This is not going to be the end of the process. This is another step along the journey toward helping to make healthcare more affordable and more accessible.

There is a lot of great work that has been done. As the Presiding Officer knows, he has been at the forefront of trying to make sure we address things like the opioid crisis, which is devastating communities across the country. I was here showing a chart yesterday that the Presiding Officer has seen, showing HIV deaths going way down thanks to modern drugs, car wrecks were still in the 30,000 range, but deaths as a result of overdoses were up around 52,000 a year, I think, is the rough number. That is a public health crisis.

We need to do everything we can to make sure we are delivering services to the people who need it most who are suffering, but if all we do is bail out insurance companies, we will not have done our job, especially toward the communities hurt by the opioid crisis.

We are going to continue to work, but at some point we are going to have to vote, and, yes, people are going to have to be put on record. Now, we are all grownups. Most of us have held political office for a fair time now. We know how to explain our votes to the voters back home, to whom we are accountable.

If you don't vote, then nobody is accountable, and everybody can blame each other for the outcome. I really do worry, unless we redouble our efforts to come up with meaningful reforms to the broken ObamaCare system, that we will be left with an untenable choice, either an insurance company bailout of the same flawed structure of ObamaCare or an immediate crisis that is going to force us to act and do the bailout without any reforms.

Mr. President, the other thing I just want to point out, in the closing minutes I wish to speak, is the process by which our Democratic friends have dragged their heels to the point of almost bringing this place to a halt, particularly when it comes to a new President getting votes on his nominees for Cabinet positions and sub-Cabinet positions. They are the first to criticize the President for not getting things done that he wants to get done, but when they sabotage his ability to try to populate these important positions in the Cabinet and sub-Cabinet positions by dragging their heels on nominations, they are causing a large part of the problem.

To put this in perspective, in 2009, 90 percent of President Obama's confirmations happened by voice vote. That is without a recorded vote, and that is without 30 hours expiring after voting and closing off the debate. This was just essentially an agreement in 90 percent of the cases.

Democrats in the Senate under the Trump administration have allowed only 10 percent of his nominees to be voice-voted. We allowed 90 percent for President Obama. We didn't agree with President Obama on a lot of things, but we agreed that he won the election, and he was entitled to populate his Cabinet and sub-Cabinet with people of his choice, assuming they weren't disqualified for some other reason.

Well, this week, we have considered Patrick Shanahan, nominated to be Defense Secretary of the Department of Defense, which is a role vitally important to the Department as it works through readiness, modernization, and of course the service to our men and women in uniform, providing them the tools and equipment and the training they need in order to protect the country. In order to accomplish that, the Defense Department needs a full team.

We spend more than $600 billion a year on national defense, and yet the President can't get his full team put in place on a timely basis because of partisan foot-dragging.

Well, it serves another purpose, I suppose, because the more we are tied up on nominations, the less time we have to deal with legislation. These kinds of tactics remind me of the former majority leader, Harry Reid, whose political schemes cost his party a 60-vote, filibuster-proof majority.

I know the distinguished senior Senator from New York, my friend, the Democratic leader, remembers that when Members of his own party can't bring back home any record of accomplishment for what they have done during their time here in Washington, it is pretty hard to make the case you should be reelected. After Harry Reid blocked participation, not just from the minority but also from the majority so they couldn't go back home and demonstrate that they had fought and accomplished things for their constituents, their party suffered a very tough political price.

So I would urge our colleagues to end this perpetual obstruction on nominations, legislation, and everything else. Noncontroversial nominees should not require days to get confirmed or judges, for that matter, should not require a 30-hour postcloture vote in order to get confirmed by more than 90 votes. That indicates it is not a controversial vote so why burn up the time except out of spite or desire to slow down this administration or this Congress in terms of getting things done.

The American people sorely want leaders at every level of our government. They are hungry for us to lead and to demonstrate we are listening to them and doing what we believe to be in their best interest, and they deserve a Senate that fulfills one of our most fundamental responsibilities, which is to consider and vote on Presidential nominees.

I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

HEALTHCARE

Mr. UDALL. Mr. President, thank you for your recognition.

Let me just say, at the beginning, I thank the Chair for the bipartisanship with which we both work on the Indian Affairs Committee. I very much appreciate that.

We are here with a few Members. I rise with my colleagues from the Senate Committee on Indian Affairs. I think Senator HEITKAMP, Senator FRANKEN, and, maybe, others will join us. I join them in reminding the Congress of its duty to Tribes and in its standing up for the healthcare of American Indians and Alaska Natives across Indian Country.

Most of us are aware of the health disparities facing Native communities. We have seen the news about the failings of the Indian Health Service, and many of us have heard directly from Tribal leaders and Native constituents about the barriers to healthcare access on reservations, pueblos, and in villages, but the Members of the Senate on the Indian Affairs Committee are uniquely aware of the complex ways that the Tribal healthcare system works and how those systems will be catastrophically disrupted by TrumpCare and the repeal of the Affordable Care Act.

The U.S. Government has a trust responsibility to provide American Indians and Alaska Natives with comprehensive, quality healthcare. The U.S. Constitution, treaties, and long-settled legal precedents are the basis for this responsibility. The Indian Health Service is the primary agency for fulfilling this obligation, but our trust responsibilities do not end there. The Medicaid and Medicare Program, Planned Parenthood, and other public health services all play key roles in the delivery of Native healthcare, and because the IHS is so consistently and severely underfunded, the ACA has made a huge difference.

Each fiscal year, the IHS receives a finite allocation of discretionary funding that it must stretch in order to meet the healthcare needs of 2.2 million Native Americans. That leaves the IHS with just over $3,500 per person—less than one-third of the national average—for healthcare spending. As a result, without additional resources, the IHS is forced to ration care, which limits Native families to hospitals and clinics that can only provide ''life and limb'' emergency medical services. Basic preventive care, like wellness visits, prenatal exams, and mammograms, have frequently been unavailable to most IHS patients.

''Don't get sick after June,'' which is the unofficial motto given to the Indian Health Service on many Indian reservations, has, tragically, become

the epitaph of too many Tribal members whose cancers have grown undetected, whose diabetes have gone untreated, and whose high-risk pregnancies have gone unnoticed. In seeing this catastrophic need for healthcare dollars, Congress enacted a series of laws that supplement IHS's resources. The Affordable Care Act is the most recent and now is the most significant.

Nearly 287,000 American Indians and Alaska Natives from 492 Tribes—almost 90 percent—have benefited from the ACA's Medicaid expansion. Another 30,000 individual Native Americans have private insurance, thanks to the ACA's individual marketplace and the Native cost-sharing subsidies. In my home State of New Mexico alone, Medicaid expansion has insured an additional 45,600 Native Americans. Thanks to the Medicaid expansion and increased access to the individual insurance market, 63 percent of IHS patients have healthcare coverage that allows them to receive care above and beyond the level of life and limb. Because of the ACA, the IHS now receives almost $1 billion to supplement its healthcare delivery, and that is an increase of 21 percent.

We can see the results. Not only are people healthier, but they are more productive. Health insurance has allowed Native Americans to finish school, return to work, and lead productive lives instead of worrying that their next illnesses could lead to an IHS referral denial or ruin them financially.

It has also improved the economy in Indian Country. The ACA has created new healthcare jobs, and it has led to the construction of new medical facilities. It has meant dialysis clinics on New Mexico pueblos, new hospitals for the Choctaw in Mississippi, and thousands of jobs for Montana's Blackfeet Indian Reservation. These are just a few examples of a nationwide trend.

TrumpCare will undo this progress. It will undo the newly expanded access to care. It will shut down those new healthcare facilities. It will freeze the economic progress of those areas. These are not just numbers and statistics. We are talking about people's lives. Individuals will be harmed by TrumpCare and the evisceration of Medicaid.

Let me tell you about Rachel, Justin, and their two children—Adalie and Jude. They are one Native family whose lives have been changed for the better under the Affordable Care Act and the Medicaid expansion. Rachel and Justin are from the Laguna Pueblo in New Mexico.

Here is a photo of them right after Jude was born in August 2015.

Before the ACA and Medicaid expansion, Rachel received hit-or-miss care from the IHS, but when she enrolled at the University of New Mexico, she was able to qualify for Medicaid because of the expansion. This meant that when Rachel and Justin decided to start a family, Rachel had access to preventive services, including prenatal and maternity care. Rachel was able to get the care she needed when she became pregnant with Adalie. Rachel's prenatal care became even more important when they decided to add to their family when Rachel was in graduate school at UNM. That pregnancy with Jude had serious complications. The doctors figured out that Rachel did not have enough amniotic fluid to support Jude, and she had to have a C-section.

Medicaid expansion allowed Rachel to complete her college education and to get a master's in public administration without her worrying about healthcare for her and her children. Medicaid expansion meant that Rachel was able to get the preventive care she needed to make sure that she and Jude were healthy.

Rachel recently got a job offer to work in her chosen field, but now that she is able to get off Medicaid, she is worried that the Republican healthcare proposals will make insurance coverage ineffective or unaffordable. Even though she lives near her Tribe's IHS facility in the Albuquerque area, she knows that she cannot depend on the IHS to guarantee critical care if insurance premiums become unaffordable. Once again, Rachel is worried about the future of her family's healthcare.

