EXECUTIVE COMMITTEE MEETING TO CONSIDER

HEALTH CARE REFORM

TUESDAY, SEPTEMBER 22, 2009

U.S. Senate,

Committee on Finance,

Washington, DC.

The hearing was convened, pursuant to notice, at 9:10 a.m., in room 216, Hart Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Rockefeller, Conrad, Bingaman, Kerry, Wyden, Schumer, Stabenow, Cantwell, Nelson, Menendez, Carper, Grassley, Hatch, Snowe, Kyl, Bunning, Crapo, Roberts, Ensign, Enzi, and Cornyn.

Also present: Democratic Staff: Bill Dauster, Deputy Staff Director and General Counsel; Russ Sullivan, Staff Director; Elizabeth Fowler, Senior Counsel to the Chairman and Chief Health Counsel; Catherine Dratz, Health Policy Advisor; and David Hughes, Senior Business and Accounting Advisor. Republican Staff: Kolan Davis, Staff Director and Chief Counsel; Mark Hayes, Republican Health Policy Director and Chief Health Counsel; Michael Park, Health Policy Counsel; Sue Walden, Health Policy Advisor; Andrew McKechnie, Health Policy Advisor; Jim Lyons, Tax Counsel; Rodney Whitlock, Health Policy Advisor; Kevin Courtois, Health Staff Assistant; and Chris Condeluci, Tax and Benefits Counsel.

Also present: Yvette Fontenot, Professional Staff; Tony Clapsis, Associate; Chris Dawe, Professional Staff; David Schwartz, Professional Staff; Shawn Bishop, Professional Staff; Neleen Eisinger, Professional Staff; Thomas Reeder, Senior Benefit Counsel; Tom Klouda, Professional Staff, Social Security; Tom Barthold, Chief of Staff of the Joint Committee on Taxation; Diedra Henry-Spires, Professional Staff; Mark Miller, Director of MedPAC, Douglas Elmendorf, Director of CBO; Josh Levasseur, Deputy Chief Clerk and Historian; and Athena Schritz, Archivist.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The Chairman. The Committee will come to order.

The Committee meets today to consider an original bill providing for health care reform. Harry S. Truman said, "Men make history, and not the other way around. Progress occurs when courageous, skillful leaders seize the opportunity to change things for the better."

My colleagues, this is our opportunity to make history. Our actions here this week will determine whether we are courageous and skillful enough to seize the opportunity to change things for the better.

Presidents from Truman to Johnson, from Nixon to Clinton, have had the courage to attempt health care reform. Once again the time has come to make the attempt. The time has come to have the courage to take on this daunting task. The time has come to reform America's health care. The times demand nothing less.

Just last week, a Harvard study found that every year in America, lack of health care leads to 45,000 deaths. People without health insurance have a 40-percent higher risk of death than those with private health insurance. No one should die because they cannot afford health care. This bill would fix that. Every 30

seconds, another American files for bankruptcy after a serious health problem. Every year, about 1.5 million families lose their homes to foreclosure because of unaffordable medical costs.

No one should go bankrupt because they get sick. This bill would fix that.

A new Kaiser Family Foundation survey found that health care coverage for the average family now costs more than $13,000 a year. If current trends continue, just 10 years from now, in 2019, the average family plan will cost more than $30,000--more than a two-fold increase. No one should have to live in fear of financial ruin from increasing insurance premiums. This bill would fix that.

The mark before us today is a balanced, common-sense plan that takes the best ideas from both sides. It is designed to get the 60 votes that it needs to pass. Now the choice is up to us. Now the question is whether we can seize the opportunity and change things for the better.

All Americans should have access to affordable, quality health care coverage. The Congressional Budget Office says that this bill would raise the share of Americans with insurance coverage from about 83 percent to about 94 percent. CBO says that this bill would

deliver coverage to 25 million people through new insurance exchanges and to 11 million more through Medicaid.

Our proposal would dramatically increase prevention and wellness. It would begin shifting health care delivery to the quality of care provided, not the quantity of services rendered. It would lower prescription drug costs dramatically for seniors. It would reform the insurance market to protect those with pre-existing conditions, prevent insurance companies from discriminating and capping coverage, and it would require insurance companies to renew policies as long as policyholders pay their premiums. No longer would insurance companies be able to drop coverage when people get sick.

These reforms would give Americans real savings. CBO tells us that the rating reforms of exchanges in our proposal would significantly lower premiums in the individual market. Under our plan, everyone making less than 133 percent of the poverty level would receive health coverage through Medicaid, and our plan would provide tax credits to help middle-income families to buy private insurance coverage.

These tax credits would means that our bill would deliver tax cuts to those whom it affects. Overall,

taxes would go down for the people affected by this bill. These tax credits would help to make insurance more affordable. And despite what some people might say, this is no Government takeover. No takeover of health care. We have built our plan on an exchange marketplace that allows choice among private health insurance company products. Each individual will be able to choose their own plan. Our plan does not include a public option. We did not include an employer mandate, and we paid for every cent.

This is a uniquely American solution. We are not Canada, we are not Britain, we are not America. We are the United States. Americans have a tradition of balance. We do not buy into Government-only solutions. But we do believe in rules of the road. We have a tradition of mixed solutions. We have a tradition of compromise. We have a tradition of balance. This is a balanced package.

And our package is fiscally balanced. It started reducing the deficit within 10 years, and by the end of the 10-year window, it is moving in the right direction.

And our package controls health care spending in the long run. CBO says that in the second 10 years, our bill would continue to reduce the deficit by half a percent of GDP. That is about $800 to $900 billion in deficit

reduction.

Now it comes down to this Committee. The other four committees have acted. Now it is our turn.

Last week, I put out my proposal, but I do not pretend it is the last word. I am eager to work with others Senators to make this an even better bill. And that is why this morning I am going to make several significant modifications to the Chairman's mark. These modifications will include ideas from a number of Senators on the Committee. These modifications will improve and strengthen the package.

Now I look forward to our amendment process here in the Committee. Through this open and democratic process, I hope we can improve the bill even further. And after that, I look forward to melding our bill with the HELP Committee's product, and I look forward to constructive floor debate starting as early as next week.

One point I want to acknowledge up front, that we did not do as much to correct the payment of doctors, especially, as I would like, under the incredibly misnamed "sustainable growth rate." The SGR needs to be fixed permanently. I look forward to further progress on this as we progress on this bill.

And so let us begin our consideration of this bill. Let us make this a time for progress, let us seize our

opportunity to make history, and let us do our part to make quality, affordable health care available to all Americans.

I now recognize Senator Grassley for any opening remarks he wishes to make.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA

Senator Grassley. Mr. Chairman, I have a long statement, so at any time you want me to quit, I will be glad to quit, because it is extra long.

First of all--

The Chairman. Senator, I suggest you just give your whole statement if you want, but I would just encourage all of us to stick within about 5 to 6 minutes, in respect to everybody else.

Senator Grassley. Okay. Well, first of all, Mr. Chairman, I applaud you for your efforts to bring us to where we are today to reform the health care system. Few people have worked as hard as you have worked on this subject. You have had a tireless dedication to moving ahead, and you have done everything you could to get us to this day. So thank you very much for that cooperation.

And you, of course, have created an environment in this Committee for bipartisanship and collegial work that is very important, particularly very important on this, the biggest issue that maybe this Committee has ever struggled with. The roundtables and the walk-throughs held this year were perhaps the most open and inclusive

process this Committee has undertaken in its history, I believe since I have been on the Committee.

But despite your dedication and commitment to this important endeavor, I have a feeling that the White House and the leadership on your side grew impatient and through artificial deadlines forced us to where we are today. It seems to me that some people in the Senate would rather have it done right now instead of being done right. That artificial deadline pushed us aside and put an end to that bipartisan work before it could produce a bipartisan bill.

It seems that the White House and the leadership from the beginning were never really going to give it time to do it right. We could get no assurances that the Democratic leadership or the White House would have backed a bipartisan effort after it left this Committee, and that was a big concern on my side of the aisle over a long period of time. And it was a genuine concern for serious reasons. No wanted to be used in a process that was going to have the rug pulled out from under it at some point down the road. Those concerns made it practically impossible to attract many of my party members to consider supporting this effort at the beginning.

I had a meeting, as five other members of this

Committee did, with President Obama on August the 6th. I told the President that if he wanted bipartisan support for the bill, then he had to indicate publicly that he would be willing to support a bill without a Government plan. I did not say that he had to give up on that at that time. I just had to have him say to me that he could support one if we presented it to him that did not have a Government plan.

Then we had a lot of back-and-forth effort between the White House and the Congress on whether or not a public option would be out there. At one time Secretary Sebelius said on CNN that a public option is "not the essential element" in a reform legislation. But then later on it seems like there was a revolt against that statement, and the White House quickly retreated and said that a public plan was on the table.

So without a commitment that was very important on my side of the aisle, it became clearer and clearer as time went on that they could not and would not be making that commitment. They could not make that commitment because they knew they wanted something Republicans would never support. They wanted a Government plan that would throw off the health care system to one operated by the Government totally.

But the American people have rejected that idea.

They know it would lead to Government deciding what doctor they can see and what treatment they can have. Just like we have seen in other countries with the government systems, they ultimately have turned to government-imposed rationing to control costs.

Instead of going down that path, restructuring the health care system is something that must be done with broad support. After all, it is one-sixth of our economy, and when you use the words "health care," you are talking about something that affects the life-and-death issue with every American.

So our health care system does face many serious challenges that need fixing. The American health care system has too many people that are without coverage. The quality of care that is provided is not as good as it should be, and the cost of health care is out of control.

The medical care we provide should be second to none, but the reality is that in some places we have world-class health care, but in many areas we lag behind other countries in the quality of care our citizens are provided.

Costs are rising in health care at an unsustainable rate, and in some parts of the country, those costs are far higher and quality far lower. The costs and quality of health care provided in America must improve.

Another major problem is the one that has been obvious for more than a decade: that the Medicare program is going bankrupt. Medical inflation consistently outpaces inflation of the economy generally, and those costs are burying families' budgets, small business budgets, State budgets, and even our Federal budget.

We have to bend the health care growth curve. We have to get health care costs under control. These are very big problems, and it is my belief that we should work together to fix health care problems in America. And we have invested months of work into this bill, and it has not been easy. This is an extraordinarily complex work. On the other hand, I can say that in every one of the meetings we have had, there was never one harsh word said between anybody. It was just six people working together to try to reach an agreement. So we ended in a friendly way, and hopefully it is not ended, but for right now it is.

We have had thousands of hours of staff time working with experts from all walks of life. It has required thousands of staff hours working with the Congressional Budget Office to come up with reliable and accurate estimates of the cost of reforming one-sixth of our economy. And we set out with a goal of paying for the

bill that we were writing. And all those things are not trivial notions. The Senate HELP Committee bill that was produced, but it was not paid for, not remotely close. The House committees have produced a bill that they were not paid for, not remotely close. And after August, they delayed their votes because of public backlash.

Writing a bill that is actually paid for is very difficult, as I am sure Senator Baucus can tell you better than I can. It requires difficult choices on spending and revenue that those other bills simply avoided. That this process has taken a long time should not be a surprise, and finding bipartisan consensus on a bill that affects one-sixth of the American economy is also not a quick and easy task.

Members have deeply held beliefs on how reform should be done. The effect of reform varies from State to State. But working together, there was significant progress made. The first time we received scores from the Congressional Budget Office, that policy was not quite paid for, by a lot, maybe a trillion dollars. But we did not quit. We did not throw in the towel. We kept working. We made hard decisions about what spending was most important and what revenues needed to be raised.

We have traded proposals with the CBO again and again, and in July, the Democratic leadership took the

most significant financing mechanism off the table. This was a huge setback for our work. And yet immediately we heard their complaints that we were not done yet.

But now here we are: The cry of impatience has won out, and the artificial deadline was put in charge of this process. They have put moving quickly over moving correctly. It would be the same as if you had a house that was half-built when the contractor declared it done and said, "Here is your house. Move in tomorrow." Would you move your family in if it did not have windows, running water, without a roof? Of course, it would be absurd to do that. Likewise, their deadline causing the end to our bipartisan work before it was done is just as absurd. I find it utterly and completely appalling.

This is about reforming one-sixth of the economy. Think of that. One out of every six dollars spent in America, we are passing legislation that is affecting that very dramatically. And it is also about everybody's health and health care. Getting it right should be our highest priority.

I know some folks want it done yesterday. I know some folks only want it done their way. But that is not how responsible legislation dealing with complex issues should occur within this great country and this great body we call the Senate.

After all our work, there are a lot of things that I can support in this package, but there are also a lot of very significant unresolved issues and provisions that I do not support.

First, the amount of spending is a serious concern. The Chairman should be congratulated for producing a bill, however, that is fully offset because being fully offset and reducing inflation of health care were the major goals that the six of us had, and the Chairman has kept to that. That is more, though, than the other committees have done, and so it ought to be recognized by everybody of how fiscally responsible this approach is, even if we disagree with it. Those other health bills add hundreds of billions of dollars to the deficit that is already expected to be a record-setting one, and $0.6 trillion this year, according to CBO. Unfortunately, all the added spending in this bill requires more and more offsets to pay for it, and as the spending goes up, more and more toxic offsets are required to pay for it.

This bill has new taxes on everything from Q-tips to pacemakers and cancer screening to pregnancy tests. There is even a $60 billion across-the-board health plan tax. Experts and economists say that all of these health care taxes will be passed on to consumers.

When the focus of reform should be on reducing

health costs, yet taxes do the opposite. They increase health costs. There is no plausible rationale for imposing all these new taxes and big spending on top of an economy that is doing its best right now to recover. And adding insult to economic injury, most of the benefits from this bill would not start until 3 or 4 years down the road while the new revenue, the new taxes start much sooner, in some cases already next year.

What I heard very clearly during August was a lot of concern about what people see the Government doing with all the spending, the Government takeover of banks and auto makers and programs like Cash for Clunkers. They are seeing these massive health care bills, and they are genuinely afraid of what all this means in the direction of our country.

In addition to concerns about cost to taxpayers and affordability for individuals, there are still some other serious outstanding issues that have yet to be resolved. Preventing taxpayer funding of abortions, enforcement against subsidies for immigrants here illegally, medical malpractice reform--all unresolved.

On abortion, despite commitments made by the President and Secretary Sebelius, this bill does not follow the longstanding principle that Federal funds should not be provided for elective abortions. Instead,

Federal funds would end up subsidizing elective abortions, and plans that offer abortion coverage would be subsidized with those same Federal funds.

And on the subject of immigrants here illegally, this bill also fails the test in at least three ways:

First, although the mark appears to require the new exchanges to verify Social Security numbers and citizenship or legal status, it does not include blocking of Social Security numbers, real IDs, verification of address and prior-year income, or any other mechanism that verifies identity to prevent identity theft.

Second, it appears to contain privacy protections limiting the use of data collected by exchanges, but it does not allow information sharing with the Internal Revenue Service and the Social Security Administration to detect and preclude the multiple use of the same Social Security number.

And, finally, I would also note that the designation of Indian tribes as express lane agency would allow them to enroll anyone under the age of 22 in Medicaid and CHIP and anyone of any age in an exchange without verification of citizenship. And we have discussed often in this Committee in the past the role of Indian tribes in verifying citizenship has been questionable.

Another area of concern is the individual mandate to

purchase coverage. As we have worked on health care reform over the past several months, I have become increasingly concerned with the intrusion into private lives that the individual mandate represents. Certainly there is a principle of personal responsibility that applies here. I do not deny that. When someone who voluntarily chooses to go without coverage gets into a serious accident or unexpectedly becomes seriously ill, those costs get passed on to the rest of us.

But the Federal mandate requires an extensive set of new enforcement tools housed in the Internal Revenue Service and backed by the full force of the Federal Government's enforcement powers. That combined with the magnitude of the penalties is cause for serious concern. The further that we waded into this, the more concerned I became.

And the Federal mandate has another significant effect on this legislation, because having a mandate to purchase coverage requires the inclusion of these very sizable Federal subsidies to make sure that coverage affordable for middle-income and lower-income families and individuals is provided.

And the mandate also results in this mandate on all States to expand their Medicaid programs to cover millions more people than they do today. The cost of

this rather massive expansion of Medicaid, and more so the Federal subsidies, is about 90 percent of the $856 billion of spending in the bill. And all this spending is driven by the inclusion of the individual mandate.

And I think that we also have to examine where the idea of mandate--or the mandated purchase of coverage originated. It, of course, originated with the health insurance industry, and for them a requirement that everyone buy their product sounds like a great idea. But to the rest of us, it might seem just a little bit self-serving.

The bottom line is that we should return to first principles when it comes to the freedoms that we enjoy in America, and consistent with that, certainly individuals should maintain their freedom to choose to whether to purchase health insurance coverage or not. And the individual mandate, by the way, is not necessary. We can make it work without that individual mandate. It may be what the powerful insurance companies demanded, for obvious reasons, but we do not have to do it the way that the insurers want it done. All the reforms of insurance can be done with a reinsurance system instead of an individual mandate.

And on the subject of medical malpractice reform, this bill also neglects to confront this growing problem,

something President Obama acknowledged as a priority. Health care reform needs to address junk lawsuits that drive up costs and put doctors out of business. President Obama has repeatedly expressed support for medical malpractice reform, going so far as to direct the Secretary of HHS to move forward on demonstration projects.

But the time for demonstration projects is over. Many States have implemented medical malpractice reform that has reduced the growth of malpractice premiums, and there is a greater potential for cost containment if physicians stop practicing defensive medicine. Real and meaningful health care reform must include medical malpractice reform, and I think that is something that the six of us had made a great deal of progress in just before we had to abandon our efforts.

It is not too late to get it done right. We can stop at any time and refocus this effort. We can lower the spending in the bill. We can improve the quality of care with delivery system reforms that reward quality instead of quantity. We can focus on health care costs. We can lower costs with medical liability reform. We can fix the insurance market.

So, Mr. Chairman, in the spirit that you and I have been working together for 10 years, but in the spirit of

which we really concentrated on this issue since January, and in the spirit of which six of us have worked together for 3 months, I hope at some point the White House and leadership will want to see the mistake that they made by ending our collaborative bipartisan work. I hope at some point they will want to let that bipartisan work begin again, and this time back that effort and give it time to get it done right.

Thank you, Mr. Chairman.

The Chairman. Thank you, Senator, very much. First, it has been great working with you, and it always has been and will be in the future. I very much hope we can find some agreement here. My door is always open.

Senator Grassley. I know.

The Chairman. I hope we can find a way where you and others can be part of this moment in history when we finally enact health care reform for America. I deeply appreciate the manner in which we have been working together, Senator. Thank you very much.

Next on the list is Senator Conrad.

OPENING STATEMENT OF HON. KENT CONRAD, A U.S. SENATOR FROM NORTH DAKOTA

Senator Conrad. Thank you, Mr. Chairman. I want to first thank you for your leadership. In my 23 years in the Senate, I have never seen any Committee Chairman dedicate himself as fully or as completely as you have to this effort, and I want to recognize you for that.

I also want to thank the other members of the Group of Six, three Democrats and three Republicans. Senator Grassley mentioned the other day that we met some 61 times, and it was a good-faith effort to try to reach agreement. And in many areas we did, and I think we made dramatic progress towards common ground.

The fact is that many things that Republicans wanted to see left out of this have been left out. There is no public option. There is no employer mandate. There is tax reform to go after Cadillac plans to reduce overutilization. There is clear language to prevent those who are here illegally from benefiting from these initiatives. There is also a clear directive to prevent Federal funding from being used to fund abortion. There is also clear language to encourage medical malpractice reform in the States. And the Senator from Iowa is also correct that we did not reach final closure on those key

issues, although we did make enormous progress.

Some have said, well, this effort was a waste of time. I do not believe that. I believe it produced a very credible package to deal with a circumstance that is absolutely unsustainable. We as a country face in health care an absolutely unsustainable future, and I would just use a few charts to illustrate.

In 2009, a family of four faced, on average, premiums of $13,000. By 2019, according to all projections, a family of four will face premiums of $22,400. $22,400 in premiums for a family of four by 2019. And it is not just our families and businesses that face unsustainable increases in their premiums. It is the overall health care system.

Currently, we spend one in every six dollars in this economy on health care, but if we stay on the current trend line, by 2050 we will be spending one in every three dollars in this economy on health care. Clearly, that is unsustainable. And in the face of a Federal debt that is soaring, under the Congressional Budget Office's long-term budget outlook, we see that Federal debt is expected to go to more than 400 percent of GDP by the 2050s on the current trend line.

That is absolutely and totally unsustainable. Our country has never faced debts anywhere close to that

amount. The highest we had was about 120 percent of GDP after World War II.

And health care costs are by far the largest unfunded liability of the United States. The unfunded liability in Medicare alone approaches $38 trillion. That is the 75-year net present value of the unfunded liability in Medicare--$38 trillion. That compares to Social Security at some $5 trillion in unfunded liability. So the unfunded liability in Medicare in 7 times as great as the unfunded liability in Social Security.

At the same time, we see the number of uninsured projected to continue rising from 46 million today to 54 million by 2019. And even though the United States spends more than any other country in the world by far, about twice as much per person as any other industrialized country, we are not getting better results. We were ranked last among the 19 industrialized countries in preventable deaths. Commonwealth Fund looked at the rest of the world, industrialized countries, looked at the United States, and looked at those illnesses that were treatable where you could prevent death. The United States ranked 19th out of 19.

We also in that study show the United States having shorter than average life expectancies compared to other

industrialized countries and one of the highest rates of medical errors. And a key reason for that is we have not adopted electronic medical records, which most of the rest of the industrialized world has.

When we look at the Baucus plan and the key elements, it promotes choice and competition, reduces deficits and controls costs, expands coverage to 94 percent of the American people, and improves the quality of care.

The initial CBO analysis shows that this will reduce the deficit by $49 billion over the next 10 years--reduce the deficit by $49 billion over the next 10 years--and over the next 10 years, would bend the cost curve in the right way. Unlike any other proposal before Congress, this proposal bends the cost curve in the right way by one-half of 1 percent of GDP over the second 10 years. That means $1.3 trillion in savings.

Let me repeat that. According to the Congressional Budget Office, in the second 10 years this proposal would bend the cost curve in the right way by $1.3 trillion.

Finally, there is no government-run health care in this proposal, no benefit cuts for seniors, no coverage for illegal immigrants, no death panels, no Federal funding for abortion services. This is a mainstream proposal that moves us in the right direction.

And let me just conclude for my progressive friends who believe that the only answer to getting costs under control and having universal coverage is by a government-run program. I would urge my colleagues to read the book by T.R. Reid, "The Healing of America." I had the chance to read it this weekend. He looks at health care systems around the world, and what he found is that in many countries they have universal coverage, they contain costs effectively, they have high-quality outcomes--in fact, higher than ours--but they are not government-run systems. In Germany, in Japan, in Switzerland, in France, in Belgium--all of them contain costs, have universal coverage, have very high-quality care, and yet are not government-run systems.

So it is entirely possible to do the things that I think most of us want to do and not have to have a government-run system. My own belief is these other systems fit the culture of the United States more closely than does those who rely on government-run operations.

So it is there for us. We have an opportunity to do something extraordinarily important for this country. We need to seize the opportunity. Mr. Chairman, you have given us a good start.

The Chairman. Thank you, Senator, and I want to thank you as Chairman of the Budget Committee for all the

great work you provided generally just helping us with the numbers, making sure we are within a budget, and also bending the cost curve in the right direction, and also a member of the Group of Six working together, you provided us invaluable assistance in keeping us fiscally on track, and thank you very, very much for your efforts in doing that.

Now I would like to recognize the Ranking Member of the Subcommittee on Health, Senator Hatch.

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH

Senator Hatch. Thank you, Mr. Chairman. Let me begin this morning by first commending you and your staff for your sincere commitment to trying to find a bipartisan solution to reforming our health care system. I can securely state that each of us on both sides of the aisle had hopes that we could be here today considering a health care reform bill that enjoyed wide bipartisan support.

Unfortunately, due to outside pressures and arbitrary timelines faced by the Chairman, we are now considering a bill that once again proposes more spending, more Government, and more taxes as the solution to reforming one-sixth of our American economy.

Affordable and quality health care for every American is neither a Republican nor a Democrat issue. It is an American issue. We are standing, in my opinion, at a historic moment both in terms of opportunity and crisis. Health care costs are out of control as they continue to rise three times faster than inflation and four times faster than wages.

Last month, a nonpartisan Congressional Budget Office estimated that our Nation's deficit for 2009 will

be a staggering $1.6 trillion, and our national debt is on a path to double within the next 5 years and triple within the next decade. And this is all before factoring in the massive price tag associated with the current health care proposals.

The desire for reform is universal. Republicans want to work towards a responsible solution, but we will not let this moment of crisis justify a solution that we cannot afford and starts us down a path of Washington takeover of our health care system. We need to take a more targeted approach. By focusing on areas of compromise rather than strife, we can reach consensus on a financially responsible and targeted bill that could earn the support of Republicans, Democrats, and, more importantly, American families.

We can reform the health insurance market to ensure that no one is denied coverage or care simply because of a pre-existing condition. We could provide greater transparency on cost and choice. We could curb frivolous lawsuits, which, by the way, literally just gets lip service in this legislation as a sense of the Senate. Encourage chronic care management to better control the health of the sickest and most costly patients, and promote prevention and wellness initiatives to keep Americans healthy.

We should give the States the flexibility to design their own unique approaches to reducing the number of uninsured instead of trying to foist a one-size-fits-all solution on the States.

Furthermore, we need to help small businesses, the economic engine that creates 70 percent of all American jobs, and the self-employed to buy affordable coverage by allowing them to band together and buy insurance just like the large corporations do.

At a time when we are drowning in red ink in government-run programs such as Medicare and Medicaid, these are headed for financial insolvency. The last thing we need is another big Federal spending bill that puts the focus on Washington instead of our families.

It is possible to achieve meaningful and bipartisan reform this year. I would mention, though, that just as an illustration, on the Kennedy-Hatch, Hatch-Kennedy CHIP bill, it took us over 2 years of hard struggling work all over the country to be able to bring that bill to fruition. But to have the meaningful and bipartisan support to do that, however, we must be more responsible and realistic in our health care reform initiatives to craft legislation of which we can all be proud.

If anyone believes that Washington--let me just repeat, Washington--can run a national health care plan

that will cost close to $1 trillion, cover all Americans, not raise taxes on anyone, not increase the deficit, and not reduce benefits or choices for our families and seniors, then I have said I have a bridge to sell to you.

I have been saying this from day one. If you are going to spend almost $1 trillion on a system that already costs more than $2 trillion a year, you will have to raise taxes on American families, including middle-class families. I do not want to do that. This bill contains almost $350 billion in new taxes on American families and businesses--this at a time when we are facing one of the toughest economic conditions our Nation has ever seen.

Let me take a moment to highlight some of the policy proposals found in the legislation that we are considering today: $27 billion in new taxes on employers that will disproportionately affect the hiring practices of low-income Americans at a time when our unemployment rate is almost in double digits;

$20 billion in new taxes on a new mandate on families making as little as $66,000, being penalized up to $3,800 for not buying a Washington-defined plan. This is a new tax on middle-class families.

$300 billion in new excise taxes on everyone from insurance providers to device makers to clinical labs,

and every expert will tell you that these so-called fees will all be simply passed on to American families on everything from their already sky-high insurance premiums to blood tests, to thermometers, to hearing aids, et cetera. So much for reducing costs.

Now, this is not all. We are taking more than $400 billion out of Medicare, a program that is going bankrupt in 2017. This is a testament to the efficiency of Washington. Use a program that has a $38 trillion unfunded liability as a piggy bank to finance more Government spending.

We have all done this long enough to know that when Washington tells you that something costs $5, it always costs at least $10 or much more.

So guess what? As our deficit continues to rise and our debt triples in the next decade, all these taxes will continue to rise. This bill is laying the seeds that we are giving Washington a whole new checkbook.

I commend the President's commitment to only signing a bill that does not add a penny to our growing deficit. I sincerely hope that we will apply the same standards of honesty on our accounting of this bill as we are now demanding from our families and businesses.

First, it is important to know that most of the major provisions of this bill do not really start until

2013 and 2014--coincidentally, right after the Presidential election. So the initial 10-year price tag of $856 billion is a significant underestimation. So, in reality, this is not a 10-year score. It is a 6- or 7-year best guess. The real 10-year costs for this bill will be significantly higher.

More importantly, I am very concerned that on legislation this important, which the Chairman has rightfully described as the "single largest social bill since the Great Depression," we will not have a complete score. At a time when Americans all over the Nation are outraged that some members do not even know what is in the bill, how can we justify making these decisions without fully understanding the impact of these policies?

I sent a letter to the President right before his joint address to Congress asking him to do exactly what American families are demanding: Step back, take a deep breath, and start over on a truly bipartisan bill. There is still time to press the reset and push for a solution that can bring us all together.

Having said all that, I do admire the Chairman, and I admire his indomitable fortitude in going through this the way he has. I just wish I could support it. But I cannot.

Thank you, Mr. Chairman.

The Chairman. Thank you, Senator.

Senator Kerry is next.

OPENING STATEMENT OF HON. JOHN F. KERRY, A U.S. SENATOR FROM MASSACHUSETTS

Senator Kerry. Mr. Chairman, thank you.

First of all, let me join others in expressing my respect for the long and tedious investment that you have made to help get us here. This is not a process that began just a few days ago. I think 15 months ago you began this process with a day-long conference over at the Library of Congress, and we have been working on it ever since. And the truth is that we have been working on this for years.

We have done mental health parity. We have done children's health. We have done portability. In 1993 and 1994, many of us on this Committee were part of that effort to get health care done.

You know, when I consider 15 months and the effort we have put into it with a number of meetings, only in Washington could people suggest that that is a rush. And for a lot of Americans who have lost their insurance-- over 80 million at some point in the past two years have gone without insurance. I just learned the other day of a friend of our kids, a young man in his 20s who went to the hospital to have a diagnosis months ago. They did not get his diagnosis back to him. When they did get it

back to him, he learns he has rectal cancer, but his insurance has been canceled.

That happens again and again and again all over the country, and it has got to end. And for that person, this is not a rush. This is long overdue.

You know, when Teddy Roosevelt ran for President as the Progressive Party candidate in 1912, he pledged a system that would protect against just what I described. He said "the hazards of sickness," and it did not happen.

Franklin Roosevelt in 1944's State of the Union address proposed a right to adequate health care, medical care for all. It did not happen.

A decade later, Harry Truman proposed the same thing. It did not happen. And many of us, as I said, were here in 1993 when President Clinton proposed the same thing, and, again, it did not happen.

In 2004, when I ran for President, I had the audacity to propose the same thing. And a funny thing happened on the way to the forum. I did not get there.

But we can get it right now. President Obama and Hillary Clinton both put forward significant efforts built on all of the years of previous effort, and you have to put it in that context. There is no surprise, listening to our colleagues on the other side of the

aisle, that they are finding a reason to disagree at this point. That is why the talks went on and on and on.

This is the time to vote. This is the time to legislate. This is the time to come here. If people have a better proposal--I think there are a lot of open minds here--we will listen. Because one thing is for certain: We do need to get this right. We need to lower the costs for Americans, as the charts that Kent Conrad showed, declare with a clarity that is frightening. And we also need to deliver better quality care in America. Those two things I think are the real standard by which we have to measure this.

And we are not here to just talk about people who do not have insurance. We are here to talk about the vast majority of Americans who do have insurance but who are increasingly finding that what they thought they had does not get delivered. What they think they have paid for they do not get; that when they want a decision, some obscure and invisible, anonymous bureaucrat is making the decision for them, not them and their doctor.

These are fundamentals we ought to be able to agree on, and I think it is absolutely critical that we do so now.

We have an opportunity. This is a historic opportunity. This is a kind of moment that will not come

again soon. And I think it is important that we are here to legislate and take these votes.

The status quo, as Senator Conrad has shown in those charts, is just unsustainable. We cannot afford to sit here and talk and not get this done in the legislation time that we have left.

Everybody has got the statistics. We know we spend more than 50 percent more on our health care than any other country, and yet all that spending is not making Americans healthier than the people in those other countries. Life expectancy in other countries is longer, and infant mortality is lower in most developed countries. That is unacceptable.

Medical bills play a role in 62 percent of all bankruptcies in the United States, and as I mentioned, we have got 87 million Americans, one in three Americans went without health insurance for some period between 2007 and 2008.

So we all know that if we do nothing, which we have proven pretty good at doing, things are going to get worse. The costs will be higher, premiums will be higher, and there will be more Americans who will be uninsured as a result.

Now, are there changes that could strengthen this proposal? I am confident there are. And it is

interesting to listen to some of our colleagues talk about Washington takeover of the banks. We did not take over the banks. We bailed out the banks. We loaned them money. We took a stock position. We did not take management. We did not kick them out. We do not run the banks. And, in fact, the truth is the banks today are repaying the taxpayers of the United States. We made the right decision, just as I believe we are going to make the right decision with respect to health care.

Now, three quick things I would mention, Mr. Chairman. I want to thank you for the work we have done with respect to the idea that I had proposed on the leveraging of an excise tax on the insurance companies in order to drive down the cost of health care on high-cost plans. I am convinced, as are most of the actuaries, that it is going to drive down costs. But I do believe--you have moved, and I appreciate that. And I thank you for the effort of the last few days as we come to this markup to try to adjust it.

I want to make certain, however, in the next days--and I appreciate your willingness to work on it--that we will make any further adjustments necessary to preserve the cost-containing effect while making sure that the burden is appropriately shared. And I look forward to working with you on that.

Secondly, I believe we have to pay attention--and I know others will talk about this--to the question of affordability on low- and moderate-income families. It is key when we finish this that we are lowering those costs in a way that makes this more affordable for them. And I strongly support the efforts to strengthen Medicaid and improve the premium tax credits to the poorest families.

I also believe very strongly, based on the Massachusetts effort on which we are drawing some considerable ideas, that we have not yet done enough to provide appropriate employer responsibility. I have a feeling about that that may differ from some, but I am confident we can work out some methodology, Mr. Chairman, by which large employers will also contribute their fair share to this effort.

And, finally, I am concerned that the bill includes a new fee on medical devices that could stifle innovation and limit the technology advances that are really critical to help reduce health care costs. Let me give you an example.

Medical devices have helped to develop rapid detection of heart attacks, for instance, which has reduced hospital costs by 30 percent. New technology has helped to diagnose and treat strokes, leading to better

outcomes and savings of more than $800 million each year for hospitals. So we need to ensure that American businesses continue to provide medical advances that can reduce the costs, and I do not want to see that innovation stifled.

Mr. Chairman, I would just close by saying to you that in the past I have seen us actually get trapped in some of the details, and we seem to lose touch with some of the larger choices about medical care that we face. In a conversation with Ted Kennedy not so long ago about health care when I was running for President trying to put together a sensible plan, he said to me, "You know, John, there are 12 to 15 ways to do this. And I am sure that each of them probably would work. You have got to decide where you want to land."

And, obviously, there are some philosophical differences here. That is appropriate to the Senate. That is appropriate to American politics. But it is not appropriate for those differences to interminably delay what we are going to do.

Senator Kennedy, as we know, wrote a letter to President Obama in which he said that this concerns more than material things. It is, above all, a moral issue, and at stake are not just the details of policy but the fundamental principles of social justice and the

character of our country.

I believe that. I think many people in the United States Senate, in the Congress, do believe that.

So I hope, Mr. Chairman, that together--I think we are going to do this. We are going to pass health care. We are going to get this done. I have been confident of that all along. I am confident of it now. And we are going to do it because we have to and because it is the right thing to do. And in the end, I think we will show something about the character and the compassion of the American people. And I applaud you for helping to get us here this far.

The Chairman. Thank you very much, Senator. You have been a real leader in health care for years, before we began this process and certainly during this process, and particularly in some certain areas of high-value policies, for example, you have been very helpful to help us find a pathway to a good solution. I thank you very much for your help.

Next, Mrs. Snowe.

OPENING STATEMENT OF HON. OLYMPIA SNOWE, A U.S. SENATOR FROM MAINE

Senator Snowe. Thank you, Mr. Chairman.

First of all, I, too, want to applaud you on your truly extraordinary efforts as you have systematically sifted through the countless intricacies of one of the most significant domestic issues of our time to identify a pathway to quality, affordable health care for hard-working Americans. It is a real tribute to your and Senator Grassley's leadership that embodies once again, I think, the finest collaborative traditions of this Committee that you both convened a bipartisan effort and participated in that effort over the last 3 months, the only bipartisan effort in this Group of Six of any committee in either the House or Senate. And it was a pleasure to work with Senator Enzi, Senator Conrad, and Senator Bingaman where we debated policy, not politics, in attempting to achieve a consensus that builds upon the best components of our health care system.

I, like Senator Grassley, regretted that those deliberations prematurely concluded. But while we did not ultimately reach an agreement, this mark and a number of facets are reflective of that good-faith effort. Indeed, for all who have asked why it has taken months to

arrive even at this juncture, it is because the American people rightly expect and are entitled to an extensive, meticulous process that places thoughtful deliberation ahead of arbitrary deadlines given the sheer magnitude of this issue. And that, like the mark before us, is a solid starting point. But we are far from the finish line.

There are many miles in this journey with more than 500 amendments that have enormous implication in both policy and financing, not to mention the process beyond. And at the conclusion of this process, I hope, Mr. Chairman, that we will have the opportunity to review the final mark and revised CBO estimates on the bill as amended before we move to any final vote.

Let us recall it took a year and a half to pass Medicare to cover 20 million seniors. So we simply cannot address one-sixth of our economy in a matter of such personal and financial significance to every American on a legislative fast track. The reality that crafting the right approach is arduous in no way obviates our responsibility to make it happen.

Everyone has differing opinions on how to address this historic challenge. Yet virtually every person that I have encountered in my home State of Maine or across the country understands unequivocally, whether you have

health insurance or, of course, those who do not, that the system is fundamentally flawed and broken, and that this is not a solution in search of a problem.

There is simply no denying that the inexorable trend of rising health care costs, which are expected to double by 2019, is not only leaving one in four Americans with inadequate or non-existing coverage, but is also threatening middle-income Americans as rising premiums place their existing coverage that they rely on at risk. Already 81 percent of working Americans are uninsured.

Recent history is also a prodigious indicator of the consequences of inaction. Ten million more Americans are uninsured since the last attempt on reform in 1993. And over the last decade, according to a recent survey, premiums have surged 131 percent, more than three times the increases in workers' wages.

These alarming numbers are but a harbinger of things to come with average premiums, according to CBO recently, for employment-based family coverage expected to rise from $12,680 to $19,000 a year in 2016.

It is indisputable that skyrocketing health expenditures are fueling rising premiums in a kind of perfect storm that will increasingly rob Americans of affordable access to coverage.

So really what it comes down to is this: Either we

accept we are on a trajectory to spend a total of $33 trillion on health care over the next 10 years, or we decide we will incrementally reorder approximately less than perhaps 3 percent to realign today's misaligned incentives and policies that are driving prices up and driving families and businesses out of the insurance market.

We know that simply increasing access would be treating the symptom while ignoring the underlying disease. The question is: How do we discern the most appropriate approach and equilibrium that will lower costs both to the consumer and to the Government, bridge the affordability gap, preserve and expand options, and assure that insurance companies actually perform?

In that light, significant work remains to be done that is critical to the outcome of this legislation. At the same time, it includes some fundamental components that are the pillars upon which we can build, reflecting the principles on which many of us have been adamant.

It fully finances reform without deficit spending, and it does so entirely within the health care system.

Responding to fears about Government takeover, it instead strengthens our existing employer-based systems, and at long last it finally ends the unfair, egregious insurance policy practices so no American can be denied

coverage, no policy can be rescinded when illness strikes, and no plan can be priced based on gender or health status.

To address the dearth of competition within the market, the health insurance exchange created in this mark can be a powerful marketplace for creating competition and lowering premiums, which CBO estimates could potentially reduce up to 10 percent in administrative costs because they believe for the first time that more than 25 million Americans will be able to shop, compare prices in one place, as insurance companies vie for those customers and as the exchange will prompt greater efficiencies in the marketing and the administration of plans.

The mark also institutes a framework that Senator Lincoln, Senator Durbin, and I developed to create an exchange for small businesses designed to reverse the stunning lack of competition in small-group markets where premiums are 12 percent higher because there are a few insurance companies dominating those markets.

For the first time, small businesses and the self-employed could access an exchange that would unleash a panoply of small business regional plans, State plans, and even plans that would be offered across State boundaries in all 50 States.

It is precisely this kind of robust competition that will lower administrative costs that consume almost 30 percent of small business premiums today.

And when larger employers, as well as those who are self-insured, both of which also are stretched at the seams due to costs--and according to the recent study by Business Roundtable, are also clamoring to be allowed to purchase plans in the exchange--I think it tells me that they recognize the effectiveness of the competitiveness that will develop in that exchange and the marketplace.

I appreciate the mark includes my amendment that would expand small business eligibility to up to 100 employees and that would expedite larger firms' access to the exchange in the future.

An additional cost driver that must be confronted is the deleterious and costly effects of medical malpractice claims encouraging defensive medicine practices. While this Committee does not have jurisdiction over this issue, the mark does call for State demonstration programs, the kind that have been extremely successful in my State of Maine for the last 25 years. So this would open the door to a more rational approach to this corrosive problem.

Collectively, these measures and others in the mark before us will help to substantially reduce the level of

cost throughout the system. However, in and of themselves, they cannot accomplish another overarching goal, and that is, affordability and health insurance coverage, particularly for those 70 percent of Americans below 300 percent of poverty level, at about $32,500 for an individual. These individuals would face premiums as high as $5,000 in 2016.

And although the mark provides sliding-scale tax credits for those between $14,000 and $32,000 for an individual and other modest premium assistance and support between $32,000 and $44,000, there remain major outstanding issues that must be resolved to ensure that everyone, whether they are in the exchange or getting employer-provided coverage, is able to afford a plan.

This is all the more disconcerting given that the mark requires individuals to either obtain coverage or pay a penalty, even where there is an absence of affordability.

For example, according to CBO estimates, a middle-income family of four making $67,000 a year that is not under employer coverage would be required to spend 20 percent of their income, or $13,200, or incur a $1,900 fine and have zero coverage to show for it. This should not be about imposing punitive measures on individuals, and particularly in these very difficult economic times.

It is about our responsibility to accomplish the goal of affordability.

Consider a family of four earning $44,000 per year. With tax credits on the exchange, their share of a $15,000 cost of an exchange plan would be reduced to $3,748. Yet if that same family is offered employer-provided coverage, before they would be permitted to access the exchange, they would have to spend 13 percent of their income on coverage. This amounts to an almost $2,000 disparity per year for a lower-income family. That is wrong and it is unfair, and I will be introducing an amendment to scale the affordability test for those offered coverage with employers so that we do not create an impenetrable firewall that blocks affordable access and creates unacceptable inequity.

Finally, Mr. Chairman, let me just say the proposed expansion of Medicaid, which is the second largest component in this legislation, presents a challenge of affordability and fairness for our States, especially given the broad gap that currently exists in Medicaid eligibility from some at the deepest level of poverty to $3,000, to others as high as $48,000. We have heard--and we have discussed this with the Governors--not only about the equitable allocation of Federal assistance between those who have already expanded their Medicaid population

and between those who have not. Moreover, States are locked in, in this mark, to maintaining current Medicaid eligibility standards which vastly exceed the levels in this bill.

Considering that burden in conjunction with the impact of broadening Medicaid, I can well appreciate that States are truly concerned about the potential for unforeseen consequences on their budgets, especially in light of one study that reports that States' revenues in 2014 will be the equivalent to the pre-recession levels of 2007.

I understand in my discussions with the Governor of Maine that the National Governors Association is proposing several initiatives, and I hope that we will continue those discussions on how to proceed as this markup unfolds.

Given all of these issues, given the gravity of this landmark endeavor, there should be no question that this undertaking commands a painstaking process and the requisite time for full consideration of the spectrum of alternatives and improvements and to ensure the numbers add up in the final analysis with the final product.

We are the only Committee of jurisdiction with respect to financing the entirety and the totality of health care reform, and that is why it is so important

that we are assured of the final estimates by the Congressional Budget Office. The implications of this legislation are simply too broad and monumental to do otherwise.

Thank you, Mr. Chairman.

The Chairman. Thank you, Senator. You have made several points which are very valid: one, that we make sure that the numbers add up first and know what the numbers are. You have made that point many, many times in many, many meetings that we have jointly attended, as well as conversations we have had, and I deeply appreciate that and agree with you.

Second, you have made some very good points about affordability, both for those with coverage and those required to get coverage. And we have tried to address some of those points in the modified mark. If you have not already seen the modifications, they have moved significantly in that direction--a direction, I might add, that other Senators have also asked us to move in. We will continue to work with you on all that because you have put your finger on some very key points here that are very valid, and we deeply appreciate it.

Next in line is Senator Schumer, who is not here right now, but following our usual custom of going back and forth, first one side, then the other, we will pass

Senator Schumer for the moment and now go to Senator Bunning.

OPENING STATEMENT OF HON. JIM BUNNING, A U.S. SENATOR FROM KENTUCKY

Senator Bunning. Thank you, Mr. Chairman.

I think everyone agrees that Congress needs to look at ways of reforming our health care system. Too many Americans are underinsured, uninsured, or cannot afford the health insurance they have. Reforming health care, which amounts to over 17 percent of our economy, is no easy task, and it is a process that should not be rushed.

Health care reform will likely touch every American through changes in their personal health care policies and having to pay higher prices for insurance policies, medical devices, and prescription drugs.

Unfortunately, I will not be able to support the health care reform bill before us as it is presently in form. I will take a minute to lay out some of my chief concerns.

I do not support a Government takeover of our health care system, just like I did not support a Government takeover of our banks and auto industries. The co-ops in this bill are unnecessary to reforming our health care system, and they run the risk of leading to a national health care system based out of Washington, D.C.

