EXECUTIVE COMMITTEE MEETING TO CONSIDER
HEALTH CARE REFORM
TUESDAY, SEPTEMBER 29, 2009
U.S. Senate,
Committee on Finance,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:13 a.m., in room 216, Hart Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Rockefeller, Conrad, Bingaman, Kerry, Lincoln, 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; Elizabeth Fowler, Senior Counsel to the Chairman and Chief Health Counsel; Andrew Hu, Health Research Assistant; Alan Cohen, Senior Budget Analyst; Cathy Koch, Chief Tax Counsel; Scott Mulhauser, Senior Advisor and Counsel; Kelly Whitener, Fellow; Russ Sullivan, Staff Director; and Chris Dawe, Professional Staff. Republican Staff: Mark Hayes, Republican Health Policy Director and Chief Health Counsel; Andrew McKechnie, Health Policy Advisor; James Lyons, Tax Counsel; Becky Shipp, Health Policy Advisor; Rodney Whitlock, Health Policy Advisor; Sue

Walden, Health Policy Advisor; and Kolan Davis, Staff Director and Chief Counsel.

Also present: Josh Levasseur, Deputy Chief Clerk and Historian; Athena Schritz, Archivist; Neleen Eisinger, Professional Staff; Yvette Fontenot, Professional Staff; Thomas Barthold, Chief of Staff of the Joint Committee on Taxation; David Schwartz, Professional Staff; Tony Clapsis, Professional Staff; and Tony Reeder, Senior Benefits Counsel.

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

The Chairman. The Committee will come to order.

Today is our fifth day of consideration of America's Healthy Future Act. It has been 15 years since this Committee has held a markup that took 5 days. The last one was over the WTO in 1994. Since then, we have held more than 150 markups, and most of those took 1 or 2 days. So we are clearly giving this bill the due consideration that it deserves. So far we have considered 60 amendments.

As discussed on Friday, this morning the pending amendment is Senator Grassley's amendment on the Geographic Practice Cost Indices, what some call "the GPCI." I believe that we are close to a compromise that many, if not all, Senators may be able to support.

After that, as we also discussed on Friday, I hope that we can address the public option this morning. I would propose we first consider Senator Rockefeller's public option amendment. Next we would consider Senator Schumer's public option amendment.

For the information of Senators, there is a vote at 5:30 and a dinner between 6:30 and 7:30. I thus expect that the Committee will break for dinner between 5:45 and

7:15 and then return thereafter.

I now recognize Senator Grassley.

Senator Grassley. This is an amendment that I was going to offer late one evening last week, and it was trying to find some middle ground. The issue is this-- and then I think because we do not have final CBO scores, Mr. Chairman, we should delay it until we get the final CBO scores because people ought to know what they are doing, because this is something that is very important to rural America.

I have heard the Senator from Montana, I have heard the Senator from North Dakota, I presume there have been other Senators that have said that their States are near the bottom in reimbursement on things dealing with formulas for reimbursement for doctors. And so it is very difficult to recruit doctors. It is very difficult to have adequate particularly primary health providers, primary doctors in rural America. Recruiting is very difficult. Maintaining is very difficult.

And so what we have tried to do through my amendment is to bring some equity to formulas that probably are outdated because they are based upon 1960 figures or they are based upon issues within CMS not having an adequate database for making some determinations for reimbursement, et cetera, et cetera.

So, originally, I crafted an amendment that would have probably hurt some areas of the country like New Jersey, New York--well, I should not say "hurt," but would not have helped them the extent to which they saw it helping urban--or rural America. So we have tried to work on a compromise through the various Senators involved for a hold-harmless. And we are just now waiting to see how those are scored, and then I think we would be able to move ahead, hopefully in a non-controversial way.

The Chairman. Senator, that is right. First of all, I thank you very much. I very much appreciate the amendment you offered because I think it is true that rural parts of America are discriminated against when it comes to the geographic formula with respect to physician's practice in different parts of the country--physician's practice, that is, we in rural America are not given our due as the GPCI formula is currently calculated.

We worked out an agreement, though, with some other States who fear that they may be cut too much under this formula--under your amendment, that is, and so as you know, the compromise is to basically hold harmless those States that otherwise would see a reduction so that the rural States get a fair increase. But the question was:

Then what happens afterwards when--I guess it is the Secretary and/or CBO--I have forgotten which--does a study and tries to make sure that the formula is implemented with due consideration to rural America as well as urban America. And the next question is: What is the default if the Secretary does not implement the results of that? As you quite properly are concerned, without a default, nothing would change, that the current discrimination might continue. That is after the 2-year period.

So we are trying to get a score on your amendment, and as is this Committee's practice, certainly in consideration of this bill, if something is--if a provision is going to score, it is ruled out of order. It is not germane. And if there is no score, but it clearly scores, that same result would occur. I was obviously trying to avoid that trying to reach a compromise here, and so I think it just makes sense to, again, defer it until we figure out what the scoring might be and what an offset might be and how we work this out. I thank you very much for working this out.

Our next order of business is to recognize Senator Rockefeller for the purpose of offering his amendment.

Senator Rockefeller. Thank you, Mr. Chairman, very much. I am going to offer this amendment and I hope very

much that it will be considered for what it is and, that is, practical and important and probably saving around $50 billion.

It is interesting about the public option because people assume that it is some kind of a Government takeover. Those are mostly people that have an ideological bent against it. And it is not. It is optional. It has been said before, you say again, people can get into it, can get out of it. It is in the exchange. It has the same benefits as others. It can increase their benefits, decrease their benefits, but they are nonprofit so they have no money to make and, therefore, premiums will go down, which will have a good effect in encouraging others in the private insurance market to bring their premiums down.

Seventy percent of the American people want this. In a study done of doctors, I think you can say at least 70 percent of doctors, all that I talked to over the weekend, want this. Doctors are the ones who are most intimately involved with the health care system and with the paperwork and with insurance companies. And you would guess that doctors would not want to change the status quo. Wrong. They want this public option. So if we do not hear, you know, we are going against the will of the American people and of the medical community.

But we need this option because our insurance companies have failed to meet their obligations in this whole matter of how do you unroll health care reform. The insurance companies in my judgment are determined to protect their profits and put their customers second. It is a harsh statement but a true statement. When this happens, families win if we get a public option, drive down the cost of health insurance, some yes, some no. It will depend on how they react. And they get to keep more of their hard-earned money, and they get to spend some of it on health care, which is sort of the point of all of this.

I know supporters of the status quo are saying that it is simply, again, a Government takeover, but let me set the record straight once and forever. This will be optional. Nobody has to do this. The estimates are that only about 5 percent or less of the American people will leave their health care insurance that they now have and go into it. But health insurance--and this will come up in some of my questioning--is making so much money off of this mark. They are getting so many subsidies under this mark in order to entice more people to get health care. And if they do, then they will raise their premiums, and the cycle that has always been true will go on.

Now, it is voluntary. It would simply guarantee

that there is at least one health insurance plan in the exchange, like everybody else, that ordinary Americans can afford and can count on to have more moderate premiums and yet the same benefits, or perhaps more. We will see. It is stable. It is affordable. I believe it saves $50 billion--that is a lot of money--for the Federal Government. It saves it for the Federal Government. It is not a lot of money for the Federal Government, but it is a lot when it saves that much for the Federal Government. And I think it acts as a counterweight to the way I would characterize health insurance companies--and I love to use the word "rapacious" because I think it is precise and on the mark.

Really, it is sort of a question of why would we not do this, because if we do not do it, what we are doing is saying go ahead, health insurance companies, and make more profits. That is the result. And we are saying that somehow people and their problems--which those are the folks who elect us, and they are having a lot of problems with health insurance--that they somehow do not count as much. So people come second and the profits come first if we are against this, in my judgment.

So I think it is a real solution to protect American families and their economic security, and I think the

public option does just that.

Mr. Chairman, with your approval or permission, I would like to ask some questions.

The Chairman. I think that would be a good idea. Go ahead.

Senator Rockefeller. Okay. This first one is to Ms. Fontenot, the victim of all questions. In testimony before the House Democratic Steering and Policy Committee on September 16th, former CIGNA executive Wendell Potter, who had worked for CIGNA for 20 years as a top executive, warned that if Congress "fails to create a public insurance option to compete with the private insurers, the bill it sends to the President might as well be called"--and these are his words--"the Insurance Industry Profit Protection and Enhancement Act."

Now, Ms. Fontenot, as you know, the insurance companies have seen their profits soar to over 400 percent since 2001 while premiums to consumers have doubled. It seems to me that the message of shared responsibility--we are asking everybody to give a little something up here. And I think it applies to every relevant health care group except insurers. And I do not understand that. I do not understand why we would make that public policy.

I would like for you to talk me through how this

works in the bills, so I have got these questions.

How are insurance companies sharing in the responsibility of comprehensive health care reform under the mark? Please provide the specific ways insurance companies are sharing responsibility for the cost of reform, like everybody else is. That is question number one.

Ms. Fontenot. Senator, the civic contribution that the insurance industry has agreed to make to the mark is approximately $20 billion in reinsurance funding to alleviate any rate shock that we will see from the new rating rules that are being put into place. That is the only specific contribution that insurance companies are making to the mark.

Senator Rockefeller. Okay. I appreciate that.

The second question would be both to you, Ms. Fontenot, and to David Schwartz. Historically, the insurance industry represents--or responds to laws to help consumers by drastically raising premiums. That has been their habit. They are under the radar. They can get away with it. People do not really know how they operate, and they pay their premiums.

To make up for new coverage or benefit requirements at the State or Federal level, insurance companies raise their premiums substantially to cover the cost of any

future medical care, because they have to do that in their minds. They have to look to the future and predict dire consequences in the future. In some cases, the premiums are so high that the coverage is unaffordable, which is a major problem.

So one can easily see where this is headed in anticipation of the necessary insurance market reforms included in the mark: no pre-existing conditions exclusions, no annual lifetime limits, no rescissions--all good stuff. Insurance companies are going to raise consumers' premiums substantially, in my judgment, because they are confronted with a new set of restraints, and they are going to have to react to that in their traditional manner.

Not only are insurance companies going to raise premiums, they are also going to raise premiums in each year after the 2013 passage of, you know--this year and then after 2013.

Now, my question to you and to Mr. Schwartz is: How much funding does the mark include for subsidies for individuals to purchase private insurance coverage? And, Mr. Schwartz, I am including you in this question because I also want to know how much of the subsidies for the purchase of private insurance are for individuals who would otherwise be eligible for Medicare or CHIP?

Ms. Fontenot. Senator, according to the CBO score of the mark, the amount devoted to tax credits in the exchange is approximately $463 billion over the 10-year period.

Senator Rockefeller. So their contribution is $20 billion. That is what they are doing to share. But what they get in subsidies to help them is $463 billion, and that is over the 10-year budget window, and I agree with you on that.

Actually, putting CHIP into the exchange and providing CHIP-eligible populations premium subsidies for private coverage will cost an additional $20 billion, so couldn't it be fairly said that it is $503 billion, over half a trillion?

Ms. Fontenot. Senator, are you referring to the difference in cost between putting those individuals in Medicaid versus putting them on an exchange?

Senator Rockefeller. Yes.

Ms. Fontenot. I believe it is approximately $20 billion.

Senator Rockefeller. That is over half a trillion in subsidies for private health insurance companies. So under this bill, as a follow-up, nearly half a trillion dollars in premiums, I believe, would go directly to the pockets of insurance companies on Wall Street. How much

of this nearly half a trillion dollars does the Finance bill require private insurance to spend on actual medical care? Because that is sort of the point of premiums, so that you can spend money on premium care and make a modest profit, a necessary profit. So how much of this requires them to spend this half-trillion-plus on medical care?

Ms. Fontenot. The mark requires insurers to report the amount that they are spending on medical care versus administrative costs. According to a letter from the Congressional Budget Office, it will result in a reduction between 7 to 8 percent of administrative costs, so the remainder will be spent on medical care versus administrative overhead.

Senator Rockefeller. Is that your opinion, or is that what is in the mark? Is it directed in the mark?

Ms. Fontenot. It is not directed in the mark. That is CBO's opinion.

Senator Rockefeller. Yes. So what is directed in the mark is what I am talking about here.

Ms. Fontenot. Directed in the mark is just a reporting requirement that they report where the funding is going.

Senator Rockefeller. Right. Okay. So the Chairman has included a provision in the mark to require

private insurance companies to report on their medical loss ratios.

Additional follow-up. While reporting of medical loss ratios is important as a first step, why not simply require a minimum medical loss ratio for all plans that receive subsidies through the exchange? It seems to me that we have significant Government giveaway to private insurers on Wall Street with no requirement that a significant portion of that half-trillion dollars in premium subsidies actually goes towards coverage, which is what my people in West Virginia need and care about.

Can you describe the House's provisions on medical loss ratio and tell me why that proposal is not included in this mark?

Ms. Fontenot. Senator, the House proposal requires an 85-percent minimum loss ratio, which, in other words, translates into 85 percent of premium dollar must be spent on medical care. If a plan does not meet that requirement, they have to offer a rebate in order to reduce the amount of spending on administrative costs.

The Chairman. I might say at this point, there is no House bill at this point. There are committees looking at bills. I only say that just for clarification here, and the House is rewriting those three committee bills. They have not come up with their final bill yet.

I do not mean to split hairs here, Senator, but just to be accurate, there is not a House bill at this point.

Senator Rockefeller. I understand that, but, you know, in the parlance of Congress, they passed out some, and--

The Chairman. No, they did not.

Senator Rockefeller. Not the full House. I understand that. But I am just referring to a particular committee or so, and they did require this 85 percent be spent on medical care, and we do not. And, therefore, that strikes me as a fairly significant difference and one, regardless of what they do, that is something we ought to be pretty mindful of.

Question number three, Ms. Fontenot, is insurance regulation. We note--

The Chairman. Can I raise this point here? Everyone has called the lady in question here--has pronounced her last name many different ways.

Senator Rockefeller. Okay. Let us get it--

[Laughter.]

The Chairman. And I just wonder if you might tell us--

Senator Rockefeller. I like "Fontenot."

The Chairman. --the correct pronunciation of your name.

Ms. Fontenot. Absolutely. It is "Fon-te-no." Thank you for asking.

The Chairman. Very good. Fontenot. Thank you, Ms. Fontenot.

Senator Rockefeller. See, we are moving rapidly here.

[Laughter.]

Senator Grassley. If she were French, it would be "fohn-te-nohn."

The Chairman. That is right.

Senator Rockefeller. Well, I do not know if she is French.

[Laughter.]

The Chairman. Let us not go down that road. Let us just stay with--

Senator Rockefeller. That would be in Cedar Rapids.

The Chairman. --how she likes her own name pronounced.

Senator Rockefeller. That is right.

We know from experience that insurance companies often exploit loopholes. They are very good at it, and they get away with as much as they can get away with because basically nobody is looking. Nobody is doing much oversight.

Three examples come to mind, and I apologize for these questions, but I do not apologize at all because they really get at why I think the public option is so important.

First is the issue of pre-existing conditions exclusions. The goal of HIPAA was to restrict when private insurers can use pre-existing conditions to limit health insurance coverage. However, insurance companies have exploited loopholes in the Federal HIPAA law for the past 13 years precisely because they can, and nobody is going to notice, they are not going to get away with it. You will know about it. But generally the public will not and regulators do not.

A second example comes from a recent House oversight hearing where three insurance companies--WellPoint, United Health, and Assurant--testified that despite Federal regulations on rescissions, they still rescinded coverage for individuals based on State law interpretations and ignored Federal regulations. Even when they were faced with that evidence, executives of these leading companies, insurance companies, testified that they would not end their practice of rescissions except in cases of fraud. That is not comforting.

Third is the controversy surrounding the United Health Ingenix database, which is this, is what we did in

the Commerce Committee. It is devastating. This is Wendell Potter's sort of gift. It is just devastating on their practices of purging and avoiding and paying incentives to people to find reasons why literally, as has been mentioned several times in public sessions like this, somebody had acne and, therefore, that was a pre-existing condition, and they cut off their insurance; or they had gallstones and the guy says, "No, I really did not, because I would know if I had gallstones." And they said, "Yes, you did," and then they cut off the insurance. That is called rescissions.

So while insurance companies have promised almost 100 million of their policyholders that they cover in their out-of-network health care services, a Senate Commerce Committee investigation found that an insurance-owned company called Ingenix was cheating consumers out of billions of dollars--and there is an interesting New York case that proves this--by properly reducing payments for out-of-network--improperly reducing payments for out-of-network health care. Sadly, these are only a few examples of the tactics that private insurers use to exploit the law.

Now, Ingenix is owned by United Group Health. It has been for years the sole creator of what people are to reimburse. You know, what they are meant to do with

premiums. They cover the entire industry. They are the only one. They have a monopoly, and all insurance companies have followed their practices--their advice.

Andrew Cuomo discovered that there was something not so good about this, and he took United Health and Ingenix to court, and they settled for $350 million, which to me says that if they had not settled, they were going to get accused of fraud. I am not a lawyer, but I think that lawyers here would agree that that is usually the way those things happen.

So my question to you, Ms. Fontenot, is: Does this mark include any provision to guarantee that private insurers are following the new rules created for insurance in the Chairman's mark? What assurances do consumers have that private insurance companies will not simply take the massive premium subsidies--again, over half a trillion dollars--and continue to apply the same terrible practice of denying coverage to increase their profits? Who would be checking to be sure that this was not happening and allowing them not to skate around the law, as they have done? And they have done this. This is the truth. And it has been, you know, taken to court, and Ingenix is going out of business. But they will create something else.

So what is in the mark to prevent them from skirting

around these good aspects of the mark on this subject?

Ms. Fontenot. Senator, the mark lays out a set of Federal rating rules that currently do not exist in law, and it relies on the State insurance commissioner in every State to enforce those rating rules as they do today. So it does not change the enforcement per se of the insurance market in each State, but it changes the rules by which the insurers have to comply.

Senator Rockefeller. Okay. By law, you know, but by practice, no, in my judgment, no. So a kind of follow-up. How do the oversight and enforcement capabilities of the State and the exchanges created under this legislation compare to the enforcement capabilities of the Massachusetts exchange, or the Connector?

Ms. Fontenot. I believe that the Massachusetts Connector and the rating rules that are in effect in Massachusetts are also enforced by their State insurance commissioner. So it is a similar structure as what is occurring in Massachusetts.

What you may be referring to is in terms of the Connector itself and the role the Connector plays in Massachusetts versus the role we have envisioned for the exchanges in the mark, which their Connector is much more of a regulatory function in that it negotiates premiums with insurers who want to enter the market, and the

exchanges we have considered in the mark are more of a consumer shopping function, more of a marketplace for consumers and less of a regulator.

Senator Rockefeller. All right. Well, then each member will have to decide how comforted they are by that response.

Okay. Question number four, and, Mr. Chairman, I appreciate your indulgence, as long as it lasts. Is there precedent for allowing an outside entity--this would be, you know, Ingenix or whatever--with no official tie to Congress, which is not at least elected or confirmed by Congress, to write Federal regulations of this magnitude? Is there any additional oversight required in this bill to make certain that these regulations are accurately reflective of congressional intent? That is my main question.

What are the specific provisions to mandate transparency of the National Association of Insurance Commissioners process to write these regulations? And I think the answer is there are not any.

Ms. Fontenot. You are correct that the mark directs the National Association of Insurance Commissioners to develop model regulations through their process, but it is then translated through Federal regulation through the regular comment--notice of proposed rulemaking and

comment period that the Secretary undergoes for any other regulation.

Senator Rockefeller. All right. One more question. The limited-benefit junk insurance is the title of my question, and it is for you, Ms. Fontenot. One of the fastest-growing products, unbeknownst to me until I got into this, in the insurance industry right now is what are called "limited-benefit insurance policies." And English translation of this term might be "health insurance that provides no real coverage when a consumer gets sick."

Why do I say that? Earlier this year, an expert from consumer reports told the Senate Commerce Committee in a very heated hearing, "Many people who believe they have adequate health insurance actually have coverage so riddled with loopholes and with limits and with exclusions"--and with "gotchas," that is my word--"that it will not come close to covering their expenses if they fall seriously ill."

Now, my reading of the young invincibles plan included in this mark looks no different than a limited-benefit plan. So, Ms. Fontenot, my question to you is: Can you explain what I have just said about limited-benefit junk insurance? And can you explain the young invincible plan included in this mark and how it is

different from what traditionally is referred to as "the limited-benefit plans"?

Ms. Fontenot. The young invincible plan is intended to be catastrophic coverage, so if an individual does get very sick, that is when the coverage would take place. So there is a maximum out-of-pocket for the individual, and then once they have hit that maximum out-of-pocket, everything else will be covered, with the exception of prevention, which is covered from the beginning under the deductible.

The mark, once the exchanges are set up in 2010, does prohibit the selling of what we call "mini meds" or "limited medical plans," and once the benefit levels and categories take place in 2013, they do require that all the benefit categories are covered within the plan and that out-of-pocket maximums are included and that no annual or lifetime limits are included.

So I think what you are referring to highlights the necessarily for having those benefit categories laid out in the mark.

Senator Rockefeller. And not only laid out in the mark, but where there is an enforcement mechanism, which already exists through the States and, in some cases, self-insured Federal, that is not doing it, because otherwise they would not be getting away with this. And

that is the point I want to make on that.

Ms. Fontenot. I think the plans that you are referring to are not prohibited under law now because there is no minimum benefit requirement for insurers. So, to the extent that they are unregulated now, it is because the law allows them to exist. Once the mark takes effect, those would no longer be allowed in the individual and small-group market.

Senator Rockefeller. Well, two points on that. One, if there is nothing that precludes them from doing that now and hoping that we can get this done this year, in the meantime they have a long history of doing it, these limited-benefit junk amendments--practices. And so there is nothing which has stopped them up until now, so what you are saying is that if we put it in the mark, they will stop. And I do not know why it is that I am so profoundly skeptical that if we put it in the mark, they will ease for a little bit, and then go right at it, because that is all they know how to do. Otherwise, why would they purge? Why would they cut people off? Why would they incentivize their employees to find reasons to cut people off of health insurance? And I mean millions of people.

It is a subject that I think ought to make all of us very angry, as I think it ought to make us very angry

that in the face of all of this, we are giving them over half a trillion dollars more subsidies. I do not understand that. I really do not understand that. Who comes first--the insurance companies or the American people? I mean, it is--maybe that is too cliche a way to put it, but I think it is a pretty fair way to put it.

I think they are getting away with terrible things that--I do not know. You know, Chuck Schumer was the Attorney General. He would be criminally prosecuting them. He left before I made that statement.

Okay. That is about all I wanted to ask.

Senator Nelson. Would the Senator yield for a question?

Senator Rockefeller. Yes.

Senator Nelson. First of all, I want to--before my question, I want to say that I think the Senator from West Virginia has laid out one of the most cogent arguments to pierce the veil of what is happening in the insurance industry. The old insurance commissioner in me is coming out by virtue of the questions that you have asked, with the answers that you have elicited, and it makes this Senator very sympathetic to your argument.

Now, here is my question: Senator Schumer is about to offer another public plan. His utilizes more the marketplace. He does not set prices. Could you contrast

his approach with your approach and specifically with regard to the charge that has been made about the concept of your amendment that it would cause the setting artificially of prices and, therefore, the disruption of the private marketplace in the health insurance exchange?

Senator Rockefeller. To my friend from Florida, yes, I could, but I am not going to because I am offering my amendment.

Senator Nelson. Well, could you address what your amendment does with regard to the setting of prices?

Senator Rockefeller. All right. Well, I have got more advice here. I maintain my answer--not to be unresponsive, but fundamentally to be unresponsive because I want to focus on my amendment.

Senator Nelson. Well, that is my question about your amendment. I am giving you bouquets. I think that you--

Senator Rockefeller. I know that, and I love that.

Senator Nelson. I think you have made one--so I want you to help me now.

Senator Rockefeller. I want to help you, too, Senator, but I want you to have to focus on this amendment before you--I mean, I assume this is going to pass unanimously. That is my assumption.

[Laughter.]

Senator Rockefeller. So we will never get to the Schumer amendment.

Senator Nelson. Okay. But my question is about your amendment.

Senator Rockefeller. Oh, I know that.

Senator Nelson. How do you set the cost of the insurance in your amendment?

Senator Rockefeller. I will not answer that question. All right? He will answer that question, if he has the opportunity to do so.

Mr. Chairman, I have one more question, and I apologize. And this is also to the beloved Ms. Fontenot. It is about insurance competition in the current marketplace. It gets a little bit of what the Senator is talking about. It is my understanding that over the last several years insurance company competitions in States has diminished. Consolidation, obviously, in the market is the reason for that, and that is understandable. That happens to almost everything. When you get 90 percent of all insurers belonging to one insurance company in Alabama, that is excessive, I assume, is extreme, but, nevertheless, the point is a real one. Consolidation of the market, everybody consolidates.

So my question, Ms. Fontenot, is: Can you tell me how the state of the insurance market competitiveness is

right now?

Ms. Fontenot. Senator, I think probably the best way to answer that question is to cite a study that I have that the American Medical Association did in 2007.

Senator Rockefeller. Yes, I am looking at the same numbers.

Ms. Fontenot. It showed the combined market share percentage of the top two insurers in a number of States, starting with Maine, which is at 88 percent; Montana at 85 percent; Wyoming at 85 percent; Arkansas at 81 percent. The lowest consolidation on the list is Florida at 45 percent, so that shows of the top two insurers in the State what percentage of the market they control.

Senator Rockefeller. And if I could expand on that, more than 400 corporate mergers have taken place with health insurers, and a small number of companies now dominate local markets. We know that. The American Medical Association reports that 94 percent of insurance markets in the United States are now highly concentrated. Contrary to industry assertions, these mergers have undermined market efficiency. Premiums have skyrocketed, increasing more than 87 percent, on average, over the past 6 years.

Now, to try to answer the Senator from Florida's question, in my public option amendment, the provider

payment rate for the first 2 years--Bob, you can just pass it on to him. The provider payment for the first 2 years in what I call the "Consumer Choice Health Plan"--I do not call it the "public option"--will be based on Medicare provider payment rates, including new delivery models enacted as a part of health care reform.

Mr. Chairman, I do not see any reason why we do not do this. I cannot understand why we would not do this. I think Adam Smith would have cooked up this amendment if I had not. Now, it put it out on the Senate floor months and months ago. It is a Republican amendment. It is a free market amendment. Yes, it was started by the Federal Government, and it had an administrator. But the administrator cannot have anything to do with what goes on, cannot set any rates or premiums, adjust up or adjust down. And it is optional--optional to the extent that most people say that less than 5 percent of people will avail themselves of this plan, at least when we start out. And it really has not gone way above that. I assume at some point maybe it will.

But what it does do--and what I cannot understand is why with this half-trillion, $503 billion subsidy to the private health insurance market, that we do not put in some kind of a--you know, in the exchange, along with everybody else, but they do not have to make any profits,

so they have to live off their premiums, which means they have to do that. It is pretty simon-pure with respect to that, pretty simple. But people are nervous about it because the word "public" is in it. But if you take the word "public" in it--and that is upsetting some people. And then on the other side, you say, well, good grief, you know, maybe this one little consumer choice plan will cause people in the health insurance industry, in the private markets, the small business markets, larger markets, whatever, to reconsider a bit the premiums they are doing because there is the competition, there is genuine competition. Because of consolidation there is not now genuine competition, and they are getting away with banditry. And they revel in it. They incent their people to find reasons to cut people off--millions. I think 9 million is the figure, an accurate figure.

I do not understand why we would not want to do this. This to me is a huge amendment in this debate, and the Chairman is being extraordinarily kind to me in allowing me to talk at this length. But I feel so strongly about it because it makes so much sense. The people that I represent need this. They need this because they are helpless in front of the insurance companies. They have nothing to respond with. They cannot even analyze what they are having to pay. They

just know it is too much when their insurance is cut off or they can no longer pay their premiums.

I do not want to see people treated like that by this bill where more than half the cost of the bill goes to subsidizing private insurance, and I think we should respond by adopting this amendment. And then if people do not like it, they can dump it. You know, they just do not have to use it. That is called "free choice." That is the marketplace acting on its own. Or if they do not like the Federal Government so much that they do not want lower premiums, then they can ignore it. Opt in, opt out. It is free market. But it does not have to make a profit.

I think it is a worthy amendment. I think we ought to adopt it, and I urge my colleagues to so do.

I thank you very much, Mr. Chairman.

The Chairman. Thank you, Senator. You make some very good points, and I agree with the intent of your amendment, which is to hold the insurance industry's feet to the fire. I think most of us here agree with that. The real question is how best to do it. Without taking a strong position one way or another on what you have just said, however, I think it is important to kind of set the record straight, because some of the questions sort of leave the implication that the mark is easy on the

insurance industry, and it is not.

For example, the mark will require rating reforms. No longer could an insurance company charge older, sicker people 10 times as much as younger, healthier people. The mark also requires insurance companies to sell insurance to all who need it; the fancy term is called guaranteed issue.

Second, the bill would require insurance companies to renew insurance as long as the beneficiary is paying. They cannot cancel or rescind as easily as you might have implied in your comments. The bill requires greater transparency for insurance companies. Insurance companies would have to disclose how much they have spent on medical care and how much they spend on administrative expenses.

We also require that insurance companies pay their fair share. For example, for one thing, the insurance companies profits will have to bear some of the cost of the high-premium excise tax. For another thing, the bill requires competitive bidding in Medicare Advantage. That will take over $100 billion out of insurance company profits. For another thing, we levy a fee on insurance companies of more than $60 billion. So this bill does hold insurance companies' feet to the fire.

As I mentioned, there is another provision in the

mark, a co-op provision, which is intended to achieve the same purchase you are trying to achieve. We all agree on the goal, that is, to hold health insurance's feet to the fire. But I just think it is important to also explain that the mark is not easy on insurance companies by any stretch of the imagination. But I do not want to argue with you if you wanted public option, but I just think it is important to set the record straight.

Is there any further discussion on the amendment?

Senator Rockefeller. Can I just respond to that?

The Chairman. Yes. Senator Grassley is seeking recognition, but go ahead.

Senator Grassley. Well, if he wants to respond I will yield.

The Chairman. Go ahead.

Senator Rockefeller. I understand what you are saying, and the mark puts new conditions on them and gives them a half a trillion dollars anew. They have never followed the rules. They just have not done it. There is a welter of testimony given up as high up in Cigna, and in fact by some of the other companies, by GAO, and others, that they do not do this. They do not follow it.

So I am glad it is in the mark, but you want to bet the farm on the fact that the insurance companies are

going to change their behavior. And maybe they will. They will have to submit to some of that. But on the other hand, their whole livelihood is made by getting around rules. So, that is a matter of concern to me. Because Kent Conrad is my next-door-neighbor in the Hart Building, when you talked about the co-ops, I have not said a thing about co-ops. But if that should ever come up, I will have some things to say about co-ops. But I have decided not to because I want to focus simply on this amendment.

The Chairman. And one final point. Not to belabor it, but just in the interest of fairness, you have several times mentioned the half a billion dollars in subsidy in the insurance industry. In fairness, that is not quite accurate. The bill, as you know, requires shared responsibility in the sense that every American will have health insurance. The dollars that you mentioned are to help those people who, today, do not have health insurance, that is, the uninsured, especially the poor people who are uninsured. Because we have this requirement in the bill, those dollars go to those poorer people so that poorer people and lower income people can buy insurance.

If they require them to get insurance, certainly there should be dollars that go to those people to help

them get insurance. That is where those dollars go. Second, presumably when those people buy insurance with the assistance of the dollars we have given them, they will get medical benefits in return.

So in fairness, when you say $500 billion in subsidy, really, it is those dollars that go to people in the expanded population in Medicaid or lower and middle income people to buy insurance because we have asked them to do so, and presumably again those people will get health benefits in return. So, that is where those dollars really go. It is not a subsidy of the industry, it is dollars to the people so they can buy insurance, and those people then again get benefits in return.

Senator Grassley?

Senator Grassley. Yes. Before I state reasons for being against the Rockefeller amendment, let me state first of all that I think for most, if not all, of us on this side of the aisle and for quite a few people in the other political party, the Democrat Party in the Senate, but obviously a minority, not a majority, have long expressed misgivings about public option. So let us just remember that this is not something new that is just now coming into the debate.

I would like to go one step further in commenting on that to take exception to something that some White House

staffer said in August or early September in speaking about my opposition to some parts of the proposals that were out of committee at that time. We are trying to make the point that I had never, in some occasions at the White House, ever brought up opposition to public option. I think they were trying to use this as a reason: if this was so important, why would I not speak directly to the President about it?

So I want to remind you of at least three occasions that I have had an opportunity to speak to the President about this point. On March 5, when we had the first White House meeting where there were stakeholders there and many members of Congress were there, and I suppose a lot of people on this committee were there, I had an opportunity to bring up then our opposition to the public option. When Senator Baucus and I had lunch with the President on May 6 at the White House, I did not bring it up, but the President brought it up and I had an opportunity to express the concern that I had about it at that particular time.

On August 6, the group of six were at the White House with the President and I said to the President, the one thing that would make it very easy to open the door to make sure that we had bipartisanship is just a simple statement from him, not that he was not supporting public

option, but would he sign a bill that did not have public option in it. Obviously I did not get a positive response. I did not necessarily get a negative response at that meeting.

So I hope that anybody at the White House that thinks that I have not been concerned enough about public option to bring it up to the President face-to-face, they are absolutely wrong. I do not know what their motivation was in trying to use that as an excuse, that the Republicans at the table in the group of six were trying to scuttle and were never serious about negotiating a bipartisan bill.

With that as background, I now want to state opposition to the Rockefeller amendment, but I would also like to make a statement about the statistic that Senator Rockefeller gave of 70 percent of the doctors supporting a public option. I would suggest, because I have seen another poll, that it kind of depends upon how you ask the question.

If you ask the question as one poll did, would you support a public option if it would weaken private health strategies that we have had for decades in this country on health insurance, you got less than a majority of doctors supporting it at that particular way of addressing the issue.

There are a variety of reasons for opposing it. Most importantly, I oppose the amendment because I think it is a slow walk towards government-controlled single-payor health care. Now, we all agree--I do not think there is a single member of the 23 of us at this table, maybe 1 or 2 that would not agree with this--and we all have pointed out things that need to be changed in our current health care system. So it is not an issue, is our health care system perfect. We all talk about getting more uninsured or under-insured insurance.

We talk about the fact that health care inflation should not be twice or three times the rate of regular inflation. We all know that outcomes are not what they ought to be in some instances, and particularly if you want to compare it to outcomes in other countries.

There are shortcomings, yes. But I do not think we should take advantage of these shortcomings to denigrate American health care because we know that most of the innovations in health care come because of research and practice of the American health care system. Why do more people come to this country for health care than Americans leaving our country for health care in other countries?

So I am not sitting here, and I do not think any of my colleagues on this committee are sitting here, arguing

for the status quo. We know that changes need to be made in our health care system, and so many of the changes that are in this mark that is before us are not really Democrat or Republican or bipartisan, they are just kind of a consensus that some changes ought to be made. But I come to the conclusion, as I did a long time before this meeting, that a government-run plan is not the answer.

In fact, I kind of wonder why, if the motivation behind most of our legislation is that we ought to make health care affordable and you ought to have easy entry to it, from that standpoint if the goal is to make sure that health care is affordable for those that cannot afford it and if we make sure that we eliminate the discrimination so that people can enter the system or not be denied entrance to the system and you get 95 percent of the people covered -- and that is the goal that we have. We say, like, 95 percent is really 100 percent. We kind of know that it is not possible to reach 100 percent under any government policy, but 95 percent, 96 percent is a goal that is attainable, then I do not understand the public option argument if everybody is supposed to have access and accessibility and affordability.

Now, here is what is wrong. A government-run plan will ultimately force private insurers out of business.

Now, I know Senator Rockefeller is not going to say that today, but there has been plenty of think tanks in this town and outside of this town, and economists that really say that that is going to be the result.

And let me say this. I believe that it is fair to say that some people that are promoting the public option--and I do not attribute this to Senator Rockefeller--really believe that a public option is a step towards a completely government-run plan that they are hoping for. I would quote, for instance, President Obama during the campaign--well, maybe this was before he was even a candidate--"I am a supporter of a single payor, but we all know that we may not get there immediately."

Or Ezra Klein, writing for the *Washington Post*, said, "They", meaning those that support a public option, "have a sneaky strategy, the point of which is to put in place something that over time will move to single payor."

Or we have Congresswoman Jan Shakowski of Illinois saying, "Private insurers are right to be frightened. Those of us who are pushing for a public health insurance option don't disagree with the goal of single payor. This," meaning the public option, "is a strategy for getting to single-payor health care."

Or Chairman Barney Frank says, "If we get a good public option it could lead to a single payor...could be the best way to reach single payor." So, you cannot attribute that. That has not been said today by people in the Senate that I know of. But the point is, we are going to come, even if that is not the motivation of people promoting single payor.

Some argue that we can create a level playing field, that it will follow the same rules as private insurers. But the Federal Government will not only be running the plan, but will also run the market in which it competes with private plans. That does not sound like a level playing field to me.

By some estimates, getting back to when I referred to the think tanks, the unfair playing field will result in 118 million Americans being forced out of their current health care coverage and 130 million Americans will end up on a government-run plan. This directly contradicts what President Obama has promised Americans, that you will be able to keep what you have.

Sometimes I wonder. We have great union support for most of these bills that are coming out of committee, but when the House bill has in it that ERISA will not be applicable after five years -- and John Deere, now, in my State and in the Midwest is negotiating union contracts

right now. Why would they be negotiating and supporting legislation at the same time that, five years down the road, would be rid of whatever they wanted to negotiate? That is if the House bill would become law. But there is at least a lot of people in Washington here, in the Congress, that feel ERISA is not the right approach, yet it is the basis for most of the very lucrative union health plans that we have in America.

If your employer drops coverage and tells everyone to sign up for a government plan, is that doing what the President said, that you can keep what you have if you want to? This is also bad policy because it will drive up the price of health care as more costs shift from public programs to private payors.

Cost shifting currently occurs in the Medicaid and Medicare programs and will increase under an expanded government plan that drives up health care. Doctors, hospitals, and private providers will be hurt by a government plan. This is because they will be reimbursed at much lower rates under expanded public coverage compared to private plans.

Let me bring out that a large share of House Democrats wrote to Speaker Pelosi, as an example, saying that they absolutely would not support a plan in the House if it did not have a public option in it, and if

that public option did not have Medicare rates to be paid. Well, just think of rural America, where it is very, very difficult to keep hospitals open when you pay 80 percent of the cost and it is difficult to recruit doctors when it is 80 percent.

If you loaded tens of millions of more people into that plan as people in the House of Representatives are demanding of the Speaker be done at an 80 percent rate, and we think we have a tough time in rural America now, think what more of a tough time we would have in rural America if that were to happen.

Doctors and physicians are underpaid by public plans and try to make up the difference then by over-charging private payors, and then that makes everybody else's premiums go up. As the base of private payors shrink, doctors will either have to charge them increasingly more or continue to be reimbursed at increasingly lower levels, or even stop seeing public payor patients entirely.

And just think of the increasing number of doctors in America that do not want to see Medicaid patients, first of all--that is the worst situation--but it is becoming even a worsening situation in the case of Medicare. The government plan will eventually lead us to a de facto single-payor system of health care. As the

government plan grows and shifts more and more costs to the private plans, the price differential will increase and make a public plan increasingly the only viable option.

This cycle will force employers to put their employees on the government-run plan in order to avoid the higher cost of private insurance, and particularly that will be true for small business in America. So over time, it is this simple: the government-run plan will be the only viable option for most Americans.

So if you support single-payor health care, if you support longer waits, crowded emergency rooms, lower quality of care -- in other words, the rationing or the denial of care or the delay of care that you get in single-payor systems, do you want that for America? If you support government bureaucrats, not doctors, making medical decisions, then you should vote for this amendment. I do not think it is what we want for America down the road a few years, and I think that is what you will get if you support this amendment. That is why, on March 5, on May 6, and on August 6 I brought these issues up with the President.

Senator Schumer. Mr. Chairman, could I ask a question?

The Chairman. Senator Hatch --

Senator Schumer. Could I please ask a question?

The Chairman. Of whom?

Senator Schumer. Of Senator Grassley.

The Chairman. Will you yield for a question?

Senator Grassley. Yes.

Senator Schumer. Thank you, Senator. I appreciate your remarks.

Senator Grassley. Yes.

Senator Schumer. I would just like to know what you think of Medicare, a government-run program that is far more government-run than what Senator Rockefeller has proposed. Do you think Medicare is a good program? Because most of the amendments on the other side have been aimed at preserving Medicare, a government-run program.

Senator Grassley. I think that Medicare is part of the social fabric of America after 40 years, just like Social Security is. I do not say that because it is perfect. There are a lot of things that need to be changed and a lot of things in this legislation are changing a lot of things that are wrong with Medicare. To say that I support it is not to say that it is the best system that it can be.

Senator Schumer. But it is a government-run plan, is that not right?

Senator Grassley. It is a government-run plan.

Senator Schumer. Thank you.

Senator Grassley. And the reason I say it is part of the social fabric of America, is there are private health insurance plans and retirement plans that are connected with Medicare and Social Security. It is not easy to undo a Medicare plan without also hurting a lot of private initiatives that are coupled with it. But that does not make it perfect. I will bet, based upon 50 years of experience, if we had to do it over again we would do it other ways, even if it were a government-run plan.

Senator Schumer. That may be. But all the hollers of a government-run plan that you elicited in reference to Senator Rockefeller's amendment, you are supportive of Medicare. I just do not understand the difference. A government plan, per se, if Medicare is good and part of the social fabric and we should keep it, which I presume you are saying --

Senator Grassley. Yes.

Senator Schumer. That is a government-run plan. The main knock you have made on Senator Rockefeller's amendment, I presume on mine, is that it is government-run.

Senator Grassley. Yes.

Senator Schumer. Medicare is government-run, and most people like it very much.

Senator Grassley. All right. And it will come to a single payor. That would denies the American people choice. What is good now about Medicare Advantage, is people in my State have 44 choices to go to. What you would be leading us to would be a system where there is not choice. Now, I want to give senior citizens choice.

Senator Nelson. Would the Senator yield? Would Senator Grassley yield? Now, you just made a statement that it will lead to a single payor.

Senator Grassley. Yes.

Senator Nelson. How in the world do you make that leap?

Senator Grassley. Well, there are health economists around here and I can only quote two, but I imagine there are dozens you can quote. The only reason I can quote two is because they are the only ones I want to keep in my head to give people answers. But one, is Heritage says that 83 million people are going to be forced out of their plan, employer plans, into a public option, and Lewin Group says 120 million people.

Whether it is 83 million or 120 million people being forced from their employer-sponsored plan into a government option, first of all, you do not get to do

what the President said that he wanted people to do, be able to keep what you have now if you have it. Number two, is if that does happen, then other people's premiums are going to go up as you have this cost shifting, particularly if the public option is tied to Medicare rates. And do not forget, a large number of the Democrats in the House of Representatives want people in the public plan, their providers, not to be paid more than what Medicare pays. You know what sort of a problem that is for your seniors in Florida.

Senator Nelson. As a matter of fact, Ms. Fontenot has already pointed out --

The Chairman. No, no. Fontenot. Let us get it straight here. Fontenot.

[Laughter].

Senator Nelson. Do not break my rhythm, Mr. Chairman.

[Laughter].

The Chairman. Oh, sorry.

Senator Nelson. Mrs. Fontenot has already pointed out that Florida has more competition in medical insurance than any other place. As a matter of fact, you are getting pretty close to a single-payor system in the private sector by virtue of the statistics she has just given for several of the States. You mentioned Wyoming.

What were the other States, Ms. Fontenot? Eighty-one percent, you said, of the market is dominated by one insurance payor in which States?

Ms. Fontenot. This is the market share of the top two insurers. So in Maine, it is 88 percent; Montana, 85; Wyoming, 85; Arkansas, 81; and the list goes down to Florida. This does not include all States, but Florida is the lowest percent concentration on this list.

Senator Nelson. Senator Grassley, that does not sound like a lot of competition to me.

Senator Grassley. What you forget in this whole process is that people are going to be in the public plan, no choice of their own. They are going to be forced out of it by small business shutting down their plans, as we have plenty of record already of small business shutting down plans because they cannot afford it. In this case, why should they afford it if you are going to have a government plan?

Senator Schumer. Mr. Chairman, just another question here.

The Chairman. Well, Senator Grassley has the floor and other Senators earlier sought recognition. If you have a question of Senator Grassley, if he agrees, that is fine. Otherwise, I have to go to other Senator who had earlier sought recognition.

Senator Schumer. Yes. I was just going to ask, with Senator Grassley's okay, he cited Medicare Advantage, which is something some of us on this side have a little more sympathy to than most. It has competition: there is Medicare and then there is Medicare Advantage, and they compete. According to what my good friend from Iowa just said, that is good.

What you are arguing in terms of public option, is that we should not have Medicare at all, just have the private companies compete. That is not what people want. They like Medicare and then they want the option of Medicare Advantage. But your arguments all say "have no Medicare because it is a government-run plan". And no one is going to be forced into it. In the bill I proposed--I support Senator Rockefeller's bill. It goes further--there is negotiated rates just like the private sector does.

Senator Rockefeller. Mr. Chairman?

Senator Schumer. So I just yield for the answer.

Senator Grassley. Well, if you want competition, you do not want the government running everything. The government is not a fair competitor. It is not even a competitor.

Senator Schumer. So you do not want Medicare?

Senator Grassley. It is a predator. I told you

that Medicare is part of the social fabric of America, and I think that there is a lot wrong with it that could be corrected. This bill does a lot to correct it, and I think other bills do as well. Most of it deals with the delivery of medicine and how we take care of people, but giving people choice is very, very important and this is going to kill choice.

The Chairman. Senator Hatch?

Senator Hatch. Thank you, Mr. Chairman. I have enjoyed this discussion. As much as Medicare is accepted in our country today, it is still $38 trillion in unfunded liability and it is still paying doctors a lot less than what is the norm, and paying hospitals a lot less than the norm.

Frankly, it has plenty of problems, as the distinguished Ranking Member here has said. This morning we are supposed to be discussing a series of government-run plan amendments. I want to take a few minutes to highlight the perils of this approach. At a time when major government programs like Medicare and Medicaid are already on the path to fiscal insolvency--and I think some of our colleagues on the other side tend to overlook that--creating a brand-new government program will not only worsen our long-term financial outlook, but also negatively impact American families who enjoy the private

coverage of their choice.