Rachel is one of thousands of Native Americans whose lives have been dramatically helped by the Affordable Care Act and who are scared that TrumpCare will leave them unable to get the healthcare that their families need in the future.

If this bill becomes law, Tribal communities will be forced back to a system of healthcare rationing. If the President and the Republican leadership eviscerate the Medicaid Program and Federal supports for public health programs, Native American lives will be lost. There is no doubt about it. Let me say this plain and simple: TrumpCare would devastate Indian Country, and it must be stopped.

Just this morning, as vice chair of the Indian Affairs Committee, I held a roundtable with Tribal leaders and Native health experts to hear more about how the Republicans' healthcare proposals would impact Tribes. I thank the leaders who came in to talk with me and my colleagues on the committee. Senator FRANKEN, Senator HEITKAMP, Senator TESTER, and Senator CANTWELL were there.

All came to hear these Native leaders, and their insight into the damage this bill could do to Native communities was profound. The Turtle Mountain chairman from North Dakota reported that ''don't get sick after June'' is no longer true on his reservation because of the ACA and Medicaid expansion. Panelists warned that the rollback of Medicaid would be devastating to Tribal members, and a representative from the San Felipe Pueblo reminded us that Indian health is not an entitlement; it is an obligation.

Now the Republican leader and the President are moving in an even more dangerous direction. They are pushing to repeal the ACA without having any replacement, which would strip healthcare from over 30 million Americans. It would devastate anyone who is sick today, anyone who relies on insurance one gets through the Medicaid expansion or the Affordable Care Act, and it sets up a disaster for anyone who might get sick after its repeal because it would destabilize insurance markets and would throw our economy into turmoil, killing up to 50,000 jobs in New Mexico alone. As often happens with policies that hurt the most vulnerable, Indian Country would be hit the hardest.

Traditionally, the Senate has worked on a bipartisan basis to address Native American issues. That tradition must continue now. We must work together to find a sustainable solution so that Native Americans can get affordable, quality healthcare when they need it.

Mr. President, I ask unanimous consent that a copy of a letter from the National Congress of American Indians, National Indian Health Board, National Council on Urban Indian Health, and the Self-Governance Communication and Education Tribal Consortium sent to Republican leadership on June 27, 2017, and shared with the Senate Committee on Indian Affairs be printed in the RECORD. This is just one example of the many such letters sent to the Senate over the last few months, and I will submit those additional letters as part of the record at our next Indian Affairs Committee Hearing.

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

JUNE 27, 2017.

Re Tribal priorities in Senate healthcare reform legislation.

Hon. MITCH MCCONNELL,
The Capitol,
Washington, DC.

DEAR SENATOR MCCONNELL: On behalf of the National Indian Health Board (NIHB), the National Congress of American Indians (NCAI), National Council on Urban Indian Health (NCUIH), Self-Governance Communication and Education (SGCE), and the Tribal Nations of the United States we serve, we write to convey and explain our strong and united opposition to the Senate's Better Care Reconciliation Act of 2017 (BCRA) in its current form.

While the legislation mirrors several provisions of the House bill that are of critical importance to Indian Country, we have grave concerns about other aspects of the BCRA that make it impossible for us to support the legislation in its current form. Specifically, we cannot support legislation that would gut the Medicaid program or eliminate cost-sharing protections for American Indians and Alaska Natives (AI/ANs). Most importantly, we request that the legislation:

1) Maintain Medicaid funding based on need, rather than capping it according to a complicated per capita allocation formula or through capped block grants.

2) Continue Medicaid Expansion, and at the very least, continue Medicaid Expansion for AI/ANs

3) Protect AVANs from barriers to care that are inconsistent with the federal trust responsibility, such as work requirements under Medicaid

4) Retain cost-sharing protections at Section 1402 of the Patient Protection and Affordable Care Act (ACA); and

5) Maintain funding for preventative services, including the Prevention and Public Health Fund and women's health services.

As you know, the federal government has a trust responsibility, agreed to long ago and reaffirmed many times by all three branches of government, to provide healthcare to Tribes and their members. Both Medicaid and IHS funding are part of the fulfillment of the trust responsibility.

However, the federal government has not done its part to live up to the responsibility to provide adequate health services to AI/ANs. IHS funding is discretionary and is appropriated every year and distributed to IHS and Tribal facilities across the country. But IHS appropriations have been about 50% of need for decades, and Medicaid revenue is essential to help fill the gap. When demand for services is higher than the funds available, services must be prioritized and rationed. As a result of this chronic underfunding, historical trauma, and a federal-state centric public health system, AI/ANs suffer from a wide array of health conditions at levels shockingly higher than other Americans. Nationally, AI/ANs live 4.5 years less than other Americans, but in some states life expectancy is 20 years less. This is not surprising given that in 2016, the IHS per capita expenditures for patient health services were just $2,834, compared to $9,990 per person for health care spending nationally. The Senate should pass reform legislation only if it does not reduce access to care for AI/ANs, or further strain the already stretched resources of Indian Health Service, Tribally-operated, and urban Indian health programs (collectively called the ''I/T/U'').

MEDICAID

Cuts to the Medicaid program outlined in the BCRA are especially troubling. Under a block grant per-capita system, States will experience a dramatic reduction in federal funding for their Medicaid programs. Most will have to either reduce eligibility for the program or reduce or eliminate benefits that are essential to many AI/ANs. Medicaid is a crucial program for the federal government in honoring its trust responsibility to provide healthcare to AI/ANs. Because health care services are guaranteed for AI/ANs, cuts in Medicaid only shift cost over to the IHS, which is already drastically underfunded. Put simply, without supplemental Medicaid resources, the Indian health system will not survive.

AI/ANs are a uniquely vulnerable population and uniquely situated in the Medicaid program. Unlike other Medicaid enrollees, because of the federal trust responsibility, AI/ANs have access to limited IHS services to fall back on at no cost to them. As a result, Medicaid enrollment and utilization incentives are completely different for AI/ANs in Medicaid. Medicaid conditions of eligibility designed to ensure that beneficiaries have ''personal investment'' do not work when mandatory in Indian country. Instead of participating in these programs, many AI/ANs will simply choose not to enroll in Medicaid and fall back on the underfunded IHS instead. This will deprive Tribal and urban programs of vital Medicaid revenue and strain limited IHS resources to the breaking point.

Medicaid is a crucial program for the federal government to fulfill the trust responsibility. Over 40 years ago, Congress permanently authorized the IHS and Tribal facilities to bill Medicaid for services provided to Medicaid-eligible AI/ANs to supplement inadequate IHS funding and as part of the federal trust responsibility. At the same time, because Congress recognized that ''. . . it would be unfair and inequitable to burden a State Medicaid program with costs which normally would have been borne by the Indian Health Service,'' it ensured that States would not have to bear any such costs, by providing that States would be reimbursed at 100 percent Federal Medical Assistance Percentage (FMAP) for services received through IHS and Tribal facilities.

The Senate Finance Committee, which has primary legislative responsibility for the Medicare and Medicaid programs, adopted a similar reimbursement provision as a part of H.R. 3153, the Social Security Amendments of 1973. In its report on the legislation, the Finance Committee justified the 100 percent FMAP by noting:

'' . . . that with respect to matters relating to Indians, the Federal Government has traditionally assumed major responsibility. The Committee wishes to assure that a State's election to participate in the Medicaid program will not result in a lessening of Federal support of health care services for this population group, or that the effect of Medicaid coverage be to shift to States a financial burden previously borne by the Federal Government.''

In light of this legislative history, Tribes are pleased to see the 100 percent FMAP preserved in the BCRA. As the Senate considers this proposed legislation, please ensure that this remains in place. In addition, because the federal trust responsibility also follows AI/ANs off of reservations, 100 percent FMAP should also be extended to services provided through urban Indian health programs (UHIPs).

With regard to Medicaid, we respectfully request that the Senate:

1) Continue to Fund Medicaid Based on Need without Caps

Medicaid is an important tool through which the federal government uses to fulfill its trust responsibility to provide for Indian health care.

The cuts proposed by Sections 133 and 134 of the BCRA would be devastating to Tribal and urban health programs. BCRA would make cuts to Medicaid that are even higher than those proposed by the House of Representatives. BCRA's caps are tied to a lower inflation factor beginning in 2025 that would result in even higher cuts to State Medicaid plans.

We were encouraged to see that BCRA contains provisions that would prevent the cost of care provided to AI/ANs from counting against either a per capita cap or a block grant. However, we request that urban Indian health programs be included in the exemption as well. Faced with the cuts proposed in Sections 133 and 134 of the bill, most States will be forced to make cuts to eligibility and/or services in future years. This will affect all providers and recipients, including Tribal/urban providers and AI/AN patients. This will lead to significant cuts in Medicaid revenues for I/T/Us, and will threaten our ability to provide healthcare services to our people. The Indian healthcare delivery system will not succeed if faced with the cuts proposed in BCRA.