I do not support the provisions in the bill that

require every American to buy health insurance or pay a tax. These provisions trample on the freedoms of Americans, and I cannot support this. It seems to me that there are better ways to increase the number of Americans with insurance without resorting to these extreme measures.

I have concerns about using cuts in the Medicare program to help fund health care reform legislation. Medicare will be broken in 2017, and our focus should be on improving the solvency of this program, not diverting money from it.

I also have concerns that the bill costs $774 billion, but leaves 25 million people uninsured, with about one-third of them being illegal immigrants. If I remember correctly, covering the uninsured was the main reason Congress needed to tackle health care reform. This bill falls short of meeting that goal.

I am deeply concerned by the tax increases in this bill, most of which break the President's promises to the American people. Let us review those promises.

First, he promised that individuals who make less than $200,000 and families earning less than $250,000 will not pay more in taxes. Nearly every tax increase in this bill will affect families who earn less than that. And I was stunned when I heard the President say this

past weekend that the individual mandate, which is an amendment to the Tax Code and is specifically called an excise tax in the Chairman's mark, is not really a tax. Perhaps we should change the name of the Tax Code to "A Shared Responsibility Code" so we are not really imposing taxes on the American people.

A second promise the President made was that if you like the health care coverage you have, you can keep it. Under the tax increases in this bill, health flexible spending accounts and health reimbursement accounts will likely disappear because of the high-cost-plan tax. And in another provision, taxpayers will lose health care coverage that allows them tax relief for the cost of over-the-counter medicine.

When the President spoke to the joint session of Congress, he made a third remarkable promise: that health reform would decrease cost of care for Government, businesses, and individuals. We already know that the tax increases in this bill will drive up out-of-pocket health care costs for individuals and make the insurance policies employers offer more expensive, and the Government will spend more, not less, on health care.

The fact that the Chairman's mark confiscates more money from the taxpayer and shifts costs to consumers in order to make the Government's books balance does not

change the fact that Government will spend more on health care than it would under the current law. We will all be spending more.

Health care reform is absolutely needed. I don't think many people think it is not. But this bill is moving us in the wrong direction. It puts too much control in Washington, D.C., tramples on American freedoms and liberties, and raises taxes. Honestly, Congress needs to listen to the American public, take a step back, and start this process over again. This issue is too important for us to get wrong.

Thank you, Mr. Chairman.

The Chairman. Thank you very much, Senator.

Next on the list is Senator Menendez.

OPENING STATEMENT OF HON. ROBERT MENENDEZ, A U.S. SENATOR FROM NEW JERSEY

Senator Menendez. Thank you, Mr. Chairman, and thank you for your leadership to where you have gotten us today. I appreciate it very much.

Mr. Chairman, more than a half-century ago, Harry Truman said, "We should resolve now that the health of this Nation is a national concern and that the health of all of its citizens deserves the help of all of the Nation."

Well, the time has come for us to act. This markup is an important moment for reforms delayed decade after decade after decade.

To those who say our current health care system is the best we can do, to those who believe that more of the same is what the American people deserve, I say that allowing a health insurance company's profit margin to come between a doctor and a patient is no way for a health care system to run; that leaving tens of millions of our fellow Americans to rely on an emergency room for their primary care is no way to treat our neighbors. And I have heard many speeches on the Senate floor about how we need to treat our neighbors and the importance of our neighbors' lives. And it certainly is no way to control

the budget deficit.

There are issues with our health care system that should eat at our national conscience every day. Middle-class families in this country who have health insurance are being bankrupted by health care costs anyhow. And when they need insurance coverage the most, it very often simply is not there for them. They get denied and denied and denied.

Throughout my 17 years in Congress, thousands of New Jerseyans have approached me on the street, visited my office, or called on the phone, sometimes in tears, to tell me their health insurance stories--some of the most heart-breaking stories you will ever hear. And millions of other families who may not be facing dire circumstances are, nevertheless, worried that their insurance is costing them more and more each year, that they have been denied coverage for a test or a visit to the doctor's office. These are the stories that exist under the present system, stories that almost every family has. These are the reasons we need to follow through with meaningful health insurance reform.

Now, I applaud the Chairman's leadership in getting us to where we are today, and I appreciate him listening to several of the concerns we have had and trying to incorporate it. But I also know the Chairman is well

aware that my focus is not just on passing any bill called reform, but on enacting actual reform that ensures that every American has access to quality and affordable health coverage. As such, there are some changes to the mark that I hope to see.

We have to make the insurance exchange more affordable for average working families regardless of where you live--a big issue in a State like mine. That means reducing the amount families spend on health care as a proportion of their budget, helping families who sit around the kitchen table trying to stretch their paycheck to cover the mortgage, groceries, and health care costs each month.

We have to ensure that a tax on high-value insurance plans does not end up hitting middle-class and working families in States like mine, many of whom are serving the public as teachers and firefighters and police officers.

And we should not let the hysteria over immigrants block American citizens' access to health care they deserve and are entitled to.

We need to strengthen consumer protections as much as possible, and I have offered a number of amendments, many of which hopefully will be accepted by the Chairman, which provide protections and support to families in

getting the care they need. And I have also offered amendments to protect federally qualified health centers, maternity coverage for young women, and better care for our Nation's children, including those with autism.

And I believe we need to ensure a level playing field for every consumer, and that is why I am a strong supporter of a strong public option. To truly level the playing field, we eventually need a discussion of a public plan in the insurance exchange. And to my less than progressive friends, we need transparency and accountability in the market, and to ensure real, honest, fair competition among qualified insurers.

We need to create a new framework and throw out the old business model that says insurers should do all they can to avoid risk rather than provide the best value at the best price to the most people.

Finally, Mr. Chairman, I know that there are legitimate disagreements in the Committee that are ideologically based, and I appreciate that. But I also have a real concern when I listen time and time again to things like death panels that never existed and would never exist. I have a real concern to hearing the constant refrain of the Government takeover of health care when not only can this be a boon to the insurance industry, and it is based on the private marketplace that

exists, but also when this plan does not even call for a public option in the present mark; and yet we hear a Government takeover of health care.

I have a real concern when I read in today's press that the National Republican Senatorial Campaign Committee has already its eyes on Democrats, including those up in 2012, a little futuristic looking, and plans to bombard Democrats who sit on the Finance Committee with attacks on their votes on controversial amendments during the Committee's deliberations. This is quoted from an article today. And their spokesperson says if Senators bow to the pressure from the White House and liberal special interest groups and think no one is watching, we will welcome that false sense of security, but the NRSCC intends to actively inform their constituents that they have put the political interests of their party's leadership ahead of the interests of the taxpayers and their States. So then I wonder whether it is an ideological divide or partisan political opportunity. And when I hear that this could be President Obama's Waterloo, again, I question the sincerity.

So, Mr. Chairman, all of us--it is shameful, I would think, to suggest that political opportunity comes by virtue of not reforming health care, because that is not

about President Obama failing. It is not about this Committee failing or the Senate failing. It is about failing the American people.

All of us have a stake in the result. All of us want to ensure that every American family has affordable access to the best health care system possible. And all of us who believe, as Harry Truman did, that the health of the Nation is a national concern that deserves the help of all of the Nation has an opportunity to act now.

Let this be the time and ours the generation that finally realizes the dream held by generations of leaders, from Harry Truman to Ted Kennedy. Let us make affordable health care for every American a national priority.

The Chairman. Thank you very much, Senator. You have been very helpful.

I recognize Senator Kyl.

OPENING STATEMENT OF HON. JON KYL, A U.S. SENATOR FROM ARIZONA

Senator Kyl. Thank you very much, Mr. Chairman.

First, let me associate myself with much of what Ranking Member Senator Grassley had to say: first, that this issue, being as important as it is, requires an amount of time commensurate with its importance, and that artificial deadlines are antithetical to the best results.

Secondly, I think our Democratic colleagues have to admit that it is hard for Republicans to make big concessions when there are no assurances that they will be respected later in the legislative process.

Third, this bill is a stunning assault on liberty, mandating that everyone buy a particular type of insurance defined by Washington, D.C. Senator Grassley is right that solutions like reinsurance, for example, are preferable to a virtual total control taken by the Government.

Fourth, he mentioned several Republican ideas that have received relatively short shrift from our Democratic friends, for example, real solutions to the problem of lawsuit abuse, the medical malpractice reforms that we have been talking about for a long time, which have the

additional benefit not only of reforming an important part of health care, but also significantly reducing costs. This, of course, should be our main goal because it is what both makes insurance more affordable and more accessible.

As Senator Grassley has pointed out, this bill increases costs. It does not lower them. The increased spending requires more offsets, which requires more taxes, which are passed on to the very people we are trying to help, and the spiral continues.

And this illustrates the essential difference in approach between most Democrats and Republicans. While this bill would spend $800 billion, offset by taxes and Medicare cuts, the net result will be an increase of costs of health insurance--and, therefore, health care--and a reduction in its availability, especially for seniors. Americans, especially seniors, can expect delays in denial--in other words, rationing of health care.

Republicans start with the premise that at least 85 percent, maybe a little over 90 percent of Americans have good care and insurance and do not want Washington to mess with it. That is the problem that most of the public opinion polls are reflecting with respect to the popularity of the President's proposal.

The problems of cost and access we believe can be dealt with without a Washington takeover of the other half of health care, the half not already government-run, and that you are not doing any favors to people like our senior citizens, for example, by cutting their Medicare by $400 or $500 billion.

Rather than taxing the insurance plans and the device manufacturers and others, making insurance and health care more expensive, Republicans believe that there are ways to reduce cost and, therefore, enhance access. Let me just mention three.

Why not consider the Republican idea to empower small businesses and other groups to be able to negotiate with insurance companies from the same bargaining power that big businesses have with the associated health plans concept? This will reduce cost and increase access.

Why not also drive down insurance costs by allowing interstate competition? Again, it does not involve any more Government involvement in the process. If there are only a couple of insurers in Alabama, for example, why not allow its residents to buy policies offered in surrounding States? We do that with health insurance to great effect, and this, too, will enhance competition and reduce costs.

Another way to reduce cost, as I mentioned before,

is in the area of medical malpractice reform. As Ranking Member Grassley said, we do not need any more demonstration projects. We know what works. Look at the State of Texas, which has significantly reduced insurance premium costs for the medical practitioners in the State. My understanding is they attracted 7,000 new physicians to that States as a result primarily of their malpractice reforms.

One study shows that over $100 billion a year is wasted because of the practice of defensive medicine. Those costs could be eliminated and applied elsewhere in our system with effective malpractice reform.

Another study showed that 10 cents on every dollar spent on health care is spent by physicians and other providers for their malpractice premiums.

My point here is that there are better alternatives, and they have the additional benefit of not harming what we already have. I mentioned harm to the seniors on Medicare, but Senator Kerry mentioned another unintended consequence of the Chairman's bill: the negative impact on life-saving innovation when you take things like medical devices. When you tax something, you get less of it.

The fundamental flaw in this bill is the taxation of the very providers of insurance and health care that we

demand take care of our health needs. The costs are then passed on in the form of higher premiums and reduced care.

Mr. Chairman, the complete Government control through the individual mandate and insurance exchange regulations guarantees an end to innovation in insurance plans. Under this bill, they become little more than prepaid health administrators for the Federal Government. And as experience in places like Massachusetts demonstrates, when costs soar, rationing of health care becomes the ultimate cost controller. This, I submit, is not reform.

The Chairman. Thank you, Senator. I would like to acknowledge your leadership on your side of the aisle--

Senator Kyl. Thank you. And, Mr. Chairman, thank you for--

The Chairman. --and presenting a certain point of view, and we look forward very much to the debate.

Senator Kyl. I appreciate the comment, and I thank you and thank Senator Crapo for switching times with me so I could leave at this point. Thanks.

The Chairman. I believe Senator Nelson, who is next, is not here, so, Senator Crapo, you are next.

OPENING STATEMENT OF HON. MIKE CRAPO, A U.S. SENATOR FROM IDAHO

Senator Crapo. Thank you very much, Mr. Chairman. And I also want to express my appreciation for your significant commitment to helping to work with the members of this Committee on trying to move forward with a strong product. And I hope that we will be able to achieve that.

That being said, I do have concerns about the speed with which the process is being moved forward. I know that we are working right now off a more than 200-page summary, which, as we all know, is not even in legislative language yet, but would probably generate well over 1,000 pages of legislative language when it does actually get written into detail.

And there is a new mark, I assume, that we are going to see early this afternoon that we have not even yet been able to see or get a score on. We have over 500 amendments filed, and I suspect that more amendments will be requested to be filed once the new mark is brought forward.

And my understanding is that we are going to be expected to bring all of this to fruition within just a matter of the few days left in this week.

I hope that we are going to have the time to work this through.

The Chairman. Well, we will work all night.

Senator Crapo. I hear you and I appreciate that. I am prepared for early mornings and late nights.

But the bottom line here is that there are a lot of very significant and heart-felt believes about how we should approach reform of health care in our country, and there are a lot of concerns about the mark. I have a number of concerns myself about the mark that has been brought forward.

For example, the plan will commit our country to almost $1 trillion in new spending at a time of unprecedented deficits and increasing public concern about rising debt. And this $856 billion cost estimate is an estimate of cost over 10 years, but the true cost is much higher because, as we know, the implementation of the major provisions of the bill are going to be delayed for a number of years, and we are only seeing about 6 years of the cost in that first 10-year cost estimate.

Some are estimating that the full 10-year cost estimate will be much closer to $2 trillion, but the fact is we do not know what the full 10-year cost of the bill is going to be.

The $856 billion plan is going to be paid for with

$507 billion in cuts to Government health care programs and $349 billion in new taxes. Most of the new taxes are going to be passed on to the consumers in the form of higher costs for everything from contact lenses and hearing aids to health insurance premiums. And the taxes are going to go into effect immediately, even though the other major provisions will not go into effect until 4 years later.

The United States already spends more than any other country on health care, and instead of reforming the system to spend this money more effectively, this proposal is going to commit us to spending even yet more without the kinds of reforms that I think will truly bend down the cost curve.

Not carrying insurance, for example, could result in a fine as steep as much as $3,800 per family or $950 for an individual, and these new taxes are going to fall largely on the middle class, which is a direct break with President Obama's pledge not to raise taxes on anybody but the wealthy. I noted that this weekend there was quite a bit of talk in the news shows about whether or not this proposal even contains a tax or not. I think that it is pretty clear--the proposal itself states that the consequences for not maintaining insurance would be an excise tax and makes it clear that the excise tax

would be assessed through the Tax Code and apply it as an additional amount of Federal tax owed. Yet the President is saying that there is no new tax in the bill, that his pledge to avoid increasing taxes for those who make under $250,000 is honored. Yet last year, in September, he indicated that under his plan no family making less than $250,000 a year will see any form of a tax increase, not your income tax, not your payroll tax, not your capital gains taxes, not any of your taxes. And yet we see this major new proposal for more taxes before us now.

The plan gives unprecedented power over reforming Medicare spending and benefits to an unelected board that would be given authority to determine payments to providers for Medicare with limited congressional review. And there are those who already have raised significant concerns about that delegation of authority to manage Medicare.

There is only a 1-year fix for the payment system for physicians, so Congress will be forced to come back next year, and in future years, which I believe it should do on a permanent basis, and increase more spending and have more offsets in future years because the bill does not totally address all of the health care spending pressures that we are seeing in the system.

The cuts to the Medicare Advantage plan are going to

break with the pledge that we can keep what we have. These cuts are going to force millions of seniors off of their current plans or reduce the benefits to them in an overwhelmingly popular program.

The bill is going to put an unsustainable burden on States through the unprecedented expansion of Medicaid, a Government program that is consumed by waste and fraud, and where we should be finding more savings. And in many States now, less than 50 percent of the doctors accept new Medicaid patients, so it is not clear what increase in access will be available under the proposal.

The President has said many times and has promised the American people, if you like your health care coverage, the coverage you currently have, you can keep it. That will not apply under this plan. For those who have the flexible spending accounts, they will see their annual limits cut from $5,000 to $2,000. It will not apply to the millions of people on Medicare Advantage who will see their funding slashed by over $123 billion. It will not apply to people who choose now to pay for their own health care and will be forced to pay--or exposed to $20 billion in penalties. And it will not apply to those with health plans valued at more than $8,000 for singles or $21,000 for families, which includes many middle-class families who will then be facing the 35-percent excise

tax that I just discussed. And so there are a lot of concerns that I think we need to be addressing, and I hope we will have the time to do so.

It is well understood that these new fees being imposed on the various sectors of the industry that some of my colleagues have discussed are going to be passed right on to the consumers. I do not think that is very debatable. But there is also another hidden cost here that will be passed on to consumers, and that is that the excise taxes and other fees paid by businesses, which generally are deductible for income tax purposes, are not deductible under this proposal. And as a result, these costs also, I believe, are going to be passed on to the consumers.

It is said that the bill bends the cost curve down, and it perhaps does so for Federal spending. I am not convinced of that yet. But I do not see that it bends the cost curve down for consumers, as these costs are going to be continually passed on and people are going to see either higher copays, fees imposed by pharmaceutical companies leading to higher drug prices, or fees that some have already talked about for higher medical device prices, leading to people paying more for everything in medical devices from home oxygen tanks to other vital medical services.

And even more troubling is that the threshold for these excise taxes on insurance plans are indexed in the bill to the CPI for urban consumers, which almost certainly is going to grow at a rate slower than the medical CPI. And that means that within just a few years we are going to see pretty much any health insurance plan from your standard Blue Cross/Blue Shield plan to even the lowest value bronze plan created under this exchange subject to a potential 35-percent excise tax.

In fact, some estimates are that because the thresholds are not indexed to medical inflation, the number of Americans subjected to the tax will almost triple in just 6 years, and we will see a similar thing that we had seen with the alternative minimum tax, with that continuing to encroach year after year as a new tax and an increasingly higher tax on the middle class.

Mr. Chairman, I think there are a lot of reforms that we can find agreement on that will bend the cost curve down and will increase access and will improve the quality of health care in our country. But as I have indicated, I have very significant concerns about a number of the provisions in this bill, and I look forward to working with you and the other members of this Committee to craft legislation that will truly reach the kinds of results that Americans are asking for.

I thank you again for your effort on the issue.

The Chairman. Thank you very much, Senator. Without getting into tit for tat, because there are things you and, frankly, others said to which there are more than adequate responses, including changes in the modification, one is the index. The modified mark does raise the index from CPI to CPI plus one, at least in partial answer to one of the points that you made. But there are many other points, too, which I will not get into at this point.

Senator Schumer, you were absent when we came to you. You are now present, so you are next.

OPENING STATEMENT OF HON. CHARLES E. SCHUMER, A U.S. SENATOR FROM NEW YORK

Senator Schumer. Thank you, Mr. Chairman, and I thank all of my colleagues.

Mr. Chairman, in the 35 years that I have been a legislator, I have never seen anything that is harder to do than health care reform, and it is not just a little bit harder. It is a lot harder. And so I want to salute the President for having the courage to put this at the top of his agenda. He could have easily walked away from it.

And I want to salute you, Mr. Chairman, who have been just forward moving, relentless, implacable, because you know how important it is that we do health care in America. It is so important to do, and we must get this done. And we know why. The numbers are stark and getting starker all the time. The costs of our health care system, the amount of GDP devoted to this sector alone have become untenable.

My colleagues have talked about the impact on the Federal deficit, and that is true and real. But there is also the impact on business and private employers who struggle to remain competitive, and to their employees and individuals who devote more and more of their incomes

to health care costs.

Quite simply, in our system we do not get what we pay for. There are elements of the system that are top-notch, no doubt about it. Medical education is the envy of the world. We have some of the best hospitals. I am proud many are in my State. We are still the leader in technological innovation and in treatments for chronic diseases.

But too many Americans and more and more of them each year lack the fundamental reassurance they deserve, the peace of mind to know that if they or a loved one gets sick, they will get the treatment they need without being bankrupted in the process. We know the statistics, 50 million people not covered. But I think it is the personal stories that I hear that affect me the most. When I go to Eerie County or Onondaga County upstate, the suburbs in Nassau, Suffolk and Brooklyn, Queens, the Bronx. There is nothing worse than having a mom look you in the eye and say, “My son, my daughter has a terrible illness and I have no way to pay for his or her treatment.”

It is devastating. It is heartbreaking. We must help them. But it also affects those who are covered, who have insurance, by the government, Medicare, a government program or private insurance.

Most Americans are covered. But they know something is wrong, but they also know that they like what they have because they do not see the problem directly. For example, seniors love Medicare as they should. It is a great program. It is one of the best things we have done in the federal government.

But it is going broke in seven years. Seniors do not see it because it is the government that is paying for it, but what are we going to tell seniors if we do nothing and in seven years Medicare is broke? And seniors know that if we wait until year six to fit it, who is going to pay the price? They will. We have to fix it now.

In the same way, those Americans who have health insurance do not see that much of the cost increase because it is their employers paying for it. But the inexorable hand of health care inflation is pushing on them as well, driving up premiums, raising deductibles, lowering their coverage. They are getting less and paying more. And we have to tell them what is going to happen.

Because private health care costs have doubled in the last six years, inevitably millions, probably ten millions of Americans in the next decade are going to be called in by their employer and that employer is going to

look them in the eye and say Jim, Mary, you are a great worker and I want to see you stay with my company as long as you can. But I have bad news for you. I'm going to have to change your health care policy.

You are going to have to pay the first $5,000 or $10,000 yourself and you are going to have to double your monthly payment for it. Or worse, Jim, Mary, you are a great worker, I want to keep you, but I can no longer give you health care insurance. That will happen if we do nothing inexorably. So act we must. Act we must.

Like many of my colleagues, I think, I have spent a lot of time talking to people across my state about health care. And those who are covered are worried about the future, want stability and security but do not want the system dramatically changed. The worry, and I understand this, is they worry that the changes will not make things better.

Mr. Chairman, that is something we need to remember as we go through this process. It is not just making sure that most people are better off. It is also making sure we do not make people worse off. In many ways, we need to recognize the ancient medical dictum, do no harm.

So this bill takes a giant step forward in that direction. It deals with some of the cost issues in very smart ways and I am pleased by them. Bundling, value

based purchasing, integrated care.

For the first time, we are beginning to move away from the fee for service model that drives much of the waste and inefficiency in our health care system. That is the fundamental reason people are paying more and getting less back. There are many other good things in this bill. Many, many, many.

But I also believe there are things we must do to make it better. I am a firm believer in the public option. Because I think it is vital we have greater competition. Ninety-four percent of insurance markets are highly concentrated.

If we do not have a public option, the people, employers, individuals, will not get competition and the costs will go down. Just remember, you are not forced to join it, it is an option. It is like, as the President said, schools, colleges.

In New York we have public and private colleges. They are both good, they compete, people make their choice based on which is better to them and each is better because we have them.

We also have to deal with affordability. We cannot tell the middle class and working class that here is an insurance policy that you can buy but you cannot afford it, or it is too much of your income. I think we have to

do better on affordability in this bill.

Finally, there is the idea of many workers in high cost states like mine but in others as well, firefighters, others, who do not get paid that great a salary but because their job is risky, they have high insurance costs. We have to protect them as well.

These and other changes must be made in the bill, and there are many and we all have lists and that is what the process will be in the next few days.

So in short, Mr. Chairman, this is a very good start. But it must be improved in the committee, on the floor and as we move to conference. I look forward to working with you, Mr. Chairman, to pass health care reform now and to provide the American people with the confidence that health care reform will work for all of them. Thank you.

The Chairman. Thank you very much, Senator. I appreciate your vigor in your addressing the subject.

Senator Nelson, you were on the list. Earlier you were absent but I see you are now here and I would like to recognize you.

OPENING STATEMENT OF HON. BILL NESLON, A U.S. SENATOR FROM FLORIDA

Senator Nelson. Mr. Chairman, thank you for bringing us to this point. Thank you, Senator Hatch for the continued input that you have and I look forward to a very substantive discussion. This Chairman's mark is a good starting place. I believe it needs to be massaged and then let us see if we can get something because after this long, hot summer where even violence got into the debate, it simply captures the passions, some political, some partisan, but some very substantive.

Any one of us has a constituent like mine that has been undergoing cancer treatment and it has been going on for a year or two and then suddenly the notice comes from the insurance company that the cancer treatment patient is going to be cancelled. That is intolerable, but it is a fact. That is what we have got to address here.

What we want at the end of the day is we want health insurance that is available but is also affordable. You know, there are many different choices. Senator Wyden and I have a proposal. It would even be budget neutral within a couple of years. But it is also a significant change from the present because it decouples insurance coverage from a system that is organized around an

employer group policy even though that proposal would allow everybody to keep their employer sponsored coverage.

So we are -– now we need to move forward. I think all of us agree that the system that we have now is unfair, it is too costly and it needs to be fixed and now we have the chance to fix it.

So the reality is that before a person dies, nine out of ten of us are going to end up in the hospital. I think this Chairman’s mark will let folks happy with their insurance keep it, and that means that senior citizens that are on Medicare and veterans, they are not going to have any change. But those who do not have insurance are going to have the opportunity or those who have insurance that they cannot afford it are going to be able to go into a health insurance exchange, a marketplace where you can get coverage at an affordable price.

Because of the free market competition, we can hold the insurer’s feet the fire by requiring them to cover everyone in that health insurance exchange in preventing them from dropping people like the constituent that I mentioned.

This mark has several measures aimed at reducing the overall medical and prescription drug costs and

eliminating waste and fraud in the system, all to the good. But I believe that we can do more for low and middle income families while keeping the overall cost of the bill reasonable.

Others have warned of the importance of addressing the high health cost of retirees not yet eligible for Medicare. It is critical that we protect and preserve health coverage for retirees not yet eligible for Medicare. For those seniors, it is not about a Cadillac or gold plated coverage. I am going to offer an amendment that would protect those retiree's health benefits from the high cost health insurance excise tax.

Mr. Chairman, it is my understanding that you may be addressing that in some modification before we would ever get to my amendment.

Another issue that troubles me is the potential for rapid cost increases to senior citizens on Medicare in Medicare HMOs which is called Medicare Advantage. Now, I do not dispute that high subsidies to Medicare Advantage insurers need to be adjusted. But I do not think that it is the right thing to ask senior citizens to give up their existing Medicare Advantage benefits because there are hundreds of thousands of senior citizens who did not conceive of Medicare Advantage but who have come to rely on it.

I intend to offer an amendment that will shield them from benefit cuts. It will be called the grandfather, to grandfather them in. Mr. Chairman, I happen to come to the table with clean hands on this issue because I voted against that Medicare advantage which was part of the prescription drug bill that was passed five years ago.

But it is the law and many senior citizens have come to rely on that coverage. And to suddenly whack it away from them I think is unconscionable. You cannot punish the seniors who signed up. If changes must be made for the future solvency of Medicare, then I think those seniors ought to be grandfathered in.

Another concern that I have is the price that the federal government currently pays for drugs. I plan to offer an amendment that would require pharmaceutical companies to provide rebates to Medicare just like they do to Medicaid.

There are more Medicaid recipients than there are Medicare recipients. Roughly 49 million Medicaid, roughly 44 million Medicare. Now, that has been the law. We get rebates. In other words, using the purchasing power of the federal government to get the cost of drugs lower to Medicaid. If that is good enough for Medicaid, why is not it good enough for Medicare to bring the cost of drugs lower?

It would certainly save Medicare a ton of money and this famous donut hole that does not ever seem to get closed, we could close that donut hole.

I have some serious concerns about state compacts allowing one state to join with another. If you do that for the purposes of getting larger numbers of people in a health insurance exchange, that is great because that gives more lives to spread the health risk over. But if there is some subterranean subterfuge that is trying to get away from the regulatory authority of a particular state by suddenly hitching up with another state who does not have much regulatory authority so that that state's authority then applies to the state with greater regulatory authority, then I have a problem with that and I start to think of my old days as the elected insurance commissioner of Florida standing up for the consumers of the state, particularly when the insurance commissioner did not have the regulatory authority to protect those consumers.

So Mr. Chairman, thank you for what you have done. I will add my accolades to all of it. If we are able to achieve this goal of expanding affordable health care to nearly all Americans, then we are going to have to do so and not take it out of the hide of the middle class or upending their coverage. At the same time, we cannot

lower the quality of health care to seniors in the process.

I commend you, Mr. Chairman. I have been one of your advocates. I stand by you that this is a good first start. Now let us go perfect it. Thank you.

The Chairman. Thank you. You have been very, very active and helpful in working with us to find a solution. I compliment you for your constructive comments and hard work. Next, Senator Wyden.

First I want to tell you, Senator, how much I appreciate and I know many, many people in the country, you have been a leader in health care for years. Those you have introduced, modifications of health care that you have introduced.

Frankly I cannot think of a Senator who spent more time, 100 percent of his or her time on health care than you over the last several years and frankly made visions -- due to your hard work and efforts you have led the way and fought a lot of ground here and I want to thank you for it.

OPENING STATEMENT OF HON. RON WYDEN, A U.S. SENATOR FROM OREGON

Senator Wyden. Mr. Chairman, thank you for those kind words. I do not want to make this a bouquet tossing contest.

The Chairman. That's okay. We can toss it back and forth.

Senator Wyden. You have made an extraordinary effort in all of these many months to bring us together. We would not even be here without the superb white paper that you put out to start this discussion.

Let me begin by saying that I guess you did not get the memo from the folks on the ideological extremes of American politics who said Max, you ought to throw in the towel on bipartisanship. You either did not get it or you wisely chose to ignore it.

As far a I am concerned, the country is for the better because of your focus on bipartisanship. You consistently said let us try to get here through consensus rather than confrontation and despite a popular myth among some people, it is impossible to enact comprehensive health reform with a 51 vote partisan effort.

So the fact is the way you have approached it trying

to reach across the aisle was the only responsible course of action. Despite the exhaustive efforts of the Chairman, the committee now finds itself short on both real reform and democrats and republicans having their name on this mark.

So the actions of this committee from this day on are going to go a long way towards determining whether the Congress will remain largely empty handed on bipartisanship and real reform.

My vote in committee is going to depend on a great extent on whether we can get on that real road to meaningful reform and bipartisanship.

In having spent a pretty fair amount of time, like a lot of colleagues here, in the bipartisan precincts of health reform, my sense is you start with three principles. The first is truth telling. You cannot truthfully argue that you can change American health care and then list all the parts of the system that are going to stay exactly as they are.

The truth telling in bipartisan health reform efforts means telling folks that tough choices have to be made, saying no when you would rather say yes and above all, showing leadership, persuading people to accept reforms that they would otherwise resist.

The second part of bipartisanship is acknowledging

that each party has a valid point. I think our party is absolutely right that you cannot fix health care unless all Americans get good quality, affordable coverage. Otherwise you have too much cost shifting and not enough prevention. Our party is right. You have to have coverage for all people.

Our friends on the other side of the aisle have valid points, too. You need a real role for the market, for private choices, for making sure you don't freeze innovation. We need to meld these principles together. Democrats on expanding coverage and Republicans on choice and markets and a role for the private sector is in my view getting real reform.

Finally, I believe real reform isn't about bringing together a who is who of health care lobbies to sign off on legislation, slowing and disrupting the price escalators in American health care that threaten the economy is much more important than reeling in yet another of these powerful interest groups.

Let me wrap up by talking a bit about the bill specifics. The Chairman's mark does some very good things. I want to repeat that, some very good things. Yet there is still a lot to do to place the country on the road to real reform.

First, the bill does not hold insurance companies

accountable. The bill does not force insurance companies to compete for our business. The bill denies choice of coverage to over 200 million Americans.

Now, the President at every rally across the country says you can keep what you have and that is great. This bill in its current form stipulates that while you can keep what you have, if you do not like what you have, you have got to keep it. You are stuck. You are denied the chance to get something better. You cannot go into the marketplace as part of a large group with real bargaining power and force the insurance companies to give you a better deal.

Real reform, colleagues is saying you can keep what you have, but it is also saying if you do not like what you have, you can get something better. We only need to look at the automobile insurance market to see that's the way it should work.

If your car insurance company jerks you around when you file your first claim, if they fail to provide enough money for repair or they attempt to avoid paying for the repairs, you whip out the yellow pages and you go to a new company.

The choice amendment that I will be offering is built around the magical words of the American system. Competition, the marketplace, empowering the individual.

It is the bottom line of health reform because in this health system for too long the system has been shielded from the powers of choice and competition.

Now, I know that I am taking on what amounts to the status quo caucus. There are very powerful insurance lobbies who like their protected lobby. There are a lot of interests who feel that having a captive workforce is profitable to them, but it is up to us to choose at whose interest, the public's or the status quo coalition's, gets to shape this legislation.

Mr. Chairman, I think that we can do better. I like a lot of what is in the bill. The way that you go to bat for low income people, the people who are walking on economic tight ropes every single day balancing their food bills against their medical bills, this is extraordinarily important to our country.

But let us do better. For example, rather than saying we are going to give people an exemption from having health insurance, during this mark up let us start with the principle that we are going to stay at it until every American is guaranteed quality affordable coverage.

I will have amendments in that regard and I close with this. This bill for a lot of colleagues is not their first choice. It is not exactly a surprise, I am one of them. But this debate is not about any of us

individually. It is not about getting a political win for one party or another. It is about getting a win for the health and economic security of the American people.

I consider this, Mr. Chairman, the most important bill I have ever worked on. It is something I have been interested in since the days when I was director of the Gray Panthers. I am committed to working with you and colleagues on both sides of the aisle to stay at it until we get it right.

The Chairman. Thank you, Senator. Your statements indicates how long you have worked in health care reform. I especially appreciate your comments about competition and choice and not being stuck with your employer if you want to go someplace else but you want to have good health insurance.

As you all know, in this legislation through the exchange it was creating a competition of choice for individuals how can choose a plan that they may want to have. But second, working with you to help make it easier for somebody to get health insurance information if they want to move someplace else and is worried about the plan that he or she now has.

You had some ideas on how to accomplish that and we can refer to that. Thank you very much for your efforts. Next, Senator Stabenow from Michigan. I am attempting to

say, Senator, affordability because I don’t know any Senators that talk to me more about affordability. Senator Stabenow, thank you very much for keeping us focused on that.

OPENING STATEMENT OF HON. DEBBIE STABENOW, A U.S. SENATOR FROM MICHIGAN

Senator Stabenow. Thank you very much, Mr. Chairman. I appreciate your patience and very much appreciate the tremendous amount of time and effort that has gone into this.

You started in the right place in working to get bipartisanship. I find it amazing that folks would talk about rushing this process given the fact that we have spent over a year in countless hearings and countless meetings and the fact that I think you have gone to extraordinary lengths to reach out to make this bipartisan effort.

I regret that it is not yet there, but there is some very, very important work that has been done on both sides of the aisle. I know we will just keep working at it.

I also want, as I have done before, but I think it is important to say think you to the staff of the Finance Committee to have worked so hard in getting this information and having sleepless, sleepless nights on an ongoing basis. I want to particularly thank my own staff as well. Oliver Kim, Kim Love, Alex Chef and Katherine Keisman who care deeply about providing affordable health

care and changing a broken system. I want to thank them for their hard work.

Mr. Chairman, this certainly is the most important debate I have been involved in in the Finance Committee or frankly since I have been here in the Senate or in my time in the House of Representatives.

We have a serious challenge and we know that. We have a current health care crisis. In some ways, the health care system has great strengths, but it also has many things that are broken that are causing tremendous challenges for people and businesses.

In my state, we have a 15.2 percent unemployment rate, the highest in the country. We know that skyrocketing insurance costs are making it hard for our businesses to compete internationally. We are losing jobs. People who have coverage are seeing their costs go up and up. People who have lost their jobs are struggling to afford coverage on their own or they are just giving up on it entirely and going without insurance. That is why we are here.

We also know that nationally every six seconds somebody loses their health care. So while we are meeting, every six seconds somebody is losing their health insurance, 14,000 people a day. Every day 5,000 people lose their home to foreclosure because of a health

emergency.

We also know regrettably that 45,000 people die every year because of lack of health care. That is more than the number of people who die in a car crash, that's more than the number of homicides.

This is truly a crisis and I think we have to ask ourselves why in American in the wealthiest country in the world do we tolerate a situation where someone dies every 12 minutes because they don't have quality health care?

The answer is we cannot tolerate it. Not anymore. The mark, Mr. Chairman, I believe has many positive aspects, and I congratulate you on many. I will not go through each one, but let me just focus on a few.

It changes the focus on health care in this country by changing the incentive to reward quality in keeping people healthy. This will save lives and it will save money. It cracks down on the worst abuses of insurance companies, it creates a real health care safety net so if you lose your job, your family will not lose their health care.

It also strengthens and improves Medicare by focusing on prevention, improving the quality of care, giving relief to seniors who fall into what has been called the donut hole in Medicare Part D so seniors and

people with disabilities will get help paying for their medicine, and I strongly support actually closing that gap in total.

It helps young people, many of whom are just starting their careers and dealing with huge student loan debt like my daughter, who are going to be able to keep their family insurance up to the age of 26.

But we have a lot of work to do to improve this bill in my judgment and truly deliver on the health care reform that Americans need and deserve. We need to make sure that insurance stays affordable for people who already have it.

Middle class families and early retirees who work hard, who gave up salary increases to get a health care plan for their family cannot be subjected to an unfair excise tax on insurance benefits and I believe Mr. Chairman that we need to work together to do better than what is in this bill.

We also, Mr. Chairman, as you have indicated, that I have talked to you about many times, we need to make insurance affordable for those who do not already have it.

We need to make sure that those who have it see their costs go down, that they can keep it, they do not get dropped. If they get sick, they have all the

protections in the bill. But for those who have not been able to find or afford insurance, it is incredibly important that we put this realistically within their reach.

I appreciate that the updated mark that you will be offering takes a step in that direction. I still believe there is more work to do to make this affordable.

Finally, you need to make sure families have a real choice of health insurance plans including a public health insurance option that keeps private insurance companies honest and keeps premiums affordable.

Mr. Chairman, I would be less concerned about the tax credits under the bill for people that are trying to buy insurance if I knew that they had a real choice that in fact if the for profit insurance companies were not giving them an insurance product that they could afford, that they would have another public option that would be the true cost of providing health care in the marketplace and they would have a choice of somewhere to go.

Not only will we help make health care affordable for families and we must, but it must be affordable for the country as well. I appreciate the efforts to focus on the overall cost and over the long run in bringing down the deficit.

This bill does not increase the deficit. In fact,

it will reduce the deficit over time. An enormous amount of our federal budget is dedicated to health care and it is crucial that we bring down costs over time as well.

Mr. Chairman, I got my start in public service fighting to keep a nursing home open and I will not tell you how many years ago it was. It was quite a long time ago. I have spent time at the county level, the state level, and now federally working on health care policy to make it better for people.

I came here to this committee to do the same thing. Fourteen thousand Americans woke up this morning without health insurance, with health insurance, but they will go to bed tonight without it.

For their sake, the time has come to get the bill done and to get it done right. I continue to pledge to work with you to do that.

The Chairman. Thank you Senator very much. I appreciate it. Next is Senator Carper. I want to just thank you, Senator, for your continued assistance and the reminder that we stay within budget, that we not add to the budget deficits.

OPENING STATEMENT OF HON. THOMAS CARPER, A U.S. SENATOR FROM DELAWARE

Senator Carper. Thanks for mentioning that. I am glad you noticed that. I tried to stay on point and I know there is a lot of points to stay on.

I want to thank you, Mr. Chairman, I want to thank Senator Grassley and I want to thank Senator Snow. I want to thank Senator Enzi, I want to thank Senator Bingaman, I want to thank Senator Conrad for spending as much time as you have to try to get us to what I call the middle of the road, actually to a bipartisan plan that will not just look good, sound good, but actually work to -- health care costs, provide better health care outcomes and extend coverage to those who do not have it.

When you say describe this, keeping out of step when everyone else is marching to the wrong tune. As you introduced your mark last week, I couldn't help but notice that they were criticized from the left, they were criticized from the right and some folks from the press said what do you think of that? I said, well, sometimes you get attacked from either end of the political spectrum means maybe you have come to a pretty good starting place and I think we have.

I like to paraphrase Churchill who used to say this

is not the end, this is not the beginning of the end, this is the end of the beginning. I think that when we finish our work at the end of this weekend I hope we put out a bill with bipartisan support that will be the beginning with a lot of work still to do.

As most of my colleagues know, I go back and forth to Washington on the train. Just about every day, and I go home just about every night. Friday I catch a train, the 7:19 train in the morning. I usually stop at the Central YMCA and work out. I try to work out every day of my life.

I drove today past the Wilmington Hospital on my way to the Y. As I drove by the Y, I was reminded, as I drove by the hospital, I was reminded last night and frankly every night and just about every day of the year, people line up at that hospital to use the emergency room.

They use the emergency room because that is about all they have. The care that is provided for them is care that we say is provided for charitable reasons. As it turns out, we pay for that. Every one of us who has health care coverage pays about, in this country, every one of us pays about $1,000 a piece to provide health care for those who do not have it.

I want to tell you at the Y this morning I got

dressed and went up to the fitness center. I got on one of the bikes and decided to ride the bike. As I rode the bike, I tried to multitask and I read, got into the new issue of Business Week. There is one little scribble here. It is in the executive summary on page 5 and it says the cost of health.

In light if Congress doesn't come through with sweeping health care reforms, that is the question, it goes on to answer, annual health care cost for business will soar 166 percent over the next decade, that is $29,000 per worker says the business roundtable. That is even worse than the prior decade when costs shot up by 131 percent.

About an hour or so after I read that article in the Business Week, I was on the train. I was on the train heading down here. As we passed through Newark, Delaware, I looked out the left side of my window and I saw a Chrysler plant that I worked for 29 years to keep open. It is closed. Four thousand people who worked there not long ago do not have jobs anymore.

Twelve miles up the road is a GM plant. It is closed, too. It closed three months ago. Three thousand people who worked there do not have jobs anymore either and eventually they may not have health care.

It is not just big companies like GM and Chrysler

going bankrupt. There is little companies, middle size companies all over this country that are finding it hard to compete. We need to do something about that.

A bunch of us did things during the recess where we had listening sessions, telephone town hall meetings, regular town hall meetings. In one of my sessions I had a guy who said to me, you know, we have the best health care coverage in the world. I said, not to be disagreeable, sir, but we don't. We spend more money on health care than any nation on earth. We do not get better outcomes.

Like Senator Stabenow just said, 14,000 people are going to wake up today with health care coverage and will not have it when they go to bed. Over 40 million people do not have any health care coverage. We help pay for them in places like the Wilmington hospital that I went by this morning.

There are big companies left and right, little companies going bankrupt, unable to compete in the world today. Instead of trying to figure out what do we do about it, too often around here we get caught up in really inflammatory issues that frankly don't contribute much to –- the health care costs and extending coverage to people who do not have it and making us competitive in the world. The death squads, assertions of government

takeover. I am not interested in that and I think my colleagues know that I would not support that sort of thing.

Issues like abortion, abortion is not provided for. We do not fund abortions in this legislation. Some are saying that we are going to provide coverage for illegal aliens. We do just the opposite in this legislation.

Rather than focus on what divides us, what do not we focus on what unites us? There is plenty in this legislation and plenty that can be added to this legislation but I think –-

I just want to mention some of my colleagues here were talking about being a recovering Governor. I am. And I like to focus on what works. I just want to talk for a couple of minutes about things that actually work to -– the health care costs and provide better outcomes.

One of the questions I have been asked a lot this year is why cannot we have the same kind of health care coverage that you have, Senator Carper? I say well that is not a bad idea. I have a federal employee health benefit plan. What it really is is a large purchasing pool the 8 million of us get to choose from and it is all private plans that we choose from.

Our administrative costs, 3 percent of premiums. If we cannot get everybody to join that, why do not we try

to replicate it, and that is what you have done, including the exchanges either on a state by state basis or regional basis or maybe by a national basis. That works.

Large purchasing pools. There are a bunch of people on this committee and that are not on this committee that have been pushing for that for years.

What else works? I went up to Cleveland –- a couple of weeks ago. I shared with some of my colleagues what I saw and I have given all these speeches about the Cleveland –- I really went to see if actually what they do is what I have been saying.

As it turns out, the –- up pretty well. They focus on primary care. This is not just Cleveland –- Kaiser Permanente, Senator Cantwell, what is it called, Group Health? They all focus on the same thing. They provide a great template for it.

They focus on primary care, they focus on prevention and wellness. They coordinate care. They focus on managing chronic diseases. Everybody there, all the patients have electronic health records. They have gotten rid of fee for service –- they are basically in business doing the same thing in the same way but they get better results and they get it for less money.

What else works? Well, competition can work. I

have a great example of that, the Medicare Part D plan with the prescription drug program. It is a huge fight some of you are calling it. Should we have a public option in the Medicare prescription drug program.

We end up with states that do not have any competition and we will provide that competition. Senator Snow and I have spent a lot of time talking about pushing for fallback plans and that kind of thing.

We have never had to use a fallback plan in any state of the Medicare prescription drug program. We have dozens of prescription drug benefit programs in every state. Patients like it, seniors like it. We have been under budget four years in a row.

What else works? Well, we could do things by defensive medicine. We have done it in my state. It used to be if Dr. Cantwell, Sarah Cantwell, my doctor, I did not like the work that she did in treating me, I used to go right into court and sue her. I can't do that anymore. I have got to go before a panel, an expert and make my case before I can go into court. Dozens of states have done that.

I like the idea –- Michigan, the University of Michigan -– works. That's a good idea. I like the idea of -– health courts where the people who serve on the courts are actually doctors or medical experts. I like

the idea saying if somebody follows best practice guidelines that maybe what we should do is provide them a safe harbor for lawsuits.

What we are going to do, and we can't do it in this committee, but I am hoping a lot of my colleagues, democratic and republican care about this issue who know that the fear for defensive medicine sort of feeds the fee for service conundrum that we're into that you will join me and a number of our colleagues and say let us use the states as laboratories in democracy. What works in some of the states, become informed by that and pledge that it be spread to other states. Reduce the cost of defensive medicine, reduce the amount of time we spend in courtrooms on medical malpractice and improve health care outcomes. I am almost done, Mr. Chairman.