Now, to put this in perspective, as of this year another government-run plan, Medicare, has a liability of almost $38 trillion, which in turn translates into a financial burden of more than $300,000 per American family. In our current fiscal environment where the government will have to borrow nearly 50 cents of every dollar it spends--that is this year, and that is going up--exploding our deficit by almost $1.6 trillion, and it may be more than that, let us think hard about what we are doing to our country and to our future generations.

The impact of a new government program on families who currently have private insurance of their choice is also alarming. The recent Milliman studies estimated that cost shifting from government payors, specifically Medicare and Medicaid, as good as they may be, translates into about $89 billion per year in cost shifting alone. This means that families with private insurance spend nearly $1,800 per year, $1,512 in higher premiums, and $276 in increased cost sharing. Now, creating another government plan will further increase these costs on our families in Utah, and across the country. I thought the goal of health reform was to actually make it more affordable.

Now, let me make a very important point. I believe

this, a new government plan, is nothing more than a Trojan Horse for a single-payor system in Washington. Washington-run programs undermine market-based competition through their ability to impose price controls and shift costs to other purchasers. Proponents of this government plan seem to count on the efficiency of the Federal Government in delivering care for American families, since it is already doing such a great job with our banking and automobile industries.

Medicare is a perfect example. It is on a path to a fiscal melt-down, with Part A already facing bankruptcy within the next decade. As I have said before, it under-pays doctors by 20 percent and hospitals by 30 percent, compared to the private sector, forcing increasing numbers of providers to simply stop seeing our Nation's seniors.

According to the June 2008 MedPAC report, 9 out of 10 Medicare beneficiaries have to get additional benefits beyond their Medicare coverage. Now, we have a broken doctor payment system in Medicare that has to be fixed every year. It is a disgrace. Every year we have got to fix it so seniors can continue to get care. This year alone, this broken formula calls for more than a 20 percent cut. Now, I can keep going, but the point here is simple. Washington is not the answer. Anybody who

believes that, it seems to me, just has not lived in the last 50 years.

And by the way, we have already had a robust debate on what Washington does with its government plans when it needs to finance its out-of-control spending: it uses these bankrupt programs as a piggy-bank. The supporters of the government plan know these facts, so they are trying a different approach by claiming that the government plan is simply competing with the private sector on a so-called "level" playing field.

Well, that is what they thought they were doing when they did Medicare and Medicaid. In fact, that is what they said. History has shown us that forcing free-market plans to compete with these government-run programs always creates an unlevel playing field and it dooms true competition, and it always costs more.

The Medicare program, once again, provides an important lesson. As a political compromise, Medicare was set up in 1965 to pay doctors and hospitals the same rates as the private sector. Now, faced with rising budget pressures, Congress quickly abandoned this level playing field that we hear so much about, this level playing field approach, and enacted price limits for doctors and hospitals.

Like I say, today Medicare payments are 20 percent

less for doctors and 30 percent less for hospitals compared to the private sector. Medicaid is even worse. It pays doctors 40 percent less and hospitals 35 percent less. That is why we continue to make this point to our friends on the other side of the aisle, that simply expanding coverage does not equal access. I have been told by doctors from Utah and across the country that if this continues, they will simply stop seeing these patients altogether.

In his March 2009 testimony before the House Energy and Commerce Committee, Doug Elmendorf, the Director of the nonpartisan Congressional Budget Office, testified that it would be "extremely difficult" to create "a system where a public plan could compete on a level playing field" against private coverage.

Now, the end result would be a Federal Government take-over of our health care system, taking decisions out of the hands of doctors and patients and placing them in the hands of the Washington, DC bureaucracy. I do not know many people in this country on either side of these debates who really believes that that is the way to solve the problem.

I am talking about the people out there, not necessarily the politicians here in Washington. If the government plan met all the exact same requirements as

private plans have to in all 50 States, there simply would be no reason to justify the enormous cost of creating a new Washington bureaucracy to administer the government plan.

Now, to make a long story short, we really have to think this through. We are talking about one-sixth of the American economy and we are talking about turning it over to a Washington-run system. Now, the people out there, Democrats, Republicans, Independents, liberals, moderates and conservatives, they do not believe -- I think the vast majority of them do not really believe that we wonderful people right here in Washington, including all of the bureaucracy that is involved here, can do it better than the private sector. They just do not believe it.

Now, everybody wants something for "free". The question is, can we afford to go this way? If we do, are we ever going to be able to change it if it is wrong? As has been argued, it would be pretty darn tough to change Medicare, pretty darn tough to change Medicaid. They are entrenched in our society today. To the extent that they can, they are trying to do a good job.

I commend those who really work hard to try and say that they do a better job, but they are becoming bankrupt. There has been some statement here on the

other side that we are really not trying to go to a single-payor system. Give me a break. As the author, along with Senator Kennedy, of the CHIP program, that program was designed to take care of the only children left out of the system, and that happened to be children of the working poor. We gave the States a lot of authority over that program and they, for the most part, ran it well. It worked.

When we debated two years ago, in then the last two years before this year, we debated how to reauthorize it. There was a tremendous move towards moving more and more people from Medicaid into CHIP because there was a higher match in CHIP, and in the process, of course, moving towards a single-payor system.

There have even been very honest statements by some of our colleagues on the other side, and certainly a lot of people on the other side of this issue who really want a single-payor system. But if we cannot get there in this health care reform, we have got to get there in increments. If you go to a single-payor system, or should I say a so-called government plan run right out of Washington here, that would be a big incremental step towards a single-payor system where the government makes all the decisions for us.

I cannot tell you how devastating that would be to

the medical profession. As someone who has worked with the medical profession many years before I came to the Senate, who actually was involved in medical liability cases, I have got to tell you, I do not know many people who really believe that our bureaucrats here in Washington are going to do a better job than our people within our States.

Now, all I can say is that if we pass a single-payor program or something that gets us there, and the most important thing to some of the left to get us there, would be a public option, we will never be able to change it. I can tell you right now, it would be a disaster. What is worse, the American people will lose an awful lot of control over their own health care needs. They will be told right here in Washington, which of course does know more about everything, I guess, what to do and how to live and how to get care, if they can. Well, I am very concerned about it, as you can see. I do not believe that some of these arguments on the other side make much sense.

Thank you, Mr. Chairman.

The Chairman. All right. On the list I have seeking recognition are: Senator Conrad, Senator Bingaman, Senator Menendez, Senator Schumer, Senator Ensign. I understand Senator Menendez has a pressing

engagement, so I was wondering if other Senators might indulge Senator Menendez to go earlier, if Senators do not mind. Senator Kyl? It is all right with you? All right. Senator Kyl, you are on the list, too.

So I recognize Senator Menendez.

Senator Stabenow. Mr. Chairman, I would like to be recognized as well.

The Chairman. Oh, I am sorry. All right. I have you both. All right.

Senator Menendez. Thank you, Mr. Chairman, and thank my colleagues for their courtesy.

I wanted just to make sure, before I have to leave in a few minutes, that I speak strongly in favor of Senator Rockefeller's amendment and I hope it will succeed. Just in case the debate melds also as to Senator Schumer's in the alternative -- as much as I hope Senator Rockefeller's will succeed, should it not--and I hope it will--then I support Senator Schumer's as well.

And I want to give some context. This, in essence, is about choice. We hear a lot about choice, but there is such a demonization about this one possibility of a choice within a panoply of other choices. It seems we are all for choice until one of the choices can be a public option, in essence, a choice of a health insurance plan separate from the private insurers that are all

going to be set up in this exchange. It is just that: a choice. Not a mandate, a choice.

In a nutshell, public option, in my view, clearly increases competition, keeps insurers honest, drives down costs. Now, why? Why do we need a public option? Well, look what is happening in the health insurance industry without one: costs are skyrocketing. In my home State of New Jersey, between 2000 and 2007, we saw insurance premiums went up 71 percent. The reality is, that is far beyond what the wages of New Jerseyians have gone up, and that is true across the country. Options are limited.

I hear a lot about how many insurers there are, but insurance is really driven by the local market, so let us look at what those are. I appreciated Senator Rockefeller's questions and the answers, and I appreciated the Chairman's intervention in some of what he had to say. But let us be honest. This is an industry that has $25 billion annual profits, $800 billion annual revenues.

That does not include investments and other proceeds that they have. So it is true that of the half a trillion dollars in subsidies we are going to create, some of those are going to be spent in the services of those people, but not everybody is going to demand a half a trillion dollars of services automatically, so there

obviously is money that will be going to the insurance companies.

So they have participated to about 8 percent over the course of the decade of what their present annual profits are, and this is before they have this whole new universe of entrants into the system, with significant subsidies by the Federal Government, and so it is hard to understand how, in the midst of all of that, a public option creates such a dire consequence to them.

Now, I have heard already, and I am sure we will hear again, that the public plan is government-run insurance. To me, that is absurd and everyone knows it. There is a reason there is such overwhelming support for a public plan. We go and talk about more and more choices, but we seem afraid of giving them the one choice that, in every poll still to date, overwhelmingly by two-thirds, American people want a public option, yet we do not want to give them what they ask for in this reform.

It will not be government-run insurance, it will be independent. It will be self-financed. It must be self-sustaining. That, to me, is not a government-run insurance program. No provider will be forced to participate in it. For patients, it will simply be one more choice. No one is required to sign up for the plan, it is an option for the public. You can stick with your

private insurance if you want to.

And there is a fundamental difference. Yes, Medicare is a government-run program. For those who are in it, they overwhelmingly like it. But there is a difference: it is also an entitlement, and as an entitlement, it is an obligation that the government has automatically for all those who qualify. But this is different. We are not talking about an entitlement in a public option, we are simply talking about a self-sustaining, independent, self-financed entity and that is fundamentally different.

So it is good to talk about Medicare being a publicly-run insurance provision for those who qualify because of their age and other conditions, but the bottom line is, that is far different than this. This is not an entitlement, and therefore a mandate.

Senator Ensign. Would the Senator yield for a question?

Senator Menendez. If I can finish my presentation, then I would be happy to.

There is already competition, we hear, plenty of competition in the marketplace. There are 11,000 health insurers in America. But actually, the opposite is quite true in terms of what we really want to hear about competition. Probably health insurance is one of the

least competitive businesses in America. Opponents of the public plan like to talk about how much competition there is in the insurance market by talking about how many insurance companies exist nationwide, but health insurance markets are almost entirely local.

Studies of how uncompetitive insurance markets are are pretty damning. If you look at the MAA, if judged by the measure used by the Justice Department, 94 percent of insurance markets in the United States are now highly concentrated. We heard the answer before to Senator Nelson's question. There are States, like North Dakota, where two companies control 92 percent. That is real competition, two companies, 92 percent? In Maine, two companies control 88 percent. In Montana, two companies control 85 percent. In Wyoming, two companies control 85 percent. In Iowa, two companies control 80 percent. In Idaho, two companies control 75 percent, and it can go on and on. My God, two companies? That is real competition. That is real competition.

Now, the other thing is this idea that the government will get more involved in your medical decisions -- that we have already heard, and probably will hear a lot more about, between the government being interposed between you and your doctor. Well, let us hear from those who we care about most in this respect:

our doctors. Our doctors.

What does the American Medical Association say about that? They say that, because of a lack of competition, quoting directly from the AMA, "the physician's role is being systematically undermined as dominant insurers are able to impose take-it-or-leave-it contracts that directly affect the provision of patient care and the patient-physician relationship."

So the existing system, the one that I just described in so many parts of the country, two companies control 80, 90 percent of the marketplace, they are already telling the physicians, because they have this incredibly dominant position in the marketplace, by the way, if you do not like this you do not have to join us, but we are covering 90 percent of the marketplace, so tough luck. So the present set of circumstances has private insurance companies interposing themselves between the physician and their patient.

Finally, the suggestion that this is going to put insurers out of business, we all know that insurance companies can compete at a lower price point, but they just do not have to right now because there is just not enough competition. This will force them to consider that lower price point. I think that is incredibly important. That still means that they will make money

and we are going to have this whole new universe of people who are now going to be insured and we are going to give big subsidies, a part of which will obviously go to profit because not all of it is going to be consumed by that health care cost, but this is about having a stand-alone, self-financed insurer who, at the end of the day, can create the type of real competition--real competition--you want to see in the marketplace.

Senator Ensign. Would the Senator yield for a question?

Senator Menendez. That is why I support Senator Rockefeller, and if his does not succeed, Senator Schumer's amendment.

Senator Ensign. Would the Senator yield for question?

Senator Menendez. I would be happy to yield.

Senator Nelson. Mr. Chairman, would the Senator yield?

Senator Menendez. I am happy to yield.

Senator Ensign. I do not know if I heard you correctly. I thought I heard you say that doctors would not have to participate in this program. I do not know if you are aware, in reading the language, that even though it is not required that they participate, if they want to participate in Medicare they have to participate

in this program under the amendment by Senator Rockefeller. Are you aware of that?

Senator Menendez. Well, I believe, at the end of the day, that --

Senator Ensign. So basically you are going to require doctors to participate in that, because that is almost all the marketplace, between this and Medicare.

Senator Menendez. I believe that, first of all, that is not the case in Senator Schumer's, which is also under discussion.

Senator Ensign. Correct. But we are talking about Senator Rockefeller's right now.

Senator Menendez. And at the end of the day, I believe that, in fact, the most important thing here is that consumers will not have to choose that option if they choose not to. They will have a choice of options, and that is the most fundamental question here.

Senator Ensign. No. But I was making the point that doctors will not have the choice, because so much of the marketplace could be dominated by this. The CBO has estimated, if Senator Rockefeller's amendment was adopted, that about a third of the marketplace would go to this "public option". Between Medicare and this, if you want to practice medicine, you are going to have to take this, so you would be required as a doctor -- almost

required if you want to stay in business, to take these patients. You would not have any choice.

Senator Rockefeller. Would the Senator yield? Would the Senator yield?

The Chairman. Senator Menendez has the floor.

Senator Menendez. I would be happy to yield, Senator Rockefeller.

Senator Rockefeller. The Senator from Nevada is making a wrong point. He is saying that doctors would be required, et cetera. They are not. Doctors, in my bill, are specifically allowed to opt out anytime they want from Medicare.

The Chairman. If I might ask staff --

Senator Conrad. Could we clarify that?

The Chairman. Yes. That is a good question. Can we get clarification of what the amendment does or not provide with respect to Medicare participation by doctors. If you can yourself, Senator, or else I was going to have Ms. Fontenot read the relevant provision in the amendment.

Senator Ensign. And the public plan as well.

Ms. Fontenot. According to the analysis by the Congressional Budget Office, the amendment would require that, for the two-year period, 2013 and 2014, doctors, hospitals and other providers would have to participate

in the public option if they wanted to participate in Medicare.

Senator Ensign. Thank you.

Senator Rockefeller. For two years.

The Chairman. All right.

Senator Bingaman. Could I just clarify, this is not in the description of the amendment, if it is Amendment Number 6, Rockefeller Number 6. What you just said CBO has concluded is not in that description. Is there some other amendment we are voting on? Does CBO have a different amendment?

The Chairman. If I might, let us get some clarity here. Let us get some clarity here. Which amendment, Senator, did you call up for debate? Which amendment?

Senator Rockefeller. C6.

The Chairman. C6.

Senator Rockefeller. That is where this language is.

The Chairman. C6. Amendment C6.

Senator, does that satisfy your question?

Senator Bingaman. Well, is there language in C6, in the description of C6 that says that or is there another document that I just have not seen?

Senator Rockefeller. It is in the amendment that I have before the committee, specifically.

The Chairman. So unless there is some further clarification, my understanding would be that the description Ms. Fontenot read is the provision that is in the amendment offered by the Senator from West Virginia, as I understand it, and is the Senator's intent for the first couple of years. Is that correct? That is what the Senator says. All right.

Senator Menendez. Mr. Chairman, if I may very briefly, after those two years, the answer is, you can be free from that participation.

Ms. Fontenot. I believe that is correct, yes.

Senator Menendez. All right. Thank you.

The Chairman. All right. On my list --

Senator Nelson. Mr. Chairman, I had a question of the Senator from New Jersey.

The Chairman. All right. Let us not abuse this, but go ahead. Go ahead.

Senator Nelson. Mr. Chairman, I just had a simple question.

The Chairman. Go ahead. Go ahead.

Senator Nelson. And I would like for the Senator to state for the record the truth about, as it has been represented to this Senator, that the public option in New Jersey is a disaster in the marketplace in the State of New Jersey. Would the Senator respond to that?

Senator Menendez. Well, a very easy response. Since there is no present public option in New Jersey, it could not possibly be a disaster.

The Chairman. All right. On my list I have Senator Conrad, Senator Bingaman, Senator Schumer, Senator Ensign, Senator Kyl, Senator Stabenow, Senator Cantwell, and Senator Bunning.

Senator Conrad?

Senator Conrad. Thank you, Mr. Chairman. And thank you, colleagues.

It strikes me, in listening to this debate, that the place where there is broad agreement is there is not enough competition in the current marketplace. That is certainly true in many of the States, and in almost half the States there is no meaningful competition. The question is, how do you most effectively provide competition? I favor an alternative that I would call the public interest option. There would be strong not-for-profit competition to the for-profit companies, but not one that is run by a government agency.

Let me begin by saying, with Senator Rockefeller's amendment, the devil is in the details. In the details of his amendment, he does tie the public option to Medicare levels of reimbursement. My State has the second-lowest level of Medicare reimbursement in the

country. Every major hospital administrator in my State has told me, if you tie public option to Medicare levels of reimbursement, which the Rockefeller amendment does for two years, every hospital in my State, every major hospital, goes broke, so I cannot possibly support an amendment that does that.

Why is that the case? Because Medicare levels of reimbursement in my State are below the cost of providing the care. Well, how do the hospitals get by today? They are able to exist today because they have higher rates of reimbursement from private insurance and even higher rates from private pay patients.

But if we were to go in the direction Senator Rockefeller suggests--and again, I admire his approach to provide strong additional competition to for-profit insurance because I believe that is critical to any success. But when you tie it to Medicare levels of reimbursement, all of us who represent States where Medicare levels of reimbursement are very low, are going to face extreme hardship in health care. That is number one.

Second, as I look at various models for achieving health care delivery, it seems to me it is a useful exercise to look around the world, see what others are doing, what works, what does not work, what outcomes they

have produced. Not that we are going to copy some other countries. We are not going to copy France, or Japan, or Germany, or certainly England or Canada. But it seems to me a useful exercise to look at the different models. It jumps out at you.

I have been sharing with my colleague the book by T.R. Reed, *Healing America*, in which he has just gone around to the major countries in the world and looked at the various medical models. What does he find? He finds the British model. The British model, if we could put up, is taxpayer-funded. The government is the only insurer. There are public providers and hospitals. That is, the doctors are government employees, the hospitals are government institutions. It does achieve universal coverage.

The second major model is a model that we see in Germany, and France, in Japan, and Belgium and Switzerland. It is based on an employer-based system like our model currently is in this country. In those countries, employees contribute, employers contribute, as is the case here, but there is also a significant role for government in providing assistance to those who cannot otherwise afford insurance.

But it is not a government-run system. They are private insurers, but they are, for the most part, not-

for-profit insurers. That is the fundamental distinction between our system and theirs. Their insurers--not exclusively, but largely--are not-for-profit providers. They also have private hospitals. The doctors and other providers are private. They also achieve universal coverage. They also do a much better job of controlling costs than we do in our system, and they get very high-quality outcomes.

Let us just look for a moment at the question of quality outcomes. On preventable deaths, the United States ranks 19th, according to The Commonwealth Fund. We rate 19th in preventable deaths. Number one is France, who has adopted the model that I was just discussing that is not-for-profit insurers, coupled with employer-based coverage where employees put in, employers put in, and they are number one in the world in preventable deaths, according to The Commonwealth Fund. Number two is Japan, who has also adopted this alternative model, again, not government run, but largely not-for-profit insurance tied to an employer-based system that does have universal coverage.

On a second metric, infant mortality, we rank 22nd. Again, at the top is Japan, a country that has adopted this alternative model that I am discussing, largely not-for-profit insurers and an employer-based system that

would build on our own.

If you go down the list, number five is France, again, a country that has adopted this alternative model, not government run, but largely not-for-profit insurance linked to an employer-based system that does achieve universal coverage, that does control costs much better than our system, that does provide quality outcomes. If you go down the list further on infant mortality, number nine is Germany, again, another country that has adopted this alternative model, that is not government run, that is private, but that is based largely on not-for-profit insurance.

It just seems to me, if we kind of connect the dots here, it kind of jumps out at you. If you want to have a system that has universal coverage, and I think most of us believe we need to expand coverage, if we want to contain costs -- and by the way, every one of these other countries, Germany, Japan, France, Belgium, Switzerland that has adopted this alternative model has much better costs than we do, much lower cost than we do, higher-quality outcomes than we do, and they are not government run. They have significant government involvement, absolutely, because the government role is to provide assistance to those who cannot otherwise afford insurance.

Government has another role in regulating insurance, not allowing preexisting conditions to be used as an exclusion, not permitting insurance companies to have annual caps, not to permit insurance companies to practice recision, which is just a fancy word for yanking somebody's insurance once they get sick, even though they have been paying premiums.

So, yes, there is an important government role, but it is not government run. I would just say to my colleagues, I wish we could get to this debate more fundamentally because, to me, that alternative model holds out a better prospect for success. I think it is closer to the culture of America, the system that has been adopted in Germany, in France, in Japan, and Switzerland, and Belgium, than the model that has been adopted in England or the model that has been adopted in Canada, because those are also examples of different models.

Senator Ensign. Would the Senator yield for a question?

Senator Conrad. I will yield in just a minute, if I could make this concluding point. Somehow it seems to me we have gotten locked in a really sterile debate that says the only alternatives are what we have got now or public option. Those are not the only alternatives.

There is another alternative and it is a model that has been adopted in country, after country, after country, and those countries do have universal coverage, they do a better job of controlling cost, and they have higher-quality outcomes than ours.

Let me just conclude on this point. For my State, I represent North Dakota. We have the second lowest level of reimbursement in the Nation under Medicare. To tie all reimbursement to Medicare levels of reimbursement would, according to every major hospital administrator in my State, bankrupt every major hospital in my State. My State is not alone, because there are other States that have low levels of reimbursement, So, the details really matter in this discussion.

I thank my colleagues.

Senator Ensign. Would the Senator yield for a question on your charts?

Senator Nelson. Would the Senator yield?

The Chairman. Does the Senator yield to a question?

Senator Conrad. Yes.

Senator Ensign. The first one you said on preventative deaths, are you aware that if you take out gun accidents and auto accidents, that the United States actually is better than those other countries?

Senator Conrad. You know, you can rack and stack these --

Senator Ensign. Yes. But that does not have anything to do with health care. Auto accidents do not have anything to do with -- I mean, we are just a much more mobile society. On the preventative deaths, if you take out auto accidents, because we drive our cars a lot more, other countries do public transportation -- so you have to compare health care system with health care system. If you compare cancer rates, survival rates after five years, cardiovascular disease after five years --

Senator Conrad. We do very well.

Senator Ensign. The United States does better than Europe.

Senator Conrad. We do very well.

Senator Ensign. We do better than any of the other countries that you pointed out.

Senator Conrad. Well, I can tell you this, I would go back to the statistics that have been generated by lots of organizations on quality outcomes. Other countries that do have universal care, that do a much better job of controlling cost than we do on metric after metric, finish ahead of us.

I would just direct you to the T.R. Reed book, which

is loaded with analysis from objective observers as to quality outcomes. Those countries--much lower cost than we do as a share of GDP, high-quality outcomes; whether we are first in a category or somebody else is first, nonetheless, high-quality outcomes in those countries at much lower cost.

Senator Ensign. I just think we should be fair --

Senator Conrad. And universal coverage.

Senator Ensign. We should be fair when we are comparing the systems.

Senator Conrad. I am always for fairness.

Senator Nelson. Would the Senator please yield for a question?

Senator Conrad. I would be happy to.

Senator Nelson. The Senator has made a very compelling argument about the need for competition among nonprofit insurance companies. The Senator is laying the predicate for his position, which is in the bill, which is a co-op. Might I suggest to the Senator that "co-op" may be a term that is used in North Dakota and is understood, but it is not in a lot of the other States. In effect, what the Senator is talking about is an insurance company that is owned by its policyholders. In normal terminology among consumers, this is known as a mutual insurance company. So the Senator might suggest

calling it the mutual health insurance nonprofit company as the competitor to the rest of the for-profit plans in the health insurance exchange.

Senator Conrad. You know, what it is called, to me, is of much less importance than what it accomplishes. What needs to be accomplished, I think, if you look at these other systems just kind of as a background test of what works and what has lower-cost, high-quality outcomes, universal coverage, are systems that have a very strong not-for-profit competitor as the insurance intermediary. That does not mean it has to be government run. A government-run system can also accomplish those things. I do not denigrate that. I do not take away from the ability of a government-run system to do that as well.

But when I look for systems that seem to me to be closest to what we have now, which is an employer-based system, and closest to the culture of our country, I see those other examples as having, to me, a better chance of fitting our country. Again, they have lower cost, they have high-quality outcomes, and they have universal coverage.

The Chairman. All right.

Senator Rockefeller. Would the Senator yield for a question?

Senator Conrad. I would be happy to.

Senator Rockefeller. The fact that you brought up co-ops is something that I was hoping would be a separate amendment, because I --

Senator Conrad. No, I did not bring it up. I responded to a question.

Senator Rockefeller. Well, in the eye of the beholder.

Senator Conrad. No, let us be clear: I did not.

Senator Rockefeller. All right. Well, anyway, that is what we have been talking about. And the amendment before us is the public option amendment. I would advise my colleagues that that is the amendment before us. I have a great deal to say about co-ops, which is not what you would say, based upon a lot of research. I want to have a chance to say that, but I want to be able to vote on my amendment, which I think is a lot more effective, also to respond to some of the criticism that has been made about it, before I get into a debate with you about co-ops, which is not a part of my amendment.

Senator Conrad. No. I have tried to stay away from that part of the debate in respect for the fact that we are on your amendment, and I have tried, in my own review, to talk about what I see as the weaknesses for

the State that I represent with your amendment. And you and I have had this conversation, as you know, many times. But also to talk about different models that we see around the rest of the world, not that we are going to adopt any of them, but as an indicator of what we might be thinking about. I think that is a worthy debate.

The Chairman. All right. Next on the list is Senator Bingaman.

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

Let me just clarify my view on this, and maybe ask a question or two of the staff. The amendment before us differs from Senator Schumer's amendment in some significant ways, and let me just mention the ones that occur to me and you tell me if I am right or wrong about this, as you understand it.

First of all, the amendment before us would have a plan administrator chosen who would then operate the plan.

Senator Rockefeller. Not true.

Senator Bingaman. Is that wrong?

Senator Rockefeller. That is wrong.

Senator Bingaman. Who operates the plan? I have the Rockefeller Amendment Number C6 in front of me.

Senator Rockefeller. I mean, it has a plan administrator to get it started, so the co-ops have $6 billion to get them started. The plan administrator is not going to be -- I said in my argument, which I wish I could get back onto rather than talking about Senator Schumer's argument and Senator Conrad's argument, is that it is not government run.

This administrator has nothing to do with setting insurance, with having anything to do with the marketplace within which the public option or the consumer choice plan would operate. So does it have an administrator? Technically the answer is yes, but that administrator has no power to involve himself or herself in anything to do with the consumer choice plan.

Senator Bingaman. All right.

Well, let me go on and describe what I understand, based on what I have read here, the amendment does. It has the Secretary of Health and Human Services establish a plan, name an administrator. Then it makes provision that for the first two years of the plan, Medicare rates apply and that providers who accept Medicare would be required to accept anyone covered by the plan during that first two-year period. Am I right so far, according to the staff, or not?

Ms. Fontenot. That is my understanding.

Senator Bingaman. And then after the second year, the administrator would be directed to set rates to determine competitive provider payment rates and adjust rates to that level. Is that accurate also?

Ms. Fontenot. According to CBO's interpretation, after 2014, HHS would have to negotiate payment rates. So it would not be quite setting the rates, but they would negotiate rates for the public option.

Senator Bingaman. All right.

So there is no difference then between the amendment we are considering now and Senator Schumer's proposal which he is going to offer later on this issue of negotiating rates, except for the two-year period. Is that your understanding?

Ms. Fontenot. That is my understanding.

Senator Bingaman. So just for the first two years, there is a requirement that Medicare rates be paid to providers under Senator Rockefeller's amendment, and in addition there is a requirement that any provider who is providing services to Medicare beneficiaries also provide services to people participating in that plan.

But after the first two years, any provider can opt out, and after the first two years there is a negotiation of rates which presumably, based on all that we have been saying around here, would mean that rates would go up if

the rates are going to be negotiated to be competitive with other health care insurance providers. Is that an accurate assumption?

Ms. Fontenot. Again, to refer back to the CBO analysis, they do assume that the rates, once the negotiation begins, would gradually increase so that, on average, they would roughly equal the rates paid by private insurers operating in the exchanges around the end of the 10-year budget window.

Senator Bingaman. And how does CBO score the amendment?

Ms. Fontenot. CBO scores the amendment as saving $50 billion over the 10-year window.

Senator Bingaman. All right.

And do they have an estimate as to the number of consumers that would choose their insurance through this option, if it occurred?

Ms. Fontenot. They do. They estimated that in 2015, enrollment in the public plan would start out higher than one-third of the 25 million who are estimated to purchase through the exchanges, so about 8 million people. That would gradually decline to one-quarter, so around 6.25 million as the premiums rise.

Senator Rockefeller. Would the Senator yield for a question?

Senator Bingaman. Sure.

Senator Rockefeller. I think that makes the point. I mean, I do not even want to get started on government run, a slippery slope into single-payor, and all the rest of it. But if you are starting up a consumer choice plan that does not exist, yes, you have an administrator, and for the first two years you have Medicare rates. But then it all stops and then the administrator does not have the authority to do any of this stuff, set any rates, any of the rest of it. That is done by the exchange, competition within the exchange.

To the CBO thing that the cost of health care will go up, well, the cost of health care has been going up forever and forever. The question is, at what rate? How fast? The clear thing about the public option or the consumer choice plan is that to some degree it would slow that rate of growth.

But even more important than that is that it would give people who do not have a way of working with their insurance companies, or their insurance companies are working them over and they do not know it, it would give them a safe harbor, a place to go in the exchange under the rules of the exchange and they would fare better there because it is nonprofit. And look, there are a lot of things -- Senator Conrad was just discussing, it would

be nonprofit. Blue Cross Blue Shield started out as nonprofit. It did not stay that way very long. It is for-profit. I do not want to get into the co-op thing now. I see that as a separate argument at a separate time.

I will mention, only about four or seven plans in the United States of America exist today. You talk about starting up a plan. I mean, good grief. That is going to be a monster project. But there is not control and there is the Medicare for two years, after which people can opt out of it, and the administrator does not have anything to do with negotiating rates, or anything else. That is done through the exchange. There is no malevolent or, as the Senator from North Dakota said, "devil is in the details" in this.

The Chairman. Senator Bingaman, you still have the floor.

Senator Bingaman. Yes. Let me finish my comments if I could, Mr. Chairman.

Senator Rockefeller. You are not going to respond to me?

Senator Bingaman. I am glad to respond.

Senator Rockefeller. All right.

Senator Bingaman. I do not understand your amendment the way you describe it, in that I do think the

administrator would be directed, after the first two years, to negotiate rates with providers that are competitive. I think that is a good feature. I am not criticizing that. I think that is a good feature. But that is a difference in interpretation of your amendment, so I certainly am glad to respond to that extent.

I do not know if staff has a point of view on that.

Ms. Fontenot. Again, I am referring simply to the CBO analysis in order to provide information that allows you to compare the score that they have given us to the assumptions they are making about the amendment that has been offered.

Senator Bingaman. Well, let me conclude my points, Mr. Chairman. I think it is obvious from the discussion -- I think, first of all, it is obvious that we need more competition in the selling of health care insurance. There are too few choices for folks out there, and we have all talked about this map that we have seen. We passed this out before to members of the committee--I think there is a big copy of it back here--which shows all the market share of the two largest health plans by State.

You can see that there is very little competition in many of our States, so we need more competition. That part is very obvious. A public option is a good antidote

to that, and therefore I strongly support having a public option. But it is clear there are various varieties of public option. The one Senator Rockefeller has now proposed, which is not my preferred choice because of the tie to Medicare. I think there is a problem in tying rates to providers to Medicare reimbursement. I think that is a mistake.

Senator Rockefeller. For two years?

Senator Bingaman. Well, even for two years I think it causes a dislocation, and I think providers strenuously object, or at least some of them who have talked to me strenuously object to the idea that we are setting it up that way. The problem with doing something for two years around here is, there are always opportunities to try to extend it.

Senator Rockefeller. But then if you are going with the two-year theory, and the Senator from North Dakota is saying it is going to put all my hospitals out of business, which, with all due respect for the Senator, he knows I have that feeling, I think is nonsense. Medicare, for two years, is just a way to get this thing started, and then it is cut off, people opt out. His hospitals do not have to worry about that. So he has got to make a case to me that all of his hospitals get shut down in two years, and I do not think he can --

Senator Bingaman. I am not trying to make that case because I do not think that those kind of dire circumstances would result. But as I say, my preference would be not to have it tied to Medicare. My preference would be to do more of what we tried to do in the Help Committee, more of what I believe Senator Schumer is going to propose later, which is to leave the setting of rates that are paid to providers for negotiation from the beginning of the program on. I think that would be preferable.

Then I think the public interest option, is what Senator Conrad talked about, the co-op idea, or mutual insurance, Senator Nelson referred to it as. I think that also has promise. As I say, I think the more direct way to do it would be to set up a nonprofit and tell them to go negotiate rates with providers and compete. That is what we tried to do in the Help Committee. I think that made sense there. I think it would make sense for us to consider that here, and hopefully do it. But the overwhelming conclusion I reach is, whichever of these options we wind up with, we will be improving the situation because we will be providing more choice. So, I compliment the Senator on offering his amendment and I will stop with that.

Senator Cantwell. Mr. Chairman?

The Chairman. Thank you. Senator Schumer is next.

Senator Cantwell. Would the Senator yield for a question?

The Chairman. Senator Bingaman, you have the floor.

Senator Bingaman. I am through, Mr. Chairman.

The Chairman. All right. Senator Schumer? Senator Schumer, you are next on the list.

Senator Schumer. Thank you, Mr. Chairman.

As is abundantly clear, Senator Rockefeller is offering an amendment. I will then offer another amendment which has some changes. But I am not discussing my amendment right now, I am here discussing Senator Rockefeller's amendment and why I support it.

Senator Rockefeller. Thank you.

Senator Schumer. The basic argument we face here is, should there be a public option? Should there be some kind of not-for-profit that is set up by the government? If a nonprofit could set up itself and spring up like grass, I think that would be a good idea. Senator Conrad, who has done a great job on this and I so respect him, and that is our disagreement, but that is for another day -- there is very little competition in the marketplace, as the chart that Senator Bingaman referred to is there. There is not much competition.

We all know, the American way is to bring more competition. My colleagues on the other side say, lead it up to the private insurance industry to bring competition. Frankly, many of us do not believe it will happen. The reason so many of our markets are highly concentrated, not just insurance, but many of the large fields have very few competitors is because it is in the shareholders' interests of each company not to compete, particularly on price. We find it in industry, after industry, after industry.

And we can all argue about how strenuous our antitrust policy should be to create more competition in the private field, but the bottom line is, we know now we do not have it. The trouble with health care is that, without competition, the prices keep going up. My friend Orrin Hatch mentioned that Medicare prices are going up. They are. So is private sector insurance, even at a greater rate.

So the increase in price is not the domain of the government or the domain of the private sector, it is rampant in both. I would say it relates to the structure of the markets: A) we do not have what the economists would call perfect knowledge. When your doctor says to you, you need this MRI spectroscopy, you do not know if you need it or not so you trust your doctor and take it.

That is fine.

At the same time, you are not paying for it because we all have either the government pay for it -- we are not paying for it directly. We are all paying for it indirectly. But you are not paying for the cost of that spectroscopy because you either are over 65 or poor and you have government paying for it, or for most--not all, but most--Americans, private insurance pays for it. And why do we have private insurance? It is very simple. Why do we have insurance in health care but not in so many other areas?

It is because health is the most important thing. It relates to God's gift to each of us, which is life. We all fear that some doctor will tell us at some point, your husband, your wife, your child, your parent, your brother, your sister needs this major operation/surgery/drug and it costs $100,000. We all fear we will not have it, so we buy insurance in case that happens to us.

But the combination of no knowledge of what we are being asked to do--take this exam, undergo this operation--we do not go to medical school. We know when we buy a Chevy versus a Cadillac, or when we buy a garden apartment versus a McMansion, the difference. We have no idea when it comes to health care, by and large. People

say you can go online. Maybe for certain kinds of prescription drugs, but not much else. I do not know how to read an X-ray and go online and look at whatever I have got in there and see if this particular operation, MRI, or whatever is needed. So you put that together and the costs are going through the roof.

The number-one imperative for us is to get those costs down. I think every one of us would agree, whether Republican, Democrat, liberal, moderate, conservative. We will get to in another point. Senator Cantwell has done amazing work. The unsung hero of this bill is her amendment on costs, which we should talk about as we move through this bill, but it is in the Chairman's mark, the one he introduced. Modification.

The Chairman. Modified.

Senator Schumer. Modification.

So the logic has been in the past, who is going to check costs when the doctor prescribes this and you do not know if you need it, but you are not paying for it directly? It should have been the insurance company because the insurance company is supposed to say, hey, that is going to be too expensive and it is not really necessary when, say, a doctor who wants to maximize his or her income goes for it.

But guess why that does not happen. In good, old

Adam Smith economics it would happen because there would be 25 insurance companies and a couple of them would say, hey, I will veto that and get more customers by having lower rates, lower premiums. But it does not happen because of this chart.

Frankly, the bill does many good things, the Chairman is right, on the insurance industry, but it does not get at this fundamental problem of concentration. Those of us who support the public option support adding some real competition to the coagulated, ossified, and fundamentally anti-competitive insurance market. And I do not blame the insurance companies. They are doing their job. Their job is to protect their shareholders.

That is what the chairman of the board and the president swear to do. But that is not our job. Our shareholders are our constituents. So we need a public option to create competition and to bring costs down. It is my belief, nothing will do it better. We can put regulations on the insurance companies, but their natural inclination is to escape those regulations because their job is to maximize their profit.

A public option does not make a profit. Whether it is Rockefeller's idea or Schumer's idea, in neither case does it make a profit. That automatically brings costs down by about 10 percent because that is what the average

profitability is. It is actually a little bit higher.

Second, it does not have to go market because if you need it you will take it. But they do not have an imperative to maximize their profits, they just want to serve their members, their people, so that saves another 10 percent and there is 20 right there.

Third, it is a different model. Because profit does not come first, when you have--God forbid--cancer, the natural inclination of the insurance company is going to be to say, this is very expensive, we had better check if it is really covered in their policy. They may find, through some negligence or some oversight, it is not.

They say, hey, we do not have an obligation here. The inclination of the public option would not be to do that, again, because profit is not hanging over their head. Now, profit does a lot of things well. Profit companies are more efficient. My guess is that a for-profit is more efficient than a not-for-profit, all things being equal, for the inverse of the same reasons, because they are making profit for their shareholder.

And so we have two different models. Frankly, nobody knows which one works best. There are some on the left--far left--who say it should be the government and that is it. By the way, for 45 million Americans that is all it is, it is Medicare, by and large. Some have

Medicare Advantage, but by and large it is Medicare.

Then there are some on the right who say, no government involvement. Although, again, in my questions to my friend Chuck Grassley, there is a bit of a contradiction here. You are so much against the government, but half the amendments here have been preserving Medicare and the RNC has been moving ads, and the NRSC, "Preserve Medicare". That is preserving a government plan. So it is sort of talking both ways. We hate a government plan, but we love Medicare and we are going to attack you because you are not preserving Medicare enough. That is not fair and it does not add up, and I think the American people will see that.

But having said that, the ideal solution, at least in my opinion, is have both. Have a public plan and let it compete with the private plan. Try--and Jay Rockefeller does this and I do this--to make it--we have somewhat different interpretations--the playing field level. In the House, for instance, I think they tie it to Medicare for good. Try to make it level and see which one prevails. The public option in both cases will not get constant infusions of government money. That is where the argument is that it might go to single payor. If it kept getting more government money every time it lost money, sure, they could set rates at 50 percent.

But Orrin Hatch is right, we cannot afford that.

So they get one infusion to get set up and then, with their different model, no profits, not too much marketing, but having the same basic rules that they face, they go after the market and provide the competition we have here. The CBO scores Rockefeller's savings at $50 billion. I would bet that is conservative. I will bet it is more. But CBO is conservative and we live with that in every way.

My plan and similar ones to it have a little less savings, but still significant savings. So we are giving people choice, we are saving the government money, and we are not being ideological that says, absolutely no public plan or absolutely no private plan. It seems to me the fair and down-the-middle way to go. It is no wonder that 65 percent of all Americans support it, despite the massive propaganda that has been waged against this.

Sixty-five percent of all Americans, according to the *New York Times* last Monday, I think it is, said they support a public option. It was not worded in a slanty way at all, it was right down the middle. Sixty-five percent, so maybe it is 75 in New York. But my guess is, if it is 65 in America, it is a majority in every State.

So what is holding us back? The system is not working. We certainly want to put some rules and

regulations on insurance, and we are doing that in the bill, and I support them. But it may not be the ideal. It is not the ideal. A public option, every day, in every way, in ways we have not thought about, will compete and bring those costs down and serve the public as opposed to simply the shareholders.

I would urge everyone on this side and everyone on that side to think about this. Take off the ideological blinders on both sides and let us just see what works for people. I am agnostic; I do not prefer the government, I do not prefer the private. I think at the end of the day, if we had a public option, it would sort of be like--I will say this in conclusion, Mr. Chairman--what we have with universities.

When a family has a daughter or son who is a senior, they have to apply to college. No one forces them to go to one college or another. But in my States--probably every State--we have public universities and private universities. Public universities are government funded, the private university is privately funded. Each family has a choice. I would argue that both the public universities, the private universities, and certainly our constituents are better off because they have that choice. Why do we not do the same for the only area where costs are going up even more, and that is health

care?

Thank you, Mr. Chairman.

The Chairman. I might say, Senator Ensign is next to be recognized. After Senator Ensign, I have six different Senators. It is 12:35. I do not know if it is possible, but if we could, I think it would be progress if we could get a vote on the Rockefeller amendment before we break for lunch.

Senator Rockefeller. Or supper.

The Chairman. Well, I would prefer lunch. But I will abide by the will of the committee on just how much more debate we want to have on this amendment. Then following debate and vote on the Rockefeller amendment, we will then turn to the debate and vote on the Schumer amendment, if we could. I would just note that point.

Senator Grassley. Mr. Chairman?

The Chairman. Yes?

Senator Grassley. Mr. Chairman, I do not know whether you announced it at the beginning of the meeting that that is the way you were going to do it, but on our side, we have got some amendments we want to offer, too. When are we going to be able to offer those?

The Chairman. Well, it would be my intention, after the vote on the Schumer amendment.

Senator Grassley. Did we agree ahead of time we

were going to have both the Rockefeller amendment and the Schumer amendment ahead of time?

The Chairman. No, there is no agreement. I just thought it would be good to put the two together, if we could, since it is the same subject. I thought it made sense.

Senator Nelson. I certainly hope you will keep to that, Mr. Chairman, because the two are symmetrical.

Senator Grassley. The only thing is, we have got some amendments we want to --

The Chairman. Then we could do two Republican amendments after that, if that is helpful, kind of balancing it out here. I see Senator Kyl has a little grin on his face. Does that work, Senator? All right.

Senator Ensign, you are recognized.

Senator Ensign. Thank you, Mr. Chairman.

I think, one interesting observation. We have heard a lot about how popular the public option is in all of the polls, and this and that from the other side. But I think it is very interesting to note, if it was so popular, why are there so many Democrats that have a problem with it? Why is it causing your side so much consternation of not being able to get the bill through? I think the reason is because it is not popular.

The reason is, if you went home in August and you

heard from your constituents the way that most of us heard from our constituents, people are really afraid of the "public option". I put it in quotes because many of us on this side believe that it will lead to a government-run system, that it will lead to a single payor, it will chip away, leading us to more and more government-dominated health care in the United States.

I think it is interesting that, under the CBO estimate of the Rockefeller plan, up front, about a third of the plans that go through exchanges will go to the public option, is that correct, and then later on, about a quarter? Are those numbers about accurate?

Ms. Fontenot. A third of the 25 million who are expected to enroll in the exchanges.

Senator Ensign. Right.

What percentage in the United States are not-for-profit insurance plans today, do you know?

Ms. Fontenot. I am sorry, I do not.

Senator Ensign. All right. Well, the statistic is about 44 percent. About 44 percent of private insurance in the United States is offered by not-for-profit today. The profit motive, Senator Rockefeller mentioned in his opening statement today -- is what has been demonized all day. Forty-four percent of the plans offered in the United States, and a lot of them are the dominant plans

that have been held up in this chart today, are not-for-profit.

What is interesting is that people are saying that this is not going to be a for-profit plan. Senator Rockefeller said that after two years, the government is not going to be running his plan. Who is going to be running the public option after two years? Who is going to be running the public option after two years?

Ms. Fontenot. I believe in the Rockefeller amendment there is an administrator.

Senator Ensign. Who does the administrator work for? Is it the private sector or is it the government?

Ms. Fontenot. I believe it is the Federal Government.

Senator Schumer. Would the --

Senator Ensign. Would the person running the plan -- I am not yielding yet. The person running the plan works for the government, but yet it is not a government-run plan. Is that somehow the logic that I am hearing from the other side? You do not have to answer that.

Senator Schumer. Could I just ask a question of Ms. Fontenot?

Senator Ensign. Let me finish.

Senator Schumer. I just want to know if Medicare is run by an administrator.

Senator Ensign. Let me finish mine. You are claiming my time.