To the extent that the Senate bill maintains such dramatic caps, it should work with Tribes to develop a mechanism to exempt reimbursements for services received through IHS/Tribal/Urban facilities from any State-imposed limitations on eligibility or services that may result from these caps. Such reimbursements would be covered by 100 percent FMAP and therefore will not affect State budgets.

We also request language be added to the bill that requires States with one or more Indian Tribes or Tribal health providers to engage in Tribal consultation on a regular and ongoing basis, and prior to the submission of any Medicaid or CHIP State Plan Amendment, waiver applications, demonstration projects or extensions that may impact them as Medicaid providers or their Tribal members as Medicaid recipients.

2) Preserve Medicaid Expansion

Medicaid Expansion has increased access to care and provided critical third-party revenues to the Indian health system. The uninsured rate for Native Americans has fallen nationally from 24.2% to 15.7% since the enactment of the Affordable Care Act, due in large part to Medicaid Expansion. This has resulted in health care services to AI/AN people who might not have normally received care. It has also resulted in saved revenues to the Medicaid program through preventing more complex and chronic health conditions and saved the Medicaid program money. Medicaid Expansion has increased Medicaid revenues at IHS/Tribal/Urban health programs that are being reinvested back into both the Indian and the larger national health care system.

The BCRA would roll back federal funding Medicaid Expansion by 2024. The Senate should preserve Medicaid Expansion as an option for States on a permanent basis. While BCRA contains important provisions designed to equalize funding between Expansion and non-Expansion States, we are concerned that the funding made available to non-Expansion States is insufficient to match that which has been provided to Expansion States. At the very least, Expansion should be retained for the AI/AN population under a special Medicaid optional eligibility category for State Plans in recognition of the federal trust responsibility.

3) Exempt AI/ANs from Work Requirements

The BCRA would allow the States to impose mandatory work requirements as a condition of Medicaid eligibility, and incentivize States that impose such requirements with a 5 percent increase in FMAP to reimburse them for the administrative costs of implementing such a requirement.

As noted above, mandatory work requirements will not work in Indian country because the incentive structures are completely different. Unlike other Medicaid beneficiaries, AI/ANs have access to IHS services. If work requirements are imposed as a condition of eligibility, many AI/ANs will elect not to enroll in Medicaid. As a result, rather than encouraging job seeking or saving program costs, mandatory work requirements will discourage AI/ANs from enrolling in Medicaid and place pressure on the already underfunded INS. Further, cash jobs are scarce or non-existent in much of Indian country, making work requirements impossible to meet and job training programs an exercise in futility.

Tribes fully support work programs and employment, but we believe such programs should be voluntary so as not to provide a barrier to access Medicaid for our members. Again, this is consistent with over 40 years of Medicaid policy for Indian Country. To the extent it considers imposing work requirements, the Senate should exempt AI/ANs from any work requirements.

MARKETPLACE

We also ask that the Senate amend the BCRA to maintain cost sharing protections for AI/ANs. These protections were included for AI/ANs in fulfillment of Congress and the United States federal trust responsibility to provide health care to Indians. Section 208 of the BCRA would repeal the cost-sharing subsidy program established by Section 1402 of the ACA. However Section 1402(d) of the ACA also includes important and critical cost sharing protections for AI/ANs who have incomes at or below 300 percent of the federal

poverty level, or who are referred for care through the IHS Purchased/Referred Care (PRC) program. These cost-sharing protections incentivize AI/ANs to sign up for health insurance and also make it affordable. Eliminating them would create a disincentive for AI/AN to sign up for insurance, since they already have access to IHS services. This would result in less third party reimbursements for the Indian health system and have a destabilizing effect on the system's ability to provide health care to AI/AN people. Dollar-for-dollar, leveraging cost sharing protections for AI/ANs and thereby encouraging insurance coverage is a very efficient means of moving the needle forward in meeting the federal trust responsibility for health care resources.

PREVENTION SERVICES

We are also deeply concerned by the proposed reduction of prevention services in the legislation. The elimination of the Prevention and Public Health Fund will cripple Tribes' efforts to support public health initiatives. Many Tribal health programs rely on PPHF directed funding to keep their public health systems operational. Unlike states, Tribes must piece together a patchwork of funds, some of which are derived from the PPHF, to administer basic prevention services. Additionally, the reduction in funding for women's health services around the country will have major impacts on Tribal members, especially those who do not have direct access to services on or near their reservation. The Senate should restore cuts to the preventative services in the legislation.

Tribes support the inclusion of state funding to address the opioid crisis. However, states do not often pass these funds to Tribes. Drug-related deaths among AI/ANs is almost twice that of the general population. To address this problem, Tribes should either receive direct federal funding to address the opioid crisis, or states should be required to engage in state-Tribal consultation on the use of funds appropriated for the states.

In conclusion, the undersigned organizations must oppose the BCRA in its current form. We could support the legislation only if needs-based finding for Medicaid is preserved, Medicaid Expansion is continued, and the other changes outlined above are made to the bill before passage. In fulfillment of the trust responsibility, current exemptions for AI/ANs from health insurance premiums, co-pays, and cost sharing must be preserved, and Medicaid-eligible AI/ANs must be allowed access to the program without further requirements attached to ensure additional burden is not placed on very limited IHS appropriations. Tribes across the country are eager to come to the table to discuss how shortcomings in the current healthcare system can be addressed, without wreaking immeasurable harm on our health programs and the people we serve.

If you have any questions please do not hesitate to contact NIHB's Executive Director Stacy A. Bohlen.

Sincerely,

VINTON HAWLEY,
Chairperson, National Indian Health Board.
ASHLEY TUOMI,
President, National Council on Urban Indian Health.
BRIAN CLADOOSBY,
President, National Congress of American Indians.
W. RON ALLEN,
Board Chairman, Self-Governance Communication & Education Tribal Consortium.

Mr. UDALL. Thank you, Mr. President.

While this small effort cannot fully replace the necessary government-to-government consultation we owe Tribes on this issue, I hope it reminds us of our Federal obligations to Tribes and to all Native Americans. TrumpCare would turn back the clock. It would violate our trust responsibilities. It would endanger the lives of Native families. We cannot let that happen.

Senator FRANKEN has been such an advocate on the Indian Affairs Committee for Tribes in his State and across the Nation. All of us have worked extensively to try to improve a situation about which, many times, we hear from Tribal members is despairing. I really appreciate his effort and thank him for coming to the floor today and participating in this discussion about Indian healthcare and what these Medicaid expansions mean.

I yield the floor to my colleague and friend from the great State of Minnesota, Senator FRANKEN.

The PRESIDING OFFICER. The Senator from Minnesota.

Mr. FRANKEN. Thank you, Mr. President.

I thank my vice chairman of the Indian Affairs Committee, and I thank the Presiding Officer, who chairs the committee. I am honored to serve under both of them.

I rise to discuss the devastating effects the various Republican healthcare proposals that have been made would have on Indian Country.

Republicans are now considering a straight repeal of the Affordable Care Act, with no replacement. This policy, like others that have come before it, would have a devastating effect on Native communities. Today, I want to describe some of the healthcare challenges that these communities face, how the Affordable Care Act has helped to address some of those challenges, and how repealing the Affordable Care Act would undermine these gains and further jeopardize healthcare for an already vulnerable population.

I have served on the Indian Affairs Committee for the past 8 years, and I am continually shocked by what I hear almost every week from Tribal leaders and other witnesses about the challenges that face Native communities. One of the biggest challenges is that the Federal Government consistently falls short of its responsibilities to Indian communities. There is a lack of attention to the concerns of Native communities. There is a dysfunctional bureaucracy and a Congress that doesn't adequately fund Indian programs, and this can create a vicious cycle. When programs don't have adequate funding, they don't work as they should.

Some of my colleagues who have failed to provide Indian Country with the funding they need point to the resulting program inefficacies as justification for continuing to cut and underfund critical programs. That just doesn't make sense to me. Healthcare has fallen prey to this vicious cycle even though the Federal Government has a trust responsibility to provide healthcare to Tribes and to their members.

Medicaid and the Indian Health Service are both part of this trust responsibility. Over the years, the Indian Health Service has suffered from lack of resources, poor staffing, and other challenges. The vice chairman was right: ''Don't get sick after June'' is unfortunately something we hear over and over again, and it is said with some irony but also hurt in Indian Country because the funding runs out then.

These challenges mean that many in Indian Country, particularly those living in remote areas, don't have reliable access to the medical care they need on a timely basis. This is healthcare that was promised by treaty and by our Constitution.

Prior to the ACA, funding shortages meant that IHS was only able to provide people with the most basic services, so a lot of the care that people needed was simply not available. For example, prior to the passage of the Affordable Care Act, the Indian Health Service could not afford to provide vital services, including women's health screenings, like mammograms, or basic diabetes care. If you suffered from diabetes, you often had to wait until dialysis was required or limb amputation was needed before being able to receive care. That is just unconscionable. That is terrible. What is more, American Indians and Alaska Natives were more likely to be uninsured than non-Native populations, which meant that many people who needed care that wasn't covered by the IHS simply went without.