What else works? We know if we incentivize people to take better care of themselves we can reign in the goal of health care costs. A lot of people used to think that Safeway was just a supermarket or a grocery chain. As it turns out, they are a health care delivery system that has figured out how to incentivize people to take better care of themselves and they have flat lined their health care costs for 200,000 employees in the last four years.

It works for them, it works in 30 states and there

is a bunch of companies that are doing the same thing and we can learn from them.

Last point what works. Prescription medicines work. They don't work for everybody. They do not work for people who do not have the ability to get the medicines. They do not work for people who actually get the medicine but do not take them. Sometimes by mapping the human genome we have learned that not all of us are made the same. God makes us differently.

Some of us the medicine will help some of us, it will not help the rest of us. We have to be smart enough and instead of wondering why we do this, figure out how to use mapping the human genome. Figure out which medicines are going to help us, we spend money on those, and which ones won't, and we won't spend that money. That will work and we will help save money.

The last thing I want to say. Senator Enzi is over there. I see Senator Enzi is talking to Senator Roberts and I want him to look at me for a second.

Senator Enzi is one of my favorite people here. I sometimes talk about the 80/20 role and it explains why he and Senator Kinney were so successful in getting so much done in the Health Committee in recent years. So we agree on 80 percent of the stuff -– talking about Senator Kinney. He said we just decided to agree on the 80

percent we agree on.

We need to do that here. Senator Enzi and I also -- presiding several years ago. He was on the floor and he was talking about his core values. He was talking about his core values. I listened to him talk about his core values and I said those sound like my core values.

Pretty much it is what it is. First of all, figure out the right thing to do and just do it. Do not do the easy thing, do not do the expedient thing, just do the right thing. That is what we are trying to do here is treat other people the way we want to be treated. Put ourselves in the shoes of the person who does not have any health insurance coverage, the doctors, the nurses, the companies that are paying for it, the taxpayers that are paying for it. Put ourselves in all their shoes as we debate this legislation.

Number three, if it is not perfect, make it better. That applies to this legislation. It also applies to our health care delivery system. It is not perfect. We can make it a heck of a lot better.

The last thing is just do not give up. Just do not give up. This one lady said to me, Mr. Chairman, as I was leaving, she said do not you all study your mark up today in the Finance Committee on Health Care Reform? I said, yes, ma'am.

She said, I want you to know that I am praying for you. I said well, that is great. I said I appreciate that, we all appreciate that. I just want you to keep praying. You know what she said to me? She said, I am going to keep praying. I want to make sure you keep working. Can you fix this system and get it right? That is what we are going to do. Thank you.

The Chairman. Thank you Senator very much. We appreciate that. Next I would like to recognize Senator Bingaman. I do not know of anybody who has spent more time in health care.

The Senator from New Mexico -– not only a senior member of this committee, but also on the HELP Committee and spent all those weeks and hours working on amendments offered -– knows the subjects very, very well and on top of that is a group of six so called and hours and hours I have got 63 meetings if I am not mistaken.

So senators, thank you for your diligent work in getting down to the details and helping us figure out a pragmatic way what is the right thing to do here. Thank you.

OPENING STATEMENT OF HON. JEFF BINGAMAN, A U.S. SENATOR FROM NEW MEXICO

Senator Bingaman. Thank you very much, Mr. Chairman. You are the one that ought to be getting the accolades today and you are to a substantial extent. The phrase that I have heard more and more members repeat here is extraordinary effort.

I endorse that. I think you have made an extraordinary effort to get us to this point and I very much appreciate it.

For a very long time, Senator Enzi and Senator Roberts and Senator Hatch and I all served on the two committees, this committee and the Health committee and we all spent a lot of time. I think we went on for I do not know how many weeks of mark up over there, but was quite awhile.

The Chairman. I heard three. Is that right?

Senator Bingaman. Years, Senator Roberts says. But it was awhile. And of course as you point out, we have spent hundreds of hours trying to get this legislation in a form that we can move ahead here in the committee working with yourself and Senator Conrad, Senator Grassley, Senator Enzi and Senator Snow. So I very much do appreciate your leadership.

I think the broad construct of this legislation accomplishes the objectives we all want to see accomplished. That is it protects those things that work in our system. It tries to reform the things that do not work and there are many of those.

It reduces the growth in cost of health care going forward which is an extremely important objective, and it provides affordable coverage to an awful lot of Americans who currently have no coverage. That I think is much to be desired.

In my home state of Mexico, we have many of these problems in spades. Nowhere in the country in my view is the problem more serious. We continue to be the second most uninsured state in the nation. We have the highest percentage of workers who are uninsured of any state in the nation.

Health insurance premiums continue to rise at an unsustainable rate. The projection is that New Mexico will experience the greatest increase in health insurance premiums in the nation over the next decade if nothing is done in the nature of the reforms contained in this legislation.

The average premium for a family of four in New Mexico was $6,000 in the year 2000. By 2006, the rate had almost doubled to $11,000. By 2016, the amount is

expected to rise even more to an astonishing $28,000. So we have a serious issue that needs addressing.

Mr. Chairman, I will not go into the detail of various amendments that I would like to see us adopt. I want to just endorse the comments that others have made about the need to be sure that the health care we are requiring people to obtain is affordable and you have moved in that direction very substantially in this bill and in the modified version of this bill which you are planning to present to the committee.

I hope we can do more in that regard. I also hope we can do something to increase competition in the sale of health insurance in the country. I know the coop proposal which is in the mark that is before us today has promise and may well accomplish that objective.

I have thought that a more straightforward public option which would be organized on a level playing field so that you would have fair competition between the public nonprofit entity and the private insurance companies would be an even better way to go. So I hope that we can make that improvement as we go forward.

I do think that Senator Snowe I think put it well by saying that the seriousness of this issue requires that we undertake a painstaking process here in the Congress and you have done that. This mark up promises to be a

pain staking process as well and I hope that the end result is one that solves many of these problems that have plagued the country for many decades now and puts us on a road to a much healthier and more sustainable situation in the country.

So again, my compliments to you and I look forward to working with you through this mark up and through consideration of this legislation in the full Senate.

The Chairman. Thank you, Senator. Next I recognize the Senator from Wyoming, Senator Enzi. A neighbor from my state of Montana and also one of the group of six.

I might say to everybody here, Senator, that during those meetings, you really forced us to drill down deeper in asking more precise questions, how does this work, how does that work? What about this and what about that?

Sometimes I think maybe that is because you were once a CPA. You probably still do practice a bit but you were very knowledgeable by forcing a third level of analysis. Good job.

OPENING STATEMENT OF HON. MIKE ENZI, A U.S. SENATOR FROM WYOMING

Senator Enzi. Thank you, and I do appreciate you calling it the group of six rather than the gang of six because my mom told me never to join a gang. I want to thank you for your tremendous efforts. I think it is unprecedented and I will talk more about that in a few minutes. First I want to briefly discuss some of the key issues in the bill and what it will mean for every American.

I do think every American should have the right to choose the health care benefits that best meet their needs. Now, this bill does still mandate a level of benefits that will significantly increase the costs of many insurance plans being sold in Wyoming and many other states across the country.

I believe that every American should have the choice to buy a lower cost health plan that covers basic services and offers catastrophic protections. Individuals should also never be compelled to enroll in the government run plan. This bill would enroll everyone with incomes below 100 percent of poverty in Medicaid. Over 40 percent of the nation’s doctors now refuse to see Medicaid patients, but this would be the only health care

option under this bill for 11 million working class Americans.

The expansion to Medicaid in this bill directly contradicts the goal stated in the President's recent speech and provide an increased choice in competition in our health care system. I believe every American should have the right to choose to enroll in private health insurance coverage.

We also need to reduce health care costs for individuals. This bill does not do enough to lower costs and in many cases, it will actually increase the cost of health care through new taxes and mandates.

I believe that health care reform legislation must address fundamental issues like medical liability reforms as Senator Carper mentioned, providing financial incentives to adopt healthy behaviors as Senator Carper mentioned, modifying our tax code to encourage more rational choices about employer health insurance and eliminating new taxes that will only drive up the prices patients pay for health care.

Medicare savings should also go to strengthen the Medicare program. This bill cuts billions from the Medicare program and then spends the money to cover the uninsured.

Medicare's physician's fees will be cut by 25

percent in 2011 and an additional 5 percent per year for the next eight years. Medicare also provides no protections to its beneficiaries against catastrophic costs. The President promised everyone would be covered for catastrophic.

I believe that we can do better and that any savings from the Medicare program should be used to strengthen and improve the Medicare program. As with Medicaid, if you cannot see your doctor, you do not have health care.

Now, today we are going to be marking up this which is a 220 page summary. This isn't all of the legislative language which would be many times that big. But I have noted that we have two volumes of amendments, 564 amendments to try and change that and I would mention that these are in some reform as well.

Now, we have talked about the need for Senators to read bills and have the actual language because sometimes the devil is in the details.

So now I have outlined some of the significant problems, but I would also like to commend the leadership of Chairman Baucus who has worked with ranking member Grassley and other republicans and democrats on the committee for months. I know that seems like years as well, in an attempt to develop a bipartisan health care reform bill.

He sought a wide range of ideas and tried to develop the best possible bill that could gain broad support of the Senate, and that is one of the problems. Now, this effort stands in marked contrast to what happened in the Help committee where I served as the ranking Republican.

The Health, Education, Labor and Pensions Committee majority staff drafted the bill with no apparent input from Republicans. The committee then voted down almost every single substantial republican amendment to improve the bill on straight party line votes.

As a result, the Health, Education, Labor and Pension Committee finally reported a partisan bill that is loved by liberals –- but has no chance of passing the Senate. I think they realized that because they didn’t even print the final version until almost the end of August so that anybody could even look at it.

Chairman Baucus resisted the temptation to give into the demands of the partisans and tried to develop a good bill that could gain the support of a large majority of the Senate.

I have said for many months that health reform should have broad, bipartisan support in order to gain the trust and support of the American people. Health care reform will affect the lives of every single American and have a dramatic impact on our economy and

the future of our nation. It is too important to be passed by narrow partisan majorities.

Unfortunately, the efforts of Chairman Baucus were relatively unable to produce a bipartisan bill that I could support in large part because of arbitrary deadlines. We are here now because he was told that is all the time you get and that was imposed by the Senate leadership and by the White House. Apparently in some circles there is a belief that passing the bill quickly is more important than getting it right. I regret that we ran out of time and we weren't able to resolve several key issues that I believe must be addressed in any comprehensive reform package.

I remain committed to working on a bipartisan health reform that addresses these issues. I will, however, continue to offer constructive ideas and hope that we still might have the opportunity to develop bipartisan solutions to address the health care challenges that are faced by our nation.

Again, I thank the Chairman for his indulgence, for his effort, his focus and his desire to get something done.

Senator Baucus. Thank you, Senator. Next is Senator -- who is not here, so I move to Senator Cantwell.

OPENING STATEMENT OF HON. MARIA CANTWELL, A U.S. SENATOR FROM WASHINGTON

Senator Cantwell. Thank you, Mr. Chairman. And Mr. Chairman, I want to say that you have proved that you are truly a distance runner because this process has been like a marathon and you have kept on pace and I guess my only request is I hope that the committee process will give the due kick to the system that we need to have at the end of this because I do think that we need to make some changes and I appreciate your willingness to make those changes.

I'm not a member of the gang of six, but I am a member of the gang of 6 million Washingtonians and the way that they look at this bill may be a little differently than the discussion that we have been having today.

That is my constituents, the 90 percent of people who have coverage want to know what we are going to do to drive down the cost of their current insurance. Now, the discussion that we are having which is the majority of the discussion about how to cover the uninsured is an interesting question. I personally do not think it is a very hard question. It is probably along philosophical lines or cost effective lines, but the real hard question

here is what policies are we going to adopt that are going to change the course curve that we are on.

We know that inflation is about 2 to 3 percent a year, but we know that health care costs are rising 8 percent a year. So the question is what policies are we going to put in this legislation that are truly going to drive down for Americans who already have insurance the cost of those premium increases that they have seen?

It is just unfair for Americans to have to pay a doubling of their insurance rate over the last 10 years and be faced with the same consequences staring them in the face. That is why doing nothing is not an option and we have to look at what policies we are going to have that really will affect that doubling of insurance rates.

When I look at it, I see Medicare spending going to double in the next 10 years if we do nothing and I see the individual premiums if we do not provide enough competition doubling in the next 10 years. So my constituents want to know what we are going to do to drive down costs.

That is why one of the things that is most important to me is the reform of the current fee for service system. Right now our medical system is rewarding an almost relentless utilization. If this was a restaurant, your waiter would be bringing everything to your table

whether you ordered it or not or whether you could consume it or not.

If this was the legislative process, we would be getting paid for how many bills we passed instead of whether they were really necessary or needed.

The fact is that we waste about $700 billion a year, 30 percent of our health care on a system that is really not doing the service to our constituents. Our constituents want to know that when they go to see a physician that they have their full attention and many practicing physicians do the best they can under a system that rewards them for how many patients they see and how many procedures they order.

But the biggest thing that we can do in this bill to change the cost curve of people who already have insurance is to reform Medicare fee for service and instead institute an efficient plan that rewards physicians not on volume but on the value that they deliver to their constituents.

I can tell you that everybody knows what it is like to go to a doctor’s office and have the physician be in a hurry. Everybody knows that there are three or four questions that they didn’t get to ask or the physician didn’t have time.

It is not to say that the physicians do not care or

are not working hard or are not talented, caring individuals. But the system right now is a disincentive for us to have efficient health care. So if we do not change this fee for service system, everything is going to be more expensive. Not just the cost of the government, but the cost of insurance is going to be more expensive.

Right now, Medicare is one n five health care dollars and it is going to make even insurance more expensive.

There is a great deal of concern across America when you can have the same insurance benefit, the same benefits to individuals cost 300 percent difference across the country. That is you can have an individual in Kentucky have the same exact benefits as someone in Massachusetts but pay drastically different amounts, almost $200 a month difference. Same individual, same age, same basic demographics and yet they are paying almost $2,400 more a year.

Is there any rhyme or reason to this? No. The issue has to do with the way that we do the reimbursement system. But there is a second issue, Mr. Chairman, and that is the lack of competition.

While we are looking at this bill and saying how we are going to institute competition, our solution right

now as it relates to the uninsured seems to be saying let's subsidize the insurance companies that are already at high concentrations of the insurance market. That is to say that two companies in 94 percent of the markets, two companies have the majority of control. So that is the other reason, the lack of competition why prices are going up.

So, Mr. Chairman, as we look at solutions in this bill, I am going to be very concerned about instead of providing true competition in the form of a public option to these insurance plans, instead we are providing consumers with a subsidy to buy the expensive insurance.

Why would we do that when it is more cost effective to drive down the cost through other measures, through actually giving them a plan that is cost effective?

So there are going to be many areas of this legislation where I am going to be fighting for more cost control measures. I am going to be fighting to change the way we fund long-term care. It is ridiculous that we continue to focus on putting people in nursing homes instead of community based care when it is 70 percent cheaper.

We ought to give the senior citizens of America the chance to stay in their home as long as possible and to give them a place to get the health care they deserve.

We have to take on the PBM market, the prescription benefit market of drug companies that are negotiating discounts from the federal government and then pocketing those discounts themselves.

We are never going to drive down the price of drugs unless we have transparency in our drug markets.

So Mr. Chairman, I applaud the efforts of this committee and the staff and my staff for the many hours that people have put into this legislation. But we have much more work to do if we are going to make this a cost effective plan for Americans and give them true choice and true competition that is going to drive down the cost of health care. I thank the Chairman.

The Chairman. Thank you, Senator. Next on the list is Senator Ensign from Nevada.

OPENING STATEMENT OF HON. JOHN ENSIGN, A U.S. SENATOR FROM NEVADA

Senator Ensign. Thank you, Mr. Chairman. The first thing I think we have to establish is that I think everybody here wants to improve the health care system. You know, sometimes in our partisan debates we question motives of each side of the aisle and I think that that is a mistake and that is where we get in some of the more rancorous type of debates.

I appreciate the work that the Chairman has done trying to lead this committee. We have some fundamental differences in philosophy, but I do appreciate the effort and know his efforts have been very, very sincere as well as other members of the committee.

There are some serious problems and I think Senator Cantwell just outlined a lot of the problems in our health care system. I think that you were spot on as far as the problems are concerned.

I have some differences as far as the solutions, but I think that your identifying the problems is exactly right.

As we are going forward, I think it is really important to understand the problems, but also how the problems got here. I think that the cost obviously is the

problem. It is not just the cost to the government, it is the cost to the individual. But how did we get here? Why is the cost out of control?

Senator Cantwell mentioned choices. Well, it is not just choices. I believe the fundamental problem with our health care system today is because the patient, the person receiving the care is not the person who has been financially accountable because we have developed a system that is basically first dollar coverage.

There is a small copayment here and there but it is basically a first dollar coverage so we incentivize people to use our health care system more and more and more and sometimes in many unnecessary ways.

During the early 1980s when HMOs came into being, why did they come into being? They came into being because the employers were saying our costs are skyrocketing, somebody has to do something about cost. Well, there were managed care companies out there, for instance, Kaiser of California, who were actually managing care and at the same time were savings some costs, so employers said we need some help. We need somebody to shop for health care in this country.

Managed care came into being and instead, however, the problem came in when managed care turned into managing cost instead of managing care. That is where we

ended up with capitated plans where we incentivize doctors to see more and more patients on a faster and faster time table and that destroyed the doctor/patient relationship.

We did that throughout our health care system. As a matter of fact, we kept looking at those cost increases on Medicare and Medicaid. So reimbursements were cut, and what did doctors have to do? They had to see more and more patients in a faster time frame, once again hurting the doctor/patient relationship.

Well, I believe it is key to reforming the system that we put the patient back into the equation and add more into the accountability loop, into the cost sharing loop. Some people actually want to wipe out costs just because somebody happens to be low income.

I think it is incredibly important that not only does the patient have skin in the game as far as their health care concerns, but they also need to have skin in the game as far as the costs are concerned.

You see, if we have all Americans responsible for their health care and the choices that they make, we will have those market forces that everybody has been talking about. We don’t have the market forces today nearly the way that we should. So what we have before us today is we have a government solution to a government caused

problem instead of going back more toward a market solution.

So Mr. Chairman, I think that what we need to do is take a fundamental look at how do we put more of the patient involved in the financial accountability loop, and there are many ways to do that.

First of all, we understand, and Senator Carper talked about the Safeway model. And you know, Mr. Chairman, I have talked a lot about the Safeway model. Basically what they have done is they have incentivized through lower premiums for making healthier choices.

They focused on four areas. They focused on smoking, on obesity, on hypertension and high cholesterol. And what they said is if you make healthier choices, we will actually give you a lower health care premium.

Well, unfortunately this bill does not reflect those kind of changes that I believe need to be in the marketplace. And by the way, Safeway saved over the last four years compared to the rest of America, 40 percent on their health care costs.

When the President said the other day, if we save one half of one percent on our health care costs, we will save trillions of dollars over a long period of time. Imagine if you could even come close to the 40 percent

savings, not a half of one percent, but the 40 percent savings that Safeway did. Unfortunately this bill does not do that and I will be offering an amendment to incentivize companies to do more of what Safeway did and other companies have done around the country.

There are some basic principles that I believe that we can put into a health care reform bill that will address what Senator Cantwell talked about, the costs.

This is not addressed in this bill because it supposedly isn't in the jurisdiction of the committee, but getting rid of frivolous lawsuits, the practice of defensive medicine, is an important part of the cost aspect. Unfortunately the Judiciary Committee hasn't taken this up to be able to marry a good medical liability reform bill into the overall package.

The President has paid lip service to medical liability reform. But unfortunately it is not included in the bill. There is a sense of the Senate that we should address this, but that's all. We need to have more medical liability reform to help control the cost and to decrease defensive medicine.

The other thing I believe, my colleague Senator Enzi has championed for years is the idea of small business health plans. Allowing small businesses to join together I believe even across state lines they should be able to

do that so that they can provide their insurance at a cost competitive rate like big businesses can. I believe that individuals should be able to buy into the same kind of a market and do it across state lines as well.

Then the last thing that we can do is to make sure the patient is in the financial accountability loop. This is a real function for government. We have the information to be able to provide consumers on cost and quality of health care around the country because we collect that information through Medicare and Medicaid. We can provide transparency on cost and quality of hospitals and doctors so that if the consumer is then shopping, they can shop especially through technology today, they can shop for cost and quality and bring in true market forces to decrease costs in our health care system today.

So Mr. Chairman, I hope as we can go forward we can look at the true reasons that costs are out of control in the health care system today and not just put more government solutions onto a government caused problems but actually bring in true market reforms that will help control the cost. This way, we don’t have a bearcat whether it’s a private sector bureaucrat in an HMO or any kind of a managed care operation, rationing care, and we don’t have a government bureaucrat rationing care. Those

kind of health care decisions should be made between the doctor or the health care provider and the patient, not by some bureaucrat out there that is just worried more about the cost than they are about the quality of the care that someone is receiving.

So I look forward, we have a lot of amendments that are substantive amendments that I believe can make a difference in this bill and I hope that we can improve the bill and do it in a way that is in a bipartisan way. So thank you, Mr. Chairman.

The Chairman. Thank you, Senator. We have three Senators left. We have Senator Cornyn, Senator Rockefeller, Senator Roberts. Senator Cornyn?

OPENING STATEMENT OF HON. JOHN CORNYN, A U.S. SENATOR FROM TEXAS

Senator Cornyn. Thank you, Mr. Chairman. Mr. Chairman, I want to join those in applauding you and Senator Grassley, Senator Snow, Senator Bingaman, Senator Conrad and Senator Enzi for your good work. I know it was not easy and I know the six of you are under a lot of pressures both internal and external.

I think it is clear to me there is strong bipartisan recognition that our health care system needs reform and this bill reflects a good faith effort to try to move us in that direction.

Health care costs as we know it more than doubled for American families over the last decade. Seniors are counting on Medicare. We also know it has $38 trillion of unfunded liabilities, about three times the national debt. Medicaid we know imposes huge unfunded costs on state taxpayers and produces unacceptably low outcomes for patients.

Our current government health programs are riddled with waste and fraud and abuse to the sum of some $90 billion a year just for Medicaid and Medicare and the fear of frivolous litigation has encouraged defensive medicine which increases America’s health care bills by

some estimate up to 9 percent every year. And as we know, millions of people lack health insurance.

We agree on the need to fix the system and so I think there are some common solutions that we could all support, some of which are reflected in this bill, some of which are not. For example, making private coverage more affordable, realigning incentives to providers to focus on value over volume, creating incentives for patients to take better care of ourselves so we are healthier and more productive and of course cutting the waste, fraud and abuse in our current entitlement programs.

I think these could be the core of a bipartisan approach. I am sorry to say that despite your good work, this bill as it currently stands I think would make many of our current problems worse, and here are my specific concerns.

First, this proposal would increase government spending at least $1.6 trillion over ten years according to one analysis. There is an $856 billion price tag as we know doesn't tell the whole story because it is not for a full ten years of implementation, not does it include the so called doc fix except for one year.

When you start the clock in 2013 of course the first full year of implementation, the bill goes up. We know

already that the American people are weary of excessive government spending and they feel like Washington is not appropriately responsive to their concerns as we have seen on our TV screens and in town hall meetings across the country.

Several studies have shown that middle class families will see higher premiums because of the new taxes in the proposal. Premiums in the individual market would go up by 10 percent according to one study. In my state alone in Texas in the individual insurance market, 91 percent of the current policies in place do not comply with the minimum actuarial value required under this bill. So again, their costs are gong to go up substantially.

Small group insurance premiums would jump by 15 percent in Ohio and up to 25 percent in California according to one study.

Of course this proposal also takes a big chunk out of Medicare. Any savings found in Medicare I believe should be dedicated to making that program solvent. This proposal cuts $125 billion out of Medicare advantage that now covers roughly 10 million seniors and of course if that passes in the current form, it would break President Obama’s promise that people can keep what they have now if they like it.

Medicaid as we know already imposes huge costs on state taxpayers and crowds out other priorities like education, law enforcement and the like. In my state, the Texas Health and Human Services Commission has given me estimates that suggest that this proposal would increase Texas Medicaid costs by $20 billion over the next 10 years and expand the number of Texans on Medicaid by roughly 10 percent, 2.5 million more.

Medicaid of course we know is an important program, but it demonstrably delivers lower health, poorer health outcomes than private insurance and of course there is the $30 billion in fraud that I mentioned a moment ago.

This proposal includes $350 billion in new taxes, not including the individual and employer mandates. We know that we are in the midst of a recession, hoping and praying for a recovery. But raising taxes during a recession is not the way to create jobs.

We know that the proposal imposes a new tax for those who do not abide by the individual mandate. This new tax is as much as $950 a year for an individual and $3,800 for a family.

The White House says this is not really a tax, but I think that defies the question that if the IRS is going to collect it, what do you call it if not a tax?

For businesses, the employer play or pay provision

is a huge burden. One grocery chain in my state estimates this provision will cost them $10 million in additional taxes. Most economists agree that the employer mandates have the effect of reducing wages and crippling job growth.

When you put all the taxes and mandates together, the total bill over the next 20 years is more than $2 trillion. This proposal not only includes, excuse me, includes only a one-year fix for the physician payment under the Medicare program, the cost of future fixes as we know is not included during the entire 10-year budget window.

This proposal outsources the future of our senior's health care to an unelected government board. This board could reduce access to medical care with very limited congressional view. In other words, by rationing.

While medical liability reform we have heard that this proposal includes only a sense of the Senate. What we have is the President called for demonstration projects, namely the laboratories of democracy like Texas where we have seen that bringing common sense medical liability reform dramatically brings down the cost of medical liability insurance and increases patient's access to doctors.

With respect, Mr. Chairman, despite your outstanding

efforts, this proposal has major flaws and I plan to offer several amendments like my colleagues. But I think in the end my biggest concern is this proposal taxes too much and grows government too much.

I would hope, but I am not optimistic, that this process together with the marrying of this bill with the health, education, labor and pensions committee product and as the bill moves across the floor, I am concerned that it will not move more in the direction of more choice and lower cost, but one that will lurch to the left in a way that will result in higher costs and less choices for the American people. Thank you, Mr. Chairman.

The Chairman. Thank you, Senator. We do not have much time left. Senator Rockefeller has graciously deferred to Senator Roberts. Senator Roberts, you can speak now or come back, it is up to you. We have about maybe six, seven minutes.

Senator Roberts. I think we had better go ahead and vote, Mr. Chairman. I do not mind riding drag in this posse and I appreciate your letting me ride in the posse. But the last shall be first and the first shall be last.

I can submit my statement for the record and then perhaps give it Wednesday when we go to mark up. What would you suggest, sir?

The Chairman. I suggest that you either submit it for the record or if you wish to speak and give your statement, you do it when we come back about 2:45.

Senator Roberts. 2:45?

Chairman Baucus: Yes.

Senator Roberts. All right, sir. I will do that.

The Chairman. Okay. And we have consent to meet today. The Senate has consent to meet, so we will continue meeting through the day. Senator Rockefeller and Senator Roberts are the two remaining speakers before we go to -– the modified mark and then go to amendments. We are in recess until 2:45.

[Whereupon, at 12:15 p.m. the meeting was recessed.]

AFTER RECESS

[2:54 p.m.]

The Chairman. The next to be recognized is the Senator from West Virginia, Senator Rockefeller.

OPENING STATEMENT OF HON. JAY ROCKEFELLER, A U.S. SENATOR FROM WEST VIRGINIA

Senator Rockefeller. Thank you, Mr. Chairman. I want to open my remarks by recognizing that we are moving forward in this process. We have enormous opportunity here to do something which is historic almost beyond imagination, the largest piece of legislation that I can remember, and all this within the context of never forgetting that we are here for the purpose of helping American families with their health care problems, and individuals.

I know that my colleagues have heard me talk a lot about too much, but it does not matter, my experience with VISTA and how that influenced me, but let it just be said that there is so much at stake. I always come to these and vote on these matters with the kids and the people of the rural community of Emmons, West Virginia, where I was a VISTA volunteer 45 years ago. That never leaves me. The system was broken then, it is broken now, and that is why we are all here, optimistically.

The injustice and the unimaginable challenges for countless hardworking Americans just has to stop. We cannot do that. We can fix that in this bill, if we are willing to come together. I know we have all been home

recently and we have all heard about heartbreaking stories and those are not just stories; those are individual people and, therefore, they count for much more, particularly now. And those stories are just the tip of the iceberg. They are everywhere. People often do not tell you, where I come from in Appalachia, what their problems are. They just do not tell you, but they are horrible.

Stories, for example, like Samuel's. He is a 9-year-old boy from West Virginia whose parents I know very well. His parents are doing everything they can to save his life and well they should be, because Samuel has leukemia. He has hit his $1 million cap on his insurance plan. And, yes, my office intervened to try and extend it a little bit through other sources within the state, but now that is running out, too.

So his parents are desperate. They fear the worst and they have every reason to. Some have gone so far as to suggest that they get a divorce, because if they get a divorce, they can put Samuel on Medicaid. This is not what we want.

Mr. Chairman, in all of the years that I have worked on health care, I have never seen such a promising opportunity as you have put here before us and to make Americans sure that they are going to have access to

quality, affordable health care, and we have got a lot of work to do to get there. Families nationwide have said enough is enough and we must listen to that, because we all know that they are right.

Mr. Chairman, I want to thank you for your efforts. This process is an extraordinarily important process of serious reform. Serious reform in something like health care is like planning for the invasion of Normandy Beach. I mean, it is really complex, it is really big, it is really important, and a lot of lives are at stake. And Chairman Baucus is our General Eisenhower right here.

I want to commend you, Mr. Chairman, more specifically, on eliminating preexisting conditions as exclusions, annual lifetime limits for health care, and including the other reforms to the individual and small group market that protect consumers and better inform them about their coverage options. You have done and I am grateful.

The mark also includes something very important to me; that is, concurrent care for children in Medicaid. This provision protects families from making the impossible choice of continuing with curative care or instead opt for palliative and hospice care.

Lastly, I appreciate that you have included in the mark a sense of the Senate, which is not law, but it is

movement long-term care. Less than 10 percent of Americans currently have long-term care insurance. That is something we actually did together in the Pepper Commission back in the late 1980s. So their only other option is the one that we discussed back in the late 1980s, and that has not changed, which is part of our dilemma here, and that is that they spend down all of their assets, their income. They get rid of their car, they get rid of their house, they get rid of their clothes, they get rid of their toys, they get rid of their washing machines, and they go down to the level of impoverishment so that they can qualify for Medicaid and then they can get long-term care.

Is this what we choose to do to the American people? Is this what I choose to put upon the people of West Virginia? No, it is not. I know you care very deeply about health care and I applaud you for your commitment in this enormous effort.

I want people to know the President's promise that if you like the coverage that you have today, you can keep it. It is a pledge that we intend to keep. Currently, this is not the case with this framework. The current bill fails to protect the coverage that vulnerable children and families in West Virginia and other places currently have through Medicaid and through

the Children's Health Insurance Program, which is a rather sacred program to me, among many.

In fact, millions of children will lose the coverage they now have under this bill because of the circumstances of being placed into the exchange. This is wrong. If we are going to promise people that if they like their insurance, they can keep, the guarantee must apply to everyone and particularly to children.

Secondly, I want people to know that we intend to improve the coverage that people have. We must include improvements to the Medicare program for seniors. There are ways of doing this. Adding new benefits and protections to Medicare for seniors, there are ways to do this, and shielding the program from the negative influence of special interests and set it on the right track so it is strong for the next 10 to 50 years, hopefully 50.

Obviously, in that, I am talking a little bit about MedPAC. That is addressed in the mark. There are some differences. I hope they can be worked out, and it is a very, very important -- very, very important subject as to the future of Medicare. I want people to know that I intend to keep working to include the strongest possible reforms to protect consumers and I believe that we need to provide families with the option of enrolling in a

public health insurance plan.

I wish it were not called a "public health insurance plan," but just a "family health insurance plan." Then I think there would be a different reaction to it. But the word "public" is not a good word these days. But that does not mean that the idea is not a good one. It is free to opt in and opt out of. It will exercise discipline on the insurance industry, which, as I have indicated a number of times, in my new favorite word, has a certain rapaciousness when it comes to the carrying out of their work. I personally do not believe that a health cooperative is workable as a solution or a replacement to the public option.

Fifth, I want people to know that we understand that we cannot possibly ask that everyone have health care in this country. We would like to. We probably cannot do that. We better own up to it at front. And then on top of that, not do all that we can to make that which we do provide -- make it affordable. We must make sure that families are not spending too much of their take-home pay so that they can afford to pay for what they get. You can provide subsidies for people, but if the subsides are not adequate, then they are not like having any subsidies at all, which is the whole question of affordability.

I do not think that the current bill does enough to

make health care coverage affordable. So I think we can work on that and we have sort of a new spirit. We had an incredible meeting last night on our side in the Finance Committee meeting and a very, very good discussion, which makes me feel that we are moving forward.

And last, Mr. Chairman, but certainly not least, I want to make it very clear that we cannot promise the American people that the insurance reforms that we have been hearing so much about will benefit everyone. The Chairman has made some modifications that greatly improve the mark, but the reality is that in this bill, only 46 percent of Americans who have health insurance will be protected and others will not.

If you belong to a self-insured larger company or larger employer, federal insurance is the rule, but the Department of Labor does not do a good job, and never has, of enforcing federal insurance as opposed to private insurance in the small market for the individuals. That is incredibly important, because that is half the American people. Most people do not know that. But we have to make sure that people in the self-insured market are guaranteed the same protections under health insurance that people in other markets are.

So in closing, Mr. Chairman, I want to say that as legislators, we are going to have to make some tough

decisions, but then, again, this is our job and we love the labyrinths of health care and, at this point, the American people do not. But we have our work to do and if we turn out a good product, they will come to see that we have.

Let us end this nightmare facing the Samuels and the caps. Everybody has to have a personal example, something that they can relate to so powerfully that it directs their attention, focuses it.

All of this can be done. We have got a good chairman. We have got a good committee. And we just have to want to be courageous and clear that the days of an unworkable status quo are officially over and, also, that the time for those wonderful speeches that you have been given February all the way through the end of August or through the end of recess or during recess are just resounding and powerful and people cheer and yell, the days for that is over.

Now, we have got to make policy and that is hard and it has got to help people. We are making progress, I would say to our Chairman, as he knows, and this moment represents a tremendous opportunity to deliver real solutions.

I am grateful that we will have this week or more to propose, debate and vote on amendments. This is sacred

work and, frankly, I have a lot of amendments.

Thank you.

The Chairman. Thank you, Senator, for all that you do for Americans, especially for better health care for America, and all of the effort you have undertaken in so many ways. I am thinking, first, of children's health insurance back in 1997, which you initiated, sponsored, pushed to help lower income kids get health insurance so that at least we can get health insurance for our kids, and that was the beginning.

The second, recently, as we have expanded CHIP coverage, too, a couple of years ago and you were a leader there, as well, certainly, as the long-time chairman of the Health Subcommittee and it is just terrific work.

I do think it is important to remind all of us, though, that under this bill, everyone is going to benefit, because health care costs are going to start to be under control; everyone, those who are in Medicaid, those who are in Medicare, those with private coverage. Everyone is going to find that the health care cost rate of growth is going to decrease. That is going to help everybody.

Then, of course, there are provisions that do apply to self-insured firms, as well, which will help the

insured, that is, the employees who work in these companies. But it is a good start and I really appreciate all your work in helping make all this happen.

Our wrap-up speaker, final one, and we do save the best for last, is the great Senator from Kansas, Senator Roberts. Senator Roberts, you are recognized.

OPENING STATEMENT OF HON. PAT ROBERTS, A U.S. SENATOR FROM KANSAS

Senator Roberts. Thank you, Mr. Chairman. I will try to be succinct. With all the brainpower that we have there at the witness table, I know people are anxious to go through the walk-through and get the benefit of their sound advice and counsel.

I want to say to my friend from West Virginia, this is the same room that we used to conduct hearings from time to time in Intelligence Committee. So I am reminded of those days and I share his goal of health care reform and that of the Chairman.

I do not know anybody here on the committee that does not. But I think where we differ is he is riding a different horse and I am riding another horse and it seems to me that the horse we are riding with this bill is going into a box canyon.

The first thing you learn when you ride into a box canyon is to turn the horse around and ride out and then very thoughtfully decide which trail will really lead to the goals that we want to achieve.

Given that as a, hopefully, some kind of a background, Senator Enzi, Senator Hatch, Senator Bingaman, myself, we are enjoying our second health care

reform markup this year as a member of both this committee and the HELP Committee.

The HELP Committee already completed its markup, obviously, a markup that was one of the most unprecedented and perplexing and partisan exercises that I have been through in my time here in the Senate and the House.

We were actually amending a bill that we had not seen and basically did not see the bill until a month after it was passed. That is not the way to conduct business. So that resulting bill really gets into the proper role of government and, also, government interference in the everyday lives of regular American citizens.

That experience with the HELP markup gives me a little different perspective on this bill here today. To be blunt, it has made it impossible for me to support the Finance Chairman's bill.

The reason for this is simple. No matter how many good faith compromises and bipartisan gestures are made here today, not one, not one person in the Democratic leadership has done anything to assure me that those compromises and that bipartisanship will be honored beyond this point.

In fact, all indications are that this bill will be

pulled increasingly toward more costs, more regulations and more rationing as it continues through this process, and I do not think that is the proper process and I think it is a shame, because I really believe that the Chairman, as many of us have said, was very sincere earlier this year when he said that he wanted a bill that could attract 70 to 80 "aye" votes on the floor.

Now, Chairman Baucus, being a man from Big Sky country and a Senator for over 30 years, knows that on legislation this big, this huge, which fundamentally alters, as everybody has said, one-sixth of the American economy and which affects decisions that are so personal to individuals and families throughout this country, bipartisan support is absolutely essential. Without it, the American people will not accept these reforms.

Public opinion has already evidenced a serious backlash against the partisan way that the HELP Committee, the House and this administration have forced this process. More Americans wanted and deserve a thoughtful step-by-step transparent process.

At this point, more Americans would rather we do nothing than pass this health care bill and, in fact, by wide margins, Americans think we should be focusing on the economy rather than on health care.

The reason for these opinions cannot be solely

attributed to the poor process or the fears over the state of our economy. The fact is once they know about it, people simply do not like the substance of this legislation.

Now, there are provisions that gained widespread approval, like some of the health insurance market reforms, incidentally, the areas where both Republicans and Democrats actually do have agreement. But for the most part, Americans who are happy with the health insurance they have do not want to see the types of fundamental changes that this bill would bring.

Now, I hear from Kansans all of the time who wonder why it is necessary to completely and radically change our system of health care in order to gain insurance coverage for a very relatively small number of uninsured Americans.

Now, they are not heartless, by any means. Do not misunderstand me. They just do not think we need to sacrifice a system that works well for some three-quarters of this country and spend trillions of dollars that we do not have when there are other more targeted options to reduce costs and increase insurance coverage, options like tort reform, tax equity, insurance market deregulation, that make both health care and health insurance more affordable for everyone.

Instead, under this proposal, many of the people in my great State of Kansas will actually see their health care costs go up. Here are just two examples on how this will happen.

Under this proposal, American costs for health care will increase, in part, because the promises that the President and others have made that, one, they will not raise taxes on those Americans earning under $250,000 and, two, if you like your health insurance, you can keep it simply are not met in this proposal.

Despite the rhetoric, the reality is the proposal passes billions of dollars of higher health care costs onto American families and individuals through higher taxes, euphemistically called "fees" on insurers, labs and medical device manufacturers.

That means that hardworking Americans will pay these costs in the form of higher health insurance costs, higher prescription drug costs, higher costs for lab tests, and higher costs for critical medical equipment.

The former director of the Congressional Budget Office estimates that these new taxes mean that American families, including those earning well under $250,000, will pay as much as $130 billion more in higher insurance premiums over the next 10 years.

Now, in the Chairman's modification of his mark,

which we just received at lunch, we see a new tax increase that raises the amount of medical expenses an individual must have to be able to deduct these expenses from their income tax.

Unlike some of the provisions in the mark that take a round-about approach to raising taxes on Americans, this is a direct tax that will disproportionately affect seniors and those with chronic illnesses.

In addition, this proposal takes away much of the flexibility and choice that more than 35 million Americans currently have to direct how they spend their health care dollars. This is a key benefit for many middle income families that allows them to plan and use their health care dollars as they see fit.

The *Wall Street Journal* summed up this proposal last week when it observed the Baucus-Obama plan would increase the cost of insurance and then force people to buy it, requiring subsidies.

Those subsidies would be paid for by taxes that make health care and, thus, insurance even more expensive, requiring even more subsidies and still higher taxes. "It is a recipe," said the *Journal,* "to ruin health care and bankrupt the country."

And this does not even get us to the really hot button issues like tax-funded abortions or government

rationing of health care. Americans are unique, a people and country bred with a strong individual spirit and a distaste for big government.

In Kansas and throughout the country, people largely just want to be left the heck alone. "Thank you, Uncle Sam, we will do it ourselves. All we want is a fair shake."

The last thing they want is the federal government sticking its nose into their personal business. Americans do not want the government taking over a health care system along with the banks and the car manufacturers and all the rest.

So for these reasons, Mr. Chairman, process, timing, substance and ideology, I will oppose the bill. Thank you, sir.

The Chairman. Thank you, Senator. A quorum is present and I thank my colleagues for their attendance. We have before us the Chairman's mark on the America's Healthy Future Act, as well as my modification to that mark.

The mark is so modified. The modification is deemed incorporated into the Chairman's mark.

Senators have had the Chairman's mark since last Wednesday. So I now ask for an explanation of the modification of the mark, a walk-through, and I will ask

Tom Barthold to briefly explain the tax components of the modification of the mark and, following Mr. Barthold, an explanation of the modification and I will ask Yvette Fontenot to briefly explain the health components of the modification of the mark.

As I say, Senators who wish to ask questions should feel free to do so. Feel free to just ask during the explanation of the modification of either Mr. Barthold, Ms. Fontenot or anyone else.

But I do ask Senators to be courteous to other members of the committee; that is, keep your questions the first time to, say, roughly five minutes or so to give other Senators a chance to ask questions, as well, and to speak on it. It will be open. So if you want to come back again and ask more questions, that would be fine.

Let us proceed. Mr. Barthold, why do you not briefly explain the tax components of the modification?

Mr. Barthold. Thank you, Mr. Chairman and Senator Grassley. I will briefly explain the revenue items. I will note that there are two tax changes related to the coverage title of the bill that, when Yvette gets to, we can talk about at that time.

The first modification that the Chairman's modification would make relates to the proposed excise

tax on high-cost insurance plans. There are basically four components to the modification. The tax rate would be increased to 40 percent. All threshold amounts in the proposal would be indexed by the Consumer Price Index plus 1 percent.

In addition, the modification creates an election at the individual within a plan level such that if one is a retired individual over age 65, purchasing an individual plan or family coverage, the threshold amount for purposes of applying the tax would be increased by $750 for individual coverage, $2,000 for family coverage.

In lieu of choosing that election, the modification proposes the same increase in thresholds on individual or family coverage for certain high risk professions. The modification then makes a minor change of moving back the effective date of the provision relating to the additional tax on distributions from health savings accounts.

It modifies the flexible spending -- the cap on flexible spending arrangements, which, in the Chairman's mark, has been proposed at $2,000 effective after 2012 to be a $2,500 limit effective after 2010. The modification also would change the annual fee imposed on manufacturers and importers of medical devices, to exclude certain lower priced Class 2 products.

Within the medical device field, there is a Class 1, Class 2 and Class 3 certification. The Chairman's mark had initially applied to all Class 2 and all Class 3 devices. The modification would exclude certain lower priced Class 2 devices.

The annual fee on health insurance providers would be increased from $6 billion in the Chairman's mark to $6.7 billion in the modification, and the Chairman's modification also would repeal or eliminate the annual fee that was imposed on the clinical labs. There is an offsetting change in terms of Medicare lab fee schedule that Yvette will probably explain related to the lab fee proposal.

That concludes my brief run-through of the revenue provisions, with the exception of two new items, one of which was noted by Senator Roberts. There is a proposal related to health benefits provided by Indian tribal governments that would clarify present law going forward to provide an exclusion from gross income for the value of certain specified Indian tribal health benefits.

These benefits could be in the form of services purchased through the Indian Health Service by the tribe, medical services provided directly by a tribe, or certain health insurance provided by the tribe.

The other new item in the Chairman's modification is

a proposal that would increase the present law 7.5 percent of adjusted gross income floor above which one can claim deductions for out-of-pocket medical expenses to a 10 percent floor.

I should note that the 10 percent floor is the floor that applies for purposes of the alternative minimum tax. So it is raising the floor under the regular tax to be the same as the under the alternative minimum tax. That proposal would be effective beginning in tax years 2013 and beyond.

That concludes my walk-through.

The Chairman. Ms. Fontenot, why do you not proceed?

Ms. Fontenot. Sure. Beginning on page 1 of the modification document, the first modification is to correct a drafting error that clarifies that the reinsurance nonprofit entities will have nonprofit tax exempt status at the federal level.

The second is to clarify that the reinsurance applies to all policies, not just those policy -- all those policies on an individual and small group market, not just those sold through the state exchanges.

The third modification changes the effective date for the subtitle that contains the rating reform to July 1, 2013. The fourth modification adds $5 billion to the

reinsurance program that was in the Chairman's mark for early retirees.

The next modification clarifies that application for unemployment insurance will be considered a change in circumstance that allows an individual to go to the exchange for redeterminations of the premium tax credit.

The next modification allows for states to opt out of federal health care reform if they have met a number of criteria. The next modification lowers the allowable age rating to four-to-one.

The next modification amends the national plan that was in the Chairman's mark to include a option for space to opt out if they choose. The next clarifies that an individual who has an existing policy that is equal in value to a young, invincible policy will meet the minimum credible coverage requirements.