It has been argued whether this is a government-run plan or not. I thought it was just important to understand who was actually running this plan. I will not argue with you that Medicare is not a government-run plan. I will actually answer your question that you asked of Senator Grassley earlier. There are problems with Medicare and Medicaid. One of the biggest problems is, there is cost shifting to the private sector, and there is no argument about that.

It is 20 to 30 percent of the cost because the government fixes the price on what we paid hospitals, and we underpay what those market forces would normally dictate. Because of that, there is cost shifting. The rest of America has their insurance rates go up, which makes it unaffordable for a lot of people, which makes a lot of people uninsured.

So if there is a public plan that is either negotiating or fixing rates, there is going to be a cost shift that happens to everybody else. That is why the Lewin Group has said 120 million Americans are going to lose their private insurance. Because of this extra cost shift, not only 20 to 30 percent more, but there will be even more cost shifting that will happen and you will end

up with people losing their private health insurance, so you end up with more people on the government. It is a spiraling effect that eventually could destroy the private insurance market, which is why a lot of us believe that we will end up with a single-payor type of a system.

Now, what is wrong with a single-payor type of a system? First of all, we have established -- I guess Senator Conrad was a pretty good spokesman for why the Canadian system and the U.K. is not a good system, but let me go a little further on why they are not good systems.

In Canada, they control health care costs. They spend about half per person what we do as far as their GDP. Their GDP is half what they spend. We spend about 17 percent of our GDP on health care, they spend, I think, around 8 percent, somewhere in there. The numbers are close. The way that they do that, is they cap the amount of money that they are going to spend. When you get that, you get huge waiting times up in Canada. One out of three doctors in Canada every year refer a patient to the United States. One out of three doctors. The quality of care in the United States is far superior.

As a matter of fact, Belinda Stronach--I do not know if I am pronouncing her name correctly. She is a former

Canadian member of parliament--opposed any privatization of Canada's health care system, and after she led that debate in parliament against a private health care system, she was tragically struck with breast cancer. A very sad situation, obviously. Where did she come to get her care? She came to the United States. She actually came to UCLA to get her care because you do not have the wait times, plus you have higher-quality care. We know the survival rates.

As a matter of fact -- do we have that chart yet? We can have this chart passed out. These are the five-year cancer survival rates, all malignancies, men and women. See the red, white and blue of the United States' flag, it is higher than the other flags? These are comparing health care with health care, serious health care with serious health care. After five years, all malignancies, for men in the United States, lead to about a 66 percent chance for survival. In Europe and in England, their survival rates are less than 50 percent. For women, it is about 63 percent in the United States, and in the low 50s in Europe and England.

We hear all the time about -- Senator Conrad made the comparisons. I made the argument earlier. He was talking about preventable deaths. We hear that they had the same kinds, or even better, results, longevity,

things like that. You have to take into account cultural factors, the fact that we drive cars a lot more than any other country, we are much more mobile. You have to take out accidental deaths due to car accidents and you take out gun deaths, because we like our guns in the United States and there are a lot more gun deaths in the United States. If you take out those two things, you adjust those, and we actually do better as far as survival rates.

There are a lot of other cultural factors you need to take into account. That is why, when you are comparing health care systems, you need to compare health care outcomes, not other factors. You need to adjust for those other factors so the statistics can be fair.

Now, Mr. Chairman, this is an important debate because Medicare and Medicaid, the SCHIP programs, this expansion, we are going more and more toward government-funded, and eventually government-run, health care in the United States. I do not believe that that is the direction that we need to go. Costs are a problem.

Senator Rockefeller has pointed out that the CBO said that this thing would score at $50 billion in savings. Well, one of the most important parts of the bill that is not going to be--and we know it is not going to be--in any of the Democrat bills is medical liability

reform. We know no serious medical liability reform is going to be in the bills that will do anything about medical liability costs. That is a huge cost to the United States. Defensive medicine, frivolous lawsuits, all of it is a huge cost so we can bring down costs in other ways than having the government compete with the private sector.

Another point that I would make on costs that I am going to bring up in an amendment later, and it is healthy behaviors. Well, we have pretty good data out there with a significant number of employees, that if you incentivize people to have healthy behaviors you can save a lot of money in health care costs, so why would that not be a major part of the proposal? Yet, it is not in this proposal. It is not in the Chairman's underlying mark. So we know there are ways to actually bring the costs down without having the government run health care and without having the government compete with the private sector. So I think we should reject this amendment. When we get to the Schumer amendment we will have a little different arguments, but basically the same. I believe that this committee should reject both of those arguments.

What I am very afraid of, though, as we go forward, is even if we reject these amendments we know where most

of the House of Representatives is right now, and that is, they want a public option. They want the Rockefeller amendment. That is why it is in the House bill. We are afraid that, no matter what the Finance Committee comes up with, when it goes to the floor, this bill will go to the left, and then when it goes to conference it will shift radically to the left.

The debate will be over at that point and it will just be, "well, we have gotten this far, we have got to pass this thing on." Once this bill becomes law, there is not going to be any repealing of it. All you have to do is ask yourselves what happened to the British system. The British system was put in at a time, because World War II was an emergency.

What happened with the British system? Well, today the British health care system is the third largest employer in the world. It has over a million and a half employees, more government bureaucrats than health care providers. That is what happens when you get government-run systems. Bureaucracies grow, they add on, they protect, and then they become a constituency to where they influence the political process to where you can never repeal these kinds of systems. This is a slippery slope for us to go down. The public option is exactly what we believe--most of us do on this side--that will

lead to a government single-payor system in the future as the government takes over more and more of our health care system.

Thank you for your indulgence, Mr. Chairman.

The Chairman. Senator Kyl?

Senator Kyl. Thank you, Mr. Chairman.

Four quick points. First, to the argument that a public plan is justified on the grounds that we have Medicare, a government plan, so it must be a good idea. A lot of experts disagree with this.

Let me quote, first of all, from the *Wall Street Journal* piece on September 11th, and they in turn were quoting a recent letter to Congress from 13 leading health care delivery organizations, including the Mayo Clinic, which said, "'Many providers suffered great financial losses associated with treating Medicare patients.'" They said that if these rates were expanded to patients who currently had private insurance, "'the result will be unsustainable for even the Nation's most efficient, high-quality providers, eventually driving them out of the market.'" Now, this was a point that Senator Bingaman made earlier, I would note.

Second, just to quote the president of Mayo Clinic, Dr. Danny Cortese, he said, "We think everybody should have insurance. When people start talking about the

public plan, it wasn't clear what kind of public plan we're talking about. And if a public plan looks like Medicare, I think the country would go broke almost overnight because Medicare is already proposed to go broke by 2015 to 2017."

So, Mr. Chairman, to that argument, Medicare is unsustainable under its present course, and these experts agree that a government-run option would likewise be unsustainable. I thought I heard the argument, secondly, that physicians actually support a public plan. In the event that there is any question about that, I would note that at least the largest physician organization, the American Medical Association, does not. A piece earlier in the *New York Times* says, "As the health care debate heats up, the American Medical Association is letting Congress know that it will oppose creation of a government-sponsored insurance plan." They specifically point out one of the reasons for it, which has been alluded to here earlier.

"The Medical Association said it cannot support any plan design that mandates physician participation," and I am quoting now from Dr. Neilson who, until very recently, was the head of AMA, Dr. Nancy Neilson. She said, "We will be engaged in the discussions in a constructive way, but we absolutely oppose government control of health

care decisions or mandatory physician participation in any insurance plan."

Now, the third point is that the public option, it is said, will create more competition. Two factors about this. First of all, it will not. It will actually crowd out private plans. That argument has been made. Let me just cite a specific comment about that from this same *New York Times* article that I submitted. These comments were actually submitted to the Senate Finance Committee, and in them the American Medical Association said the following: "The AMA does not believe that creating a public health insurance option for non-disabled individuals under age 65 is the best way to expand health insurance coverage and lower costs. The introduction of a new public plan threatens to restrict patient choice by driving out private insurers which currently provide coverage for nearly 70 percent of Americans. In other words, rather than create more competition there will be less competition because of the crowd-out factor."

Also, the second point I would like to make with respect to this is, if in fact there is not enough competition in some of the States, the first question should be asked, why is that so, and then perhaps address the reason. There are two primary reasons. First of all, there are some States that have State laws that

primarily involve mandated insurance coverage, which makes it very unproductive for private plans to compete in those States. The obvious answer is for them to conform their practices more to other States that do not have such onerous mandates.

The second, is the small population in a lot of States so that you have a smaller risk pool, and it simply is not possible to have a lot of insurers dividing up a very small risk pool. Adding another insurance company, government or not, does not solve that problem. Republicans, rather, have identified several alternative proposals to meet the real reason why there is not as much competition in some States as there should be. I suggested fewer mandates. We have talked about association plans with larger risk pools, and you can achieve that as well by the interstate sale of insurance, which we have spoken of frequently.

The final point I would make is that a public option using Medicare rates, which this proposed amendment would do, will obviously raise private premiums. This is what happens with Medicare. When you use the Medicare rates, somebody has to pay the difference between those rates and what it costs medical providers to actually deliver the medical services.

Milliman, for example, estimated that the hidden

cost that the private plans pay to subsidize the cost of Medicare and Medicaid is $88.8 billion a year, and they conclude that this means average health care spending is $1,788, or about 10 percent more annually per family than it would be without this kind of cost shift. That, of course, would simply be exacerbated if you had a public option with payments similar to Medicare.

So these are all very strong reasons to argue against or to suggest that we should not be supporting an amendment such as the Rockefeller amendment, or frankly any public plan that would have the deleterious effects that these experts that I have quoted say that it would have.

The Chairman. All right. I have to get my list out here.

Next, I have Senator Stabenow.

Senator Stabenow. Thank you, Mr. Chairman.

The Chairman. Just so everybody knows, I have Senator Stabenow, Senator Cantwell, Senator Bunning, Senator Crapo, Senator Kerry, and Senator Nelson. I think that after you finish, Senator Stabenow, we are going to break for lunch. There will be about a 45-minute break, depending on how long you wish to speak. Then we will come back, whenever that 45 minutes will transpire.

Senator Stabenow. Well, thank you, Mr. Chairman.

The Chairman. Senator Stabenow, you are recognized.

Senator Stabenow. I appreciate it.

First, I want to thank Senator Rockefeller for his passion for this amendment, which I think is very, very important. I do want to make just a couple of comments, first, responding to debate from colleagues. Just to note, the chart that was held up on cancer survival rates, it is interesting that the response from Great Britain to this chart, which obviously they are the lowest of the three.

Mike Richards from the U.K. Department of Health said, "Many more lives could be saved if all countries were brought up to the standards of Norway, Sweden and Finland", which goes to Senator Conrad's earlier comparisons. I say this only to say that on this chart we may have done well, but there are many other countries doing better. The good news of the chart about cancer, which goes to, I think, another important point, which is a foundation for this legislation, it is my understanding that in analyzing cancer rates one of the reasons we do better in terms of life expectancy for men, is that we have coverage for PSA screening for men for prostate cancer. That is a good thing.

There is coverage in this legislation, a requirement as it relates to prevention and wellness and focusing on those kinds of items. I also would just say for the record that, in Senator Conrad's chart, when we come out 22nd on infant mortality, actually we are below Fuba in Honduras. In part, that is because we do not offer, widely, maternity care, just for the record. Prenatal care, what is happening to babies in the first year of life, one of the reasons why this bill and the coverage that we are talking about is so important.

I think the real challenge for us, Mr. Chairman, is that we do not have one system that we are building on in order to make sure that small businesses and people that do not have insurance can be able to get insurance that they need, that they can afford, and that they can find. We basically have, I think, just about every system that Senator Conrad talked about. We have a system for our armed forces and for our veterans that is wholly government run. The VA, in fact, has been the leader in electronic medical records, in looking at health information technology and new quality measures. But that is a completely government-run system.

Then we have Medicare, which is a single-payor, government-run system which is different than the VA. Then we have employer-based care and employers kick in,

employees kick in a piece. Most employees, instead of a wage increase, are getting health care coverage. So we have different systems, which makes this so tough. This is a complicated issue because we are committed, the President is committed, I am committed, we have all said we want people to be able to keep what they have, but what they have is involved in very different systems.

So to me, how do we bring together and pool people in an exchange, people that do not have insurance, cannot find it, cannot afford it? How do we do that in a way that makes sense? To me, Senator Rockefeller's amendment, and then, second, Senator Schumer's, is the grand compromise because it says we are going to create a group market, we are going to allow people to go in and get the benefit of lower cost through negotiation and a big group, and choose between private insurance companies. But they also can choose what a lot of people in America have, which is a public insurance choice, a public option.

We have been told by CBO, who we all know is conservative, that over time, about 25 percent of Americans that do not have insurance today will choose that. So it is not everyone. It is not decimating the entire private sector system. If you go back and look at the debate on Medicare, the very same arguments were used

in the 1960s, that we could not have Medicare for seniors because it would destroy the private markets, it would destroy the private insurance system. That is not what happened.

Replay to today: same arguments again. Yet, we hear from CBO that, in fact, they estimate over time, 1 out of 4 Americans that do not have insurance today, they are not in Medicare, they are not in the VA or one of our troops serving us in harm's way, they are not in an employer system, but people who do not have insurance through a small business or through their inability to get a good price as an individual, going to an insurance company, that 1 out of 4 will choose a public option. I do not know what the fuss is all about.

I mean, there is a lot of demagoguery about government which I find, frankly, Mr. Chairman, very concerning because we are all part of the government. We have this great democracy that we all talk about, and liberty, and Constitution. Yet, with that comes the requirement that we work together through government, as well as the private sector, to address the concerns of Americans. We know that the recent polling indicates about 68 percent of voters would like this choice. They may not take it.

CBO, according to their numbers, not all those 68

percent will take it, but they would like to have the choice: liberty, freedom, choice, people being able to make their own decisions. Seventy-three percent of the doctors, according to the *New England Journal of Medicine*, 73 percent of medical doctors support a public option of some kind. Who would know better in terms of what is happening right now than doctors that are trying to work their way through this system?

So in my judgment, when we look at the fact that people would like the option, physicians would like to see this happen, the fact that we know it saves $50 billion to taxpayers, we know from the independent Commonwealth Fund that over 10 years for the whole system -- they would estimate reforms that include a public option would reduce spending nearly $3 trillion over 10 years. Those are big, big numbers. In my judgment, this is reasonable, rational.

When you get by all the hyperbole, this is part of the way we make sure the reforms in the bill work. We have tough insurance reforms in this bill. We have important reforms to allow somebody , if they lose their job, to know that they and their families will not lose their insurance.

We have ways to bring down costs over time that are incredibly important in this bill, but from my judgment

the way to make sure it is really affordable, it is really affordable for Americans, is to make sure there is real competition and real choice. It has been done before, it should be done again. Mr. Chairman, to me this seals the deal in terms of having a package that guarantees the American people that the new system will be able to deliver on what it is we all hope it will do.

Thank you, Mr. Chairman.

The Chairman. Thank you, Senator.

We will now recess for about 45 minutes. The list I have of Senators wishing to seek recognition are: Senator Cantwell, Senator Bunning, Senator Crapo, Senator Kerry, Senator Nelson, and I will recognize whoever is here when we resume at 1:45. The committee is in recess until 1:45.

[Whereupon, at 1:08 p.m. the meeting was recessed.]

AFTER RECESS

[1:53 P.M.]

The Chairman. I see Senator Bunning is here. Thank you, Senator for being here.

Senator Bunning. Thank you, Mr. Chairman.

The Chairman. And you are recognized.

Senator Bunning. There have been a lot of charts being used quite frequently today and I would like to call this chart before us market share of two largest health plans by states and I would like to bring it forward once again and explain the reason why.

If states could have sold insurance across state lines, they would all be like Oklahoma. They would all have many more insurance companies bidding for their business. So we would have much more competition.

I can tell you in 1992 the Kentucky General Assembly passed restrictive laws. We had 48 competitive insurance companies in Kentucky at that time. After the law passed in 1992, we had one and a half insurance companies bidding on health care in Kentucky. One was Blue Cross/Blue Shield, Anthem Blue Cross/Blue Shield which at that time was nonprofit, and just to have competition, we had a health care sponsored by the state.

So we had one and what I call a half health care bidders for business. That is why I differ completely

with Senator Rockefeller's position that the public option would create more health care options if we would allow insurance companies to sell health care across state lines, we would have many, many more health care companies bidding for business not only in Kentucky, but all the other 49 states. We don't need a public option to do that.

One of the other things that has been brought up quite frequently today is that 73 percent of the doctors are for this plan. It was quoted in the Journal of the American Medical Association. I hope everybody realizes that 20 percent of the doctors in the United States of America belong to the American Medical Association. Twenty percent. That means 80 percent do not belong.

So if you get 73 percent of 20 percent, that is the amount of doctors you might be talking about which amounts to about 14 percent of all doctors in the United States.

So I do not think it is a fair quote to say that 73 percent of all doctors in the United States are for a public option plan.

Medicare has been mentioned quite frequently. That is a given public option, absolutely. We all agree it is. We all agree it has been here since 1965. We all agree that it also overspends to the tune of having a $37

trillion unfunded liability, $37 trillion. Does anybody have any idea how much money that is? $37 trillion.

I do not think anybody can imagine how much money that is. Since we are, our national debt is approximately $12 trillion, but in 2017 or 18 depending on who is counting the numbers, Medicare Part A will go bankrupt. So unless we do something in this medical fix to take care of the bankruptcy and there is arguments on both sides about what kind of fix we have on Medicare, and I am not going to get into that discussion other than to say that yes, Medicare is something that we created in 1965. It services those over 65 or is supposed to in health care benefits, but there are a lot of people that do not trust Medicare and will keep private insurance because they think that private insurance is more reliable than Medicare and pays the doctors and the hospitals what they are supposed to get paid for the services they render.

So I think it is very, very important for the people who are listening to understand that some of us feel that if we are going to pass this option for our medical improvement, that the people in Congress and their staffs and the people in the administration and their staffs and the people in the judiciary and their staffs should be governed by the same law.

In other words, there should be an option that we all are covered under this same medical care that we are proposing for the American people and that there shouldn't be all these things that allow us a way out.

If I heard one thing during August, why Senator are you not including yourself in what is being proposed? And I said it is not my bill, but I will try to make that change when we go back and we just date this bill. And as far as the public option is concerned, we on our side of the aisle really feel strongly that this is a major step towards universal health care coverage in the future. Not tomorrow, not next year. Maybe in 2014 or 2013 depending on when it gets there.

With 40 grandkids, I do not want them covered under the public option. I do not ask them because some of them are not capable of even telling me what they want because they are very young and very uninformed. As I have heard it said that most of the people that are medical shoppers for Medicare and Medicaid are private coverage do not know what they are buying.

Well, if we have a single payer medical coverage for all America, we are going to restrict what is available just like Canada does, just like England does. I heard profits mentioned so many times today that the profits of the health care community and the insurers are just out

of sight.

Well, as of the last quarter, and this is a chart that I will just show. I do not have these big charts, I have just little ones. It shows that health care plans made a profit of 3.3 percent in the last quarter. If we get to the beer companies down the road, they have a profit of 18 percent, and cigarette companies are 15.7, wireless communication companies, 11.5, restaurants, 7.7, waste management companies, 6.3, soft drink companies, 5.9 and the least of that group is health care plans which have a 3.3 percent profit margin.

So if we want to make sure that we keep profits low for the health care companies, we need to change a lot of things including Medicare and Medicaid and make some changes that will make them more efficient and more usable for those and make sure that our doctors are accepting those patients.

What good is Medicare and Medicaid if doctors refuse to cover them? If all of a sudden we have priced by lowering the reimbursement rate to 80 to 85 percent, we have priced our reimbursements to the doctor and to the hospitals below what they can get? Obviously they are making up the difference on private insurers, but that will not last that long. It is not going to last if we do not change what we are doing.

So we on our side would like to see some significant changes in Medicare and Medicaid to make sure that we do get the reimbursement that the doctors and the hospitals deserve. That is why I am not for the current public option that has been put before us and I thank the Chairman.

The Chairman. Thank you, Senator. Senator Cantwell?

Senator Cantwell. Thank you, Mr. Chairman. I apologize for not being here right at the reconvening of the committee. I do want to speak in support of Senator Rockefeller's public option amendment, but I would like to ask Ms. Fontenot a question first which is we have had a lot of discussion here about Medicare and Medicare rates as it relates to the way the amendment is drafted.

It is my understanding that Senator Rockefeller's amendment says that you would pay Medicare rates based on current law. In the underlying bill, assuming that both Senator Rockefeller's amendment was adopted and the bill as currently in the modification would be adopted, that Medicare rates would be very different than they are today and that Senator Conrad's concern that providers in his state might not be getting an adequate reimbursement would be changed under this formula, is that correct?

Ms. Fontenot. It is correct under the Senator's

amendment. The public option would pay based on the current Medicare reimbursement rates which are dramatically changed in this bill. So it would reflect the policy changes that we are considering.

Senator Cantwell. And so if you were from an efficient state that had efficient low cost delivery system, a good outcome, you would actually be making more than you are currently today. So if you were from a state like Senator Conrad's, chances are you would be making more money and it would not be as an exacerbated problem as it is today, is that correct?

Ms. Fontenot. Correct.

Senator Cantwell. Which I think is an important point because the underlying bill is making a fundamental policy shift in the way we pay for Medicare services, not just in Medicare advantage, but in accountable care organizations and saying that we are going to have global budgeting and that organizations are going to move to global budgeting and that they are going to reap the benefits from being efficient care providers and sharing in some of the profit.

The value index that I proposed that was adopted by the Chairman also says that you are going to pay based on the quality of outcome which means that if you are better than the national average in delivering care and quality,

you are going to get paid more and you are going to get an incentive. So I actually think that that is an important part to the debate about Senator Rockefeller's amendment in the public option and Medicare.

Mr. Chairman, my fundamental view about this is about market competition and it is about market forces. I certainly believe as I look at this bill, we are spending at least half the money, some of the money is going to Medicaid expansion, but $483 billion is going to tax subsidies to basically buy insurance that is expensive insurance and I would like to see more competition to that.

I would like to see more competition in the market place and I think one of the providers of that competition can be the federal government.

Now why do I want to see that competition? Well, frankly I am, as this chart shows where we have been in America, we have been at a point where wages have only gone up 29 percent, the insurance premiums have gone up 120 percent and we have seen insurance profits go up 428 percent. Insurance profits went up 428 percent in a 10-year period of time where we know where the money came from, it came from an increase in insurance premiums.

Now, that is Robert Wood Johnson Foundation information. So the fact that they have had these

extraordinary profits in a short period of time has gotten many people in Washington State and many people across the country asking a fundamental question which is what are we going to do to restore competition in the marketplace so that somebody isn't just walking away with the store here.

My constituents who look a things and say geez, I do not know what you guys are doing but oil numbers went through the roof on future derivatives and what did you do about that because I got gouged there. They want to know what we are doing about banks who went crazy on credit default swaps and then basically got a bailout and what are you doing for me because last I checked I cannot even get, you know, they are saying they are having problems with their own banking.

Credit card companies are now, even though we supposedly passed a law of running away with, you know, having made money off the situation and now gouging consumers with higher interest premiums, so to say nothing of the drug companies which we also were going to debate this issue as it related to Part D, what do we do instead of adopting, having clout in the marketplace with Medicare we ended up with going to the private sector and saying we are going to drive down the price of prescription drugs.

Well, I would ask anybody to look at the price of prescription drugs in the last couple of years and we haven't driven them down. So to me, the key point here is are we going to stand with the public and use the bulk purchasing power of the public to drive down the cost of health care. And so I support a public option to do that. I support a public option that will drive down the cost by using that power in the marketplace to be an alternative to the private sector.

Now, I know that we will have a chance to talk about other amendments and I certainly support other amendments. I plan on offering one myself that would allow the private sector to participate through the negotiations similar to what Senator Conrad was saying of using non for profits as a tool to drive down the cost and have them use the clout of the government to help drive down that cost. That will be another debate.

This debate is really about whether we are going to have the kind of competition that will help us with this very, very consolidated market of 94 percent consolidation and the fact that people have very few choices.

Now, we have heard a lot of discussion about well, isn't this going to be cost shifting? Isn't this going to cause problems in the marketplace?

Well, CMS as it does today in working with the medical community is going to have to pay a rate if this came into play would have to pay a rate that is going to attract physicians to cover and carry this market. That will be a fundamental part of the legislation just as accountable care organizations and the value index is in providing care.

But if we do nothing, if we do nothing and the rates go up another 120 percent in the private sector which is what the plan is basically that every agrees is going to happen if we do nothing, it is going to be an unacceptable outcome to the American people.

So I hope my colleagues will stand on the side of competition but on the side of competition of letting the American people, you know, Costco is a great store in Washington State and I know many people, my colleagues here they love to tell me about how they go to Costco and they buy something.

Well, they go to Costco and they buy something because somebody has bought that product in bulk and has driven down the price for them and they have driven down the price because they have been able to buy in large volume.

That is what the American people want. They want us to stand on their side and drive down the price by buying

in bulk and compete with this unrelenting increase in rates that they have seen.

So Mr. Chairman, I support Senator Rockefeller, I will support Senator Schumer and I will continue to offer my own amendments to make sure that we continue this effort to give the consumers that kind of competition in the marketplace. I thank the Chair.

The Chairman. Thank you. Senator Crapo?

Senator Crapo. Thank you very much, Mr. Chairman. I would also like to ask Ms. Fontenot a question, again also about the Medicare rates and what the underlying bill would do to change Medicare compensation policy.

I understand that the bill would have about $113 billion of reductions in Medicare advantage payments and that it has a one-year SGR adjustment which then snaps back. But what other Medicare reimbursement policies are changed by the underlying bill?

Ms. Fontenot. Senator, actually I'm going to defer to my Medicare colleague on that and allow her to answer.

Senator Crapo. All right. Thank you.

Ms. Eisenger. There are a variety of Medicare changes in the bill spanning from what we typically call the delivery system reforms which are the policies that Senator Cantwell referred to that would move towards value based purchasing for hospitals, home health,

nursing homes, physicians and so forth. There are provisions related to reducing hospital readmissions and reducing avoidable hospital acquired conditions, so there is a whole host of, and then there is accountable care organizations, a whole host of delivery system reforms that try to move from a fee for service system to one that pays based on quality.

There is also a set of provisions related to improving accuracy. So in areas where MPAC in particular has recommended that the payment rates in Medicare are higher than the costs justify, we make payments to reform those payment systems and you see a few of those changes in the package.

Thirdly, there is a host of provisions related to market basket adjustments which over time would require increased productivity on the part of providers and changes of that nature, so there is a whole host of Medicare related provisions in the package.

Senator Crapo. And with regard to those provisions, what is the net budget impact of that? The reduction of some amount of money, but could you tell me what the net reduction of Medicaid spending is under those proposals?

Ms. Eisenger. Medicaid or Medicare?

Senator Crapo. Excuse me. Medicare.

Ms. Eisenger. I do not have the most recent number as some of the amendments have been accepted, but it is somewhere north of $400 billion.

Senator Crapo. In reductions?

Ms. Eisenger. Correct.

Senator Crapo. All right. That is adequate. Thank you very much.

Mr. Chairman, I want to speak in opposition to the proposal for a government option for a number of reasons. Most of the debate today has focused on choice and competition and I am going to focus primarily on that as well.

I strongly believe that if we were to adopt a government option, that the net result would be to reduce choice and to reduce competition. I personally see that a government run plan is really the only way to surely reduce the kind of competition and choice that we need to be facilitating in the health insurance market.

First, excessive regulation itself causes a reduction in competition. In fact, the Federal Trade Commission in analyzing competition within the health care sector stated, and I am quoting the FTC at this point, not referencing this bill but just referencing the issue of competition within the health care sector stated that regulatory rules can also reduce the rewards from

innovation and sometimes create perverse incentives, rewarding inefficient conduct and poor results.

Restrictions on entry and extensive regulation of other aspects of provider behavior in organizational form can –- new entrance and hinder the development of new forms of competition.

The point is that as we move into more government controls over the provision of health care, we necessarily see the impact of excessive regulation on competition.

Secondly, and I personally think that the studies show that creating a government option will ultimately drive people out of the private sector and then again reduce competition.

One independent estimate showed that a government run plan with the ability to set prices at Medicare rates, and that is why I asked the question I had about Medicare. A government run plan with the ability to set prices at Medicare rates will result in more than 118 million Americans losing their private insurance.

Now, I know that there are people who say these studies are not accurate, but the bottom line is that as we approach valuing what establishing a government run option would be when that option, that government run entity would have the ability to set prices and pay at

Medicare rates, rates which we know today are not adequate and which would result in an inability of that provider to be providing the mandated insurance at a much lower rate than the private sector is going to result, necessarily result in a reduction in competition. It is also going to result in a reduction in quality.

One of the arguments that has consistently been put out today is that Medicare, you know, the Republicans last week were concerned about the impacts of this legislation on Medicare and why were they concerned about the impacts on Medicare if they truly oppose a government run health care system which Medicare is.

The point of last week's debate was not to say that we should adopt a Medicare type system. The point was to explain that Medicare is unsustainable and that some of the things in this proposed legislation were going to make it even more unsustainable. In fact, last week one of the amendments that I brought on Medicare was dealing with Medicare advantage as the Chairman will recall.

The point that I made and many others made was that here in this one part of Medicare where we actually have succeeded in allowing the private sector to have some access to the provision of health care, we have phenomenally high levels of satisfaction and the opportunity to provide access in areas, rural areas of

the country which Medicare was not being successful in reaching.

Yet what we are faced with with the proposed government option is this. We today have two major health care government provided systems, Medicare and Medicaid. Two major government run health care entitlements in the United States, both of which are unsustainable, both of which are going to basically hit the wall and go off the cliff soon and the proposal is that we should establish yet another major entitlement and have the government run it as well.

Now, I understand that the proposal is not to have the government run all of it, though there are concerns by many of us that the net result will be a necessarily large transition of the health care provision in the United Sates beyond Medicare and beyond Medicaid into the new government run proposal. That can be nothing but harmful to competition.

It has been said here today that 65 percent of the public supports a government option. I was reading today's latest polling numbers which say that 56 percent of the public oppose the President's proposal which has included in it a government option and 41 percent support.

We can talk about how many in the public support

this or how many in the public support that, but I think that anybody who paid attention during August when this Congress was home in their states knows that there is a significant amount of unhappiness about the notion that we should move toward a government run option in our proposed health care systems..

Lastly, back to the question of competition. What can we do to really deal with competition? We had a lot of discussion about how many effective insurance companies there are and what kind of competition there really is in the marketplace.

I and my colleagues on this side have acknowledged that we need to do things to increase competition and to strengthen the private sector and the ability of people to compete.

Well, for one we can expand those insurance pools by allowing for AHA insurance pools like we have talked about before. Let small businesses group together, expand business pools or insurance pools which will in and of itself create tremendous ability to bring downward pressure on price and upward pressure on quality and product as we have a more robust, competitive environment.

We can allow competition across state lines which also will help to expand pools and increase competitive

opportunities and frankly we can look at the causes of why we see some market entrance, market participants leaving markets these days which, much of which has been identified as very, very restrictive state laws that have made it very difficult for companies to effectively compete by adding continuing mandates onto the product requirements of the companies as they provide insurance.

It is some of these things that help make the market more robust and more capable, to expand insurance pools and to approach the question of providing greater competition by looking at what it is that is stopping competition in the markets today that we should be focused on rather than saying since we would like to see greater competition and greater choice, we want to turn to the government.

Experience in the past has shown that turning to the government as an alternative is not going to provide that choice and is not going to provide that competition.

The Chairman. Thank you, Senator. We are getting close to a vote. I have two senators remaining. Senator Kerry and then Senator Nelson.

Senator Kerry. Thank you very much, Mr. Chairman. I have been listening fairly carefully to the debate and it is interesting because I think that people are sort of talking past each other a little bit here. I certainly

think our friends on the other side of the aisle are arguing and talking about and indeed trying to even scare some people about the prospect of a public plan that is not in fact being talked about here.

They keep using the example of Medicare and Medicaid and how their sort of difficulty is a reason to suggest that what is proposed by Senator Rockefeller ought not to be accepted.

Now, Medicare and Medicaid are entitlements. Senator Rockefeller's plan is not. Medicare and Medicaid appeal to specific populations with different kinds of medical needs obviously. This is a plan that is by law under Senator Rockefeller's requirements required to pay for itself. The premiums must sustain this plan.

This plan must operate by the same rules as the private plans. So the question really has to be asked is what are our friends really afraid of? Are they afraid of a competitive choice that in fact provides quality care at an affordable rate to Americans or are they more interested in protecting the insurance companies and the people who have been raising the rates and not necessarily fulfilling the needs? That is the question here.

I mean, look at this. This is a very telling chart. One of the most important facts that has been put in

front of us. You look at the United States of America and there are ten states in which 80 to 100 percent of the insurance market is cornered by just two companies. There are 11 states in which 70 to 79 percent. So in almost half the states in the country 70 percent up to 100 percent of the market is cornered by just two companies.

We are talking about an insurance plan started by the federal government under a set of rules that expends less administrative overhead, less cost and therefore helps provide more affordable insurance to people and that will drive the private sector to have to be more competitive in ways that it simply has not been.

Now, the fact is that we are not talking about, and this is another thing lost in this debate. We are not talking about a product like a car or clothes that you buy or something in the normal marketplace. We are talking about care, health care, care for human beings who may be suffering from some disease and they cannot afford the care they need.

The fact is there is a trail here of millions of Americans who get cut off of their insurance, who are denied coverage after they have paid their premiums religiously year after year and who are cast out into the world and told tough luck, you have got whatever disease

you have got, deal with it. We are not there for you when we said we would be.

So we have a right at this point I think to claim that it is appropriate to have some entity that is going to provide an affordable set of alternatives to people and be competitive. Now, what will that do? I heard a lot of talk about crowd out. Most of the discussions we have heard, Mr. Chairman, about crowd out make assumptions about federal subsidies and about a federal plan and a bailout. I think public plan is really the wrong name for this in a sense because it is not the kind of plan that is being talked about by the folks who are opposing it. It is not going to have those subsidies. They are prohibited.

It is not going to have a bailout. That is prohibited. The premiums themselves paid by the people who take part in it have to sustain the plan as you go along. Your savings are precisely where they ought to be. Now, why do I say that? Well, a lot of people believe you could have a more effective expenditure of the medical dollar.

Currently the average is that 25 percent of the premiums that people pay in America goes to profit and administration. Twenty-five percent on average. In the group market it is about 20 percent. In the private

market it is 30 percent. So here we have people defending a 30 percent profit and administrative margin. If you get sick, you may not even get the benefit of the premium you paid for.

I think we have a right to have an entity come in here that says we are simply going to compete and we are not going to charge the 25 percent profit overhead. We are not going to charge the same administrative costs because we can deliver it more effectively. What will that do? That will drive the other companies to try to be more competitive.

Now it is ironic here. Senator Hatch and others were talking about this is the first step to single payer. Well, if people are paying the premiums that are charged to cover the cost and it is not allowed to have a federal subsidy and there is no bailout allowed and after the first two years the prices are set according to the private market negotiation, what are we scared of? That Americans might like a competitive plan that is in fact paying for itself and providing good service?

If that suddenly becomes something that Americans like more and go to, more power to them. That is precisely the choice that they ought to get. The very people who have been arguing about freedom of choice, freedom of choice, freedom of choice are unwilling to

allow a competitive entity that actually allows people real freedom of choice to choose something that is paying for the cost of the service that they are getting without being prisoners of exorbitant amounts of profit.

Now, I say this and I say this with a lot of respect and admiration for what our health system is able to do in most respects. I would also point out that a lot of that comes with also federal dollars. National Institutes of Health, National Science Foundation and other things. There is a synergy here. We ought to keep that synergy going in providing an effective alternative to people in how they get their health care.

The question is really what is an appropriate profit margin? Twenty-five, 30 percent at the expense of people's ability to be able to afford to take care of themselves? That is really what this choice is. It is a fundamental human choice as far as I am concerned.

Let me point out something else which I think is mistaken in the presentation by our colleagues. They have talked about the so called cost shifting. Well, that has actually been debunked by the national authority on Medicare, MedPAC. The Medicare Payment Advisory Commission contradicts what our colleagues were saying about low Medicare reimbursement necessitating a higher private reimbursement.

It is exactly the other way around. According to MedPAC, higher private reimbursement causes Medicare reimbursement to look low, but MedPAC argues that the high profits for non Medicare sources permit the hospitals to actually spend more and we wind up without the kind of cost reduction that we are looking for here.

So folks, this is a really fundamental kind of choice for people. The fact is that most Americans are angry, deeply upset about the way they get treated by a lot of private insurance companies. The fact is that a study by Price Waterhouse Cooper last year revealed that the collective medical loss ratios of the seven largest for profit insurers fell from the 85 percent that we were talking about in 1998 down to about 81 percent and that is just for the top seven.

It happens to actually translate into a lot higher levels for the rest of the market. That translates into a transfer of several billions of dollars in favor of insurance company shareholders and executives for nothing to do with the actual delivery of care to people. But it goes into the pockets of insurers at the expense of a system that is now broken.

So I strongly support this measure. I think it will provide competitive pressure to the rest of the insurance industry. If it takes a market share away from a private

insurer through a lower cost and better service, and remember, it is going to have to provide better service to attract people privately which is the way it is set up.

If people are going to pay a premium based on the cost of the service, that service is going to have to be good. If that service is good and they are able to provide it, that will act as a dampener on the rampant cost increases, benefit cuts, copay increases and all of the other things that citizens have been subjected to. It will provide improved service and frankly ultimately a division of customers according to the quality of the program that is being provided.

So the market will actually work its magic more effectively with this option, Senator Rockefeller's option and if that is not successful, Senator Schumer's, by providing real competition and the incentive to hold down costs.

We have experience with this. It has already been mentioned. Medicare and Medicare Advantage. We have seen what happens. The fact is that many more people like Medicare and they go to it, compared to those who choose Medicare Advantage. That is precisely the kind of choice we ought to be providing the American people. Thank you, Mr. Chairman.

The Chairman. Thank you, Senator. Senator Nelson?

Senator Nelson. Mr. Chairman, I would like to wait and speak on Senator Schumer's amendment.

The Chairman. All right. There is one Senator remaining to speak and that is Senator Cornyn. Then Senator Rockefeller will wrap up. Senator Cornyn?

Senator Cornyn. Thank you, Mr. Chairman. Mr. Chairman, I do not understand why under this amendment we would create another entitlement program when the existing entitlement programs we have in this country threaten to bankrupt our country and those who are such staunch advocates of choice in competition are the ones who voted against giving Medicaid beneficiaries choice when it came to the benefits that they are entitled to and those who suggested Medicaid advantage now presents an appropriate choice.

I do not understand how that is consistent with the previous arguments that really the problem here is with insurance companies.

Now, I think insurance companies ought to be strictly and vigorously regulated. But if there are no insurance companies offering health care plans, that leaves the federal government. I suspect that that really is the ultimate goal and that is why some on our side have said we see the proposal for a public option as

a pathway to a single payer system.

As far as the current entitlement program serving as a good model for this public option, well, I suggest to you that Medicare is a poor model to replicate when it comes to increasing competition and giving Americans more choices.

First of all, we know the federal government does not compete fairly. Indeed it is subsidized by the taxpayer, they will be able to sell a product at a lower rate that will undercut any private competitors. Indeed I suspect that is one of the ultimate goals here on a pathway to a single payer system.

Ultimately creating a government plan will take away choices for Americans, not give them more choices. So let me just mention a couple of the problems and the reasons why I suggest Medicare is not a good role model that ought to be emulated by this public option.

Every year in the Medicare program, the government program we already have, we debate how to ensure that seniors have access to doctors by fixing the flawed reimbursement formula, the so called sustainable growth rate formula in Medicare.

Balancing access for the federal budget is a perpetual challenge. We all know, and on that would only be exacerbated by adding a new entitlement program on top

of the ones that we have now.

Senator Schumer. Would the Senator yield for a question?

Senator Cornyn. After I am through commenting, I will be glad to entertain a question.

We know that Congress will be lobbied to increase reimbursements under these programs and include additional mandates that will make it more expensive. Unfortunately I think this is an area where we found that the existing entitlement programs have a fundamental flaw when policymakers and politicians are the ones that determine what is in the product, what has to be sold and at what price, then it is the very antithesis of the marketplace that will set lower prices that improve services.

I mentioned Medicare is going bankrupt in 2017 and it is under funded by $38 trillion over the long term. That is three times our current national debt. So adding yet another government program will only make those problems worse in addition to the fact that the fund, the underlying program here, we are talking about taking money out of Medicare in order to fund this new program, this new government proposal.

Then of course Medicare is riddled with waste, fraud and abuse, something that the President acknowledged in

his joint session of Congress speech. One study estimates Medicare fraud steals $60 billion a year from the taxpayer.

In the Medicaid program, waste, fraud and abuse consume 10 percent of the program's annual budget. Is that something that we ought to replicate? Is that something we want to serve as a model for what health care delivery ought to be like in the company? And we know the track record that government bureaucrats have in managing taxpayer dollars and a new government program will only result in more waste of taxpayer dollars.

Let me point out what Dr. Elmendorf has said, the Director of the Congressional Budget office. He said there will not be a level playing field for private insurers. He said it would be extremely difficult to create a system where a public or government-run plan could compete on a level playing field against private coverage. That is intuitive I would suggest, but there you have the expert saying so.

Of course there are in addition to the, I am unfamiliar with the reference that the Senator from Massachusetts had about cost shifting, the actuary –- estimates that the hidden tax commercial payers paid a subsidized cost of Medicare and Medicaid is $88.8 billion a year, raising private health insurance premiums by

$1,500 because of the low reimbursement rates of Medicare and Medicaid, $1,500 more for the rest of us who have private coverage.

We know that doctors and health care providers will be hurt by a government run plan. –- estimates that hospital payment levels would decrease by 26 percent and physician payment levels by 17 percent for enrollees in a Medicare-like government run plan who previously had private coverage.

Now, I want to emphasize that every estimate about a government run plan has shown that millions of Americans will lose the coverage they have now which is the promise the President has made and they will be forced into a government run plan because the government run plan will shift costs to the private market and have unfair advantages over existing plans.

One estimate, and we are all familiar with it, show that as many as 118 million Americans who currently have coverage that they like will actually lose it and 130 million Americans could end up on a government run health care plan.

The points I have made in closing, let me just say the points I have made have convinced others to oppose a government or public option as a bad idea. The American Medical Association in comments they have submitted to

the committee says they do not believe that it would result in an improvement, conversely they conclude it would make things worse.

The Mayo Clinic said it would bankrupt the country, Dr. Cortase, the President of the Mayo Clinic. The U.S. Chamber of Commerce opposes it. The business community opposes it because they know there is no free lunch and ultimately employers will have to pay more and workers will receive less as a result of a public option.

And finally, Mr. Chairman, I think there are some in the public who actually think that members of Congress have a government option or a public option when in fact we do not. As the Chairman knows, there is no public option for members of Congress, but indeed I think all, everyone in the country ought to have the same kind of choices among private coverage that members of Congress have, and indeed this plan, this amendment if passed would deny them those choices, not increase those choices.

For that reason, I would hope that my colleagues would oppose it. Thank you, Mr. Chairman.

The Chairman. Thank you, Senator. Before I recognize Senator Rockefeller to close, I might say this has been, the last four hours approximately, a very good debate.

We are all trying to get to the same result I think. That is how to improve our health care system. We really do not have a system today. It is just a hodgepodge, a collection of various different components and factors. Our goal here frankly is to get some consistency, some coherence into a health care reform that reforms the health insurance market that reduces the rate of growth in health care costs in our country and also provides coverage for more Americans.

My job is to put together a bill that would become law. In the Senate, that means my job is to put together a bill that gets 60 votes. Now, I can count. And no one has been able to show me how they can count up to 60 votes with a public option in the bill. Thus, I have constrained to vote against it.

My larger goal is to enact health care reform. I want the strongest bill that I can possibly get. I want a bill that will become law.

As I have said before, I see a lot to like in public option. There is a lot here. I included, for example, a public option in the white paper that I released last year and the public option would help to hold insurance companies' feet to the fire. I do not think there is much doubt about that.

But my first job is to get this bill across the

finish line. There is a lot in this bill that will reform the insurance market. There is a lot in this bill that will control costs. There is a lot in this bill that will expand coverage to millions of Americans. Those things have to be my priority and thus I will have to vote no today on this amendment.

It is also important to remind ourselves that Rome was not built in a day and only a few major pieces of legislation were totally complete upon enactment. For example, in 1935 this is what President Roosevelt said about Social Security. He said, "This law too represents a cornerstone in a structure which is being built but is by no means complete."

That is what he said. And we could also say that about this bill. We hope that it will be the cornerstone of meaningful reform, I think that it will be, but it is by no means a complete rewriting of the American health care system.

We very much hope and expect this bill will work, but if there are things that do not work about it, we will revisit it. We will amend it just as we did the Social Security.

The point is that today, this year, we need to start to lay that foundation and I fear that if this provision is in this bill as it comes out of this committee that it

will jeopardize any real health care reform. It will jeopardize laying that cornerstone this year. Senator Rockefeller?

Senator Rockefeller. Thank you, Mr. Chairman. First of all, I think it would be good to remind the people I represent from West Virginia and from Appalachia and across the country in another capacity that what this is all about is people. Whether people get health care that is good that has outcomes measurement involved with it and whether or not they can afford to pay for it.

What this discussion has been, and I agree with the Chairman that it has been, I mean, you know, the public option is absolutely dead. It was not even, it was a non-starter. We are finishing close to five hours of discussion, very intense discussion on this and I think I can say pretty accurately that virtually everybody on this side of the aisle including the Chairman agree that having an entity which because it does not have to make a profit and because all other insurance companies do have to make a profit that they will want that option. It just makes sense. For a lot of West Virginians it makes sense. They feel out in the cold, they feel helpless in front of their insurance companies.

Insurance companies are remote, distant and they just read them in little small writing with all kinds of

conditions written in. It is not a fair system. It is a one side system. The people are on the short end of the stick and the insurance companies are making all the money.

You can laugh at $44 billion and say there are a lot of companies that make more than that, but that is a tremendous amount of money compared to what is happening to 14,000 people every day, that is losing their health insurance, what is happening to the thousands of people who every day are going into bankruptcy, a majority of those being caused by the failures of the insurance system and their inability to pay their premiums.