The ACA helped change all of this for the better. First, the ACA gave States the option to expand their Medicaid Programs to include low-income adults without dependent children. Thanks to Medicaid expansion, 11 million Americans, including more than 290,000 American Indians and Alaska Natives, were able to get health insurance. The ACA's Medicaid expansion made it possible for an estimated 60 percent of uninsured American Indians and Alaska Natives to qualify for healthcare coverage.

This expansion, coupled with other Medicaid policy reforms, such as those that simplified the enrollment process, helped increase the total number of people covered under the program. In fact, IHS reported earlier this year that 42 percent of patients receiving services—of those who receive the services—did so because they had coverage through Medicaid. That is what the Indian Health Service said. Forty-two percent of those who received healthcare services did so because they are covered by Medicaid. In Grand Portage, which is a beautiful spot on the

northeastern corner of Minnesota, this meant that well over 20 more band members, many of them children, received coverage. We know from a recent report out of Georgetown University that, nationwide, 54 percent of children in American Indian and Alaska Native families were enrolled in Medicaid in 2015, compared to 39 percent of all children.

This program has been a vital source of coverage, and, with health insurance coverage, people have finally been able to access the healthcare they need. That is what healthcare is really about. Healthcare is about having coverage so that you have routine visits for primary care. So if you are diabetic, you have routine visits. It is not about the emergency heroic event; healthcare is about the constancy of care. That is what improves people's health. That is what improves their lives.

Another way the ACA helped improve healthcare for Native populations was by transitioning the IHS to be the payer of last resort. By establishing that Medicare, Medicaid, and private insurance would be the primary payers, the ACA ensured that there was more money going to provide a wider range of services that people needed, while simultaneously reducing the financial burden on the IHS.

Yet there is more that we need to do to strengthen the Affordable Care Act and improve rates of coverage and access within Native communities. For example, we need to do more to address workforce shortages and lack of competition in insurance markets in rural areas. The Presiding Officer knows that. Also, it is imperative that we tackle the opioid epidemic in Indian Country. But recent Republican efforts to repeal the Affordable Care Act will do nothing to address these outstanding needs and would undermine the recent health and coverage gains Tribal communities have been able to achieve. I know the last bill had money targeted at opioid treatment, but it wasn't anywhere near what will be taken away when the Medicaid expansion and cuts to Medicaid are figured in.

The Republicans' proposals would hurt Indian communities in a number of important ways.

First, they would cause tens of millions of people, including many American Indians and Alaska Natives, to lose coverage, with between 15 million and 18 million Americans losing coverage immediately. For example, Republican plans would end the Medicaid expansion, as I have said, which has been central to providing health coverage to many in Native communities.

Second, they would jeopardize the sustainability and stability of the individual market, while giving huge tax breaks to powerful corporate interests.

Finally, they would increase premiums and reduce subsidies that low-income people receive to help pay for their healthcare, which would put private health coverage out of reach for so many.

Efforts to repeal the Affordable Care Act are just bad for Native communities and bad for the country as a whole.

As many of my colleagues know well, American Indians and Alaska Natives are twice as likely, as compared to non-Hispanic Whites, to be overweight, obese, diagnosed with diabetes, and experience hopelessness and depression. In Minnesota, American Indian women are also more likely than Whites to be diagnosed with maternal opiate dependency during pregnancy, and more children are born opioid dependent. Reducing coverage and driving up healthcare costs is the last thing these communities need.

Indian Tribes in Minnesota and in North Dakota and in all of our States are grappling with challenging and complex healthcare needs. They need our help. They don't need legislation that is hastily put together for ideological reasons. They don't need policies that undercut their care and livelihood.

I believe we need to work together across partisan lines. I really hope that is what we are going to do.

The Republican healthcare plans that have been put forward so far break the Federal Government's trust responsibility and undermine the very programs that are helping Indian communities. That is what I sincerely believe.

I urge my colleagues to reject Republican efforts to repeal the Affordable Care Act and instead work with us on a bipartisan basis, in regular order, with hearings before our committees, to strengthen care options for our Native communities and for all Americans. I believe we can do that, and I believe we can work together. It is just the right thing to do.

Thank you, Mr. President.

I yield to the vice chairman of the Indian Affairs Committee, the Senator from New Mexico.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. UDALL. Mr. President, we have been joined by Senator HEITKAMP of North Dakota. I appreciate her work on the subcommittee, her incredibly hard work and hard dedication that she has put in. She has been a champion for her Tribes in North Dakota, a champion for Native children and Native women, and a champion for Native Americans across the country.

I yield to Senator HEITKAMP.

The PRESIDING OFFICER. The Senator from North Dakota.

Ms. HEITKAMP. Mr. President, I think that anyone who picked up the Wall Street Journal over the last couple of weeks and read the stories about Indian health and what is happening, especially in our region of the world in the Great Plains—it shocked the conscience. It should have resulted in a prolonged level of outrage that would bring us all together.

Unfortunately, we have seen this movie one too many times. Things happen where we see national stories about challenges in Indian Country, about the failure to fulfill commitments under treaty rights. We see despair. We see the incredible rates of poverty, the incredible rates of unemployment, even in a State like ours where unemployment rates are never the issue. We wonder, why isn't something being done? Guess who wasn't shocked. Those of us who serve on the Indian Affairs Committee.

We on the committee spent a lot of time looking at this last year, trying to figure out how we could engage the bureaucracy to be more responsive and more responsible and how we could look at sourcing the dollars we needed to make sure that Indian health was supplemented and that the level of care we expect when we walk into our hospitals—that that is the level of care Native American people who go to the Indian Health Service on their reservations and who might go to an Indian run, a Tribal run facility, would expect. That is what we expect, and I think that is what the American public might think is actually going on, but those of us on the committee know differently.

We held a roundtable today to talk about what those challenges are, what Native American leaders believe are those challenges, and to ask them a simple question: What has Medicaid expansion meant to your Tribes? What does access to Medicare and Medicaid mean for delivery of healthcare services?

I want to start off by saying that they have a lot of great ideas, and I will run through some of these.

Chairman Keplin from Turtle Mountain said: We need local doctors. It is hard to get people to live on the reservation if they are not from the reservation, so we need to figure out how we are going to get local folks to be trained, and we are willing to do that in our Tribal colleges. We need to build relationships with other healthcare providers, like Sanford, that can bring specialists. We need our cancer infusion center to be there so that people can get cancer treatment right at home. And we need to make sure we are doing everything we can to make sure we can treat diabetes right there at home.

So the healthcare challenges were amazing, but the cost challenges were also amazing.

Duane from Pueblo in New Mexico had some very interesting perspectives. Eighty percent of his patient load comes to the clinic. They speak their Native language. They have had stability in their workforce, but they are looking at transitioning to a Tribal facility. But those people don't want to transition because of Federal retirement. So is there something we can do to keep these treasured healthcare providers working for the Tribe and working for their people—the people who know the language and who are familiar with the case studies?

Lincoln from Alaska said: One of our biggest problems is year-to-year funding. The VA has 2-year funding. We don't know what the money is going to be and when it is going to come. We also need to train local people.

Sam said: We have a huge need to continue to build out our cultural resources and our attention to culture and prevention.

Ron from Washington talked a lot about the recruitment of workforce. The employer mandate came up because so much of the employment on the reservations is in fact Tribal members. They are talking about that they are mandated to buy this health insurance, but these same members have a treaty right to that healthcare. Is there a way to help those stretched Tribal resources go a little further by taking a look at some relief from the employer mandate?

The definition of what constitutes an Indian came up over and over.

From Massachusetts, Cheryl talked about permanent reauthorization of Indian healthcare and more resources in diabetes, because that is a pervasive problem, and Indian employment, again, talking about that issue of buying health insurance.

As to marketplace access for Native American enrollees who are not living on the reservation, how do they make sure they are able to get their treaty rights?

Talking about mental well-being and talking about culture is prevention. One of my favorite lines that came out of this was when we asked about prevention, and Ashley said: Culture is prevention. We need better access to 1115 waivers. Take a look at the Canadian model, she suggested. They do more with cultural sensitivity.

The list goes on and on of great ideas. Not one of these ideas said: Repeal the Affordable Care Act. Not one of them said: Let's get rid of Medicaid expansion; let's not look at what we can do.

Let's just all acknowledge what we who serve on this committee know: We have challenges that far exceed many other populations. We have come to the floor to talk about how the repeal of the Affordable Care Act and how the Republican healthcare bill would hurt different populations. We have talked about the elderly. We have talked about children with disabilities. We have talked about rural communities. We have talked about many, many more folks. I think we haven't done enough to talk about what this means for Indian people.

We have a special relationship with Indian people in my State because every Tribe in my State is, in fact, a treaty Tribe with a treaty right to healthcare.

Last night, it obviously became clear that the bill, as it stands, wouldn't get enough votes to move forward. But we need to keep talking about this bill, and we need to keep talking about what the questions are. Instead of talking about this bill or that bill or all of the acronyms, let's start with healthcare. Let's have a conversation about healthcare that starts with healthcare. Where are we doing it right? Where are we doing it wrong? How can we reduce costs? Who is being left behind?

