through the nose when they need care. I think the President called the House version of this attempt a mean bill, and I think the original Senate bill was just as mean, if not meaner, with the number of people who would be cut off of Medicaid over a period of time and left without access to care.

Today's bill also includes an amendment or a package of ideas by my colleagues from Texas and Utah—a provision that allows insurers to sell junk insurance on the individual health insurance market. As long as they offer at least one plan that is real insurance, insurers could offer a bunch of plans that, as CBO has said, are not really insurance; that is, they just cover one or two things. Yes, they would be cheaper, but if CBO doesn't consider these types of plans insurance, how are they insurance?

I think the whole notion of junk insurance being invested into this bill is very problematic. Under junk insurance plans, they can limit or deny coverage of essential benefits, including hospitalization, maternity care, preventive care, prescription drugs, laboratory care, and substance abuse treatment. That is what they can limit. We wouldn't want those limited. This is why CBO says that if you can't go to the hospital and get care, then it is not really insurance. I have to agree with them on that.

These plans could charge people more or simply deny them based on preexisting conditions, and these plans could pay out less than 60 percent of the healthcare expenses, leaving the beneficiary with unbelievable, insurmountable deductibles that would be hard to pay. These plans could also impose an annual or lifetime cap on insurance.

I had a young woman come to my office today who was treated at Seattle Children's Hospital in our State. This family actually lives in a neighboring State, but Seattle Children's Hospital is such a regional entity in the State of Washington, in Seattle, and we are so proud of that. They told me about the debilitating disease this young child was born with and how many surgeries she has had. Literally, with the brain treatments she has had to receive, she and her mother told me that if there had ever been any lifetime caps, they would have exhausted them in the first few years. I am so proud that she came to see us today and is continuing to talk about why capping healthcare plans would be so devastating to somebody like her.

We don't want to create two markets of insurance. We don't want the one that is the real plan, real insurance, and the one where everybody goes and buys insurance that even CBO says is not real insurance.

I know that probably in the last few days of discussion, people have said: Ok, we will put a bunch of money in to help the real, or regulated market. I talked to my insurance commissioner in the State of Washington, and he said: Listen, when you don't spread out risk, you are not going to have a market and you are going to create problems.

So the notion that you think that catastrophic out-of-pocket costs won't be borne by these individual patients, I think, is wrong or that these higher premiums and deductibles could be paid by these individuals. It turns out that these junk plans, as I said, do not even count as insurance, and everybody who is in the real insurance market would then end up having to pay more.

The bill explicitly states that noncompliant plans will not count as creditable coverage for the purpose of individuals demonstrating that they have insurance.

I am checking with my staff.

Is that right? Is that what is in the proposal?

Yes. The bill explicitly states that noncompliance plans will not count as credible coverage for the purpose of individuals demonstrating that they have insurance.

Under this bill, if someone gets one of those junk plans—if somehow you see that marketed and you buy into it because you think it is cheap and you think it is the greatest thing ever—and then you try to enroll in a comprehensive plan, there is a good chance that you will get a lockout period of 6 months before you can get coverage.

Why am I here talking about this? Because the State of Washington tried this. We tried this approach in the 1990s. After our State had passed a major healthcare reform bill in the 1990s, a group of State legislators allowed these junk plans to be sold along with compliant plans. Guess what happened? Nearly all of the insurers in our State pulled out of the individual insurance market, and a death spiral ensued. Why? Because the cost then of that individual market was so high and so great that they could not service it.

They said: Oh my gosh, if I have to offer a compliant plan along with this junk insurance, I cannot make the compliant plan work because it costs so much. We are not staying.

This very important experience taught us that that is not the way for us to spread risk.