This is about people. Now, we are talking process here a lot and I understand that and I understand what being a Chairman is. He has a responsibility. He has to count votes and all the rest of it.

But I do not want us to come a point where we are saying that process makes more difference than people. I am not talking just about this amendment. I do not want us to be there. I do not buy it when somebody says I want to have a health care bill and I do not care what is in it, I just want to have a health care bill so I can sign it. I am not referring to the President necessarily, but I do not like that philosophy.

We are here for a serious people where people know

that we have spent thousands of hours preparing for these hearings that continue to go on. But most of all I have to tell you that I am absolutely astounded that my Republican colleagues are as satisfied as they are with the $483 billon, $483 billion of new subsidies. The Chairman would disagree with that, but I do not, being given to insurance companies on top of everything they are already getting. On top of the fact that they are not really competing in so many states, not just the ten, only two, but all the rest where there are very few. I d not know how many there are in West Virginia, but there are not many.

So to me, it is obscene to be spending that amount of money on health insurance companies and not on people's health care. So what you do about that is you introduce a concept called consumer choice option, or if you will, public option to give people a choice. What is wrong with giving people a choice?

You say well, it has something to do with the government. Well, then take on the VA system which everybody agrees is the best health care system in the country. Then take on all the other things that we have discussed.

The VA system reacts. They produce for the most complicated types of diseases, many of them new coming

back from the two new wars. This is about people and you have got to see people in your minds when you push the button that does your vote. You have got to see people in your minds. Insurance companies can take care of themselves. They always have, they always will.

Let me say this to my colleagues on the left. That is that if there is anything which is absolutely certain, their insistence on keeping the status quo exactly as it is, let the insurance companies get those subsidies, let the insurance companies continue to do what they do in spite of some of the restrictions within the mark if in fact they choose to obey those which they have not as I have indicated in some of my previous testimony.

But if they want to talk about sliding towards a single payer system, I cannot think of a better way for that to happen which I do not favor, than what they are doing. That is jus saying no. No change, no difference, everything is fine the way it is. You do that and instead of having 14,000 people a day lose their health insurance, in five or ten years it will be 20,000 people or 25,000 people.

You cannot argue the polls. The polls show that the people overwhelmingly support a public option, that the doctors overwhelmingly support either a single payer system which is interesting, I mean, that is how

frustrated they are with the insurance companies or the public option, up to 70 or 80 percent combined between those two.

That is the doctors. Medical journals took this poll. So you want to slide back into a government takeover? Do what the Republicans are doing. Just vote no, no change. Let it go just exactly the way it is. Let the insurance companies prevail. The private sector does it all. Yes, Medicare has all kinds of problems with it, that's the reason it is so popular I guess.

I guess you could say the same about Social Security if that were a health care system, but it isn't. And you can say that about Medicaid. But, you know, back where I started in West Virginia, they didn't criticize Medicaid. They did not know what an insurance company was, but they knew what Medicaid was because they got it and they liked it because it was the only way they got their health insurance.

These are people. These are 11-year-old kids. These are families and we have to respect them. You respect them by giving them a choice in which they for the first time are able to go should they choose to something called a public option or consumer choice plan which makes no money, does not answer to any Wall Street shareholder problems, just gives a simple service and

does not make any profit.

They will love that. They have said they will love that and they will love that. Now, we will take our vote here and we will see what happens and there will be another vote if this one fails and we will see what happens. But I am just telling you this. The public option is on the march and if you want the single payer system or government controlled health care system, you do exactly what my Republican friends are doing. Just say no to everything that comes up, every amendment. Devil is in the details, peck out the smallest thing, ridicule it.

American people listen to that, they buy it because everybody believes everything they see on television. It is a very serious decision. It is a model decision, it is an ethical decision, it is a human decision, it is a health care decision. It is read large in our legacies.

I urge my colleagues to support the amendment.

The Chairman. The clerk will call the role.

The Clerk. Mr. Rockefeller?

Senator Rockefeller. Aye.

The Clerk. Mr. Conrad?

Senator Conrad. No.

The Clerk. Mr. Bingaman?

Senator Bingaman. Aye.

The Clerk. Mr. Kerry?
Senator Kerry. Aye.
The Clerk. Mrs. Lincoln?
Senator Lincoln. No.
The Clerk. Mr. Wyden?
Senator Wyden. Aye.
The Clerk. Mr. Schumer?
Senator Schumer. Aye.
The Clerk. Ms. Stabenow?
Senator Stabenow. Aye.
The Clerk. Ms. Cantwell?
Senator Cantwell. Aye.
The Clerk. Mr. Nelson?
Senator Nelson. No.
The Clerk. Mr. Menendez?
Senator Menendez. Aye.
The Clerk. Mr. Carper?
Senator Carper. No.
The Clerk. Mr. Grassley?
Senator Grassley. No.
The Clerk. Mr. Hatch?
Senator Grassley. No by proxy.
The Clerk. Ms. Snowe?
Senator Snowe. No.
The Clerk. Mr. Ky.?

Senator Kyl. No.
The Clerk. Mr. Bunning?
Senator Bunning. No.
The Clerk. Mr. Crapo?
Senator Crapo. No.
The Clerk. Mr. Roberts?
Senator Grassley. No by proxy.
The Clerk. Mr. Ensign?
Senator Grassley. No by proxy.
The Clerk. Mr. Enzi?
Senator Grassley. No by proxy.
The Clerk. Mr. Cornyn?
Senator Cornyn. No.
The Clerk. Mr. Chairman?
The Chairman. No.
The Clerk. Mr. Chairman, the final tally is eight ayes, 15 nays.
The Chairman. The amendment fails. Now Senator Schumer for the purpose of offering his amendment, I might just note that the debate of the last amendment took many hours, we have another amendment with the same subject but different.
I would hope that the debate on this amendment not take quite as long as the last one because I presume a lot of arguments will be repeated on both sides. Not

all, but most arguments. Senator Schumer?

Senator Schumer. Thank you, Mr. Chairman. And I would like to offer Amendment C1, co-sponsored by Senators Bingaman, Stabenow, Menendez, Cantwell and Rockefeller as well as myself.

First, I want to thank Senator Rockefeller. He ahs made a compelling case. It was just a great speech, but more important than the speech was the hard work that he has put into this and how he cares so much about this issue.

His amendment I support it fully, builds a compelling case off the successes of Medicare and it generates $50 billion in savings in our health care system. I applaud his efforts and am going to continue to work with him towards our common goal of securing a public option in the final bill.

Mr. Chairman, in acknowledgement of your desire to move things along a little bit, I will ask my entire statement be read in the record, trying not to go over some of the old ground that we talked about and we just mentioned some of the new stuff.

The Chairman. I appreciate that very much, Senator.

Senator Schumer. Okay. So the first thing I would say is this. I just want to reiterate the fact that

there are some who want just public, some who want just private.

Senator Rockefeller and I believe you can have competition in both and what I have tried to do in this amendment is to make that competition as level as possible. So neither side will have an advantage. So both the public side and the private side can compete. There will be different models, no doubt about it, that is why we are doing this. It is not going to be just another insurance company, but they will have all the same requirements and then we will see. We will see who does a better job.

We have all been working on this endeavor for a long time now, for months. We have been doing it because there is no question that health insurance needs reform and in my judgment, there is no question that the public option would improve this good bill.

Four out of four congressional committees have joined President Obama in concluding that the only real mechanism for increasing competition in the insurance industry and keeping private insurers honest is to create a guaranteed affordable option to compete alongside them in the marketplace. That is what we are talking about today. More competition so consumers have more choice.

Let me be clear again. The best way to achieve this

goal is to create fair competition. It is my genuine intent to create a public option plan that has no built in legislative advantage over the private insurance market.

They will have to meet the same rules, the same regulations, the same reserves, the same requirements. Let the best plan win. But my colleagues on the other side seem afraid of competition.

On the one hand they talk about the robust, vital, strong private insurance industry and yet even though in our public option if the public option fails, it goes. It does not get continued infusions of federal funds. They are afraid they will almost push this giant over with just one finger.

It is a contradiction. If the private insurance market is serving America so well, they have no public option to fear. If they are serving it poorly, the public option will force them to serve better. So it is a win/win and we will set about to do this.

Let me just explain the differences between my amendment and Senator Rockefeller's, and frankly I might prefer Senator Rockefeller's, but I too like Senator Baucus am a realist. We are trying to garner as much support as we can.

Our amendment will have the public option stand on

its own and compete on its own. No provider will be required to participate. You do not want to participate, you do not have to. The public option of course will try to garner as many customers as possible to make them valuable in that competition, but that means they will set lower prices and get better service.

The prices will be negotiated. There is no setting the rates on Medicare or Medicare Plus Five or Medicare Plus Ten, the House bill had that. Jay's bill had it for two years. This they have got to negotiate like any other private insurer right from the get go.

Those are the key differences in our bills. The level playing field option does not set prices. They are negotiated just like with the private insurer. Maybe they will be a better negotiator. Maybe they will be a worse negotiator, but why not try? Why tell the public you have to stick with the private insurance model even if you do not like it. That is what you are saying.

There are some who like it. Stay with it. There are some who do not like it. We are giving you another option but an option that is going to have to compete with the same level playing field. It is going to be independent, self-financed and self-sustaining.

I want to say this again because I know there are a lot of fears that this will become a single payer. I do

not see how they are based. But this one sentence should slay those fears. There will not be another infusion of federal dollars into the public option if it cannot make it the first time around. And if it fails, it will fail because it did not offer better quality service at lower prices, plain and simple. That is America. And I am not going to go back to my dialogue with Senator Grassley and others. Medicare has far more Government involvement than this public option, and yet most of the amendments from the other side and much of the rhetoric from the other side says keep Medicare the way it is, do not touch it.

Well, if you believe that, then how can you object to the public option which has a lesser Government involvement?

We believe that the public option will succeed because it will remove many of the incentives that lead too many insurers to prioritize profits and growth over health care of their customers. They are supposed to do that. They are a for-profit company. They are supposed to serve their shareholders. But the level playing field option will have reduced marketing costs. It will be able to use its purchasing power to generate real savings. And it will not have to generate profits. That amounts to approximately a 20-percent cost saving right

off the bat without Government involvement once it is set up. Why would we want to deprive our constituents of a plan that has 20 percent lower costs? Why?

And as I mentioned before--and I am not going to repeat it--in the many instances where the private insurers' interest, whether it is somebody who has cancer or a parent discovering a child has diabetes, there is no incentive to try and wriggle out of the insurance contract because, again, profits are not number one. There is nothing wrong with profits. We want to see which works better, and probably for different people different models will work better. And it is important to remember it is a choice, not a mandate.

Over August, we heard a lot of fear: you are going to be forced to take the public option. No one will be forced to take the public option. If you like your insurance, you keep it. There is nothing in this legislation that either says or implies you have to go into the public option. It is a choice. That is all. Nothing else.

Now, Mr. Chairman, in conclusion, the debate over the public plan has been long and intense so far. I agree with you. It was an excellent debate, and reasonable people can differ. But I will tell you this: We are going to keep at this and at this and at this

until we succeed because we believe in it so strongly. This vote will be a good test so that the American people know there is significant support in this Committee for a level-playing-field public option. This is not the first word on the public insurance option, and it will not be the last.

The more Senators and the more the American people hear about the public option and what it is, the more they like it. That is one of the reasons we are optimistic about its success. Even today members came over to me and said: This makes sense.

I am working with moderate colleagues. Senator Rockefeller and I are working with moderate colleagues, both in this Committee and on the floor, to find changes they find acceptable.

Senator Carper, I want to thank you--he is not here--for helping us move to a place where we can find a consensus. My moderate colleagues have been very engaged and very interested. I have talked to just about every one of them. And I appreciate their involvement. I am optimistic that we can come up with a compromise.

I am also glad to hear the Chairman agrees with the concept of the option and bases his no vote--and I understand it given how long and hard the Chairman has worked--on the fact that we cannot get 60 votes on the

floor on a bill with public option in it.

Mr. Chairman, with a great deal of respect for you and in a desire to help, we will work as hard as we can as the bill moves forward on to the Senate floor to show you we can get 60 votes.

In conclusion, for some the public option has simply become a symbol of how serious we are about reforming our health care system. But to many of us, to Senator Rockefeller, to myself, this is far more than a symbol. This is not an ideological fight. It is vital to make this bill--which is a good bill--a better bill, to keep costs down and provide real choice. We will keep fighting so that the bill that lands on the President's desk has a good, strong, robust public option that will pass the Senate floor.

I ask all of my colleagues who support health care reform to join us in addressing the competition problem the best way we know how: by creating a guaranteed competitor that competes on a level playing field with the powerful insurance companies and gives Americans an affordable choice no matter where they live.

Thank you.

The Chairman. Senator Nelson.

Senator Nelson. Mr. Chairman, this has been one of

the best debates that I have heard in a decade in the Senate. I want to thank you and I want to thank my colleagues for the quality of the debate, and I will vote for the Schumer amendment.

If you think back to the hot August recess, it was hot more than just in temperature. It was a debate that, in many cases, was carried on with a lack of civility, sometimes with violence, with a simplification of the arguments so that the crux of this issue facing us, which is competition in a free marketplace, should be encouraged.

Now, what is that marketplace? Well, in most of our States, that marketplace is no more than 25 percent of all of the insureds, including children, in that State. In my State of Florida, there are 20 percent that are uninsured, and there are about 5 percent that are in the individual market, not the group market, with an employer.

So you are looking at a max, if everybody went into the health insurance exchange, of 25 percent. The rest of the people are covered, basically half in the employer group market; another 16 percent in Medicare; another 10 percent in Medicaid; a percent in Veterans Administration and Department of Defense. You add all that up, and that is about three-quarters.

So the max amount that we are talking and why Senator Grassley is concerned that this is going to go to a single-payer system--in this Senator's opinion is an incorrect argument--is the max that we are talking about in a State is about 25 percent of that whole State is going to be in this health insurance exchange. So to bring down those costs so that people can, in fact, afford that insurance, we need to get that competition.

Now, let me give you just a couple of comments from my experience as the elected commissioner of Florida, which has been some 15 years ago.

I can tell you that during my tenure the best health insurance company in Florida was Blue Cross/Blue Shield. Remember what Ms. Fontenot said earlier, that Florida has the most competitive market in the entire country? And in that competition, Blue Cross, it is a nonprofit--and we have heard that word here today--and it is also a mutual insurance company. In other words, it is owned not by the stockholders. It is owned by the policyholders.

Now, what I have found as a regulator is that if you did not crack the whip, there was going to be cherry-picking, there was going to be every excuse not to cover. And the way you get around that and what we are trying to create here is competition. And that is why I have

come down on the side of voting for the Schumer amendment.

I think what Senator Rockefeller said today was absolutely riveting, that we are contributing $463 billion in Federal subsidies in order to make this health insurance exchange work. If we putting that much investment in this of the taxpayers' money, we sure better make sure that the competition on that health insurance exchange works. And it seems to me that this is very important that we have this competition. It has all the safeguards in it because, remember what Senator Schumer has said, the providers--that is, the doctors and the other health providers--they voluntarily opt into the network. And remember that they would be paid negotiated rates like the private insurance plans, and they would have to be financially self-sufficient.

Now, that is the same rules as competition on the insurance marketplace, and I think those safeguards of the free enterprise marketplace are there.

Thank you, Mr. Chairman.

The Chairman. ???Okay. On my list I have Senator--

Senator Grassley. Comments?

The Chairman. Okay. After Senator Nelson, I have Senator Bingaman, then Senator Conrad, then Senator

Grassley.

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

First, let me say that I supported Senator Rockefeller's amendment, and I congratulate him on putting that amendment forward. I did state at the time prior to the vote that my preference would be to have a public option where there was no tie to Medicare. It seemed to me that made more sense. It was fairer to the providers, and, accordingly, my preference would be for us to adopt an amendment along the lines that Senator Schumer has put forward here. I think that is a better way to design an alternative health insurance provider that would be available for folks to choose from.

I would just ask Senator Schumer one question. It is not clear from the sheet that he has passed out here, the modified Schumer C-1, and that is, I am assuming that this entity that would be out there selling insurance would be operated as a nonprofit. Is that accurate?

Senator Schumer. Yes.

Senator Bingaman. That was my understanding, and I think that is another good feature of this provision. I think having a board of directors in charge of carrying out the duties of a nonprofit is a helpful safeguard as well. I am particularly glad to support this amendment

because, as Senator Schumer said, it does not require anybody to participate, and it does not require any provider to participate. And I think it is important that rates not be set at any particular rate, that they be negotiated, and that no provider or individual be required to be involved in the insurance and purchasing the insurance or in providing services to those who do purchase the insurance that is sold through this public entity.

So I hope we will adopt this amendment. I think it would strengthen the bill. It is similar to what we did in the HELP Committee. I strongly supported that effort in that Committee as well, and I hope this will become part of our legislation.

The Chairman. Okay. Next is Senator Conrad. I would just remind our colleagues that some of these points of have been made earlier with the Rockefeller amendment, so I would urge us to keep our comments short so we can go on to other subjects.

Senator Conrad?

Senator Conrad. Mr. Chairman and colleagues, first of all, I thank Senator Schumer. I think his amendment does reflect a significant change and one that makes a significant improvement in this approach.

First of all, I think it is a significant

improvement because it is not tied to Medicare levels of reimbursement. But when we look at what is coming out of the House or the committee of jurisdiction there, it is public option tied to Medicare levels of reimbursement. And because my State has the second lowest levels of reimbursement in the country under Medicare, I see that as a very significant threat to my State. Not only do I see it, but every hospital administrator in my State sees it. So that gives me great concern.

Second, I like very much that this is posed to be a not-for-profit competitor because I personally believe that is where we ultimately have to get a not-for-profit competitor for for-profit insurance companies. The place where we still have a difference--and the best thing we can do is be honest with each other about these differences--is the question of whether this not-for-profit competitor is run by the Government or not.

When I look around the world for models, I see the British model that does achieve universal coverage. It is government-run. It see as an alternative efforts by different countries that have also achieved universal coverage that do a much better job of controlling costs than we do, that get equivalent or even better health care outcomes than we do; that they are not government-run. And those models would be Germany, France, Japan,

Belgium, Switzerland.

And I come down on the size of a contest between the two models. I believe the stronger model, the one that gets the better results on containing costs on quality outcomes and expanding coverage, the one that to me wins the race is the alternative. I would call it the "public interest option," one that is not Government-run, but there is a significant Government role because it provides assistance to those who cannot otherwise afford insurance; is based on an employer-based system, which I think is clearly something that needs to be preserved here because it is the basis for our current system; where employers put in something, employees put in something; Government assists those who cannot otherwise afford it. That is how they achieve universal coverage. But the insurance intermediary in this alternative model is largely--not exclusively, but very significantly not-for profit competitors.

That is, I believe, the model that has the greatest potential to carry the day in this country and to be effective. The costs in those systems is dramatically lower than ours, the health care outcomes at least equivalent and, on many measures, superior to ours.

I know Senator Ensign raised the question on cancer and raised the question on automobiles and the question

on guns and the differentiation between our markets on that basis. But I could provide to him--and I will during the floor debate--dozens and dozens of metrics that show their system getting even better results than ours, at least equivalent results in other areas, but at much less cost and, again, without the Government running it.

So that is the difference here. Again, I want to conclude by saying to Senator Schumer, you are moving much closer to where I think we need to get to have a package that can get 60 votes on the floor and, also, more important than that, deliver for the American people.

When I compare the British model and the models in these other countries, frankly, the British model comes in second--I just think very clearly it does--on outcomes, on cost. So this debate will continue. It has certainly been a healthy one here today.

The Chairman. Thank you, Senator.

Senator Grassley?

Senator Grassley. I would like to say something to Senator Schumer before I tell him why I am against his amendment, and that is, he kept bringing up about those of us on this side want to keep Medicare and think it is

all right just the way it is, I would like to have you remember that we have voted several times to make changes in Medicare to make it better for our people. One would be our oversight of the program that would reduce the fraud. Another one would be the prescription drug program for seniors.

We are going to have an amendment here this afternoon that would improve the delivery for rural health care through the GPCI amendment. Another one would be that we wanted to give seniors choice, and that is why we set up Medicare Advantage.

So I hope you realize that there have been changes made to Medicare in the period of time, and we would vote to improve it and continue to improve it.

I want to say why I have come down on the side of being against the Schumer amendment, even though it tries to do some better than what the Rockefeller amendment did. And I guess I would get back to the comparisons that Senator Schumer used against us about our liking Medicare. I would show some promises that were made in Medicare that have not been carried out to show to Senator Schumer that he can in good faith tell us all of the assurances that he is putting in this bill that will make sure that it is a competitive model, not something that is going to be Government-run, and it has got to

compete so it is not an unlevel playing field as we said about the Rockefeller amendment. So I would ask you to consider those things as I get into this.

Unfortunately, I think a level playing field between private health insurance and a Government-run plan is an unattainable goal. It is impossible to create a fair playing field between the private system and a Government plan backed by the Federal Government. And even if you could, Congress could easily undo the safeguards that Senator Schumer has put into his bill.

In fact, today's debate over a Government-run plan is eerily similar to the debate in 1965 before Medicare was created, before the bill became law. Doctors, hospitals, and other health care providers were concerned that this new Government-run health care program, much like today, they were worried that the Government would use this program to ration care or to cut payments.

To deal with these concerns, Congress then wanted to put some certainty into the law so that did not happen, just like Senator Schumer is telling us about the certainty he wants to put into the law. Congress at that time and the President promised doctors and others that they would continue to pay their usual and customary rates. The original Medicare legislation said, "Nothing in this title shall authorize any Federal officer or

employee to exercise any supervision or control over the practice of medicine or compensation of any person providing health care services," end of quote of the law.

But the costs of the program and, maybe more so, political pressure increased over time. Congress eventually broke its promises to health care providers and changed the rules. Legislation in the late 1980s placed limits on what doctors could charge and put in place Government-mandated fee schedules.

One American Medical Association trustee recounted the AMA's original concerns about Medicare by stating, "Many of the things that we feared have come to pass" despite the promise to pay reasonable rates when Medicare was created. Today the Government pays between 60 and 70 percent of what private insurers pay.

By setting payment rates well below cost, it is becoming more and more difficult for seniors to find a doctor to accept Medicare, and access issues in Medicaid are even worse. But some say that we can avoid these problems by putting the Government-run plan on a level playing field with private insurers. They say Congress could set up a system so that the Government-run health insurance plan has to follow the same rules as private insurers. They say it would have to pay the same rates, form networks, be independently solvent.

So my question is this: When this new Government-run health insurance plan starts to cost too much, is Congress going to start breaking it promises again? Will it change the rules?

A recent Wall Street Journal article said, "Any policy guard rails"--remember, policy guard rails--"built this year can be dismantled once the basic public option architecture is in place. That is what has always happened with government-run health care plans."

So maybe at first, as is suggested by Senator Schumer in good faith, Congress sets this up, but then it repeals the requirement that the Government-run plan has to form a network. Next, Congress might allow the Government plan to start paying lower rates than private insurers, just like Medicare and Medicaid. At that point, Congress might let the Government-run plan dip into the Treasury from time to time to keep the Government plan solvent. This would increase Government costs of everyone. As the Government takes more and more control over the plan, providers would get paid less and taxpayers would end up paying more.

Rates for the Government-run health insurance plan would be lower than private insurers because the Government can impose lower rates by law. Always--this is also known, you might recognize, as price fixing.

This is a common talking point for supporters of a Government-run plan. They say Government can use its influence to lower costs. But as the Government cuts payments to providers, costs will go up for everyone else in the private market. Slowly but surely, the Government plan would take over the market. Eventually, all the promises about creating a level playing field have been broken, and we would be left with a single-pay, Government-run health insurance program.

The simple truth is supporters of a Government plan absolutely intend for this to be the outcome. You can see that in the previous vote. This will make our emergency rooms more crowded than they are today. It will limit access to high-quality care through rationing and price fixing. It will increase waiting times for lab results and life-saving and life-enhancing procedures. It will add hundreds of billions to new Government spending.

This is not the kind of change the American people are looking for, so I urge my colleagues not to support this amendment.

The Chairman. Senator Ensign.

Senator Ensign. Thank you, Mr. Chairman. Just a couple of brief comments.

First of all, earlier I stated this and I think it

needs to be reemphasized--that about 44 percent of the insurance that is sold in the private market in the United States is done by not-for-profit companies today. Senator Nelson even talked about how wonderful Blue Cross and Blue Shield is down in Florida.

The points that Senator Grassley was making is exactly what worries a lot of us, why we think all of this is a slippery slope toward Government-run, complete Government-run health care, complete Government takeover of our health care system, is that a lot of the things that we do around here we put into place--supposedly safeguards are put into place. But when we see the effects and people like Government program, they then defend those Government programs, and they make them want to compete and want to survive that much more.

You know, as Ronald Reagan said that the best way to eternal life is to become a Government program. So it is said that if it does not survive on its own, it will go away. Does anybody here really believe that this Congress would let this Government program go away once it has constituency? There is no chance--no chance. I mean, we cannot--we just had a vote on the floor in the appropriations bills. Of all of the things that President Obama is saying, ineffective program, we should eliminate that, eliminate that, eliminate that, but we

are not eliminating, I do not think, hardly anything this year. If they are, they are so tiny they are insignificant. And to have a large program like this, once it is started, you are never going to get rid of it. As a matter of fact, all you are going to do is what Senator Grassley said. We are going to subsidize it more; we are going to allow it to grow; we are going to allow it to compete because there is a difference in philosophy. There is a difference. Some people believe--and I believe there is a legitimate difference in the role of Government and differences in philosophies.

I said at the very beginning of this debate, that you all want to do, on your side of the aisle, the right thing. You sincerely believe that what you are trying to do is the right thing. I think Senator Schumer has offered this because he believes in this strongly and believes everything that you are saying today. I do not think you have any hidden motives here. But what I think we believe is, looking at history, these Government programs start and then they grow and they grow and they grow and they grow, and the debate that was held in the Finance Chairman, which, if we are few years down the line looking back, no one will remember that. Well, okay, that was not really the intent, or, well, that is

not the reality of the situation today. We need to make sure that this program stays and stays competing. And, yeah, it needs a little help right now, but that will just be temporary help, and it will grow and it will grow and it will grow.

And the things that we said about the Rockefeller amendment I think apply here as well, is that you are going to get cost shifting. And, once again, it is the people who--the rest of the people who have private health insurance who are going to have their costs go up when you have the cost shifted from a Government program.

So I do not believe that that is fair, and, by the way, I fundamentally disagree that the Government should be competing with the private sector. Okay? We do not need a Government auto company just because auto companies are making a profit. Oh, sorry, maybe we already have one of those.

But we do not need the Government competing with the private sector. Our Constitution was set up to limit the powers of the Federal Government, not to expand them. And the Federal Government was set up to do the things that Government needed to do, not to do the things that necessarily we wanted it to do, but just the things that it needed to do. And I believe that this is a tremendous expansion of the Federal Government that the Federal

Government does not need to do. This is something that if we make the right changes in our health care policies, the Federal Government does not have to get involved. The private sector can come up with the solutions to control our costs and some of the things that I detailed earlier.

Thank you, Mr. Chairman.

The Chairman. Thank you, Senator.

Senator Bunning, you are next.

Senator Bunning. Thank you, Mr. Chairman. I am going to be very short because I don't want to repeat, or try to repeat the debate. Senator Schumer, you must not be hearing the same thing I have been hearing on Medicare from this side.

We believe Medicare is a good thing, and needs to be dealt with because it is failing the American people. We think it is a good thing.

Your bill, unfortunately, will make competitive disadvantage for the health care that is now provided. I don't think that is what you intend to do. I think you intend to do just the opposite.

Medicare Advantage has been gutted in this bill. That is the private sector portion section of Medicare, 120 billion -- 112 billion dollars. I will put it right.

So, if we are going to improve the private sector,

we are going to have to improve -- because in my state, fee-for-service doesn't cover 90 counties out of 120. So you want to substitute a Government option for those 90 counties to compete with Medicare fee-for-service. That is not what you want, but that is what you are going to get.

So last but not least, the private sector is not doing exactly what it should do with medical services, but it can. This bill as written tries to help it out. And everybody, not everybody, but most of the people on that side do not want to do it. They do not want to help the insurance company cover the additional 45 million people that are left uncovered, but we have to do something to cover them.

You are suggesting a Government option. Our bill or the bill that has been devised by the Chairman has got some changes in Medicare and Medicaid and other things that will try to cover those 45 million people.

Thank you Mr. Chairman.

The Chairman. Thank you, Senator. Next I have Senator Kyl?

Senator Kyl. Thank you, Mr. Chairman. I have three points. Senator Ensign actually made

Senator Kyl. Thank you, Mr. Chairman. I had three points. Senator Ensign actually made one of those points

which is that this is going to be too big to fail, or maybe I should say too important to fail. Congress is not going to let it fail anymore than Fannie Mae and Freddie Mac failed and the taxpayers had to back them up.

The first point I wanted to make is this argument that we need a public option in order to keep the private insurance companies honest. It is an argument we have heard the President make over and over.

But I submit that is not really an honest argument. The State Insurance Commissioners are empowered to keep the insurance companies honest. If they engage in behavior that is false or fraudulent in any way, state insurance directors have the ability and frequently do take action to stop that.

The competitor from the government would not actually play in that arena. I think rather than saying that the public option is there to keep the private companies honest, it is more honest to say that you want more competition. But there again I think it is a solution in search of a problem.

I talked before about some of the reasons there may be not be competition. But to the extent that in most of the places there isn't sufficient competition, it is because there is a small risk pool and there is just not room for a lot of companies to play. Adding one more

company pollutes the pool, it does not make the situation better.

Then finally the argument if you like it, you get to keep it. That is not true. The public option has the effect according to the experts who have studied this, of taking people from private coverage, private market, into the government market.

CBO, Milliman, they all say it, they have different numbers because they use different assumptions. When you look at a fee, for example, of $400 per employee for a year, if they go onto the public option as opposed to maybe $10,000 or more to provide insurance to an individual, it is not hard to see what a lot of companies are going to do. They are going to say sorry my good and trusted employee, it is time for you to go to the public option. I will pay the $400 fee rather than $10,000 or $12,000 to cover you.

That is why groups like Louman say that well over 100 million people are going to end up on the public option, about 88 million of whom have coverage today in the private sector.

So Mr. Chairman, I think those are arguments that we did not make with respect to the Rockefeller amendment but apply equally to that amendment as to Senator Schumer’s amendment and argue against the adoption of

this amendment.

Senator Cornyn. Senator, will you yield for a question?

Senator Kyl. Yes, I would.

Senator Cornyn. Just a brief question. Thank you, Mr. Chairman. You have heard the argument that this public option is necessary to keep insurance companies honest, but I know the Senator had a distinguished career as a lawyer in Arizona and is familiar with the state regulatory regime.

You mentioned the role of the State Insurance Commissioner, but I would ask the senator, isn't it also true that the state attorney generals and the Consumer Protection Division in those offices are charged with the responsibility of enforcing the law against insurance companies in their state, and as well as in many states, of course in mine there is consumer protection legislation which provides an opportunity for private attorney generals, basically individuals to sue when they are wronged by an insurance company and a right to recover their attorneys fees and other costs in addition to compensation.

Would you see that as an effective regime to keep insurance companies honest? Or do we need the federal government to create an alternative public option?

Senator Kyl. Mr. Chairman, Senator Cornyn, you bring up a very good point. I was not as thorough in my explanation as I perhaps should have been. There are insurance commissioners and insurance directors and they have the first responsibility, but you are absolutely right. There is both the law enforcement mechanism of the state primarily the authority of the Attorney General and you certainly would be well aware of that in your previous capacity, as well as in most states there are private causes of action that can be taken as well.

So I really do not think anybody is seriously arguing that you need a public insurance company to substitute for all of these mechanisms that exist in states to keep insurance companies honest. I think the more honest argument is that you want that for a different purpose and we have addressed that.

The Chairman. Okay. Senator Cantwell?

Senator Cantwell. Thank you, Mr. Chairman. I am happy to be a sponsor of Senator Schumer’s amendment and obviously spoke earlier, but I would like to make a few points.

First of all, we know where we are. Insurance rates have gone up 120 percent in the last ten years. We know this. I mean, this is from the Kaiser Family Foundation. But what we also know is that if we do not make

significant changes, they are going to go up another 120 percent in the next ten years. That means a family is paying $7,000 more now than what they just paid a few years ago for the exact same benefits.

That means that as inflation is only 2 or 3 percent, that health care costs are rising about 7 or 8 percent annually. That is what is happening and that is what is going to happen again. Now, CBO is saying as we have put these exchanges in that maybe we will see a reduction of the increase of about 10 percent and I am all for the value index that we are putting in here that we are going to decrease because of provider issues, some of the costs, but my guess is we are still going to see 100 percent increase in insurance costs unless we bring real competition into the marketplace with a public option that gives us the ability to leverage some of the costs that we are seeing with being able to buy in bulk and have true competition in the marketplace.

This is about whether we are going to continue to do the same things that we are doing today or whether we are going to give the public a choice to do something differently. Without that choice to do something differently, we are going to see exorbitant rates.

Now, to my colleagues, I will be offering another amendment later that hopefully will give us some of the

mechanisms that people I am hearing say that they would support in having non for profits drive the cost of the public benefit plan and I am all for that. But without this competition, we have seen so many families hurt, we have seen so many businesses hurt, it is an unsustainable situation.

So I hope my colleagues will support the Schumer amendment knowing that without that competition in the marketplace, we are buying into an exorbitant increase in insurance premiums. I do not want to see that. We cannot sustain it. Having the status quo is not going to help the American economy and for the price of allowing the same function of driving down costs that we have done with other programs, it is for the benefit of everybody. For the US economy and for those who currently do not have insurance.

The Chairman. Thank you, Senator. Before Senator Schumer closes, I might say that while I do think there is a lot to like about public option and frankly I think there is a little more to like about Senator Schumer's version of the public option, still I do not see how the public option gets 60 votes on the floor at this point.

For those reasons, I will vote against his amendment. My goal is to get a bill out of this committee, get a bill that becomes law, a bill against 60

votes. I do not see a bill out of this committee with public option getting 60 votes. I am going to vote against the amendment.

Senator Schumer. Thank you, Mr. Chairman.

The Chairman. Senator Schumer?

Senator Schumer. First, let me thank all of my colleagues, again, for a really fine debate. We have differences. They are honest and heart felt differences and it sort of dates to the division of the Republican Party and Democratic Party. You have a little more faith in the private sector, we have a little more faith in getting the government more involved. That has been true since Franklin Roosevelt's time, maybe even earlier. Probably Wilson, Woodrow Wilson.

It is understandable we would have some differences. I think we all find it regrettable that we could not come together on a bipartisan bill which I know the Chairman tried long and hard for and is still trying, but at this point we are not together. But that does not lessen the value of this debate.

Just one point and then I will conclude. If the State Insurance Commissioners are doing such a good job, then why are the costs going through the roof? If the State Insurance Commissioners are doing such a good job, then why do we hear every day complaints from so many of

our constituents who feel that they are not being treated well by their insurance companies even when their policy seems to say in black and white that they are entitled to something?

The present system is broken. It is broken on the private side. Costs are going up everywhere. I would argue that the public side, Medicare, does a good job. People are happy. But the biggest problem there again is not what the public sees, but costs. Costs are at the nub of this bill.

If costs were only going up at 2 percent, we could gradually cover everybody, keep the same system in place and that would be it. But they are not. They are going up faster than anything else in America.

Here I would like to just speak to the average American who has insurance as to why they need the public option. We all know why those who are not covered would need it. It is pretty obvious. It gives them another choice, it helps keep costs down. But what about the majority of Americans who either have Medicare or private insurance, why do they need a public option because they can stay where they are. It is not going to change Medicare directly. It is not going to change those who are on private insurance. Here is why.

We must get the costs down. If we do not, here is

what is going to happen to you. Let us say you are a senior citizen. Medicare is going broke. You may not see it, but when you look at the federal budget, we see it. If it goes broke in seven years say which is I think the latest actuarial projection, I guess Senator Conrad, is that right, seven years?

If it goes broke in seven years, what are you going to do? I would say to the average Medicare recipient, if you know darn well if we wait until year five or year six to fix it, who is going to get hurt? You are.

What do we say to the people on private insurance? Let us say you are happy with your private insurance as many, many, many Americans are. I would concede that to the other side. The problem is the costs are going up even faster than Medicare. That is where it is broken.

Senator Hatch talked about Medicare incurring a huge debt. Well, so has private health care except the debt are the employers and employees who have to pay it and cannot anymore. Here is what is going to happen to you. Your boss is going to call you in in three years or five years in all too many cases and say Jim, Mary, you are a great worker here. You have worked hard, you dedicate yourself to this company or this group and I love you and I want you to stay here as long as you can. But I have got bad news. We cannot afford health care for you

anymore, as much as I love your job, the job you do.

Or maybe he says I can afford health care but it is a new plan and you have to pay the first $10,000 and your premium goes up. What are we going to say to Jim and Mary when that happens?

The reason we are pushing the public option above all is not an ideological dispute. It is not symbolism. It is very simply that the costs are going through the roof and we have to try to two or three major tools at our disposal. One again is the amendment that Senator Cantwell has put in the modification which deals with fee for service. I think it will do more than anybody knows and it makes me prouder to support this proposal.

Another is the exchange. But the third leg of that cost reduction stool which is essential because left to their own devices with the weak insurance commissioners, private insurance will keep going up. The third leg of that stool to reduce costs is the public option.

I have tried and I appreciate my colleagues on the other side conceding to create a fair public option that competes on a level playing field. If they have suggestions how to make it a little fairer, this is not written in stone.

We need to do it. Because it is so important and because it is so right, I do believe with some work and

some compromise we can get the 60 votes on the floor of the Senate which we do not have now. I will be the first to admit that, that will make our system better by creating a strong, real, viable and fair public option. I hope as many of my colleagues as can will vote for this amendment now.

The Chairman. Okay. The clerk will call the role.

The Clerk. Mr. Rockefeller?

Senator Rockefeller. Aye.

The Clerk. Mr. Conrad?

Senator Conrad. No.

The Clerk. Mr. Bingaman?

Senator Bingaman. Aye.

The Clerk. Mr. Kerry?

The Chairman. Aye by proxy.

The Clerk. Mrs. Lincoln?

The Chairman. No by proxy.

The Clerk. Mr. Wyden?

Senator Wyden. Aye.

The Clerk. Mr. Schumer?

Senator Schumer. Aye.

The Clerk. Ms. Stabenow?

Senator Stabenow. Aye.

The Clerk. Ms. Cantwell?

Senator Cantwell. Aye.

The Clerk. Mr. Nelson?
Senator Nelson. Aye.
The Clerk. Mr. Menendez?
Senator Menendez. Aye.
The Clerk. Mr. Carper?
The Chairman. Aye by proxy.
The Clerk. Mr. Grassley?
Senator Grassley. No.
The Clerk. Mr. Hatch?
Senator Grassley. No by proxy.
The Clerk. Ms. Snowe?
Senator Snowe. No.
The Clerk. Mr. Kyl?
Senator Kyl. No.
The Clerk. Mr. Bunning?
Senator Bunning. No.
The Clerk. Mr. Crapo?
Senator Grassley. No by proxy.
The Clerk. Mr. Roberts?
Senator Roberts. No.
The Clerk. Mr. Ensign?
Senator Ensign. No.
The Clerk. Mr. Enzi?
Senator Grassley. No by proxy.
The Clerk. Mr. Cornyn?

Senator Cornyn. No.

The Clerk. Mr. Chairman?

The Chairman. No.

The Clerk. Mr. Chairman, the final tally is ten ayes, 13 nays.

The Chairman. The amendment fails. I now recognize Senator Roberts for an amendment.

Senator Roberts. Thank you, Mr. Chairman. I am glad that we are finally considering my amendment after what has been a rather lengthy ongoing debate on government run health care with everybody trying to find the level playing field.

The Chairman. Could you identify your amendment so we know which one it is?

Senator Roberts. Yes. It is Roberts Amendment D4, Title 3, Subtitle F, Patient Standard Outcome Research Act of 2009, short title, Protect Patients and Doctors, Strike Title 3, Subtitle F, Patient Standard Outcome Research Act of 2009.

The Chairman. Thank you.

Senator Roberts. Mr. Chairman, I am glad that we are considering my amendment after this ongoing lengthy debate on government run health care because I think my amendment illustrates some of the dangers that are inherent in such a system.

I want to thank Senator Bingaman and Senator Conrad in particular for pointing out actually asking the question who runs such a public option or a government run health care system. I can tell you very quickly who runs it. It will be eventually given to HHS which used to be HEW, Department of Health and Human Services and an outfit called CMS.

My Amendment D4 strikes the Chairman's mark provision of establishing a new patient centered outcomes research institute to conduct comparative effectiveness research or CER. All the folks that are tired of acronyms, I apologize for that. CER, it is Comparative Effectiveness Research.

Basically CER is the comparison of two or more medical treatment options to determine which is better. Now, this can be a very good thing and something that is needed obviously, advancing medical science and improving patient outcomes.

But CER can also be a very bad thing if it is done incorrectly or for the primary purpose of containing costs through the rationing of care. This is the first of several rationing amendments that we are introducing today.

It is the latter version of CER that I have strongly opposed in which I seek to prevent with this amendment.

First, I would like to acknowledge the hard work that Chairman Baucus and Senator Conrad have done on this section. It represents a big improvement over the comparative effectiveness research provision in the stimulus bill which is operating right now with regards to funding and also funding to the Secretary of HHS.

It is also an improvement over the HELP Committee's health care reform bill in which we tried to address the subject of rationing and were not successful. That said, I still have major concerns with the establishment of this new institute. My first overarching concern is that this institute is unnecessary because this type of research and dissemination of best practices is already happening.

Medical societies already develop this type of guidance and make it available to their doctors. The federal government even has a guideline clearinghouse. If you didn't know that, there is a guideline clearinghouse where you can search for medical guidelines by disease or disorder and specialty.

This clearing house now contains 2,458 individual summaries of guidelines that have been put out by over 100 different medical societies. Most are very much up to date. Sometimes doctors follow these guidelines and then again, Mr. Chairman, sometimes they do not. It

depends on the unique condition of their patient and the doctor's professional judgment, as it should.

So if this debate is really about best practices and clinical guidelines, I do not think that the federal government, which is mostly concerned with the rising cost of health care, should duplicate the efforts of those already being undertaken by medical societies whose only concern is for improved patient care, not cost.

The only reason I can think of for the government to repeat the current efforts is if the true aim of this section is to shift the focus from improving better patient care to rationing based on cost. We do not need so called best practices national standards enforced by CMS payment policies that will replace the personalized judgment of your doctor with a one size fits all government mandate.

Moreover, it does not even really make sense to spend so much time and money developing national standards that restrict doctor's abilities to practice medicine. Medical science is constantly evolving. Thus, these standards will likely become obsolete almost immediately, making payment conditional on doctors following these polices out of date and even dangerous which is why my second overarching issue with this section and this new CER institute is that it will be

ineffective, out of date and possibly dangerous from the outset.

Comparing the effectiveness of two or more treatment options, especially in a manner that properly takes into account the individualized needs of diverse patients is an expensive and time consuming process that often may not even result in a clear cut answer to the question of whether one option is better than the other.

Past attempts by the federal government to evaluate the comparative effectiveness of two treatment options do provide a good illustration of the frustrating nature of this research. Even when the studies are well designed and appropriately funded. Here are the examples.

Three government trials are often cited as examples. One compared older and newer blood pressure medications, another compared older and newer schizophrenia medications, and one studied the side effects of hormone replacement therapy for menopausal women.

These three government run studies, CER if you will, cost a total of $900 million, resulted in the more expensive treatment being disfavored of course and were subsequently at least partially debunked following closer scrutiny and additional studies.

It is very unclear to me whether the CER studies to be carried out under the direction of this new institute

will even be as rigorous or as fully funded as those examples. Although it is clear that the CER provisions that passed as part of the stimulus package earlier this year most certainly will not.

Moreover, the selective interpretation of the data gathered from each of these studies reveals the inherent conflict of interest that arises when government is both the payer and the researcher. It is thus clear to me that government run CER, Comparative Effectiveness Research, especially if it is being conducted to inform coverage or payment levels, is likely to be ineffective and even dangerous for patients.

That brings me to my final concern and that is the potential for CER to be used as a rationing tool by the government, i.e., CMS.

In light of the huge incentives for the government to use CER as a justification to reign in costs, I am very concerned with this bill’s failure to protect patients and doctors against CER-driven government rationing and interference.

We must prohibit the government from using the results of CER to ration care. Instead, the results of CER, Mr. Chairman, should be disseminated to patients and doctors so that they can evaluate what treatment decisions are best, not the government.

Additionally, we must prohibit costs from being a factor in the conduct of CER, patient outcomes should be the only allowable factor in determining the effectiveness of competing treatment options.

Because this section establishing the patient centered outcomes research institute is unnecessary, because it is likely to be out of date from its inception, ineffective and perhaps even dangerous, and because it does not sufficiently protect patients and the doctor/patient relationship from government rationing and interference, the Roberts Amendment D4 strikes the entire section. I urge my colleague's support.

The Chairman. Senator Conrad?

Senator Conrad. This debate reminds me a little about reading about the medical treatment of George Washington in his final days. At the time medical practice dictated that if a patient was week, would you bleed him. That is what they did to President Washington. They bled him.

In the notes, if you read the notes it is very interesting. The notes kept by the medical team, they said that we noted that General Washington, President Washington was weak so they bled him. Then the next set of notes said he seemed even weaker, so we bled him some more.

Hours later they noted he seems to weaken further, so we bled him some more. The whole point of Comparative Effectiveness Research is to use science to determine what works and what does not work.

Let me just tell you a partial list of the groups who have endorsed the patient centered outcomes research that is in this bill. The American Medical Association, the American Medical Group Association which represents the large groups, multi-specialty groups that all of us have talked about as being the best examples in American medical care. That includes Kaiser Permanente, the Mayo Clinic, the Cleveland Clinic, Geisinger, AARP, the Friends of Cancer Research, the American Association of Neurological Surgeons, the Alliance for Specialty medicine, the National Health Council, the Society for woman's' Health Research, the American Association of People with Disabilities, the Alliance for Aging Research, the Association of Clinical Research Organizations, the Epilepsy Foundation, the National Alliance on mental illness, the National Business Group on health, the National Breast Cancer Coalition, the consortium for Citizens with Disabilities, the Mental Health America, the Heart Rhythm Society, the American Society of Plastic Surgeons and on and on and on it goes.