It is clear to me that in the healthcare world—never mind the Affordable Care Act or the Better Care Act, whatever the Republican bill was called. That is a discussion for politics. That is not a discussion for healthcare. So let's talk about what Native Americans need. Let's talk about how we have failed.

As I said earlier today, Senator UDALL led a really important discussion about how we need to preserve Medicaid. When we look at the Indian Health Service, I think anyone who really looks at the numbers has to admit that it is chronically underfunded.

Last year, I brought the former IHS Director to North Dakota to press her on maintaining quality care in our Tribal communities. This was especially important because of the severe challenges Indian healthcare has. We know that the lack of funding for Indian healthcare can be critically augmented by three main sources: Medicaid, Medicare, and private insurance. If every person walking in has the ability to pay, we are going to improve access to care, and we are going to improve the opportunity to recruit a workforce.

I think some people may roll their eyes when they say: Don't get sick in June. My husband is a family physician and practices about 60 miles north of the Standing Rock Sioux Tribe. He can tell you that there have been times when people from the reservation have come to the clinic to see him because the clinic in Fort Yates is shuttered—no money that day, no opportunity for healthcare. So people come to get the healthcare they need, but they have to drive a long way. It is wrong. You see a new doctor whom you have never seen before and who may not, in fact, understand your condition.

So the Turtle Mountain Band of Chippewa, who are represented today, have over 33,000 enrolled members, of which approximately 14,500 actively receive treatment and benefits for services at the local IHS hospital. Thanks to Medicaid expansion and increased enrollment efforts by the Turtle Mountain Band of Chippewa in my State of North Dakota, their Indian Health Service hospital is now able to offer so much more in services to their people and increase their outreach and prevention.

In June alone, Turtle Mountain's IHS clinic served nearly 13,000 clinical patients and provided over 1,000 emergency room services. Third-party billing revenue has now allowed the Tribes to make renovations to their emergency room and their clinic, to purchase new medical equipment, including neonatal monitors, to recruit and hire additional staff, including licensed professionals, to increase staff training and education, to provide Wi-Fi throughout the hospital, and to expand their behavioral healthcare facility to serve more patients.

Since the Medicaid expansion, they have had a 9-percent increase in the number of individuals they have served. Their hospital is also experiencing a decrease in the number of uninsured patients—still too high, in my opinion, at 39 percent. We can get that lower if we get more people to take advantage of Medicaid expansion.

But, unfortunately, a Republican healthcare plan that would eliminate cost-sharing subsidies is making that private health insurance less affordable and less successful.

So let's be honest about how we are affecting our Native American population and talk about the multiple times this expansion has been so important to our Native families.

In North Dakota, the Republican bill would cause an estimated 984 Native Americans to lose cost-sharing reduction subsidies. The Senate Republican healthcare bill would also get rid of the Medicaid expansion and cap the amount of Federal funding States can get to cover those on traditional Medicaid. As a result, it would drastically reduce the amount of Medicaid funding going to the States. This would push the remaining costs to the States and counties that can't afford it.

The American Hospital Association estimates that North Dakota Medicaid would lose $1.2 billion. I will say that again. North Dakota Medicaid would lose $1.2 billion through 2026.

Right now, 9,000 North Dakota children and individuals with disabilities—Native Americans, seniors, and low-income families—rely on Medicaid for affordable, quality care, but this bill would rip it away in so many wrong ways.

The uninsured rate for Native Americans has fallen nationally from 24 percent to 15 percent, largely due to Medicaid expansion.

We go on and on. Currently, Medicaid accounts for 24 percent of the Indian Health Service workforce. The Senate Republican bill would strip away $772 billion from Medicaid, and the White House proposes cutting an already underfunded Indian Health Service budget by 6 percent.

We already know that the per-patient cost in the Indian healthcare system is greatly below that of Medicaid reimbursement cost, on average. So if we take away Medicaid reimbursement, we are hurting not only the providers, but we are once again making healthcare less affordable.

This is a crisis. I can't begin to tell the Members of this body what a crisis Indian healthcare is in. We have known it on the committee for many, many years. In fact, Senator Dorgan was the first one to really sound the alarm of the crisis in the Great Plains area,

thinking that a report that was so damaging would result in change. Guess what. It didn't. It didn't result in change. But the one thing we can point to that is a bright shining light has been access to Medicaid dollars. It has given them access to capital expenditure, and it has given them access to workforce. It has given a more consistent way for people who don't live on the reservations to get healthcare.

I have said this many, many times: We need to not go backward; we need to go forward. When people say: We are going to take a step back, we are going to reduce actual appropriations by 6 percent for Indian health, and we are going to eliminate Medicaid expansion, I say: You had better look before you take a step backward because you might be off the cliff. That is how dire it is in Indian Country.

The one thing I am going to conclude with is that for many, many years in healthcare we have not done what we need to do to consult with Tribal people: Here is the facility; this is what we are going to provide. Good luck. One size fits all.

What we need to do and what Medicaid has allowed is that flexibility for Tribes to engage, for Tribal people to engage in what their needs are, and to take a look at those community health models that do dental care, eye care, and mental health and addiction counseling. All of this needs to be wrapped up. When people say there is no hope, there certainly is no hope without help.

There is an old saying: When you have your health, you have everything. I can tell you from personal experience that it is absolutely true. You could be the richest man in the world, but if you don't have good health, your quality of life is not what it could be.

When we look across the indicators of what has happened in Indian health with indigenous people throughout our country, when we know this is our obligation—this is that treaty obligation, the treaty right that has been bargained for—shame on us.

Medicaid can be that bridge. It can be the bridge to better healthcare. That is why it is so critical, Mr. President and my vice chairman, that we be out here speaking for our communities, speaking for these unique groups of folks who depend so much on Medicaid expansion but who also depend on us to do a better job, to be better stewards of that relationship, to be better citizens as it relates to living up to the obligations that our ancestors negotiated.

I ask everybody who hasn't really been exposed to this issue to read the articles in the Wall Street Journal. But don't just read them and wring your hands and say: This is horrible. Take a step to change the outcome. Don't just read them and say: Boy, that is horrible. Take responsibility for what you read. Every one of us in the Senate and in the Congress is responsible for fulfilling the obligations of these treaties. When we aren't doing it, it is a failure on every one of us, and it is a failure to protect some of the most vulnerable people in our country—and that is Native American children.

I yield the floor and turn it back to my vice chairman, Senator UDALL.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. UDALL. Mr. President, I know Senator DURBIN is on the floor so I am going to wrap up very quickly. I first want to thank Senator FRANKEN, who came down here and advocated for his State and for Native Americans across the country. I thank Senator HEITKAMP for her passionate speech about Native Americans and Native children. I have known her almost 30 years, as the State attorney general, when she was doing the same things, and she has made real progress.

You can see from this roundtable today—and I really appreciate Senator HEITKAMP coming and helping me chair that. I had to slip out to Foreign Relations, but she spent a significant amount of time chairing that roundtable. I think it really made a difference to all of the Tribal leaders there.

I want to finish with what one of those Tribal leaders said to us.

Senator HEITKAMP, you said something very similar.

This Tribal leader reminded us, he said: Decades ago, Tribes made a downpayment on the healthcare they receive. We are not asking for a handout. We made a downpayment.

What was he talking about?

We made a downpayment with our land, with our water, and with large areas of what were then either territories or the United States—that they considered their homelands. How sad it is to see that we are not fulfilling the promises of these sacred treaties they entered into.

With that, I would conclude—as Senator FRANKEN did and I believe it was the same thrust of what Senator HEITKAMP was saying—with this. We have hit a wall on healthcare. We have come up to the point where you don't know where to go. The best thing to do when you hit a wall is to get back to the regular order, work on a bipartisan basis, go into committee, let people put proposals forward, have amendments, open up the process.

That is where we need to go at this point. I would urge the Republican leadership to take a look at the regular order. That may help us find our way out to improve the healthcare situation for not only Native Americans but all Americans, which is what we face with this TrumpCare, which is taking us in the wrong direction.

With that, I yield the floor.

The PRESIDING OFFICER (Mr. DAINES). The Senator from Illinois.

Mr. DURBIN. Mr. President, let me thank my colleagues for coming to the floor and speaking on behalf of Native Americans and the Indian Health Service, its shortcomings and challenges that it creates for us.

I don't have an Indian reservation in my State, but I certainly have visited these Indian reservations in other States and believe we have an ongoing responsibility—social and moral responsibility—to those who were in this country long before many of our ancestors and who have not been treated fairly many, many times when it comes to the poverty they face in this country and the challenges they face.

It is as bad as or worse than any other group in America. We can do better, and we need to start with the Indian Health Service and health services. I thank my colleagues for raising that issue.

Mr. President, it is interesting, this is a historic week in the Senate because we have been engaged in a debate for weeks about what to do about healthcare in America. The Senate, of course, is under the majority control of the Republicans, as the House of Representatives is, and, of course, with a Republican President. They all came to Washington at the beginning of this year and said: The first thing we want to do is to repeal ObamaCare. We have said it for 6 years. We are finally going to do it. We are going to get rid of ObamaCare, the Affordable Care Act, once and for all.