The next allows exchanges to enter into contracts with Medicaid agencies to determine eligibility. The next one, at the top of page 3 in the document, allows exchanges to have the choice to enter an agreement with sub-exchanges.

The next allows the state exchanges to develop rating systems for plans and indicate the rating of those plans on the exchange website. The next provision strikes the allowance in the Chairman's mark for multiple

exchanges.

The next provision allows standalone dental, vision and long-term care insurance plans to list their benefits on the exchange. The next requires the Secretary to conduct a study on methods to encourage the use of electronic health records by health care providers.

The next is a clarification that agents and brokers are allowed the immediate right to enroll individuals and employers in the state exchanges. The next gives the option to federal employees to purchase through state-based exchanges rather than through the Federal Employees Health Benefit Plan.

The next allows states to -- states must allow small businesses up to 100 employees to purchase through the exchanges beginning in 2010 and states allow employers with more than 100 employees to purchase through the state exchanges beginning in 2017.

At the top of page 4 of the mark, the modification allows small businesses that grow beyond the upper employee limit to continue to purchase their coverage through the exchanges. I am going to defer to Mr. Barthold on the remainder of that page.

Mr. Barthold. The Chairman's modification would make a change in how income is determined for purposes of eligibility for the exchange subsidies. So simply put,

under the Chairman's mark, the income is determined by looking at a taxpayer's adjusted gross income and adding back foreign earned income, certain possession income, and tax-exempt interest.

The modification would determine income without regard to any of the deductions of gross income that get you to adjusted gross income, still adding back those items I noted.

Maybe to be more precise, since members fill out their tax returns, if you were to look at a tax return, you would be starting from line 22 on Form 1040, which the IRS refers to as total income, and you would be adding to that foreign earned income, certain possession income, and tax-exempt interest. That would be the new determination of income under the Chairman's modification.

Then the next change is with regard to the small business tax credit. The modification extends the small business tax credit to Section 501(c)(3) charitable organizations, but with a smaller credit rate than in the mark for taxable businesses.

The credit rate under Phase 1 would be limited to 25 percent and under Phase 2 to 35 percent.

Ms. Fontenot. The next modification corrects a drafting error on page 26 of the mark. On the top of

page 5, this modification clarifies that these are the requirements for the large group market to meet minimum credit coverage.

The next modification eliminates annual and lifetime limits for all plans in the state exchanges beginning in 2010 and precludes larger employers from imposing unreasonable annual and lifetime limits on coverage.

The next modification allows the secretary to establish alternative income determinations for the premium tax credit for those who did not file a tax return in the prior year.

The next modification allows the Secretary to define the benefit categories, as long as they are consistent with the typical employer-sponsored plans. The next clarifies that a change in household size will be a circumstance for which an individual can seek a change in their tax credit amounts.

The next requires that all states ensure that there are available in every exchange plan a plan that is at least actuarially equivalent to Blue Cross/Blue Shield standard.

On the top of page 6, the next modification clarifies that the percentage of income that an individual or family will be required -- after which they will receive a tax credit will go from two to 12 as

opposed to three to 13, as it was in the Chairman's mark.

The next reduces the out-of-pocket maximum limits for those between 300 and 400 percent of poverty to two-thirds of the current HSA limits. The next adds immunizations, as recommended by the Advisory Committee on Immunization Practices, to the benefit categories.

The next allows that for those who qualify for the exemption from the individual assessments and purchase the young invincible policy --

The Chairman. What page are you on?

Ms. Fontenot. I am on page 6 of the modification.

The Chairman. Six of the modification.

Ms. Fontenot. Right.

The Chairman. Thank you.

Ms. Fontenot. In the middle.

The Chairman. Thank you.

Ms. Fontenot. The next requires that small employers provide a plan with a deductible that does not exceed $2,000 for an individual and $4,000 for families.

The final modification on page 6 clarifies that the employer responsibility payment is a flat dollar amount equal to the national average tax credit.

At the top of page 7, I am going to --

The Chairman. You do not have to go through every single line.

Ms. Fontenot. All right.

The Chairman. Just hit the high points, summarize.

Ms. Fontenot. All right. I am going to defer to Tom Reeder on the top of page 7.

The Chairman. For all of you, just hit the high points and summarize. There is no use going through this line-by-line.

Mr. Reeder. The top one is just a technical error, drafting error. We can skip that.

Ms. Fontenot. Continuing on page 7, there are clarifications in terms of when the employer mandate will occur, a delay in the personal responsibility requirements, and a reduction of the penalty that families above 300 percent of poverty will pay.

Then there are a number of provisions related to the co-op that were in the Chairman's mark.

The Chairman. Are you still on page 7?

Ms. Fontenot. I am at the bottom of page 7 now.

The Chairman. Why do you not read that one in the middle of page 7? That is important.

Ms. Fontenot. The penalty?

The Chairman. No, no, no, no. The modification accepts amendment number C-2.

Ms. Fontenot. That allows employees who would have to pay more than 10 percent of their income to get their

employer coverage to opt out and receive the tax credit. Then there are a number of provisions at the bottom of page 7 and top of page 8 that relate to the co-ops that were in the Chairman's mark, including the concept that they have to abide by all state solvency requirements, that they have to play on a level playing field and abide by all state licensing requirements equal to a private insurer; that their federal funds cannot be used for lobbying or marketing.

There are a number of provisions that bring some transparency and accountability, part of the Chairman's mark, including allowing individuals to seek ombudsman services for a greater number of reasons, those that were listed in the Chairman's mark. At the top of page 9, there are additions to the transparency provisions that would require definitions for common insurance terms and medical terms and easier to read claims for consumers.

With that, I am going to let my colleague, Mr. Schwartz, go through the Medicaid provisions.

The Chairman. All right. Mr. Schwartz?

Mr. Schwartz. Thank you, Mr. Chairman.

The Chairman. Hit the high points.

Mr. Schwartz. Sure. At the bottom of page 9, there are some clarifications for the eligibility standards under Medicaid, including cost-sharing and the

fact that states are as flexible under this as they are today to continue to offer coverage above the minimum levels specified in the Chairman's mark.

Moving on to page 10, the first modification at the top is a new requirement on states to report changes in their enrollment.

The Chairman. And a lot of these are accepting amendments offered by Senators.

Mr. Schwartz. That is correct.

The Chairman. Sometimes with modifications.

Mr. Schwartz. That is correct.

The Chairman. But, basically, that is what a lot of these are.

Mr. Schwartz. The great majority are.

The Chairman. Thank you.

Mr. Schwartz. In the middle of the page, there is a provision that would give additional assistance to states that we call high need states, which is in addition to the enhanced FMAP rates that were contained in the Chairman's mark.

Towards the bottom of the page, there is a rescinding of funds in what is known as the Medicaid Improvement Fund, $700 million.

At the bottom of page 10, that is accepting a couple of amendments and it imposes a requirement on the

Secretary of Health and Human Services to certify that exchange coverage is comparable to CHIP coverage before children can be transitioned from CHIP as it is today into exchange plans.

On page 11, we have several clarifications of provisions that were in the Chairman's mark. At the bottom of page 11, we have an amendment that was accepted that would add what is known as the community first choice option to the long-term services section of the mark. This is a five-year option that will make home community-based services much more widely available through the Medicaid program.

Then we add a couple of more things on long-term services and supports on page 12; a sense of the Senate amendment offered by Senator Rockefeller; a Kerry amendment that will also help home and community-based services to be more widely available by easing restrictions on spousal impoverishment rules; and, finally, a Cantwell amendment related to incentivizing states to expand their offering of home and community-based services.

Page 13 starts with a technical clarification, then moves on to a state option for family planning services under Medicaid, and at the bottom is a new grant program for school-based health centers.

At the top of page 14, a provision that was in the Chairman's mark that would have made prescription drugs a mandatory benefit in the Medicaid program is removed; technical clarifications follow. There is GAO report and then -- sorry, I lost my place.

At the bottom of page 14 is the technical clarification to the language surrounding disproportionate share hospital payments. Then at the bottom of page 14 and onto page 15 is replacement of language that was in the Chairman's mark related to a new office at the Centers for Medicare and Medicaid Services that will focus on individuals who are eligible for both Medicare and Medicaid.

At the bottom of page 15, there is a new demonstration program for global payments. It is followed by another new demonstration program in Medicaid for accountable care organizations. Previously, the Chairman's mark addressed that only in Medicare. This would add it for pediatrics in Medicaid.

There is a third demo which is focused on psychiatric care and expanding the availability of psychiatric care in Medicaid; then some technical issues at the bottom of page 16.

Ms. Henry-Spires. Continuing at the bottom of page 16 and to the top of page 17, the Kerry amendment, C-4,

is accepted that ensures children aging out of the foster care system have the opportunity to designate a medical power of attorney.

In the next section of health disparities, there is a modification that simply clarifies language in the section. Following that, maternal and infant, early childhood education, there is a correction to yearly funding allocations that does not have any scoring implications.

In the same section, there is an acceptance of the Menendez amendment, C-14, which provides post-partum depression services to women that may be suffering from the condition.

Then, also, accepted in that section is amendment C-12, with modifications, a Hatch amendment, prohibiting federal funds from being used for assisted suicide and that offers contents protection to providers.

Mr. Dawe. I will begin on page 18 with the following modifications, which are to Title II of the Chairman's mark, promoting disease prevention and wellness.

Mr. Schwartz. I apologize, Mr. Chairman. At the top of page 18, you will note that it says to accept Lincoln amendment number D-5. That should actually say Lincoln-Hatch. I apologize, Senator Hatch. That is my

fault. But this is the point in the modifications where we accept the Elder Justice Act as part of the Chairman's mark.

The Chairman. Thank you.

Mr. Dawe. Modifications to Title II begin with corrections or drafting efforts in the annual wellness visit, the removal of barriers to prevention services, and Medicare incentives for health lifestyles.

The modification accepts Stabenow amendment D-5, which makes Medicaid enrollees with at least one serious and persistent mental health condition qualified to receive services under the option.

The modification accepts Bingaman amendment number D-9 to start community mental health centers in the mark. The modification accepts, with modification, the Carper amendment C-1, provides $200 million to the Secretary of HHS for up to five years to make grants to small businesses with less than 100 employees, to provide access to comprehensive, evidence-based, workplace wellness programs.

It accepts Carper amendment C-4, which requires the Secretary of HHS to issue guidance to states and health care providers regarding Medicaid coverage of obesity-related services and preventive services.

Now, to new Title II, it adds a new subtitle,

employer sponsored wellness programs, this codified provision of HIPAA nondiscrimination regulations which allow for rewards to be provided to employees for participation in or meeting certain health status targets related to a wellness program.

The next set of modifications are to Title III of the Chairman's mark, improving the quality and efficiency of health care. The first accepted, with modification, the Cantwell amendment number D-1, this established a separate budget-neutral payment modifier to the Medicare physician fee schedule based on the value of care that physicians deliver.

Ms. Eisinger. The next amendment would accept Menendez number D-3.

The Chairman. What page are you on?

Ms. Eisinger. The bottom of page 22.

The Chairman. Thank you.

Ms. Eisinger. This amendment, again, Menendez D-3, would add health care acquired conditions to the list of eligible measures for purposes of the hospital value-based purchasing program. Now, we are onto 23.

Mr. Dawe. The next provision adjusts the implementation dates and levels of future payment incentives in the physician quality reporting initiative. The next two adjustments are to the physician fee-backed

program. It requires the Secretary of HHS to coordinate this provision with other relevant value-based purchasing reforms and it clarifies that the program begins in 2014, not 2015.

Ms. Eisinger. The next amendment would accept Rockefeller number D-1, which would add additional members to the Interagency Working Group on Quality in the quality infrastructure section.

Mr. Dawe. Steps, with modification, Rockefeller amendment D-3, which adds free clinics to the list of providers who are eligible for Medicare and Medicaid health information technology incentives.

The next amendment is the Kerry modified amendment D-3, adds "regardless of specialty" to the definition of physicians and ACOs. The next modification clarifies that the CMS Innovation Center will be required to be established by January 1, 2011.

The next accepts Conrad amendment D-1, adds new criteria for the Innovation Center to consider that promotes improved quality and reduced costs. The next accepts the Carper amendment D-2. This clarifies the criteria for the Innovation Center --

The Chairman. You are on page 25.

Mr. Dawe. Yes, we are on 25. This clarifies the criteria for the Innovation Center to consider to include

specialist physicians and other health care providers. It also accepts Kerry amendment D-5, which adds the Medicaid and CHIP programs to the CMS Innovation Center.

The Chairman. You do not have to do it all. Just hit the highlights.

Senator Bunning. Mr. Chairman?

The Chairman. Senator Bunning?

Senator Bunning. Is it my understanding that Dr. Elmendorf is going to have to leave? If we could at least question him while he is available.

The Chairman. That makes good sense.

Senator Bunning. And make sure we can continue on reading through the mark. But I sure would like to ask him some questions.

Dr. Elmendorf. Mr. Chairman, Senator Bunning, we do not want to stay indefinitely, because we are trying to work on estimates of more of your amendments, but I gather that the staff think that they are within 10 minutes of finishing.

The Chairman. How long are you going to with us? That is what my question is.

Dr. Elmendorf. We will stay for several hours.

The Chairman. All right. Thank you.

Ms. Eisinger. The next item would correct an error related to the redistribution of unused graduate medical

education slots and this relates to the funding level.

The Chairman. Where are you?

Ms. Eisinger. We are in the middle of page 25.

The Chairman. Speak up a little, please.

Ms. Eisinger. Sure. The next amendment would accept Bingaman amendment number D-2 that would amend the criteria for the GME redistribution policy referenced above.

The final amendment on the bottom of page 25 would accept, with modification, Bingaman amendment D-8 to establish teaching health centers, to increase primary care training.

Turning to page 26, at the bottom of page 26, to accept, with modification, Stabenow amendment D-4 that would establish a graduate nurse education demo in Medicare.

Turning to page 27, to accept, with modification, Stabenow number D-9 to clarify requirements in the quality infrastructure section. The next amendment, to accept, with modification, Nelson number D-6 to provide additional resources for the GME slot redistribution policies.

The bottom of 27, to correct drafting errors in Title III related to the low volume hospitals adjustment programs.

Turning to page 28, to clarify in Title III rules regarding payments for critical access hospitals. To accept, with modification, Rockefeller amendment D-7 related to provisions in S.1634.

Mr. Dawe. Now, on page 31, the top, the first provision is a replacement for the clinical lab fee that Dr. Barthold referred to. This would create an additional payment reduction, a temporary additional payment reduction to the clinical lab fee schedule for the years 2011 through 2015.

The Chairman. What happened to the earlier pages?

Senator Conrad. We went from 28 to 31 there.

Ms. Bishop. We should not have switched these. So back to page 28, I am going to be brief. There is a list of amendments, modifications that were made to the mark related to Medicare Advantage and the prescription drug program.

The main amendment we accepted into the mark was an amendment filed by Senator Nelson that would create a grandfather program for Medicare Advantage plans that offer benefits in areas of the country where plans are bidding at 85 percent of fee-for-service cost or below.

They would be able to grandfather their current enrollees into their plans, but only in those areas of the country. The amendment would also eliminate the

efficiency bonus that was included in the competitive bidding program.

Senator Ensign. Mr. Chairman?

The Chairman. Can she just clarify that? Do you know what areas of the country that that affected and what areas it did not or at least a percentage of Medicare Advantage people that it affected and what it did not?

Ms. Bishop. I do not and the reason for that is the information that is used to calculate the bids that Medicare Advantage plans submit to CMS is proprietary.

So instead of being able to look and see which areas of the country the bids fall under a certain percentage, we basically chose the policy number of 85 percent because we felt that that would represent areas of the country that were efficient relative to fee-for-service, because there are some areas of the country that have relatively high fee-for-service costs that include high utilization or maybe even high amounts of fraud.

So we did not want to use just a 100 percent of fee-for-service. So we decided that efficient would probably be some level below fee-for-service cost. So we chose 85, and we do not know what areas of the country that will include until CMS -- if this bill were to become law, CMS would have to identify what areas those were so

that plans could know what areas of the country they could be grandfathered into.

Senator Nelson. Mr. Chairman?

The Chairman. Yes, Senator Nelson.

Senator Nelson. We did a run on that and in Nevada, it would affect Nye, Clark, Pershing and Esmeralda Counties.

Senator Ensign. How can he have the information and they cannot?

The Chairman. I was asking myself the same question.

[Laughter].

Senator Ensign. If it's proprietary, how do you get it and they do not?

Senator Nelson. I got it from you all.

Ms. Bishop. No, no, no, no. Wait, wait, wait, wait. No, no.

[Laughter].

Ms. Bishop. We do not have the data. There is information that actuarial firms that prepared the bids for Medicare Advantage plans, they can share their sort of general information about where the bids are in the country. But there is no one actuarial firm that has all of the bids in the United States. The only entity that has all the bids are CMS, CBO, and MedPAC, and they are

not allowed to provide us with county-level, or even State-level, information.

Senator Nelson. Is it possible for MedPAC to answer that question? From what I understand, they have that information, and Mark Miller is in the audience.

The Chairman. Mr. Miller? You are in the audience somewhere. MedPAC? There you are. Thank you.

Mr. Miller. My understanding with the problem and doing the impacts, is that the data that we have does not conform to the areas that people will be bidding on, so we do not have the ability to estimate the impacts under the competitive option broadly, and this proposal specifically.

Senator Nelson. May I, Mr. Chairman, just put that into common street language? The data that they have now is broken out by counties what they anticipate in the future is going to be by metropolitan statistical areas. Is that correct?

Mr. Miller. It is very close. It is a little more complex than that. Currently, the data that we have is on service area. The counties will be the -- you could convert -- the current payment unit is counties, but under this rule those counties will be aggregated up to MSA. Our problem is, there is a mismatch between the bids by the geographic units, whether it is county or

whether it is MSA.

Senator Nelson. During the mark-up, could we at least get the information so we know whether it affects what areas of the country, what counties, that kind of thing?

Mr. Miller. That is the problem, you will not. It does not tell you that.

Senator Nelson. So we will have an amendment here that we do not know the effect. Is that what I am understanding? It sounds like it.

The Chairman. You will know some effect.

So Ms. Bishop, could you explain what effect -- what will Senators know?

Ms. Bishop. Right. Just to give you a sense of the information that we received from a large actuarial firm, when we looked at the data, there were many States that would have areas that would be grandfathered. So off the top of my head, we were just eyeballing which States would be affected. Texas, Louisiana, Kansas, Tennessee, Nevada, Florida, New York, Georgia. I am thinking of other places in the country. Anyway, there were at least 15 or 20 States. And like I said, we were not trying to --

Senator Ensign. And they would be completely grandfathered in, all of those States?

Ms. Bishop. No. No.

Senator Ensign. The President has promised that anybody who has their health care coverage now will not lose their health care coverage. So when we have a senior ask us in our area, and this amendment may affect that, we kind of need to know whether or not we can answer them honestly and say, yes you are going to keep your coverage, or no you are not going to keep your coverage. It does not sound like to me we are going to have the information to be able to tell them that.

Senator Nelson. What this amendment does, the Chairman is willing to put into his package, it gets us part of the way there. It does not get us the whole way there. Now, I will offer another amendment that will get us the whole way there, but at least he is gracious enough to get us, for the counties -- and those four counties, you know them in your State that I just named, which is where they have the biggest differentials on Medicare Advantage.

The Chairman. Senator Conrad?

Senator Conrad. Can somebody help us understand, and I do not know if this is the appropriate place, Mr. Chairman, to ask this question.

The Chairman. Go ahead.

Senator Conrad. I know this was part of the

discussion yesterday or the day before. I thought I understood it then, but maybe it would be useful for others, and I think for me, too, to hear the explanation of the implications of this policy. You are saying that those who are below 85 percent of fee-for-service -- what would be the advantage to them?

Ms. Bishop. So, this is sort of getting at the question of, what is the policy rationale, this grandfather --

Senator Conrad. Right.

Ms. Bishop. [Continuing]. That would be limited, if you will, to areas of the country where plans are bidding at 85 percent or below fee-for-service. The idea there, the policy rationale for this, is that today, in those areas of the country where plans are bidding significant below fee-for-service costs--and there are lots of areas of the country where that is the case.

The Chairman. Like, what level?

Ms. Bishop. There are areas of the country where plans are bidding at 70 percent of local fee-for-service cost.

Senator Conrad. And it is because fee-for-service in those areas is very high.

Ms. Bishop. Right. Generally speaking--and just to clarify--when I mean that plans are bidding, what I

mean is that their estimates, their projections of their benefit costs, their profit, their marketing, and their broker fees are 70 percent of what it costs the Medicare program to provide benefits in that area, so their costs are significantly lower than fee-for-service. One of the reasons why plans are able to bid low in some areas of the country is because the fee-for-service costs in those locations are high relative to the national average.

Now, they could be high because there are high utilization patterns. They could be high because there is--and MedPAC has mentioned this in one of its meetings--more significant amounts of potential fraud in some areas of the Medicare program. So there are lots of reasons why an area of the country has high fee-for-service costs, but the implications to beneficiaries--I think this gets to your question--is that in those areas of the country where fee-for-service costs are high, plans are able to bid below those costs. It is relatively easy for them to bid below costs that are sort of inflated.

And so the current law allows the plans to keep 75 percent of the difference between their bids and the fee-for-service costs. They get to retain that as an extra payment. The plan gets to retain that as an extra payment for themselves. They must provide extra benefits

to beneficiaries with those extra payments, so beneficiaries in areas of the country, by no fault of their own, have had relatively generous extra benefits because the law allows the plans to keep 75 percent of the difference.

But there is significant variation around the country in how much extra benefits beneficiaries have been able to retain under the current Medicare Advantage program. Competitive bidding is going to make consistent the amount of dollars that will be available for extra benefits across the country. It is going to be the same dollar amount, but plans have to earn it, it is not automatic. So in areas of the country where beneficiaries have been able to retain high amounts of extra benefits, this grandfathering provision will allow their extra benefits to --

Senator Conrad. Be stepped down.

Ms. Bishop. [Continuing]. To be stepped down slowly over time, whereas in other areas of the country where plans are bidding closer to fee-for-service, competitive bidding is not going to have a shock effect, if you will. So this is an opportunity, as we are calling it, the way it was presented in Senator Nelson's amendment, is just to kind of stabilize the benefits in areas of the country that have high costs so that there

is not a --

Senator Nelson. Shock effect.

The Chairman. All right.

Yes, Senator Hatch?

Senator Hatch. Mr. Chairman, I would just like to ask Mr. Barthold a question. In connection with the Chairman's modified mark, there is a new tax increase included on taxpayers who take advantage of the itemized deduction for medical expenses.

Now, Mr. Barthold, could you tell me what kind of taxpayers, both age and income, are most likely to be hurt by this increase, and would these likely be only those that are making more than $200,000 as individuals, or $250,000 as couples?

Mr. Barthold. Senator Hatch, any taxpayer who itemizes, if they have sufficiently high qualifying medical expenses, can claim that itemized deduction. So as you know, people may itemize with incomes of $50,000, $75,000, $100,000. So it would affect taxpayers with incomes of less than $200,000, $250,000.

The profile tends to be where it picks up people with extraordinary medical expenses in any one year. That is what the floor has the effect of doing. If you have very unusually high medical expenses, the Internal Revenue Code has permitted individuals to reduce their

tax base to account for that unusual circumstance that applies in that one year.

You asked a little bit about age. I do not have, at the moment--I might in a couple of minutes--actual numbers, but approximately half of the dollar value of the revenue effect in the table that was provided to you, JCX-36, is from returns where either the taxpayer or the taxpayer's spouse is aged 65 or older. So I guess that is sort of disproportionate to the age distribution population.

Senator Hatch. Well, as I understand it, and I think it is true, that those who claim this deduction are mostly elderly people.

Mr. Barthold. I am sorry, I could not hear you.

Senator Hatch. They are mostly elderly people, or lower or middle income people. Does the current law's 7.5 percent threshold not already pretty well guarantee that they are not getting a tax benefit now unless they have a lot of medical expenses relative to their income? Is there any reason to believe that the current law threshold is deficient or is being abused by people? This bill will raise this to 10 percent from the current threshold of 7.5 percent.

Mr. Barthold. Well, Senator, as I noted, approximately half of the revenue is related to taxpayers

where either the taxpayer or the taxpayer's spouse is aged 65 or over. In terms of numbers of returns, we estimate that in 2013, approximately 11.5 million taxpayers would be affected by this proposal. Of that amount--I am just quickly eyeballing it--about half of that number would have incomes less than $75,000 and half would have incomes greater than $75,000.

Senator Hatch. But not much more than $100,000?

Mr. Barthold. I still could not hear you. I am sorry, Senator.

Senator Hatch. But not much more than $100,000?

Mr. Barthold. Over about 2.2 million returns with incomes in excess of $100,000 would be affected by the proposal.

Senator Hatch. So you would have about 9 million returns that would be under $100,000?

Mr. Barthold. That is correct, sir.

Senator Hatch. Most of them would be under $75,000.

Mr. Barthold. Roughly adding it here, roughly half would be under $75,000.

Senator Hatch. Do you have a sense of whether most taxpayers who claim the medical itemized deduction do not really need this deduction or would they be made whole with other parts of the bill before us?

Mr. Barthold. I could not make an assessment on the overall effect of the proposal since the committee is considering rather substantial changes in the overall health care system, sir.

Mr. Reeder. I would like to point out that there are other aspects of the bill that will ameliorate the effect of this because all people will have access to insurance that will cover costs that are commonly claimed as excess medical deductions on Schedule A.

Senator Hatch. But a lot of people today have insurance and they still use this faithfully.

Mr. Reeder. There are other aspects of the bill as well: there are caps on the out-of-pocket costs under insurance; there is assistance with out-of-pocket costs for lower income folks. So there are other aspects of the bill that will address the reasons why people use this deduction.

The Chairman. Right. And I think it is an important point to keep in mind. The deduction, I would guess, is primarily taken for catastrophic costs. We have a limit now of roughly $6,000 per person so that the person will not have to pay more than $6,000. I would think that, therefore, the need for the early 7.5 percent deduction is not as great as it otherwise would be. Plus, the other provisions in the bill which give

economic benefits to people at middle income and lower income levels.

Senator Grassley. Mr. Chairman, that might be true for people that are not senior citizens, but senior citizens do not have catastrophic coverage through Medicare.

The Chairman. Well, that is right. I think that is a problem.

Senator Grassley. This would be particularly tough on senior citizens, it seems to me.

The Chairman. It could be. It could be. This is something that was, frankly, put together pretty quickly in order to satisfy other needs. But Senator, you make a good point. Let us see if we can modify it so that seniors are not hit by this, as a down point. As we work through this, let us see if we can find a modification.

Ms. Bishop, are you finished? Why do you not move on?

Ms. Bishop. All right. So, I just wanted to say one more thing about the amendments that were accepted related to Part D. We accepted several amendments related to the prescription drug program. One of them would equalized co-payments for dual eligibles that utilize home- and community-based services instead of residing in long-term care institutions. Another

modification--these are the major ones--was an amendment filed by Senator Stabenow that would allow prescription drug plans to waive Part D co-payments for the first fill for generic drugs.

Ms. Henry-Spires. Continuing on page 30 at the top, or one down, to accept, with modification, Lincoln Amendment Number D6 regarding rules for the calculation of the Medicare Hospital Wage Index. The next one, Wyden Amendment D1, would create a hospice concurrent care demonstration in Medicare. That was Wyden D1. The final one on the bottom of page 32, accept, with modification, Menendez Amendment D1 regarding, again, rules on Hospital Wage Index.

We are now turning to page 31.

Mr. Dawe. Modification accepts the Conrad Amendment D6, which eliminates the sunset on the Medicare Commission and sets the growth target beyond 2019 at GDP per capita, plus 1 percent. Also accepts, with modification, Lincoln Amendment D2. This provision temporarily reinstates reimbursement for certain bone density services, to 70 percent of their 2006 payment rates.

On the top of page 32, modification accepts Conrad Amendment D5. This extends, until January 1, 2012, the bonus payments under Medicare to ambulance service

providers in super-rural areas, as defined in the MMA.

Mr. Schwartz. Mr. Chairman, there is one modification in Title 4, "Transparency and Program Integrity". It is really just a clarification of the definition of "additional disclosable parties" under "Nursing Home Transparency". Then in Title 5, there is one clarification of exceptions that are available to the provider application fee. I believe that concludes the walk-through.

The Chairman. Very good.

Are there any questions from Senators on the mark or of Dr. Elmendorf, since we have him here? Senator Grassley?

Senator Grassley. Yes. I want to ask Joint Tax, it gets back to something that President Obama was speaking about on the Sunday talk shows, trying to say that it is not true that a penalty for not getting insurance is a tax, referring to the individual mandate. The mark before us makes it pretty clear that the penalty is a tax. It looks like the tax is now up to about $2,000 a year. So Mr. Barthold, is the penalty here not an excise tax, and will it not affect people making under $250,000 a year?

Mr. Barthold. Senator Grassley, the penalty proposed in the Chairman's mark is, as you observed,

structured as a penalty excise tax. We have other penalty excise taxes in the Internal Revenue Code. We have not separately analyzed. We have worked in conjunction with Dr. Elmendorf and his colleagues at the Congressional Budget Office in terms of the overall effects of what sort of people might purchase insurance through the exchange who would not have insurance provided by their employer, and where the individual mandate or the employer free rider penalty would arise.

We have not done a combined distribution analysis across income to specifically answer your question, but to the extent that, yes, we think that some people would be subject to the penalty excise tax when everything shakes out, we would expect that some would have incomes less than $200,000.

The Chairman. Let me just say on that point, it is an interesting question. This is really a penalty that is being collected by the Internal Revenue Service. It could be collected by another body, another entity, another agency, perhaps HHS. I mean, HHS could set up a different apparatus. Maybe the Help bill has something similar, I do not know. That leads to all kinds of complications; they do not have the data, they are not efficient. But somebody is going to have to collect the penalty, to the degree to which a penalty is paid.

The modification, too, will reduce the penalty significantly, will cut it in half, so it is much smaller than it otherwise was. But somebody is going to have to collect it to the degree that there is one, and it is this committee's determination--at least it is my determination so far--that the better, more efficient is for the IRS, which is set up to collect these kinds of penalties. So it is really a penalty that we are talking about here, just the IRS, not HHS, is collecting the penalty.

Senator Wyden. Mr. Chairman?

Senator Grassley. I think the Chairman made the point that the IRS now is the one in this bill that is collecting this penalty or excise tax, or penalty excise tax, whatever you want to call it.

Senator Snowe. Mr. Chairman?

Senator Grassley. I am done.

The Chairman. All right.

Senator Wyden?

Senator Wyden. Thank you, Mr. Chairman.

Director Elmendorf sent you a letter today, Mr. Chairman, going through some of the payments that middle class folks would be paying in their subsidies. Director Elmendorf, if you could go to that letter, it is dated September 22. I just want to make sure I am reading the

chart right. The analysis looks to me like Americans at the exchange, middle class families with incomes between 200 and 400 percent of the poverty line, would be paying 19 or 20 percent of their incomes in premiums and cost-sharing for their health care.

Can you go to the back of that letter you sent to the Chairman and tell me if I am reading that chart right? Because it looks to me like that is in the outline for a family of four, and it looks like 250 to 300 percent of poverty, they would be paying 20 percent of their income for one of the cheaper plans. Is that a correct analysis of that chart?

Dr. Elmendorf. That is the correct interpretation of that table. I should emphasize that this table and the letter are based on specifications as they were released last week, including income caps ranging from 3 percent to 13 percent, and then would be indexed over time.

The Chairman. And that analysis was before the modification.

Dr. Elmendorf. Yes. And the modification today lowers those caps, so these numbers would be somewhat smaller given the modification. We have not recalculated them since we finished this at 11:00 this morning.

Senator Wyden. Give me a sense -- and I appreciate

that, because you dated the letter today, and that was what I was, in effect, responding to.

Is it likely to be 3 or 4 percentage points less? Because obviously the Federal Agency for Health Care Quality Research says if people are paying more than 10 percent of their income, then it is a high financial burden for these kinds of families. So you have got it pegged on this chart, before the modifications, at 19 or 20. Is it likely to go down even 3 or 4 percentage points? Because that would still be substantially over 10 percent. Is it still likely to be, say, 15 or 16?

Dr. Elmendorf. No, I do not think so. The caps have been lowered by 1 percent of income, as I understand the modification. That will more or less reduce the amounts in the righthand column by about 1 percent of income. It was just lowering the caps, the share of income that families will have to pay, from 3 to 2, or 13 to 12. That is indexed over time. Though I cannot do the precise math in my head, but I think basically it reduces those numbers by around 1 percentage point. So the ones that are 19 and 20 would be in the 18 to 19 percent range.

Senator Wyden. So middle class families, with the modifications, would be paying about 18 or 19 percent of their income for health care?

Dr. Elmendorf. Those in the exchange.

Senator Wyden. Right.

Dr. Elmendorf. In 2016, buying the second-lowest cost, silver, plan. Yes, Senator.

Senator Wyden. Thank you, Mr. Chairman.

Senator Snowe. Mr. Chairman?

The Chairman. Senator Snowe?

Senator Snowe. Thank you, Mr. Chairman.

Dr. Elmendorf, how many people do you estimate would be captured by the individual mandate penalty?

Dr. Elmendorf. I am sorry, Senator. I did not hear that.

Senator Snowe. How many individuals would be captured by the individual mandate penalty?

Dr. Elmendorf. I do not think we have an estimate of the number of people, Senator. We did estimate that, given the way the penalty was constructed, again, in the original mark of last week, that the amount of money that would be collected by the government would be in the neighborhood of $20 billion over the 10 years. But I do not think we have a number handy of the number of people.

Senator Snowe. How do you arrive at that calculation then?

Dr. Elmendorf. The modeling that we do incorporates people who would be charged a penalty, but I

do not have that number at hand. I think it is a number that we can look up, but it is not one that we reported in the letter and it is not one that I have with me.

The Chairman. And your analysis was since the modification. It was before the modification.

Dr. Elmendorf. This was before the modification.

The Chairman. And we have cut the penalty in half for those at 300 percent.

Dr. Elmendorf. That is right. But how much that changes the number of people, that is a little more complicated, because there is an incentive effect of reducing the penalty. So there are some offsetting pieces. We have not done this. Maybe I should just explain clearly that we have been spending our time, since last week, focusing on estimating the various modifications that the committee staff has put to us and the amendments that you all have put to us.

We received dozens of requests for modifications from the committee staff, and as you know, over 500 amendments from members of the committee. Even when we asked for the priority list, there were nearly 200 amendments that were viewed as high priorities. So we are delivering, I think, dozens of estimates and have dozens more on their way tonight, tomorrow, and the next day, but we decided it was more useful for you for us to

focus on working our way through the list of amendments rather than trying to collect the set of things that are part of the modification today, which does require extra work because there are interactions among the pieces that we do not estimate.

Of course, we have given you individual amendment scores. We will have to go back and do it eventually if the bill is adopted by the committee, but we thought, rather than spending the time to pull all those pieces together and re-do all the analysis from last week, we thought it was more useful for you to devote our energy to scoring your amendments. But I understand that creates some complication, in that some of the things that I will be saying refer to the bill as it existed before the release of the modification this morning.

Senator Snowe. Are you prepared to give us a final estimate on the bill, as amended, before we vote on it?

Dr. Elmendorf. It will take us some time to create a final estimate, an official CBO cost estimate of legislation. As you understand, this is very complicated legislation and the pieces do interact. So in the preliminary analysis that we provided last week, we tried to keep track of all those interactions and we will go back and do that again at such time as the committee adopts and settles on a particular piece of legislation.

But that takes some work. There are some things that were preliminary last week, and will still be preliminary until we have time to refine that. So our turning this preliminary analysis into a final estimate will take some time after the committee --

The Chairman. Dr. Elmendorf, this is a very critical question and it is one that is important to, I daresay, every single member of this committee. We need that final estimate, certainly the preliminary. In answer to Senator Snowe's question you said it takes some time, but you did then say we would get a preliminary estimate in the interim, if I heard you correctly.

Dr. Elmendorf. Well, again, I think it is a choice. We can respond to your preferences. If we did a preliminary analysis of the modification, that would take us the time that we would otherwise spend in estimating amendments that we have not yet gotten to score. There are only so many things -- we are working almost literally around the clock. But it is very important for us to maintain the quality of the analyses and estimates that we present, so we are moving at what I have described to the staff on some occasions as the "maximum safe speed".

The Chairman. Well, we want CBO to be relevant on the most important issues facing us, and certainly a

preliminary score and some of the most important amendments will make CBO relevant. I tell you, Dr. Elmendorf, this is a very serious concern of this committee and I would urge you to, with all deliberate speed, make sure that you address the scoring of this bill and the modification and give us a preliminary as soon as you can. But I cannot over-emphasize how important this point is.

Dr. Elmendorf. I understand, Mr. Chairman. Let me emphasize again, we have delivered estimates of dozens of amendments and modifications requested by the committee staff since the end of last week. The prioritized list of amendments arrived in our e-mail inboxes less than 48 hours ago. We have turned around a vast amount of material for you, but there are limits. I think a crucial part of CBO's relevance over time has been its reputation for doing our work carefully, as well as quickly, and we will continue to proceed at maximum safe speed to serve you well.

The Chairman. And also, frankly, making judgments, exercising your discretion.

Dr. Elmendorf. I think a very important part of my judgment as Director, Mr. Chairman, is what that maximum safe speed is. We are not sitting around obsessing over the fine decimal places, if that is your concern, but to

get the analysis right we need to think about what is proposed in the amendments, the effects they would have.

The Chairman. I would be doing very little analysis on amendments that are incorporated in the modification because they have already been incorporated.

Dr. Elmendorf. Well, for us to put a cost on them, we need to do that analysis.

The Chairman. That is your scoring in the preliminary, not individually, separately.

Dr. Elmendorf. I am just saying, given the number of changes that have been made, the number of changes that were considered over the past week, that we are turning around estimates of those effects as rapidly as we can, considering --

The Chairman. I am not going to waste your time. I think you got the message.

On my list, I have Senator Bunning.

Senator Bunning. Thank you, Mr. Chairman.

Dr. Elmendorf, this is not contained in the modifications in the Chairman's mark, so CBO ought to have a very good handle on this. In the original Chairman's mark, the doc fix was for one year. Is that correct?

Dr. Elmendorf. Yes, Senator.

Senator Bunning. Over the additional 9 years of

the mark--10 years--how much would it cost if we flat-lined the doc benefits? How much additional costs would that be if it were flat-lined?

Dr. Elmendorf. I will stall for --

Senator Bunning. Stall for some help?

Dr. Elmendorf. While we find the number.

Senator Bunning. All right.

The Chairman. While he is stalling, I think it is important to remind ourselves that this Congress is paid for updating the SGR every year, but for one. I have forgotten what year it is. But a long time ago, we paid for it.

Senator Bunning. That is why I am trying to --

The Chairman. If you look at our history, if you look at --

Senator Bunning. That is why I am trying to get a handle on it.

The Chairman. If you look at our history, we have paid for it.

Senator Bunning. Mr. Chairman?

The Chairman. So it should not add to the deficit. We follow that customary practice.

Dr. Elmendorf. So, Senator, the cost of the additional nine years of the policy you described is about $200 billion of extra spending relative to current

law.

Senator Bunning. Two hundred billion?

Dr. Elmendorf. Yes, Senator.

Senator Bunning. Have you done any possible estimates if there was an additional 1 percent increase in each of the nine years? In other words, how much --

Dr. Elmendorf. A growth rate of 1 percentage point higher each year over that period.

Senator Bunning. Correct. Because eventually we are going to have to do something other than just flat-line.

Dr. Elmendorf. I do not think we have that number at hand, but we have done many estimates of alternatives and we can certainly send that to you, Senator.

Senator Bunning. Just an additional $200 billion.

Dr. Elmendorf. For the first policy you described.

Senator Bunning. All right.

Dr. Elmendorf. Yes, Senator.

Senator Bunning. One last question. Mr. Barthold, I want to follow up on Senator Hatch's question and ask you about a modification in the Chairman's mark which increases the threshold amount for itemized deductions for medical expenses from 7.5 of adjusted gross income to 10 percent. Under current law, senior citizens with incomes of $10,000 per year have to spend about $751 out

of pocket for health care in order to get the first few cents of tax relief. Under the modification, however, how much will a senior citizen with an adjusted gross income of only $10,000 have to spend before they get a few cents of tax relief?

Mr. Barthold. Senator, the way the floor works, is we take 10 percent of adjusted gross income. So you said $10,000, $1,000. If you have medical expenses, qualifying medical expenses in excess of $1,000 claimed as a deduction, the excess over $1,000. So if it were $1,200, you could claim a $200 tax deduction.

Senator Bunning. Would it be fair to say that taxpayers with high catastrophic health care costs relative to their income--let us say someone with a terminal illness--will have to experience even higher catastrophic health care costs before they can take this deduction?

Mr. Barthold. The effect of the floor is that, in order to claim an itemized deduction, you would have to have greater expenses to get over the floor.

Senator Bunning. In other words, there is a limit, also, is there not?

Mr. Barthold. Correct. And if you were over the floor, less of your expenses compared to present law would be allowed, the difference between 7.5 percent of

adjusted gross income and 10 percent. I should note, in your example, Senator, that an adjusted gross income of $10,000, the individual is unlikely to have a tax liability and they would probably be claiming the standard deduction and the personal exemptions and would have a tax liability.

Senator Bunning. But if they had a catastrophic illness -- in other words, the standard deduction would be -- all that would be able to take --

Mr. Barthold. The standard deduction would wipe out their tax liability. Remember, this is an itemized --

Senator Bunning. They probably would not have a tax liability.

Mr. Barthold. That is correct, sir.

Senator Bunning. All right. Thank you.

Dr. Elmendorf. Senator, can I just add? About $235 billion for the first proposal you mentioned, the flat line, and the 1 percent growth rate per year would be about $280 billion.

Senator Bunning. Each of the 9 years, if you increased at a 1 percent fix, it would be 285?

Dr. Elmendorf. Total cost would be about $280 billion.

The Chairman. Thank you, Senator.

One point I would like to clear up a little bit, there is a big tax cut in this bill, which some do not like to remind us of, but I think is important to get out to the public.

Mr. Barthold, if you would tell me, with the tax credits that people receive, do you have any estimates as to the total number of dollars that would be tax cuts the American people would receive under this bill?

Mr. Barthold. Mr. Chairman, I do have that. But could you have another Senator inquire while I dig out the piece of paper?

The Chairman. We will give you lots of time because this is a very valid point.

Mr. Barthold. All right.

The Chairman. All right.

Next on my list is Senator Ensign.

Senator Ensign. Thank you, Mr. Chairman.

Just go back to what Senator Snowe talked about, I think the bottom line is, and what Senator Snowe has been really pushing for, is that we have an estimate, as accurate as CBO can be--obviously there is a lot of guesswork in all of this--not only of the bill as modified, but the final bill that we are going to be voting on, which would include amendments. I think the point that you were making is, you need the time to do

this thing right.

I think what Senator Snowe has been arguing for this whole time is that, because the implications -- President Obama said that he would not sign a bill that added one dime to the deficit. That was his promise in the speech before the Congress. Well, for us to know whether we are voting on a bill, the final bill, we have to have estimates from CBO that says whether we are in fact voting for a bill that increases the deficit or not. You had a preliminary estimate of the mark, but now it is modified.

Once we add amendments to it, there may be costs associated, significant costs, because, as you said, they interact--you adjust one part, it interacts. There may be significant cost to it. So I just wanted to make that point, that I believe, instead of artificial deadlines like we have already had set before us, we should have the time to get this thing right and know what we are voting on.

That is one of the reasons I think Senator Snowe has been asking for not only estimates, but legislative language, so we know exactly what we are voting on. The American people have been saying, are you going to read this bill? Well, we will not even have a bill to be able to read, from what I understand, before at least the

committee votes on it. So, I think those are legitimate points.

The question that I had, though, for Joint Tax was dealing with the excise tax. In the modification, from what I understand, it goes from 35 percent up to 40 percent. In our preliminary discussions, I asked you all, between CBO and Joint Tax, this question. The major savings in the bill, from what I understand are in this excise tax, there are a couple hundred billion dollars in savings.

Is the major reason for the big savings because it is not indexed for medical inflation, it is only indexed for CPI, and now in the Chairman's modification it is indexed for CPI plus 1 percent? But in the out years and the second 10 years, we start picking up more and more of the people affected by this plan, is that not correct?

Mr. Barthold. Senator Ensign, as we discussed, I believe it was last Friday, the threshold imposes a tax and creates incentives for people to perhaps change the type of coverage that they have if they have an overall plan that is above the threshold amount. Under the Congressional Budget Office's baseline projections, the medical cost expenses, and thus, expenses of medical health plans, is growing more rapidly per year than the Consumer Price Index.

It is also growing more rapidly per year than the Consumer Price Index plus 1 percent. So that means the threshold is not growing as quickly as a plan's cost might increase, so year by year there would be more incentive to change the plan. And, as we discussed last Friday, more people with plans, if they did not change their plan, would find that their plan was now above the threshold.

Senator Ensign. If the business is going to be taxed at this, I mean, their effort is going to be to try to pass that cost on. I mean, that is what businesses do. When a tax is imposed on them, if possible--and most of the time they do that, they try to pass the tax on--so in effect, would we not be passing this tax on to more and more consumers into the future?

Mr. Barthold. Well, again, as we discussed on Friday, we have analyzed this as largely falling on the consumer. It could happen in a couple of different ways. It is noted, if consumers say we would not like to pay this excise tax, we will opt for a less expansive plan, or a plan that perhaps has higher co-pays so that they are below the tax threshold, that would result in them actually taking a greater income inclusion and there would be additional income tax and payroll tax receipts. That is part of the underlying revenue estimate.