The American Medical Association said this about the

provisions in the bill. We believe this approach will promote physician confidence in CER research and advance adoption of CER findings into clinical practice. CER stands for Comparative Effectiveness Research.

We are pleased the Chairman's mark includes provisions establishing secure and stable funding for a broad research focus. The Chairman's mark establishes the framework, the framework that ensures high evidentiary and scientifically based methodological standards are met.

They go on to say the Chairman's mark strikes an important balance between support of research and dissemination of the findings. We are pleased the bill will include language that underscores the comparative effectiveness research ultimately is designed to support informed decision-making, not dictated.

The concerns raised about comparative effectiveness research have already been addressed in the Baucus plan. It establishes limits in how the HHS Secretary can use CE research and requires a transparent process. It prevents the Secretary from denying coverage for a service or item based solely on comparative effectiveness research.

It prohibits the Secretary from using the research for coverage or reimbursement in ways that discriminate against individuals because of age, disability or

terminal illness and it prevents the use of dollars per quality adjusted life year as a threshold to establish which treatments are recommended.

Finally, Mr. Chairman, let me just say that there are real world examples of why comparative effectiveness research is important. Prostate cancer, there are three treatment options today. No one knows for certain which one works best. Research could help patients and doctors make a more informed decision.

On coronary disease, in 2009 comparative effectiveness studies showed for patients age 65 and up mortality was lower with coronary artery bypass surgery. For patients 55 and younger, mortality was lower with per-cutaneous coronary intervention.

On colon cancer. Within the past two years, CE research has identified which treatments are toxic for patients so they can be spared from treatments having no benefit for them.

On breast cancer. In 2004 a comparative effectiveness study found that MRIs are more sensitive for detecting breast cancers than mammography, clinical breast exams or ultrasound in women carrying certain genetic mutations.

Mr. Chairman, members of the committee, comparative effectiveness research is about science. Science in

medicine. That is something that was led, the scientific method was led in the United States. Johns Hopkins is the 19 teens led scientific revolution in medicine. It has paid enormous dividends. Let us pursue that path. Let us not turn back the clock.

Senator Kyl. Mr. Chairman?

The Chairman. Senator Kyl?

Senator Kyl. Thank you. I strongly support Senator Roberts' amendment and I would like to address three of the points that Senator Conrad just made. He referred to the famous bleeding of President Washington.

But I submit that had this legislation been the law at that time, that is exactly what would have happened, because that was the standard of care recognized in the industry at the time.

Senator Roberts. Would the Senator yield on that point?

Senator Kyl. Sure.

Senator Roberts. I think that --

Senator Kyl. You may remember that, as a matter of fact.

Senator Roberts. Yes, I was here during that particular time. I think the General was covered by a form of Medicare that was very early in that particular stage. The CER recommendation was to use leeches as

opposed to bleeding.

So, consequently, I do not think we got anywhere. It is a good comparison on regard to what CER could be used by by CMS under the direction of the Department of Health and Human Services, when we are having all these adequate studies by the very people that the Senator mentioned who were conducting -- I think there are 2,000 something here -- pardon me for the delay -- 2,458 individual summaries of guidelines have been put out by over 100 different medical societies, basically the same people that the distinguished Senator mentioned.

I thank the Senator for yielding.

Senator Kyl. Thank you, Senator Roberts. The bottom line here is there does need to be flexibility on the part of providers to determine what the best standard of care in a particular situation is.

When you lock that in with the decisions that are made by the Federal Government based upon a particular study, you have automatically limited that flexibility.

Senator Conrad cited several benefits of CER, noting various studies and Johns Hopkins was one that he specifically mentioned. I would note these are all private studies and, as Senator Roberts just said, over the last decades, there have been probably billions and billions of dollars spent by private entities,

universities, research groups and others to determine what the best practice is in a given situation.

This kind of research, CER, has been around for a long time and all the folks in the medical profession will tell you that it is very helpful to them. It is very beneficial.

That is not the point. Nobody is arguing that CER is not good, comparative effective research. What we are arguing is that in the hands of the private sector, the folks that Senator Conrad was referring to, it has been very useful.

But you have the government in charge of that research and you immediately get into a situation where the government is going to use that research for making decisions on coverage, on reimbursement, and on other factors that will ultimately lead to the rationing of health care.

Now, when I get to my amendment, I will point out that that concern has obviously been recognized, because there is even a provision of the bill that seeks to prevent that bad result, recognizing that it would be a bad result. But I will also point out why the bill, while it gives with one hand and takes away with the other and is ineffective in achieving the result.

So I think we all fear that the CER could be used by

the government to deny care. It is just a question of whether we have an adequate safeguard to prevent that from happening or not.

Finally, I would just note that while the Senator read a list of groups that support the bill, supporting the bill is not the same as supporting this particular provision without amendment and I would note the American Medical Association, in particular, has supported my Patients Act, which is the name of the legislation that I had raised on the floor of the Senate and which I will be offering next as an amendment that would specifically bar the use of this research for rationing rather than to rely on the language of the bill, which does not do the job.

Thank you, Mr. Chairman.

Senator Ensign. Mr. Chairman?

The Chairman. Thank you very much, Senator. Who seeks recognition? Senator Ensign?

Senator Ensign. Mr. Chairman, just a couple of comments. When you are a health care provider and you are out there, when you are whatever kind of a physician you are and you are looking at your patient and there is a best practice, only about half the doctors, from what I understand, in the United States do practice best practices today and that needs to be improved. That is

completely unacceptable.

We can have lower costs with better outcomes, with the idea of what the Chairman has in his mark. I think what some of us are concerned about is that when the government is involved, medicine advances so rapidly. Even -- even though this is a partnership, when the government has an involvement, changing the best practice can happen too slowly compared to medical advances, and that is what I am concerned about.

The other concern is, obviously, whether this gets used in rationing. NICE, the National Institute of Comparative Effectiveness, over in Great Britain was set up with the same kinds of ideas that are in this amendment.

I realize you have tried to put in the safeguards, but it is now used over in Europe, over in Great Britain, to ration care, to basically put a value on somebody's life, and if they are not valued at a certain point, then they get denied care. They get rationed care, and I think that that is what some people are also concerned with.

But the idea that the Chairman has put in his mark, and the reason I think that you are seeing even some of the groups out there, like Cleveland Clinic, like the idea of this, is because to get to best practices is the

right thing to do, to set those standards out there.

As a matter of fact, for instance, if you can set up algorithms in electronic health records for best practices, not to necessarily determine the care, but at least if a patient is not responding exactly the way a best practice should be, a doctor should be alerted to when they are going outside of best practice. They should know what the best practice is, and that is one of the reasons technology can actually help us with this.

The fear, though, is that when you put it in the government, when you need to make those changes, as medicine advances, those changes will not be able to be made fast enough. I will give you just one quick example from my own personal experience.

When I was doing my veterinary internship down in Los Angeles, I actually did a study. It was dealing with CPR and I was doing a study, and I did it at UCLA and comparing the newer techniques in CPR.

Well, even in the private sector, when newer techniques in CPR were developed, getting those changes in standard practice were very difficult. Even though the research was showing that they needed to be changed, with some of the drugs that were used, with some of the techniques that were used, it was very difficult to get those changes. It literally took years.

Well, if you put government on top of that, it could literally take even longer to get some of the changes in best practices. So I think there are legitimate concerns, Mr. Chairman, with what is in the mark, but your intent in the mark, I think, is right. It is just in the practice of it, I think that a lot of us have concerns with how exactly it will be carried out.

The Chairman. Thank you, Senator. Not to prolong the debate, but let me ask Ms. Bishop a couple of questions just to clear the record here, so we all have an idea what is and what is not in the modified mark.

I wonder, Ms. Bishop, if you could address several concerns that have been raised here. One is rationing. It is my understanding that requests to various organizations we have written in language that addresses that point. If you could just outline what some of the protections are in the mark.

Ms. Bishop. Thank you, Mr. Chairman. I will be happy to do that. I think that the concern about rationing care really came to us as a concern about the government using the research to ration care, either the Secretary of HHS through the Medicare program and whatnot.

So the protections that we have in the Chairman's mark are -- we have several protections. One is that we

have put limitations around the use of the research for the Secretary of HHS. So the Secretary of HHS would be, in a sense, able to use the research that would come from the institute, but they would do so as a privilege, if you will.

They would not be able to use the research in any manner -- the Secretary would not be able to use the research in any manner that the Secretary saw fit. So what we say is we say that the Secretary may use any research that comes from the institute as long as certain conditions are met.

The Secretary can use the research as long as it does so in a transparent way. So the Secretary can use the research as long as, in the use of the research, it provides for public comment on how it uses the research and it makes it absolutely clear how it is using the research.

It cannot use the research in a backdoor way where nobody understands --

The Chairman. What would the Secretary do with the research?

Ms. Bishop. Excuse me. The Secretary can use the research to make coverage decisions in certain federal programs. So the Secretary can use the research, if it felt like it was appropriate, to make a coverage

determination within, let us say, its domestic programs.

The Chairman. What about the cost concerns? There is some concern that the Secretary is going to deny certain procedures or drugs or whatnot because it is too costly.

Ms. Bishop. Right. So we have dealt with that issue in that we have prohibit or we limit the institute in the type of research that it can pursue to clinical comparative effectiveness outcomes.

So it is not going to be looking at cost comparisons. It only is going to be authorized to look at the clinical outcomes. So in other words, not what technologies cost relative to each other, but how well they perform in clinical outcomes, for example, mortality.

The Chairman. So is cost a consideration at all?

Ms. Bishop. No.

The Chairman. Not at all. It is all clinical, clinical comparativeness.

Ms. Bishop. It is clinical. Very clearly, the institute is prescribed only to focus on clinical outcomes.

The Chairman. What about the repetition argument? It is already done, this research.

Ms. Bishop. I think that is a very interesting

argument. I just wanted to, if I could, just read a sentence from the MedPAC report about comparative effectiveness research.

Basically, MedPAC says that there is not enough credible empirically-based information for health care providers and patients to make informed decisions about alternative services for diagnosing and treating the most common clinical conditions.

So what that means, to Senator Ensign's point, is that the practice of medicine needs to improve and that it needs to be encouraged to use the evidence that is there. But there is another piece to the puzzle. There is not enough credible evidence on which these guidelines or these decisions are based. We need both.

MedPAC is saying we need more credible evidence and then there needs to be a way in which the medical societies, if you will, have more encouragement to use the medical evidence.

But that is not what the Chairman's mark does. The Chairman's mark only creates more opportunity to provide more evidence. So we are really working on the part of the equation that says do we know enough about how medicine actually works.

The Chairman. Is there anything in this mark that could be interpreted as comparative effectiveness

research getting in the way between a patient and his or her doctor? My understanding is that this is just information, evidence-based information. Then the provider can make any decision that he or she wants to make in consultation with the patient. Is that correct?

Ms. Bishop. That is correct.

The Chairman. Any further discussion?

Senator Roberts. Yes, Mr. Chairman. I have a couple of questions for the staff, and I thank the staff. Number one, about transparency and to make sure that the Secretary of HHS, and really you are talking about whoever heads up CMS.

But my question -- does anything in this provision prohibit costs from being a factor in CER, prohibit?

Ms. Bishop. There is not a specific prohibition on the institute looking at costs. But because this mark actually establishes, there is no authority for the institute to go beyond what is prescribed in the statute.

Senator Roberts. But that institute will make recommendations to the Secretary and, in turn, to CMS. I mean, they have to implement it.

Ms. Bishop. No. But the institute does not make any recommendations. It is prohibited from making any recommendations about any medical decisions. There are no recommendations that the institute can make. It is

expressly prohibited from making any recommendations.

Senator Roberts. But the Secretary can still use that, Mr. Chairman. Let me just remind you, the Federal Government has a guideline clearinghouse with 2,458 individual summaries of guidelines that have been put out, over 100 different medical societies, the very societies mentioned by my friend from North Dakota. Sometimes these doctors follow the guidelines, sometimes they do not.

But as Senator Ensign pointed out, it depends on the doctor and the patient. I am concerned that, because the Secretary administers Medicare, her CER-informed policies will necessarily disparately impact the elderly. And I am also concerned because there is not anything in this bill that prohibits them from using cost as a factor in CER.

Same amendment we considered in the Health Committee. They took a look at the word "prohibit." It was the definition of what "prohibit" is and held it over for a day and then it was dropped.

I do not see anything in this provision that prohibits the Secretary and, more especially, the people that run CMS and their past record, from doing this kind of thing.

I just want to make it very clear that I am not

against advancing medical science. That would be absurd for anybody on this committee. What I oppose is the government, a body primarily concerned with reining in costs, conducting CER, especially without prohibitions against cost being a factor and, also, protections for our patients and our doctors.

Senator Kyl. Mr. Chairman, may I ask a question?

The Chairman. Senator Kyl?

Senator Kyl. There is nothing in the mark that prohibits the Secretary from considering cost, as well as clinical effectiveness, is there?

Ms. Bishop. For Medicare purposes, the Secretary has no authority to consider cost and coverage determinations. There is no authority today for the Secretary to do that and this mark does not change that.

Senator Kyl. Is there any prohibition? That is my question.

Ms. Bishop. There is no prohibition, because there is no authority. There is no authority for the Secretary to use cost and coverage determinations today.

The Chairman. Let me ask this question. Why not just add the sentence? If there is no authority, why not just add the sentence that prohibits cost as a basis?

Senator Roberts. That was my second amendment.

The Chairman. I do not know. I am just asking the

question. If there is no authority, I understand that.

Senator Kyl. Mr. Chairman, that is exactly the point. Then the second point is that it is not just the Secretary, because there are other federal agencies, entities, people and so on. So you would have to have CMS, for example -- that is what Senator Roberts is greatly concerned about is CMS.

The Chairman. I understand.

Senator Kyl. I take your point.

The Chairman. I am just trying to see if there is any reason not to add the sentence that cost -- that prohibits the use of cost in making a decision here.

Ms. Bishop. One of the things that we do include in the mark is a prohibition, and there are actually more prohibitions that I did not describe, but we do have a prohibition that reflects the concern about quality adjusted life years; in other words, the measures that are used by the U.K.

We expressly prohibit the institute from developing any cost thresholds and the Secretary from using or developing any cost thresholds.

But I guess the concern was for the prohibition that when the institute is looking at the areas that need study, that need research, that one of the issues that it could consider is how much evidence is there for a

particular treatment or condition and whether or not this condition is prevalent in the United States in terms of the number of people who have it or the amount of money that is spent on it.

I think the concern there, the reason why we did not include an express prohibition is that we did not want to limit the institute from considering areas of science that have a budgetary impact, if you will.

What I mean is that the criteria that the institute is like is there an evidence gap, is there variation, is this something that has a large impact on expenditure.

Senator Roberts. That is precisely what I am worried about. I accept the Chairman's concern or sharing my concern, but it falls to the Secretary and while she does not have authority to do that, CMS has to implement it and if you get into one of these -- how did you describe it, large what -- large outcomes that would affect costs of health care, et cetera, et cetera.

Ms. Bishop. What I said was that it is a criteria that the institute could look at, could use to focus the research, for example, on blood pressure or diabetes. The institute needs to be able to consider the prevalence of the gap in evidence.

Then if we were to prohibit the institute from looking at costs, it would limit the institute from

saying, "Well, how big of a problem is this?" We need to focus on the problems that are the most prevalent, that are the most worrisome from a clinical perspective, but also how many people does this have an impact on.

Senator Roberts. I think we already know that, Mr. Chairman, with the NIH and with these guidelines that are already out by this National Guideline Center. I am not saying it right. I think everybody on this committee could list the top five in regard to our concern in regard to patients and the effectiveness of trying to treat these patients.

It also occurs to me that the mark allows the Secretary to ration care so long as she does so in an open and transparent manner. You mentioned, sir, that it might be a good idea to protect patients and doctors. I have an amendment here to prohibit costs from being a factor in any comparative clinical effectiveness research conducted using federal funds, including funds from the subtitle, et cetera, et cetera, et cetera.

Again, I tried it in the Health Committee. Everybody thought it was a pretty good idea until they started to thinking about it and then it went the way of all things.

I just think that given the past record of CMS and given the past record of what could happen, that CMS

already uses, if you will pardon the expression, pseudoscience, like least costly alternatives and substantial equivalent, to deny coverage of expensive drugs and treatments based on cost.

CER will be the new golden grail or rod that the head of CMS will come down from the mountain, Obama Care, and inflict all of these decisions on all of our providers.

The Chairman. Senator Bingaman?

Senator Bingaman. Mr. Chairman, let me just express my view. I do think we are meeting ourselves coming around the corner here. I think our problem in our health care system is not that we are giving too much attention to cost.

I think that, clearly, we should be doing research in areas that hold out promise of saving us money as a country, as a government, everything else. There are certain procedures and problems that afflict Americans that are extremely costly and extremely painful and cause all sorts of difficulty for the individuals who contract those health care problems, and I think those are exactly the areas that we ought to be concentrating our research in.

So I would not want to support explicit prohibitions against the Secretary or the institute ever looking at

the issue of cost. I think that would be a mistake.

The Chairman. Senator Stabenow?

Senator Stabenow. Thank you, Mr. Chairman. I would also speak against the amendment. I appreciate the concerns and frustrations about CMS and, certainly, over the years here as a Senator, I have had those, as well.

But I think Senator Bingaman's "We are meeting ourselves going around the corner" is a pretty good example of what is happening here in terms of the circular nature of this whole discussion.

Right now, we have rationing in this country. It is based on whether or not you can afford to get insurance and whether or not you can afford to pay for good insurance and pay the co-pays and deductibles and so on.

I view what we are trying to do in this bill is to stop that so that we do not have rationing based on the fact that somebody may lose their job or may not be able to afford to get health care or small business cannot afford to get health care.

What I do not understand is this idea that somehow having information about what works, what medical procedures are the best, is dangerous. I find that a very interesting discussion. I know that this has been whipped into a frenzy and it is all involved in all the fear tactics that have been used about this legislation

and about what the President has been talking about, as well.

But at the same time, we have had strong bipartisan support for the National Institutes of Health to gain information, to develop cures and treatments and to find out what causes various diseases. So to go the next step and say that for clinical purposes, to be able to find out what works the best and what does not work and make sure that is available for doctors, why would that be a problem?

I do not understand that. When we look at what we are talking about in terms of clinical outcomes, we have seen tremendous cost savings by comparing generic drugs with brand name drugs and being able to put competition in the marketplace, but sort of comparing options and giving doctors and patients choices.

That had nothing to do with taking away care. It had nothing to do with rationing in the sense of saying to someone "You cost too much" or "You are too old" or some other criteria in terms of withholding care. None of us would be supporting that, none of us.

The idea that this has been blown up into some issue I think is really, really unfortunate, because I do not know about anyone else on the committee, but I certainly want for my daughter and son and daughter-in-law and two

small grandchildren to make sure that my doctor and their doctors know the best treatments and have the best clinical evidence to be able to treat them.

I cannot imagine that somehow from what the Chairman has worked on so hard to take us to that point, that we have turned that around to somehow be afraid of having information about what works and what does not work.

I certainly appreciate the constraints that have been on in the mark to make sure that the information is used appropriately. I think we would all support that.

Mr. Chairman, I oppose the amendment.

The Chairman. Senator Cornyn?

Senator Cornyn. Mr. Chairman, thank you. Just briefly. Surely, my colleague from Michigan would understand the concern when professional medical associations, which already have best practices for their various medical specialties, we all understand the benefit of that.

We want the best practices to be used in each and every circumstance. When you marry that with who pays the bills, that is where the concern comes in and that is, to me, the concern about the public option, about the growth of government being not only the one who pays the bills, but the one that decides what they are going to pay for.

As we have seen in the course of Medicare and Medicaid, government cuts payments to physicians and providers as a way of controlling cost, which is rationing writ large.

So it is not a tremendous leap to say if you are going to combine this comparative effectiveness research with the power to decide who gets paid and who gets paid for what that it will be used to limit access to care. That is the concern I have and that is really the underlying concern, I think, in the amendment, which I strongly support.

The Chairman. I see no Senator seeking recognition. A roll call has been requested. The Clerk will call the roll.

The Clerk. Mr. Rockefeller?

The Chairman. No by proxy.

The Clerk. Mr. Conrad?

The Chairman. No by proxy.

The Clerk. Mr. Bingaman?

Senator Bingaman. No.

The Clerk. Mr. Kerry?

The Chairman. No by proxy.

The Clerk. Mrs. Lincoln?

The Chairman. No by proxy.

The Clerk. Mr. Wyden?

The Chairman. No by proxy.
The Clerk. Mr. Schumer?
The Chairman. No by proxy.
The Clerk. Ms. Stabenow?
The Chairman. No.
The Clerk. Ms. Cantwell?
The Chairman. Pass.
The Clerk. Mr. Nelson?
The Chairman. No by proxy.
The Clerk. Mr. Menendez?
The Chairman. No by proxy.
The Clerk. Mr. Carper?
The Chairman. No by proxy.
The Clerk. Mr. Grassley?
Senator Grassley. Aye.
The Clerk. Mr. Hatch?
Senator Grassley. Aye by proxy.
The Clerk. Ms. Snowe?
Senator Snowe. No.
The Clerk. Mr. Kyl?
Senator Kyl. Aye.
The Clerk. Mr. Bunning?
Senator Bunning. Aye.
The Clerk. Mr. Crapo?
Senator Crapo. Aye.

The Clerk. Mr. Roberts?
Senator Roberts. Aye.
The Clerk. Mr. Ensign?
Senator Ensign. Aye.
The Clerk. Mr. Enzi?
Senator Grassley. Aye by proxy.
The Clerk. Mr. Cornyn?
Senator Cornyn. Aye.
The Clerk. Mr. Chairman?
The Chairman. No.
The Clerk. Ms. Cantwell?
Senator Cantwell. No.
The Chairman. The Clerk will tally the vote.
The Clerk. Mr. Chairman, the final tally is nine ayes and 14 nays.
The Chairman. The amendment fails. Senator Kyl, you are recognized.
Senator Kyl. Thank you, Mr. Chairman. This is amendment number D-8 and it does follow on directly to Senator Roberts' amendment.
This is a more restricted version. Rather than striking the title, we simply say that this research cannot be used for rationing. There is no objection to CER research, although most people at least -- let me put it this way.

I would prefer to see research conducted in the private sector. This is not something the government needs to do, as Senator Conrad pointed out a while ago. There has been a lot of research in this area and physicians and hospitals and others find it very, very useful.

But it is one thing to find a new study useful in determining what to do in a particular case. It is quite another to have the government tell you that you must use treatment C rather than treatment A or B. You are the doctor, you have examined the patient, you have a sense as to what is best in this particular case, and that research can guide you and inform you, but that is much different than saying that it has got to be used.

So what our amendment does is to prohibit the use of the research for denying coverage, in other words, rationing care.

Now, this amendment is the same as the Patients Act of 2009, with just two changes. By the way, Mr. Chairman, the amendment D-8 has been modified in two ways and I will explain what those two ways are.

Originally, it simply said the Secretary of HHS. It is clear that there are other governmental entities or agencies or persons who may also have some role, as Senator Roberts has said, for example, CMS. So this

amendment simply applies to any federal department, office or representative.

So that should pick up anybody who might be using this research to establish coverage decisions. Second, in addition to applying to government programs, of course, it applies, as well, to private insurance.

And here is exactly what it says, that notwithstanding any other provision of law, any federal department, office or representative shall not use data obtained from the conduct of comparative effectiveness research, including such research that is conducted or supported using funds appropriated under the stimulus law, to deny coverage of an item or service under a federal health insurance program, as defined in law, or private insurance, and that it shall ensure that comparative research conducted or supported by the Federal Government accounts for factors contributing to differences in the treatment response and treatment preferences of patients, including patient reported outcomes, genomics, and personalized medicine, the unique needs of health disparity populations and indirect patient benefits; and, of course, finally, that nothing in the section would be construed as affecting the authority of the drug commissioner, the Commissioner of FDA to deny certain drugs being put on the market.

The point here is to say that if this research is going to be conducted and paid for, in part, by the United States Government, at least no federal official will use it to deny coverage.

Now, the mark that the Chairman has actually recognizes this problem. It recognizes that it could be a big problem, and that is why there is specific language in there that says the Secretary of HHS would be prohibited from denying coverage based solely on a study conducted by the institute.

Now, the problem with that limitation is that there are four big loopholes in it. In other words, if we are really trying to make sure that the Secretary or any other federal official does not use this to ration care, let us say that, as my amendment does.

Here are the four loopholes in the existing language. First, as I said, it is not just the Secretary. So let us make sure it is any federal official.

Second, from denying coverage based solely on a study. Now, you can deny coverage based on a lot of different factors and if you have a study that says this is much more cost-effective than that, it is not hard to come up with some factor that you also base your decision on.

That word "solely" is big enough to drive a truck through. So that caveat does not work to really limit the Secretary or anybody else from using this research to ration care.

Third, on a study conducted by the institute. There may be other research that is done in addition to the study conducted by the institute. For example, the bulk of the stimulus money did not go to the institute, but will be used to conduct comparative effectiveness research, but it is a different entity that uses it.

What is that entity called? The Federal Coordinating Council. I am sorry. So the bottom line here is I very much appreciate what both Senator Conrad and Senator Baucus tried to do in being response to the various concerns expressed about rationing.

But if we acknowledge those concerns are real, let us make sure the language is tight enough so that it does not permit rationing. When you say "based solely on," you are not prohibiting it. When you say just the Secretary, you are not saying it applies to others. When you are saying a study conducted by the institute, what about the impact of research conducted by the entity that is funded under the stimulus package by over $1 billion?

Again, that is the Federal Coordinating Council, again, just for the record. Of that $1.1 billion,

actually, only $10 million would apply to the institute under this bill.

I think the other point is that, again, what we give on one hand we take away on the other. There is a provision that says the Secretary would be required to use an iterative and transparent process when using research from the institute in making coverage determinations.

So it is clear that while the Secretary is going to have to be transparent, she can still use the research to make coverage determinations, and that is what our concern is here. Use the research to allow physicians and other providers to appreciate what, in normal circumstances for most people, is the best practice, but do not purport to say that we are going to dictate, to determine, to specify, to make coverage determinations as a Federal Government entity here based upon that research, which would be binding in all cases.

That, I think, is the reason why the AMA supports the legislation that I introduced, because it would ensure that physicians can use the research, but the government cannot use it to ration care.

There are some examples here, Mr. Chairman. In the interest of time, I will not cite the examples, but I will note that you can look to the experience in Great

Britain and see how this very same type of research is used to make coverage determinations and those coverage determinations have the effect of rationing care.

So perhaps, since maybe there is some consensus on this, I will quite while I am ahead. If there is any question or concern about it, then I can respond to that.

Senator Roberts. Mr. Chairman?

The Chairman. Senator Roberts?

Senator Roberts. I know you would like to ration debate, but others have had an average of 40 minutes and Senator Kyl and I have worried about this one particular topic for some time and, as I have indicated, that has been the biggest problem I have faced with the Rural Health Care Coalition in the Senate and the House, being chairman of both.

Senator Kyl was absolutely right. It is true that, with your direction, this bill is better than the current policy or the CER that was put into the stimulus. It is also true that it is better than language in the House bill, but, in my view, is still not enough.

The government should be absolutely prohibited from using CER to deny payment for coverage for health care, period, and that prohibition must cover this institute, as well as the CER funded through the stimulus bill and any other legislation.

The government already rations health care. CMS may not be as explicit as NICE, the infamous NICE in the United Kingdom. But make no mistake, the government currently denies treatments and services to Medicare patients. CMS is always looking for ways to deny payment for more expensive treatments.

Their recent attempts to use the least costly alternative policy for asthma treatment is one example that comes to mind. Another is their refusal to cover the more costly virtual colonoscopies, which doctors say could save thousands of lives per year.

Already, too often, cost seems to be the driving factor in many Medicare coverage decisions, not patient care. In addition, the President is using the Medicare program as a virtual bank to fund this huge new entitlement program and he says we can squeeze $500 billion out of Medicare now.

Now, I do not know how on earth you are going to do that. You can bet that if that is the case, it is going to be a huge target in the future. Look no further than the United Kingdom, as the Senator has indicated, the gentleman from Arizona, for evidence of that conflict of what happens.

So under this kind of budgetary pressure that we have today and with CMS' own history of rationing,

rationing today, I do not trust that agency or any other government entity not to use CER to improperly justify the denial of payment for certain treatments.

And which treatments will be the government target? Obviously, they are going to be the most expensive, which are usually the most innovative, and they will target the oldest and the sickest among us. It does not take a rocket scientist to see the danger of this happening.

I do not say this as a scare tactic. This is a warning. If we do not prohibit government from using CER to deny coverage, there is a very real threat this country could go down the road that the U.K. has.

The Chairman. Senator Bingaman, you are next.

Senator Bingaman. Mr. Chairman, let me be very brief on this. I would oppose the amendment. It strikes me that we are trying to take a position here that just is Luddite, to pick a phrase out of the previous years.

I think saying that this institute can exist, it can do this research, but the research cannot be used for any purpose just does not seem to me to make a lot of sense. I have heard my colleagues and I agree with some of their comments criticizing all of the state mandates that have been put on with regard to health care, and there are 60 or 70 of these.

Now, I assume that the Secretary and the Federal Government is going to draw the line and say we are not going to subsidize all of this. There are things we are going to subsidize, but there is stuff that we are not going to subsidize and if the state wants to do it, then I have a separate amendment to try to address that issue and make it real clear that that is what our position ought to be.

But in deciding that, I would hope that the Secretary would have the very best information about what are the effective treatments that are available and, as you have pointed out, Mr. Chairman, and staff has pointed out, we already provide in the mark that you have presented to us that there could be no denying of coverage based solely on a study conducted by the institute.

That does not, to me, justify us going to the next step and saying we cannot even consider a study done by the institute or the outcome of a study done by the institute.

So I would strongly oppose the amendment.

The Chairman. I might say I have got some questions, too. As I read the amendment, it basically says any federal department, office or representative shall not use data obtained from the conducting of

comparative effectiveness research.

It states what it says. No federal agency can use any data which is produced by comparative effectiveness research to deny coverage of an item or service.

What if clinical research shows without a doubt that one medicine, one procedure, one treatment is not ineffective, it is harmful, which has often been the case? This says that that evidence cannot be used in any coverage decisions and I do not quite get that.

Somebody used the word "luddite." I do not know if that is too strong or not.

Senator Kyl. That is probably a little strong, yes, because --

The Chairman. I am sorry, Senator, I have the floor. I just do not quite understand why we want to deny any information to any federal entity, including the VA, including the Pentagon, including any federal agency.

Senator Kyl. Any federal program.

The Chairman. Any federal program. Those are federal programs.

Senator Kyl. That is right and your mark says the Secretary of HHS would be prohibited from denying coverage based solely on a study conducted by the institute, as I said. We have said the same thing.

But there are two caveats in the mark's language

that are big loopholes. One is denying coverage solely based on that. You can always find something else to justify your decision. Second, this is $10 million today to the institute, though there is other funding provided to the institute, but there is over $1 billion provided to the Federal Coordinating Council by the stimulus bill.

So it is not just research conducted by the institute. It is research that the Federal Government conducts in other ways.

But your question actually, I think, raises one other point. Why would the Federal Government fund this research if it is not going to use it? That is the fundamental question.

For years, decades, this research has been funded by the private sector and it has been used by the private sector to good effect. That is the way it should be. As soon as you get the Federal Government funding the research, somebody asks the question you did. Well, do we not want to use this for some purpose other than just helping doctors appreciate what good practices are; telling them that if there is a dangerous practice, for example? Should we not use it to make coverage decisions?

That is what happens when you get the government involved in spending the money on this research. If you

want to use it for some other purpose --

The Chairman. Would my friend yield for a question when you are done?

Senator Kyl. Let me just finish my thought here. You want to use it for some other purpose other than for what the research has been used for all of these decades and in not just a benign way, but a very effective way to help physicians and other providers figure out what the best treatment is. But as soon as we start funding it, then there is going to be another purpose for it.

Mr. Chairman, you acknowledged the danger of that additional purpose with the limitation in the mark right now that the Secretary would be prohibited from denying coverage based solely on the institute's research.

I am simply saying why just on the institute's research. The Federal Coordinating will have a whole lot more money to do the research than the institute, but we should not use that money for denying coverage any more than we should use the institute's money.

That is why I simply tried to broaden the amendment to make sure that there was not a big loophole in it.

Senator Stabenow. My friend, Senator, you raised the issue of private insurance companies have been doing this for years and your concern is about the public sector.

My question would be do you have any concern about the private sector, who has been doing this kind of research for years and using it in their decisions to decide when to deny people, when to authorize payment.

From my knowledge, they have been using this in the private sector for years. The majority of people get their insurance right now from the private sector, and, yet, this information is used to determine whether or not they are going to make payments, whether or not they are going to provide coverage for people.

Senator Kyl. Senator Stabenow, I do not think that is correct. What Senator Conrad and I were referring to was the research conducted by entities like Johns Hopkins University, medical associations. I know of several different studies. Research facilities conduct these studies and the primary purpose is to define best practices.

I am not aware of insurance companies conducting studies to figure out what is most cost efficient for them.

Senator Stabenow. It is my understanding, if I might just add, that private insurers, in fact, have been involved in comparative research and as they move forward conducting their business, with making medical decisions and how they are going to rate and what they are going to

pay for and so on.

I would ask Ms. Bishop. This amendment would not affect private insurance. That is correct. But to your knowledge, are private insurers involved in doing this kind of research?

Ms. Bishop. That is correct. I think that, for example, the Blue Cross/Blue Shield network of plans has a technology evaluation center that they use to evaluate technologies and the effectiveness of technologies.

But I think the consensus is that there is not enough of this research that is credible, that is unbiased so that this institute would be able to look where are the gaps in knowledge sort of on a national scale; where do Americans feel that they do not have enough evidence to use when they go to the doctor.

So that is the point of it. It is not to replace what a particular health plan or provider, the research that they provide. It is actually to say, all right, we need to look at what Americans need as a whole, what consumers need, what patients need, and those folks are actually going to be part of the decision-making process on the board of this new institute, as well.

So this is not a government --

Senator Kyl. Mr. Chairman, let me reclaim my time, though, because we are way off the point. There is a big

difference between an insurance company that today, will not be so in the future under this bill, but today adjusts risks. Of course, they do that kind of research.

It is one thing for a private insurance company to decide what kind of risk it wants to cover and how much it wants to charge for that. It is quite another for the United States Government to conduct research, as a result of which it says to a Medicare patient, for example, "We are not going to pay for X service. You cannot get X service, because we do not think it is cost effective or clinically effective."

There is a big difference. One is an insurance contract and the other is the United States Government telling you you cannot get it, and that is all we are trying to do here, to say that if the government is going to get into the business of doing this research, then we have got to make sure that it does not deny coverage based on that.

The Chairman's mark goes a long way toward that, saying, quote, "The Secretary of HHS would be prohibited from denying coverage based solely on a study conducted by the institute."

If that is a valid principle, why would we limit it just to a study conducted by the institute, when over $1 billion in the stimulus package went to the Federal

Coordinating Council to do the research, not just the institute?

Second, I do think that the word "solely" in there is a loophole big enough to drive a truck through, since you could always find some other reason to deny coverage in addition to what the research study showed.

Senator Cornyn. Mr. Chairman?

The Chairman. Senator Cornyn?

Senator Cornyn. Thank you, Mr. Chairman. If I may ask Ms. Bishop. Does the Center for Medicare and Medicaid Services have least costly alternative authority now?

The Chairman. I am sorry, Senator. Could you speak up a little bit? I did not hear.

Senator Cornyn. Sure. Let me say that louder. Does the Center for Medicare and Medicaid Services have least costly alternative authority now?

Ms. Bishop. I am checking right now. One second. Our CMS folks here say that the agency has asserted that it does have authority to use the least costly alternative criteria in making reimbursement decisions, but not coverage decisions.

Senator Cornyn. Well, that is, I think, a distinction without a difference. You say it has the authority to do it in determining coverage, but not

reimbursement.

Ms. Bishop. Reimbursement, but not coverage. So it cannot say that something is not covered, but it can use it in making reimbursement decisions, but not coverage decisions.

Senator Cornyn. But the bottom line is that the Center for Medicare and Medicaid Services, if it determines that there is a less costly alternative, can decide not to pay for it.

Ms. Bishop. I am going to check and see if that is how the authority is actually implemented.

Senator Cornyn. Well, you say not in deciding coverage, but in deciding reimbursement, if you do not get paid for one way or another.

Ms. Bishop. No, Senator. The way that CMS has interpreted that authority is that they will pay the lowest cost for that item. They will not deny access to that item. They will pay the lowest cost for it. So it is a reimbursement policy. It is not a coverage policy.

So if something is covered, CMS will pay the lowest cost for it. It is almost like paying the generic cost for a drug or whatever. But it is not used to deny anybody access to services.

CMS does not have authority to use cost analysis in making coverage determinations. They just do not.

Senator Roberts. Will the Senator yield?

Senator Cornyn. Yes.

Senator Roberts. That is the point. CMS is already rationing via the doctors by changing reimbursement policy to favor less expensive treatments. CMS is telling the doctor you will do it in the least costly manner, or you will have to pay the difference between the more expensive treatment that you prescribe and the less expensive treatment that CMS will pay for. That is exactly what happened with asthma. That is exactly what happened with colonoscopy, which every member of this committee ought to have.

This is the noninvasive type. The other type, people do not want to do that. But the noninvasive procedure is more expensive. So CMS discourages it through its reimbursement policies. That is why we are having rationing now in regards to Medicare and who pays for what. That is how Medicare is being rationed.

The same thing is true with home health care and the same thing is true with doctors and the same thing is true with hospitals.

You are doing it through reimbursement in terms of rationing care now. What this will do is make that problem much worse.

The Chairman. Senator, I might say just the exact

opposite the case. We are trying to get doctors to practice much more, and they want to desperately, evidence-based medicine. They want the information.

You will not believe the number of doctors I have talked to who want to move much more in that direction. We all talk about these institutes here, like Mayo and so on and so forth. They very much want to move much farther in the direction of so-called evidence-based medicine.

Right now, as we well know, if you are a physician, who visits you a lot? Well, it is the drug rep. The drug rep comes to your office peddling that particular brand name drug, it is the greatest thing since sliced bread. These poor doctors become inundated with all these reps coming into their office, want this and do that, so on and so forth.

To be honest, doctors try their very best. They stay up at night reading the latest up-to-date reports, et cetera. They want help. The hope here is that finally -- finally -- but here is an institute that will just kind of help just give clinical comparative analysis. That is all, just clinical. Then doctors can decide for themselves in consultation with their patients, what carrot makes sense, which is helping evidence-based medicine.

Frankly, evidence-based medicine, in my judgment, is going to help bring down excessive costs. There are a lot of areas where there are excessive costs in this system. It is bloated, it is wasteful.

If doctors know that this procedure works really an awful lot better than that procedure, that is going to help bring down excessive costs. But we are just trying to help doctors here and help providers here and we have built in lots of guidelines, a lot of safeguards here to help prevent some of the abuses that you are concerned about.

I understand that, but I think, on the whole, AMA wants this. I have a letter I received six days ago. They want this. The American Medical Association wants this. So I just urge us to do what is right here and to try to put in a procedure which is going to help.

Senator Cornyn. Mr. Chairman, if I could reclaim my time.

The Chairman. Senator Cornyn, I think we should vote pretty soon.

Senator Cornyn. I agree with Senator Kyl that the Chairman's mark goes a long way toward achieving the goal that we want to achieve. What we would like to do is close the loop entirely and make sure that the government does not make decisions based solely on cost.

If the government is making decisions based on evidence-based medicines or quality of outcomes as a component of that, that is what we would expect. But to make decisions based solely on cost is the concern.

This is not an illusory concern, because of what I believe Senator Roberts and Senator Kyl mentioned, the experience in Great Britain with the National Institute for Health and Clinical Excellence, or NICE, which recently determined that $45,000 was the most the government would pay to extend a kidney patient's life by one quality adjusted year.

That is the kind of abuse that I know you do not agree with, I do not agree with, and that we need to make sure is completely out of bounds.

The Chairman. Does any other Senator seek recognition?

Senator Cornyn. We know that Great Britain uses this kind of research to make coverage decisions and it has had an impact on medical outcomes in Great Britain relative to here in the United States.

Some of these statistics have been cited earlier, but between 1990 and 2002, for example, deaths from breast cancer in the United States declined 2.3 percent. Today, nearly 98 percent of women with early stage breast cancer survive at least five years.

In Great Britain, the five-year survival rate for breast cancer caught early is 78 percent, 98 percent in the United States, 78 percent in Great Britain. The same is true of colon cancer. The five-year relative survival is 60 percent in the United States and only 44 percent in Great Britain.

So we all want our medical providers to give us the best quality based upon what is going to provide the best outcome, but we do not want government denying us access to treatment because they are trying to save money when they could be saving lives.

The Chairman. Senator Conrad?

Senator Conrad. I sometimes think we do have at times in this committee where we just talk past each other. As I look at this amendment, I would call it the amendment that says let us keep doing things that we know do not work.

I go back to how I started this discussion with what they did to President Washington. They kept bleeding him, because at the time, they thought that was good.

What we are trying to say is we are going to use science to determine what advice goes to doctors and patients so they make decisions that are fully informed, and this amendment jus goes way too far.

I have heard one member after another on the other

side say the Chairman's mark goes a long way toward meeting their objectives, and indeed it does. The Chairman's mark prevents the Secretary from denying coverage for a service or item based solely on comparative effectiveness research.

The Chairman's mark also prohibits the Secretary from using this research for coverage or reimbursement in ways that discriminate against individuals because of their age, disability or terminal illness.

The whole effort here is to give scientific research to doctors and patients on what works and what does not and then to go, as this amendment does, and say, well, you cannot use it for any other purpose, you cannot stop doing things that we actually know are harmful, that just goes too far.

Senator Kyl. Mr. Chairman, it is my amendment. Could I make a closing point here?

The Chairman. Senator Kyl?

Senator Kyl. Thank you very much. I really do believe that at least, Mr. Chairman, you and I are not that far apart here. What Senator Conrad just said is, and I am quoting now, "What advice goes to doctors and patients so they can make informed decisions," exact quote.

No. It could go far beyond that. It could go far

beyond advice. It could say you may not have this coverage. In view of that concern, the Chairman's mark says that the Secretary of HHS would be prohibited from denying coverage.

So we are not talking just about advice here. We are concerned about rationing. So the Chairman's mark says the Secretary would be prohibited from denying coverage based on this research.

I have two questions. First, why just the Secretary? Why not CMS or any other federal official? There is no good answer to that, that I know of. If you all have one, please tell me what it is.

Second, why just the research of the institute? It gets $10 million. The Federal Coordinating Council has already gotten $1 billion. If we think it is bad policy for a study by the institute to be the basis for the Secretary's denial of coverage, why would we not feel the same way about research conducted by the Federal Coordinating Council?

I would just ask the Chairman. Mr. Chairman, let me just ask you these two questions. If it is good policy for the Secretary not to deny coverage based on this, is there any reason why we should not say other governmental officials, too? First question.

The Chairman. Well, the Secretary has jurisdiction

over CMS. So the Secretary is prohibited, any HHS agency is also, by definition, prohibited.

Senator Kyl. But if the theory is we do not want any federal agency or entity or individual doing this, I gather there would be no harm in saying that.

The Chairman. Well, one problem is the U.S. Army is not in our jurisdiction.

Senator Kyl. So?

The Chairman. We are HHS. We do not have jurisdiction over the U.S. Army or VA.

Senator Kyl. We will write it so it says "under the jurisdiction of this committee." Second, why would we just limit it to the research conducted by the institute? Why do we not include the Federal Coordinating Council, for example? Any reason not to?

The Chairman. I do not know if that is the right jurisdiction either. Ms. Bishop, do you have any comment on that?

Ms. Bishop. I guess my thought there was we could do that. Why could we not say that the Secretary cannot use research in a manner that is prohibited under the mark, why can we not say that the Secretary also cannot use the funds from RI? I see no reason why we could not do that. That seems like a parallel thing. I say we could do that.

Senator Kyl. That is why I say I really do not think you and I, at least, are that far apart. Then the only remaining question is this question of "solely" and that is a big loophole, I think everybody would acknowledge.

You can make a decision based on this research and always come up with some other reason that also justifies the decision. I respectfully suggest that is a pretty big -- I should not use the word "loophole," but a pretty big caveat there.

The Chairman. Ms. Bishop, do you have another comment?

Ms. Bishop. There was a rationale for that that word "solely" and it was intended to prohibit the Secretary from making any automatic links through reimbursement or any kind of other mechanism to any singular study that came out from the institute.

So the reason why we used that word "solely" was to prohibit the Secretary from saying anything that comes out from the institute we are automatically not going to pay for. But I wanted to just -- can I just --

Senator Kyl. Well, let me just say this. But you can see how, by qualifying it with the word "solely," we are then, in effect, saying it is all right for the Secretary to use institute research to do this so long as

there is another reason.

Ms. Bishop. And the reason why I do not believe that that is the case, even though we do not say that, as you say, is because the standard that is in the statute that we wanted to leave intact, the standard for making coverage decisions is not change by the mark and the standard for making coverage decisions is anything that is reasonable and necessary, and this mark does not override that.

Senator Kyl. Mr. Chairman, let me just reclaim my time to make this point. Here is what President Obama said, brand new interview in the *New York Times*. "What I think the government can do effectively is to be an honest broker in assessing and evaluating treatment options."

That is what polls show the American people are so afraid of, that the government is going to get in between the doctor and the patient. They do not want that, even if the government is an honest broker in these treatment options.

If it simply advisory and doctors can take it or leave it, that is fine. But then let us say that they cannot deny coverage based upon this, whether it is the Secretary or somebody else, whether it is on this based solely or there is some other rationale for it,

theoretically, and whether it is the Federal Coordinating Council money or just the institute money.

The Chairman. All right. Let us vote. All in favor of the Kyl amendment -- the Clerk will call the roll. Excuse me.

The Clerk. Mr. Rockefeller?

Senator Rockefeller. No.

The Clerk. Mr. Conrad?

Senator Conrad. No.

The Clerk. Mr. Bingaman?

The Chairman. No by proxy.