I am concerned—and I have heard from a number of patient advocacy groups, not just the young woman from Seattle Children's Hospital who came to see me today but consumer groups and health insurers themselves, like America's Health Insurance Plans, Blue Cross Blue Shield Association, AARP, American Cancer Society's Cancer Action Network, American Diabetes Association, American Heart and Lung Association, Cystic Fibrosis Foundation, March of Dimes, National MS Society, National Health Council, and the National Coalition for Women

with Heart Disease. All of these organizations do not like this idea of junk insurance, of saying you can have a compliant plan that is real insurance and a marketplace in which there are things that are not really insurance, because then people are going to go buy a bunch of things that are not really insurance and then not have the ability to get cost and care and run up uncompensated care. Then you are going to make the real market unsustainable and unsupportive, and the rates are going to go so high that people are just going to pull out.

A group of 10 of those leading patient advocacy groups wrote:

> Under the amendment, insurance companies would be allowed to charge higher premiums to people based on their health status—in addition to opting out of other patient protections in current law, such as the guarantee of essential health benefits—

Those are the things I was going over a few minutes ago—

> and the prohibition on annual and lifetime coverage caps.

They go on to write:

> Separating healthy enrollees from those with preexisting conditions will also lead to severe instability of the insurance market. This is unacceptable for our patients.

Yesterday, America's Health Insurance Plans wrote:

> Allowing health insurance products governed by different rules and standards would further destabilize the individual market and increase costs for those with preexisting conditions.

That is the largest health insurance group in the country, and they are writing this.

If they are telling us in advance that this is going to really destabilize the market and cause problems, we should listen because right now what we have had is an expansion of Medicaid and covering more people, raising the GDP and helping areas of our States and country and creating more stability.

We have had some challenges in the individual market. We should fix that. We should definitely drive down the cost of the delivery system by continuing to improve it. But the notion that this is the fix for the individual market when the providers are telling us it is going to destabilize the market and drive us out—we should understand what the result of that is going to be.

Yesterday, the Blue Cross Blue Shield Association wrote:

> The result (of Cruz/Lee) would be higher premiums, increased Federal tax credit costs for coverage available on the exchanges, and insurers exiting the market or pricing coverage out of reach of consumers.

I believe our goals should be trying to drive down the cost of insurance. We have lots of ideas about that, and I want to work with our colleagues on that, but I am very concerned that this approach to try to get people supporting a Senate proposal is the wrong approach and will drive people out of the market.

I think the bill is still a war on Medicaid. The bill still permanently cuts and caps the Medicaid Program. I have said numerous times that we saved $2 billion in the State of Washington by rebalancing people off of nursing home care and on to community-based care. It is a great concept. Look, we have a lot of people who are going to live longer. We have baby boomers who are reaching retirement. The number of people who are going to demand services, whether from Medicaid or Medicare, is going to be increased just because of the population bubble. We should be doing things to drive down the costs of care.

There are great ideas, and I was able to get some of those in the bill. We ended up passing those things, and some States are actually working on that. More than 15 States are actually working on that concept of rebalancing to community-based care and making long-term care more affordable under this provision. I guarantee you that we have to do that, but if you permanently cap or cut Medicaid, you are going to have veterans who use access to Medicaid for care who are not going to get care. You are going to get people who need opioid treatment.

I find it interesting that we would have this program over here. I see that my colleague from Michigan is on the floor. We call it the Saginaw Health Clinic.

One would say: OK, Saginaw Health Clinic, there is a bunch of money in this bill. Apply for opioid help.

They would say: OK. We are going to get $10 million.

When you walk in the door of the opioid Saginaw Health Clinic, the first thing they will ask is if you are on Medicaid. If you are not on Medicaid, you are not going to get any opioid help.

So the notion that we would cut people off of Medicaid but put more money in the opioid problem is not what we need to do to solve our challenge. What we need to do is make sure we are delivering the most cost-effective care as possible and make sure people are getting access to care.

That is why I have been all over the State of Washington. I have met so many people. I have met people at healthcare facilities who have told me that some of their highest costs were from a patient who continually came to see them in the emergency room, maybe 30 times a year, because he did not have coverage, so he drove up the cost for everybody. They said they finally got this person on the Medicaid expansion. Guess what. They do not have those costs anymore in their hospitals and facilities. It has driven down the costs.