Alternatively, if they are happy with their plan, do not want to change, or at least in the short run, there could be excise tax receipts as part of the revenue estimate, but we would expect that that would become part of the cost of the plan, which would raise their cost and there would actually be a little bit of an offset in terms of cash compensation effects.

Senator Ensign. Mr. Chairman, I will close with this. I understand why the committee, and why you have decided to put this in the mark. With the "Cadillac" plans, there is the tendency for over-utilization in the health care field. But I keep going back to what President Obama has said, that if you like your plan you will be able to keep it. But if you are forcing people through taxes to change their plan, well, they may not have the option.

Their employer may decide to do something differently, because if these plans are passed on to basically the employers, because they pay most of the cost, then that, in fact, will cause people to not stay in their plans, not because of a choice that they are making, but because of a choice that the government has imposed a tax on that plan. I think it is important, at least, to be honest with the American people that that is the effect of what this excise tax, in effect, could do.

The Chairman. If I might, just on this, I mean, we are going to hear a lot of this from a certain side of the aisle here. I just think it is important to kind of clear the air a little bit. What we hear is the promise, if you like what you have, you can keep it. The fact is, currently, today, you cannot keep what you like in many, many cases by not passing any law. That is because employers are changing plans all the time. They are adding co-pays, they are adding deductibles, they are dropping. You would not believe it. I do not know the number.

Being very conservative, we hear that 14,000 people lose health coverage a day. They have lost their plans. Fourteen thousand Americans have lost their plans. They could not keep it. That is the current, the status quo, as we all know. A lot of people cannot keep the plans they want. This bill goes a long way to provide stability so that people are more likely to -- first, they can choose the plans that they want, and they are more likely to keep them. There are limitations on rescission here. There are limitations on annual and out-of-pocket coverage caps that insurance companies have. There is insurance market reform here.

So, two main points. One, today, you cannot keep what you have now, you just cannot. Now, some can, but

for those folks who find their employer has dropped their coverage, those folks are experiencing a dramatic change willy-nilly by their employer's insurance plan, they cannot keep what they have, and they sure do not want to keep what they have. They do not have any more.

The second point being, we are requiring a lot more stability here with this legislation so that people are more likely to like what they have, and if they want to move, they could more easily move to something that they like.

Another point I want to make with Tom Barthold, which is, it is my understanding, Mr. Barthold, that it is easier a Joint Tax analysis, or maybe it is CBO, that these higher-cost plans, the analysis is that because these plans do not go into effect, this law does not go into effect until 2013, that your analysis is that many insurance companies and employers will change their compensation packages, and as a result, wages and salaries will increase. That may increase taxes because salaries and wages are increasing, but on a net basis it is money in your pocket as compensation for not having, perhaps, the same high-value plan that you earlier had.

Mr. Barthold. That is correct, Mr. Chairman. As I was explaining to Senator Ensign, we view this as putting pressure on choices that people make. If they opt out of

their current plan by, as I said, perhaps choosing a plan with a higher co-pay rate, higher deductible rate so that it is no longer subject to the excise tax, that would be reflected in their compensation package in terms of more cash compensation.

The Chairman. Nothing is perfect here in their trade-offs, but does this not help bend the cost curve? Let me ask Dr. Elmendorf that question. I mean, if it is below medical inflation, the index, and some limit here, high-value plans, does that or does that not help bend the cost curve in the right way?

Dr. Elmendorf. So imposing this tax would, in our judgment, together with the Joint Tax Committee staff, reduce health spending over time by removing what is essentially a subsidy in the current Tax Code to buy more health insurance relative to buying things that you have to purchase with after-tax income, and by offsetting that subsidy, it puts the purchase of health insurance more on a level playing field with the purchase of other goods and services and would, in our judgment, reduce the purchase of health insurance.

Of course, CBO is not for or against any policies, but I think it is important to note that a very wide range of experts in health policy think that removing this subsidy, making people confront the true cost of the

extra insurance without the government subsidy, would lead to better choices over time.

The Chairman. All right.

Senator Kyl, you are next.

Senator Kyl. Thank you, Mr. Chairman.

Mr. Barthold. Mr. Chairman? I am sorry, Senator Kyl. I interrupted you. I did recover the piece of paper that the Chairman asked me to look for. I did not know if this might be a good point to --

The Chairman. Briefly, yes. Fine.

Mr. Barthold. Mr. Chairman, you had asked, just briefly, if we had done any analysis of looking at the low-income subsidies provided through the exchange and the cost-sharing subsidies for individuals purchasing insurance policies through the exchange in comparison to the high-premium excise tax.

Now, keeping in mind that we did this analysis based on the Chairman's mark and not as modified, to choose one calendar year, 2017, there are almost 45 million taxpayers who either receive a benefit or have income inclusion or experience a higher excise tax from the high-premium excise tax. But of those 45 million, on average, 25 million have a net tax reduction due to the subsidies available through the exchange and the cost-sharing subsidies for out-of-pocket medical expenses.

The Chairman. But just to make it clear here, I grabbed my chart in front of me. If I read the chart correctly, at the top it says, "Distributional Effects of Proposal", et cetera. I have several charts. One is 2017.

Mr. Barthold. I was looking at 2017.

The Chairman. All right. In 2017, my chart says, for all returns, total of all taxpayer, a tax reduction for all affected taxpayers of about $38 billion?

Mr. Barthold. That is correct.

The Chairman. And roughly, round out, 45 million Americans will get a tax cut.

Mr. Barthold. Well, I was breaking it down.

The Chairman. And this is for all taxpayers.

Mr. Barthold. That is overall.

The Chairman. Yes.

Mr. Barthold. Most of the tax cut, as you had noted earlier, occurs at incomes less than $75,000.

The Chairman. Right. That is correct. But for overall -- I am only able to do the grand total, not able to do the subtotals. I cannot think that quickly. But the grand total is, 44 million Americans get a tax cut in 2017, and it is proportionately higher, and higher, and higher as each year goes by.

Mr. Barthold. That is correct, sir.

The Chairman. Thank you.

Senator Grassley. But is it not true, Dr. Elmendorf, that CBO considers these refundable tax credits as outlays, which would be spending?

Dr. Elmendorf. It is a longstanding budget convention. I do not know who originally started it. The "refundable" part of refundable tax credits are reported on the outlay side of the budget, and on the part of the refundable tax credit that reduces tax liability, it is reported as a reduction in revenues.

The Chairman. They are still tax cuts.

Senator Grassley. The only thing I am saying is, he just got done saying it was an expenditure, an outlay.

Dr. Elmendorf. The convention of how it is recorded in the budget and how one thinks about it is something that I will have to leave to you to discuss. Maybe I would just say, briefly, in the estimates that we have prepared, the preliminary analysis, we have, together with the Joint Tax Committee staff, have looked at the net effect on the budget deficit. We have not yet broken that out into the way it would ultimately appear on the revenue and expenditure side of the budget, which involves working through issues like the one that you just raised, Senator Grassley. That is part of moving toward a formal cost estimate that we have not yet

completed.

The Chairman. Senator Kyl has been very patient.

Senator Kyl. Thank you, Mr. Chairman. I would just note that a refundable tax credit, obviously, is money in excess of tax liability, and therefore it is hard to characterize that as a tax cut when you do not have any tax liability. But I appreciate your admonition that we do the characterization and you do the figuring.

Dr. Elmendorf. Thank you, Senator.

Senator Kyl. I have four quick questions. The first, is the Senate Budget Committee, using CBO scoring numbers, has estimated that the real 10-year cost of the bill, when fully implemented--in other words, when we have both the benefits and the taxes--is $1.67 trillion. Do you know whether that is the correct number, or can you get us the correct number?

Dr. Elmendorf. I cannot speak to that one way or the other, Senator. We are not trying to estimate the bill on the impossible supposition that it would be implemented right away. What we have done instead, to offer you and the other members of the committee and the Congress a sense of the long-run effects of the bill, is to talk in vague, but the most precise terms we think we can about the effect in the second 10 years. We have said we view that, if the law is implemented as written

and not changed, would be a reduction in the Federal budget deficits in the second 10 years.

The Chairman. About $800, $900 billion.

Senator Kyl. Well, but if you take the first 10 years in which it is fully implemented when you have both sides of the equation, what is the amount of money? That is what I am asking about. According to this calculation, using CBO numbers, it is $1.67 trillion.

The Chairman. What is the net? What is the net?

Dr. Elmendorf. So if you did it for the first 10 years in which it was implemented --

Senator Kyl. Yes.

Dr. Elmendorf. Maybe you are referring to the 2013 to 2022 period.

Senator Kyl. Exactly. Yes, exactly.

Dr. Elmendorf. So we have not done that estimate. We think that the crystal ball is hazy enough for the first 10 years, and beyond that becomes hazier still to the point where doing a cost estimate of the sort we normally deal with, all the interacting pieces carefully traced and so on, it just gives you an unrealistic sense of our powers as forecasters. So we really do draw the line on that sort of detailed cost estimate at 2019, the end of the 10-year budget window. For the following decade, all we think we can do is to give you a ballpark

sense of the effects of the legislation by extrapolating some of the key components.

Senator Kyl. Well, let me follow up on that then, because you do predict the long-term deficit reductions. You note, and I think you are absolutely correct on this, that they depend on Congress repeatedly approving cuts year after year, for example, to Medicare providers, an assumption which you say "is often not the case with major legislation", and you cite the SGR for doctors as the example for that.

So the score would depend on Congress doing something that we may well not do, or to use your language, that we often do not do. Is that correct?

Dr. Elmendorf. The one change I would make in what you said is that Congress does not have to approve future cuts in payments, they have to not act to disapprove.

Senator Kyl. Right.

Dr. Elmendorf. So I think that is important. We scored the legislation as it is written. If the legislation required future congressional action, we would not score that now. We would score it as part of future legislation. The reason we score it here is because it will take effect unless you --

Senator Kyl. Yes. And that is a perfectly appropriate way to do it. I am not arguing with that.

But you also make the point that, citing the physician SGR, we often do make the adjustment for political reasons or other reasons that we deem important. So in making an estimate like this, I think it is appropriate to note the reality of what we usually do rather than just the way the bill happens to be written right now.

Dr. Elmendorf. So you understand, Senator, our job is to project the effect of the bills as written, not to second-guess what you do. But in general, we tried very hard here to be transparent about the assumptions that underlie those projections so you and your colleagues can form your own judgments.

Senator Kyl. And I do appreciate your observation about our tendencies. That helps, at least in the debate.

Third, let me just read something that you wrote in a brief entitled, "Effects of Changes to the Health Insurance System on Labor Markets". This pertains to the so-called "free rider" provision in the mark. "Supporters of such surcharges often refer to them as free rider penalties. Although the surcharges would be imposed on the firms, workers in those firms would ultimately bear the burden of those fees, just as they would with pay-or-play requirements." This also relates to something Senator Ensign was talking about earlier, in

which you noted that the excise tax would fall mostly on the consumer.

Here, you note "employer surcharges tend to be more targeted. Many of those workers are more likely to have earnings at or near the minimum wage, and the signs of such surcharges, if based on actual costs imposed on government programs, could be larger per affected worker than the assessments being considered in many pay-or-play requirements." So the bottom line, I gather, is that this kind of surcharge, or so-called free rider penalty, does disproportionately affect the low-income workers.

Dr. Elmendorf. Yes. I think that is right, Senator. As we wrote in the brief, economists believe, through theory and evidence, that charges of this sort tend to be passed through to workers' wages, and where those wages are fixed in some way and cannot be passed through--for example, by minimum wage--then in those cases they may have employment effects.

Who is affected is a complicated business to keep track of, beyond the generalities that you have quoted correctly and I have just said, because it depends a lot on what those workers do, whether a worker decides, for example, to get insurance through a spouse's policy and so on. There is tremendous diversity in the country, so it is hard to make general characterizations beyond what

we have said here.

Senator Kyl. Yes. And I appreciate that.

Finally, after Senator Nelson's grandfathering provision on Medicare Advantage--you know what I am speaking of--have you done the analysis of what effect that would have on enrollment since then or do you just have the analysis of the original Chairman's mark?

Dr. Elmendorf. On Senator Nelson's amendment, I believe that our very preliminary analysis of the amendment is that it would add about $10 billion to the cost of the legislation. I do not know if we have numbers on people affected. So I am told there is very little effect on enrollment in the program, Senator.

Senator Kyl. All right.

And do you recall what the reduction in enrollment was under the original Chairman's mark? My recollection was that it was around $3 million, but I am not sure over what period of time. But you should have the number there, I think.

Dr. Elmendorf. Senator, I believe I have it here in the stack, and I think my colleagues have it as well.

Senator Kyl. All right. They are nodding as if that may be ballpark. I am not sure.

Dr. Elmendorf. I believe, Senator, that the reduction in enrollment that we project for 2019 is about

2.7 million people, or 20 percent of the baseline level of enrollment.

Senator Kyl. All right. About 20 percent of the baseline enrolled, and not much change, you think, as a result of the Nelson proposal?

Dr. Elmendorf. That is right, Senator.

Senator Kyl. All right.

And this is just a subset, but do you have a breakdown between urban and rural? If you do and could get that to us later, that is fine. I do not mean to use the time right now.

Dr. Elmendorf. We do not have that with us, but we will see what we can do about that for you.

Senator Kyl. All right. If you already have it, fine. I am not asking you to do extra work.

Dr. Elmendorf. Thank you, Senator.

Senator Kyl. I agree with your maximum safe speed proposition. Thank you.

Dr. Elmendorf. Thank you, Senator.

The Chairman. Thank you very much.

Senator Conrad?

Senator Conrad. Dr. Elmendorf, unfortunately I was called away to take a call that has significant effects on my State, so I apologize that I was not here.

Dr. Elmendorf, I would be interested to know, your

assessment has been that the Chairman's mark, as originally put out, was paid for and actually reduced the deficit by $49 billion over the first 10 years.

Dr. Elmendorf. Yes, Senator.

Senator Conrad. Your further analysis was that it bent the cost curve in the right way, that is, reduced long-term costs from what they would otherwise be by one-half of 1 percent of GDP.

Dr. Elmendorf. Yes, Senator. That is correct.

Senator Conrad. And our analysis of GDP over the second 10 years, is we are looking at roughly $260 trillion of Gross Domestic Product over that period, so one-half of 1 percent would be roughly $1.3 trillion. Is that math correct?

Dr. Elmendorf. The calculation sounds right. I cannot vouch for the GDP number. We deliberately presented our answer as a percentage of GDP for two reasons. One, because I think it is hard for people to understand what a dollar in 2029, say, is worth today, given inflation that will ensue over that time. Second, because the dollar figure has the risk of looking too precise when, in fact, as I have said, we are looking through a pretty hazy crystal ball at that point. So we think it is most useful for you and for others to think about this as a percentage of GDP, and you quoted our

conclusion correctly.

Senator Conrad. Yes. Fair enough. I think you have done it in a very professional way.

With respect to the issue of when scoring might be available, because this is obviously a sensitive matter, it is critically important that we have scoring before a final vote is cast in the committee and it is obviously critically important that we have your best assessments on the costs of amendments as we consider them -- and I know, and I want to applaud you and your staff, for the extraordinary personal and professional commitment that all of you have made at CBO to this effort, because I know that you and your staff have been working not only nights, but weekends, for months. It is deeply appreciated by this committee, and it is certainly appreciated by the committee that I had.

With that said, it is important for us to know, once there is a package after the amendment process here, can you give us some rough estimate in days of how long it would take to have a CBO score?

Dr. Elmendorf. First of all, thank you for your appreciation for our work. I will pass that along to my colleagues at the office, and that will cheer them greatly. I think we can update our preliminary analysis, give you something comparable to what we gave you last

week, for the bill, including the amendments that are adopted, within a few days of the package actually being set.

A formal cost estimate would require--and we have said this to people on the House and Senate side--two weeks of work by us once the package is settled. And that may seem like a long time, but there are a lot of complications in doing this right, as you need it to be done. It is the interaction effects among the provisions. It is reading the legislative language. Our official cost estimates are based on reading of actual language. It is very complicated to write this language and to interpret it correctly, and that often involves a certain amount of iteration between us and the staff of the relevant committees.

We also need to develop a more complete budget presentation rather than just the effects on the deficit, which is the way we have been summarizing for you so far. So we have told all the people who have asked that it will take us about two weeks to do a formal cost estimate after we have a full bill, but as I said, we can do an updated preliminary analysis more quickly than that.

Senator Conrad. And that preliminary analysis, if it tracks what you did for us in the preliminary analysis done thus far, would include effects on the deficit in

this 10-year period, as well as whether or not we successfully bend the cost curve thereafter.

Dr. Elmendorf. Yes, that is right, Senator.

Senator Conrad. And those conclusions by you, preliminary though they may be, would be of enormous importance to this committee, certainly to this member before I cast a vote, because I want to be absolutely assured that we are going to have this paid for, and better than that, that we are going to bend the cost curve in the long term in the right way. I think many of us would not be able to support legislation that did not accomplish those very important objectives. The President has made clear he would not sign legislation that did not meet those objectives. So that part of the analysis would take several days after the package is complete here, as I hear you say it.

Dr. Elmendorf. Yes. That is right, Senator.

Senator Conrad. I think that is extremely important and very helpful.

I thank the Chairman. Again, I want to thank you, Dr. Elmendorf, and your team. This has been an extraordinary effort by you and your staff, and we appreciate it.

Dr. Elmendorf. Thank you, Senator.

The Chairman. That is an interesting conversation,

but the real question is: how do we get ourselves out of this box? I would like your help to get us out of this box. What is the box? The box is, let us say we pass legislation. Let us say we put out a bill, just for sake of discussion, Thursday. As I understand your answers, you are saying only then could you start to do a preliminary analysis. And if I understood you correctly, you said it would take a few days, and if I understood you further, you said two weeks after that to do a final.

So the box we are in, if we pass legislation, we have got to cool our heels here for up to two to three weeks before we know the final. That is unacceptable, clearly. We cannot operate that way. So you have got to help us get out of this box somehow. It seems to me that, to the degree that you could tell us the preliminary -- I have a hard time seeing why it takes that long to do a preliminary, because you are probably doing it as we go along each day with amendments.

Let me finish. Let me finish. Let me finish.

I have got to think that the final could not be that different from the preliminary, so long as the description of what we do accurately represents what we are doing, so in good faith, the legislative language does reflect what we are doing, and that would seem to me that therefore, if that is the case when we write this up

that this is actually what this really does do, that that should be sufficient to give you a pretty good indication of what the scoring will be, and that the final, which as you say we get two weeks later, is not going to be very much different from a good-faith preliminary.

Dr. Elmendorf. I think, Senator, one of the crucial parts of this long period--which I understand may seem very surprising to you--is the drafting and review of legislative language. It is not a matter of our doubting anybody's faith, it is simply hard to write down in law, translate into law, what is in specifications. The experience of people who have been at CBO much longer than I have and have seen much more of this happen is that that process invariably takes more time than people like me and you guess it will up front. It is hard to predict how long that is.

I assure you, Senator, we will be working as fast as we can, while maintaining our quality. But the experience has been--and I want to be honest about that up front--that it takes a long time to turn a bill of this complexity into legislative language. I am not a lawyer, so I cannot even really explain that to you, but that is the --

The Chairman. Let me ask the question again. Assuming good faith in the drafting of the mark, the

modified mark and amendments, we are going the extra mile to make sure that the language adequately reflects what we are intending here and so forth, my question is, if that is the case--and that will be case, as far as I am concerned. This will be a good-faith drafting. We are not trying to fuzz anything--that when the actual legislative language is written, this committee does not do legislative language. The tradition, the history is not to do legislative -- let me finish. To do legislative language while we are debating, while we are offering amendments and so forth. I have been on this committee for 30 years and that has been the case. Only later is the legislative language actually written.

But my question is this: assuming good faith and the actual descriptive language, for want of a better expression, what would the final-final--two weeks later, however long it takes--be pretty close to what you preliminarily determined?

Dr. Elmendorf. If your question is, if the legislative language implements the specifications --

The Chairman. Accurately.

Dr. Elmendorf. [Continuing]. As we understood them.

The Chairman. Accurately reflects.

Dr. Elmendorf. Then that simplifies the process.

The Chairman. Yes.

Dr. Elmendorf. But just the discovery of that will take some time. Again, it is not a matter of anybody acting in bad faith, it is just a matter of the difficulty, the number of pages of legislation that will need to be written. I am not even sure how far along your staffs will be on that process. I am not sure even what legislation we will be asked to do an official cost estimate of because there are multiple committees. We have not done a final cost estimate of the Help Committee's bill. So I am not sure when this process will even start formally. It depends on what it is that is most useful for the members of the Senate for us to devote our attention to.

The Chairman. All right. But you only estimate our bill, in a preliminary fashion, at least, very quickly?

Dr. Elmendorf. As I understand your request, once the committee has finished adopting or rejecting a set of amendments so that there is a well-defined bill, we know what is in it and what is out of it, then we will turn to estimating, to doing a preliminary analysis of that bill.

The Chairman. Well, we have got a lot of work to do, I can tell right now. We will figure a way out of this box together, but we need your good-faith help to

get us out of this box. All right.

Senator Rockefeller, you are next.

Senator Rockefeller. Thank you.

David Schwartz, under this mark, would all individuals in Medicaid and the Children's Health Insurance Program be able to keep the coverage that they currently have?

Mr. Schwartz. No, Senator, they would not. For kids who are in CHIP today, which you well know could take different forms depending on how the State has structured its program, they would not all necessarily be able to stay in because the provision in the Chairman's mark would be to transition from the current structure of CHIP to a different structure where what we have referred to as the core benefits would be provided through an exchange plan with a wrap-around done by the State to the full extent of EPSDT or the Medicaid package.

Senator Rockefeller. It is incredibly important to me that the Children's Health Insurance Program, which represents children, they have specific benefit requirements. It has been a defined benefit package, now it is going to the exchange and who knows what it will be. You talk about wrap-around. Can you give me an example recently of a State which has effectively worked a wrap-around?

Mr. Schwartz. To be honest, I am less familiar with individual State plans and how they --

Senator Rockefeller. Well, to be honest, I cannot. So the wrap-around argument, I think, becomes a way of trying to get out of the perils of putting children in the health exchange, which I find unacceptable, and a wrap-around is not going to do it.

Second, under current laws, States have the option to provide flexible benefits through a State plan amendment. This simply means that they can offer less generous coverage to new employees. So, Mr. Schwartz, it is my understanding that this flexibility provision would become mandatory for newly-eligible populations in Medicaid, like parents and childless adults, under the mark. Is that correct?

Mr. Schwartz. That is correct.

Senator Rockefeller. Mr. Schwartz, would new enrollees be in less need or greater need of Medicaid benefits than current enrollees?

Mr. Schwartz. I am not sure that there is an answer. I think it would vary based on the individuals. In some cases it could be greater, in some cases it could be less, and in some cases it could be the same.

Senator Rockefeller. Well, and I think what you are saying, therefore, is that you are creating--and this

is my point--a two-tiered Medicaid system, which I think a lot of people are just going to be getting less benefits, which you answered, in response to my first question and I think is buttressed by this flexibility. Some governors love flexibility, like Medicaid waivers, because they do not have to do as much and they can cut people off of CHIP and whatever they want. And that is just the nature of governors; I know, I was one.

The next question. On the flexibility, Mr. Schwartz, what is the origin of this benefit flexibility language?

Mr. Schwartz. It is codified as Section 1937, as you said, of the Social Security Act.

Senator Rockefeller. Which is called the Deficit Reduction Act.

Mr. Schwartz. It originally passed Congress as part of the Deficit Reduction Act.

Senator Rockefeller. Now, my understanding is--and this is going to sound political, and I guess it is--that it was passed without a single Democratic vote.

Mr. Schwartz. I believe that is correct, Senator.

Senator Rockefeller. Under Republican control. It was passed under something called "reconciliation". Am I correct?

Mr. Schwartz. You are correct, Senator.

Senator Rockefeller. Thank you, Mr. Schwartz. You are outstanding.

[Laughter].

Senator Rockefeller. What has been the impact of this so-called flexibility on States like West Virginia?

Mr. Schwartz. States like West Virginia have used the flexibility available in Section 1937 to provide -- the language in the Act is "a benchmark or benchmark equivalent" benefit package and they have scaled back the benefits that were available prior to creating that flexibility.

Senator Rockefeller. Thank you.

I want to go on just for a moment to Medicare sustainability and MedPAC. We skirt around this issue, but I want to confront it directly. Under the Medicare Commission proposal, I see that Congress still has the opportunity to vote recommendations down. That is not my choice, but that is in the mark. As you know, this is not what I want.

Actually, I am going to ask this to Mr. Dawe. Is it possible, under this proposal, for Congress to block the recommended Medicare reforms just as they do today?

Mr. Dawe. Under the Chairman's mark, Congress would have an opportunity to come up with an alternative proposal between January 1 when the Commission's proposal

is due to Congress and August 15. They would have an opportunity to pass an alternative proposal that would achieve the same amount of budgetary savings. If Congress failed to act, then the Medicare Commission's proposals would take effect automatically.

Senator Rockefeller. I very much doubt that the Congress would fail to act, and I very much fear that the Congress would turn them down. The reason for that is that MedPAC, which is official but has no authority, created in 1997, makes their recommendations based on evidence-based outcomes, et cetera.

In other words, it is not just the power of a lobbyist to persuade somebody to do more for oxygen or less for something else, medical equipment, and that kind of thing. It is evidence-based. All of it is evidence-based and it is very specific and it is very nuanced and very complicated, and not always politically correct, but is accurate.

Now, my proposal would not allow that to happen because I do not want Congress to be able to vote on it because I do not want lobbyists to be able to vote on it, if I make myself clear.

I mean, how are we going to improve the accuracy of what we do in Medicare? How are we going to make it better for seniors if we are literally, with 14,000

health care lobbyists wandering around in Washington, DC, each with one particular service or one particular client that they need to show that they have earned their money in carrying out their efforts towards Congress, how are we going to make Medicare more efficient, more accountable, more explainable, and more beneficial to seniors if we allow Congress to act as they have been over these recent years?

Mr. Dawe. Well, I can only speak to what is in the mark. The Chairman's mark would create an independent, 15-member commission. The mark lays out that the members of the commission should have similar qualifications to the members of MedPAC. So the intent of the provision is to establish an independent body that would be expert-based and evidence-based to create proposals and then give Congress an opportunity to review those and act on its own. If Congress fails, then the commission would take effect.

Senator Rockefeller. Right. And so you would have to believe that Congress was not going to fail to sustain MedPAC's proposals. I think MedPAC is tremendously misunderstood. Congress is fundamentally offended by the fact that it cannot make all of those decisions. If you accept the fact, as I do, that there is a relatively small percentage of people in Congress who really

understand the nuances of Medicare--health care in general, but Medicare, let us say--and how to adjust that, how to give updates, how to recognize that rural health care centers have to be given more -- we have the problem of pediatricians going through medical school and doing their residencies, and they practice for a couple of years, but they cannot make enough money, so off they go into some other specialty.

As the Nation gets older, the doctors that treat them get fewer. That can be adjusted, and would be adjusted by MedPAC, to reimburse geriatricians more in their practices so they would be less likely to leave them. I mean, that is just as an example of the kinds of things which affect seniors better in health care.

Now, the health care trust fund in Medicare is set to start declining in 2017. This proposal, however it comes out, will not take effect until 2013 and it is sunsetted, I think, although that has been cleared up now, thankfully. But I just do not understand how we can make proper Medicare decisions without professional analysis and the accepting of that professional analysis over extremely nuanced conditions across a country full of MSAs, rural, urban, and all kinds of geographic differences that make Medicare very, very complicated.

Mr. Dawe. The intent of the proposal is to strike

a balance between preserving a role for Congress and empowering an independent group to make the nuanced proposals that you speak of, and then again to allow Congress to have its opportunity, but to have some accountability built in by allowing the commission's proposals to take --

Senator Rockefeller. No. I think we understand each other. I would just hope that my colleagues would think seriously about the year 2017 when the Medicare trust fund begins to go down and the need, therefore, to make the best evidence-based Medicare decisions that we possibly can, which has to be done, I think, through professionals. I hope they would think about that, not as taking away from their power, but would add to the health of the seniors that they represent.

I thank the Chair.

The Chairman. Thank you, Senator Rockefeller.

Next on my list is Senator Crapo.

Senator Crapo. Thank you very much, Mr. Chairman.

Dr. Elmendorf, I want to start out with you and go back to the Medicare Advantage question. I would just like you to help me work through that a little bit so we understand exactly what the proposal in the mark does and how the change that was made in the Chairman's modifications to the mark impact that.

If we start on the original mark, which had approximately $123 billion of reduction in Medicare Advantage programs under Medicare, can you explain to me what the impact of that provision was in terms of how it would change the provision of health care through Medicare Advantage?

Dr. Elmendorf. In our estimate, Senator, the effect of the original Chairman's mark on Medicare Advantage enrollment in 2019 would be a reduction of roughly 2.7 million people, or 20 percent of the enrollment that we project under current law.

Senator Crapo. And what would be the reason for that reduction?

Dr. Elmendorf. Because the competitive bidding process would reduce the extra benefits that would be made available to beneficiaries through Medicare Advantage plans, fewer of them would end up choosing Medicare Advantage and more would choose the fee-for-service part of Medicare.

Senator Crapo. So in effect, I think you said the number was about 20 percent of the enrollee who would then choose to leave Medicare Advantage.

Dr. Elmendorf. That is right.

Senator Crapo. The effect then is that the reason they are going to choose to leave Medicare Advantage is

because their Medicare Advantage plan is less beneficial to them under the proposal than it is today, and therefore they would have to choose some other option.

Dr. Elmendorf. They would not receive as much additional benefits today in the current Medicare Advantage system. Beneficiaries who choose Medicare Advantage receive benefits that beneficiaries in the fee-for-service system do not receive.

Senator Crapo. Well, I understand --

Dr. Elmendorf. And additional benefits would be smaller. I want to be sure I am clear about something. This reduction in enrollment is not necessarily people who are in who would leave. It may be others who would not join at all. So it is not the number who are leaving Medicare Advantage, but a fewer number who would be there. Some of them may leave, and some may be ones that just will not join.

Senator Crapo. But there would be a loss of enrollment.

Dr. Elmendorf. There would be less enrollment overall by about 20 percent. Yes, Senator.

Senator Crapo. So are you saying that people would not leave Medicare Advantage?

Dr. Elmendorf. No. What I wanted to clarify was that this 20 percent is not all people who are leaving.

Some might be those who leave, others would be those who just would not join.

Senator Crapo. Do you have an understanding of what ratios it would be as to those who simply do not join versus those who leave?

Dr. Elmendorf. It is almost all not joining. I think the logic here is, the people who are in a plan that they are happy with are likely to stay. There is a great deal of inertia in people's choices. Even new people choosing what to do will come at this with a different set of choices than people would under current law.

Senator Crapo. My understanding is that, under your analysis, the value of the additional benefits that those in Medicare Advantage today receive would end up being reduced to about $46 per member, per month in 2019. That is a little more, but not too much more than half of what it is today. Is that correct?

Dr. Elmendorf. My notes say $42 of additional benefits per month in 2019, and I am told it is a little less than half of what we would project under current law.

Senator Crapo. So approximately half of the additional benefit would be lost to those current Medicare Advantage policyholders?

Dr. Elmendorf. For those who would be enrolled otherwise under current law, yes.

Senator Crapo. Is it true that part of the decrease in the enrollment could result from plans that are just leaving different areas and no longer offering Medicare Advantage to current enrollees?

Dr. Elmendorf. I am relying again on my expert colleagues. The competitive bidding system would, in our judgment, keep the plans essentially in the same place as they would be under current law. It is just that new people joining Medicare and deciding what to do are less likely to choose a Medicare Advantage plan. The competitive bidding process should enable these plans to continue to operate where they are, just with a lower level of additional benefits than would be the case under current law.

Senator Crapo. About half the level of current benefits.

Dr. Elmendorf. Yes, that is right.

Senator Crapo. So the current plan holders would recognize about half the benefits that they see today under the current law?

Dr. Elmendorf. Yes, that is right.

Senator Crapo. All right. Thank you.

I would like to shift gears, quickly, just to one

other area. That is on the excise tax on premiums. The Chairman's mark adjusts it from a CPI adjustment to a CPI plus one adjustment. I am interested in how that relates to the health care inflation rate as opposed to the CPI inflation rate. If you add one percentage to it, does it get you a close approximation? What is the approximate differential there in terms of the actual inflation rate of health care versus what is now included in the modified Chairman's mark?

Dr. Elmendorf. Adding 1 percent moves it closer to health care spending, but it is still less than we think the rate of increase in health care spending will be.

Senator Crapo. Do you have any estimates as to what you believe that rate will be?

Dr. Elmendorf. Our 75-year estimates of budget outcomes include numbers for a lot of decades, but I would not want to, as we have in general in talking about the budget effects of this legislation, put a lot of weight on those specific numbers. We do have some slowing in excess cost growth in health care over the subsequent decades because we think that the pressures of the rising health spending will affect more firms', individuals', State and local governments' behavior.

But I do not want to put much emphasis on those numbers. What I would say is that we, just to give you a

ballpark, think that excess cost growth in health care, the rate by which health spending rises per capita above the rate of GDP growth per capita, would be between 1.5 and 2 percent over the 2020 to 2029 decade. So that 1.5 to 2 percent, you can see that raising the indexing mark for the tax provision moves toward that, but not all the way to that.

Senator Crapo. All right. Thank you very much. I see that my time is up.

The Chairman. Senator Nelson is next on the list. I have Senator Nelson, Senator Snowe, and Senator Cornyn, and Senator Enzi following you, and Cantwell is following Enzi.

Senator Nelson. Senator Crapo, there would not be that cut in Medicare Advantage if the Nelson amendment is adopted.

Senator Crapo. I did not have time, but I was then going to ask, what would the impact be of the Nelson amendment. I would love to hear you inquire about that, Senator.

Senator Nelson. Well, as a matter of fact, I am going to ask Dr. Elmendorf. Let me get his attention.

Dr. Elmendorf. I am sorry. I am sorry, Senator.

Senator Nelson. You are doing a great job and you have got a lot on your plate to know, so let me just add

one other. I am not going to ask you about Medicare Advantage because we have already gotten into that, and your problem would be taken care of by my amendment.

I want to ask you about an amendment I am considering offering which would close the donut hole by requiring the Medicaid drug rebates to be available for dual eligible--Medicaid and Medicare eligibles--under Part D of the Medicare prescription drug benefit. Do you have a revenue estimate for that amendment that I am considering? I might say that you gave a revenue estimate in the House of $86 million over 10 years that that amendment would cover. Now, we have got a little bit different proposal here.

Dr. Elmendorf. Right. So we are still working on that amendment, Senator. Certainly we think the effects would be in the tens of billions of dollars, but the actual number, we cannot reason very directly from the House number because the policy interacts a lot with other parts of the health reform proposal here. So we really need to do the estimate, essentially from scratch, on its own. I do not want to predict where that will come out, but it is in the tens of billions of dollars.

Senator Nelson. Right. Is it true--and I want the Chairman to hear this--that it was an accurate figure of $86 million of additional revenue with regard to the

Waxman provision in the House bill? This is dual eligibles, Mr. Chairman, the amendment I am considering offering.

Dr. Elmendorf. So I think, Senator, the number that you have in mind from our analysis of the House bill includes several provisions. The particular piece that you are focused on, I cannot separate out while sitting here. I am sorry, it is one of those things that we just have not yet had time to do, but we are working on it and we will try to complete that estimate for you as quickly as we can.

Senator Nelson. All right.

Mr. Chairman, do you not allow us to offer an amendment unless we have a revenue estimate?

The Chairman. It can be allowed. It has to be offset. It should be offset.

Senator Nelson. Well, this does not need an offset. This is producing tons of revenue.

The Chairman. If you can add revenue, then we are fine with that.

[Laughter].

Senator Nelson. All right. Glad to know that. I just did not want to get caught in the things getting slowed down in your shop. All right.

Let me ask Mr. Barthold, I am considering an

amendment that would impose an excise tax on a patent challenge settlement under the Hatch-Waxman Act. Orrin Hatch and Henry Waxman have a law and it required something to do with generic drug companies challenging a patent of a brand-name drug company. When they have these big settlements, they are not taxable. So I am considering an amendment that would make that taxable. Do you have a revenue estimate for that?

Mr. Barthold. Senator Nelson, I do not have an estimate at the present time. I do have a couple of my colleagues who have been researching the case law. The Federal Trade Commission maintains a record base of these settlements. We have been using that to try and develop a baseline to have an idea of the scale of which this excise tax might apply, and I hope to have a response to you sometime tomorrow.

Senator Nelson. Would it be safe to say that that revenue estimate would be a substantial additional new revenue?

Mr. Barthold. I do not want to prejudge the magnitude and then have my colleagues prove me wrong and put you and me in a difficult position.

Senator Nelson. All right.

Again, Mr. Chairman, I pose to you, since this would be a proposed amendment that would not have a cost

consequence but would in fact produce new revenue, I would not have to have this estimate by the time that I would offer this amendment.

The Chairman. It would be in order.

Senator Nelson. All right.

Mr. Barthold, let me ask you just one more question. The Chairman's modification increases the excise tax threshold on the Cadillac plans for retirees up to $8,750 from $8,000 for individuals, and to $23,000 from $21,000 for families. How much does that specific change cost?

Mr. Barthold. I do not have a line-item breakout on that. I can get that for you, Senator. I will get that for you later this evening.

Senator Nelson. It is in the Chairman's modification.

Mr. Barthold. Oh, no. I understand. The reason is, I do not have the breakdown of that one piece -- holding everything else constant at it. We worked it through the model where the Chairman's modification had proposed four different changes, and we worked those through the model at once. So I will ask one of my colleagues if we can re-run our model holding the three modifications as it, and looking at the incremental effect of the one change. I will see if I can get that response to you yet this evening, sir.

Senator Nelson. All right.

And Mr. Barthold, I am considering an amendment that has been filed that, for retirees now--this is retirees under these health insurance plans--that it would increase it to $10,000 for individuals and $25,000 for families, and only above that figure would the excise tax come in. If you could also offer how much it would cost for that, would you oppose the amendment? I sure would be appreciative.

Mr. Barthold. Senator, if I could ask, would your preference be to have the second estimate first?

Senator Nelson. Well, since I am going to be offering that amendment, possibly, yes.

Mr. Barthold. All right. Thank you, sir.

Senator Nelson. Thank you.

Mr. Barthold. We will get it to you.

The Chairman. Thank you, Senator.

Next, Senator Snowe.

Senator Snowe. Thank you. I just have a couple of questions, one of Dr. Elmendorf, and then one of the staff.

I just want to be clear. How much of the legislative language have you received regarding the Chairman's mark at this point?

Dr. Elmendorf. We have been working our way

through pieces of it, Senator. But of course, the provisions are changing rapidly and we have been trying mostly to focus on estimates of the specifications as they have arrived for the Chairman's mark, for the amendments that are part of the modification, or for other amendments that may be introduced.

So we have made some progress, and we have worked with the staff on some of this, but I think there is still a good deal to go, even for the mark itself. Then, of course, the amendments that are adopted will require additional work.

Senator Snowe. I know that you have offered important caveats in the preliminary analysis about the impact on a comprehensive cost estimate, and that the legislative specifications and legislative language is very important and can have a significant effect on the final cost and the final analysis. I was just wondering if you have received a lot of the language or you have not, and whether or not that would really have a material impact on the bottom line.

Dr. Elmendorf. I am told that we have received a good deal of language in terms of covering the pieces of the Chairman's mark, but that a lot of it requires a good deal of further iteration between us and the committee staff, and I think to some extent CMS, in an effort to

make sure that it actually achieves what the specifications are trying to achieve.

Senator Snowe. Right.

Dr. Elmendorf. That is the iterative process that I have described. It is not a matter of anybody trying to do anything wrong, it is just the difficulty of actually doing it right.

Senator Snowe. Well, especially if there is a calculation with a surplus in the mark, if that is affected in some way, and significantly. It is possible, is that not correct?

Dr. Elmendorf. It is possible, Senator. I mean, we have worked very carefully to try to understand the specifications, and I know the staff are working very hard to translate that into legislative language. But it is a complicated business and it is hard.

Senator Snowe. Right. And you made that clear many times within the group of six in wanting the legislative language for that purpose, so I really appreciate it, and that of the staff's hard work.

I just want to confirm my reading of the Chairman's modifications. Are all of the offsets within health care? Are there any offsets that are outside health care?

Dr. Elmendorf. On the tax side --

Senator Snowe. No. Within the Chairman's modification.

The Chairman. No.

Senator Snowe. The amendments that you have accepted.

The Chairman. My staff tells me, within the modification, no. All within health care.

Senator Snowe. Right. Right.

The Chairman. In the mark, there is corporate --

Senator Snowe. The corporate. But in the modifications.

The Chairman. In the mark itself.

Senator Snowe. Because I noticed, when some of the amendments were accepted, that there were offsets outside health care. So I am presumably looking at this list, if this is accurate in terms of --

The Chairman. Well, let me double check. I am informed that it is, but let me double check.

Mr. Barthold. In terms of the financing title, all of the changes in your modification have a health angle. The two new starters were the Indian Health Services, the itemized deduction, AGI, floor. Then you modified the high-premium excise tax. You had modifications to the effective date on the HSA penalty on improper distributions, and you had a change in the limitation and

the effective date on the flexible spending accounts. You made a modification to the medical definition of the base for medical devices. So, all, arguably, a health connection.

Senator Snowe. All right. Thank you.

The Chairman. All right. Are you through, Senator?

Next, Senator Cornyn.

Senator Cornyn. Thank you, Mr. Chairman.

I just want to make sure, Dr. Elmendorf, as I understand your desire to achieve the fastest safe speed of your work, being a new member of the committee, I understand this committee, unlike any other committee in the Congress, deals with concepts rather than legislative language. So I just want to understand, once the committee reduces its product to legislative language, my understanding is, then, you said it will take some time--obviously as quickly as you can do it safely--to score it.

But let me ask you this next wrinkle. My understanding is that the Help Committee product, the Health, Education, Labor and Pensions Committee, and the product of this committee will then be merged at some point. Presumably there will then be a new legislative product. Will you then have to score that product in

order for us to know what we are voting on when the bill comes to the floor and how much it will cost?

Dr. Elmendorf. We will try to focus our energy.

The Chairman. The answer is yes. The answer is yes. We are going to score it. It is very simple.

Dr. Elmendorf. We will try to focus our energy on whatever piece of legislation is most relevant for the Congress, and if that means completing a full analysis and the formal score for the committee bill, we will do that. If it means, instead, shifting our focus to scoring some combined bill that goes to the floor of the Senate, we will focus on that. So I am not clear whether we will actually do both of these things in order or whether, in fact, we will move on to address whatever is the more pressing need of the Senate.

Senator Cornyn. I appreciate the Chairman's response. I think, Mr. Chairman, the answer is--if I heard him correctly--yes, that whatever we are going to be voting on, we ought to be able to read and understand how much it is going to cost.

Dr. Elmendorf. The only point I was trying to clarify was that I am not sure that the most productive use of our time in helping you is to spend several weeks on your bill and then several weeks on the bill for the Senate as a whole, because it may be that the better use

of our time is to shift to the bill that the Senate as a whole will consider.

Senator Cornyn. I heard from my constituents in August, and I think we all heard from our constituents, their sense of growing concern, is a nice way to put it--outrage would perhaps be more accurate--that Congress is voting on legislation that we have not had a chance to read. Certainly, I think that would include voting on legislation that we do not know how much it will cost and what its impact will be on the budget.

So I would associate myself with the concerns expressed by Senator Conrad and Senator Snowe, and I think the Chairman -- we appreciate the difficulty of your job and we want you to get it right, but I need to know, and I think others need to know, what it is we are voting on, what is in the bill, how much it is going to cost before we can intelligently exercise the duties, the fiduciary duty, that we have as an elected member representing our States. So, I appreciate that.

Let me ask you, in that vein, I understand in response to Senator Kyl's questions, that you explained the complexities of projecting out a 10-year full implementation of this proposal by the Chairman. But would it not be true to say that in 2019, which is the final year of the budget window when the new programs are

fully implemented, that the annual spending under the Chairman's mark, according to the CBO, would be $154 billion?

Dr. Elmendorf. The problem with answering that question directly is that we, in the announcements we have done with staff of the Joint Tax Committee, we have looked at the net impact on the deficit and we have not, in fact, broken this down entirely in terms of what would appear on the revenue side and what would appear on the spending side.

Senator Grassley noted just one of the many issues that raises, which is the extent of the refundability of tax -- how much of they money that goes out in these tax credits would be for people who have no tax liability, and thus appear on the expenditure side versus how much is a reduction in tax liability and would appear on the revenue side.

So there are a host of other issues. We mentioned another one in our letter, I think, which was that the risk-adjusted payments among plans and insurance exchanges would appear, in matching magnitude on the revenue and spending side of the budget, money that would be collected from plans with healthier-than-average enrollees and directed to those with sicker-than-average enrollees.

So we do not have a total of spending and a total of the revenue, we have some revenue pieces. There are some pieces that are clearly changes in spending, but there are others floating around we have not estimated separately. So, I do not have a total spending effect or a total revenue effect.

The Chairman. But you have a net. You do have a net.

Dr. Elmendorf. We have the net effect, and that is what we focused on.

The Chairman. That is positive.

Dr. Elmendorf. Which is the reduction of deficits of $49 billion over the 10 years.

The Chairman. Thank you.

Senator Cornyn. I am looking at a document. It says the source is the Congressional Budget Office, and the staff of the Joint Committee on Taxation, which is a preliminary analysis of the insurance coverage specifications provided by the Senate Finance Committee.