The Clerk. Mr. Kerry?

The Chairman. No by proxy.

The Clerk. Mrs. Lincoln?

The Chairman. No by proxy.

The Clerk. Mr. Wyden?

Senator Wyden. No.

The Clerk. Mr. Schumer?

The Chairman. No by proxy.

The Clerk. Ms. Stabenow?

Senator Stabenow. No.

The Clerk. Ms. Cantwell?

Senator Cantwell. No.

The Clerk. Mr. Nelson?

The Chairman. No by proxy.

The Clerk. Mr. Menendez?
The Chairman. No by proxy.
The Clerk. Mr. Carper?
The Chairman. No by proxy.
The Clerk. Mr. Grassley?
Senator Grassley. Aye.
The Clerk. Mr. Hatch?
Senator Grassley. Aye by proxy.
The Clerk. Ms. Snowe?
Senator Grassley. Aye by proxy.
The Clerk. Mr. Kyl?
Senator Kyl. Aye.
The Clerk. Mr. Bunning?
Senator Bunning. Aye.
The Clerk. Mr. Crapo?
Senator Crapo. Aye.
The Clerk. Mr. Roberts?
Senator Roberts. Aye.
The Clerk. Mr. Ensign?
Senator Grassley. Aye by proxy.
The Clerk. Mr. Enzi?
Senator Grassley. Aye by proxy.
The Clerk. Mr. Cornyn?
Senator Grassley. Aye by proxy.
The Clerk. Mr. Chairman?

The Chairman. No. The Clerk will tally the vote.

The Clerk. Mr. Chairman, the final tally is 10 ayes and 13 nays.

The Chairman. The amendment fails.

Senator Roberts. Mr. Chairman?

The Chairman. Yes, Senator Roberts? Before I recognize Senator Grassley for an amendment. Senator Roberts?

Senator Roberts. I still have this amendment on cost, not getting rid of the whole shebang in regard to the institute. I could read three paragraphs, ask for a vote, I know where it is going, if that would suit the Chair.

The Chairman. I do not know the three paragraphs, but if that is what you predict, let us take this up.

Senator Roberts. Well, it is Luddite number three. Mr. Chairman, this is Roberts amendment D-5 to Title III, Subtitle F, Patient-Centered Outcomes Research Act, to protect patients and doctors. It says spare the cost from being a factor in any comparative clinical effectiveness research conducted using federal funds, including funds under the subtitle.

Simply put, if we are really serious about using CER to advance medical science, as so eloquently outlined by my friends to my right, rather than to limit or ration

care, then we should have no problem removing the cost of the treatments from the calculation of which one is better.

Treatment options should be compared on their effects on patient outcomes and nothing else. I understand that the mark refers to comparative clinical effectiveness research as opposed to comparative cost-effectiveness research.

This was a great step forward, but this does not prohibit cost from being a factor, and I would refer to the arguments made by myself previously and that of Senator Kyl and would ask for a vote, unless there are any more comments.

The Chairman. The Clerk will call the roll.

The Clerk. Mr. Rockefeller?

Senator Rockefeller. No.

The Clerk. Mr. Conrad?

Senator Conrad. No.

The Clerk. Mr. Bingaman?

The Chairman. No by proxy.

The Clerk. Mr. Kerry?

The Chairman. No by proxy.

The Clerk. Mrs. Lincoln?

The Chairman. No by proxy.

The Clerk. Mr. Wyden?

Senator Wyden. No.
The Clerk. Mr. Schumer?
The Chairman. No by proxy.
The Clerk. Ms. Stabenow?
Senator Stabenow. No.
The Clerk. Ms. Cantwell?
Senator Cantwell. No.
The Clerk. Mr. Nelson?
The Chairman. No by proxy.
The Clerk. Mr. Menendez?
The Chairman. No by proxy.
The Clerk. Mr. Carper?
The Chairman. No by proxy.
The Clerk. Mr. Grassley?
Senator Grassley. Pass momentarily.
The Clerk. Mr. Hatch?
Senator Hatch. Aye by proxy.
The Clerk. Ms. Snowe?
Senator Grassley. No by proxy.
The Clerk. Mr. Kyl?
Senator Grassley. Pass momentarily.
The Clerk. Mr. Bunning?
Senator Bunning. Aye.
The Clerk. Mr. Crapo?
Senator Crapo. Aye.

The Clerk. Mr. Roberts?
Senator Roberts. Aye.
The Clerk. Mr. Ensign?
Senator Grassley. Pass.
The Clerk. Mr. Enzi?
Senator Grassley. Aye by proxy.
The Clerk. Mr. Cornyn?
Senator Grassley. Aye by proxy.
The Clerk. Mr. Chairman?
The Chairman. No.
Senator Grassley. I will vote now.
The Clerk. Mr. Grassley?
Senator Grassley. Aye. Could we change one more vote from pass to aye for Kyl by proxy?
The Clerk. Mr. Kyl aye by proxy.
The Chairman. The clerk will tally the vote.
The Clerk. Mr. Chairman, the final tally is eight ayes, 14 nays and one pass.
The Chairman. The amendment does not pass. Senator Grassley?
Senator Grassley. Mr. Chairman, we are going to bring up the amendment that you and I worked out over the weekend and yesterday and it is very good and I thank you very much for working it out.
I want to give a short explanation of it, because I

did not go into it when we had it up last week before we started working on our compromise. I think that was Thursday.

The Medicare payment system for physicians is flawed in many ways. One of those flaws results in unfair payments to physicians in high quality, low cost areas, like my home state of Iowa, but there are also a lot of other members on this committee that could make that same statement, as well.

This has been a longstanding problem in my state and those other states. It has been a thorn in the side of physicians in Iowa who are not being fairly compensated for their services. I filed this amendment to address one aspect of geographic disparity in physicians' payments.

My amendment calls for Medicare to use accurate data in making these geographic adjustments in physician payments. Everyone should want Medicare to use the most accurate data possible.

My amendment also would have made a temporary adjustment to this geographic adjustment called the geographic practice cost index, GPCI for short. My amendment, as filed, made the temporary adjustment in a budget-neutral way. That is, it would have made downward adjustments in some areas and increased payments in

others.

It might come as no surprise that members who represent states with a downward adjustment had some concern about that. So last Thursday, rather than proceed with my amendment, I agreed to work with Chairman Baucus to see if we could work out a compromise.

I am pleased to say that we have now worked it out and I am offering this modified amendment. This modified version reflects the agreement we have worked out.

Physicians in Iowa provide some of the highest quality care in the country, yet they receive some of the lowest Medicare payments. So you might wonder why. Medicare payment varies throughout the country based upon geographic adjustment intended to reflect differences in physicians' costs, but the existing adjustments have failed to do the job.

They do not accurately represent the cost of practicing in Iowa and other rural states. They do not provide the equity in physicians' payments that they are supposed to create. Instead, they discourage physicians from practicing in rural areas like New Mexico, North Dakota, Arkansas, Wyoming and Iowa, among other states, because they make Medicare reimbursement rates so low.

This leads to growing shortages of physicians in rural areas that will adversely impact seniors' access to

care. President Obama recognized this problem when he addressed the importance of health care in rural American during the presidential campaign, and I have the letter here and I want to quote from this letter.

Quote, "Extending insurance coverage is a hollow victory of there are no facilities or providers available." Continuing to quote, "That is why I," meaning candidate Obama, "will take concrete steps to address this geographic inequity."

Continuing to quote, "I," meaning the President now, "will work to fix the historical disparities in Medicare and Medicaid reimbursement rates, in which rural providers often get paid less than their urban counterparts."

So I hope you will pay attention to what the President said and promised and, as far as I know, he still expresses that as President as he did as candidate. So I share President Obama's concern.

This amendment that I am offering today will provide help to fix this problem. It will protect seniors' access to rural care. We must provide greater equity in Medicare physician payments and we must ensure that seniors in rural America continue to have access to needed health care.

So fixing this problem we must. The goal is an

accurate adjustment that reflects physicians' true costs. This amendment that I have developed with the Chairman will do that.

So, Mr. Chairman, I ask consent that we submit the letter from then former Senator from Illinois and now the President to the National Rural Health Association for the record.

The Chairman. Without objection.

[The letter appears at the end of the transcript.]

Senator Grassley. And that is the end of my statement.

The Chairman. Senator Conrad?

Senator Conrad. Mr. Chairman, I just want to thank Senator Grassley for offering the amendment and I want to thank the Chairman for working diligently to find a way of reconciling the various positions on the committee.

I think it came out to be a reasonable conclusion. This is a deeply felt problem in my state and in other very rural states. We believe the formulas have been unfair to us and I think it is pretty clear that they have been.

So this is at last a step in the right direction and, again, I want to thank the Senator from Iowa for pushing it and I especially thank the Chairman for working this out.

The Chairman. Thank you, Senator. I might say, and you have already said it, this is a good example of, frankly, working things out. The Senator from Iowa had a very legitimate problem, which is shared by me in my state and some other states.

Yet, on the other hand, there are some other parts of the country obviously who have concerns on the opposite side. Like most solutions, this was a compromise. We kept working at it and working at it until we found ways to find that adjustment, find that compromise, and I just very much thank you, Senator, and all the others on the committee who helped achieve this result.

Senator Grassley. If I could add one or two sentences. You are absolutely right in these rural states. I have said that, you said it, the Senator from North Dakota said it. But there are also some rural parts of heavily populated states where this is an inequity and this will correct the inequity for those parts of urban states, heavily populated states, but their rural parts.

The Chairman. All right.

Senator Grassley. Could I have a roll call? Thank you.

The Chairman. The Clerk will call the roll.

The Clerk. Mr. Rockefeller?
Senator Rockefeller. Aye.
The Clerk. Mr. Conrad?
Senator Conrad. Aye.
The Clerk. Mr. Bingaman?
The Chairman. Aye by proxy.
The Clerk. Mr. Kerry?
The Chairman. Aye by proxy.
The Clerk. Mrs. Lincoln?
The Chairman. Aye by proxy.
The Clerk. Mr. Wyden?
Senator Wyden. Pass.
The Clerk. Mr. Schumer?
The Chairman. Aye by proxy.
The Clerk. Ms. Stabenow?
Senator Stabenow. Aye.
The Clerk. Ms. Cantwell?
Senator Cantwell. Aye.
The Clerk. Mr. Nelson?
Senator Nelson. Aye.
The Clerk. Mr. Menendez?
The Chairman. Aye by proxy.
The Clerk. Mr. Carper?
The Chairman. Aye by proxy.
The Clerk. Mr. Grassley?

Senator Grassley. Aye.

The Clerk. Mr. Hatch?

Senator Grassley. Aye by proxy. Can I interrupt? Hatch wanted to be a cosponsor of this. Could we put him on as a cosponsor, please?

The Chairman. Without objection.

Senator Grassley. Hatch aye by proxy.

The Clerk. Ms. Snowe?

Senator Grassley. Aye by proxy.

The Clerk. Mr. Kyl?

Senator Grassley. Aye by proxy.

The Clerk. Mr. Bunning?

Senator Bunning. Aye.

The Clerk. Mr. Crapo?

Senator Crapo. Aye.

The Clerk. Mr. Roberts?

Senator Grassley. Aye by proxy.

The Clerk. Mr. Ensign?

Senator Grassley. Aye by proxy for Senator Ensign.

The Clerk. Mr. Enzi?

Senator Grassley. Aye by proxy.

The Clerk. Mr. Cornyn?

Senator Grassley. Aye by proxy.

The Clerk. Mr. Chairman?

The Chairman. Aye.

The Clerk. Mr. Wyden?

Senator Wyden. Aye.

The Clerk. Mr. Chairman, the final tally is 23 ayes and zero nays.

The Chairman. Sounds like a pass. The amendment passes. Congratulations, Senator.

Senator Grassley. Thank you very much, appreciate that.

The Chairman. Senator Stabenow, are you ready to offer an amendment? She is ready. Senator Stabenow?

Senator Stabenow. Thank you, Mr. Chairman. I have a modified version of an amendment that I hope we are ready to pass.

I am sorry, Mr. Chairman, but at the moment, I think we do not have a modification to pass out. If you could give us a moment, unless someone else has an amendment.

The Chairman. Senator Nelson, are you going to offer an amendment? Senator Wyden, do you have one? We are looking for amendments. We could even wrap this up tonight.

Senator Wyden. Mr. Chairman, I am hoping that we will have independence at home, which is something that -- Mr. Chairman, a number of Senators on this committee on both sides of the aisle and Senator Burr of North Carolina and I have worked on.

In effect, primary care providers perform house calls on vulnerable people rather than have them receive million dollar workups at the hospital. We are hopeful that Independence at Home will be low cost or not cost. We hope to be able to offer it soon and do it in an expeditious way.

Your staff has been very helpful and I hope we will have it ready to go very shortly.

The Chairman. All right.

Senator Bunning. Mr. Chairman, I do have an amendment ready. Senator Stabenow?

Senator Stabenow. I do have the amendment.

The Chairman. Senator Stabenow, why do you not offer yours? Otherwise, it sounds like Senator Bunning is ready.

Senator Stabenow. Thank you, Mr. Chairman. This is an amendment just to make sure that as we are doing reforms in the states dealing with insurance, that there is a level playing field with any state that has a public nonprofit insurance company, like Michigan does, set up by state statute versus other insurers that will be coming into the state.

We have a number of ways in which we are giving the states the ability, Senator Wyden's amendment, others that may come forward, giving states the ability to look

at different options, and all this does is say that any market reforms that we are instituting or are done at the state level would be provided in a uniform manner to all insurers.

It is basically just to make sure there is a level playing field in any state. There is no cost, I believe, your staff has indicated. It is fairly straightforward, just to make sure that any particular state has the ability to make sure that any reforms that we are doing or are being done at the state level would be applied uniformly to insurers.

The Chairman. Is there any discussion?

[No response.]

The Chairman. Senator, I hear what you are saying. I am just trying to confirm.

Senator Stabenow. We have been working with your staff and it was my understanding that there was not an objection.

The Chairman. I personally, Senator, have no objection. I might check with my colleagues over here. Without objection, I would otherwise accept the amendment.

It sound we are all right. Good job, Senator. Without objection, it is accepted.

Senator Bunning?

Senator Bunning. I would like to call up Bunning amendment C-1.

The Chairman. It is C-1, Bunning C-1?

Senator Bunning. C-1. I want to wait until it is distributed.

The Chairman. All right.

Senator Bunning. Excuse me. It is not modified, so it is in your binder.

The Chairman. All right. C-1, not modified. Thank you.

Senator Bunning. My amendment is fairly simple and makes a small change to the Chairman's mark. It ensures that every American has the option of buying the most affordable health insurance policy through the exchange, regardless of their age.

The Chairman's mark requires that only four types of health insurance policies can be offered in the exchange -- bronze, silver, gold and platinum. All plans would have to offer certain benefits and meet certain criteria.

However, the Chairman's mark creates a special plan called the "young invincible" policy; that is, catastrophic coverage for only people 25 years and younger.

Catastrophic coverage is the right type of health insurance for many different types of Americans; for

example, young people, unmarried people and healthy folks. These plans are affordable and work well for many Americans today.

For example, the young man in his mid 30s who is not married, eats right, exercises, does not smoke, he is not a big user of health care and does not need a comprehensive policy. Instead, he needs and wants -- what he wants is a catastrophic plan. So if he is in an accident or gets seriously ill, he will be covered.

Under this bill, the young man could not buy into the young invincible policy, even though that is what he wants and needs. It seems kind of un-American that we would set up arbitrary restrictions on anyone who can join a particular health care plan.

Who are we to dictate to the American public what plans they can or cannot join? Why would Congress restrict access to the most affordable insurance option that is available? Are we really going to tell 25-year-olds that on their next birthday, their 26th, Congress will require that they will be forced out of the health plan that they have had for years and they will be forced to join another plan?

One of the fundamental problems I have with the bill before us is that it infringes on Americans' liberty and this provision illustrates that point.

This bill will require all Americans to buy insurance and if they do not, we will charge the a tax. But at the same time, we are going to let only certain people join certain plans.

I believe that is un-American, unfair, and it should leave all Americans questioning exactly what we are doing up here. I urge members of the committee to support this amendment.

The Chairman. Any further discussion?

[No response.]

The Chairman. Senator, I hear you. Essentially, in the mark, we do try and address the legitimate concern. It is, for wont of a better expression, the young invincibles.

We provide in the mark that a separate so-called young invincible policy be available for people 25 years or younger and this would be a catastrophic only policy, and, of course, the catastrophic coverage level would be set at the HSA current limit, but prevention benefits would be exempt from the deductible.

Your amendment, in effect, would change that limit -- it is currently in the mark for those persons 25 years or younger -- to anyone, if I understand it.

Senator Bunning. That is correct.

The Chairman. There are several concerns here.

Basically, what we are trying to accomplish in the bill is to address those persons -- help people who do not have insurance to get insurance and for those people who are underinsured, that they would be no longer underinsured.

The figure that was bandied about, about 49, 46, 47 million Americans uninsured. Of course, if you take out the illegals and so forth, it is actually less than that. The figure I recall is about 25 million Americans are, quote, "underinsured." They have insurance, but it is not great insurance.

The concern here is that by allowing the so-called young invincible policy to be available for everyone would, in effect, mean that a very high number of people would be underinsured.

Right now, in the mark, it is not only those persons 25 years and younger able to buy a catastrophic only policy, but we also, as you know, in the mark, have an affordability waiver to address the concerns of those folks who, because they have to get insurance, might not be able to afford it.

The waiver, of course, is if a policy costs more than 10 percent of the -- if the premium is more than 10 percent of income, the waiver would occur.

Right now, the minimum creditable coverage in the

mark tries to strike this balance. That is, on the one hand, you want insurance that is semi-decent insurance; on the other hand, you do not want it to cost too much.

We have worked on that very point, that is, trying to find that balance, for, frankly, months, as all of us have. The concern is that the effect of your amendment would mean that for those folks who want it, that is, minimum creditable coverage would be much, much less lower than the current 65 percent actual value.

Currently, that 65 percent is -- and after lots of discussion, it should be higher, it should be lower, I have forgotten exactly. I think at one point, we were discussing minimum creditable coverage to be around 70 percent. I think in other bills, it is in that nature. So we came down to 65 percent to address some cost concerns.

I would just say, Senator, I just think that the effect of your amendment would mean that many Americans would end up being very much underinsured and end up costing all of us by ending up in emergency rooms or declaring medical bankruptcy because their insurance would be so low.

I recognize the point you are making, but I think the effect of your amendment would too much undermine the goal hereof helping people to have decent insurance. So

I would have to oppose the amendment.

I might also say I think there is six minutes left on a vote. We could vote now.

Senator Bunning. Let me just use a one-liner. If the goal of the bill is to make sure that everyone has insurance, this is one way to do it.

The Chairman. It is one way, that is true. I grant you that it is.

The Clerk will call the roll.

The Clerk. Mr. Rockefeller?

Senator Rockefeller. No.

The Clerk. Mr. Conrad?

The Chairman. No by proxy.

The Clerk. Mr. Bingaman?

The Chairman. No by proxy.

The Clerk. Mr. Kerry?

The Chairman. No by proxy.

The Clerk. Mrs. Lincoln?

The Chairman. Pass.

The Clerk. Mr. Wyden?

Senator Wyden. No.

The Clerk. Mr. Schumer?

The Chairman. No by proxy.

The Clerk. Ms. Stabenow?

Senator Stabenow. No.

The Clerk. Ms. Cantwell?
Senator Cantwell. No.
The Clerk. Mr. Nelson?
Senator Nelson. No.
The Clerk. Mr. Menendez?
The Chairman. No by proxy.
The Clerk. Mr. Carper?
The Chairman. No by proxy.
The Clerk. Mr. Grassley?
Senator Grassley. Aye.
The Clerk. Mr. Hatch?
Senator Grassley. Aye by proxy.
The Clerk. Ms. Snowe?
Senator Grassley. No by proxy.
The Clerk. Mr. Kyl?
Senator Grassley. Aye by proxy.
The Clerk. Mr. Bunning?
Senator Bunning. Aye.
The Clerk. Mr. Crapo?
Senator Crapo. Aye.
The Clerk. Mr. Roberts?
Senator Grassley. Aye by proxy.
The Clerk. Mr. Ensign?
Senator Grassley. Aye by proxy.
The Clerk. Mr. Enzi?

Senator Grassley. Aye by proxy.

The Clerk. Mr. Cornyn?

Senator Grassley. Aye by proxy.

The Clerk. Mr. Chairman?

The Chairman. No. Senator Lincoln is no by proxy. The Clerk will tally the vote.

The Clerk. Mr. Chairman, the final tally is nine ayes and 14 nays.

The Chairman. The amendment does not pass. I might say this before I announce that the committee will stand in recess until 7:15. I might say that I plan to work late tonight and work quite late tonight just to make progress, just to keep going and get amendments passed, and we will continue the same thing tomorrow and, also, work late tomorrow night and all day Thursday and, if necessary, very late Thursday night. But we will be prepared to work quite late tonight.

The committee stands in recess until 7:15.

[Whereupon, at 5:44 p.m., the committee was recessed.]

AFTER RECESS

[7:32 p.m.]

The Chairman. The Committee will come to order.

The next amendment is offered by the Senator from Oregon.

Senator Wyden. Thank you, Mr. Chairman.

Mr. Chairman, I think we on this Committee understand that dollar for dollar there is probably no better --

The Chairman. I am sorry, Senator, is this D16?

Senator Wyden. Yes, it is.

The Chairman. Thank you.

Senator Wyden. Mr. Chairman and colleagues, dollar for dollar there is probably no better investment in American health care than the hospice program. The hospice margins are about 3 percent. You do not get any leaner than the hospice program, which is a lifeline for Americans across the country. This is not a benefit that is gouging taxpayers

We are looking at the prospect of additional cuts under the legislation for hospice programs. This comes on top of cuts that are already in place that start October 1st. It is my view that these cuts are going to be very, very harsh with respect to the impact on services for those who rely on hospice.

We have been having discussions with your staff with respect, Mr. Chairman, to how best to handle this. The proposal that I have made, your staff has indicated could be an alternative. I am encouraged by the discussions that we have had. I would expect that they would continue and we would make additional progress towards a solution that would respond to the urgent needs of hospice patients and providers across the country and would be mutually acceptable to members on both sides of the aisle.

Mr. Chairman, I would be willing to withdraw my amendment at this time pending a discussion with you about how we could continue to work together as we have in the last few days to address this issue, an issue that is vitally important to patients and providers across the country.

The Chairman. Well, thank you, Senator, I think you are on the right track. Let us keep working together to find a constructive resolution here.

Is the issue here an offset, or that is not the issue?

Senator Wyden. The issue, of course, are the budget ramifications. We have looked at a variety of different ways for addressing the cuts and I think that we have an opportunity moving forward.

The Chairman. Well, it is not that much. It is not that costly. So we could figure it out.

Thank you, Senator.

Senator Wyden. Thank you. And with that, Mr. Chairman, I would withdraw the amendment.

The Chairman. Yes, we also have an actual matter that is very important to raise at this point. It is Senator Nelson's birthday. Let us all sing happy birthday.

[Singing.]

[Laughter.]

[Applause.]

Senator Nelson. Mr. Chairman, I am at the age where birthdays are starting to get in the way, but the alternative is worse.

The Chairman. Wise advice. Okay.

[Laughter.]

The Chairman. Who is next? Senator Kyl, do you have an amendment?

Senator Kyl. I do, Mr. Chairman.

The Chairman. Is this D2?

Senator Kyl. Yes, this is amendment number D2.

The Chairman. D2?

Senator Kyl. Correct. And this amendment ensures that seniors' care will not be rationed through the

physician feedback program.

This is, I think, one of the least appreciated problems with this bill. I really hope that my colleagues who helped to craft this provision will think carefully about either adopting my amendment or making some other change that limits the effects of this particular provision of the bill.

It strikes Subtitle A of Title 3, specifically the provision related to feedback program. And I will just quote the provision.

"Beginning in 2015 payment to physicians here would be reduced by 5 percent if an aggregation of the physicians' resource use is at or above the 90th percentile of national utilization. After five years the Secretary would have the authority to convert the 90th percentile threshold for payment reductions to a standard measure of utilization such as deviation from the national mean."

Now, what does this mean? If a Medicare physician is in the top 10 percent of spending, regardless of why, by spending I mean the care that he provides to his patients, then his payment is reduced by 5 percent. Nothing else matters. It is simply an arbitrary number.

Doctors obviously are going to think twice about the care that they provide to their patients because of this.

Because every dollar of care adds up and leads to the possibility that the physician will be in the top 10 percent and therefore will be penalized.

The doctor is going to look at every patient as potentially someone who will reduce his payments by 10 percent or by 5 percent.

We already know that a lot of physicians are having second thoughts about treating Medicare patients. In fact, a lot have decided not to treat Medicare patients.

I think, Mr. Chairman, we should be bending over backward to provide every incentive we can to encourage physicians to take care of Medicare patients. But this would actually work the other way.

My office regularly gets phone calls from seniors who have been turned away. The Arizona Medical Association informs me that proposals that would already reduce -- or excuse me, that would reduce already low reimbursements would only add to the access issues that Arizona seniors have.

We also know that once a physician leaves Medicare he or she is very likely never to return. And that is true for both primary and specialty care.

I am extremely concerned that this physician feedback program would result in inevitable delay and denial of seniors' care.

I would like to ask unanimous consent to put an editorial dated September 25th of the *Washington Times* in the record at the conclusion of my remarks.

The Chairman. All right.

Senator Kyl. I just want to put this in the record and then I am going to go for a minute.

The Chairman. I am sorry. Without objection.

Senator Kyl. Thank you.

Here is in part what it says. If a doctor authorizes expensive care, no matter how successfully, the government will punish him by scrimping on what already is a low reimbursement rate for treating Medicare patients. The incentive therefore is for the doctor always to provide less care for his patients for fear of having his payments docked. And because no doctor will know who falls in the top 10 percent until year's end, or what total average cost will break the 10 percent threshold, the pressure will be intense to withhold care and withhold it again and then withhold it some more. Where at least to prescribe cheaper care no matter how much less effective in order to avoid the penalties.

So, Mr. Chairman, the mark would create a race to the bottom where doctors would be financially encouraged to under-spend one another rather than ensure that appropriate care is delivered. The formula perversely

ensures that regardless of how careful physicians are, 10 percent of them will take a hit no matter how good they are at controlling their costs, irrespective of the results.

We have been focusing a lot here in the Committee on results. Yet, this would not focus on results at all. It would simply say the top 10 percent, regardless of how well they have all done, take a hit in their reimbursements.

Now, the National Right to Life shares my concerns and here, among the things that they wrote, here is what they said: "this is the cruelest and most effective way to ensure that doctors are forced to ration care for their senior citizens patients. It takes the tell-tale fingerprints from the government instead of bureaucrats directly specifying the treatment denials that would mean death and poorer health for older people. It compels individual doctors to do the dirty work. It is an outrageous way to provide coverage for the uninsured by taking it away from America's senior citizens."

This is pure and simple the rationing of health care. Albeit indirectly by doctors rather than the government dictating. It is most inappropriate.

The President in his joint session urged seniors not to pay attention to those scary stories about how your

benefits will be cut. He said it will not happen on his watch. And, yet, here is another provision in the mark that virtually ensures that there will be lower spending on America's senior citizens in order to pay for the new entitlement program that this created.

So my amendment again is the strike of the physician payment penalty. It represents an opportunity, I think, to uphold the President's commitment to America's seniors. I would also note that the Alliance of Special Medicine supports the amendment.

Excuse me, and Mr. Chairman, I also want to just make this point. If somebody would just like to answer this question, perhaps they can do so. It is unclear -- there are two things about this that are unclear.

I assume that what we are talking about here is per capita. That is to say, surely we do not mean that the more patients a doctor treats so that the total cost of his treatments are in the upper 10 percent, therefore he is going to be penalized. But if that is true, I do not know how a per capita expenditure can be calculated without knowledge of a lot of the other affects and adjustments that would be required to rationalize a pure per capita division into the total amount of expenditures authorized.

I am also unclear what the term "resource use" in

the amendment means. And perhaps -- Mr. Dawe is looking at me like maybe he knows the answer. So perhaps I can just ask you that question.

Mr. Dawe. Senator, you are correct. The feedback report is on a per-beneficiary basis. So they compare utilization for patients with similar conditions based on an episode of care per beneficiary throughout a certain time frame, probably a year. So it combines separate, but clinically relevant services into an episode.

And then you are also correct that it would then combine those episodes together to provide a per capita or a per beneficiary report on how much service -- how many services a physician is utilizing or providing relative to his or her peers.

Senator Kyl. And is the term “resource use” the composite total of what he --

Mr. Dawe. Of per beneficiary utilization.

Senator Kyl. Right.

Mr. Dawe. And, of course, the reports are standardized. So you take into account the health status, demographics and risk profile of the patient.

Senator Kyl. Right.

Mr. Dawe. So as not to penalize a physician --

Senator Kyl. Right.

Mr. Dawe. -- who has an unusually sick --

Senator Kyl. And I know that -- Mr. Chairman, just let me conclude.

First of all, this is going to require a very subjective computation. And no two patients are exactly the same. And as soon as you get into some complications of one kind or another, it is very, very difficult to compare the total program that took care of a particular patient with that of another patient.

But, in any event, my primary point here is that if we are focused on evidence-based outcomes here, clearly a good outcome is how can we, in good conscience, simply take an arbitrary number and say, we do not care how good the doctors were last year, 10 percent of them are going to be penalized by knocking 5 percent off of their reimbursements.

As I said, every physician is going to -- because the margins are so close right now and they are not making back what it costs them to take care of Medicare patients, they are going to ask in every case whether or not they should authorize a particular treatment for a patient. I believe the incentives are totally perverse here and frankly contrary to the oath that a physician takes. He has got a very big conflict of interest. If he does what he thinks in the best interest of the patient, it could well put him in a position where he

takes 5 percent less reimbursement and therefore is less able to take care of all of his patients.

I think this is the wrong way for us to try to reduce care -- or costs. And clearly because it will result in rationing, should be no part of the legislation that passes out of this Committee.

The Chairman. Mr. Dawe, I am just a little confused here. How can one differentiate between proper heavy utilization on one hand and improper/over-utilization on the other? What if a physician that does perform many procedures on a per-patient basis, but I think Senator Kyl has a point here, maybe that patient should have many more procedures. Compared to the situation where some physicians probably because we have a fee-for-service system just order lots of test or maybe lots of X-rays, lots of imaging, frankly is unnecessary or perhaps even harmful.

I saw some place that imaging varies around the country. That is, incidents of imaging varies all around the country. I think Vermont had a low rate and I think Florida is the highest rate, eight-fold difference. If I recall it correctly.

So how do we get at this problem of improper or over -- I guess it is a redundant phrase, but how do we get at this problem of over-utilization versus heavy proper

utilization?

Mr. Dawe. So I think the key is that the feedback reports would be standardized so that you will be comparing utilization by a physician on an equal basis for the same -- a patient with the same condition and same health status. So you will be able to see on an apples-to-apples basis how certain physicians compare to others in terms of the amount of service that they provide. And the policy would target those who are at the 90th percentile. So they are several deviations from the mean, if you will, in terms of on a per-beneficiary standardized basis the amount of service that they are providing.

The Chairman. Do you have any evidence of -- what evidence is there of over utilization? Because in the literature, and some people say that there is over utilization in some parts of the country and some states. Maybe it is some practice patterns, I am not sure what. But how do we get at this problem of over utilization?

Mr. Dawe. Well, I think the JO study, I believe, that you quoted is a good example in the area of high-cost imaging services which is something that I think a number of experts and private payers, private health plans who utilize similar methods have found to have oftentimes have limited clinical value in terms of the

additional amounts of imaging that is provided.

Also, I would refer to the Dartmouth data that shows that 30 percent of health spending -- at least 30 percent of Medicare spending does not relate to improved clinical outcomes. So those were additional services that are not providing any additional health benefit for beneficiaries according to Dartmouth.

The Chairman. Where did this idea come from? That is, this feedback --

Mr. Dawe. This is a fairly well-used method in the private sector. This is something that health plans have found is important to help them understand how the physicians in the networks are utilizing services in different ways for the enrollees. This is also something that CBO has pointed to as a method for bending the cost curve in that it will start to provide an incentive for the highest utilizers to come back towards the meat.

The Chairman. So what do health plans do when they find a physician that seems to be, quote, “over utilizing”? What does the plan do about that?

Mr. Dawe. Well, they have several options. They are a payer. Like Medicare they could adjust their payment rates or they could, as most health plans develop networks, they can structure their networks around physicians who they believe are providing evidence-based

appropriate care.

The Chairman. What do they do? You said what they could do. I am just wondering, do plans say, oh, here is a doctor that is, uh-oh, he or she is abusing the system here by ordering all these, let us say, imaging tests. What do plans do about that?

Mr. Dawe. Well, I think they use their power as a purchaser to change the payment rates for providers and their networks. Or they have the ability to shape their network. So they could eliminate a provider from their network if they found that that provider was not providing their enrollees with an appropriate amount of care.

The Chairman. Now, what is going to happen under the mark in the year 2012? That is, does certain kinds of information have to be proposed?

Mr. Dawe. So, in 2012, the mark requires that the Secretary of HHS provide these feedback reports to physicians. Again, so that they have a better understanding of how they compare with their peers in terms of on a pro-beneficiary basis how much service they are utilizing.

The Chairman. Okay.

Mr. Dawe. Then beginning in 2014, the Secretary would look at across all physicians how physicians

compare to one another and those who were found to be outliers in the highest 10 percent would face a payment reduction of 5 percent. After five years, the Secretary would have the authority to convert that to a standard measure as opposed to a percentile base. Because it would be its potential -- potentially that variation -- the variation that we are now seeing in the amount of utilization and the amount of services being provided could start to condense based on this policy or other policies in the mark or future policy.

So to the extent that that variation condenses it would be potentially more appropriate to use a standard measure. Say, two standard deviations from the mean as a standard of measure of what is appropriate.

The Chairman. What opportunities does the Congress have or any other group have to make sure that this is properly implemented?

I can see a lot of physicians say, whoa, wait a minute here, you mean you are going to reduce my payment by 5 percent. I have got -- that is Senator Kyl's point, I have patients that need this heavy volume of service. They are sick. They need some help. So you mean you are preventing me from giving proper care.

Mr. Dawe. Well, the idea of physician feedback is something that CMS is already pursuing. It was already

included in NIPA, last summer's doc fix bill. So that CMS has got -- beginning on the process of developing the methodology for providing this feedback.

The Chairman's mark also is clear that the methodology for defining what an episode of care will be, they are required to seek the endorsement of the entity that has a contract with the Secretary to look at quality-based measures; which is, for now, NQF. Which is a multi-stakeholder board that includes physicians, hospitals, consumers, beneficiary representatives. So the Secretary would have to vet their methodology through this multi-stakeholder.

The Chairman. Who supports this? I mean, are there physicians groups? Are there institutions? Are there, you know, integrated systems, you know, COs? Who supports this?

Mr. Dawe. Providing better feedback to physicians is a concept that has broad support. MEDPAK has recommended this as a way to alert physicians or give them better information on how they are practicing relative to --

Senator Kyl. Can I just interrupt here? I just want to be really clear. When you say, "has recommended this" -- two or three times you said "this" payment feedback is recommended. Have they recommended an

arbitrary 10 percent? Doctors get whacked regardless of how they come in on the physician feedback? You have to be very careful about that.

Mr. Dawe. You are correct. MEDPAK has recommended -- when I said this I meant the --

Senator Kyl. The physician feedback.

Mr. Dawe. -- feedback.

Senator Kyl. But not the penalty of 10 percent regardless of how well they did?

Mr. Dawe. That was not included in their recommendation.

Senator Kyl. Thank you.

The Chairman. I have two things, I have 5 percent and 10 percent, which is which?

Mr. Dawe. Ten percent is the threshold for who would be eligible for the penalty. It's a 5 percent payment penalty.

The Chairman. So where did this 5 percent penalty come from?

Mr. Dawe. It was a policy judgment on a level that was appropriate and not extreme, but would have the intended effects to put pressure on those who were found to be in the extreme of utilization to begin to reduce their over utilization.

The Chairman. Now, is this similar or dissimilar

from the hospital readmission issue? That is, after a certain period of time respective payments to hospitals would be reduced if certain hospitals' readmission rates was above a certain level? Is that --

Mr. Dawe. Yes.

The Chairman. -- is that similar or is it --

Mr. Dawe. Yes, it is.

Senator Conrad. Mr. Chairman?

The Chairman. Senator Conrad.

Senator Conrad. Mr. Chairman, while I strongly disagree with the pay for that Senator Kyl has here, I do think that Senator Kyl has a point here. And I think this is an area where we could have unintended consequences.

As I tried to think about putting my shoes -- my feet in the shoes of a doctor, who might be treating Medicare patients facing this construct, it is one thing to have the feedback. I think we should absolutely -- and Senator Kyl, if I could have your attention. I think it is one thing to have the feedback. I think we should do that. But I think this putting in a penalty, that really leaves me cold.

I do not know how you separate out over utilization that is really over utilization from those doctors who may have a group of patients who require more treatment

than another group of patients.

When you are put in the position of there is no way of knowing as you go through the year what is going to happen at the end of the year. And so what does any doctor who wants to avoid being in this penalty box have to do?

I mean, I think this is one part of this that I think we should think long and hard about.

Senator Kyl. Mr. Chairman, if Senator Conrad could just yield for a second here. I agree with you about the offset. It's a billion dollars. It's not six billion, but still maybe we can come up with something else.

Second, the physician feedback, I think, is not something that physicians would not support. It is, a, very hard to do. And they are the best ones to figure out how to do it. And I could give you a personal example how you got two --

Both my wife and I have a torn meniscus. All right. I have not had surgery, but she has. Her surgery resulted in some additional treatments. Now, I have talked to a lot of people with bad knees and we are all a little different. And, oh, mine worked out fine; no, mine did not, I had to go in a second time. Well, I did not, thank God. And I had to have these four injections afterward, which is what my wife is doing right now. So,

I mean, it is hard to do, number one. But physicians should study this and try to figure out what best practices are.

That is what insurance companies do, do. Mr. Dawe is right. They are looking at this all the time because they have the preauthorizations and all that to make sure that they do not have a lot of waste, fraud, and abuse.

But to me, the most pernicious thing is that we just say arbitrarily 10 percent of the physicians are going to take a 5 percent cut. And that does not make sense to me.

So I agree with you that the review is a good thing for us to have somehow or other. And the professionals ought to be the ones who are doing it.

But you cannot just have an arbitrary penalty like this. Because, I mean, one year you may have 30 percent of the doctors that are really messing up, you may have 2 percent of them that are messing up, and this is arbitrary and, therefore, I think not good.

The Chairman. If I might? I just think -- let us move on this. Frankly I think the Senator makes a good point. But on balance I think we better start going down this road and addressing the realization.

And I just pledge to the Senator that because of the points he has made that I am going to work to see where

we can -- what modifications we can make to address his concerns.

But I do think it is important for our country to start addressing over utilization. We know it occurs and a lot of it is geographically based. Some parts of the country over utilize much more than other parts of the county. And maybe the Senator from Florida will not like saying this, but by definition almost this will affect those parts of the country -- physicians in those parts of the country that do probably over utilize compared to other parts of the country where there is not over utilization.

Senator Conrad. Mr. Chairman.

The Chairman. I also don't like to pay for it because it cuts into the coop.

Senator Conrad. Mr. Chairman, might I inquire of this Senator from Arizona? If he would be willing to lay this aside and see if we cannot find a different pay for.

But I must say, I agree with the Senator from Arizona. I think this is something we would get down the road and we would regret.

Senator Kyl. Since it is only a billion dollars, I think we could and therefore I would be happy to do that.

The Chairman. The Senator withdraws the amendment.

Senator Kyl. For the time being.

The Chairman. For the time being.

Other amendments?

Okay. Senator Grassley has an amendment.

Senator Grassley. Modified amendment C-3. And Senator Bunning would join me as a coauthor of this amendment.

I am going to have to engage staff during some of my remarks. Pretty straightforward amendment. There was an effort to include this amendment in the Chairman's modification. The modification to the Chairman's mark said, "Federal employees or members of Congress may choose to buy insurance in the exchange where the word 'may' being the main word." This is very different than what I had suggested for the modification. Because the word "may" obviously makes this approach an option and I was going to make it mandatory.

So my modified amendment would apply the original intent of my amendment and require that after the year 2013 all members of Congress and staff would have to purchase coverage through state-based exchanges.

At almost every town meeting -- okay, I apologize. I was going to engage staff on this. This is not the amendment that I was going to engage staff. So forget that.

[Laughter.]

Senator Grassley. I have another amendment. In regard to this amendment, I am sure every one of you that had town meetings had the same thing come up at your town meetings that come up at mine. My constituents ask if all the new rules and regulations that we are debating would apply to the members of Congress.

I think it is only fair that if our constituents are going to be buying through an exchange, so should we on Capitol Hill. After all, the exchange will offer the same type of private coverage options as the current federal employee health benefit plan.

This not only makes good policy sense, but will also improve trust and accountability.

We had one last poll of 1,000 voters conducted last week show only 41 percent of Americans support health reform, 56 percent opposing. This is the lowest support that has been of the health care reform since the debate began.

One of the reasons is that we are not applying any of these new rules and regulations to members of Congress. So I think that with the adoption of this amendment it would help that effort.

My interest in having members of Congress participate in exchange is consistent with my long-held view that Congress should live under the same laws that

it passed for the rest of the country. And I think most of you know the history of the Congressional Accountability Act that I got passed in 1995, signed by President Clinton. Prior to that for several decades Congress had exempted itself from laws that apply to the rest of the country.

But we as employers of our staff and we're each individual employers, did not apply those same laws to us. So I authored the Congressional Accountability Act and it took six years to get it enacted. It applied federal labor and employment laws to Congress for the first time ever.

To be consistent -- and I think it's legitimate -- that the same argument can be made today with health care that was made with these work force laws. We should not be considering anything here today that we are not willing to apply to ourselves and our own families. Every one of us has heard our constituents say that they want health insurance like members of Congress get.

This amendment will level the playing field so that we get the same deal private citizens do and vice versa. Just like under the Congressional Accountability Act, it is only fair that the same standards apply. The more the members of Congress experience the laws we pass, the better the laws are likely to be. At least we are going

to have sympathy for what out constituents go through.

So I urge my colleagues to support the amendment offered by Grassley and Bunning.

The Chairman. Well, Senator, I am very gratified that you have so much confidence in our program that you want to be able to purchase insurance in this new program. And I am confident too that the system work very well and I therefore accept the amendment.

Senator Kerry. Mr. Chairman, are we not in fact subject to those anyway?

The Chairman. Sorry?

Senator Kerry. Are we not in fact -- I thought just like every American our program is grandfathered in and if you opt out you are under the same rules as everybody else anyway; are we not?

The Chairman. No, this requirement that we are required to purchase in --

Senator Grassley. Through the exchange.

The Chairman. -- through the exchange.

Senator Kerry. I see, I am sorry. I misunderstood that. I appreciate it.

The Chairman. Okay. The amendment is accepted.

Next amendment.

Senator Crapo, do you have one?

Senator Crapo. Mr. Chairman, yes, I have one.

Mr. Chairman, this would be my amendment number C-1 as modified.

The Chairman. C-1.

Senator Crapo. This amendment would amend the employers' share of responsibility requirement outlined in Title I of Subtitle D of the Chairman's mark. On page 31 of the mark it states that all employers with more than 50 employees that do not offer coverage would be required to pay a fee for each employee who receives a tax credit for health insurance through a state exchange.

My amendment would simply assist more small businesses by increasing the exemption from 50 employees -- small businesses with 50 employees to small businesses with 499 employees.

The amendment -- excuse me. The Congressional Budget Office previously reported that employees and not employers are going to pay the cost of the employer mandates just like the mandates like the free writer penalty on this bill or the pay or play mandates in the House bill.

CBO has clearly stated that employees and not employers will ultimately pay for this type of penalty. The July 2009 CBO economic and budget brief entitled *Effects of Changes to the Health Insurance System on Labor Markets* clearly states, "Supporters of such pay or

play requirements generally justify those provisions in a way to ensure that employers pay a portion of their employees' health care costs. Referring to those requirements in some cases as 'employer responsibility payments.' However, if employers who did not offer insurance were required to pay a fee employees' wages and other forms of compensation would generally decline by the amount of that fee from what they otherwise would have been, just as wages are generally lower, all else being equal, to offset employers' contributions toward health insurance.

The Director of the Office of Management and Budget, Peter Orszag, has also said that increased costs to employers would be passed on to the workers as reduced take-home pay. When he was the Director of the Congressional Budget Office, Orszag said, "The economic evidence is overwhelming, the theory is overwhelming. That when your firm pays for your health insurance, you actually pay through reduced take-home pay. The firm is not giving that to you for free. Your other wages, or what have you, are reduced as a result. I don't think that most workers realize that."

The purpose of this amendment is to minimize harmful damage to small businesses and ultimately to their employees that would be required under the Chairman's

mark to contribute to their employees' health insurance premium.

Unfortunately, this tax is designed to hit many small businesses that are not financially able to cover their employees. Small business is the engine that drives our economy. It creates jobs in our economy particularly in rural states like my home state of Idaho.

We should not impose tens of billions of dollars in new taxes during these times of economic downturn and rapidly escalating costs. Adding additional financial burdens would be extremely counterproductive as studies have shown that these costs to employers are simply going to be passed on to their employees in the form of lower wages or even layoffs.

Now, while I do not agree with any of the forms of pay or play mandates, my amendment would increase the threshold, as I said, outlined in the Chairman's mark to companies with 499 or fewer employees, a common definition of small business in federal law, as being exempt from this new tax increase.

I would just conclude, Mr. Chairman, by point out an interesting thing. We were able to get a score from CBO on this amendment. And the score was a cost of $20 billion over ten years due, as CBO says, primarily to reduce collection of penalty payments.

The thing that was interesting about the score, though, Mr. Chairman, is that CBO went on to state, when they reported this to us, that in any given year it would result in a reduction of employment-based coverage of less than 0.5 million and a corresponding increase enrollment in the exchange. Still quoting, "There would not be a substantial effect on the number of uninsured people relative to the Chairman's mark."