I do not want to see people kicked off of Medicaid. I do not want to see it cut in a declining budget. I want us to improve Medicaid and make it more cost-effective and more utilized and supported.

Estimates by the CBO of the original Senate bill are that the Medicaid cut would be $772 billion over the next decade and that the Federal investment would be cut by 35 percent within the next two decades, relative to current law projections. That is a lot of consequence for the Medicaid population. I think that is why we have so many groups and organizations here that are anxious about this proposal and where we go. We definitely want to talk to our colleagues.

One former CBO Director said, the junk insurance idea is ''a recipe for a meltdown.'' This is someone who served in past Republican administrations, and I take his word seriously.

I think what we need to do is work together to make sure we get a program that addresses our most fundamental issues—the challenges in the individual market, keep addressing how we keep and stabilize a population on the most affordable rates there are, and keep the things we know have worked very well, like the Medicaid expansion. It has worked. It has supported people, and it has helped us stabilize the market.

I will remind my colleagues, too, that the State of New York took one provision of the Affordable Care Act and has 650,000 people in New York on a very, very affordable insurance plan. We think that if you are an individual in the individual market, you should be able to get the same clout as somebody who works for a large employer. You should be able to go in and buy in bulk as a class, as a group of people, and when you buy in bulk, you should get a discount. That is what we think will help us in the individual market to drive down these costs for what is about 7 percent of the marketplace.

I urge my colleagues to reject this latest proposal. Let's get serious about fixing the things that we know we can fix and improve upon, but for the over 22 million Americans who are very nervous about this proposal because they know they are going to get cut off of care, let's not do that to them. Let's improve where we need to go in affordability in the healthcare arena and not think that a junk insurance program or cutting people off is the solution for the future.

Thank you, Mr. President.

I yield the floor.

The PRESIDING OFFICER. The Senator from Michigan.

Ms. STABENOW. Mr. President, first, I want to thank my friend from Washington State, who has been such a leader on healthcare.

In looking at her chart, at the junk insurance amendment and all of the groups opposing it, it reminds me of the calls I used to get prior to the Affordable Care Act from someone who was healthy and young and had a policy for years that was only $50 a month. He thought it was great. Then, all of a sudden, he got sick or his child got sick.

He called me up and said: I paid into insurance all of these years, and they only covered 1 day in the hospital.

I remember having that conversation with somebody—or no days in the hospital. That is what you call a junk insurance plan.

This latest version of the healthcare bill would allow that to come back so that somebody will have the false confidence in paying $30, $40, $50 a month and thinking he has insurance. Then, if something happens, he will find out it is just a bunch of junk and that it does not cover anything. That is going to be legal again. Right now, it is not legal to do that. With health reform, we stopped that. But that would be legal again under this proposal, and I am deeply concerned about that.

I am obviously rising to talk about the Republican healthcare bill. I do not believe it is a healthcare bill, but that is what we are debating, is healthcare or whether healthcare will be taken away. What I would rather be doing is working with my friend who is in the chair on lowering the cost of prescription drugs. We have worked on many things together—mental health and addiction services. I would rather be doing that than debating what we are debating. I would rather be focused on how we lower the cost of prescription drugs, which is the cost I hear about the most from my constituents, or about other out-of-pocket costs for people who are in the private insurance system, the individual insurance market.

We do have situations in which copays and deductibles are too high in the private insurance market. Gutting Medicaid will do nothing about that—nothing. It will just take away healthcare from tens of millions of people. It will not change the private insurance market at all, which is where I believe we need to focus, and I am anxious to do that and work across the aisle in order to do that.