They set out to do it in a variety of ways. President Trump's first Executive order to the agencies of the Federal Government said: Do everything you can to discourage ObamaCare. He turned around and did just that. His agency stopped advertising for people to sign up for ObamaCare. They were determined to put an end to it.

In the House of Representatives, they took a step beyond that. They introduced legislation to repeal it and replace it. What they replaced it with was a disaster. The Congressional Budget Office took a look at the Republican repeal plan in the House and said 24 million people will lose their health insurance.

Beyond that, they talked about the changes that would take place in health insurance policies with the Republican repeal plan. It passed the House by four votes, which meant that if two Republican Members—and only Republicans voted for it—had voted the other way, it wouldn't have passed. It was that close.

Then it was sent to the Senate, and it was up to the Senate Republicans to decide what they would do with this bill and what they would do with the repeal of ObamaCare. They spent many weeks in conversation and discussion about what they might do. Thirteen Members, Republican Senators, sat in private rooms and talked about what they would do to replace ObamaCare.

Finally, they reported a bill. It turns out their bill was an improvement over the House bill. The House bill eliminated health insurance for 24 million Americans. The Senate bill eliminated health insurance for 23 million Americans. Still, when you look at it, it is a horrible thing.

In my State of Illinois, a million people in my State would have lost health insurance with either the House or Senate Republican bills. It is the reason there has been resistance in my State to this Republican effort from the start.

You would expect it on a political basis. Sure, the Democrats will oppose the Republicans on issues, but this went beyond it. There wasn't a single medical advocacy group in the United States that supported what the Republicans were doing, not one. The hospital associations across America, the medical society of doctors, the nurses, the pediatricians, they all opposed what the Republicans set out to do.

When it looked like there were problems in passing one version of the Senate Republican repeal bill, they sat down to rewrite it. As they sat down to rewrite it, they got into deeper water and bigger problems.

Senator CRUZ, the junior Senator from Texas, said: Well, one way to bring down the cost of health insurance is to take out some of the protections of a health insurance policy. We can get premiums down pretty low if we take away the protections of a health insurance policy that are in the Affordable Care Act.

That was his proposal.

Just this weekend, Blue Cross Blue Shield and the major health insurance industry said that this will be a disaster. If you have some people buying real insurance and real protection and others paying rock-bottom premiums for little or no coverage, you are going to create two classes of Americans, and you are going to see premiums going through the roof for those who are buying full-coverage policies. They came out against the Cruz proposal.

This week, we returned to face the votes. We were supposed to be voting today, a vote on whether to repeal ObamaCare. As of last night, things started changing. Two Republican Senators joined two others and said they were opposing the effort, and so the Republican majority did not have the votes it needed to go forward.

They said: Well, at least we will vote on repealing ObamaCare.

Three Republican Senators have announced, as of today, that voting for simple repeal is something they will not do. Many of them make the argument that just repealing ObamaCare without replacing it is irresponsible. They are right.

If you don't like the current system, I believe you are duty-bound, as a Senator or Congressman, to come up with a better idea, something that serves America better. They have been unable to reach that point.

Where are we? At this moment, we are at a standstill. The Republican efforts to repeal and replace have stopped as of this moment. There may be a vote, an official vote this week. I don't know. That is up to Senator MCCONNELL as the Republican leader, but it appears there is no plan coming out of the Republican side to replace the Affordable Care Act.

I am proud to have voted for it. I voted for it for very simple reasons. When it comes to health insurance, I believe that is one of the basics in life. I am one of those politicians who believes healthcare is a right, just like police and fire protection. It should be part of who we are in America. I don't believe it is a question of how rich you are or how lucky you are as to whether you have health insurance in this country.

We can do better as a nation. The Affordable Care Act set out to do that. We reduced the number of uninsured Americans with ObamaCare when we passed it 6 years ago by 50 percent. We reduced by half the uninsured people living in my State of Illinois. Many of them went to the insurance exchanges, bought private health insurance. If they had lower incomes, they got subsidies to help pay the premiums. Others picked up Medicaid coverage as their health insurance. It was significant.

I ran into people all across my State, from Chicago to downstate, who had never had health insurance 1 day in their lives. These are not lazy people. These are hard-working people who happen to have the kind of jobs that didn't offer health insurance.

Ray Romanowski, big Polish fellow, guitarist and musician in Chicago said: Senator, I have never had health insurance. I am a musician. Nobody was ever going to provide me with health insurance.

He said: Lucky I have it now because I have been diagnosed with diabetes. I am in my sixties, and I have, through the Affordable Care Act, health insurance through Medicaid.

Similar story, almost identical story in deep Southern Illinois. Judy, who works as a hospitality hostess in a local motel—she is the one who greets you with a smile when you come in for that free breakfast. Judy is 62 years of age. She never had health insurance 1 day in her life. She holds down two and three jobs at a time. The only health insurance she ever had is what she has now under Medicaid.

What is going to happen to those people if we eliminate Medicaid coverage—which the proposals before us suggested—if Medicaid coverage is cut back dramatically?

Those two people, Ray and Judy, are still going to face health challenges. They are still going to get sick and go to the hospital, but if they don't have health insurance, will the hospital treat them? Yes. What will happen to their bills? Their costs will be passed on to everyone else. That is the way it used to be done.

What we have learned this week in Washington, in this national healthcare debate, is there are of course concerns about whether the current healthcare system is what it should be, and I think it can be improved, but we have learned one basic thing. We are not going back. We are not going back to the days when health insurance companies could deny coverage to you or your family because of a preexisting condition. We are not going back to the days where they put a limit on how much they would pay on your health insurance plan.

Remember when you first realized that a $100,000 limit was not worth that much if you had a serious diagnosis or a serious accident? We are not going back to the days when that health insurance plan literally expired in coverage, forcing you and your family into bankruptcy over medical bills.

We are not going back to the day when families couldn't cover their kids coming out of college. The Affordable Care Act said you can keep your child on your health insurance plan as a family until they reach the age of 26.

Those of us who have had kids who have graduated college realize they don't always get a great job right off the bat. Some of them start as interns or part-time workers, and they don't have health insurance. They now know they have the peace of mind of the family health insurance plan.

We want to make sure we protect that. We are not going back to the day when those young people had no coverage at a critical moment in their lives. We are not going back to the day when we allow these insurance companies to charge whatever premiums they wish.

We put provisions in the law that limit the premiums that can be charged on Americans, that limit the profits that are taken out of health insurance companies. Those were moves that had to be made to protect innocent American families who, unfortunately, were struggling with medical bills before this law passed and now at least have some chance of paying for them.

What we learned in the course of this national debate is significant. We learned that if you put up a proposal, as the Republicans did in the House and the Senate, that takes health insurance away from over 20 million Americans, you have a problem. People are going to push back and say that it isn't fair to take away health insurance and the protection and peace of mind that come with it. If you come up with a plan that ends up dramatically cutting back on Medicaid, you are going to get a lot of people who are concerned about it.

Across America, the Medicaid Program as we know it does many significant things. One-half of the babies born in my State of Illinois are covered by Medicaid. Mom and her prenatal care, the delivery of the baby, and the caring for mom and the child afterward are covered by Medicaid. If you make a cut in the reimbursement for Medicaid, you will endanger the basic treatment needed to have a healthy baby.

The second thing we know is that Medicaid is critical for people with disabilities. I met a mother in Champagne, IL, and she came up and told me

she has a 23-year-old autistic son. It has been a struggle for her and her family, but now he has a somewhat independent life. She said: Senator, if you take away Medicaid insurance from him, I will have to put him in some institutional program that I cannot afford. There is nowhere to turn.

I also want to remind people that Medicaid pays school districts to take care of kids with special education needs, transportation, counselors, even feeding tubes for the severely disabled. That is an important part of Medicaid.

I haven't touched on the most expensive part of the Medicaid Program in America. The most expensive part is for those who are in nursing homes, those who are older Americans and need Medicaid to get by. They have Social Security and they have Medicare, but they need Medicaid. If you cut back on Medicaid as proposed by the Republicans in both the House and the Senate, who will take care of these elderly folks who are in a situation where they have exhausted their savings? Do they move back in with the family? Sometimes that is not even possible, but that is one of the prospects faced.

What we need to do is to accept the obvious. We have reached an important political milestone here where the Republicans don't have the votes to move forward, but we still have the challenge of the current system. I was proud to vote for it, but it is far from perfect. The current healthcare system in America, the Affordable Care Act, needs help, needs changes. We need to do it. We ought to just surprise the heck out of America by working together, both political parties, to solve the problems.

Let's identify a few of the most obvious problems.

No. 1, the Affordable Care Act in America today does not address the cost of prescription drugs. You ask a health insurance company: What is driving the cost of premiums? Prescription drugs.

Did you ever notice that when you turn on the television at certain times of the day, it is all about drugs? It is all about new drugs, things you can hardly pronounce. These new drugs are being advertised on television time and again. And then there is a 2- or 3-minute disclaimer: Be careful. If you take this drug, you might die. Be sure and tell your doctor if you have ever had a liver transplant.