My point being that the provision which I am seeking to have adjusted, if left unchanged, will result in a 20 billion dollar cost to small businesses in the United States for no appreciable impact on reducing the number of uninsured or changing the number of those insured by these same small businesses.

As the CBO score makes very clear, we can eliminate this 20 billion dollar tax on small businesses in the United States included in the bill without reducing the number of uninsured, without impacting the number of uninsured and without changing the number of people who would be able to gain health insurance because of these taxes. And so this is purely a revenue matter in the bill as I see it, Mr. Chairman. And a revenue matter that has taken 20 billion dollars right out of the pocketbooks of our small businesses.

And so for those reasons, I would encourage the

committee to accept the amendment.

The Chairman. First of all, I might ask, so CBO scored this --

Senator Crapo. Yes, this --

The Chairman. -- cost about 20 billion?

Senator Crapo. -- at about 20 billion. But as I said, Mr. Chairman, they also pointed out that this 20 billion dollar cost, the tax that would be paid by the small businesses would have a minimal reduction in employment-based coverage, less than 0.5 million, and no substantial impact on the number of uninsured.

And so the point is that CBO, in scoring the amendment, has also made it clear that making this change is going to have an insubstantial or insignificant impact on both creating employer-based insurance at these small business levels of impacting a number of uninsured in our country. But it will come at a huge price tag to these small businesses.

The Chairman. All right. Now, you say the offset is corresponding reduction in insurance subsidies. Actually, not subsidies, they are tax credits. We are actually lowering taxes for many, many Americans. So you are asking for a corresponding reduction in tax credits. And would you explain what you mean by “corresponding reduction in tax credits” in the mark?

Senator Crapo. Yes. The Chairman's mark contains subsidies for individuals to purchase insurance up to 400 percent of federal poverty level. That is approximately $88,000 a year for a family of four. And this offset would decrease those subsidies so that they would be targeted to lower-income people to the amount necessary to recoup the 20 billion dollar cost.

The Chairman. So, I mean, is it a proportionate reduction? Do you start at 20 percent of poverty? What is the intent here?

Senator Crapo. Yes. A proportionate reduction.

The Chairman. So, basically you want to harm middle-income Americans who otherwise are getting health insurance by making their insurance much more costly or otherwise would be to the tune of 20 billion dollars?

Senator Crapo. This would be to reduce the subsidy; yes. I would not describe it the way you have, Mr. Chairman. But it would reduce the subsidy for those making approximately $88,000 per year for a family of four.

The Chairman. Well, I think it would be more than that because it goes down to -- you are reducing the tax credits down to what level of poverty? What is the effect? CBO is not here.

Senator Crapo. I do not have the exact number of

that, but -- so you were correct, Mr. Chairman, when you indicated that it would come from about 400 percent of poverty down to about 300 percent of poverty.

The Chairman. My understanding is that the tax credits in the mark are about -- is it about 300 percent? About 300 percent are costs -- it is about 10 billion. So you would have to go below 300 percent of poverty. You would have to go to households in the low $60,000 -- probably roughly households of about $50,000. You are going to hit them, maybe $40,000.

Senator Crapo. Okay. My understanding is that you are correct, Mr. Chairman, it would have to go down, not as far as you have indicated, but down to about 250 percent of poverty.

The Chairman. Oh, that is pretty far. That is 50,000; 250 percent of poverty is about 40,000 -- 44,000. So you are getting -- 44,000, so you are getting up to about 50.

Senator Crapo. Well, then what I would suggest, Mr. Chairman, is we work to try to find a compromise. Because this small business employees that we are talking about are losing this 20 billion dollars. This 20 billion dollars, it is not like this 20 billion dollars is just being picked up out of thin air. The people who are paying this 20 billion dollar impact are the

employees of these small businesses. So if you want to say they are losing it in their subsidy because of the offset, let's work with regard to the offset to adjust it better.

But, as I indicated in my initial remarks, it is very clear. CBO and Peter Orszag have made it very clear that these kinds of impacts on small businesses are directly in the end paid by their employees. So we are talking about employees of small businesses. And, frankly, Mr. Chairman, I have also been given information that indicates that we are talking about around $55,000 as to where the subsidy level would be.

The Chairman. That is right. It is about 55,000.

I might point out, I think maybe you did in your remarks, that the mark does exempt firms of 50 or fewer employees.

Senator Crapo. Yes, I did point that out. So there is an exemption. My point is simply that you can increase this exemption to what I think is a more standard definition of a small business, and that is under 500 rather than under 50. But my point is, for those people in this country who are employed by a small business that has between 50 and 500 employees, we are going to be taking 20 billion dollars out of their salaries.

I know that the way that the bill is worded it says that their employer is paying those fees. But, as I indicated, all of the studies clearly show that it comes directly from the employees themselves.

The Chairman. Well, presumably they will not drop coverage.

Senator Crapo. And as I indicated also in my remarks, CBO has indicated that if we save this fee, this 20 billion dollars of fees on the small business making between 50 and 500 -- hire between 50 and 500 employees, it will have no significant impact on the uninsured and a very minimal impact on the level of employer-provided coverage.

The Chairman. Who wants to go? Senator Kerry.

Senator Kerry. Not only does this have the impact that you have just described, it unfairly impacts middle-income and lower-income folks, which the Senator purports that we are trying to protect. But additionally, two things.

One, the Chairman's mark embodies the concept of a shared responsibility. And, as you know, individuals are required to obtain health insurance and they cannot buy it just a moment before they get sick. Employers are also required to do their part. And we have been talking about how that is going to happen. A lot of us think it

ought to happen to a greater degree. But an employer responsibility -- shared responsibility is an essential component of health reform.

Two, the fact is that 95 percent of firms with 50 to 500 employees already offer health insurance coverage. So this amendment would actually wind up rewarding a minority of firms that do not offer that kind of coverage. I do not think it makes sense. I think, Mr. Chairman, there are enough negative impacts as a consequence of that. Not to mention that -- and Senator Snowe knows this -- we both chaired the Small Business Committee -- the break point is about 50 employees where you normally try to get employers to offer that kind of coverage.

Senator Crapo. Mr. Chairman?

The Chairman. Senator Crapo.

Senator Crapo. Mr. Chairman, the point is, regardless of what percentage of these small businesses between 50 and 500 provide or do not provide health care coverage, CBO has analyzed it and has told us that it is going to be a 20 billion dollar fee that the small businesses will collectively pay. And it appears to me that -- let me read again, I think Peter Orszag's quote is the one that says it the best, that CBO makes the same point.

Peter Orszag says, his words, “The economic evidence is overwhelming. The theory is overwhelming. That when your firm pays for your health insurance you actually pay through reduced take-home pay.”

The same thing that was said by the CBO study that when the firm through these plans where the employer is penalized for not providing the health care coverage the cost of that comes out of the employees.

So what we have here is a situation where the employees of small businesses, between 50 and 500 employees, are the ones who are paying 20 billion dollars. And I understand that it is difficult in trying to find us that is in this legislation to find a place where we can adjust that properly. But if it is not acceptable to deal with the pro rata impact on the subsidies, for those at higher levels of income than that, then I believe we should work to find some other place, in the administrative costs of Medicare or in some the other savings that the bill has to address this question. Because we have a direct 20 billion dollar impact on employees of small businesses that are not given this exemption. And this 20 billion dollar impact, again, I state, comes with no substantial impact on the number of uninsured and a minimal impact on the level of employment-based coverage.

Senator Conrad. Mr. Chairman?

The Chairman. Senator Conrad.

Senator Conrad. Mr. Chairman, you know, we have gone over these provisions, I do not know how many times in the group of six, over them and over them in the other deliberations of this committee repeatedly reviewed them. Employers 50 and below are completely exempt. That is a significant majority of the employers in my state.

Ninety-five percent of the employers in this country between 50 and 500 already provide health insurance, 95 percent. This applies only if the employer does not offer his or her employees' coverage and if his or her employees' get -- wind up getting taxpayer assistance through the exchange. To me this is just kind of basic fairness.

I mean, a very small percentage of employers, if the Crapo amendment were to pass, would be allowed to have their employees paid for by all the rest of us. When the vast majority of employers are providing health care coverage to their employees. Ninety-five percent of them with employees of 50 to 500 provide employer-based coverage. So, I think it is pretty modest what is being asked here. The penalty is that you pay the amount of the exchange assistance for those employees that get it, or you pay $400 an employee for all of your employees,

whichever is less. I mean, really, that to me is an entirely fair sharing of the burden.

Senator Crapo. Mr. Chairman?

The Chairman. Senator Crapo.

Senator Crapo. You know, I understand the points that are being made by Senator Kerry and Senator Conrad. And I could understand and even have a little better acceptance of it, if it were the employer who was paying the fee. And I understand that the way that the bill is written that that is the case. But this is not a situation in where 5 percent of 95 percent of these small businesses are getting some kind of special deal because they are stingy and will not provide health care. That 5 percent is having a difficulty providing the health care because of the nature of their business or what have you.

And it is clear, I do not believe it can be argued that it is not the case that it is not the employer that is paying this cost. It is these employers' employees who are paying. So what we are saying, when you say we want to have shared responsibility here, is to say that the employees of these employers are going to share the cost with other individuals in our society for these subsidies. And in some cases it is actually the employees themselves who would be receiving these subsidies.

So, again, Mr. Chairman, this is not a case where we are talking about shared responsibility. The employees of these small businesses are really Americans just as all of the other Americans we are dealing with in this bill are. And they are being hit with a 20 billion dollar impact here that we can find a way around if we wanted to work through it.

Senator Bingaman. Mr. Chairman?

The Chairman. Okay. We are close to a vote here. We are starting to reach diminishing returns.

Senator Stabenow.

Senator Stabenow. Thank you, Mr. Chairman.

I have been listening to my friend and I think first of all we all want to help small business, that is why we are doing this. I mean, that is, 80 percent of the people that do not have insurance are working. So this is about small business, helping small businesses and certainly we want to help employees.

My concern in putting this together because it has been put together in a way to make sure that the exchange works because we want people to be able to get insurance. And we want people to be able to afford to get insurance. And my biggest concern is with the fact that you are talking about taking money away from people, somebody $55,000 a year with two children, a family of

four, that is not a lot of money when you are trying to pay the bills and try to have a mortgage and try to do all the things that families are trying to do today.

So, I appreciate the concern about not having the $400 for the employee trickle down, but at the same -- to the employee, but at the same time you are talking about making this change on the backs of middle class families who we are trying to help.

And so I would have, Mr. Chairman, a concern as you have and oppose the amendment.

Senator Conrad. Mr. Chairman?

The Chairman. Mr. Conrad.

Senator Conrad. Mr. Chairman, I just want to go back to this point. Because the way it works, as I understand it, this only applies if the employer does not offer insurance and if his or her employees wind up getting taxpayer assistance on the exchange.

Now, the Senator from Idaho is saying, well, those employees should not have any responsibility for that. Why not? The only possible way that firm pays anything is if some of their employees are getting taxpayer assistance on the exchange. So it is asking those people who are getting the benefit from all the rest of us to pay something.

I mean, for the life of me, I do not understand how

that is unfair.

Senator Crapo. Mr. Chairman?

The Chairman. Senator Crapo.

Senator Crapo. Mr. Chairman, let me respond very -- Mr. Chairman, I do not know the level of salaries that are being paid by this apparently 5 percent of the small businesses that do not have the ability to provide health care to their employees in the 50 to 500 range. But I would guess that the salaries are not significantly, in large part, in excess of the $55,000 we are talking about. That is just an estimate on my part. I do not have the data on that.

But, we are talking about people who are going to have these costs put directly on them who are probably not any better off than those who you are talking about who should benefit from them paying this extra money. And I would also indicate that my point is also made, not just by CBO and by Director Orszag, but by the Center on Budget and Priorities which is certainly not a hardcore, rightwing group. But they have pointed out that this provision, this limit of the protection for small businesses down at the level of 50 employees is going to have a significant -- we create a significant employer barrier for low-income, single mothers who are trying to get work instead of relying on welfare, or for those who

are at poverty levels that would cause the company to have to pay these penalties on their behalf if it hires them.

So we can go about this any way you want and try to say that, you know, it is a shared responsibility of the small businesses. Or that the people who are the employees of these small businesses do not deserve to be cared for by the bill as much as others who will get the subsidy. But the bottom line here is that we are talking about people who are hired by these small businesses who do not have enough income to be able to purchase their own health care and who therefore are purchasing with subsidies and are now being asked to pay a 20 billion dollar, collective, fine because their small business does not have the ability to provide them, through the business, the health care.

I just believe that we have got to find some way in this legislation, if it is not acceptable to look at the subsidies, then there has to be other cost savings in this bill that can help us deal with it. Because, make not mistake about it, the provision I have raised, raises 20 billion dollars on the backs of those who are in the category of those who are receiving health care through this legislation who can least afford it.

The Chairman. Are we ready for a vote?

Senator Bingaman. Mr. Chairman, could I just clarify one thing?

I believe the Senator from Idaho indicated the Center on Budget and Policy Priorities agreed with this. My understanding of their position is they do have great concern about the provision in here -- in this legislation that triggers an employer mandate at the time that a low-income worker goes to the exchange to get subsidies. They think that should not be done that way. But they certainly do not embrace the concept of exempting all employees up to 499 or all employers up to 499 employees from any mandate. Which is the effect of the Senator's amendment. At least that is my understanding of their position.

Senator Crapo. Mr. Chairman, let me clarify that.

The Chairman. We are getting kind of back -- we need to vote very quickly.

Senator Crapo. Well, let me -- the Center on Budget and Policy Priorities has not taken a position on my specific amendment. You are correct, Senator Bingaman. But I want to be very clear, the Center has analyzed the Chairman's mark and the provisions in the mark that are the subject of my amendment. And it is their conclusion, as I have indicated, that the provisions n the mark as they are will represent a significant employment barrier

for low-income, single mothers who are trying to work instead of rely on welfare, since fewer of them would be hired. And that it is likely that the child poverty levels would then increase as well.

This is not my analysis. This is the Center's analysis.

[Simultaneous conversation.]

The Chairman. All right. All right. Let's vote. All of those in favor say --

Senator Crapo. I would like a vote, Mr. Chairman.

The Chairman. All right. A recorded vote was requested.

The Clerk. Mr. Rockefeller?

Senator Rockefeller. No.

The Clerk. Mr. Conrad?

Senator Conrad. No.

The Clerk. Mr. Bingaman?

Senator Bingaman. No.

The Clerk. Mr. Kerry?

The Chairman. No by proxy.

The Clerk. Mrs. Lincoln?

Senator Lincoln. Pass.

The Clerk. Mr. Wyden?

Senator Wyden. No.

The Clerk. Mr. Schumer?

The Chairman. No by proxy.
The Clerk. Ms. Stabenow?
Senator Stabenow. No.
The Clerk. Ms. Cantwell?
The Chairman. Pass.
The Clerk. Mr. Nelson?
The Chairman. No by proxy.
The Clerk. Mr. Menendez?
The Chairman. No by proxy.
The Clerk. Mr. Carper?
Senator Carper. No.
The Clerk. Mr. Grassley?
Senator Grassley. Aye.
The Clerk. Mr. Hatch?
Senator Hatch. Aye.
The Clerk. Ms. Snowe?
Senator Snowe. Aye.
The Clerk. Mr. Kyl?
Senator Kyl. Aye.
The Clerk. Mr. Bunning?
Senator Bunning. Aye.
The Clerk. Mr. Crapo?
Senator Crapo. Aye.
The Clerk. Mr. Roberts?
Senator Grassley. Aye by proxy.

The Clerk. Mr. Ensign?
Senator Ensign. Aye.
The Clerk. Mr. Enzi?
Senator Grassley. Aye by proxy.
The Clerk. Mr. Cornyn?
Senator Grassley. Aye by proxy.
The Clerk. Mr. Chairman?
The Chairman. No.
The Clerk. Mrs. Lincoln?
Senator Lincoln. No.
The Clerk. Ms. Cantwell?
Senator Cantwell. No.
The Chairman. The clerk will tally the vote.
The Clerk. Mr. Chairman, the final tally is 10 ayes and 13 nays.
The Chairman. The amendment does not pass.
Are there further amendments?
Senator Ensign. Mr. Chairman?
The Chairman. Mr. Ensign.
Senator Ensign. Let me see, Mr. Chairman, it is number C-5 as modified. The Ensign amendment C-5.
The Chairman. All right.
Senator Ensign. It is a health savings account amendment.
The Chairman. C-5, that is a big one.

Senator Ensign. C-5.

The Chairman. All right. C-5A.

Do we have copies of the modified? I only have the unmodified.

Senator Ensign. It is being passed out.

Let me describe the amendment as it is being passed out.

Mr. Chairman, just in general about health savings accounts first. The reason that I have been a supporter over the years of health savings accounts, I actually do not think that we have done the health savings accounts exactly right. But we certainly want to do whatever we can to protect folks with health savings accounts and that is what this amendment is attempting to do, especially if they are faced with bankruptcy.

The reason that I support health savings accounts in the first place, and I have talked about this before. You know, back when we started employer-based health care, the reason we did that was because there was a wage freeze in this country. And kind of as a favor to the labor unions in this country, instead of doing away with the wage freeze we put into effect the ability to give, as a benefit -- pretax benefit -- health care in the United States.

Well, the unintended consequence of that has been

that we basically ended up with the person who is receiving the care was not responsible for paying for the care and had no relation there. And so over the next several decades prices kept going out of site and the employer was paying the bill; the employee did not care, the doctors did not care, the insurance companies did not care, because the insurance companies have made more money. The doctors have made more money. Anybody in health care, hospitals made more money, pharmaceutical companies made more money, employees did not care because they did not understand their wages were not going up as fast because the health care burden, the health care costs associated with employing them kept going up. And instead of giving them raises, they had to give folks -- they had to pay more for folks' health care.

Well, the idea behind the health savings account was to have a higher deductible policy to where you had money in an account where the person who then was receiving the care would shop for those -- the first couple thousand dollars of that care.

Now, the reason that that makes sense, and I will go back and I know some people do not think that this is a fair comparison, but my profession, the veterinary profession is a very good example of how market forces work in health care when people are paying out of their

pockets for health care.

If someone brings their dog or cat or whatever pet that they do to the veterinarian, it is mostly a cash and carry business. And what happens is that as a veterinarian, especially if there is something seriously wrong, I have to talk to you about costs. I have to -- especially if I am the general practitioner and your dog needs a specialist, for instance, I have to be the person that acts as your advocate. I have to say, this specialist over here may charge more money for a knee surgery or a hip surgery. You know, people do not understand how sophisticated veterinary medicine is today. We do total hip replacements. We do incredibly sophisticated knee surgeries. They do brain surgeries. We do MRIs, CAT scans, we do the whole gamut of what human medicine does practically in veterinary medicine today. It is a very sophisticated level of medicine.

But the difference is, because people are paying out with their own pocket money that we have to be sensitive to the costs. So we have to look for all the efficiencies that we can get in the system. But we also have to spend the time to educate.

You know, today with HMOs, what does a doctor do, they are paid per capa -- you know, per capitated rate. So in other words they are paid per patient that they

have in the plan, so they are encouraged to destroy the doctor/patient relationship and just get as many people through the door as they can possibly get through the door.

And then you have somebody else who is going to regulate the care where if you have a health savings account that is your money now and the doctor has to be responsible, or the health care provider has to be responsible because it is your money.

Well, health savings accounts bring some other efficiencies in. Because they do not have to worry about getting paid from Medicare or an insurance company or all the bureaucracies, do you know how many people doctor's have in their offices to collect bills today? To go to the HMO to get approval for something?

Senator Conrad. Would the Senator just yield for a question?

Senator Ensign. Yes.

Senator Conrad. A couple of us are following your discussion and looking at the amendment that has been passed out, do we have the right amendment?

Senator Ensign. It is on health savings accounts. It is on protecting them from bankruptcy. I am making the case of why health savings accounts are good. And then I am going to make the case of why we should protect

them.

Senator Conrad. All right. I thought maybe it was--

The Chairman. Senator, you still have the floor. Go ahead.

Senator Ensign. Thank you. So, as I was saying, because it is now your money in this health savings account, the health care provider, whether it is a chiropractor or a physician, a nurse practitioner, whoever it is. One reason is they know that they do not have to worry about getting paid two months from now or whatever. They are going to get paid now because it is your debit account out of your health savings account.

See, there is incredible efficiencies out of the private bureaucracy that we have developed in this health care market just to collect fees.

If you are in a physician's office, think about it this way. If somebody has health insurance, you do not really care how much the bill is. But if somebody is paying out of their own pocket, you are thinking, "I want to make sure, I want to do the right thing by them," but, "maybe this person cannot really afford to pay a higher price. So maybe I am going to discount it a little bit." We do this all the time in veterinary medicine. I used to do that all the time.

I would have, you know, an 80-year-old couple come in with their dog. I knew they could not pay a lot. I would not even tell them I was discounting their bill. I would discount that. We did that all the time because I knew they were paying out of their pocket.

Well, those are the kinds of dynamics that happen with health savings accounts. And we get true market forces because people are shopping for the health care that they are getting because they are paying out of their own health savings account for the first couple thousand dollars.

Now, having said that, what my amendment does is, let us say somebody right now, especially with as many people are going through bankruptcy in this country and obviously my state other than maybe Senator Stabenow's is -- a worst effect.

The Chairman. Senator, I am going to have to ask you to try to truncate your remarks, because this committee has no jurisdiction over this amendment.

Senator Ensign. Well, I am going to argue how it is.

The Chairman. It is really not very relevant.

Senator Ensign. I am going to argue how it does in just a moment.

The Chairman. Well, I am going to rule the other

way.

Senator Ensign. Well, it is nice that you are going to rule that way before hearing my argument. But the purpose of protecting the health savings account is that with people going through bankruptcy today we are talking about it today. Should they lose their health care? Well, this may be the only help -- this may be the health care that they have chosen. And if we can protect that in this health care bill, their health savings account, they can maintain that health care that they really have come to enjoy.

So I think that is something that we can and should protect.

Now, why isn't this under the jurisdiction of this Committee. First of all health savings accounts are strictly creatures of the Internal Revenue Code, which is certainly the jurisdiction of this Committee. The Committee has the jurisdiction of the Internal Revenue Code and this is also a conceptual mark. My amendment would amend the Internal Revenue Code and would only cross-reference Section 522 of the Bankruptcy Code. So we are actually amending the IRS Code and that is why it is in the jurisdiction of this Committee.

On the larger point, health savings accounts are a health care related tax matter. And this is a health

care reform markup.

Some members of the Committee may not like health savings accounts, but we should be voting on the merits of the amendment and not the germaneness.

The Chairman. All right. It is my opinion this amends bankruptcy law. Therefore, it is not germane to this Committee and therefore I rule the amendment out of order.

Senator Ensign. I would like a vote to appeal the ruling of the Chair.

The Chairman. Do you really want to do that?

Senator Ensign. Yes, I do.

The Chairman. All right. The Clerk will call the roll.

The Clerk. Mr. Rockefeller?

Senator Rockefeller. No.

The Clerk. Mr. Conrad?

Senator Conrad. No.

The Clerk. Mr. Bingaman?

Senator Bingaman. No.

The Clerk. Mrs. Lincoln?

Senator Lincoln. No.

The Clerk. Ms. Cantwell?

Senator Cantwell. No.

The Clerk. Mr. Menendez?

Senator Menendez. No.
The Clerk. Mr. Grassley?
Senator Grassley. Aye.
The Clerk. Mr. Hatch?
Senator Hatch. Aye.
The Clerk. Ms. Snowe?
Senator Snowe. Aye.
The Clerk. Mr. Kyl?
Senator Kyl. Aye.
The Clerk. Mr. Bunning?
Senator Bunning. Aye.
The Clerk. Mr. Crapo?
Senator Crapo. Aye.
The Clerk. Mr. Ensign?
Senator Ensign. Aye.
The Clerk. Mr. Chairman?
The Chairman. No.
The Clerk. Mr. Chairman, the final tally is seven ayes and seven nays.
The Chairman. Two-thirds of the members present not having voted in the affirmative, the order of the Chair is sustained.
Senator Menendez, your amendment?
Senator Menendez. Sure.
The Chairman. Good idea.

Senator Menendez. Thank you, Mr. Chairman.

I would like to call up C-6 as modified. I believe the amendments are at the desk.

The Chairman. Thank you.

Senator Menendez. Mr. Chairman, in the interest of time since I see it is being distribute to everybody.

The Chairman. Why not proceed?

Senator Menendez. Thank you.

Mr. Chairman, this is about emergency room protections. This amendment requires that each health care plan and health care insurer offering coverage in the exchange must provide enrolled individuals coverage for emergency room services without regard to prior authorization or the emergency care providers' contractual relationship with the health plan.

Further enrollees may not be charged co-payments or cost sharing for emergency room services furnished out of network that are higher than in network rates.

The amendment is critical because patients who face emergencies have little control over whether or not they use in network facilities. They may be rushed by ambulance to the closest hospital that has the capacity to serve them or they may get themselves to the closest emergency room. Once there, they must see whatever physician is on duty at that time. And even if they

sought care at an in-network facility, there is no guarantee that the doctor on duty will be in network.

This amendment guarantees that the co-payments and cost sharing patients are charged in an emergency room will be no higher than their in-network cost sharing rates. For example, this amendment would help mothers who rush to a hospital for delivery only to find that the doctor on duty or the neonatal care unit is out of network.

The amendment would help accident victims who may not have access to an in-network physician in the emergency room. It is designed to ensure that although many plans do not charge individuals out of network co-payments and cost sharing in an emergency, some plans do, and it is designed to address that.

CBO has confirmed that this amendment is budget neutral. It is supported by a wide range of organizations including the American Heart Association, the American Stroke Association, to name a few. And when people are rushed to an emergency room they should not be worried about which hospital their ambulance is headed towards.

With that, Mr. Chairman, I ask for the support of the Committee.

The Chairman. Sounds like a great amendment. I

know of many instances where people go to get emergency care only to find out that they are out of network. It is just wrong. This is absolutely wrong.

Let me just check with Ms. Fontenot.

Is there a CBO cost to this? Is there a cost to this?

Ms. Fontenot. No. CBO is budget neutral.

The Chairman. No cost. I urge the amendment be accepted.

Senator Ensign. Mr. Chairman, can I just as a question about it? And this is just from a personal experience. I remember a few years ago some folks were nominated as EMTs of the year, came back and visited in the office. You know, how you sit down in the office and have these visits. This was a very interesting thing and I do not know if there is anything in the mark that addresses this, but under Medicaid, and they said this was a significant occurrence, this was not like just every once in a while. But what they said was that many of the Medicaid emergency visits were folks who they could not afford a cab ride to get their prescriptions filled, but they knew if they called an ambulance and went to the emergency room that they could get their prescriptions then done there by -- and obviously it costs a lot of money for the ambulance ride and

everything. So they would basically kind of fake an emergency, get there and then say, oh, I am feeling better and then get their prescriptions filled. And that would be their transportation.

And from the EMTs anecdotally, they said that it was a fairly common occurrence. And both of the EMTs, they were separate, there were two of them there getting the award, they obviously worked separately, but they both said that it was a fairly common occurrence.

I do not know if that is anything that the staff has come across or anything in the bill. It is one of those things that obviously, you know, if people are taking up the emergency rooms that should not be there, it should be addressed. So is there anything, I guess, the question would be, is there anything in the bill that would say if somebody is really kind of trying to take advantage of this that it is really not truly an emergency. What you are bringing up is a true emergency and that should be addressed. But maybe -- I do not know if there is anything else that we need to look at for that.

The Chairman. Is there anything further?

Yes, Ms. Fontenot? Go ahead.

Ms. Fontenot. It is not an anecdote I am familiar with. There is nothing particularly in the mark that

addresses that.

Senator Ensign. All right. I appreciate it. Thank you, Mr. Chairman.

The Chairman. Thank you, Senator.

Without objection, the amendment is agreed to.

Senator Kyl, I think you sought recognition.

Senator Kyl. Mr. Chairman, I am trying to figure out what the CBO score would be to determine whether we have to have an offset. So if I could defer it for the time being until I can determine that.

The Chairman. Okay. And what amendment is that, just so we have some --

Senator Kyl. That is C-11.

The Chairman. C-11. All right. We are open to other amendments.

Senator Lincoln?

Senator Lincoln. Yes.

The Chairman. You are recognized.

Senator Lincoln. Are you ready for me?

The Chairman. Yes, you bet.

Senator Lincoln. Great.

Mr. Chairman, I would like to call up my amendment number D-9 as modified.

The Chairman. B-9?

Senator Lincoln. D as in David.

The Chairman. D. D as in David.

Senator Lincoln. Expanding CMS Innovation Center.

The Chairman. All right.

Senator Lincoln. Mr. Chairman, a real key component of our efforts this year on health care reform have been to improve access to services that will enable an individual to remain healthy. We are looking to, obviously improve wellness and prevention. This is commendable. And I think it is going to be an enormous part of what keeps our costs down in the out years.

I believe it is equally important to ensure that the those who are injured or have an illness requiring rehabilitation are able to gain quick access to services of a physical therapist so that they might return to full function and independence as soon as possible. That means they are back in the work force, they are back in their home, they are back doing the things that they need and want to do.

It is with this in mind that I offer today a modified amendment that would ask the new CMS Center for Innovation to look into models that could improve access to physical therapists in my rural state of Arkansas and other states, certainly rural states in which physicians are scares and where quick access to rehabilitation services can speed recovery to full function and

independence, thus reducing the overall cost of care that is provided.

Direct access to therapy could enable seniors and individuals with disabilities who reside in primary care health professional shortage areas that are located in a rural area to access the services of a physical therapist.

Today Medicare laws require a beneficiary who receives outpatient physical therapy services to be under the care of a physician. However, this may not be necessary for seniors who are generally healthy. And I believe that the example of the states is very, very clear to us here tonight. Today some 44 states allow for direct access to the services of licensed physical therapists for evaluation and treatment.

So my amendment does not do away with the current statute. Instead it would give CMS the authority to investigate direct access models to enable seniors with the ability to receive valuable rehabilitation services from a licensed physical therapist or other provider without being under the care of a physician so that their recovery to full function and independence can be realized in the quickest manner possible.

It is very similar to -- well, at least we are trying to achieve the same goal that we do in our direct

access bill. I know there are several members of the Committee that joined me as cosponsors of that bill, Senators Cantwell, Menendez, Senator Kerry, Senator Crapo, and Senator Ensign. So it is very similar. We are trying to reach those objectives within the confines of this bill and really improve the ability in rural America to access to physical therapists so that people can get the therapy that they need from physical therapists and other providers and move on back into their lives and into being contributing parts of the community.

So I thank you for continuing to work with me and with my staff on this amendment and the modification and I certainly appreciate your consideration of it.

The Chairman. Thank you, Senator. This amendment does not have a score; is that correct?

Senator Lincoln. Sir?

The Chairman. It does not have a score?

Senator Lincoln. No, sir. It does not have a score.

The Chairman. All right. Frankly, I think it is not bad to add as a list of models for consideration of the Innovation Center the activities that you suggest. As I understand it, it is basically models that do not require a physician or other health professional to refer

the service -- say when the service is to provide --

The point of the amendment again is to -- somebody get it straight. What is the point?

Senator Lincoln. Well, it does not do away with the current statute. Instead it just gives the CMS and the Center for Innovation the ability to look into models that could improve the access for physical therapists and other providers.

The Chairman. All right.

Senator Lincoln. In rural areas.

The Chairman. All right.

Senator Lincoln. And I think it -- you know, that is exactly the group that we want to see in terms of looking for innovation. And these are ways that we can create greater access to therapists and other providers in rural areas.

The Chairman. Well, as an ardent champion of rural America, Senator, I appreciate you picking this up.

[Laughter.]

The Chairman. Is there further discussion of the amendment?

[No response.]

The Chairman. Seeing none, without objection the amendment is agreed to.

Senator Kyl.

Senator Kyl. Mr. Chairman, actually, I could do amendment C-11 now, if you would like for me to do that.

The Chairman. Sure.

Senator Kyl. We do not --

Senator Lincoln. Did you already accept mine?

The Chairman. It is accepted.

Senator Lincoln. Great. Thank you, Mr. Chairman.

Senator Kyl. We do not believe there would be a score for the amendment, so therefore we can proceed to that, I think.

This is amendment number C-11.

The Chairman. C-11. Thank you.

Senator Kyl. This would prohibit the Federal Government from limiting consumer choice by setting the actual values for the insurance policies.

Under the Chairman’s mark the Federal Government would actually limit insurance plans to four specific types. You would have to offer two, you could not offer any more than four. Otherwise you do not sell through the exchange that eventually is the only way you are going to be able to sell insurance. These limits are set at four described levels, bronze, silver, gold, and platinum, that is 65, 70, 80 and 90 percent actuarial value.

This, I submit, Mr. Chairman, is an act on the part

of the Committee and not taking anything from the intelligence of the people that came up with these numbers. They are arbitrary. They suggest that we know what products insurance companies should come up with. And I think the reality is that current experience shows that we got the numbers wrong, even if we think we should try to figure out what these numbers are.

Just for a moment, I want folks at home to realize what we are doing here. Forget the insurance market right now, the Federal Government is going to say there can only be four types of plans. A company has to offer at least two of them and cannot offer more than these four. And they have to be limited by these numbers.

For the life of me, I do not see why Washington has to dictate what kind of insurance policies folks can sell.

CBO our holy grail here says that the actuarial values of an individual insurance policy generally range from 40 percent to 80 percent with an average value that is between 55 and 65 percent. So this is way below the bronze plan which is the lowest actuarial plan. Generally from 40 to 80 percent, average between 55 and 60. The very lowest of these four plans is 65 percent.

According to information in my state of Arizona, the average actuarial value for an individual plan is 61

percent. Still below the bronze plan actuarial value. And Milliman, an independent actuarial firm with which we are all familiar, found that the average actuarial value of a high deductible health plan is 48 percent. Again, below the bronze plan. I mean, one could conclude that contrary to what we have been saying around here, we are actually going to be encouraging Cadillac plans. Because we are saying that you have to issue a plan that is 90 percent, 80 percent, 70, or the very cheap low one is 65. But they go all the way to 90 and you cannot go below 65.

Why would we be doing this when the average is and the general value of these plans is significantly less than the 65 percent. The result of this in the Chairman's mark would effectively eliminate many of the low-cost options that are currently available for individuals in the private market by mandating that all of the plans must fit into one of these categories.

In fact, Milliman specifically defined -- this is at a reformed proposal like the mark, that sets the lowest actuarial value plan at 65 percent will increase health care premiums by 35 percent for those with high deductible plans. So to our commitment that we are going to reduce the cost of health insurance, wrong. We are going to increase them by 35 percent, those that have a

high deductible plan. Welcome to the wonderful world of Washington dictating what kind of insurance you get to buy and just gratuitously increasing your premiums by 35 percent.

Individuals enrolled in individual health plans with a lower actuarial value than 65 percent, according to Milliman, would see their premiums increased by 18 percent.

In addition to increasing the cost of health insurance mandating these specific four benefit categories limits the insurers' flexibility to deny products that satisfy consumer preferences. Instead of limiting consumer choice, Washington ought to be promoting policies that increase consumer choice.

We heard a lot of talk this morning about more competition. And yet here we are constraining competition.

Somehow we think that by controlling every single aspect of health care that we can think of, we are going to lower its cost and provide more competition when exactly the contrary is the case. When well-respected actuarials like Milliman point out this is just not accurate that it will lead to significant rate increases. What we ought to be doing, it seems to me, is attacking the cost problem by putting into practice what I heard a

lot of us talk about early in the game which was for folks to have more skin in the game to be more intelligent consumers of health care with higher deductibles or co-payments, for example, to appreciate the fact that they are spending money on this particular health item and maybe they don't need it. Maybe they will be a little smarter consumer.

Instead, we are back in the syndrome of not washing the rent-a-car. So we are not going to lower costs. We are not going to lower premiums.

And, finally, let me just quote from an e-mail I got from a friend of mine. The man has a business in Arizona. He said, "There is already a model that works to reduce health care costs and the data is incontrovertible. Our costs on a per-member basis have declined substantially since we began offering employees a health savings account to which the company makes a substantial annual contribution combined with a high deductible insurance plan. We have compared the medical and financial benefits of our plan against members in our peer group and we are confident that our health benefits exceed those of our competitors.

At the same time our costs, as reported by our administrator are 33.6 percent below our industry peers and 41.5 percent below the national average on a per-

member basis. We attribute these remarkable results to a plan design that is very consumer driven." Just what I was talking about.

"When consumption and payment are linked, people make better choices. It shows in our plan results and in the cushion created by our associates' health savings accounts to be for future health care spending. Consumer-driven choices in the market work and our company's results are a clear example of how well. Feel free to share this information with your colleagues."

So, Mr. Chairman, I shared that information with my colleagues to point out that these kind of high-deductible plans can work. People are very satisfied with them, and on this basis that if you like your insurance you get to keep it. But by setting these four specifically designed values, we are going to take that choice away from a lot of people. And according to the averages that CBO and Milliman have both identified here, there are an awful lot of folks that are going to fall outside of the four parameters that we would establish in this legislation.

So, again, my amendment would simply prevent the Government from using these kinds of specific actuarial values to limit consumer choices.

The Chairman. Senator, do you have a score on this

amendment?

Senator Kyl. We do not. According to the minority staff, we do not believe it will score.

The Chairman. Ms. Fontenot, will this score or not score?

Ms. Fontenot. I am not certain. The tax credits in the mark are tied to a specific actuarial value. If you eliminate the actual value as laid out in the mark, I am not certain of the impact on the score of that.

The Chairman. Could it increase score? Could it cost?

Ms. Fontenot. I assume it could. I mean, I think there would be ripple effects that would go beyond what I could hypothesize on.

The Chairman. All right. I urge the Committee not to accept this amendment for a couple reasons.

One, we do not know the score.

Second, this is an amendment for the status quo. And I think the majority of Americans do not want to accept the status quo. The status quo where insurance companies currently can cherry pick and do to provide a myriad of plans with different premiums, different co-pays, different deductibles, et cetera. And frankly, in this bill we are trying to find the right balance between affordability and proper coverage.

Under this amendment, if I understand it, the current 65 percent actual value for credible coverage would be eliminated. The result of that would be any insurance company could offer any insurance policy with any actuarial value. You could get down to 50 percent, down to 40 percent, and 30 percent. The insurance company could offer a plan with 30 percent actual value which means that 30 percent of the medical costs, on average, would be covered. And that plan might be a terrible plan. It might have low premiums, but an extremely high deductible or vice versa. It just enables a company to cherry pick and to take advantage of people by offering just too much variety of doctor bills, co-pays, and premiums which are net at a very low value. Or stated differently, have very low coverage for the insured.

The balance we are trying to strike here is between affordability and coverage. That is, we want coverage to be high enough so it's decent coverage. It is not pseudo coverage. That is, it really does help people a little bit. If the coverage is at least 65 percent, it is going to probably reduce the incidence of bankruptcies.

I saw a figure someplace, every 30 seconds, someone in America goes into bankruptcy due to medical care costs. Or at least it is medical cost related. We are

trying to stop that.

If people have at least 65 percent of coverage, and as we know under the mark, people can choose all kinds -- can choose about four different kinds of coverage. Sixty-five percent is a minimum. Then there is hard cover up to, I think, one is 90 percent or 91 percent.

And we have another category to deal with the young invincibles. That is, younger people who are, you know, they feel like they are immortal, they are invincible and they do not want to buy health insurance, so it is okay if you are 25 and under, you can buy a plan with lower credible coverage.

So the effect of this amendment really is several fold besides the fact that we do not have a score. It is an amendment for the status quo which allows companies to take advantage of people frankly. And I think that we should have at least sufficient coverage. And the judgment, we the Committee have made so far, is that coverage is 65 percent actual value. Otherwise, where are they going to get their health care? Say a person has a 30 percent valued plan, which under this amendment the insurance company could offer, that person will end up in the emergency room. That person could end up in bankruptcy and all the rest of us are paying for it.

It just seems to me that the balance we have struck

may not be perfect, but I think it is pretty good with a minimal credible coverage of 65, but yet that person is going to have to buy the plan and then for low-income people, for middle-income people we give the tax credits so they can actually buy, at least, minimum credible coverage.

So I just urge my colleagues to --

Senator Kyl. Mr. Chairman?

The Chairman. Senator from Arizona.

Senator Kyl. Again, I cannot imagine purchasing cheaper plans would raise the score. Previous amendments that related to this I do not think had any score. So I really do not think that is an issue.

Secondly, you are right when you say, gee, an insurance company could offer any kind of plan that they want to. Well, if they qualify in their state, why should they not? If they get customers to buy it, why should we make the decision rather than the consumer? We know best. That is what our constituents do not like about us. We think we know best. If they can find a policy, and obviously if nobody buys the policy, then the company is not going to make any money on it. But if people do buy it, presumably there is a demand for it. So why should we be making that judgment especially when it would appear, based upon the CBO and Milliman

analysis, that we are setting the value way higher than the policies that are generally acquired, or the average of those policies which would be substantially, in one case, a lot lower than that 65 percent.

The Chairman is right that the people who wrote the mark are trying to get a balance between affordability and coverage. But, again, how about instead of us trying to figure out exactly what that balance should be, let the consumer decide. Again, if the plan is not any good, people are not going to buy it. If it is, why should they not be able to buy it?

And I guess the final point here is, we are not doing any favor by raising the cost. As I indicated here, according to Milliman, with an actual lowest plan value at 65 percent, Milliman says, “the mark will increase health insurance premiums by 35 percent for those with high-deductible plans.” And we just trying to do away with high deductible plans? If that is the exercise, we might as well say that right now. I think we are going to make a lot of people very, very unhappy.

The Chairman. At the risk of prolonging the debate, let me just say, CBO says on average our premiums will actually go down under the mark.

Are we ready for a vote? Would you like a --

Senator Kyl. Excuse me for just one moment. That

is about the third time that has been whizzed by and it is not true. CBO, under Chairman Baucus, September 22nd, at the same time, premiums in the new insurance exchanges would tend to be higher than the average premiums in the current law individual market. Higher, not lower.

Senator Conrad. Mr. Chairman, just on that point.

The Chairman. Senator Conrad.

Senator Conrad. Let me just say that that letter from CBO is about as poorly worded as any letter --

[Laughter.]

Senator Conrad. No, I mean, listen to the explanation before you reach a conclusion, please.

We called CBO because I wondered about what that letter meant after reading it three or four times. Because it sounds like, if you read that letter, your premiums would increase. This is not what they have said. We called them and asked, what did you mean to communicate with that letter? Here is what they told us.

"We have only examined the effect on premiums on one portion, the administrative expenses, which on average are 23 cents out of every dollar. Our analysis is on administrative expenses. There would be a reduction of 7 to 8 cents of that 23 cents of administrative expense. That would then be offset by a 3 cent increase for the cost of running the exchange for a net reduction on the

administrative cost," which the only thing they have evaluated, "of 4 to 5 cents out of the 23 cents of administrative expense."

That is what they have told us they meant to communicate in that letter. I would acknowledge reading that letter left me with a very different impression. But that is what they have told us they meant to communicate.

The Chairman. Right. And, frankly, that is what the letter very obliquely says on pages 5 and 6.

Senator Stabenow. Mr. Chairman?

Senator Kyl. Mr. Chairman, might I just respond to one other thing you said here?

You said there would not be any limits, people could go bankrupt, they could sell a plan that only covers 30 percent or whatever. Remember your mark contains two very important limits on out-of-pocket expenses that can be incurred by individuals --

The Chairman. That is correct.

Senator Kyl. -- and also the lifetime limits. So I do not -- I mean, unless --

The Chairman. I understand.

Senator Kyl. -- unless those limits are inadequate. Hopefully we have protected against the concern that you expressed.

The Chairman. Senator Stabenow. We are ready for a vote here.

Senator Stabenow. Mr. Chairman, I just wanted to emphasize again something that you said earlier. This really is about whether or not we think the status quo is okay, whether or not insurance companies making decisions as to what people are going to be able to find or afford is okay. If it was working, it would be fine. But the current situation is not working and we have way too many people who are having a very difficult time trying to find insurance that they can afford. They end up with these policies with huge deductibles and co-pays that they think cover something. It covers very little, but they are spending a lot of money and that is what we are trying to change. So I hope we will vote no on this amendment.

The Chairman. I presume the Senator wants the Clerk to declare the vote?

Senator Kyl. Yes, please.

The Chairman. The Clerk will call the roll.

The Clerk. Mr. Rockefeller?

Senator Rockefeller. No.

The Clerk. Mr. Conrad?

Senator Conrad. No.

The Clerk. Mr. Bingaman?

Senator Bingaman. No.
The Clerk. Mr. Kerry?
The Chairman. No by proxy.
The Clerk. Mrs. Lincoln?
Senator Lincoln. No.
The Clerk. Mr. Wyden?
Senator Wyden. No.
The Clerk. Mr. Schumer?
The Chairman. No by proxy.
The Clerk. Mrs. Stabenow?
Senator Stabenow. No.
The Clerk. Ms. Cantwell?
Senator Cantwell. No.
The Clerk. Mr. Nelson?
The Chairman. No by proxy.
The Clerk. Mr. Menendez?
The Chairman. No by proxy.
The Clerk. Mr. Carper?
The Chairman. No by proxy.
The Clerk. Mr. Grassley?
Senator Grassley. Aye.
The Clerk. Mr. Hatch?
Senator Hatch. Aye.
The Clerk. Ms. Snowe?
Senator Snowe. No.

The Clerk. Mr. Kyl?
Senator Kyl. Aye.
The Clerk. Mr. Bunning?
Senator Bunning. Aye.
The Clerk. Mr. Crapo?
Senator Crapo. Aye.
The Clerk. Mr. Roberts?
Senator Grassley. Aye by proxy.
The Clerk. Mr. Ensign?
Senator Ensign. Aye.
The Clerk. Mr. Enzi?
Senator Grassley. Aye by proxy.
The Clerk. Mr. Cornyn?
Senator Grassley. Aye by proxy.
The Clerk. Mr. Chairman?
The Chairman. No. The clerk will tally the vote.
The Clerk. Mr. Chairman, the final tally is nine ayes, 14 nays.
The Chairman. The amendment fails.
Senator Grassley.
Senator Grassley. While I make my presentation I would like to engage staff for some questions and understanding of the bill. I think I understand it, but I want to find out for sure.
This amendment would allow any high deductible

health plan that meets the current federal requirements for a health savings account to meet the minimum coverage requirement in the Chairman's mark.