I want to make sure we are talking about building on healthcare coverage, lowering costs, and tackling prescription drug costs. Instead, this bill would take away healthcare from millions of Americans. We know that from the nonpartisan Congressional Budget Office. We don't know yet how many millions under the current version, but we know that at some point, we will get a score on that from the Budget Office. We know it will be a lot of people who are going to lose their insurance, and they don't need to lose their insurance in order to tackle bringing down the cost of insurance.

So what do we know about this proposal? The versions keep changing, but it is the same old song over and over again—a little bit of change, a little bit of different refrain, but it is the same old song in the end. What we know is that doctors don't like it and nurses don't like it, hospitals don't like it, insurance companies don't like it.

People in Michigan don't like it. They have called and written and told me in person, people approaching me in Fourth of July parades. People are scared. They are concerned. A woman's mom is in a nursing home who has Alzheimer's disease, and she is panicked. Three out of five seniors in nursing homes in Michigan are there with the help of Medicaid health insurance. Others are deeply concerned about their family members, their children, themselves.

This is called the Better Care Act, but there is nothing better about it. Democrats have ideas to actually make our healthcare system better, by stabilizing our insurance markets and making premiums more affordable. My friend Senator SHAHEEN of New Hampshire introduced the Marketplace Certainty Act. It would ensure cost-sharing payments that were part of healthcare reform, that they would actually remain in a stabilizing way so they could be counted on. This would offer peace of mind to families and stability to the market.

Senators CARPER, KAINE, NELSON, and SHAHEEN introduced the Individual Health Insurance Marketplace Improvement Act, which would create a permanent reinsurance program, which we had before—before it was changed 2 years ago—to stabilize the market and bring down premiums.

There have been things that would happen to destabilize the markets. Two years ago, there was an action, and now with a new administration we need to stop that and reverse it and stabilize the markets.

Senator HEITKAMP has a proposal that helps more families afford health insurance by smoothing out the individual market tax credit cliff that is there—the tax credits that help low-income, moderate-income people be able to afford insurance—to fix that in a way that is more beneficial to families.

Senator MCCASKILL's Health Care Options for All Act would allow people who live in a county without an insurer on the exchange—they don't have anybody in the private individual marketplace exchange, no insurance company—to sign up for the same exchange plans we have. There are people being covered. We hear a lot about Iowa, for instance. Even though there may be no private insurance companies doing a private marketplace option, Senators, Representatives, our staffs who are required to be in, as they say, ObamaCare or the Affordable Care Act, have an exchange. So to help people immediately, we could allow the people of Iowa to get the same option that their Members of Congress in Iowa have and that their staffs have. That would be possible, as a way to address this issue in the short run and to help people. I don't know why somebody who is in Iowa or Michigan or anyplace else shouldn't be able to get the exact same coverage a Member of Congress can get.

Here is what we do know in terms of the ideas in the bill. Our Republican colleagues know how unpopular the bill is. A new poll found that only 12 percent—12 percent—of Americans support this bill. It is so unpopular they have been trying to rewrite it and get enough votes to pass it. We keep hearing about changes, but unfortunately none of these amendments make it better. In some cases, like the junk insurance policies that will be allowed, they actually make it worse.

Now, the proposal that would provide $45 million to tackle the opioid epidemic, even Republican Ohio Gov. John Kasich said it would be like spitting in the ocean. It is not enough, he said. I appreciate the focus on that. It is a horrible epidemic. It is an epidemic in Michigan and across the country, but it is certainly not enough to make up for the huge cuts to Medicaid insurance—healthcare insurance, as the Senator from Washington State indicated.

The other proposal that we understand is in the new bill, as I mentioned before, would give insurers the freedom to once again refuse to cover basic health services like maternity care or addiction treatment, as long as one plan they offer, among many, would include essential health benefits. So everything else could be junk, and there would be one high-cost plan that would actually cover things families need.