I listen to all these warnings, and I am thinking, this is being sold in advertising for the general population? Did you know that there are only three countries in the world that allow television advertising of prescription drugs—the United States, New Zealand, and Brazil?

Why do the pharmaceutical companies advertise drugs on television? Certainly if you want to inform a doctor about a new drug, you wouldn't buy a television ad, would you? The reason they are on television is so that we, as individual consumers and patients, will walk into the doctor's office and say: Doctor, it took me five times, but I finally figured out how to spell ''Xarelto,'' and I want Xarelto as my blood thinner.

The doctor has a choice: He or she can explain to you that you may not need Xarelto, that there is a cheaper version of blood thinner or that this isn't the one that really fits your needs in this circumstance. Doctors don't do that. Many of them just write out the prescription. That is why the television advertising is taking place—to convince the consumer, who asks the doctor and who ends up with the high-priced drug being scripted for them. That is the reality of why the costs of healthcare keep going up.

What does the Affordable Care Act do about that? Nothing. It does nothing when it comes to the cost of prescription drugs. I want these drug companies to make a profit, don't get me wrong. If they are profitable while looking for new cures, that is the way it should be. But when they charge through the roof and double and triple the cost of these pharmaceutical drugs, that is not fair. It is not fair to consumers, and it is not fair to taxpayers.

Think about the fact that many of exactly the same drugs made in the United States are sold in other countries for a fraction of what they cost in the United States. Even in Canada, they charge about one-half or one-third for many of the most popular drugs because the Canadian Government said to the drug companies in America: We are drawing the line. We are not going to let you charge anything you want to charge.

Why don't we do something in America to protect consumers? Why don't we at least inform people when pharmaceutical companies are overcharging so that we can put some pressure on them to stop? That is part of the change to the Affordable Care Act that I think will save us money and at the same time deal with an issue most Americans really are concerned about.

We also should be concerned about the fact that when it comes to the individual health insurance market, that is where most of the problems are. Six percent of the American population buying health insurance through the exchanges—half of them have to pay the full premiums, and some of those premiums go through the roof. Why? Because the people who are buying this insurance are usually people with a medical history or they are older folks and they want to have the peace of mind of coverage. The healthy, younger folks aren't buying it. As a result, the insurance risk pool gets pretty expensive when it comes to premiums. We need to fix that, and we can fix that. That is another thing on which we should come together as Democrats and Republicans to try to achieve.

For those who say: Well, I promised my entire political career that I couldn't wait for the day to come forward and vote to repeal ObamaCare, I just want to tell them that they should be aware that when the Congressional Budget Office looked at the impact of just repealing the Affordable Care Act and not replacing it, they said the following: This would force more insurance companies to leave the market immediately. It would increase premiums by 20 percent a year and double the price of premiums over 10 years, and it would take health insurance away from 32 million people.

So taking that vote to repeal the Affordable Care Act may earn you a cheer at some political rally, but it is not responsible. It is not good. It will raise the cost of health insurance for families across our country if we just repeal and don't replace, and it will take health insurance away from over 30 million people, according to the Congressional Budget Office. It is better that we replace it with something responsible, better that we take the current system and make it stronger.

This has been an interesting debate. I have learned a lot in the course of this debate because I went and visited the hospitals in Illinois. The Illinois Hospital Association opposed the Republican plan in the House and opposed the proposal in the Senate. They said it would cost us 60 to 80,000 jobs in Illinois and it would close down some hospitals we need in rural parts of our State, smalltown hospitals that are critically important. I don't want to see that happen, the people who live there don't want to see that happen, and you won't be able to keep and attract good employers and good jobs if that does happen. So I have worked with these hospital administrators and want to move forward with them on an alternative.

I will close by saying this: It is interesting how many people say ''I can't wait until I reach age 65 because I will qualify for Medicare.'' Medicare doesn't discriminate based on preexisting conditions and provides good health insurance for millions of Americans. It is an illustration and a lesson for us that if you have something that isn't driven by the profit motive, that people trust, that has provided basic, good care for Americans, good hospitals and good doctors, that is what people are looking for. Why shouldn't they? That should be part of the American dream. It should be part of our right as Americans.

Mr. President, I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. JOHNSON). The clerk will call the roll.

The assistant bill clerk proceeded to call the roll.

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

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

Mr. ENZI. Mr. President, in our job, we get a lot of books, probably two or three a week at least, and for the last year most of those have been on

healthcare and healthcare reform. A book I received recently is one called ''Demystifying ObamaCare,'' by David G. Brown, who is a doctor. It was helpful enough to me that I thought I would share a part of it with anybody listening. It always fascinates me when we are here talking and maybe somebody is listening.

Page 7 starts out by talking about, ''How Does ObamaCare Look After Seven Years?'' Incidentally, this one is all well documented and footnoted, which is one of the unusual things about this book. It is not just speculation on his part—it is a lot of research that he has done and shared. He says:

ObamaCare actually reduces insurance market competition by strict rules, regulations, and mandates.

ObamaCare significantly increases healthcare cost by the way it attempts to assist those who cannot afford coverage.

ObamaCare does not tackle the underlying causes of increased costs. Instead, it worsens the factors that drive up the cost of healthcare with the addition of mandates, regulations, and taxes. ObamaCare does nothing to decrease the factors that increase costs.

ObamaCare has increased the total number of healthcare spending. The cost is not $938 billion dollars, but now is $2.6 trillion dollars over 10 years, or almost 3 times the original figure.

ObamaCare increases cost for families, businesses, and individuals for their healthcare. This includes not simply ObamaCare exchanges but health insurance across the board. Associated with this, there has been a marked increase in healthcare premiums, costs for medications, deductibles, and copays.

There has been reduction of access to care in ObamaCare plans, i.e. ObamaCare exchanges (insurance does not equal access).

ObamaCare, to some extent, has reduced the number of uninsured but not handled the problem of the uninsured population.

ObamaCare does not effectively address the problems of the safety net system, i.e. putting new people into Medicaid has exacerbated the problems for Medicaid, and removes its original safety net function.

ObamaCare has reduced funding and thus care for programs for the elderly, Medicare.

ObamaCare has taken the decision making process out of the hands of patients and their families. It has done so by removing their freedom to make those decisions.

This is from the book, ''Demystifying ObamaCare,'' by David Brown, who is a doctor.

It goes on later to say:

The individual mandate was instituted as a way to force patients into having health insurance or else pay a financial penalty for not having it. The employer mandate, which was just instituted in 2016 after several delays, was intended to move those with employer-based insurance into the government sector. Additionally, the HHS required all individual and small group policies to meet the ''essential health benefit'' requirements. These benefits were determined by the secretary of the HHS and required involvement of not simply government, but also non-government plans. The individual and small group policies then had to be sold at a more significant cost to the consumer.

How is the Employer-Based System changed so employees could be moved into a government system?

Businesses with 50 or more full-time employees had to provide health insurance approved by HHS or be financially penalized.

The cost for businesses for the penalties for not providing insurance was less than the cost of the insurance.

ObamaCare exchanges were there to take in anyone who needed to have insurance. Employer based mandates were a way of moving employees out of the employee-based marketplace into a government program. It is the back door way of having a government based healthcare system. It was ingenious but fortunately, for the American people it was flawed.

Yes, Americans in the individual market lost their insurance (5 million Americans) but the employer-based mandate was postponed through the efforts of Congress. Many of the larger companies have self-insured their employees. The ObamaCare exchange program has been very expensive for the consumers. It has also significantly limited access to care i.e. narrowed networks of providers, (doctors and hospitals). ObamaCare has increased the numbers in Medicaid but this program itself has severe flaws.

Again, in ''Demystifying ObamaCare'' by David Brown, a doctor, going to page 18, ''What Are the Facts About Medicaid and Medicaid Expansion?''

Costs of Medicaid (total federal and state spending) will more than double i.e. more than $427 billion to $896 billion between 2014 and 2024. The costs of this will be borne by the taxpayers.

The cost of Medicaid to the states has a tremendous impact on other services. It is often the second most expensive budgetary item. With Medicaid expansion, there are increased costs to the states, even in those states, which have accepted Medicaid expansion and increased federal funding for it. Other state services may have to be reduced even in states who have not accepted Medicaid expansion.

Medicaid is actually a safety net for the poorest and most vulnerable Americans but expansion changes this. It reduces the access to care for others who are already in the system. The single adult able-bodied American is competing for care with those who need the care as a safety net.

It severely underpays doctors and hospitals, and the number of Medicaid providers are declining. It compensates doctors an average of 50% less than private insurance. By CBO estimates, by the time of full implementation of ObamaCare, one out of every six hospitals will be in the red because of severe underpayment from Medicaid and Medicare.

Medicaid expansion does not reduce inappropriate utilization of emergency rooms. A recent study showed Medicaid patients utilize the emergency rooms for their routine care 40% more than those who are uninsured.