It talks about the effect on the Federal budget deficit, starts at 2010, and goes to 2019. But there is a figure of $154 billion there for Medicaid, CHIP outlays, exchange subsidies, and associated effects on tax revenues. Am I not reading that correctly? Is that not the estimated cost of the bill during all these new

programs, fully implemented --

Dr. Elmendorf. The table you are reading from, Senator, is the effect of insurance coverage specifications, but that number is a combination of increases in outlays and reductions in revenues. That number is the net effect on the budget deficit of the Federal deficit of that part of the coverage provisions. So I am sorry, it is just part of the complexity of putting this together; we have a number of tables and they interact in complicated ways. That is a piece of the net effect on the deficit, of the coverage provision.

Senator Cornyn. Let me ask it another way and see if I can --

Dr. Elmendorf. I am sorry.

Senator Cornyn. No. I appreciate the complexity that you are speaking to. Can you tell the committee what the cost of the Chairman's mark will be in 2019, the final year of the budget window in which the new programs are fully implemented?

Dr. Elmendorf. Our estimate, with the staff of the Joint Tax Committee, is that in 2019, the Chairman's mark, at least last week, would reduce the budget deficit by $16 billion, on net, taking into account the insurance coverage provisions, the changes in Medicare, the other revenue provisions, and so on. But the cost estimate,

there is an issue we discussed last week, which is what counts as the cost.

We talked last week about a 10-year total, the gross cost, if you will, of the insurance coverage pieces, as being $774 billion. I think that is the number which the 154 that you mentioned is the number for the tenth year. But that is just the gross cost of the insurance coverage expansions, and there are a set of other pieces that affect the deficit in different ways. The net of all of that is the $16 billion reduction in the deficit.

Senator Cornyn. Let me ask you about your letter of September 22 to the Chairman where you talk about the fees--really, taxes--on manufacturers of brand-name drugs and medical devices, on health insurance providers, and on clinical laboratories. You say these fees would increase costs for the affected firms, which would be passed on to purchasers and which would ultimately raise insurance premiums by a corresponding amount.

So it is true that these additional fees ultimately would be passed down to the health care consumer and be reflected and not lower insurance premiums, but higher insurance premiums?

Dr. Elmendorf. As you have read from the letter, Senator, our judgment is that that piece of the legislation would raise insurance premiums by roughly the

amount of the revenue collected.

Senator Cornyn. And at the same time, the premiums in the new insurance exchanges would tend to be higher than average premiums under current law for the individual market. Again, all other factors being equal--you say this, I think, on page 6--because the new policies would have to cover things that they do not currently cover, which is pre-existing medical conditions and the insurance companies could not deny coverage to people with high expected costs for health care.

Dr. Elmendorf. As you say, Senator, in the letter we note that that piece of the legislation would raise premiums, on average. Of course, people who are sicker than average would experience a reduction in premiums, those who are healthier than average would experience an increase in premiums from bringing these sicker people into the pool and covering their medical expenses. But that is only a piece.

One of the things I think it is probably disappointing to the readers, we list on pages 5 and 6 of this letter today a collection of factors pushing in different directions in the comparison of premiums in the proposed insurance exchanges and under current law, and we have not been able to quantify all of these factors at this point, but we are not able to produce a net

comparison, which I know many members, and we, are interested in knowing.

It is a bit of a laundry list, but there are a lot of differences, as we explained here, about the ones that you have mentioned, but also issues about differences in the actuarial value of the policies, the amount of total health expenses that are covered that are different that affects premiums in one way and cost-sharing expenses in a different way.

It is a different group of people who would be enrolled in insurance coverage because of the mandate and other features. So it is just very difficult to assess, at the end of the day, how these factors shake out. Unfortunately, the best we can do for you at this point is to help you think through the different pieces, pushing in different directions, but we cannot actually sum them up in a quantitative way for you.

Senator Cornyn. But just in terms of the additional taxes being put on drug companies, device manufacturers and the like, your opinion is, those will ultimately be reflected in the insurance premiums paid by the consumer?

Dr. Elmendorf. Yes. That is right, Senator.

Senator Cornyn. And then let me, finally, ask you for right now--because there is a lot more I would like

to ask you, but time is short, at least for now--about the excise tax for failure to maintain insurance. The Chairman's modified mark imposes a penalty of up to $950 for individuals and $1,900 for families on those who do not get coverage. Maybe this is a question for Mr. Barthold, maybe for you. Does the Joint Tax Committee predict that this excise tax will have an impact on families making less than $250,000 a year?

Mr. Barthold. Senator Cornyn, as I believe I told Senator Ensign, or it was Senator Grassley who asked a similar question, we have worked on this jointly with the Congressional Budget Office. It, in combination with the free rider penalty, helped determine who purchases insurance through the exchange, what employers may provider or not provide in employer-provided insurance.

What we have not done is tried to do a complete distribution analysis of the whole package, breaking out the individual components and saying, ah, there are X number of people, by category, paying the penalty, buying insurance. But we do think that some individuals will pay and will be subject to the penalty under the mandate. It basically follows from that that some of those individuals, since we think those individuals will not all be high-income individuals, would earn less than $250,000. But we have not done a formal analysis that

says it is a substantial number or a modest number.

Senator Cornyn. I appreciate your answer, and Dr. Elmendorf's. I think what your answers demonstrate, at least to me, is this is incredibly complex and interactive. That is the reason why I think it is so important we not only have final legislative language, but we actually have a CBO score so we know what we are voting on and what it costs before we are required to do so.

Thank you very much.

The Chairman. Thank you, Senator. You are correct, this is exceedingly complex and interactive. For example, I might also read from the same letter that you were quoting, which goes in the other direction and shows some of the benefits. On a net basis, the letter is pretty inconclusive.

I would just ask, Dr. Elmendorf, on page 5 down near the bottom, is it not correct that you write, "CBO currently estimates that about 23 percent of premiums for policies that are purchased in the non-group market under current law go toward administrative costs and overhead, but under the proposal, that share would be reduced by 4 or 5 percentage points, and that reduction reflects a 7 or 8 percentage points decrease in the types of administrative costs that are currently borne by non-

group insurers, offset partly by a surcharge that exchange plans would have to pay to cover operating costs of the exchanges, which would add about 3 percent." So on a net basis, there are benefits there, too.

Dr. Elmendorf. Yes. I think that is a very important aspect of the bill. As I said, there are pieces blowing different directions, but this reduction in administrative costs stems, I think, most importantly from insurers not spending the time trying to figure out whether certain medical expenses are due to pre-existing conditions or not, and that turns out to be, from our discussions with insurance companies, an important expense that they would not have to pay under the proposal.

The Chairman. Thank you.

Next, Senator Enzi.

Senator Enzi. Thank you, Mr. Chairman.

Thank you, Dr. Elmendorf. I appreciate the volume of work that you have had to do in the short period of time you have to do it in, and all of the different committees that are asking for your help. I appreciate you being here.

Last week in the closed-door walk-through, you commented that the Chairman's mark does not solve the Medicare sustainability problem and that it does not

solve the long-term deficit problem. Do today's changes in the mark solve these problems?

Dr. Elmendorf. I do not recall saying, Senator, that it did not solve the long-term deficit problem. What we said in the letter, and what I tried to say in the session last week, was that as the legislation is written, if it is not overturned by subsequent legislation and is implemented as written, then we expect it would reduce budget deficits by $49 billion in the first decade and by about half a percent of GDP in the second decade. That was our understanding of the effects of the mark. We have not worked that out even in the first 10-year estimate for the modification today, and that would be a precondition for looking at the second 10 years beyond that. So, we have not updated that overall description.

Senator Enzi. Thank you.

Going to the actuarial value of the different plans, if the value of the bronze plan was decreased from 65 percent to 60 percent, what direction and kind of impact do you estimate that it would have on premiums?

Dr. Elmendorf. A few thoughts, if I understand your question correctly. If you reduce the actuarial value from 65 to 60 percent, then the percentage reduction in the medical costs covered is 5/65ths,

essentially, so on the order of 7 percent or so. Premiums do not fall quite as much because there is administrative loan that does not change when you do that. So maybe premiums fall on the order of 5 percent or so, I do not know.

But the other thing to remember--and I am not sure where you are going with the question--but in the legislation that has been proposed, people in lower income brackets would receive cost-sharing subsidies that would raise the actuarial value, essentially, of their plans at 90 percent or 80 percent, depending on just how long their income was. So reductions in actuarial value may not affect the net benefits received or the net cost of the government or categories of people because of the way the cost-sharing subsidies were constructed.

Senator Enzi. All right.

I did note in your estimate that capped premium costs at 13 percent of individual income for individuals earning less than 400 percent of poverty, that it would translate to $1,900 in Federal Government subsidies for families that are earning $90,100 a year. Is that correct?

Dr. Elmendorf. I am sorry, Senator. What was the number that you --

Senator Enzi. The premium cost of 13 percent of

income for a person earning less than 400 percent of poverty would translate to $1,900 in subsidies for a family earning $90,100 a year.

Dr. Elmendorf. Yes, I think that is correct. This is the category of people earning between the mid-point of the 350 to 400 percent of poverty range in 2016, where the middle of that range is about $90,000.

Senator Enzi. All right. Thank you.

Dr. Elmendorf. Yes, Senator.

Senator Enzi. That just seems to me like a lot of taxpayer money to spend on somebody making $90,000 a year.

For Medicaid counsel, is there greater access to care in the private sector than in Medicaid? Are individuals more likely to receive the preventive care that we talk about? Why would Medicaid beneficiaries not be better off in the same system as everyone else?

Mr. Schwartz. Senator Enzi, the first question that you asked, typically most people would say that access to specialists and individual physicians is probably a little bit greater in the private sector.

The Chairman. Mr. Schwartz, could you speak up, please? Maybe pull the microphone a little closer.

Mr. Schwartz. I am sorry. Is that better?

The Chairman. That is much better, thank you.

Mr. Schwartz. I was saying that access to specialists and individual physicians is probably a little bit greater in the private sector, but that hospital access is pretty much equal across the board.

Senator Enzi. All right.

Mr. Schwartz. And -- oh, go ahead.

Senator Enzi. In the Help Committee mark-up we were told by CBO that it cost 20 percent more to cover a person in the exchange than through Medicaid. Is that true? If so, why is it more expensive in the exchange and less expense in Medicaid? Can you tell us what the trade-offs are for a person going into one versus the other such that it would be more costly for a person in the insurance than where they would have the enhanced access?

Mr. Schwartz. Sure. We heard a similar number from CBO, and I do not know if Doug--he is shaking his head--stands by it. There are big differences, obviously, between a Medicaid operation and a private insurer. There are different costs, and then there are also different reimbursement rates that Medicaid and a private insurer might pay to a hospital or a doctor who provides services.

So typically a private payor would pay an individual physician or a specialist more than Medicaid would pay

them. Hospital payment rates seem to be closer together, but still probably Medicaid coming in a little bit lower. So the cost of actually providing care will be different, and that, in part, contributes, I think, to the 20 percent difference. But that is not my number, so I do not know if CBO wants to explain it in more detail.

Senator Enzi. If we went to the private sector instead of to Medicaid, what would that mean for States regarding the costs?

Mr. Schwartz. Well, of course, States today can leverage the private sector through Medicaid managed care, so financially States are still responsible for paying for the care for that beneficiary, but it is delivered through a private model. But I think you may be asking, if Medicaid played no role, then there would be, in theory, no State contribution.

Senator Enzi. I have got a lot of other questions, but I am out of time, Mr. Chairman. I appreciate your indulging me.

The Chairman. You bet. Thank you, Senator.

Senator Cantwell?

Senator Cantwell. Thank you, Mr. Chairman.

Dr. Elmendorf, we had a conversation on the briefing of the previous draft of the bill. I know, since our meeting this morning, the Chairman's modification has

made some changes to bending the cost curve in Medicare. Mr. Chairman, I very much appreciate the adoption of that language, which helped us put a stake in the heart, if you will, of fee-for-service and really start to focus on a value index. My colleague Senator Klobuchar, who worked very diligently on this as well and who introduced original legislation, very much appreciates that this language is now included in the modification.

So if I could, Dr. Elmendorf, I think we were looking at and discussing this bending the cost curve of Medicare. The baseline growth rate that we all have been talking about, the doubling of Medicare, 89 percent, something like 6 percent a year, or a little more than that, the previous mark estimates were that, instead of that doubling, it would be something like a 61 percent. I think that was a conservative increase. Is that right? A 61 percent increase in the Medicare growth rate.

Dr. Elmendorf. Senator, I actually do not know offhand what the growth rate was of incorporating the Chairman's mark. But, yes. The mark and the modification, of course, maintains a very substantial reduction in Medicare payments relative to what would happen under current law.

Senator Cantwell. And I am just trying to get an idea of what substantial is from this perspective. I

think inflation is 48 percent, is that right? So if we were looking at Medicare and we were looking at a 48 percent increase, that is what we think general inflation is?

Dr. Elmendorf. I am sorry, Senator. I understand this is a useful line of inquiry for you, but you have me at a disadvantage in terms of the cumulative growth rates of these things over the 10-year window, which I just do not know offhand.

Senator Cantwell. All right. Well, we are not trying to stump you, for sure.

Dr. Elmendorf. Well, you are doing all right at that.

[Laughter].

Senator Cantwell. We are just trying to get to the point of the change that we have been able to make and how substantive it is. I would love to ask you that just right out, but I am assuming you will tell me you do not know what the impact of that is. So I am trying to --

Dr. Elmendorf. Well, I have better days and worse days. My hypothesis--but I will wait for my colleagues to stop me if I am wrong--is that the reduction in Medicare payments relative to the baseline, by 2019, is on the order of 10 percent of baseline Medicare spending.

So if you picture baseline spending rising like

this, being brought down like this, there is a growing wedge. The wedge, by the end of the 10-year window, looks to be in the neighborhood of 10 percent of baseline spending. That is quite significant. Many of the proposals that are in this legislation to explore value-based purchasing, to look at different ways of structuring accountable care organizations, all these sorts of changes that experts talk about need to be experimented with, and discovered, and worked with. So it is difficult to achieve very large savings overnight.

Senator Cantwell. Well, I guess that is the difference. The language that probably is still in the modification, but in the previous draft, yes, we had accountable care organizations and global budgeting, which will definitely move us towards this goal of really driving down costs. But I fail to see that as substantive.

I mean, I do not see we are going to see a huge migration to accountable care organizations. I would love to accelerate that. Some of the other value-based purchasing and some of the other things were pilot programs. So to me, I think this is the most substantive reduction to Medicare that has been introduced.

Dr. Elmendorf. Let me make sure I am clear. Quantitatively, in terms of the reductions in Medicare

spending relative to current law, by far the largest piece are reductions in payment rates under the existing structure, that the changes that are made to the structure of payments are there and matter, but are much less important quantitatively in our estimates than simply the reduced payment rates for services under current law. So again, I think this should not be, in some sense, surprising. If providers and beneficiaries were pushed into new systems, more savings might be achievable more quickly. But in fact, experts generally agree that a lot of work is needed to develop just what those new systems would be.

Senator Cantwell. But we are saying something different. In the modification today, we are saying that, no, you are going to change. You are going to change to a value index, and that we are going to steer a way of doing things just on volume.

Dr. Elmendorf. So I think we are still looking at the pieces of the changes in the modification released today, and maybe I will have a more developed view of this down the road. But I think it would be difficult to change the system so aggressively as to match over the next few years, or several years, the reductions, the savings from just lower payment updates. But I will take a close look at what is in the modification.

Senator Cantwell. You are saying more than the payment updates, is what you are saying?

Dr. Elmendorf. Yes. I think payment updates are so important quantitatively.

Senator Cantwell. Yes. I would definitely like to see, and I know the Chairman has been pounding on, when are we going to get numbers. But the reason this is so important is because this is about also reducing the cost of health care for the 90 percent of Americans who have care, and we should be spending far more time on the discussion of which of the policies that we are proposing or are in the draft are going to affect that number, because I do not think we are doing that.

We are spending a lot of time talking and debating about what we are going to do about the uninsured population, which I care very much about too, in covering them. But this is the measure, I think, of this bill, is how much we are reducing those costs. So I would be very curious, and obviously disappointed, to also find out that this would result in a very go-slow approach. I think we know what is working. We know where cost-effective coordinated care is delivering better care, and we ought to migrate. We should not walk, we should not skip, we should run towards that model if we want to have the most savings and also deliver the best care. But I

look forward to your numbers.

Another one. Not, again, trying to stump you, but looking for the same kind of numbers and analysis also in the modification proposal to transition long-term care, which is about $100 billion of our Medicaid spending--of course, that is a split number--to try to focus on community-based care. Again, the notion that it is 70 percent per-person cheaper to do community-based care -- our Federal system is still very oriented towards nursing home care and this moves an incentive program. So, thoughts on how we can get some numbers on the impact of that as well.

Dr. Elmendorf. Senator, I am told that the net effect of the puzzle that you are discussing, which we have been working on, is to increase Federal spending, but that will seem counterintuitive. Let me try to explain. For a given set of people --

Senator Cantwell. It is not counterintuitive. Sorry.

Dr. Elmendorf. [Continuing]. It can be much cheaper to treat them in a home or community setting than in some institutional facility, but providing Medicare support for that kind of service in a more generous way will tend to draw more people in to take that service. So that is why, for a given individual currently

receiving care in an institutional setting, this might be a saving to the government and obviously can be an improvement in the lives of those people. It is likely to be a cost on net because of the extra people who are drawn in to take that service and receive that benefit.

Senator Cantwell. Certainly the State of Washington has served more people and covered a larger population, but the per-individual savings is, instead of spending $42,000 on the health care of these individuals, it is only $2,400 per individual. So, that is the different and that is the migration we hope the Federal Government, with the baby boom population reaching retirement age, we hope that they will do the same and move towards it because this policy of focusing on long-term care is just unsustainable. So, we will look forward to those numbers.

I am aware that part of the proposal is to incent States to move to the model, so we are putting a little, if you will, sugar out to get States to migrate. But the savings are for us in the long run, and a policy that keeps people in their homes, which I think America will respond very positively to.

Dr. Elmendorf. Well, we look forward to that. We will keep working on those amendments and get back to you, Senator.

Senator Cantwell. Thank you. Thank you.

Thank you, Mr. Chairman. And thanks for including both of those proposals in the modification. I think they will help us in reducing the costs for Medicare and make substantial progress for us as a Nation. Thank you.

The Chairman. You are very welcome.

There is a vote going on--two votes, I am told. We have roughly, I am guessing, five minutes left on the vote. Senator Stabenow, you are next on the list. So, I suggest you go --

Senator Stabenow. Mr. Chairman, I have two quick questions.

The Chairman. Right now? Just do it. Ask those two questions. It is my intention to come back and get to amendments right after we return.

Senator Stabenow. I simply would like--and I am not sure if anybody has the answer now--but again, realizing all of the challenges you have on scores, this is critical for us to make decisions. I am very interested in having more information, scores, as it relates to a range on the tax credits and subsidies in terms of affordability so that we would look at a range below 10 percent, and hopefully we will have that.

Dr. Elmendorf. Yes, Senator. So working on amendments of that sort is a very high priority for us

and we will give you some alternatives.

Senator Stabenow. Terrific.

And the other is raising the threshold on which the excise tax would begin on insurance plans from 21 percent to 25 percent. It is my understanding, I believe Senator Nelson asked for that number as it related to retirees. I would like to know that number as it relates to all plans in terms of the cost of that.

Mr. Barthold. We will get a response to you soon, Senator.

Senator Stabenow. Thank you.

Thank you, Mr. Chairman.

The Chairman. All right. It is my intention to recess until 6:45. That is going to be the dinner hour, now until 6:45. At 6:45, we are just going to wrap up a couple of questions. Senator Kyl said he would like to ask a couple of questions. Then I want to get to amendments and we will just keep going well into the evening.

Dr. Elmendorf. Mr. Chairman, as I said, we need to get back and continue these estimates.

The Chairman. I want you to go back to go to work.

Dr. Elmendorf. We will have somebody here who can field questions and get them back to us. Thank you very much.

The Chairman. Thank you. Very good idea. Thank you.

The committee is in recess until 6:45.

[Whereupon, at 6:03 p.m. the meeting was recessed.]

AFTER RECESS

[6:52 p.m.]

The Chairman. The committee will come back to order. We left Senator Wyden wished to ask some questions and following him Senator Kyl wanted to ask some questions. So Senator Wyden, why do not you proceed?

Senator Wyden. Thank you very much, Mr. Chairman. I will be brief. This is just to follow on with CBO. I think we have lost Director Elmendorf. Who do we have from CBO who is going to answer questions for the record?

The Chairman. Is there going to be a CBO person here?

Senator Wyden. Mr. Chairman, let us just proceed with Senator Kyl.

The Chairman. Okay. Senator Kyl?

Senator Kyl. Thank you, Mr. Chairman. Mr. Barthold, my questions are for you and they relate to the premium excise tax which has, according to the Chairman's mark as I understand it been raised from 35 to 40 percent.

I am interested first in whether or not you have done any analysis of the new number and then whether or not you have, I have some follow-up questions.

Mr. Barthold. Well, the only analysis that we have

done thus far of the Chairman's modification is to estimate the revenue consequences of the combined four changes he made.

I did report to the Chairman earlier while I believe that you were out of the room, he had asked about some distributional analysis that we had prepared under the original mark. So I have done some distributional analysis of some of the original marks.

Senator Kyl. Well, I will go ahead and ask these questions and you can caveat it if that is necessary. So the primary impact of this provision with respect, well, what were the primary impacts as you analyzed with the new 40 percent number?

Mr. Barthold. Well, the 40 percent number is the same basic structure obviously as the 35 percent number. So the basic analysis is that for plans for employers and employees with plans above the threshold, there is an incentive to change behavior or pay the excise tax.

Now, ways to change the behavior could be to go to a less costly plan. Plans can be made less costly by either shrinking the scale of benefits so if, for example, you had a plan that offered dental coverage --

Senator Kyl. I understand.

Mr. Barthold. You understand. Or to change of course copayments, coinsurance rates. When that occurs,

our view of the economics of this type of proposal is that the employer and the employee are then agreeing to change the compensation package.

So under present law, the compensation package when there is health care, that is excludable from income for both the income and payroll taxes. If we make a change to go to a less costly plan by any of the methods that I sketched out, we would expect that the compensation package changes so that the employee receives more cash compensation.

So one of the effects is that there can be greater income inclusions for both income tax and the payroll tax. Now of course if the employee and the employer still think that this is a good plan, a good benefit even with the excise tax in place raising the cost on the incremental part, then there would be some excise tax payments made.

We view the excise tax as ultimately being born by the employee in the form of higher premiums essentially grossed up to reflect the excise tax in terms of the economic analysis of the revenue, that means that in fact there is a higher compensation component that would be in terms of health care insurance and would be excludable, so there would be a little bit of an offset of the excise tax receipts for a reduced income and payroll taxes as

the compensation makes changes.

Senator Kyl. Well, did you do either for the previous 35 percent rate or the 40 percent rate an estimate of what percentage of the revenue would come from the collection of the tax, the new excise tax, and what percent would come from the increased income tax and payroll tax revenues that you anticipate would occur?

Mr. Barthold. Let me give a qualified yes to that. I do not have hard numbers. Again, I will tell you sort of our process on this.

Through time as was noted in response to a question from Senator Ensign, the excise tax applies to potentially more plans. There is more cost pressure, there is more potential for income inclusion and we think as employees and employers learn about the plan, you know, if you try and shift the cost of the excise tax forward onto the premium maybe employees think well, if that plan is not worth this incremental cost so I am going to change my mind back again and I want to do something to reduce it so that we think through time we will see growing income inclusions which means growing receipts from income and payroll tax relative to excise tax receipts.

So sort of the short summary is initially there is excise tax receipts and some income and payroll tax

receipts. Through time, the income and payroll tax receipts grow relative to the excise tax.

Senator Kyl. Would you anticipate that after, that in the 10th year let us say that the majority of the revenue, that more than half of the revenue would be from the income payroll tax site as opposed to the receipts from the excess tax?

Mr. Barthold. I will say yes if you let me qualify that. I would want to double check it with my couple of economist colleagues who have been doing the modeling on it.

But we do view it as growing through time and the income conclusions becoming more significant.

Senator Kyl. Got it. Do you think you will actually have some, and you do not need to have them right now, but do you actually have numbers that you could supply to us on that at some point?

Mr. Barthold. I can at least give you some rough trends.

Senator Kyl. Yes, that would be good. With respect to the number of, I think you referred to them as units, tax units, whether it is an individual filed or a family filed, so the number would be understated I guess.

But my understanding is that you estimated under the 35 percent that about 13.8 million policy holders would

be affected in 2013, rising to 39.1 million in 2019.

Now, obviously there have been some changes in, I gather that was before the transition provisions and it was before the 40 percent, the increase in the rate to 40 percent I presume. You can tell me whether that is correct or not.

Mr. Barthold. If you can give me a couple of seconds to shuffle some papers here. The figures that you are referring to were an analysis that we did and it was based on 35 percent excise tax for thresholds again, 8,000, 21,000, which were indexed by the CPI. The Chairman's modification of CPI plus one.

It provided the high state transition relief but did not have the additional provisions about over age 55 retirees or high risk, deemed high risk occupation.

Senator Kyl. Okay. In fact --

Mr. Barthold. The figures you read were just a report from our table.

Senator Kyl. Yes. And this is in the letter to Senator Ensign which I just was handed, you have the estimate of in the year 2019 39.1 million tax filing units would be affected. That is to say, well, let me ask you.

Mr. Barthold. Well, that would mean either they are indirectly paying the excise tax by having a higher

premium or they have chosen to have an increased cash comp at the expense of a less costly plan, or both.

Senator Kyl. Do you break that down and get those numbers to us later? Or is that, or do you not do that?

Mr. Barthold. Well, if later can count tomorrow.

Senator Kyl. Yes. And it is true that actually the number of people impacted would be more because like if you have a family of five or four, that counts as one tax unit, correct?

Mr. Barthold. Presumably a family of four would be filing a joint return or head of household. Yes, sir, that would be one tax filing unit.

Senator Kyl. So the number of people would actually be more than that. Did you calculate the number of plans or did you estimate the number of plans you believe will exceed the threshold and either continue to offer or not continue to offer that plan after the tax takes effect?

Mr. Barthold. On a plan, we did not do it on a plan basis. We have tried to impute information about value costs of health care packages to our individual tax model and then we have estimated the proposals on the individual tax model.

We have not actually on the individual tax model assigned specific plans to specific individuals. So the

short answer is no.

Senator Kyl. I wasn't speaking specific plans, but simply to get an idea of how many plans –-

Mr. Barthold. Well, it is for the reason that we have not imputed from the universe of plans to, we have imputed dollar values to people, but not plans. So while I could, to make up a number while I could say, well, there are 13 million tax filing units have a plan value above that threshold, I could not say for time how many plans that might represent.

Senator Kyl. I wasn't sure of the answer to Senator Ensign's question. He was getting at the difference between the CPI and the medical inflation index and I think his question was is that one of the reasons why the number of the people was going to rise, the number of tax units would rise from 13.8 to 39.1 over time. You just assigned another reason for it, but how significant a factor is the factor that he was referring to?

Mr. Barthold. Well, that's the main, I would say that is the primary factor driving them. Again, just to review, remember the Congressional Budget Office baseline and essentially all outside people who study this are projecting that health care costs will rise at a rate in excess of the general inflation rate.

So that, without making changes, the cost of any one given plan will grow through time. So that means if we are not moving the threshold at which the tax applies, not at the same rate, and we are not, that more plans will cross that threshold, more people will cross it.

Senator Kyl. So you would say the majority of the increase is attributable to that factor, is that accurate?

Mr. Barthold. I would say a substantial majority.

Senator Kyl. Substantial majority? Okay. Final. My understanding is that the mark before us has a provision that requires an employer to calculate and report the amount of tax owed by each insurance company with which it does business whether or not the insurer offers one of these high cost plans.

A, is that correct? B, are there any other taxes that you know of or any other provision of the tax code where they, where somebody other than the taxpayer or IRS is calculating taxes owed by another taxpayer?

Mr. Barthold. Well, the first answer is the mark contemplates that employers will report to the insurance company if they are purchasing insurance or the plan administrator if they are using either an outside administrator or some large firms actually have a captive in-house plan administrator. So in a sense in that case

they would be reporting to themselves the value of the health care provided.

Now, the reason that the mark and the modified mark went that way is an employer might provide health care from multiple sources. You could buy a basic health plan from Company A and you might buy either a supplemental health plan or you might buy a vision plan from Company B.

Our understanding of the basic policy is if you are spending a lot under excludable income, so if you are above this threshold if you wanted to have people essentially think about it and maybe, you know, think about the income inclusion and make a different cost trade off decision.

Since the employer is buying from potentially two different sources, you would get the same result as if you had bought all those same services from one source, you had to have a mechanism of reporting that back and treating different plans that are otherwise equal but structured differently, consistently.

So there is this reporting mechanism. That was a long answer to your basic question to which I apologize.

It is somewhat unique, yes, but there are other circumstances where the taxes collected and all the recordkeeping is done by a person who is not liable for

the tax.

An example of that is the communications excise tax. The liability is actually on me and my local and line phone. The telephone company does all the reporting.

Senator Kyl. But here is what I do not quite understand. Take the example where you have two companies.

The question is what exceeded the $21,000? Was it Company A or the benefits from Company B?

Mr. Barthold. That is obviously a critical question, Senator Kyl, and the mark envisions that it is a pro rata treatment. I mean, you could come, your question seemed to suggest should I stack one policy first and lay all the excise tax on the second policy, but the mark envisions pro rata.

Senator Kyl. So it really does have the employer then doing the calculations?

Mr. Barthold. That is fair, yes.

Senator Kyl. And then that information is submitted to IRS?

Mr. Barthold. For tax administration and tax enforcement, there has to be reporting to the IRS. So the amount would be reported to the IRS and it would be reported to the insurance company or the insurance companies in the case that you posit.

Senator Kyl. So the companies find out after April 15th what their liability is based on information that they had no reason to necessarily know. I guess they could adjust --

Mr. Barthold. In practice, yes, that is possible. But in practice I think what I would imagine would happen is first of all you often have people bidding with different employees and so they ask what terms, you know, is this going to be in conjunction with something else. So it might have sort of an idea of what the employer is trying to do.

Then it would not be unusual, you actually see this in some, in cross-border financial transactions all the time. There can be tax indemnity clauses to the contract that should a tax amount arise under the contract that I am writing, that the contract price is then grossed up by the amount of the tax liability.

That would be sort of a very simple contractual arrangement that the two insurance companies who might be bidding to provide basic health and dental would contract the employer.

Senator Kyl. Let me get down to the legislative language here. We might want to be pretty careful.

The Chairman. You ask the questions.

Senator Kyl. If this stays then we are going to

have to be really careful how this particular provision is implicated. I think we can all see the potential dangers involved.

The Chairman. Thank you, Senator. Both sides have agreed to our first round amendments and I would like to just give the list right now, the Senators whose names I read to come so they can offer their amendments. We are going back and forth, Republic and Democrat.

Bunning on transparency language, Conrad, CMS Invasion Center, Senator Kyl, strike Title 3, Kerry, Home Health Payment Reform, Roberts, strike Title 3E, Wyden, Independence at Home, Hatch, MA Cuts Require CBO Certification, Schumer, Part B Drug Reimbursement for Bio Similars, Grassley, MA Access for World Beneficiaries, Rockefeller, Modifying Medicare Provision, Roberts, strike Home Health Nursing Home Hospital Cuts, Stabenow, Emergency Care Doctors, Ensign, Apply Medicare Savings to Solvency, Cantwell, Physician Work Force Enhancement, Cornyn, Strike Medicare Commission, Nelson, Donut Hole Eligible Rebate –- DHS provision or DSH provisions, and then there is Urban Medical Hospitals.

Kyl, partial strike of Medicare Commission, Carper, Medicaid Overpayments, Kyl or Hatch, strike MA Cuts, Bingaman, Federally Qualified Health Centers.

Next on my list to ask questions is Senator Hatch.

Senator Hatch. Thank you, Mr. Chairman. I have a number of questions. Can you hear me all right?

Mr. Barthold. Yes, Senator.

Senator Hatch. I would like to talk about the transition relief for a few minutes. I have quite a few questions.

Let me just ask you, why is a -– increase of 20 percent when it is obvious that each of the high cost states are not the same? Why isn't that based on the various factors of affordability?

And also, if this is a good idea, why phase it out? And most importantly, why just 17 states? Why not 10 or why not 25?

Mr. Barthold. Those are all questions that I am really not in a position to answer.

Senator Hatch. Who is in the position to answer?

Mr. Barthold. I think they are policy decisions that grew out of discussions in part from the group of six and there is certainly some ease of administration in terms of having a fixed percentage increase rather than going state by state and having a finely tuned calculation.

One certainly could conceive and try to move the proposal in that direction. As to number of states, a reason that you might limit to a certain number of states

is if there are some studies, there is the NEPS statistics for example give a rough distribution of costs of different states. So you might look at the NEPS distribution and say well how many states are more than one standard deviation away from the mean?

If that came out to be 10 or 15 or whatever, that could be a rational basis for saying how you wanted to set up some of the –-

Senator Hatch. Let me get into it a little bit more. On page 199 of the Chairman's mark, it imposes an excise tax on insurers if the aggregate value of employer sponsored health coverage for an employee exceeds a certain threshold amount.

So the employee picks his coverage, the employer submits the information to the insurer and the insurer pays the tax, correct?

Mr. Barthold. Yes. That's the point that Senator Kyl just discussed.

Senator Hatch. Okay. And this tax is based upon the aggregate value coverage for an employee on an individual basis, correct?

Mr. Barthold. Yes, that's correct.

Senator Hatch. Okay. Now, looking at the transition relief provided on page 201 of the Chairman's mark, it states that a transition –- apply to 17 states

determined by the Secretary in which health care was least affordable for the year ending December 31st, 2012, correct?

Mr. Barthold. It was highest cost.

Senator Hatch. Okay. This transition role raises the threshold amount to 20 percent. Is the District of Columbia considered as one of those states?

Mr. Barthold. We have, in terms of estimating the proposal, Senator, we have not tried to identify any specific set of 17 states. That doesn't mean we are not cognizant of existing data, but the mark envisions that the Secretary of the Treasury in 2012 will look at data available in 2011 and 2012.

Senator Hatch. Would you expect the District of Columbia --

Mr. Barthold. The District of Columbia would count as a state.

Senator Hatch. That is my point. Now, is the transition determined by the state of residence of the policy holder, employer or the insurer?

Mr. Barthold. The employer, sir.

Senator Hatch. Okay. So if I am an employer living in DC which is determined to be a least affordable state where the transition rule applies and I work in Virginia which is determined not to be a least affordable

state –-

Mr. Barthold. Actually it is the location of where the, when you said employer, it is the employers, where the employer has the employee.

Senator Hatch. Okay. Well, let me go through that.

Mr. Reeder. There is a clarification in the modified mark.

Senator Hatch. Okay. Let me go through this again. If I am an employee living in DC which is determined to be a least affordable state where the transition rule applies and I work in Virginia which is determined not to be a least affordable state and my employer buys insurance from an insurance company located in Maryland, also not determined to be a least affordable state, I will be able to get higher cost coverage through my employer than a coworker that lives in Virginia, is that correct?

Mr. Barthold. I believe that is correct under the modification, the state of the individual.

Senator Hatch. Now, Article 1 Section 9 of the Constitution requires that direct taxes be apportioned among the states on the basis of the population. In contrast, the tax imposed under the Chairman’s mark upon the sale of certain –- expensive health insurance plans

would be a true excise tax required by Article 1, Section 8 to -– throughout the Unites States.

We are not talking about a defined geographic region in the Unites States versus Susinski. We are talking about states, right?

Mr. Barthold. The transition is defined by states.

Senator Hatch. Because this relief is limited to certain states. Is the transition related to geographically –- throughout the United States as provided by the Constitution? You know what the answer to that is.

Mr. Barthold. Well, I cannot really comment about the Constitution.

Senator Hatch. The answer is no.

Mr. Barthold. It is, as you observed –-

The Chairman. If I can. The point here is where the insured lives. That is the employee because that is the person who is affected.

Senator Hatch. That is not what he said.

The Chairman. Well, the intent is where the employee or the insured lives.

Senator Hatch. Let us go further. While we are on the topic of upholding the Constitution, the -– legislation would require all U.S. citizens and legal residents to purchase a certain level of health insurance

coverage.

They must record qualified coverage on the federal income tax return. Failure to do so would result in an excise tax of $750 on individuals applied as an additional amount of federal tax owed. Would that be a direct tax?

Mr. Barthold. If we applied an excise tax on all individuals –-

Senator Hatch. But you are not. I am told that this would be the first time in our history that Americans would be faced with the situation where they were ordered to do some specific act by the federal government which if they refuse to do it they would be subject to a tax. Is that correct?

Mr. Barthold. I do not know, Senator.

Senator Hatch. I think it is.

Mr. Reeder. If I could jump in here and just add that the code, the Internal Revenue code is replete with excised taxes that are applies as penalties.

Senator Hatch. Well, this is on a person, not a service or product.

Mr. Reeder. There are lots of excised taxes that are applied to an individual.

Senator Hatch. I guess I’m asking do you believe this individual mandate raises possible Constitutional

issues as I have been told? It sure seems like it to me.

Mr. Barthold. Senator, it is just not something that I am qualified to answer. An excise tax applied on activities by all individuals would not seem to be beyond the flush of the Constitution's authority for the Congress to assess a tax. But I am not the right person to engage in a Constitutional discussion. I'm sorry.

Senator Hatch. It would be a tax on a person for doing absolutely nothing. I mean, can anyone on the panel say whether the mandate of excise tax would be constitutional? Anybody?

The Chairman. Well, I will. This is an equally applied penalty for all persons meeting a certain category. I think it is a stretch to say this is unconstitutional. I will take that argument any day that it is not constitutional. It is constitutional.

Mr. Reeder. We did refer this to CRS and we got guidance from them that it is.

Senator Hatch. To be honest with you, I do not think it is at all. Let me move on.

The Chairman's mark provides a tax credit for qualified small employers with no more than 25 full time equivalent employees. These employees have annual full time equivalent wages that average no more than $40,000.

Moreover, the full amount of the credit would be

available only to the employer with ten or fewer employees and whose employees have an average full time equivalent wages of less than $20,000.

What economic disincentives do these requirements create for growing a business beyond 10 or 20 employees or increasing wages beyond $20,000 or $40,000?

Mr. Barthold. Well, Senator, this was partially addressed by Dr. Elmendorf when he was here, the Congressional Budget Office has written a paper on some of the employment effects from health care reform.

One of the points that Doug made when he was here and Sandy Davis may want to follow up with his colleagues at the CBO because I do not want to misstate their results, but as a subsidy phases out, it essentially makes the next worker a higher cost worker than the preceding worker.

I think that was the point that you were raising, and that goes into employment decisions. It is a consequence in part of the phase out of the subsidy that is being offered.

Senator Hatch. What is bothering me a great deal about this whole exercise is that there is such a rush in just a few months to get done 1/6 of the American economy on a conceptual bill, which is what we do in this committee, that has to be finally put into final language

and then that has to be scored so at least we know what we are doing and so the American people at least can look at it and see if they agree with it.

I know how long it takes to put really important health care legislation through because I have put a lot through with my friends on the other side. We seem to be rushing very hard. But let me just ask you this.

According to the Chairman's mark, the individuals who failed to maintain health insurance are subject to an excise tax, right?

Mr. Barthold. It is the penalty, excise tax penalty.

Senator Hatch. The penalty for excise tax. The excise tax would be assessed with a tax code and applied as an additional amount of federal tax owed. However, there are various rules protecting those who are uninsured for less than three months or to the extent that the cost of the health insurance premium exceeds 10 percent of adjusted gross income.

Are there any excise taxes in the current tax system that are treated this way? And are there any other excise taxes that vary based on the taxpayer's income? Are there any other taxes at all in our current tax system that are furthered by the failure of the taxpayer to take some action?

Mr. Barthold. Well, as Mr. Reeder noted, there are some penalty excise taxes that apply to individuals for either actions that they take or in some instances for not having taken an appropriate action.

We have penalty excise taxes on excess distributions or premature distributions from qualified retirement plans. There is excise taxes in the tax exempt organization area for, I guess for lack of a better term, for inappropriate activities or decisions made by management of the tax exempt order.

Senator Hatch. But are they based on the taxpayer's income?

Mr. Barthold. None of those are based on taxpayer's income. The excise taxes on the distribution indirectly are based on income in the penalty taxes for early withdrawals for example key off of the size of the withdrawal.

Senator Hatch. Well, this excise tax is imposed upon the insurer for which plan it offers which exceeds a threshold amount. When the insurer –-

Mr. Barthold. That is a different excise tax.

Senator Hatch. Okay. I understand that. I'm moving on. When the insurer pays this tax, it is likely that the insurer will pass the cost along to the employer who purchased the high cost insurance? And do you

believe that this would result in less revenue for the employer in which it can hire more employees and provide higher salaries?

Mr. Barthold. As I was discussing with Senator Kyl a few moments ago, the way we analyze this is the excise tax itself essentially sets up a question of do I want to pay more for this current health care benefit or would I potentially like to reallocate my compensation by perhaps choosing a lower cost plan either through accepting higher deductibles, higher copays, perhaps less coverage of certain items that may be deemed non essential.

When I do that, I receive greater cash income. I am trading in excludable compensation benefits in the form of health care and receiving more cash income.

In that analysis and in the way we have analyzed this and I believe the Congressional Budget Office has largely concurred with our analysis, we view the tax as being born ultimately by the employee, by the policy holder.

From the business side, whether the business compensates its employees with cash, with retirement benefits, with health care benefits, they are somewhat indifferent. It all adds up and it is all the compensation cost. It is the price, sort of the expanded concept of the wage that they are paying the employee.

So our view of the excise tax is that it essentially just works to change the compensation package decision. Some employees in negotiation with their employer may choose to keep a plan that is subject to the excise tax. We believe that the premium will increase to reflect the tax as partly the point we were discussing earlier in which case we have essentially chosen to have a little bit more of their compensation being the form of health care premium and less wage compensation. But we do not view it as impeding, as raising the price of labor and impeding the business's choice to hire additional workers as it might expand given a positive outlook for market conditions.

Senator Hatch. Let me ask you, what are the implications suggesting CPI-U plus one as the index of the threshold as opposed to some other index? Would this index cause a growing number of plans to be cut? I would like to at least know the answer to that.

Mr. Barthold. The original Chairman's mark –- the thresholds by the CPI. The modification index is the threshold by CPI plus one. So the modification will cause fewer plans to be potentially subject to the excise tax and will be underlying mark.

Senator Hatch. Okay.

The Chairman. Okay.

Senator Hatch. I am not through yet.

The Chairman. We have five minutes and we can come back to you. If you could wrap up, that would be helpful.

Senator Hatch. Well, let me just ask one last thing. I thought we were going to just be able to finish what our line of questions are.

Can you share the CRS report with us that you said you were relying on for the constitutionality of this? I would like to have a copy of it.

Mr. Reeder. I'm sorry. It was an oral conversation where they recited some case law which I can --

Senator Hatch. Well, did not they put that in writing? Usually CRS will put a --

Mr. Reeder. We can ask them.

Senator Hatch. Well, again, we are missing this bill without answering questions that are really important like the constitutionality of some of the provisions. These are important issues. They are not just itty bitty issues.

I do not understand why the rest of them when it involves 1/6 of our American economy and people all over this country are up in arms about it because they do not understand it and we do not understand it.

It is pretty hard to understand when you are looking

from a conceptual plan without scoring except preliminary type scoring that may or may not be accurate.

I have lot of confidence in Dr. Elmendorf. I think he is an honest man, I think he is trying to do a good job and he has been honest in telling us it is pretty hard to get all the scoring done on this in the limited time that we are given for this.

It just seems to me, Mr. Chairman, I do not blame you for this. I know there is a lot of pressure on you. But it seems to me that we ought to take our time on this and make sure we get it right.

If I am right, then a number of these things are unconstitutional. This could wind up being not only an exercise in futility but one that really costs our country an undue amount of money that could really hurt our country and our economy in the end.

I will reserve my time to ask more questions later.

Mr. Reeder. If I might add that the CRS does have a report on their website addressing the constitutionality of these provisions.

The Chairman. We are going to get a CRS report. Senator Grassley?

Senator Grassley. My first question would be to finance staff. Preliminary to it which by I would not expect any of you to know, but in 1995 I got a bill

passed called the government accountability Act which applied all the laws from the 1930s that Congress had exempted itself from that they had applied to Congress.

So I am concerned about your modified amendment C3. The amendment that I put in would require that all members of Congress and federal employees get their health coverage through the exchanges when they are up and running. This is something that we not only need but I think in a lot of other states people heard in their town halls because many people at the grass roots believe that members of Congress should get the same coverage that we are coming up with for everyone else.

So that is what my amendment was intended to do and this amendment will not only hold us accountable, but will also help improve the Chairman's' mark by creating a more vibrant market by adding more people to it.

But in the modification, my amendment was modified to say that elected officials and federal employees may purchase their coverage in the exchange. It appears to make it optional for members to go into the exchange, and is that right, and if it does let me say that part of this is to get members of Congress to understand what the average citizen does navigating the exchange and having the same thing that other people have.

Ms. Fontenot. You are right, Senator. The

modification to the amendment gives federal employees the option to enroll the way that any private sector employee would have the option to enroll.

Senator Grassley. Okay. Well, I have explained where I am coming from on that and I will probably proceed with my original amendment. I appreciate the consideration you gave it by including it, but it just goes in the opposite direction that I was intending to go.

I want to speak about immigrants who are here illegally. This is based, if anybody on the finance staff wants to respond, but I just want to point out some things that bother me.

There is almost no topic that generates more controversy. Despite the controversy, the committee has responsibility to consider the impact on immigrants here illegally on our health care system.

So last week I sent a letter to CBO requesting more information on this issue. Earlier today I received a response from CBO which states I part, we do not have a detailed estimate you requested.

Since I didn’t get a complete response to my earlier questions, I would like to take a moment to focus on what the letter says.

According to the letter, CBO assumes there will be

14 million unauthorized immigrants residing in the United States in 2019. CBO assumes 8 million will be uninsured, 4 million will have employer-based coverage, one million would have Medicaid coverage and one million would have other coverage.