Insurance companies themselves know this is a terrible idea. In a letter to Senator CRUZ and Senator LEE, Scott Serota, president and CEO of Blue Cross Blue Shield Association, wrote that their plan ''is unworkable as it would undermine pre-existing condition protections, increase premiums and destabilize the market.'' That is what is viewed as this great new provision in the bill.

He added: ''The result would be higher premiums, increased federal tax credit costs for coverage available on exchanges, and insurers exiting the market or pricing coverage out of reach of consumers.''

In other words, premiums would skyrocket for older people, people who take prescription drug medications, people with chronic conditions. Everyone else would be left with the junk insurance policy that doesn't cover really anything, and they feel OK unless they get sick. We would all be stuck with a fragmented, destabilized insurance market.

Remember preexisting conditions? This would bring them right back.

This bill is wrong for many, many people, but let me mention Felicia. In 2011, she was an AmeriCorps member serving in Lansing who didn't have health insurance. When she started feeling tired all the time and losing weight, she went to the Center for Family Health in Jackson.

Felicia was diagnosed with stage IV Hodgkin's lymphoma. The Center for Family Health helped her get coverage through Medicaid and care at the University of Michigan, including chemotherapy and later a stem cell transplant.

Felicia writes:

Now I am feeling awesome. I am cancer-free, and I am working part time while I am

finishing up college. I feel that I owe my life to the Center for Family Health.

Felicia knows the importance of comprehensive health coverage. It saved her life.

Nick and Chelsey know it too. They and their three young children are covered by Healthy Michigan, our State's Medicaid expansion. Nick and Chelsey are both employed full time. Chelsey also attends college full time.

During a routine visit, doctors discovered that her oldest son was born with an obstructed kidney, which had lost one-third of its function by the time he was 5 years old. Thanks to the Medicaid expansion, he was able to have surgery before his kidney lost all function. Without the Medicaid expansion, which ends under the Republican bill, these working parents and their three children couldn't afford healthcare coverage, let alone surgery.

Margo knows this because she sees it every day. She manages a clinic in Kent County on the west side of the State. She said the lives of patients are much different today than they were a few years ago. Margo wrote:

Seeing working people who have struggled all of their adult lives to manage their chronic health conditions finally have access to regular doctor visits, health education, and prescription medications has been a tremendous relief. You cannot imagine the sense of dignity our patients feel.

She added:

Please see it in your heart to care about the people of Michigan who work but do not get insurance through their employer.

So, finally, let me just say, doctors know this is a bad bill. Nurses know this is a bad bill. Hospitals know this is a bad bill. Insurance companies know this is a bad bill. I know that even many of my Republican friends know this is a bad bill. Their amendments haven't changed that. Costs go up and care goes down. Preexisting conditions come back. Millions lose their coverage.

What we should be doing is working together to stabilize the marketplace, reduce out-of-pocket costs, and lower the outrageous costs of prescription drugs—by the way, not giving a tax cut to prescription drug companies, as is in this bill, and other companies as well.

Felicia, Nick, Chelsey, and millions more like them in Michigan and across this country deserve that much.

I sincerely hope that when it comes time to vote on whether to proceed to this bill, that the majority of the Members in the Senate will say no.

Thank you, Mr. President.

The PRESIDING OFFICER. The majority leader.

LEGISLATIVE SESSION

MORNING BUSINESS

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Senate be in a period of morning business, with Senators permitted to speak therein for up to 10 minutes each.

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

(At the request of Mr. SCHUMER, the following statement was ordered to be printed in the RECORD.)

VOTE EXPLANATION

● Mrs. MCCASKILL. Mr. President, I was necessarily absent for today's vote on confirmation of Executive Calendar No. 104, William Francis Hagerty IV to be Ambassador to Japan. Had I been present, I would have voted yea.●

HELP FOR WILDLIFE ACT

Mr. CARDIN. Mr. President, a few weeks ago, I joined Senators BARRASSO, CAPITO, KLOBUCHAR, BOOZMAN, and BALDWIN in introducing S. 1514, the Hunting Heritage and Environmental Legacy Preservation—HELP—for Wildlife Act.