Medicaid has the worst clinical outcomes compared with any other medical program. There are worse outcomes including conditions such as heart disease, cancer, complications from major surgery, transplants, and AIDS. These outcomes are independent of patient factors and reflect the program itself. It may be no better than having no insurance at all. A recent study comparing Medicaid patients with those who are uninsured showed no difference in blood pressure, glucose, and cholesterol levels after two years of observation.

In short Medicaid expansion reduces access to care, increases cost of care and places people within the program that has the worst possible outcomes to care.

Going on in ''Demystifying ObamaCare,'' by David Brown, page 25, ''Medicaid Expansion Update: How Does It Stand Today?''

Thirty-one states and the District of Columbia have adopted Medicaid expansion. Three states have considered it but rejected Medicaid expansion. The other sixteen states have refused to participate in it.

Medicaid expansion has increased the Medicaid number from 58 million to approximately 70 million people, 20% of the uninsured population. It has caused overall expansion of the number of people in the program.

ObamaCare has increased the number of individuals insured by allowing them to participate in the existing Medicaid program. In order to do so, the inclusion criteria for their enrollments have changed. Medicaid expansion is now based on age and financial criteria. That includes both the able-bodied individuals who are able to work and chose not to and those who were previously involved in the Medicaid safety net. For example, the lower income mother with children.

It was thought that the states that accepted Medicaid expansion would have ''free money'' if they participated with this Federal program. 100% of the costs of adding new patients were picked up by the federal government with that figure gradually being reduced to 90% of the cost starting in 2017.

This was for new patients added to Medicaid and not the existing patient population. States however found that their Medicaid programs were flooded with new enrollees, many of which had met the criteria for Medicaid before the ''woodwork effect.''

The overall expansion of Medicaid with increasing numbers of enrollees has led to marked increase in spending on Medicaid and marked increase in total costs for Medicaid.

It goes on with a lot of numbers which have a lot of significance to accountants, but I will skip over those and continue on with his last two points.

Medicaid is associated with the worst possible clinical success rate across the board for all medical and surgical illnesses. It is worse than any other program, including any government programs such as Medicare or any private program. In certain studies, it has shown to have worse clinical outcomes than having no insurance at all. No data has developed during the course of Medicaid expansion to change these findings.

Medicaid expansion is associated with a huge financial burden on the states and the cost to the states with Medicaid expansion has increased dramatically.

Again, at the end of the chapter it shows a lot of references for where he got this information.

Continuing with ''Demystifying ObamaCare'' and moving on to page 31 is ''What are ObamaCare Insurance Exchanges?''

ObamaCare insurance exchanges are federally constructed and state run markets where individuals and families can purchase insurance plans. Private healthcare insurance companies participate but the insurance companies are only able to sell plans that are acceptable to the Secretary of the HHS. Many individuals and families then could receive subsidies provided by the government, (i.e. taxpayers funded subsidies). The subsidies are [to] be on a sliding scale, families whose income is up to 400% of the federal poverty level can be in the ObamaCare exchange ($97,000 dollars a year for a family of four). The program is tightly regulated by the Federal Government. The choice is limited to four plans (bronze, silver, gold, and platinum.) Each state was required to set up their own insurance exchanges and then regulate them. If a state

did not set up such an exchange, the Federal Government did that for them.

''What Effects These Policies Have on Those Inside and Outside the Exchanges?''

The public must know that the exchanges dramatically restrict patient care by restricting access to care. Exchanges decrease access by reducing access to doctors and hospitals. This includes access to some of the most important specialized care. The exchanges have a limited network of providers.

The public must understand that they do [not have] protection from fraud. Some of the most sensitive information is given to navigators to help enroll people in the exchanges. The enrollees then become ''fair game.''

The ObamaCare website, ''Healthcare.gov'' does not automatically verify enrollee's eligibility, i.e., whether they legally qualify for subsidies. Various sources indicate that at least 2 million enrollees (some estimates are significantly higher) are receiving subsidies that they did not legally qualify for. Douglas Holtz-Eakins, former director of the CBO, estimates that over the first 10 years of ObamaCare, overpayments and inappropriate payments could add up to $152 billion dollars. Who pays the bill? The American taxpayer. The website, ''Healthcare.gov'' cost taxpayers $1.4 billion dollars in 2014.

He goes on to explain how that increases the costs for all taxpayers.

I will continue with some of the other lessons in this book at another time. The leader is coming to the floor to speak in a few moments.

What we are trying to do is to find some solutions for the American people so they have access to healthcare—and more extensively than now. I recommend for reading this book called ''Demystifying ObamaCare'' by David Brown. It is very eye-opening. There is a section I will cover later that covers some of the solutions that will be useful.

I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. RUBIO). The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

ORDER OF BUSINESS

Mr. MCCONNELL. Mr. President, for the information of all Senators, at the request of the President and the Vice President, and after consulting with our Members, we will have the vote on the motion to proceed to the ObamaCare repeal bill early next week.

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.

FLOODING IN NORTHERN ILLINOIS

Mr. DURBIN. Mr. President, for the second time this year, Illinois communities are assessing damage and cleaning up after flooding. My thoughts and prayers are with the families and first responders in northern Illinois who are working to recover after heavy rain caused severe flooding in Lake, McHenry, Kane, and Cook Counties last week.

The water has started to recede in some communities, but in some areas, water levels will likely continue rising this week. Thousands of buildings—including homes, businesses, and schools—have been damaged by floodwaters.

Lake County has been one of the areas most impacted by this flooding. Last weekend, I visited two towns in this area—Libertyville and Gurnee—and I saw street after street of flood damage to homes and businesses. What I saw was heartbreaking. I spoke with residents who were concerned about being able to recover from the flood and resulting damages and who voiced the need to find long-term solutions that will mitigate the impact of future flood events. I am extremely grateful for the hard work of local first responders and county officials. Thankfully, there have been no reports of injuries or fatalities as a result of this historic flooding.

I want to acknowledge the dedication of both the State and local employees and volunteers who have come out to help at every level, from the Illinois Emergency Management Agency and the American Red Cross, to county emergency management agencies. Many volunteers have helped with sandbagging. County board chairman Aaron Lawlor has also been helpful in securing resources and making sure residents have information about where to find shelter and access cleanup supplies.

People from all around the area are pitching in to help their neighbors and even strangers protect property and get back on their feet.

I would also like to thank James Joseph, director of the Illinois Emergency Management Agency, for his hard work. He has been there during a time when Illinois constituents and communities need him the most.

The State has provided 850,000 sandbags and deployed an emergency management assistance team for flood mitigation and response efforts. Representatives from the Illinois Emergency Management Agency are working closely with local officials to make sure communities have the resources needed to protect critical infrastructure and clean up when water begins to recede.

The Governor has declared four counties State disaster areas. In the coming days, the State will work with FEMA and local officials to begin conducting preliminary damage assessments.

Once we have an idea of the scope of the damage, the Governor has the ability to request a Presidential disaster declaration. In the past, it has been challenging for Illinois to receive Federal aid after a disaster occurs, but the Illinois delegation and I stand ready to do whatever we can to help get any Federal assistance needed so that these communities can clean up and recover.

There is more work to be done, and cleanup may be difficult and dangerous, but I have no doubt the people who live and work in the impacted communities will make incredible progress rebuilding with the help and support of volunteers, local officials, and State agencies.

I want to thank everyone who has been engaged in the response and mitigation efforts and all those who will be engaged in recovery efforts in the weeks to come. We will rebuild, as Illinoisans always do, and we will be stronger for it.

REMEMBERING BARBARA ANDREWS-MEE

Ms. MURKOWSKI. Mr. President, this Saturday Alaskans will observe ''Ted Stevens Day,'' a living memory to Alaska's greatest Senator, who left us 7 years ago next month. As family, friends, and former staffers of Senator Stevens gather in Alaska for this annual observance, many will take time off on Thursday to honor a beloved member of the Stevens' team, Ted's loyal assistant and State director, Barbara Andrews-Mee, who passed away earlier this year. I will not be able to attend this event because the Senate will be in session on Thursday, but I wanted to take this opportunity to speak in memory of this loyal and dedicated employee of the U.S. Senate, as well as great friend of Alaska.

Barb's tenure with Senator Stevens long predates his Senate service. Barb began working with Ted in 1962, 2 years after she came to Alaska. She followed him to the Alaska Legislature and the U.S. Senate, retiring in 1997. Upon her retirement, Stevens said, ''For half of my life—and two-thirds of hers—Barbara Andrews-Mee has been my boss. . . .'' Barb returned the compliment noting that she had been with Ted Stevens longer than she had been with three husbands.

Barb had a great sense of humor and a huge and welcoming personality. She was regarded as a mentor and grandmother-like figure to generations of young staffers who went to work for Senator Stevens.

She could sure turn a phrase. Alaska humorist Mike Doogan published a few of Barb's quips in the Anchorage Daily News to celebrate her retirement. Among them, Barb, who was 5-feet tall, once said, ''I tell people I used to be 6-foot-2, and then I went to work for Stevens.'' But she wasn't always so humble. Another ''Barbism'' was ''[m]y grandmother always told me dynamite comes in small packages.'' I am told that one came in handy when she was working difficult constituent problems