With respect to Medicaid, the letter says that this coverage primarily reflects emergency care services. The letter also states that some unauthorized immigrants will obtain full year Medicare coverage even though they do not qualify for it. However, we believe state agencies successfully screening out most ineligible individuals.

I am not sure what the statement is based on, whether CBO is aware of any statistically valid audit to determine the reliability of the state's citizenship verification procedures or not.

The letter says CBO assumes that the enforcement mechanisms in the bill would be highly effective in keeping ineligible individuals from receiving tax credits.

Although the bill requires the exchange to verify the Social Security numbers and the legal status of participating individuals, there is no provision in the bill to prevent anyone from using somebody else's Social Security number.

I will say this parenthetically. That is something

that we were working on as we ended our bipartisan negotiations and I was hoping that we would arrive at some sort of a consensus on that, but we did not.

Lastly I want to say small business with low wage workers who provide insurance in 2011 and 2012 would be eligible to receive temporary credits to purchase insurance. There is no provision in the bill to verify the legal status of workers employed by these small businesses.

Now, that is my analysis of that letter. If anybody on the Finance Committee staff wants to comment on it, otherwise I will go onto another question. Is there any rebuttal you need to give on that?

The Chairman. I want to ask Mr. Klouda to comment on the degree of how robust is the screening right now and what are the different screens?

Mr. Klouda. Senator, right now the way the Chairman's mark is structured, people applying to the exchange or seeking a tax credit, their name, date of birth and social security number is verified with the Social Security Administration.

If those individuals assert that they are citizens of the United States, that is checked with the SSA records as well. For individuals who are not citizens of the United States, then they --

The Chairman. But who are here legally.

Mr. Klouda. But, well, are here legally, their information would be checked with the records at DHS to see if their claim of lawful status is what their DHS records reflect.

Senator Grassley. That still does not cover though what I said about people that could steal Social Security numbers.

Mr. Klouda. Yes, Senator. Well, people who are applying for exchange are going to put their income information and that will be verified with the IRS as well.

The Chairman. So if someone stole a social security number, what? What would happen?

Mr. Klouda. Well, they also have to have the other pieces of that person's identity information. We check to see if there is a concern with identify theft in some of our other health care programs.

We contacted the National Association of Medicaid Fraud Units, and they mentioned that there is a minor degree of identity theft in Medicaid, but it is very small. It is not one of their main concerns in terms of Medicaid fraud issues.

So we feel that someone committing identify theft through this system, not only would they have to get all

the information, have it verified, but then they would have to actually present themselves at a health care center or doctor's office and collect benefits.

Some people that we have talked to are experts in identify theft and just feel that is unlikely that people would want to enter the system that way and have to sort of maintain the fraud.

Senator Grassley. You know one instance that you do not cover is the fact that if you steal a social security number and you have that number, you can write and get income information based upon that number.

Mr. Klouda. I am not sure what you are referring to.

Senator Grassley. I am referring to the fact that if you have a social security number, you can write to Social Security and get pay records for what has been paid in under that number.

In other words, I could write in and ask Social Security for my record.

Mr. Klouda. That may be true. I just wanted to point out that the IRS would not pay a credit for the same person twice. So if I were to luck out and find the, somebody who is eligible for the credit and steal their identity, the IRS would only pay that credit once.

Senator Grassley. I will go onto another question

for joint tax. You have hit some of this a couple of times already, but I want to hit it from another angle.

In regard to employers who are less than 500 employees are less likely to self-insure their employee's medical claims under the proposal to impose a fee on health insurance providers, employers who are self-insured are exempt from the fee. This means only insurance companies that sell health insurance policies to, for example, small businesses would be required to pay the fee.

This would also include self-employed who purchased individual health insurance. Does this mean that the premiums for small business and the self-employed will go up? And how many years will the costs seem to go up?

Mr. Barthold. Yes, Senator Grassley, I guess we haven't spoken about this industry wide fee which –- modification would be $6.7 billion allocated across the industry.

As you observed, it does not apply to self-insurers and you also stated that generally you are less likely to self-insure if your employer is under 500 individuals. That is certainly the case. Self-insurers tend to be larger companies.

We, and again the Congressional Budget Office is in concurrence with this, believe that these fees will

generally be reflected in premium costs. As you observed, it is people purchasing group insurance so it would be smaller employers.

The small employer market, individual market would be included. We think we'd have some of the economic effect of making it more likely that some modest size employers might consider self-insuring. It would make it less likely that some of the larger firms would choose to opt out of self-insurance into the purchased group insurance market. I hope that's responsive to you.

Senator Grassley. You responded to the fact that the costs would go up, but you didn't say how long. How many years did you expect them to go up? I would expect them to go up at least three to five years until the health insurance reforms kicked in. Would that be fair to say?

Mr. Barthold. The proposal is a permanent proposal. We would expect that it would have, I mean, the analysis would hold year by year, so we would expect it to have an impact in each year.

Now, I guess I cannot answer on my own without checking how we have coordinated this with the Congressional Budget Office because we do expect insurance market reforms in other changes in the broader goal to have effects on premiums in the group market.

So if your question is would this feed the totally -- or not totally offset by the other changes in the bill, I don't have an answer for that at the present time.

Senator Grassley. The fee is an excise tax?

Mr. Barthold. It is not a normal structure one, but we analyze it as an excise tax. It is essentially saying if you based on the volume of your business there is a tax imposed.

Now, that tax varies by the overall volume of business in the marketplace and that of your competitors. So it is a different sort of variable rate excise tax. We do see it as an excise tax.

Senator Grassley. Under the Chairman's mark, the insurance company is required to report to Treasury the net premiums written by a company in the previous year.

Based on this information, Treasury will determine a company's market share. Has a tax ever been based on market share?

Mr. Barthold. I believe that the Chairman in his mark based this structure and the structure on medical devices and also to a degree the industry fee on the branded pharmaceuticals on the tobacco settlement. The tobacco settlement does collect fees from each company based on the company's market share as it evolves.

There is a precedent out there. There may be some

other precedents as well.

Senator Grassley. I guess my other questions were CBO and they are not here. So did anybody on your, he asked me to call on somebody. Senator Kyl?

Senator Kyl. I just had one question of staff. There is an indication in the modification of the Chairman's mark on page 2 at the very top of the page it is described as an amendment to accept the modification -- and related amendments, Grassley 15 and 16, Hatch 4, Kyl amendment number 6 and Cornyn number 10.

I just wanted to disassociate myself with this because I do not think my amendment has anything to do with what this does.

As I understand it, well, my amendment which is referred to as number six there allows states to opt out of all of Title 1, meaning the insurance reforms, the exchange, the subsidized mandate, the coop, Medicaid expansion and so on which of course is not what the modification does.

I understand the modification would simply allow states to apply for a waiver on just the insurance reforms if the state and only if the state provides, and I am quoting now, coverage that is at least as comprehensive as required under the mark.

So I just want to make it clear in indicating that

it is adopted at least in part, my amendment, I don't think it does any such things. I want the record to be clear on that point.

Senator Grassley. Senator Hatch?

Senator Kyl. And if any staff would like to contradict that, please do.

Senator Grassley. I'm sorry. You didn't get an answer.

Senator Kyl. No, I guess it is a comment. But if any staff thinks I am incorrect on that, then please say so.

Senator Grassley. Let me ask one more question and then I will call on Senator Hatch. To the staff. The Chairman's mark explains that for purposes of determining eligibility for premium credit, individuals must submit personal information to the state exchange.

The mark also states that the eligibility determinations will be conducted by a federal agency. So the state would seem contradictory.

Will the state exchange or a separate federal agency be responsible for verifying the income and legal status of an individual and his or her family?

Ms. Fontenot. Senator, the state exchanges will have to interface with the IRS in order to confirm income levels. So it will be an eligibility determination that

is based on information submitted to the state exchanges that has been verified by the IRS.

Senator Grassley. Well, the mark doesn't describe the federal agency. Which federal agency would be responsible?

Ms. Fontenot. We anticipate it would be the IRS. They hold the income verification information. They hold the tax filings where they can verify the income.

Senator Grassley. You anticipate it, but it seems to my staff that it is not firmly stated in the mark. Or is it your intention that that will be the case?

Ms. Fontenot. It is our intention that IRS will continue to hold the income information and the verification will be done with IRS records.

Senator Grassley. I am sorry. Senator Hatch, I forgot that I was going to call on you. You are next.

Senator Hatch. We have been looking over the CRS. We did get the CRS language and it does not specifically mean what I think you have interpreted it to mean. But I will try and get that prepared for us by tomorrow or even later tonight.

Mr. Reeder. And we will follow-up, as well.

Senator Hatch. Because I am very concerned about that. Let me just ask a couple of more questions on this. In connection with determining the amount of

employer-provided health insurance coverage that exceeds the threshold, for determining the new excise tax, why would the aggregate include the amount of the employee's flexible spending arrangements?

After all, are these not the employee's dollars and not dollars provided by the employer? It seems strange and wrong to me to treat these amounts as employer-provided health insurance.

Likewise, does not this proposal also include toward the threshold the employee's portion of health insurance premiums? Is it not true then that this is not just a tax on employer-provided health insurance, but also a tax on employee contributions, some of which have already been taxed once?

Mr. Barthold. Senator Hatch, you are correct. To go to the second question, the mark would provide that in aggregating the value of health care benefits that might be subject to the excise tax, it would include benefits that were paid with employee after-tax dollars.

Now, as to the point on, I guess, the policy of including an FSA, a health flexible spending arrangement, the effect of the flexible spending arrangement is to permit the employee to make payments for certain health-related expenditures with pre-tax dollars.

Now, that has the same effect as complete employer-

provided health insurance. It has the extra effect, I think, in the context of the Chairman's mark, and I will not --

Senator Hatch. But the difference is --

Mr. Barthold. -- the Chairman as to motivation, but it does essentially mean that you could pay with pre-tax dollars the deductible, and I believe the Chairman's intention with the excise tax was he wanted to create some cost consciousness.

Senator Hatch. That is fine, but these are employee dollars, not employer dollars.

` Mr. Barthold. The flexible spending account -- well, our view and most economists' view is that all the dollars are employee dollars. It was the point that we were talking about before about the mix of the compensation.

Senator Hatch. But there is no question that flexible spending accounts are employee dollars.

Mr. Barthold. They are pre-tax employee dollars, just as the purchased health insurance policy can be with pre-tax employee dollars. But on the point that you are making that the flexible spending account represents dollars only until they are spent, whereas the health insurance policy is a policy that is agreed to at the beginning, that, of course, is true.

Senator Hatch. All right. Now, there are many employers who provide basic health care coverage to their employees. Employees sometimes purchase supplemental coverage that goes beyond what the employer-provided health insurance coverage, such as coverage for cancer.

In calculating the threshold amount, will employers be less likely to offer supplemental coverage to employees exceeding the threshold a month, in your opinion? Is that possible?

Mr. Barthold. Well, the calculation is based upon what the employees are choosing, what they are offering. As we discussed before, there would be incentives for employees and employers to say "I do not want the overall benefit package to exceed these thresholds" and, as you were observing, one way to do that would be not to offer or not to purchase certain supplemental policies.

Senator Hatch. Mr. Chairman, your own Chairman's mark recognizes the differences between employer-provided contributions and employee-funded FSA, or flexible spending account, contributions.

On page 202, the reporting requirement excludes FSA contributions. Likewise, on page 23 of the mark, the small employer tax credit does not allow FSA contributions to count toward amounts paid by employers for purposes of determining the credit.

Is this not a "heads I win, tails you lose" approach as far as FSA users are concerned?

Mr. Barthold. I misunderstood your question, Senator. I am sorry.

Senator Hatch. Let me state it again. The Chairman's mark does recognize the difference between employer-provided contributions and employee-funded FSA contributions. Yet, on page 202, the reporting requirement excludes FSA contributions.

Likewise, on page 23 of the mark, the small employer tax credit does not allow FSA contributions to count towards amounts paid by employers for purposes of determining the credit. That is why I ask if it is a "heads I win, tails you lose" approach as far as FSA users are concerned. Does that make it more clear?

Mr. Barthold. I am wasting your time, which is counting down, by not understanding. I will have to think about it. Maybe we can speak separately.

Senator Hatch. We will submit that question to you, then.

The Chairman. If I might, Senator, just a proposal here so we can take some action here tonight. I have consulted with Senators and I suggest -- including at least your staff, maybe you, too -- we take up your amendment, Senator, the one with regard to MA cuts that

require CBO certification; the Conrad amendment, CMS Innovation Center; the Nelson amendment to the dual eligibles; and, I suggest we take those three up, we debate them, and then we will vote on those tomorrow when we come back.

Senator Hatch. That would be fine. But can I finish my questions?

The Chairman. Sure. Senator Schumer? Let us kind of get the sense here of what is going on first, Senator. Let me see what Senator Schumer has in mind.

Senator Schumer. After Senator Hatch finishes with his line, I have one question I would like to ask before we stop.

Senator Hatch. I have a few now. The CRS report concludes the government can require individuals to obtain health insurance and penalize you if you do not. However, the penalty must be something the government has already given you and can take away, such as the right to a deduction.

Now, this is an excise tax imposed on you, regardless of if you have a tax liability or not. I think the CRS has not analyzed the Chairman's proposal. So I want you to really look at that, because the CRS has not concluded that this is constitutional and I think we can make a case that it is not, and you ought to at least

get that right before we proceed with this bill and I think that would be a very, very important thing to do.

Now, let me go back to where I was and that is regarding the distribution of taxes and whether the mark will raise taxes on middle income families. What are the distributional effects of this excise tax on high-cost insurance plans? The distributional effects.

Mr. Barthold. The distributional effects, as we were discussing earlier, Senator, we review the economics, leading to a couple of possible outcomes. One is that employees and their employers may decide that they want to reconfigure their compensation plans to offer a less expensive health care package, which could be achieved by a number of different means.

When that happens, they would be receiving more cash compensation, leading to increased income and payroll taxes. Another possibility is that the employees like the package, the fact that the price has increased, they may make some changes, but we expect that the tax will increase the cost of the policy. In that case, there is some direct excise tax payment made.

The price has gone up to the employee. Again, because it is part of the compensation package, there would be some offset in terms of by having more expense in health care, there would be less wage cash

compensation. So there would be some modest offset to the excise tax receipts from reduced income and payroll taxes.

Distributionally, as we discussed earlier, this is on the employee basis. Since plans often cover employees of many different income levels, the income inclusions or the higher premium from the excise tax would be reflected in the tax payments or premium payments of individuals of many different income levels.

Senator Hatch. In connection with the $2,500 FSA threshold, how many families would find themselves limited in the amount they wish to contribute to their flexible spending account?

I note that this threshold does not appear to be indexed for inflation and my question is is that an oversight. Given CBO inflation forecasts, how many families would be limited in their FSA funding, let us say, in five years, in 10 years?

I think it is a legitimate question, because that is a very important part of our tax code right now and I personally appreciate FSAs and I think most people do.

Mr. Barthold. Senator, as you know, the FSA proposal in the Chairman's original mark was to limit it to $2,000. In the modification, it increases that limitation to $2,500. But as you observed, in neither

the mark nor the modification does it index that threshold amount.

We don't have a very good projection on the number of families for which this would be binding. I think some of the available statistics are that it is really only about 20 percent of employees of whose employers offers the possibility of a flexible spending arrangement choose to set one up for health.

Our data is really kind of thin going beyond that. So I cannot give you much more of an answer.

Senator Hatch. I saw an estimate of 35 million Americans who use flexible spending accounts, but I do not know that that is --

Mr. Barthold. Well, the flexible spending accounts, remember, are not all health. There can be dependent care flexible spending accounts.

Senator Hatch. It is estimated that in --

Mr. Barthold. The cap on attentive care flexible spending accounts is a non-indexed cap under present policy.

Senator Hatch. It is estimated that in 2008, the average FSA participant earned approximately $55,000 per year. Many individuals use FSAs to seek the services or prescriptions for chronic conditions that require ongoing care and medical supplies.

Looking at the provision that would conform the definition of medical expenses for health savings accounts, it appears that under the mark, employees can no longer use pre-tax dollars to pay for over-the-counter medicine, such as aspirin, or any other over-the-counter medicine.

In addition, there is a proposal in the Chairman's mark to increase the penalty for nonqualified health savings account distributions to 20 percent.

Now, assuming you are in the top tax bracket, would you see up to a 55 percent tax increase on a bottle of aspirin? A 35 percent increases in taxes and 20 percent penalty is the way I look at it. Am I off on that?

Mr. Barthold. Senator, if someone were in the 35 percent tax bracket and used their HSA in a nonqualified distribution, there would be now a 20 percent penalty on that distribution.

If you say the income that was -- there is also the income inclusion. So, yes, it would be 55 percent.

Senator Hatch. Has Congress ever enacted a tax on an entire industry segment that is then allocated among the segment's companies based on their portion of the total sales and does this not introduce new kinds of complexity into the tax system?

What about predictability? Should not business

enterprises be able to reasonably compute what their tax liability should be without waiting to see how the rest of the industry segment did for the year?

Now, you answered that, in part, with Senator Kyl, I believe. But these questions, I think, are legitimate questions.

Mr. Barthold. The base question of have we imposed something like this before, I believe the Chairman stated that you saw, as a model of this, the tobacco settlement. So the tobacco settlement does allocate a certain amount of dollars as a fee on manufacturers of tobacco based on their sales.

Now, as the administrability and predictability, you are correct, it is not as precise and predictable as, for example, the cigarette excise tax of $1.01 per pack. But in practice, many of the businesses that would be subject to the tax have projections of what their sales are likely to be over the coming year.

They have projections of their market, market share. So they would have a reasonable projection of what their tax liability might be. Now, those are only projections. It is not certainty.

Senator Hatch. The tobacco settlement was a settlement with the states, not individuals, and it was not part of the tax code.

Mr. Barthold. You are correct, sir. The tobacco settlement is not part of the Internal Revenue Code, but the model of the tobacco settlement is that payments are made based upon an overall dollar value which is allocated across the manufacturers and importers of tobacco products and that is really the same kind of model that you can see in these proposals that are in the Chairman's mark.

Senator Hatch. Now, would these things be placed in the Internal Revenue Code and would the IRS be the agency that collects and enforces these fees and, if so, would these not more properly be called taxes?

Mr. Barthold. I am not the person to make a judgment of what names -- whether to call something a tax or a fee or an assessment. I can tell you, economically, we have modeled the effect of being like an excise tax.

As I think I was noting to Senator Grassley, we view it as a variable rate excise tax. The rate varies across different companies, but it is basically a tax that depends upon the amount of production or the amount of sales that you, the business, undertake during the taxable period.

Senator Hatch. It also seems to me that these fees are going to be due even if the entire segment loses money or has zero profit. Am I correct on that?

Mr. Barthold. As an excise tax, Senator, that is always the case. It is also the case, of course, for the payroll tax. The employer's share of payroll tax liabilities is due regardless of whether the employer is operating a profitable enterprise or not.

So the excise taxes on alcoholic beverages or the excise taxes are due even if the brewer, the winery or the distiller is not profitable in that year.

Senator Hatch. This set of industry fees covers four different segments of the health care industry.

Mr. Barthold. Actually, I believe the Chairman's modification strikes the clinical laboratory fee. So it is branded pharmaceuticals, medical devices, and insurance.

The Chairman. Senator, how much longer are you? We have got to get some amendments here.

Senator Hatch. Well, I have got a lot of questions.

The Chairman. Well, at some point, we are going to have to get to amendments.

Senator Hatch. Well, at some point, we ought to understand what is in this doggone bill.

The Chairman. That bill has been out there a week, Senator.

Senator Hatch. No, it has not. You have got a

conceptual bill that really does not even have the final language. It does not have a score to it.

The Chairman. This committee, as you know, Senator, you have been on this committee many, many years, only because conceptual --

Senator Hatch. I understand that we use conceptual language in this, but let us understand it is just conceptual.

The Chairman. That is what we have always done.

Senator Hatch. Well, fine. I do not have any problem with that, except it is strange compared to --

The Chairman. We are going to get to amendments pretty soon now.

Senator Hatch. You what?

The Chairman. We are going to get to amendments pretty soon.

Senator Hatch. Well, let me ask you, Mr. Chairman. Are we going to be serious about really understanding this bill or are we just going to move ahead and just roll on everybody without understanding it?

These are legitimate questions. These are not a bunch of make-work questions. And I have a pile of questions that I think we have got to have answers to before we vote on this or before we even do amendments to this conceptual bill.

Now, I am not trying to be a problem here. I think I have always cooperated, but golly, we are talking about one-sixth of the American economy and we are not going to do what we should to ask appropriate questions.

What really bothers me more than anything else is that I do not blame the CBO. They have been under the gun like you cannot believe. I have asked them to do work for the bill that we have come up with and I cannot get anything done there and to send it on time.

So I can imagine they are just inundated with this particular bill, but it is bothering me that we have to just push forward on this bill even without asking the questions that really ought to be asked.

This is a complex bill. This will be over 1,000 pages when it is done. It is going to involve somewhere between, over a 10-year period, $1.5 trillion to $2 trillion on top of our $2.4 trillion that we already spend.

It seems to me we ought to get it right. We ought to at least know what it is all about. These are our experts and they are doing a darn good job, in my opinion, of answering these questions, at least as far as I am concerned.

I certainly do not want to be a clog or obnoxious about this, but I do think these are legitimate

questions. They are questions that ought to be asked, and I have got plenty of questions that I think are legitimate, important, will help us to understand this better and may help the public to understand it better and may actually be fruitful to us if we take the time to go through them.

I know what you are trying to do and I know you have got lots of pressure on you from the White House and elsewhere, from the administration, but this is the United States Senate and this is the most important committee in the United States Senate, and we ought to look at these things seriously and we ought to be able to ask all the questions that we have if they are legitimate questions. If they are not, tell me and I will withdraw them.

But these questions I have asked here this evening are very, very important and they are on and they are a very limited part of the bill.

The Chairman. I will make a proposal Senator, a suggestion, which is let us bring up and debate some of these amendments and then we can set a time tomorrow when we vote on amendments.

Senator Hatch. Can I ask my questions tomorrow morning?

The Chairman. No, no. I will stay here all night

long while you are asking your questions of staff. I will just sit here and be here and all the staff will stay here so you can ask questions and get answers to all your questions.

I will be here as long as you want to ask questions tonight and all the staff will be here.

Senator Hatch. I would rather treat staff a little more --

The Chairman. They want to answer your questions. I know they want to answer your questions.

Senator Hatch. I think we ought to ask the questions before we vote. I think it is very, very important to do that. I think it is critical to the understanding of this issue.

If this was some itty-bitty bill, I could back off very easily on this and just say, "Look, all right, I agree." This is not some itty-bitty bill. This could wreck the country.

The Chairman. Let us do this. Let us debate the amendments and also --

Senator Hatch. Why do that before you know what in the world we are talking about?

The Chairman. Some of these amendments are on different subjects than your questions. Let us debate the amendments. Then we will be here to ask -- so we

will be able to listen to questions and answer the questions that you have.

Senator Hatch. Well, I would rather ask the questions now so that we know where we are going.

Senator Kyl. Mr. Chairman, might I just interpose a question?

The Chairman. Yes, sure.

Senator Kyl. I have a related, but separate concern. It has been hard for me to get from my staff an analysis of the mark, the substitute mark that you just filed.

We are keeping staff here for a long time. They have got to hang around here and I do not know when they have time to analyze the mark. For example, and I will mention one thing in particular, I am very intrigued by the language that is described for Senator Cantwell's amendment.

I do not understand it and my staff was not able to figure it out. I do not know whether they were able to visit with your staff yet or not. But it looks to me like it is a very thorough amendment; that is to say it is not a little thing. It is a big thing, it looks like to me, and I really think we need some time and our staff needs some time to evaluate these things.

So as you figure out the schedule here -- we work

our staff hard, they work all weekend, they work at night and so on. We may go home, but then they are expected to keep on working. So I do think we need to have some time for them to give us the advice we need.

The Chairman. Well, we will have ample opportunity tomorrow or the next day to debate Senator Cantwell's amendment. We could stay an hour, two hours on her amendment, to understand her amendment when it comes up, whenever it comes up.

Senator Kyl. And I appreciate that, but it would be nice to have some feeling of these things before the debate starts.

The Chairman. Well, I do not know when she is going to offer her amendment. I mean, she will wait for a day or two --

Senator Kyl. Well, I am not trying to pick on Senator Cantwell, of course.

Senator Cantwell. Mr. Chairman, just a clarification. I think Senator Kyl is talking about in the modification, the language that was adopted on the value index.

Senator Kyl. Correct.

Senator Cantwell. Thank you.

Senator Kyl. Yes.

The Chairman. Let me ask this, Senator Hatch. Why

do you not ask questions for maybe another 15-20 minutes? Then we will go to the amendments and we will debate those amendments and put the vote for the amendment off to tomorrow. Then we will get to the rest of your questions tonight.

Senator Hatch. Let me just say that some of my questions have to do with the amendments that are going to be called up.

The Chairman. Well, we could ask your questions when the amendment is called up.

Senator Hatch. Ask them after the amendments have been passed.

The Chairman. Not passed. The amendment is called up and you ask your questions on that amendment and we vote on that amendment that tomorrow.

Senator Schumer. He is just commenting how good you are at this, Orrin.

Senator Hatch. Well, I am glad to be called good at something, I will tell you. But let me just tell you, it is not just a matter of being good. These are tough questions.

I will do one thing before I take my 15 or 20 minutes. You had a question that you wanted to ask. I feel guilty not letting you ask your question. If you have more, I will even wait until after you ask more.

Senator Schumer. I am sure you will.

Senator Hatch. Because I recognize the importance of this body as a deliberative body, not as one that just rushes things through, especially one-sixth of the American economy.

Again, Mr. Chairman, I do not blame you. I think you have got an inordinate push from the White House and others who know that they are trying to push something on the American people that they otherwise would not be for, and I just want to make sure that the American people know what they are getting pushed on.

I will be happy to yield for the purpose of one question, two questions.

The Chairman. Senator, I am setting my own agenda. As Chairman of this committee, I am setting my own agenda. I am not going to be told --

Senator Hatch. Then this is the first time in all my time in the Senate with you, as a dear friend, where you have tried to cut off questions. I have never seen it before, never.

The Chairman. I am trying to encourage things along here. My agenda is to act fairly, expeditiously, but fairly.

Senator Hatch. Well, that has always been your way.

The Chairman. So that Senators have an opportunity to ask all their questions.

Senator Hatch. I will yield to the Senator for his two questions.

Senator Schumer. Is that all right, Mr. Chairman?

The Chairman. You bet.

Senator Schumer. Thank you.

Senator Hatch. But I want it back as soon as he is through.

Senator Schumer. I just had a question on one amendment. This deals with new physicians. Senator Nelson and I worked on an amendment that would address the critical workforce shortages.

We are going to need more doctors if we are going to have more insured people. There were two things that we wanted to do. The second and more important which I am not going to discuss now, we will debate that amendment, is adding 10,000 newly funded slots that, accordingly to researchers, are desperately needed, with a slant to having those slots go into primary care.

But the first is the pooling of unused residency positions and reallocating them to hospitals that want to create or expand their primary care programs. As I read the amendment, I do not know which staff member is in charge of this, Ms. Eisinger, the way they are

reallocated -- and it is a big, complicated formula which is sort of outcome determinative.

New York, which trains one out of every six, one out of every seven of the nation's doctors does not get any of them. The original amendment did, because it was the top 25 states. By this formula, which is -- I am not saying it is not meritorious, but you can cut the formula any way you want, and now we are cut out, as are some other states.

I was wondering what is the logic of that other than politics. Mr. Chairman, I would like to be able to work with you and the staff to correct it.

The Chairman. Do not say politics.

Senator Schumer. No. Preferences, preferences.

The Chairman. Policy.

Senator Schumer. Policy.

Ms. Eisinger. The logic was a combination of policy and dollars, actually, not politics, per se. But the amendment you are referring to is one that was filed by Senator Bingaman.

Just to step back, there are basic ways that these training slots are getting redistributed. One has to do with the amount of people living in a health professional shortage area, in a state relative to the population.

So in other words, states with more underserved

areas would be prioritized, and that is the list you are referring to, where I think New York was number 18 in terms of the number of underserved areas relative to population.

Then the other criteria had to do with the number of medical residents in training relative to population. That one, obviously, you are, I think, 50th on the list of the most medical residents.

Senator Schumer. But most of the residents go elsewhere and do medicine.

Ms. Eisinger. Right. So in terms of the Bingaman amendment, stepping back, right now, there are 1,100 unused slots in the system when you carve out certain states and certain situations.

One of the carve-outs we did, there is actually a total of 1,800 slots available, but 300 of those are slots that were not filled because in the Balanced Budget Act, there was an incentive given to certain facilities, and most of these were New York facilities, not to fill those slots, because at the time, back in 1997, there was thought to be an oversupply of physicians.

So those 300 or so slots that are primarily in New York would not be subject to this policy. In other words, they would not lose those slots. So that is the first thing. So New York is protected in that sense.

But of the pool that is left once you do these carve-outs, it is 1,100, as I said. We had hoped to be able to afford to fill all of those slots. Unfortunately, our resources were limited. We ended up spending or allocating $750 million, which would get us 900 of those 1,100 slots.

So on the first question, we did not have enough resources in the package to get all of the remaining available slots into the system. That is the first thing.

Then the Bingaman amendment, recognizing that, proposed to constrict where the slots could go to the top 10 states that had the most need. So given the interplay between limited dollars and a question between do we target it to the most need and do more or spread it thin and go further, the Bingaman amendment pushed to limit it and that was an amendment that we accepted. Clearly, this could be revisited.

Senator Schumer. Mr. Chairman, I would just ask that we be able to work with the staff and try to work something out.

The Chairman. Absolutely, absolutely.

Senator Schumer. I am finished.

Senator Conrad. Mr. Chairman?

The Chairman. Senator Conrad?

Senator Conrad. Mr. Chairman, I would just go back to the conversation you were having with Senator Hatch and I would ask Senator Hatch to accept the what seems to me a very generous offer of the Chairman, which is to allow us to proceed to amendments.

There are a number of us that have amendments pending. Allow us to debate those amendments, including any questions that you have got, and then let the rest of us go so that we can do the work that you were talking about.

We have got lots of analysis to do in preparation for tomorrow, and let you go on and answer any question that you have got of the staff. The Chairman has said he would stay here to listen to those questions.

But you going forward before we call up the amendments is holding all kinds of staff here who need to be working on preparation for tomorrow. I have been on the committee for 15 years. I have never seen a circumstance where any member just got unlimited questions. I have never seen that.

Senator Hatch. Well, have you ever seen a bill that was one-sixth of the American economy, which the Chairman described as the most important welfare bill since --

Senator Conrad. Yes, I did. I saw it with the tax

cuts in the Bush administration and I had lots of questions. It affected 100 percent of the economy and we were not given unlimited questions. You talk about a disaster for the country, that turned out to be.

The Chairman. I must add, just for the information of the committee, the 2001 tax cut bill was, I guess, a $1.3 trillion bill. We spent I do not know how many days on that, not too many days. This is a $900 billion bill.

Senator Kerry. The 1986 tax reform bill, and then we can find a few of them.

The Chairman. I agree, Senator Hatch, this is a big bill. It takes time.

Senator Hatch. It is a big bill.

The Chairman. It is complex. But this committee has not spent actually more than two days in markup for 10 years. But this is a big bill and we are just trying to find a way to find the right balance here, the balance between understanding the bill, on the one hand, and acting, on the other.

My sense is that the right balance is along the lines that we have now been discussing; namely, maybe 10 or 15 minutes more of some questions, then we get to amendments, and you can clearly ask questions on those amendments. Then we vote on those amendments tomorrow.

Senator Hatch. Well, I do not intend to keep

anybody here forever nor do I intend to ask unlimited questions.

I might add there is a difference between the tax bills and even in the current tax situation we are living under, because it sunsets in 10 years. This bill, if it passes, would be on our backsides the rest of our lives and it is going to be in a way that could be very detrimental to the country if we do not get it right.

Now, if we get it right, it could be a tremendous boom to our society. I am just interested in trying to get it right, but, look, I am not going to keep my colleagues here. But I do think that it is outrageous that we have to do this in two or three days when we have got some time to do it, and I think we ought to all be able to ask whatever questions we want to ask, certainly, within reason and I will try to be reasonable about it.

The Chairman. I appreciate that very much. Thank you, Senator.

Senator Hatch. I understand you have a tough job. I have been there, too, in a number of committees and it is difficult. But this is a very, very important bill. Once this bill becomes law, if it becomes law, and I hope that the current bill does not, we are going to be stuck with it the rest of our lives. Our children will be stuck with it, our grandchildren are going to be stuck

with it, and, in Elaine and my case, our great-grandchildren.

Let me just take a second to dissociate my Hatch coverage amendment number four from the Chairman's modified mark, where it has been grouped with the Wyden coverage amendment, C-8. My amendment is a very straightforward amendment. It is a straight strike at the new individual mandate tax proposed in this bill.

It reverts to current law, wherein the decision on this issue falls back on the state. So Massachusetts, for example, can have a mandate, but Utah does not have to because the state does not want to.

The federal government should not be in this business. It does not require the state that decline to have an individual mandate to still meet all the requirements imposed under this bill or go to a Medicaid or CHIP-like waiver process to get out of this mandate to have a state referendum.

It is simply a straight strike and simply makes it a state option with no preconditions. So I would like to dissociate my amendment C-4 from being grouped with Wyden C-8 and direct our respective staffs to work on it to reach a resolution that expresses the true intent of my amendment.

The Chairman. You want the portion that is your

amendment to be stricken.

Senator Hatch. Yes.

The Chairman. You have the right to do so, if you wanted to strike that portion.

Senator Hatch. Mine is simply a straight strike. It simply makes it state option with no preconditions.

The Chairman. Could someone on the staff who knows this subject comment? What portion?

Senator Hatch. Just to come out of the modified mark.

The Chairman. One portion of Senator Hatch's amendment is in. What would happen if we could just delete Senator Hatch's portion from the modified mark?

Ms. Fontenot. Senator, there were a number of -- I apologize. I did not want to interrupt you.

Senator Hatch. Go ahead. No, I did not want to interrupt you.

Ms. Fontenot. There were a number of amendments that were filed that dealt with state options, whether it be in terms of allowing states the option to waive the individual mandate, allowing states the option to waive the rating rules, allowing state the option to not participate in federal health care reform in some way.

One of those included an amendment from Senator Wyden that required states to file a waiver and meet

certain requirements and then would allow them, if they met certain requirements, to waive out of all the federal health care reform legislation.

So we were trying to accommodate all of the various amendments that were seeking some sort of state option with regard to how they comply with this legislation.

Senator Hatch. I understand you are diligently trying to do this. I just want to make it clear that my amendment should not be lumped with the Wyden amendment and it is a straight strike with no preconditions. As long as I can present it that way, I will be happy.

Let me just take a few more minutes on just a few more questions and then I will honor my distinguished Chairman and the rest of my colleagues on the other side, even though I have all kinds of questions that I think need to be answered.

Now, President Obama has said over and over again that no one will lose their health benefits or their current health coverage, while the Finance mark includes $113 billion in reductions for the Medicare Advantage program.

Is it not true that if these cuts go into effect, Medicare beneficiaries who have their health care coverage through Medicare Advantage plans are going to lose benefits? Does anybody want to answer that? You

are the lucky one.

Ms. Bishop. Let me see if I can answer that question. I would like to try to draw a distinction between Medicare covered benefits, which are benefits that beneficiaries are entitled to in the statute, to draw a distinction between those benefits and the extra benefits that beneficiaries have available to them through Medicare Advantage, and we tend to use the same word for both of those benefits.

We use the word "benefit," but they are really different. The one set of benefits, the covered benefits are the ones that the statute and the Congress makes available to every Medicare beneficiary no matter where they decide to get their care, whether it is in the traditional program or whether it is through Medicare Advantage.

The extra benefits that are available in Medicare Advantage are available because the law allows Medicare Advantage plans to offer them, first of all, to Medicare Advantage beneficiaries and, also, the statute provides for extra funds that are paid to Medicare Advantage plans and they use those funds to cover the costs of providing those extra benefits.

So earlier today, when there was a Q-and-A with Doug Elmendorf, the question came up about are Medicare

Advantage beneficiaries going to lose benefits under competitive bidding. We actually went back and looked at the transcript, because we wanted to make sure that we had this exactly right.

The answer is that Medicare Advantage beneficiaries are not going to lose any covered benefits under competitive bidding. It is unlawful.

Senator Hatch. My question is this. Will Medicare Advantage beneficiaries lose their current Medicare Advantage benefits? The answer has to be yes.

Ms. Bishop. I am going to go there. I am almost there.

Senator Hatch. Well, take $113 billion out of the program.

Ms. Bishop. Right. I am going to just make the distinction between they are not losing any of their Medicare covered benefits; that Medicare Advantage plans are never allowed to not cover the Medicare statutory benefits.

The $113 billion is a reduction in the extra benefits, the added additional benefits that Medicare Advantage enrollees have available to them and those benefits come in the form of vision, dental, reduced hospital deductible.

It is unstatutory, it is unlawful for any Medicare

Advantage plan to reduce the A/B covered benefits that they provide. That is by statute. They have to provide that.

They are going to have a reduction in the added benefits that they have in Medicare Advantage. So it is a reduction in benefits, but it is additional extra benefits that they have above what they are entitled to by law on the fee-for-service side.

Senator Hatch. I guess what I am getting to us under the competitive bidding model, how will Medicare Advantage beneficiaries living in rural states like Utah and Montana be impacted? Will the number of Medicare Advantage plans offered in those states be reduced once this legislation is enacted?

In addition, how will beneficiaries living in states with a high concentration of seniors participating in Medicare Advantage plans, Florida, California, Oregon, Washington, be affected by these reductions?

Ms. Bishop. Well, to be honest, CBO has provided, on a few occasions since we have been looking into this issue, they have provided some analysis. They provided the provided the letter to Senator Crapo and a letter to Senator Kyl over the last couple of months and I will just describe that, because I know that they are not at the table here.

There is distributional impacts of competitive bidding and they are going to differ by areas of the country that you just described. In areas like Montana and Utah and rural states, mainly rural states, competitive bidding is going to, to a large extent, keep the program and the number of plans relatively stable as they are today.

So there will be plans available in rural areas. In some of the rural states, there will be more dollars available for the extra benefits than there is today. So to a certain extent, competitive bidding has an advantage, if you will, in rural areas, because it makes the level of extra benefits consistent across the country.

Where there is going to be more of an effect from competitive bidding is going to be in the large urban areas where today the level of extra benefits are very high and those level of extra benefits are determined solely based on whether or not the plan can bid below an external benchmark.

So in other words, urban areas that have high levels of extra benefits today, in some areas of the country, beneficiaries receive $250 per member per month in extra benefits through the Medicare Advantage program, and those are free dollars, if you will. Those are taxpayer-

funded dollars.

In other areas of the country, in rural states, the level of extra benefits is about $25 or $30 per month. So there is a wide variation. So what we are going to do is we are going to equalize the amount of extra benefits that are available to Medicare beneficiaries. So that means there are going to be distributional impacts of those changes.

Senator Hatch. Well, I do not know how you do that and take $113 billion out. Also, competitive bidding has not worked in these rural areas.

Be that as it may, let me go to the next question, because --

Senator Schumer. Would my colleague yield? I just had a question along these lines, a serious question.

Senator Hatch. Sure.

Senator Schumer. Would it make sense -- you said they could cut the extra benefits or I suppose they could raise the premium, right?

Ms. Bishop. They could.

Senator Schumer. Which is probably the thing they are more likely to do. But would it be possible to -- Senator Nelson has been leading the charge on the grandfather and we have not been able to fully do that in the bill, although we have made efforts.

What about limiting the premium increase to a certain percent and keeping the benefits so people are not clobbered? They are paying $30 a month and it goes up to $150. Have you considered that? It is along the lines of what you are talking about, Orrin.

Ms. Bishop. I think that is a very interesting idea, because the -- but I am wondering if the potential -- there are two answers to that.

One is when you increase the amount of dollars available for extra benefits, you obviate the need for plans to charge higher premiums. So in areas where there is going to be more consistent, higher levels of extra benefits available, there is not a need for them to raise their premiums.

In urban areas, where we are going to be lowering the amount of funds available for extra benefits, in high-cost urban areas, the plans are going to be compelled, if you will, to charge a premium for those extra benefits because they are no longer going to get paid for those extra benefits from the Medicare program.

So they are going to do two things. They are going to want to reduce the amount of extra benefits that are available or they are going to want to charge a premium for those things.

Now, that already happens today in a lot of areas of

the country. A lot of beneficiaries in Medicare Advantage pay premiums for extra benefits, but it does not happen in urban areas, because the level of subsidy, if you will, of the extra benefit is very, very high.

So once competitive bidding starts to shrink the pie, there will be pressure, if you will, on the plans to raise their premiums. In an area that could be eligible for a grandfather, what we have done is the grandfather freezes the amount that is available for extra benefits. It freezes it. It does not index it.

So that it kind of holds it constant over time. That is going to reduce and, in some instances, obviate the need for those plans, plans that get to grandfather those from charging a premium, because we are holding constant the amount of money that they are going to get paid for extra benefits.

Remember, plans only charge premiums for extra benefits. They do not charge premiums to provide the A/B benefit. The Medicare program pays 100 percent of that. So they are charging premiums for extra benefits. We are going to hold that constant and there is no need for them to charge a premium.

So in a sense, even though we are grandfathering the extra benefits, it is like grandfathering premiums. It has that secondary effect of grandfathering premiums.

Senator Schumer. But there are large areas in many of our states that are not included in the grandfather here, that are 90 percent or 95 and not at 85. Some of them are urban areas. So that is why I am saying a limit on how much the premium could go up.

Ms. Bishop. Right. And you could accomplish that -- there was not an amendment to do that and that was not included in the Chairman's mark. One way to accomplish that would be to require the Secretary of HHS, when they are reviewing the bids, to deny a bid of a plan that raises their premiums by some amount.

The Chairman. Well, look at that.

Ms. Bishop. All right.

The Chairman. Just an idea, just look at it.

Senator Kerry. Mr. Chairman, could I ask a question?

The Chairman. Sure.

Senator Kerry. Could you tell me, for the $118 billion, how many people are we talking about, number one?

Number two, is there any analysis about the difference in the quality of care between those higher benefits and what you are going to reduce them to?

Ms. Bishop. Can I just pull out a table from CBO? You can see that. This is a letter that was written to

Senator Kyl on May 8, 2009. Then we actually have a more recent table. I wanted to read from that.

The Chairman. Another question. She can be looking at that if that might help, Senator, but give her time to look it up, if you have another question.

Senator Kerry. No. I just wanted to pursue that. That is fine.

The Chairman. She has it.

Senator Hatch. Have you noticed, just on this itty-bitty question here, that my colleagues had questions? You can imagine, if I could ask all my questions, how much it would, I think, really help all of us.

Now, you are a good person and I know that, but you have to --

The Chairman. We missed you in our group of six.

Senator Hatch. There are so many of these kinds of questions. You have got to admit that there are issues with competitive bidding in rural states. I think you would admit that. It is not as simple as it sounds.

Ms. Bishop. We thought about this a lot and my honest view, my honest -- as a policy analyst, my view is that competitive bidding would be good for rural areas.

That is my honest view, because they are going to get paid their bids and they are going to have more funds

available to provide extra benefits.

Senator Hatch. It has not been good in the past, I will tell you, where they have tried it. Let me just ask one more question. I do want to cooperate with my colleagues, even though I feel like we ought to be able to submit questions to somebody in the White House to answer that we do not have time to ask here, because these are important.

I have got a raft of important questions that would help us to understand this bill a lot more and maybe help us not to make a lot of mistakes that are going to cost the American taxpayers dearly.

But let me just ask this question, because it is one that concerns a lot of people in this country. I do not know who will answer this, but I will just throw it out there.

How does this mark ensure that federal taxpayer dollars would not be used to pay for abortions? Will health care plans offered through the co-op be able to include abortion services as a benefit? That is a question some people have.

How does the mark treat medical providers who do not want to offer abortions? Are they going to be treated fairly or are they going to be pushed into positions that they really cannot ethically do?

Under the Baucus language, it says -- and I do not mean to blame you for this language, except I do not know how to call it other than the Baucus language. It says, quote, "Abortion cannot be a mandated benefit as part of a minimum benefits package, except in those cases for which federal funds appropriated for the Department of Health and Human Services are permitted," unquote.

Now, as we all know, currently, the federal appropriations rider, known as the Hyde amendment, which must be renewed annually, allows only three types of abortion -- rape, incest and to save the life of the mother.

Mr. Chairman, if the fiscal year 2011 appropriations bill, for example, did not include the Hyde amendment and allowed federal funding for abortion on demand, is it not true that your bill would then also allow and, in fact, could mandate health care plans to cover abortion on demand?

The Chairman. All right.

Senator Hatch. I would like to know the answer to that.

The Chairman. I will have Ms. Henry-Spires answer that question. Before I do, though, just to remind all of us, it is my intent and I think the intent of most of us in this committee that this be a health care reform

bill and not be an abortion bill.

Senator Hatch. Fine, but that is --

The Chairman. If I may continue. That the goal here is for this committee to be neutral on that subject and to respect the status quo and, also, not allow federal funds for abortions.

Let me ask Ms. Henry-Spires to give a little more sophisticated answer.

Senator Hatch. Well, if I could just ask the last part of my question here before you do. Under the Chairman's mark, as I view it, the Secretary of HHS must ensure that each state exchange has, quote, "at least one plan that provides coverage of abortions beyond those for which federal funds appropriated for the Department of Health and Human Services are permitted," unquote.

If that state has no or few abortion providers, it would seem the coverage of abortion would be meaningless. Right? So how would this provision work for a state that has no or a small number of abortion providers?

How will the Secretary ensure that there are plans to cover abortion in those that do not?