This bill represents a more than $100 million annual Federal investment in the protecting the bay. The bill has several provisions, one of which reauthorizes the programs at the heart of restoring and maintaining the health of the Chesapeake Bay watershed. S. 1514 reauthorizes the U.S. Environmental Protection Agency's, EPA, Chesapeake Bay Program through 2022 at $90 million per year, which is more than the program has ever been funded in its history. This unique regional partnership, managed by EPA through the Chesapeake Bay Program office in Annapolis, helps program partners collaborate to achieve the goals of the voluntary, bipartisan Chesapeake Bay agreement. Because this program expired in 2005, reauthorizing the program is critical to secure necessary appropriations and reject the Trump administration's proposal to eliminate the program.

S. 1514 also reauthorizes the Chesapeake Bay gateways and watertrails network and the Chesapeake Bay Gateways Grants Assistance Program, which provides $6 million per year throughout the watershed in technical and financial assistance to State, community, and nongovernmental partners to increase access to the Chesapeake Bay and its tributaries. The bill also reauthorizes the National Fish and Wildlife Foundation, NFWF, until 2023. As the Nation's largest conservation grant-maker, NFWF has been instrumental in completing conservation projects in Maryland and around the Chesapeake Bay. In 2016, the State received nearly $5 million in funding for projects protecting and restoring habitat for fish and wildlife.

S. 1514 also reauthorizes the North American Wetlands Conservation Act, NAWCA, which provides grants to increase and protect wetlands which not only provide habitat for wildlife, but also reduce the severity of flooding and coastal erosion, and improve water quality. In the 2014 to 2015 grant period alone, Maryland received $1 million from the NAWCA program, which was leveraged with nearly $3 million in additional contributions by outside partners to protect 1,600 acres of wetlands in the State.

The bill reauthorizes the Neotropical Migratory Bird Conservation Act for another 5 years and authorizes $6.5 million to be spent each year on conservation projects that protect more than 350 different species of birds which summer in the United States and winter in the tropical regions. Twenty-one different State birds are neotropical migrants, including Maryland's famous and beloved Baltimore Oriole.

S. 1514 codifies the National Fish Habitat Partnership, a collaboration between public agencies, private citizens, and nonprofits for promoting fish conservation. America is home to more than 3,000 species of fish, and 22 percent of the stream miles in this country are at high or very high risk of current habitat degradation. Over the past few years, $175,000 in funds from this program were used in Maryland to rehabilitate three different streams, funding which was 27 matched by $843,000 from private investors. The partnership estimates that the improved habitat in the three streams for brook trout provided a total socio/economic impact of $9.2 million.

I am proud that S. 1514 contains so many provisions to help the Chesapeake Bay and the State of Maryland.

I would like to speak for a minute about the importance of reauthorizing these programs and the ''power of the purse.'' As my colleagues in the Senate well know, the ''power of the purse'' is the two-step process of authorizing and appropriating. Authorizing legislation can establish, continue, or change programs and activities, and it signals to the appropriators that they should fund these programs. The budget process is not complete until the appropriations process provides the actual funding for the activities and programs established through the authorization process.

Office of Management and Budget Director Mick Mulvaney has said that President Donald Trump is sending a deliberate message to Congress about spending money on unauthorized programs. With the President putting an emphasis on boosting defense spending without adding to the deficit, administration officials are looking closely at expired authorizations. By reauthorizing these programs, we are sending our own clear message back: these programs matter to our constituents and to us.

Mr. Mulvaney said lawmakers too often ignore the ''regular order'' process of approving a budget, authorizing specific programs, and then appropriating the money for those programs. ''We actually spend a lot of money in the federal government on programs that aren't authorized at all,'' he said. ''Either they used to be authorized and they lapsed, or they were never authorized in the first place. They simply were appropriated without any authorization. It's the wrong way to do it.''