The Chairman. Ms. Henry-Spires, could you answer that question, Deirdre?

Ms. Henry-Spires. Sure. To your first question, Senator Hatch, the language that you refer to was

stricken in the Chairman's modification. So the language that says -- and I can pull it up for you. On page 26 of the modification, it strikes the reference to the Hyde exceptions, meaning then that the Chairman's mark ensures that no federal funds -- there is no mandate for abortions by private insurance companies. It means there are no mandates for abortions by private insurance companies.

Senator Hatch. Can they do abortions?

Ms. Henry-Spires. Excuse me?

Senator Hatch. Can they do abortions beyond those three exceptions?

Ms. Henry-Spires. They are allowed to do them now under current law. Any private plan can offer abortion. Many do. Some do not. But the Chairman's mark in no way tries to make law that exceeds what is allowable under current law now.

To your second question, one that does not, the provision that says one plan must cover abortion and one plan must not, it is left to the Secretary to ensure that within an exchange, a state exchange, that there is a plan that does one of each.

However, there are some states that do not allow for the coverage of abortion in their private plans. In those states, the provision that no state law is

preempted would trump that.

So your question is -- so it leaves current law stable in states and for the federal government. Your question to how would the Secretary ensure this, the Secretary could use the free market to ensure, then FEHBP.

For the two years that abortions were permitted under FEHBP, about half the plans, 178 of them, offered abortion and the rest of them did not. So it seems that the free market manages to sort this out for itself.

However, the Secretary would also have at her disposal regional exchanges. So that you would not overstep the laws in any given state, but state are allowed to band together across territories to offer coverages that are necessary. But she is not allowed to require abortion coverage.

Senator Hatch. I guess the final thing I would like to ask about this, in addition to the ethical question that I raised, as well, whether health care people are going to have to participate in abortions.

May federal dollars be used to pay for abortions under this mark?

Ms. Henry-Spires. No, not beyond the Hyde exceptions, which you yourself brought up. So it makes no change to federal law.

Senator Hatch. What about the ethical question, though?

Ms. Henry-Spires. The ethical question, all conscience protections are left in place. Some of them are actually even extended. So Weldon, for example, is extended to include private insurers.

Before folks had providers and plans had -- well, providers, not plans, had protection, federal and state and local governments had protection, conscience protection, they could be willing to provide a service or not willing to provide a service.

This expands that to include private insurers who would be willing to provide a service or not willing to provide a service. So current law is expanded in that way. There are increased protections.

Senator Hatch. Thank you.

The Chairman. Now, is any Senator ready to offer his or her amendment?

Senator Kyl. Mr. Chairman, might I just ask one follow-up question to the staff.

The Chairman. Sure.

Senator Kyl. I am sorry, I do not know your name.

Ms. Henry-Spires. Henry-Spires.

Senator Kyl. Could you later, you do not have to do it right now, point to the language in the -- I know

it is conceptual language, not legislative language, but point me to the language in the Chairman's mark that does ensure that no federal funds here can be used to purchase abortion coverage?

Ms. Henry-Spires. Gladly.

Senator Kyl. Thank you.

The Chairman. Senator Conrad?

Senator Conrad. Mr. Chairman, I call up my amendment D-3. This amendment would expand the list of criteria for care coordination models to be tested by the CMS Innovation Center to include the following: to facilitate inpatient care, including intensive care of hospitalized Medicare beneficiaries at their local hospitals through the use of electronic monitoring by specialists, including intensivists and critical care specialists based in integrated health systems.

Colleagues and Chairman, the evidence demonstrates that the application of best practices, including the use of intensivists, application of standardized protocols and 24/7 response capability reduces cost, saves lives, and improves outcomes.

Despite these advancements, 50 percent of ICUs in the country lack intensivist coverage and less than 26 percent meet the leapfrog group standard in this area. The proposed system by Geisinger Health Systems, who came

before the committee, is to incorporate centralized monitoring of ICU beds from a command center with continuous real-time monitoring of the status of each patient, intelligence software, and real-time clinical alerts.

Adoption of this technology would allow one or two intensivists, two to three critical care nurses, and two to three clerical staff to monitor 50 to 100 ICU beds in a shift.

Implementation of this system in rural areas has resulted in significant reductions in ICU mortality, hospital mortality, ICU length of stay and hospital length of stay, as well as lowering costs in both larger and smaller community hospitals.

So I hope my colleagues would support this amendment. Again, it comes directly from the Geisinger experience that was shared by all members of the committee when the Geisinger representatives were here to testify before the committee.

It is basically to use telemedicine to link up intensive care units that do not have the most advanced specialists available 24/7 to monitor on a real-time basis the patients who are in those ICUs and the results of the application of this principle in hospitals and ICUs run by Geisinger was to reduce mortality, to reduce

length of stay, to save money, and to get better hospital outcomes.

I think it is left out of the CMS Innovation Center language perhaps inadvertently, but I think it would be unfortunate to not include it.

The Chairman. Well, Senator, I think it is a great idea. I, at least speaking for myself, have been very impressed with the Geisinger and other integrated systems in the country and, as I recall, a lot of people were part of the Geisinger system.

It is sub-rural, urban and some rural settings and some rural settings, as well. Frankly, I think this is the direction health care is headed in this country. It is more toward these kinds of integrated systems, which both cut costs and increase value, save time.

It is really astounding what they have done and it is basically because they are integrated and because their focus, therefore, is on the patient. It is care coordination and it is much more focused on the patient than some other delivery systems.

I understand this amendment has no cost and if there is not further debate on this, I see no reason why we just do not accept it.

Senator Rockefeller?

Senator Rockefeller. I support this amendment, but

I just need to -- I am going to worry a little bit about it and I am going to assume that it is going to be worked out well.

This is a very hands-on process when you are dealing with more than one individual and when you have tele-health, which I think is the future of all of this. The hands-on with multiple individuals in a state where only 4 percent of the land is flat, are we at that point yet? I am not willing to bet that we are not. So I support the amendment.

The Chairman. Great. If there is no further objection, the amendment is adopted.

Senator Kerry. Mr. Chairman?

The Chairman. Senator Kerry?

Senator Kyl. Mr. Chairman?

The Chairman. Senator Kyl?

Senator Kyl. I am sorry. I wanted to discuss this amendment, if I could.

The Chairman. I am sorry. Without objection, adopted, and gives you a chance to --

Senator Kyl. I asked Senator Conrad for a little bit more of an explanation of what he was trying to get at here and I think what he was talking about has the potential to provide a new kind of service particularly in communities where you would have either a very small

hospital or perhaps it is a rural hospital and you would not have access to the kind of people who might be available in a bigger hospital setting.

The problem that I have, and I mentioned this to him, is that it amends a provision in your mark that I think has provisions that are not adequately restricted or, to put it another way, are too broad in the authority that is given to the Secretary.

Perhaps the best way to deal with that is to seek to amend the provision more broadly, which would have an impact on what Senator Conrad is seeking to do here, but it does not go directly to what he is trying to add to the provision in your mark.

The Chairman. I would suggest those are two separate concepts.

Senator Kyl. They are.

The Chairman. I would suggest that we adopt the Conrad amendment and then later on you can offer an amendment that addresses the breadth of the concept, which would necessarily -- yes.

Senator Kyl. What I gather we will need to do is to modify language of an amendment that we have already offered or do a second degree or something.

So I would not be precluded from doing that later. I could do a second degree to Senator Conrad.

The Chairman. Well, let us not get tangled up like that.

Senator Kyl. That is fine, as long as I can do that, then.

The Chairman. Sure.

Senator Kyl. Thank you very much, appreciate it.

Senator Conrad. Mr. Chairman, might I just note -- Senator Kyl asked me, because I constructed this, in my own mind, with respect to rural areas. I represent a rural area. It is really not limited to that, because the 50 percent of ICUs that do not have intensivist coverage are not exclusively in rural areas.

They disproportionately are, but the Geisinger folks told us that our hospitals in urban settings that do not have 24/7 intensivist coverage and by telemedicine you can extend that kind of specialist care via telemedicine to those who are providing the hands-on coverage in those intensive care settings.

So I really do think it is an idea that has merit, certainly, first and foremost, for rural areas, but not exclusively.

Senator Kyl. Mr. Chairman, to be clear, it would not be my intention to try to make that distinction. I was simply inquiring of that. That is not the point of the problem that I raised.

I appreciate, Mr. Chairman, that we can get back to this at a different time.

The Chairman. So, Senator, I presume you do not object to adopting his amendment. Without objection, the amendment is adopted.

Are there further amendments?

Senator Kerry. Mr. Chairman?

Senator Kerry. Senator Kerry?

Senator Kerry. Thank you very much, Mr. Chairman. I was pleased to support that amendment. I think it is a good amendment by Senator Conrad.

Mr. Chairman, I would like to call up amendment 29, Kerry D-2. This is an amendment that is designed to ease the impact on homebound seniors of home health cuts that are proposed in the Chairman's mark.

Senator Stabenow has joined me in cosponsoring this amendment. I have some modifications to the amendment which are at the desk and I ask that those modifications might be distributed to the members.

As we all know, home health care is a key part of our health care delivery system for Medicare beneficiaries. It is cost-effective, it is high quality, and it fulfills one of the greatest desires of all patients, which is to be able to be treated at home.

Currently, over three million Medicare beneficiaries

receive home health services across the country. These are people with acute illnesses, injuries or numerous chronic conditions.

Mr. Chairman, I understand that your mark will reduce the Medicare payments to home health providers by about $43 billion over 10 years. These cuts come, I want to emphasize, through some things that we all support. They are through re-basing payments to home health agencies, providing a cap on outlier payments and instituting productivity adjustments. We want those and I respect the provisions in the mark that are targeted to improve payment accuracy.

But I am concerned that the overall impact of these reductions would negatively impact access to home health care.

So my amendment would reduce those cuts to home health agencies by about $5 billion from the $43 billion to $38 billion over a 10-year budget window and it achieves this reduction by ensuring that re-based payments to home health providers are reduced by no more than 3 percent in a given year versus the 3.5 percent that is set forward in the mark.

I believe this amendment will encourage the efficiencies that we want, while, at the same time, ensuring that Medicare beneficiaries have access to home

health care.

Home health agencies will still face significant rate cuts, far greater proportionately, incidentally, than any other provider group. But I think the amendment will help to preserve the ability of agencies to continue to serve a very vulnerable segment of the population.

I might add, Mr. Chairman, the President has promised that Medicare provider cuts will not impact Medicare beneficiaries' access to any Medicare services and I think if we did this adjustment, we would, in fact, help the President to keep that promise.

I know, Mr. Chairman, that you have worked very, very closely with the home health sector to target delivery payment reforms within the payment system. I just feel we need to do a little more to make sure that those who are homebound get the skilled nursing and the therapy services which are so critical.

So I would ask, Mr. Chairman, if we could even agree to work on this in the next days, I would certainly take a good faith effort to do that and not necessarily have to have a vote on this, if we could do that.

I do not know if Senator Stabenow wants to say anything.

Senator Stabenow. Mr. Chairman?

The Chairman. Senator Stabenow?

Senator Stabenow. Thank you. I appreciate Senator Kerry putting forward this amendment and am pleased to join him in it. We all recognize that home health care is critical both in being able to support people to have the kinds of care that they want in the community and at home and, also, in reducing costs as it relates to moving from institutional care to giving people the kind of care that they would like at home in the community and the difference in both quality and cost is measurable.

What Senator Kerry and I are doing is basically proposing to go back to the level that the President proposed when he was putting forward his recommendations on provider cutbacks, and I would hope that we would be able to remain at that level, because even at that level, I believe that is still going to cause some real challenges for home health care providers.

Certainly, I know in Michigan, there are more and more people relying on home health care providers. I think as we baby boomers are retiring, as people are living longer and are in a position where they can be at home rather than in a nursing home, it is going to become greater -- greater and greater demand will be on home health care services.

So I would hope, Mr. Chairman, that we could work with you and have this amendment adopted. Thank you.

Senator Nelson. Senator Kerry, I support your amendment.

Senator Kyl. Mr. Chairman?

The Chairman. Senator Kyl?

Senator Kyl. Thank you. Mr. Chairman, I gather it was Senator Kerry's intention to not call for a vote right now, but to discuss this later. But I have a question that pertains to this amendment and would also perhaps pertain to some others.

I gather that the reference to an offset by closing corporate tax loopholes is accompanied by something more specific than that and that there is some kind of score for this.

I am just wondering how we will deal with offsets as we proceed through this mark.

The Chairman. That is a very good question.

Senator Kerry. Mr. Chairman, first of all, it is a placeholder, but we have been informed that it scored at $5 billion.

Senator Kyl. $5 billion.

Senator Kerry. $5 billion.

Senator Kyl. And my question really is -- I gather, by placeholder, there is a specific provision in that.

Senator Kerry. There is not a specific provision

yet. That is what we want to work with the Chairman on.

Senator Kyl. I see. So the idea will be that as amendments are offered, before we vote on them, there will be a specific offset that would be identified.

Senator Kerry. Absolutely. Of course, I am awaiting the Chairman's reply to my inquiry here with respect to what we can do in the next days, in which case I would not ask for a vote at this time.

Senator Kyl. Thank you.

Senator Kerry. And consider withdrawing the amendment.

The Chairman. There are really two issues here. The first issue is the one called for by this amendment; that is, should there be a reduction. The second issue is the one raised by Senator Kyl more generally, when offsets are recommended, that we know what the offsets are, not just this amendment, but future amendments.

Clearly, it makes sense to work with Senators who would like a reduction here. It is important to remind us, though, that MedPAC has made this recommendation, that is, the cut that is in the modified mark.

I might also add the home health industry has profit margins about 16 percent, but in this mark here, based on the MedPAC recommendations, would re-base home care provider payments to improve advocacy, to perform home

health outlier payments, and, also, to cover costs of treating higher cost patients.

But the main point is clearly we will work with the Senator on his amendment, because we have got to find the right balance here between the recommended cuts and what makes sense here.

Senator Schumer. Mr. Chairman, in New York, and I am fully supportive of this, we are not even for-profit. It is visiting nurse service, Visiting Nurse Association that does all this, and they are really getting clobbered and they are not a for-profit.

The Chairman. We will work with you. The amendment is withdrawn.

Other amendments?

Senator Stabenow. Mr. Chairman?

The Chairman. Senator Stabenow? There was an order here and the order I have, which is probably dated -- you are right, Senator.

Senator Hatch, actually, if he wants to offer his amendments. He is not here at the moment. Senator Conrad, number three was -- you are right, Senator Nelson. You are next.

Senator Nelson. Thank you, Mr. Chairman. Mr. Chairman, this involves the fact that Medicare pays more for its prescription drugs than does Medicaid.

As a matter of fact, the law used to read that if you were a dual eligible, that you were eligible for Medicaid and you were also eligible for Medicare, you got your drugs at the cheaper price of Medicaid.

But that was reversed when we passed the Medicare Part D prescription drug benefit by saying, no, that the lower cost of drugs on Medicaid could not be transferred on behalf of that Medicaid eligible who was also getting Medicare. The result is that there are seven million low income seniors who are dual eligible for both Medicare and Medicaid who no longer receive drugs that were paid for by the Medicaid program at a lower negotiated rate.

Medicare now pays on the average of 30 percent more for its drugs than Medicaid. So low income seniors receive their drugs through Medicare now as a result of the prescription drug bill and, therefore, these higher prices have resulted in, in just two years, $3.7 billion more for the pharmaceutical companies.

Now, I think we ought to revert back to what the law used to be, that we should not be charging the government the higher price drugs for dual eligibles, drugs that otherwise under Medicaid we would get at the lower price.

Today, seven million low income seniors receive their drugs, they are dual eligible, seven million, they receive their drugs through Medicare Part D. They are

just one-fourth of the Medicare drug beneficiaries, but they represent one-half of Medicare drug expenses.

So what this amendment does is requires pharmaceutical companies to pay rebates on prescriptions for low income seniors, the same rebates that they pay on Medicaid folks, they will pay those same rebates for the dual eligible Medicaid recipient who is getting their drugs under Medicare and it will lower drug costs over $86 billion over 10 years.

Now, I asked earlier of Dr. Elmendorf. That price of $86 billion was the price that they had estimated to Chairman Waxman in his House committee-passed bill, $86 billion. We do not have an exact figure, as Dr. Elmendorf said, but we know he said it is going to be tens of billions of dollars.

So let me suggest to you what you can do with $86 billion, new found money. First of all, you can completely close the donut hole with it and, over and above that, you can have another $30 billion of surplus. $86 billion of revenue, what can you do with it? You can totally close the donut hole on prescription drug benefits for seniors, all seniors, not just dual eligibles, all seniors on Medicare prescription drug Part D and you can have another $30 billion left over.

Now, needless to say, this is going to be a hard

fought amendment. I do not come to this emotionally. I come to this to say that I really want to revert back to the law and what it was before.

And I will conclude with this, Mr. Chairman. I remind everybody, the law said before that if you were dual eligible, you are a low income senior, Medicaid, the Federal government, got your drugs cheaper. It said if you were dual eligible, Medicaid and also receiving Medicare, you got your drugs at that same low price, because of the discounts.

I want to revert back to what the law was before it was superseded by the prescription drug bill passed five years ago.

Senator Grassley. Well, then why do you not do it by just putting Medicare people or dual eligibles back into Medicaid then? Why do you not do it that way instead of this way?

Senator Nelson. Well, why should we when the law was that they were eligible to begin with? We expanded the benefit to them. We expanded that they could get their drugs under Medicare.

So why should they not be able, Medicaid eligible, to be able to get the lower priced drugs like they used to instead of having to pay higher prices for their drugs in Medicare Part D?

Senator Kerry. Mr. Chairman?

The Chairman. Senator Kerry?

Senator Kerry. Mr. Chairman, this is really an excellent amendment. I think it is a very important amendment and I would like to be added as a cosponsor to it.

I can remember when Part D was established and the donut hole was created and, ever since then, we have always been looking for a way to close it. This is really a common sense, fair-minded way to restore a benefit that existed for our seniors. In Medicaid, dual eligibles received a better price on drugs. Restoring this rebate and closing the donut hole would deliver savings at a time when we are struggling.

For instance, I just offered an amendment to reduce home health cuts by $5 billion. Here is an offset. We have a huge ability to do well by seniors, to do good for the overall reform effort and to be fair in the process and I think it makes all the sense in the world and I hope the colleagues will support it.

The Chairman. Senator Rockefeller?

Senator Rockefeller. Thank you, Mr. Chairman. I am a cosponsor of this and it is, in a sense, like a dream come true to me. I do not want to wax too emotional, because Senator Schumer may start sobbing.

But I have always had this incredible instinct that dual eligibles should not be treated as second class citizens. That is number one. I feel really passionately about that. I spoke up to President Bush very passionately about that.

The other thing is that every single meeting that I have had with seniors, this donut hole has always come up and I have always felt that I was inadequate in being able to respond to that question of why can you not do this, and then they would talk about the F-22 or something of this sort.

But the point is we can do it. So if you want to talk about improving services for senior citizens in America, this is the way to do it. I think they are going to be shocked and happy that you have taken a problem which they considered insoluble, which was this band, a period where they got no benefits and had to pay the premiums, nevertheless, which is patently unfair and along comes the Senator from Florida with this amendment, which I think solves this problem in a way which is fair.

Again, dual eligibles cannot be treated as second class citizens. It is not your fault if you are poor. At least in West Virginia, it is not.

I think it is an excellent amendment and it does something which I think is going to be astoundingly

popular and deservedly so for seniors.

The Chairman. Senator Stabenow?

Senator Stabenow. Thank you, Mr. Chairman. I would also ask my friend from Florida add me on as a cosponsor, as well. When the original Medicare bill passed, one of my biggest concerns was low income seniors.

We certainly do not want to take people who are low income seniors out of Medicare, but we know that when someone qualifies as a senior for Medicaid, they are probably in a nursing home, which has been the most challenging part of the prescription drug bill effort.

In talking to folks working with seniors in nursing homes, they will tell you that. One of the most challenging parts of not having a public option kick in in terms of competition under the prescription drug bill is that those who are poor seniors have not had the same kind of choice in competition as other areas.

They have gotten the worst situation, I believe. So I strongly support this. There are nearly three million Medicare Part D beneficiaries that are going to fall in this gap which we now call the donut hole this year and it will force them to spend over $4,000 for medications.

Would it not be terrific if we could indicate to those folks that they will be covered and to be able to

do it in a way that would also make sure that our poor senior citizens, most of whom are in nursing homes, will have the opportunity to go back to a system that worked so much better for them?

I am very hopeful that we will join together and support this and have the opportunity then to have some resources to address other critical parts of the bill.

The Chairman. Senator Schumer?

Senator Schumer. I would also like to be added as a cosponsor. This amendment is one of the early amendments, but it is going to show the direction we are headed. There is almost no argument against this.

If you are below a certain age, you get the Medicaid reimbursement rate. Why, if you are older and poor, do you change it simply to put money in the pharmaceutical industry's pocket.

Now, we are asking everyone to make sacrifices here. This is a huge amount of money. It closes the donut hole, something, as my colleague from West Virginia so beautifully put it, will really -- it does bring tears to one's eyes to just recall the speech.

But it will really help seniors who need it. It will create $30 billion. We are scrounging for $2 billion here, $4 billion here, $3 billion here to do all the things we want to do, and, frankly, most people would

say the so-called deal that pharma cut with whomever was pretty lenient, more lenient than just about what any other industry did.

So we hear a lot of talk here, the government is doing this. This is not the government. This is the government saving money. Which side are you on? The senior citizen who needs help saving money in this bill on one side, pharma on the other. It is hard to imagine an argument against it that could be made publicly.

So I hope we unanimously pass this amendment and show where we are. This amendment, in a certain sense, is a metaphor for where this bill is headed.

Senator Grassley. Mr. Chairman?

The Chairman. Senator Grassley? Senator Carper, you wanted to speak.

Senator Carper. Let me yield to Senator Grassley and then I will go.

Senator Grassley. Well, what do you mean, Senator Schumer, whomever cut the deal? You know who cut the deal. Do not fool anybody. We all know what pharma did. They made a deal and that deal is going to stick.

Senator Schumer. Not if we vote against it.

Senator Grassley. Pardon?

Senator Schumer. Not if we overturn it here tonight. If we overturn it here tonight, if we all vote

here for this amendment.

Senator Grassley. If it is such a good principle, Senator Nelson, it seems to me that you would want to apply Medicaid to doctors and everybody else, health care professionals. Then where are you going to get?

You cannot get anybody to take care of Medicaid people now and if you want those low rates of Medicaid, apply it across the board. You will really save a lot of money, but you are not going to have any services either. So I think that it is a poor idea.

Senator Kerry. Would the Senator yield for a question? I would ask you, is there a distinction between a service and a product?

Senator Grassley. It is a principal that you can save money because it is Medicaid. I do not know what the principal is. It does not do any good to have the product and the service kind of go together, it seems to me.

Senator Nelson. Why were you doing it before?

Senator Grassley. You understand that before, 30 percent of the senior citizens never had pharmaceuticals. Why do you think we passed the bill?

Senator Nelson. Well, the Medicaid folks certainly did and, I am telling you, we are not talking about a few people. We are talking about several million, eight

million low income seniors, Medicaid, also receive their drugs through Medicare because they are dual eligible, eight million.

Senator Kyl. Mr. Chairman, while we are just having a pause here, could I ask Senator Nelson a question? Maybe it was answered before. That is, what is the cost of this, what is the score in here?

Senator Nelson. It will produce $86 billion.

Senator Kyl. $86 billion.

Senator Nelson. That is correct. It is not a cost. It will produce $86 billion of revenue.

Senator Kyl. Because if I could--and maybe I missed this. Because this is a proposal to impose a new tax?

Senator Nelson. This is a proposal that Medicare pays less for its drugs by getting the same discount on the Medicare drugs for only dual eligibles that it gets already in discount for Medicaid recipients.

Senator Kyl. Thank you. And the method by which that is done is? Is that spelled out in your amendment?

Senator Nelson. That is correct. And this used to be the law, Senator. This was the law before the passage of the Medicare prescription drug benefit. Dual eligibles, Medicare and Medicaid dual-eligible recipients, they got the discount that Medicaid

recipients got on their drugs--

Senator Schumer. Would the Senator yield for a second? Just in reference to what Senator Kyl is getting at here, and Senator Grassley, Medicaid recipients now who are not 65 get these drugs. They just get them at a lower price. It does not really hurt the availability. It relates to what Senator Kerry was saying, difference between a service and a good, and a product.

And, furthermore, I do not believe there is any evidence that before we change the law that senior citizens suffered in any way when they got the Medicaid rate.

So this is just a win-win-win. I did not understand why we did this in the Part D bill other than to--you know, maybe there were some compromises that had to be made to win PhRMA over or something. But they did pretty well in the Part D bill, and it was sort of piling on in a certain sense.

If you believe--whatever side you are on, you are conservative, you want to save the Government money, you should be for this; if you are a liberal, you want to fill the doughnut hole or everyone wants--I do not know if that is liberal or conservative; we all want to fill the doughnut hole--you should be for this. If you want to reduce the deficit, you should be for this, because

even after you fill the doughnut hole, you have got $36 billion extra. And it does not reduce services to the recipient in any way.

The Chairman. Okay. Senator Kyl is--

Senator Snowe. Mr. Chairman, I just would like to ask a question of the sponsor, Senator Nelson. Does this take into account the 50-percent reduction in the doughnut hole on brand-name drugs as a result of the agreement with the pharmaceuticals?

Senator Nelson. No, ma'am.

Senator Snowe. It does not. So this is in addition to that.

The Chairman. That is my understanding.

Senator Kyl?

Senator Kyl. Mr. Chairman, just a question maybe to staff, maybe to Joint Tax. I am not sure. Maybe CBO would be the one. Is there an understanding of whether or not the cost--I presume this is paid for by a cost shift to private insurance, and I am just wondering if there is any analysis of that by staff. Money has to come from somewhere. It does not come out of--

Senator Grassley. It is going to raise prices for people--

Senator Kerry. It comes from the drug industry.

Senator Grassley. It is going to raise prices for

people with private insurance.

Senator Kyl. Yes. Thank you.

Senator Grassley. It is going to raise prices on early retirees. It is going to raise prices on children. It is going to mean higher prices for people that are fighting cancer.

Senator Kyl. The money has to come from somewhere.

Senator Grassley. Absolutely. There is no free lunch. But these people talk like there is a free lunch.

Senator Kyl. So presumably the private sector would have to charge that to the private sector patients that already have insurance.

Senator Grassley. Of course. We discussed this 3 years ago with a Yale professor named Dr. Morton, and she told us--this is her quote: "Tying the price of a large government customer to a reference price is poor policy because the effect on government sales is so large, the firm prefers to distort its choices for the rest of the market."

Senator Kyl. Meaning cost shifting.

Senator Grassley. Yes.

The Chairman. Wait, slow down here. Senator Carper sought recognition some time ago.

Senator Carper. Thanks very much. A question, if I could, for staff. Let me kind of go back in time. I

am trying to recall the Medicare Part D debate. My recollection when we were debating Part D, the prescription drug program under Medicare, is we said that for folks who signed up for the Medicare Part D program, the first $2,000 of prescriptions that they bought in a particular year, they roughly paid for maybe a quarter of the cost of that, and Medicare bore the cost for the other 75 percent. I think that is correct. But once their purchases exceeded roughly $2,000, most seniors had to bear up until maybe $5,000 in annual purchases, between $2,000 and $5,000, seniors for the most part bore all of those costs.

And then when a person's purchases, a senior citizen's purchases exceeded $5,000, my recollection is that Medicare picked up maybe 90 percent of the cost, something like that. And except if the person was low income, and if the senior participating in the Part D program is low income, I do not think they had to bear the first 25 percent of the cost. I think they got a pretty good deal, in the first 25 percent up to $2,000.

As I recall, the low-income Medicare Part D participants did not fall into the doughnut hole. They basically got a pretty good deal right through the doughnut hole up to $5,000, and at $5,000 Medicare picks up 90 percent of the cost.

Let me just ask staff, do I have that right?

Senator Grassley. 95 percent.

Senator Carper. Is it 95 percent? Basically is that the right--

Ms. Bishop. Yes, that is correct. We have folks here from CMS, too, if you want to be more precise, but that is basically right. And those levels have changed over time because they have been indexed. But basically that is right. There is the low-income subsidy folks. The folks who are dual eligible, who are eligible for Medicare and Medicaid, have larger subsidies than folks who are not on those programs, so they do not pay the full price in the doughnut hole.

Senator Carper. Okay. When I have described this program to folks back in Delaware, over the last 4 or 5 years, I have said if you happen to not use somewhere between $2,000 and $5,000 worth of medicines a year, if you are below $2,000 or over $5,000, it is actually a pretty good deal, the Medicare Part D program. If you happen to be fairly low income, it happens to be a pretty good deal as well. If you are not low income and you do not use more than $5,000, but use somewhere between the $2,000 and $5,000, it is maybe not such a great deal, but it could be okay for you.

So I just want to set that premise. The program is

set up to actually treat low-income seniors very favorably. I just kind of want to put that on the record.

The second point I would like to make in this regard is I was not involved in negotiations with PhRMA, but I believe that the administration was, obviously PhRMA was, and I presume this Committee was involved in some way in those negotiations. And what PhRMA agreed to do through those negotiations is to pay about $80 billion over 10 years to help fill up half the doughnut hole. That is my understanding. And they are prepared to go forward and to honor that commitment.

As I understand it, the amendment from our colleague Senator Nelson would basically double what was negotiated with PhRMA, and whether you like PhRMA or not--we talked earlier today in our opening statements, I talked about four core values and one of those is the Golden Rule: Treat other people the way I want to be treated. I tell you, if somebody negotiated a deal with me and I agreed to put up, let us say, $80 or $80 million or $80 billion, and then you came back and said to me a couple of weeks later, Oh, no, no, I know you agreed to do $80 billion, and I know you are willing to help support through an advertising campaign this particular--not even this particular bill, just the idea of generic health care

reform, no, we are going to double what you agreed in those negotiations to do, that is not the way--that is not what I consider treating people the way I would want to be treated. That just does not seem right to me. And whether you like PhRMA or not, we have a deal. I think they are willing to abide by the deal. They are willing to put up their money. They are willing to put up their money to help encourage people in this country to support health care reform. And now we are going to say we want to double the amount you committed to contribute? That just does not seem fair.

Senator Stabenow. Mr. Chairman?

The Chairman. Senator Stabenow.

Senator Stabenow. Thank you, Mr. Chairman.

There are a lot of ways why I hope this bill will be fair when we get done, and I am not going to debate the larger Medicare prescription drug bill right now, which we could. But I think the way I would look at this really is that if this saves $86 billion, then that means that prior to the Medicare prescription drug bill passing, the poorest seniors in the country over a 10-year period were paying $86 billion less. That is what that means. They already had good coverage, with all due respect; they were the ones who were already being covered under Medicaid. They went into a different

system that has increased those costs $86 billion.

They were not the ones originally that we were focusing on in terms of needing help with prescription drugs. They already had help through Medicaid.

So my concern is I guess I would view this as returning to where we were before with the poorest seniors in the country who were paying $86 billion less before this bill passed over a 10-year period. I do not see any rationale for continuing to charge them $86 billion more when we can take those dollars and put them into other areas of increasing services for people.

I would really, I would strongly support the Nelson and others' amendment in which I am very pleased to join, and hopefully we will be able to use those resources in a way that will actually expand more coverage for people.

The Chairman. Senator Schumer?

Senator Schumer. Yes, just two quick points. To Tom, if you think the original deal was fair, yes, you should not break it. But it is not unfair--I was not at the table. None of us were at the table. And if you think the deal was too fair to PhRMA and not fair enough to citizens, there is nothing unfair about breaking it. That is a value judgment.

And the only other thing I would say, Mr. Chairman, this is going to be a constant debate when we come to

this bill, and it is a difficult--I do not disagree. It is a difficult balance. But how often do we side with one of the interest groups? And some of those interest groups could be interest groups Democrats like; some of them could be interest groups Republicans like. And how often do we side with the average citizen? And the further away we get from siding with the average citizen, the less good this bill is going to be for the people.

Senator Grassley. If this is a bad deal, you ought to be embarrassed for your President for sitting down with these folks. It did not come from anybody on this side making that sort of a deal?

Senator Kerry. Mr. Chairman?

The Chairman. Senator Kerry.

Senator Kerry. I do not know if the President personally sat down with them or if the White House staff did.

Senator Grassley. Well, the President had the new conference with them.

Senator Kerry. I understand, but the Congress is the Congress, and we do not have to abide by every single decision that has been made. And the people who head up PhRMA understand that, particularly their chief lobbyist used to be a Chairman up here. He understands that.

Congress has the right and the ability to make a

different decision. I listened to the explanation a few minutes ago about the subsidy process, and Senator Nelson talked about how they get a fairly good deal. You know who pays for that deal? The taxpayers. The taxpayers are paying for that. The taxpayers are covering the difference because PhRMA will not.

Now, hospitals are taking a $155 billion cut here. A $155 billion out of the hospitals, and we are quibbling about $80 billion out of PhRMA? Please. PhRMA sets the price. PhRMA says we are going to give you a 50-percent deduction. Well, they set the price. They could raise the price and give you a 50-percent deduction and still walk off with enormous sums of money.

Look at all those advertisements on television today. It is stunning, which is another mistake that was made a number of years ago.

Doctors will tell you that advertisements are driving the cost of health care because people come in and say, "I saw this on TV. You have got to give me this." And they are all afraid to say no.

So PhRMA is driving a lot of these costs in a lot of ways that are not even fully measured here. And I think it is entirely appropriate for us to question going back to a law that was more fair. These are dual-eligible people who once upon a time had the benefit of this lower

cost. It was taken away from them and entirely went into the pockets of PhRMA. It did not come to the Government. It did not pay for some additional care. It did not pay for another benefit. It went to PhRMA.

The President, incidentally, sent a message to the Congress recently saying he wants to close the doughnut hole. Well, here we have an opportunity to close the doughnut hole, provide a lower price, and I think wind up with a much more fair allocation of the pain that has got to be shared in this effort to try to reduce the costs.

So, you know, Mr. Chairman, we are not talking about private insurance, as Senator Grassley said. Children would not be adversely affected by this policy. Children do not manufacture the drugs, and private insurance companies do not manufacture the drugs. PhRMA manufactures them, and PhRMA sells them, and PhRMA sets the price. And if they decide to pass it on, that is because we have not set up a structure that fairly protects people. And what this amendment by Senator Nelson seeks to do is protect people. And I think it is appropriate.

The Chairman. Senator Carper?

Senator Carper. Mr. Chairman, again, another question for staff. Help me on this if you will. The question is--and it is a reasonable question that Senator

Kerry suggests. What is a fair contribution by PhRMA, if you will, to this agreement? And the administration negotiated, I think with involvement by our Committee, $80 billion over 10 years. And the hospitals have negotiated--what is it, $150 billion? Is that it?--over the same period of time.

I do not recall exactly what--when you look at the total amount of money that we are spending for health care in this country, what percentage can be attributed to pharmaceuticals, for some reason I think that it is 10 percent or so. Is it a little less than 10? Right around 10? People are nodding their heads, about 10 percent.

Ms. Bishop. Of medical expenditures, not of total expenditures in the U.S. but of medical expenditures.

Senator Carper. So 10 percent. And if you look at hospital expenditures as a percentage, if you can give me apples to apples to apples, what would hospitals be? Is it 10 percent? Is it less than 10 percent? Is it more than 10 percent?

Mr. Clapsis. I would double check, but we think it is around 30 or 40 percent.

Senator Carper. It is 30 or 40 percent for hospitals? So we are saying--well, we will say it is 35 percent then, 35 percent for hospitals, roughly 10

percent for pharmaceuticals. Pharmaceuticals are asked to give $80 billion to make this deal work, and hospitals $150 billion.

Now, when I look at 35 percent versus 10 percent, that is three and a half times more. And when I look at $150 billion to $80 billion, that is less than 2:1. The argument here, if we are going to try to do something that is comparable between what the hospitals are donating, are giving, and what PhRMA is, under that agreement either the hospitals should be doing close to--I think close to about $250 billion, or maybe closer to $300 billion, and PhRMA should be doing maybe less. That is the logical conclusion that one would get to.

Let me just ask the staff. Am I totally off base here? If you have got the hospitals--let me just finish. If you have got the hospitals, they are 35 percent of the cost, and they only have to contribute $150 billion, and PhRMA is about 10 percent and they have to contribute $80 billion--

Senator Kerry. Would the Senator yield just for a moment? Isn't there a distinction, though, that a lot of teaching hospitals and children's hospitals are not-for-profit? That is a very different animal from a for-profit company.

Senator Nelson. If the Senator would yield--

Senator Kerry. It is just a huge distinction.

Senator Nelson. I will ask the staff in that answer that you provide to talk about profit margins, hospital profit margins and the pharmaceutical industry profit margins.

Mr. Clapsis. Sure, Senator, certainly a lot of perspectives, I think, and ways to approach the issue.

In terms of hospitals, I think one of the sensitivities is around their margins, specifically Medicare margins. MedPAC has found over the last few years that Medicare margins are typically negative, so obviously you approach, I think, hospital reimbursement with some trepidation.

On the flip side, hospitals are probably the industry that has the most to gain out of health care reform broadly, and just to give you the context, sometimes about 15 to 20 percent of hospital revenues go towards their uncompensated care costs. This is a combination of bad debt, things they write off, the free care that hospitals actually give away.

So if you look out over the next 10 years and look at some of the AHA data, it suggests hospitals have possibly $300 or $400 billion in uncompensated care costs that they are going to see. So, clearly, reform for a hospital is a very different equation than almost any

other industry sector because there is such a significant benefit from having that uncompensated care cost--so, again, not getting paid anything, and now actually getting revenue for those uninsured patients that they did not get before.

So that is why hospitals, I think, are a little bit different, negative Medicare margins, but the flip side, they have a significant benefit coming from reform, and I think those are just some of the factors you have to look at, I think, when you are looking at the hospital side.

Senator Schumer. What percentage of hospitals are nonprofit? And then what percentage of PhRMA is nonprofit?

[Laughter.]

Mr. Clapsis. A little more than half of hospitals are nonprofit.

Senator Grassley. And every hospital in the State of Iowa is a nonprofit.

Senator Schumer. And they are now in the red--overall, hospitals are in the red. They are losing money. Is that right? What is their profit margin?

Mr. Clapsis. I think MedPAC's data--and I think Mark Miller is still here--suggests their Medicare margins are negative, but not necessarily hospitals' overall margins.

Senator Schumer. I think in my State 85 percent of the hospitals are in the red.

Mr. Miller. The overall Medicare margin for hospitals is about negative 6. The overall margin across all payers is about positive 4 or positive 5.

Senator Schumer. And what is PhRMA?

Mr. Miller. I have no idea.

Senator Schumer. I think it is like 15 or 18. I do not know. I think it is about that.

The Chairman. Senator Rockefeller?

Senator Rockefeller. Mr. Chairman, this is a stunning argument that we are listening to here. Let me say something which may seem a bit odd.

I remember when George Mitchell was Leader in the Senate, and we had the majority, and President Clinton had just been elected. And President Clinton typically came to our caucus thinking that he kind of belonged there, you know. And George Mitchell said, "Mr. President, we respect your office greatly. There are times when the executive branch is fully in control. There are times when the legislative branch needs to do its policy discussions." And we had this rather extraordinary sight of the President of the United States and the Secret Service being ushered out of the Democratic Caucus.

Now, why do I make that point? I make that point because you were talking about a deal. I am talking about a deal, too. You are talking about a deal that we made with pharmaceuticals--we, somebody, made with pharmaceuticals, primarily the executive. And I am talking about a deal that we failed to make, promised to make and then failed to make with the senior citizens of the United States of America on the doughnut hole. A painful deal in which 8 million of them, at least, have to cough up between $2,700 and $5,800, whatever that span is, over a period of months, they have to cough up enormous sums of money in premiums while they are receiving nothing in the way of coverage.

Now, that is a deal, too. That is a deal with real people. And you are talking about a deal--this is not a nonprofit thing for them. This is a huge loss for them, for the seniors, 8 million of them.

PhRMA is an association of companies that make a lot of money. They invest in clinical trials and with research institutes, and then they will pull out of them when they realize they are not going to bear fruit. That is part of the way they do deals. So there is nothing sacred about that deal.

There is something sacred about the deal that we thought we were going to make and did not make, did not

honor our original commitment to seniors on the doughnut hole.

Now, people feel good because we have done half of that. Well, that is fine, but there are still 8 million people out there having to pay premiums when they are getting no services, no benefits, nothing. Nothing.

I just think it is one of the most one-sided--you are worried about the deal with the pharmaceuticals. Well, I mean, there may come a day when I am, too, but it is not going to be when it is compared to 8 million seniors and the doughnut hole that has not been filled up, and they are doing something which ought to be illegal in this country: paying premiums when they are receiving no services, which is the opposite of everything that we do in this country.

So I think it is a very good amendment, and it keeps Medicare honest, and it does right by dual eligibles. And I do not know what this comparison between the deal with pharmaceuticals and the deal with 8 million Americans--it is just not a close argument.

Senator Nelson. Senator Rockefeller, it is a deal with 44 million Americans in Medicare Part D prescription drug benefit. That will fill the doughnut hole not just for the dual eligibles; it will be enough money to fill the doughnut hole for the entire Medicare prescription

drug benefit D.

Senator Rockefeller. So it is a much bigger deal.

Senator Nelson. Forty-four million.

Senator Grassley. What do you mean? Twelve percent of the 44 million. Twelve percent of the 44 million.

Senator Nelson. No.

Senator Grassley. Twelve percent are in the doughnut hole.

Senator Nelson. I take it that you tend to disagree with my numbers.

[Laughter.]

Senator Grassley. There are 44 million people on Medicare. There is 12 percent that are in the doughnut hole. And none of the dual eligibles are in the doughnut hole, because they do not have a doughnut hole.

Senator Nelson. The government is paying more for their drugs. They are paying at rates that are offered higher under Medicare than what they used to have as dual eligibles where they were paying lower rates because of greater rebates under Medicaid.

Now, the facts are the facts. You can disagree, most agreeably, Senator, but the facts are the facts. This is reverting to what the law used to be before it was changed under the prescription drug bill that was

passed about 5 years ago.

The Chairman. Okay. I think we have had a good debate here. We will vote on this amendment tomorrow, and I am wondering--we have had a good debate here. We will vote on this tomorrow, and I am wondering if any other Senators have other amendments they wish to offer. Maybe they can offer and we can accept.

Senator Stabenow?

Senator Stabenow. Mr. Chairman, I like that possibility. Thank you, Mr. Chairman.

Mr. Chairman, to change the debate just a little bit, one of the very positive things in the bill is moving towards primary care, and--or let me say first I would call up amendment D-7 to Chairman's mark.

In the legislation, we are moving towards primary care to move people out of emergency rooms. We provide a 10-percent bonus for primary care doctors, which is a very positive step forward in moving people from emergency rooms and encouraging more primary care doctors and more people having the opportunity to see their family doctor.

But before we get to that system, we are still confronted over the next few years, between now and 2014, with the fact that our emergency rooms are dramatically overcrowded, and we are having difficulty in finding on-

call specialists to serve in the emergency rooms right now.

And so this particular amendment, for the period until we get the exchange up and going and until we are fully focused on primary care, would give a 5-percent Medicare reimbursement bonus for emergency room physicians and on-call specialists that are performing services in an emergency room.

Mr. Chairman, I would reference a GAO report commissioned by yourself that was released in June. GAO found that patients in need of immediate care between 1 minute or 14 minutes time frame response waited an average of 28 minutes and exceeded the recommended wait almost 75 percent of the time.

The report cited a lack of inpatient beds as the largest contributor to overcrowded emergency rooms and, of course, inadequate access to primary care was also a factor.

I am very pleased that in the HELP bill they included a version of another amendment that I will not offer today that would establish guidelines for critical issues such as boarding that are overcrowding our emergency rooms, and I am going to work very hard, Mr. Chairman, and I want to work with you when the two bills are merged to take this provision from the HELP Committee

and put it into the final bill.

One of the other issues identified by a report by the respected Institute of Medicine is that we have a lack of specialists right now that are willing to be on call in emergency rooms. Specifically, the IOM noted that one of the most troubling trends is the increasing difficulty of finding specialists to take emergency calls, providing emergency calls become unattractive in many specialties, including neurosurgery, orthopedics. Specialists have difficulty collecting payment for on-call services, in part because many emergency and trauma patients are uninsured. Nearly 80 percent of specialists in one survey had difficulty obtaining payment for those services.

And so, Mr. Chairman, my goal would be to just recognize between now and when we, in fact, have an exchange running and a focus on primary care, during this short window to allow some ability to provide relief to emergency rooms, emergency room physicians, and address what is currently a crisis, as we all know, in our emergency rooms, help them get through this period until health care reform takes effect.

The Chairman. Well, I appreciate that, Senator. You make some good points. Clearly, the goal here is to encourage people not to go to emergency rooms, but have

the insured see maybe an internist or primary care doctor, and there is such a shortage of primary care doctors.

On the other hand, there is generally a significant workforce shortage in this country, including specialists to provide emergency care. I think you have a good idea here. Let us see if we can work something out here. Let us see what we can do.

Senator Stabenow. Thank you, Mr. Chairman. I would just emphasize again, this is a stop-gap to get us to the point where hopefully the goals of the bill will be able to be realized in terms of increased primary care. But we have a serious crisis occurring in emergency rooms across the country right now.

The Chairman. Okay. I do not see any more Senators seeking recognition to offer amendments. This has been a good first day, a good, productive day for amendments, and I thank all staff and everyone else who has been here for working so diligently here today.

We will continue tomorrow, and the Committee will recess until 9:30 tomorrow morning.

[Whereupon, at 9:55 p.m., the Committee was adjourned, to reconvene Wednesday, September 22, 2009, at 9:30 a.m.]

I N D E X