I would ask staff, is it true that if this bill is enacted into law some high deductible health plans that are currently sold in the individual market could no longer be sold to new beneficiaries? I hope it is -- I think it is yes.

Ms. Fontenot. Yes, high deductible health plans that are below the 65 percent actuarial value unless it is a young, young person.

Senator Grassley. Under the reforms in place in Massachusetts do health savings accounts qualify high deductible health plans meet the individual mandate requirement?

Ms. Fontenot. I believe so.

Senator Grassley. Is it true that the lowest actuarial value currently sold in Massachusetts is approximately 56 percent?

Ms. Fontenot. I am not certain about that.

Senator Grassley. Then let us just leave it, but that is my understanding. But I thought I needed a professional verification.

The actual value in the Chairman's mark is 65 percent?

Ms. Fontenot. Unless you qualify for a young invincible plan.

Senator Grassley. Can federal employees or members of Congress buy a high deductible plan with a HAS?

Ms. Fontenot. Federal employees in FHBP?

Senator Grassley. Yes.

Ms. Fontenot. Yes.

Senator Grassley. Is there a minimum actuarial value required by OPM for members of Congress or federal employees?

Ms. Fontenot. I do not believe so.

Senator Grassley. According to some data that I have seen from health plans across the country, a lot of plans currently sold in the individual market have actuarial values considerably lower than 65. I would cite some data.

In Michigan 40 percent of the plans are below the new standard that we are proposing.

In West Virginia 75 percent of the plans are below this new federal standard.

In Maine, 87 percent are below the minimum credible coverage in the mark.

And in Washington state 100 percent of the plans are below the 65 actuarial value.

I understand that some of these plans may not

provide adequate benefits, so that is a given as far as I am concerned. And I do not consider myself a fan of mini-medical policies or limited indemnity plans. I think that we would be improving the market if health reform got rid of those limited benefit policies altogether. But I also want to make sure our constituents can still purchase affordable policies.

I know a number of my colleagues across the aisle share my view.

So another question for staff. Is it likely that in many states, especially the 19 states that currently do not have rate bands in individual markets, prices are going to increase for some populations as a result of the new 4:1 rate bands.

Ms. Fontenot. For the populations that are currently covered, they can maintain the coverage they have and there should be minimal effect on their premiums. For population who are currently uninsured and will be buying under the new rating structure, for the healthier individuals coming in, premiums may be slightly higher than what they see unless they are buying the young invincible plan which is likely to be more affordable for them.

Senator Grassley. So the new 4:1 rate bands could effectively for a lot of people that do not have coverage

today that their plans would go up, so people would be required to purchase a more extensive level of benefits at a higher cost and premiums will be higher because of the new rating bands.

Going back to the list of states I mentioned, my question to staff, in Washington state according to data from Blue Cross and Blue Shield, 100 percent of individual plans are currently below 65 percent requirement. If the Chairman's mark is adopted will some people face higher prices when they have to buy coverage that meets the new federal standard?

Ms. Fontenot. Well, again, Senator, those people already have coverage, so none of them will be required to purchase new coverage. They can grandfather the plan they have and their premium will be virtually unaffected.

Senator Grassley. Okay.

Ms. Fontenot. For people who are newly covered, buying coverage, it is hard to compare because they do not currently have coverage. So, will their premium be higher than what? What is the baseline that we are comparing to?

Senator Ensign. Mr. Chairman, will Senator Grassley yield for a clarification? Would you yield for a clarification from staff?

Senator Grassley. Yes.

Senator Ensign. Would, under his line of questioning, from what I understand, if an employer changes the kind of plan that they have, now if they go to a different plan they have to adopt these minimum 65 percent coverages; is that correct?

Ms. Fontenot. If an employer changes their plan?

Senator Ensign. Yes.

Ms. Fontenot. An employer can grandfather their plan.

Senator Ensign. Yes, but I am saying if they change their plan now. They want to select a different plan.

Ms. Fontenot. They have the ability to make modifications in the plan they are offering, and it would still be grandfathered. They would have to end their contract and begin new plan coverage.

Senator Ensign. What if they kept a similar type of plan, but just went with a different company?

Ms. Fontenot. If they went to a different company, then I think they are ending the contract with the current company.

Senator Ensign. So they would then have to buy the more expensive plan?

Ms. Fontenot. Well, the employer requirement for those above the small group market are just that they

have, coverage prevention, that they have --

Senator Ensign. Let us take the small plan then.

Ms. Fontenot. For the small group plan, if they went to a different company, then they would have to -- it would have to meet the 65 percent.

Senator Ensign. So what Senator Grassley is saying that --

The Chairman. I am sorry, could you say that again please and into the microphone please.

Ms. Fontenot. Sure. The Senator was asking in the small group market if a small employer discontinues their coverage with a certain insurer and ends that contract and then wants to pick up a contract with a new insurer, then that plan would not be grandfathered. They would have to meet then the minimum credible coverage requirements.

Senator Ensign. Yes, in other words,small employers change their plans. I mean, I remember when I was a practicing veterinarian; we probably changed plans in five years three different times. That is not an unusual thing to change plans. You are shopping for the best price all the time. But, you may lock people, one, into a plan that they are not really crazy about because if they are going to another plan it is going to be a lot more expensive for them. I think that is part of the

point of what Senator Grassley is trying to get at.

Ms. Fontenot. Right. But the plan they have is less expensive than letting go of the grandfather.

Senator Ensign. Right.

Ms. Fontenot. They have no choice not to --

Senator Ensign. What I am saying is, they may not be crazy about the plan, but you may lock them into that plan. Because if they go away from their grandfathered plan, now they have to go to a more expensive plan. It will be like, we are not crazy about this plan over here that we have. We want to switch to another plan, but because of what the government did, we cannot afford to switch to that plan.

Senator Lincoln. Mr. Chairman?

The Chairman. Senator Grassley, are you still --

Senator Grassley. I am not done with my questioning.

The Chairman. Right.

Senator Grassley. But, if Senator Lincoln had something along this line, I would not mind yielding to her if it is along the lines of what he was questioning about.

Senator Lincoln. Yes, sir. I am just trying to better understand it as well. But just a question for the staff.

So is it not true that HSA plans qualify at the 65 percent actuarial minimum credible coverage but actually from a typical employer-sponsored HSA they are at 76 percent which is well above the minimal coverage; right?

Ms. Fontenot. Correct.

Senator Lincoln. So in terms of the people that you are worried about, I mean, there is a pretty good distance between the 65 percent actuarial minimum coverage and the 76 percent, would that not pretty much cover a lot of the people that Senator Ensign is talking about?

Senator Ensign. That was not who I was talking about.

Senator Lincoln. Oh, you are talking about if you just switch plans?

Senator Ensign. I was just talking about if a small employer switched plans because they were not crazy about the plan, their plan that they have now would be grandfathered, but if they switched companies, for instance, they were not crazy about this other company. What happens if through no choice of their own, the company goes out of business? The health insurance company they are with goes out of business, so they now have to switch plans, not because of something they chose, but because the company went out of business?

They would then have to buy a more expensive plan; yes?

Senator Lincoln. Mr. Chairman. Sorry, go ahead. Sorry.

Senator Ensign. If they were under the 65 percent previously?

Ms. Fontenot. If they were under the 65 percent previously they would have to go to the individual market and purchase. So they would have somewhere to go, but it might be --

Senator Lincoln. But, Mr. Chairman, Senator Grassley's --

The Chairman. I'm sorry.

Senator Grassley. I have the floor, but --

The Chairman. Senator Grassley still has the floor.

Senator Grassley. -- but I would let Senator Lincoln finish her point.

Senator Lincoln. Thank you, Senator Grassley. I just was -- I think to his point of what his amendment is, if the typical employer-sponsored HSA qualified high deductible health plans at 76 percent of the actuarial minimal coverage -- credible coverage, then that is pretty high above the 65 percent. So in essence, I mean, we are giving them certainly very good options. Am I reading that correctly?

Ms. Fontenot. Yes, I think that is right. So the option would be actually to move to a lower actuarial plan.

Senator Lincoln. Right. So it says under the actuarial values 93 percent including employer HSA contributions of 750 in actuarial value and that is not with the subsidy?

Ms. Fontenot. Right.

Senator Lincoln. I mean, that is even without the subsidy?

Ms. Fontenot. Right.

Senator Lincoln. Right. All right. Thank you.

Thank you, Senator Grassley.

Senator Grassley. Where I left off with you, Ms. Fontenot, is that some people would face higher prices when they have to buy coverage that meet the new federal standards. So you said if they are continuing their existing policy they would not have to. But if you had somebody that did not have insurance today and wanted to buy a policy that was less than the 65 percent, once this law goes into effect, they would be paying more; right?

So that brings me then to this point. Would allowing them to purchase any high deductible health plan that qualifies for a HSA give consumers an option with lower premiums?

Ms. Fontenot. Well, you can offer -- you can create an HDHP with a HSA at a 65 percent actuarial value. So it does not preclude the offering of a high deductible health plan.

Senator Grassley. Yes, my staff reminds me that if the actuarial value was lower, the premiums would be lower, obviously.

Ms. Fontenot. Yes.

Senator Grassley. Do HSA qualified, high deductible health plans have an out-of-pocket limit under current law?

Ms. Fontenot. Yes.

Senator Grassley. So there is some protections already in place to prevent people from medical bankruptcy. And according to the Kaiser Family Foundation, about 92 percent offer first dollar coverage of prevention. I know some people across the aisle want to get rid of high deductible plans and HSAs altogether. But as someone who wants to make sure that people have affordable options, if health reform is enacted, I think we should approve this amendment.

My colleagues keep saying that they want to make sure coverage is affordable, so I hope they will join me in supporting this amendment because it would make plans more affordable to more people.

The Chairman. Is there further discussion?

Senator Conrad. Mr. Chairman.

The Chairman. Senator Conrad.

Senator Grassley. Oh, the amendment is C-4, I am sorry. Did I not make that clear? I am sorry.

The Chairman. C-4. Is it modified?

If it was not modified, it is in the book. If that helps any. If it is not modified.

Senator Grassley. It was not modified.

The Chairman. It is not modified. So you have it before you if you want to page through the book.

Senator Conrad.

Senator Conrad. Mr. Chairman, might I ask the staff a couple of questions?

The Chairman. Sure.

Senator Conrad. You know, this is an area where I am not sure we have got this entirely right. I think it does make sense to have groupings of plans under actuarial value because that will help people compare. And it gives companies a great deal of discretion how to structure their plans. So there you have four different levels of actuarial value, really five, because there is the young invincible plan. Companies are completely free to structure their offerings to meet those actuarial values. Is that not the case?

Ms. Fontenot. That is correct.

Senator Conrad. So this does not mean that there would only be five plans available to people. This means there would be five levels of actuarial value and companies would be able to meet those actuarial values by varying deductibles, co-pays and all the rest; is that not the case?

Ms. Fontenot. That is right. There could be many variations within each actuarial value.

Senator Conrad. With that said, I ask for an analysis all across the country in the individual market and the small group market of where actuarial values lie? What do we see across the country in terms of the spread of actuarial values to see if the 90, 80, 70, 65, and the young and invincible plan fully reflect where things are across the country.

And basically from the plans that have been provided to us by Blue Cross/Blue Shield, states all across the country, four from the northeast, probably seven from the Midwest, four from the south, four or five from the west, it does appear that this formulation, the young invincible, the 65, 70, 80, 90 kind of reflects where things are across the country with one exception that strikes me. And that is the 65 percent. And could you help me understand and maybe members of the committee

understand, why was 65 percent chosen rather than, for example, 60 percent?

If it was 60 percent then we would have the young and invincible plan that may be as low as 50, we would have a 60 percent, a 70, an 80, and 90. The 70, 80, and 90 kind of reflects what you see across the country in terms of where people are buying. But the 65, at least with respect to plans in a number of states, appears to be high.

And this is limited. I mean, this is one company, plans that they are offering across the country. So it is not conclusive on this question. But it does strike me that there are states--not mine--but others that have a fair percentage of their plans below 60 percent.

Ms. Fontenot. Right. I think, as the Chairman said, we were trying to strike a balance here between affordability on the front end and meaningful coverage. In terms of what exists in the market today, we have no idea if those policies are meaningful.

In other words, if they do protect people from bankruptcy, if they do keep people from having costs on the back end that they actually cannot afford, even though they could afford the upfront premium. I think the fact that we have allowed for the people who currently have those plans to maintain those plans and

they will meet minimum credible coverage for as long as they maintain them allows us to have a slightly higher actuarial value for new plans that strikes this balance a little more clearly between affordability and meaningful coverage.

Senator Conrad. I am not prepared to reach a conclusion based on this chart, this analysis, that one company has provided us for plans all across the country, in every region of the country. But it does strike me from looking at this that the 65 percent may be somewhat high in relationship to what is selling in the marketplace in some parts of the country. I think this requires additional analysis.

The Chairman. That may be true. But on the other hand we are trying to reduce the incidence of bankruptcy. If you do not have adequate coverage you are more likely to go bankrupt. We also have the $6,000 individual limit on out-of-pocket coverage. And this infamous letter we have all talked about that we cannot understand and cannot read, we think basically says that premiums will come down net about 4 or 5 percent.

I understand your point, but I think to some degree in some parts of the country some companies tend to have pretty low actual value which could be a bit of an issue.

Senator Bingaman.

Senator Bingaman. Let me just ask to be sure I understand what is being discussed. My understanding of the present circumstance is we have a lot of people who are uninsured. We also have a substantial number who are deemed to be underinsured. Meaning that although they have coverage, their coverage is so bad or so inadequate that if they really get sick they are going to find out that they cannot afford the health care that they need.

As you lower the actuarial value of the policy, you are essentially saying that the insurance company is committed to pay 65 percent of the health care needs that you may incur this year. Or 60 percent, or 40 percent, or 70 percent. I think it is a judgment call as to what we think is appropriate. But my understanding of the thinking behind what we have in the mark, what the Chairman has in the mark is that we wanted to address both the problem of the uninsured and the problem of the underinsured and try to get the extent of the coverage that people actually have to a level that is meaningful to folks if they actually get sick. Is that a fair description of what we have been trying to do in this mark?

Ms. Fontenot. I think that is exactly right.

Senator Ensign. Mr. Chairman.

The Chairman. Senator Ensign.

Senator Ensign. Ms. Fontenot, I do not know if I heard you right, I just want to clarify this and maybe ask a further question. Did I hear you or understand you to say that you were not sure of the level of actuarial value and whether that prevents bankruptcy at what level? Did I hear you correctly on that? You were not sure at what level it would actually prevent folks from going into bankruptcy?

Ms. Fontenot. What I was saying to Senator Conrad's point, I do not know what the coverage that currently exists in the market that is far below the 65 percent actuarial value looks like, what it includes in that coverage.

Senator Ensign. Let me go a little bit further because it has been said that some parts of the country have very low actuarial values. Do you know of any studies, or maybe you can get us the citations if you do know, where they looked at the lower actuarial value and bankruptcy rates due to health care? Are there any studies?

Ms. Fontenot. I do not know. We can look into that.

Senator Ensign. The reason I ask that is it would seem a pertinent question if that is why you are setting the 65 percent level. Is that one of the purposes here is

that you are trying not to have somebody go into bankruptcy if they have a serious health problem? And if we do not know at what level that is, or if there is an association? In other words, these plans may be low actuarial value, but they are still protecting against bankruptcy and that is what the person could afford and that is what they wanted. Why would we not allow it for a lower actuarial value?

I know Senator Enzi has talked to me that they are, I think, one of the states that have that. And this is going for that small company that I described earlier that decides to change companies; they would not be able to in his state because it could dramatically raise the cost of insurance for a small company in his state or for an individual. So if we do not know what the actual value is that relates to a bankruptcy, it seems to me that it is kind of an arbitrary, do we take a dart and throw it at the board and it hits 65, or what do we do?

Ms. Fontenot. No, I think, obviously the level of bankruptcy is going to depend on a person's income. We do know that millions of people enter medical bankruptcy a year. We have worked with actuaries over the course of the past couple of years to figure out what is the right balance of meaningful coverage. The fact that we have allowed grandfathering of plans and the fact that we now

have this young invincible plan has resulted in 65 percent actuarial value being the balance that we struck between affordability and meaningful coverage.

Senator Stabenow. Mr. Chairman, I have a question also for Ms. Fontenot.

The Chairman. Senator Stabenow.

Senator Stabenow. Thank you.

I have not yet heard a discussion of the Snowe amendment in the Chairman's modified mark that expands the so-called young invincibles. I wondered if you might just speak to that because I think it, as I understand it, would address some of the concerns that are addressed, I think, in the amendment.

Ms. Fontenot. The modification in the mark allows anyone who receives an affordability waiver, because the lowest cost option to them exceeds 10 percent of their income, to enroll in the young invincible plan regardless of age. So if you are in the market and the lowest-cost plan available to you would exceed 10 percent of your income, then we make available to you a more affordable, catastrophic only plan.

Senator Stabenow. And this includes prevention --

Ms. Fontenot. Yes.

Senator Stabenow. -- as well?

Ms. Fontenot. Right.

Senator Stabenow. So it would seem that with the modification, Mr. Chairman, in your mark that we have addressed those individuals.

The Chairman. I see no Senator seeking recognition. Does the Senator want to vote?

Senator Grassley. I think only one point and that is, that when it comes to the issue of bankruptcy and out-of-pocket expenses and limits on those, the point is that the mark requires that for plans HSAs have had these all the time. And if we adopt my amendment we will have an opportunity for more people to be able to buy plans that are more affordable for them. And at the same time preserve the principles that you have in your legislation which is already part of the principle of HSAs.

The Chairman. I appreciate that. I do not know if this helps at all, Senators, especially Senator Ensign and Senator Grassley. You know, this is a tough issue. We had actuaries in, a little so-called group of six, and very credible. I mean, these folks were smart, objective and could speak English and explain this stuff to us. And are wrestling with it. Where is the balance? Where is the balance? And I cannot say precisely that this is what they recommended on this particular issue. But I do have a very strong recollection that we asked all these questions and listened to the actuaries that this is

about what they said is a good balance with no axes to grind, you know, no longer with the companies and so forth.

Some of you might remember talking with the actuaries. And I -- you know, it is probably no perfect --

Senator Grassley. Can I make --

The Chairman. But this is the general impression and it is about the right balance.

Senator Grassley. Can I make a point? And I want to give Senator Kyl credit for this. But if you will go back to March, and I was not thoroughly versed on everything that we had in the paper that we put down, that was a discussion paper. But Senator Kyl pointed out that under whatever was in the discussion paper that we were going to ruin HSAs. So I brought up the point, I think at another time when Senator Kyl was no around that the President made this promise about if you want what you have you ought to be able to keep it. Now, I know that is true for older HSAs and it is going to change a little bit for new HSAs.

But the point is that it is something that people have, it is working, it fits individual needs and I made the plea that we ought to just leave HSAs alone. And quite frankly I thought we were going to do that.

Now it is modified to some extent because of people that are just buying new products, HSAs a little more. But if you have got where people are assuming so much of the first dollar coverage and they have a catastrophic policy, it seems to me that we ought to be able to accomplish the goals that we want to accomplish and leave those people alone. That is the way I see it.

The Chairman. All right. The Clerk will call the roll.

The Clerk. Mr. Rockefeller?

The Chairman. No by proxy.

The Clerk. Mr. Conrad?

Senator Conrad. No.

The Clerk. Mr. Bingaman?

The Chairman. No by proxy.

The Clerk. Mr. Kerry?

The Chairman. No by proxy.

The Clerk. Mrs. Lincoln?

The Chairman. No by proxy.

The Clerk. Mr. Wyden?

Senator Wyden. No.

The Clerk. Mr. Schumer?

The Chairman. No by Proxy.

The Clerk. Ms. Stabenow?

Senator Stabenow. No.

The Clerk. Ms. Cantwell?
Senator Cantwell. No.
The Clerk. Mr. Nelson?
The Chairman. No by proxy.
The Clerk. Mr. Menendez?
The Chairman. No by proxy.
The Clerk. Mr. Carper?
Senator Carper. Aye.
The Clerk. Mr. Grassley?
Senator Grassley. Aye.
The Clerk. Mr. Hatch?
Senator Hatch. Aye.
The Clerk. Ms. Snowe?
Senator Snowe. Aye.
The Clerk. Mr. Kyl?
Senator Kyl. Aye.
The Clerk. Mr. Bunning?
Senator Bunning. Aye.
The Clerk. Mr. Crapo?
Senator Crapo. Aye.
The Clerk. Mr. Roberts?
Senator Grassley. Aye by proxy.
The Clerk. Mr. Ensign?
Senator Ensign. Aye.
The Clerk. Mr. Enzi?

Senator Grassley. Aye by proxy.

The Clerk. Mr. Cornyn?

Senator Grassley. Aye by proxy.

The Clerk. Mr. Chairman?

The Chairman. No.

The Clerk. Mrs. Lincoln?

Senator Lincoln. No.

The Clerk. Mr. Chairman, the tally is 11 ayes, 12 nays.

The Chairman. The amendment does not pass.

Senator Hatch. Mr. Chairman.

The Chairman. Senator Hatch, you are recognized.

Senator Hatch. Mr. Chairman, I call up amendment number C-10.

Now, this amendment would restore funding to the abstinence education program. More specifically, it would provide $50 million per year through fiscal year 2014 to the program.

Mr. Chairman, abstinence education works. Several evaluations published in peer reviewed journals have demonstrated that the abstinence education effectively reduces teen pregnancy.

During a recent congressional briefing, Dr. Stan E. Reed of the Institute for Research and Evaluation, IRE, presented evidence that refuted recent claims that

abstinence education has failed while comprehensive sex education had been successful.

Dr. Reed states that research evidence does not support the widespread distribution of comprehensive sex education or the elimination of abstinence education as a viable prevention strategy.

Now, teens that begin sexual activity early have increased risk of out of wedlock pregnancy, increased maternal and child poverty, increased depression, and are more likely to attempt suicide than youth who are not sexually active.

Let me just say this. Polling on abstinence reveals that parents want their teens taught core principles of abstinence education. Namely that adolescents could be expected or should be expected to abstain from sexual activity during high school years.

Funding for abstinence education in the past has been on a small percentage of funding spending comprehensive sex education. In 2002 when the Federal Government funded abstinence education, federal and state governments spent $12 million on comprehensive sex education -- or $12 on comprehensive sex education for every $1 spent on abstinence.

Now, all my amendment does is restore this one small funding stream so that teens and parents have the option

to participate in programs that have demonstrated success in reducing teen sexual activity.

Now, I would also, Mr. Chairman, ask that my amendment's offset be modified to exempt Medicare. And I hope that I can get my colleagues to support this amendment because I think it is a very important amendment.

The Chairman. You certainly have a right to modify your amendment. So you want -- will be C-10, but exempting?

Senator Hatch. Medicare. Yes, that would be it.

The Chairman. Any further discussion?

[No response.]

The Chairman. I think we will have two votes here, one on the Hatch amendment and the second on the side-by-side which I will offer.

It is true that teen pregnancy rates have increased across the county. The last several years, I might say, in my state it is above the national average, so I take this very seriously.

To address it I have been working on legislation to provide resources to states for adult preparation including the prevention of teen pregnancy. Programs will educate adolescents on both abstinence and contraception. It must be evidence-based, medically

accurate, and age appropriate. But adults and preparation is more than just this. And my proposal would make funds available to address other preparation subjects including healthy relationships, adolescent development and financial literacy.

Fifteen million will be provided to states on a formula basis. An addition 25 million will be available for innovative solutions in high-risk populations like troubled youth and homeless youth and for research and evaluation.

I think that is a better approach than the one proposed by the Senator.

If there is no further discussion we will have two separate votes.

The first vote would be on --

Senator Grassley. Can we have an opportunity to study this for just a minute?

The Chairman. Sure.

[Pause.]

Senator Ensign. Mr. Chairman, can I ask a question of counsel?

The Chairman. Yes, go ahead, Senator.

Senator Ensign. What are the, other than abstinence programs, what are the monies available right now for the programs that are listed in the Chairman's

amendment?

The Chairman. First of all, Senator, let me say, we do not have copies yet for the side-by-side. So why not ask questions while we are waiting for the side-by-side so you have a copy in front of you.

I am sorry, did you have a question, Senator?

Senator Ensign. Yes, I asked the question of the staff.

I asked the question --

Senator Hatch. Mr. Chairman.

The Chairman. First of all --

Senator Ensign. Yes, the question I asked was, what is the funding available for other than abstinence, what are the other programs that are in that Chairman's amendment, what are the funding sources available and how much for these other things already?

And I guess a follow-up to that is, without Senator Hatch's amendment, how much funding is available for abstinence?

Ms. Henry-Spires. So the answer to your first question was -- let me restate your first question to make sure that I get it correct.

Your first question was, how much funding is available now?

Senator Ensign. Correct.

Ms. Henry-Spires. For prevention?

Senator Ensign. Basically everything else that is in his amendment other than abstinence?

Ms. Henry-Spires. There is none available right now. Currently in Title V those funds have expired. There was an abstinence-only program that expired under Title V. It did not provide money or funding for a comprehensive teen pregnancy prevention.

The Chairman's --

Senator Ensign. Under that title, but what about in other places? Other funding sources in the Federal Government?

Ms. Henry-Spires. There really are not other funding sources that are dedicated funding sources to teen pregnancy prevention. You may be alluding to Medicaid Family Planning Dollars or something of that sort, but there are no dedicated funding streams to teen pregnancy prevention currently operating.

This was the one funding source and it had been for years solely dedicated to abstinence-only funding.

The Chairman's side-by-side seeks to fill that void.

Senator Hatch. There was 50 million each year up until the funds were exhausted; right?

Ms. Henry-Spires. That is right, but they were for abstinence only. And only for abstinence.

Senator Hatch. Right. Only for abstinence.

Ms. Henry-Spires. Yes, sir.

Senator Hatch. That is the difference between -- as I view it the difference between my version of this and the distinguished Chairman's version is that he includes a number of other matters, sexually transmitted infections including HIV/AIDS, et cetera, et cetera.

Personally, I think we ought to -- Mr. Chairman, maybe we should set this aside so we can look at it and see if there is something we can get together on here. Because I think we all have the same desire to --

The Chairman. Well, that may be. I am just saying that abstinence-only programs I think have been ineffective. We have to do a lot more than abstinence only.

Senator Hatch. Not according to what we have been --

[Simultaneous conversation.]

The Chairman. Beyond that I think we may have a problem, we just have to vote.

Senator Ensign. Just for clarification, what about the Public Health Act? There is no funding for these types of programs under the --

Ms. Henry-Spires. Not any longer. Not any longer. They were both dedicated funding streams only for

abstinence only. So for the last few years all the dedicated funding preventing pregnancy had come through abstinence-only programming. This seeks to change that, at least within Title V which the Finance Communication has jurisdiction over.

So what it would seek to do and I am remembering clearly now your first question which was, what else is the Chairman's mark dedicating funds to do? They are dedicated to provide abstinence-only education as well as for active -- sexually active -- people contraception, education and so for the prevention of HIV/AIDS and sexually transmitted infections as well as life skills lessons. So the ability for a program to offer three of six life skill model trainings, things like financial literacy, things like healthy relationships to prevent teen violence. Things like parent and child relationship building, career building. Really focusing young people on things other than just sex education, but really building healthy adults.

The Chairman's side-by-side really focuses on how do you build healthy adults and give them the appropriate tools to grow into healthy adults without a singular focus on sexual activity.

Senator Ensign. Do you know what the National Teen Pregnancy Prevention Resource Center is? I mean, that is

what it says at the bottom of the bill. It says, "Including the National Teen Pregnancy Prevention Resource Center"; do you know what that is?

Ms. Henry-Spires. It would create one. It would create one so that people --

Senator Ensign. Is that a Government or is that a private?

Ms. Henry-Spires. It would be private. It would give the HHS the ability to contract and have a warehouse, a one-stop-shop where parents could go, kids could go to ask questions. It could be web-based. It really allows for the building of an evidence-based, a one-stop-shop to get this kind of information.

Senator Stabenow. Mr. Chairman?

The Chairman. Senator Stabenow.

Senator Stabenow. Thank you, Mr. Chairman.

I think it is important for the record to just indicate the organizations that oppose abstinence-only programming. American Association of School Administrators, the AMA, the American Medical Association, the American Academy of Pediatrics, the American Nurses Association, the American College of Obstetricians and Gynecologists, the American Psychological Association, the American Public Health Association, to name a few. And the reason for that is

because when this was in place nearly half of the states opted out of receiving these federal funds. Opted out of Section 510, choosing to leave federal dollars on the table because these programs were found not to be effective. They were ineffective and in some cases there were concerns about potential harm.

For example, in 2007, the Mathematica Policy Research Institute issued a congressionally mandated report that found these programs simply were not working. They found that there was no difference in behavior between students who participated in these programs and students who did not. And so I believe that was the reason that the funding was no longer continued.

I think what the Chairman has proposed instead is in line with what nationally the medical organizations, educational organizations, and school boards and parents across the country have concluded.

The Chairman. Senator Hatch?

Senator Hatch. Well, as I brought up, a number of peer reviewed journals and have demonstrated that abstinence education effectively reduces teen pregnancy.

Now, we have been given $50 million to that program. What the distinguished Chairman's amendment does is give a total of $50 million a year, but then dilutes that program for all of these others. Some of these other

matters I am not against. But I do not want to see abstinence condoned.

This Augby Poll in December 2003 found that 96 percent of parents said they want teenagers to be taught that abstinence is best; 96 percent. Seventy-nine percent said they want young people taught that sex should be reserved for marriage or in an adult relationship leading to marriage.

In addition the poll showed that 93 percent of parents want teens taught that the younger the age an individual begins sexual activity, the more likely he or she is to be infected by STDs, sexually transmitted diseases, to have an abortion, or to give birth out of wedlock.

Now, we ought to work this out some way or other. What I do not want, I am not necessarily against a number of the things the distinguished Chairman has put in here, but I sure do not want the abstinence education to be short-changed. If we go with his amendment, how much of this money, $50 million a year is going to go for abstinence education?

Ms. Henry-Spires. Well, to your point, Senator Hatch, if abstinence-only education has been peer reviewed and found to be effective, then it would be a fair competitor for 50 million dollar pot. It would have

just as much an ability to be funded as any other model.

This model does not exclude abstinence-only funding. It just says it must be an evidence-based model. There must be some peer review journal, some proof of its evidence-base.

Senator Hatch. I understand.

Ms. Henry-Spires. And it also states that it must be medically accurate and complete. Those are the only two requirements for funding under the first pot of money.

Additionally, just to the question that you have around would the funds be diluted. There is 50 million dollars to evidence-based models. There is also 25 million dollars to fund innovative strategies as well as to ensure that the smaller states that were really severely under funded under the old program for abstinence only receive a floor of funding of at least $250,000.

There were states like the Chairman’s state that were trying to do these programs on less than $200,000 for an entire state. So we at least set a floor able any model that can fit the evidence-based criteria to be able to compete for the dollars and then set up an innovative pot for program models that may be more anecdotally successful, but that need some more evaluation. They can

still be funded competitively. So there are lots of places were an abstinence-only program that you have described that is peer reviewed could fit in, in the Chairman's proposal.

The Chairman. I think we know where we are in this. Let us vote on it. The first vote will be on Senator Hatch's amendment, number C-10. The second vote will be on the Chairman's side-by-side.

The Clerk will call the roll on the Hatch amendment.

The Clerk. Mr. Rockefeller?

The Chairman. No by proxy.

The Clerk. Mr. Conrad?

Senator Conrad. Pass.

The Clerk. Mr. Bingaman?

The Chairman. No by proxy.

The Clerk. Mr. Kerry?

The Chairman. No by proxy.

The Clerk. Mrs. Lincoln?

Senator Lincoln. Pass.

The Clerk. Mr. Wyden?

The Chairman. No by proxy.

The Clerk. Mr. Schumer?

The Chairman. No by proxy.

The Clerk. Ms. Stabenow?

Senator Stabenow. No.

The Clerk. Ms. Cantwell?
Senator Cantwell. No.
The Clerk. Mr. Nelson?
The Chairman. No by proxy.
The Clerk. Mr. Menendez?
Senator Menendez. No.
The Clerk. Mr. Carper?
Senator Carper. No.
The Clerk. Mr. Grassley?
Senator Grassley. Aye.
The Clerk. Mr. Hatch?
Senator Hatch. Aye.
The Clerk. Ms. Snowe?
Senator Snowe. Aye.
The Clerk. Mr. Kyl?
Senator Kyl. Aye.
The Clerk. Mr. Bunning?
Senator Bunning. Aye.
The Clerk. Mr. Crapo?
Senator Grassley. Aye by proxy.
The Clerk. Mr. Roberts?
Senator Grassley. Aye by proxy.
The Clerk. Mr. Ensign?
Senator Ensign. Aye.
The Clerk. Mr. Enzi?

Senator Grassley. Aye by proxy.
The Clerk. Mr. Cornyn?
Senator Grassley. Aye by proxy.
The Clerk. Mr. Chairman?
The Chairman. No. Senator Lincoln?
The Clerk. Mrs. Lincoln?
Senator Lincoln. Aye.
The Clerk. Mr. Conrad?
Senator Conrad. Aye.
The Chairman. The clerk will tally the vote.
The Clerk. Mr. Chairman, the final tally is 12 ayes and 11 nays.
The Chairman. The amendment carries.
The second vote now on the Chairman’s side-by-side.
The Clerk. Mr. Rockefeller?
The Chairman. Aye by proxy.
The Clerk. Mr. Conrad?
Senator Conrad. Aye.
The Clerk. Mr. Bingaman?
The Chairman. Aye by proxy.
The Clerk. Mr. Kerry?
The Chairman. Aye by proxy.
The Clerk. Mrs. Lincoln?
Senator Lincoln. Aye.
The Clerk. Mr. Wyden?

The Chairman. Aye by proxy.
The Clerk. Mr. Schumer?
The Chairman. Aye by proxy.
The Clerk. Ms. Stabenow?
Senator Stabenow. Aye.
The Clerk. Ms. Cantwell?
Senator Cantwell. Aye.
The Clerk. Mr. Nelson?
The Chairman. Aye by proxy.
The Clerk. Mr. Menendez?
Senator Menendez. Aye.
The Clerk. Mr. Carper?
Senator Carper. Aye.
The Clerk. Mr. Grassley?
Senator Grassley. No.
The Clerk. Mr. Hatch?
Senator Hatch. No.
The Clerk. Ms. Snowe?
Senator Snowe. Aye.
The Clerk. Mr. Kyl?
Senator Kyl. No.
The Clerk. Mr. Bunning?
Senator Bunning. No.
The Clerk. Mr. Crapo?
Senator Grassley. No by proxy.

The Clerk. Mr. Roberts?

Senator Grassley. No by proxy.

The Clerk. Mr. Ensign?

Senator Ensign. No.

The Clerk. Mr. Enzi?

Senator Grassley. No by proxy.

The Clerk. Mr. Cornyn?

Senator Grassley. No by proxy.

The Chairman. Mr. Chairman?

The Chairman. Aye. The clerk will tally the vote.

The Clerk. Mr. Chairman, the final tally is 14 ayes and 9 nays.

The Chairman. The amendment passes. So they both pass. That is not unusual in these kinds of situations. When we get to 10 o'clock things start to happen.

Senator Ensign. Mr. Chairman, I have an amendment on the healthy behaviors that I just wanted to get your encouragement. We have been working with Senator Crapo on it. We think we have worked out language if we could just get you to help maybe nudge CBO along. Because obviously we do not have a score it would be real non-germane and we think it is a very important amendment to debate and stuff. It is just not ready or otherwise I would offer it tonight.

The Chairman. Okay. I appreciate you raising

that, let me see what we can do.

Senator Grassley. Can I go ahead?

The Chairman. Yes, Senator Grassley.

Senator Grassley. This is modified amendment C-15. Last week I offered an amendment to have a state opt out of the individual mandate. Senator Wyden raised the question that he thought that maybe his amendment covered what I was trying to accomplish, so I asked it to be laid aside. So now we are at a point where I think that after looking at the situation that Senator Wyden brought up and visiting with various staff people, I think that Senator Wyden's approach will not take care of my intended goal.

Now the Chairman's mark achieves 94 percent health insurance coverage by the year 2019. That is a commendable goal. It achieves these coverage numbers for two main reasons, about 750 billion dollars in exchange subsidies and Medicaid spending, and a strict individual mandate with fines in the neighborhood of $2,000.

One of the reasons that I could not support that Chairman's market is because I believe it spends too much. But another reason and maybe more important is that I did not think an intrusive individual mandate enforced by the Internal Revenue Service was the right approach to getting people covered.

But I think if you ask CBO they would tell you it is virtually impossible to cover 94 percent of the population or more without a strict federal requirement for every American to buy insurance. So I accept that if a state opts out of the individual mandate because they feel it is too intrusive, or not the right approach for residents of that state, the number of people buying insurance may decline. But I do not think that a state should be prohibited from opting out of an individual mandate just because a state cannot achieve near universal coverage.

In Iowa, for instance, more than 90 percent of the population already has coverage. That, of course, is not perfect, but it is one of the highest insured rates in the country. But if Iowa wanted to look at some alternative to the individual mandate that improved the state's coverage even more or maybe did not achieve the 94 percent in the Chairman's mark, I think my state or any state ought to be able to do that.

So my modified amendment would make three changes to Senator Wyden's original opt-out proposal. Number one, it would explicitly say that a state can choose to opt out of the individual mandate.

Number two, it would say that states need to have a plan, quote "to improve health insurance coverage" end of

quote.

And, three, the state would receive a proportional amount of federal subsidies based on the improved level of coverage. This amendment would build on the flexibility introduced by Senator Wyden and make it clear that a state can opt out of the individual mandate and choose alternative mechanisms to improve coverage.

So I hope we will not try to fool ourselves into thinking that Washington always knows best. I am sure there is more than one way to do this. So let us make sure that we do not subject citizens to a strict new federal requirement and costly fines if we do not have to. That is the amendment, Mr. Chairman.

The Chairman. Is there further discussion?

Several points here. First of all, it is minor but not so minor amendment. It incorrectly states a penalty for a family. It does not bridge coverage that is $3800. The modification lowers that maximum amount to 1900.

Senator Grassley. I just in my comments, near 2000 roughly.

The Chairman. Okay. Thank you.

Second, as we discussed the first time around, the modification already includes a process for a state to opt out of all the requirements of the mark. So this amendment is a bit redundant.

But third the amendment allows a state to opt out of the personal responsibility requirement and would be eligible to receive the same amount of federal financial assistance. But does not require the state to achieve the same coverage level. So they would be giving the state the same amount of assistance without the state achieving the same level of coverage. I think that is not good policy.

In addition I oppose the amendment because the offset eliminates assistance for middle-class families.

Senator Grassley. Can I correct that point?

The Chairman. Yes.

Senator Grassley. The state -- pardon me -- a state would not get, as you said, the same amount of money. It would get a proportional amount according to the number -- the higher level of people that are covered under the way the state wanted to do it.

The Chairman. Well, the net effect of this is the states would be getting, as I understand it, funds without having the requirement to keep the same coverage.

Senator Grassley. Yeah. But they would not get the same amount of money that they would otherwise get if the same number of people were getting the federal subsidy without the opt out.

The Chairman. And so how do you calculate the

proportional amount of the funds? How does that get calculated?

Senator Grassley. It would be calculated in exactly the number of people that have come to approximating what you mandate in your mark for coverage like on a national average 95 percent, I guess.

That may not be the way to say it. Just wait a minute. Yeah, my staff says that I am right the way that I said it, but it would be worked out in a budget-neutral way.

The Chairman. Yes, Senator Wyden.

Senator Wyden. Thank you, Mr. Chairman. I was out of the room and may have missed a part of this. But what I think I would like counsel to do is to compare the Grassley amendment with the amendment that is now in the mark that I authored. And Senator Grassley, let me give you my sense of what we were trying to do and then we will see what in addition to what is in the mark you are trying to do.

What I sought to do in my state waiver amendment is to give the states the maximum flexibility in terms of trying to meet the coverage requirements in the law. I think it was relevant a couple of days ago. If anything, it is more relevant given the reports in the last couple of days that states, for example, are trying to get out

from under the individual mandate.

Now, counsel, as I understood your response to my earlier question, you believe that under what is in the mark now, it would be possible for a state to go about a variety of different approaches including not having an individual mandate if they complied with the coverage requirements in our proposal; is that correct?

Ms. Fontenot. That is correct.

The Chairman. Senator, can you speak up? I have a hard time hearing you.

Senator Wyden. Okay.

Ms. Fontenot. That is correct. What is currently contained in the modification of the mark would allow a state to waive the personal responsibility requirement and use some other mechanism, but would require them to obtain the same level of coverage. And I believe what Senator Grassley's modification is doing is to strike that requirement that they achieve the same level of coverage.

Senator Wyden. So is that working now, Mr. Chairman? I cannot tell.

The Chairman. I do not think your microphone works.

Senator Wyden. All right. Here we go. So, counsel, what I think you have said is that instead of

being required to meet the general coverage requirements in the proposal, states could essentially waive them and if that is the case, what would replace what we have in the bill?

Ms. Fontenot. There would be no required level of coverage that the states would have to obtain.

Senator Wyden. So there would be no required coverage. What would the states use the money for?

Ms. Fontenot. Well, I believe what Senator Grassley is proposing is that anyone who is income eligible and obtains coverage under the state's new mechanism would still be able to get the tax credit, but that the states would not have to achieve any particular level of coverage.

Senator Wyden. Okay. I would just like to say to my friend from Iowa because he and I have worked often on this, I will continue to work with you. Because I think the general objective of giving the states the maximum amount of flexibility to meet the coverage requirements in this proposal is a sensible idea. I am prepared to let the states have that kind of running room including the freedom to get out from under the individual mandate. But if counsel has told us that a state would not have to meet any requirements for coverage at all, I think that is just more than this Senator could accept.

But I want the Senator from Iowa to know that I am going to continue to work with him. I think the Senator from Iowa and I agree that clearly the most contentious part of this debate is the individual mandate. We ought to stay at it until this issue is addressed. And in my view, addressed in a bipartisan way. But to do this in a fashion that would have no requirement with respect to coverage at all is a bit too far.

Mr. Chairman, thank you.

The Chairman. Let me ask Ms. Fontenot, is it not true that if this amendment were to pass that fewer people would be covered?

Ms. Fontenot. I guess it depends on what mechanism the state picks to replace the personal responsibility requirement. It is true that CBO has said that it is very difficult, if not impossible, to achieve the same levels of coverage without having a personal responsibility requirement.

The Chairman. Well, I asked that because I understand the amendment, at least the description that I am reading, the amendment would strike the requirement that states must, quote, “Provide coverage to the same insured” and replace it with the language, “improves coverage.”

Ms. Fontenot. Right.

The Chairman. That is a lot of discretion.

Ms. Fontenot. That is right. I mean, there would be no particular target. They would just have to cover some --

[Simultaneous conversation.]

The Chairman. And some states would probably have a lower standard.

Ms. Fontenot. Yes.

The Chairman. So in all likelihood the probability is it would probably increase the number of uninsured? I mean, the coverage would not be as high as it would be.

Ms. Fontenot. Would otherwise be.

The Chairman. Would otherwise appear in the mark.

Ms. Fontenot. Right.

Senator Grassley. Mr. Chairman, that gets us back though to the problem that we had with what is in the mark. And regardless of Senator Wyden’s good intentions, the effect of the coverage requirement under the waiver that is in the mark would essentially require the mandate. And that is the problem that I am trying to correct.

Ms. Fontenot. I think to achieve -- again, it would depend on what the state implements. But according to CBO to achieve the coverage levels that we have achieved would essentially require something like what

we've put in the mark.

The Chairman. All right. Let us vote.

Does the Senator want a roll call vote?

Senator Grassley. Yes, please.

The Chairman. All right. The Clerk will call the roll.

The Clerk will call the roll on the Grassley amendment.

The Clerk. Mr. Rockefeller?

The Chairman. No by proxy.

The Clerk. Mr. Conrad?

Senator Conrad. No.

The Clerk. Mr. Bingaman?

The Chairman. No by proxy.

The Clerk. Mr. Kerry?

The Chairman. No by proxy.

The Clerk. Mrs. Lincoln?

Senator Lincoln. No.

The Clerk. Mr. Wyden?

Senator Wyden. No.

The Clerk. Mr. Schumer?

Senator Schumer. No.

The Clerk. Ms. Stabenow?

Senator Stabenow. No.

The Clerk. Ms. Cantwell?

Senator Cantwell. No.
The Clerk. Mr. Nelson?
The Chairman. No by proxy.
The Clerk. Mr. Menendez?
Senator Menendez. No.
The Clerk. Mr. Carper?
Senator Carper. Pass.
The Clerk. Mr. Grassley?
Senator Grassley. Aye.
The Clerk. Mr. Hatch?
Senator Grassley. Aye by proxy.
The Clerk. Ms. Snowe?
Senator Snowe. Aye.
The Clerk. Mr. Kyl?
Senator Kyl. Aye.
The Clerk. Mr. Bunning?
Senator Bunning. Aye.
The Clerk. Mr. Crapo?
Senator Crapo. Aye.
The Clerk. Mr. Roberts?
Senator Grassley. Aye by proxy.
The Clerk. Mr. Ensign?
Senator Ensign. Aye.
The Clerk. Mr. Enzi?
Senator Grassley. Aye by proxy.

The Clerk. Mr. Cornyn?

Senator Grassley. Aye by proxy.

The Chairman. Mr. Chairman?

The Chairman. No.

The Clerk. Mr. Carper?

Senator Carper. No.

The Clerk. Mr. Chairman, the final tally is 10 ayes and 13 nays.

The Chairman. The amendment fails.

What I would like to do tonight is see if we can wrap up all the coverage amendments. I do not want to take up any financing amendments tonight. We will defer those until tomorrow. But if we can finish up the coverage tonight, then we can leave earlier than we otherwise might.

Senator Kyl. Mr. Chairman?

The Chairman. Senator Kyl.

Senator Kyl. If there are democrat amendments they certainly would have a precedence here. I have an amendment we are waiting for the score on it. But I would be happy to present it and talk about it.

The Chairman. Well, that is generally what we do.

Mr. Menendez?

Senator Menendez. Mr. Chairman, I have an amendment that I intend to offer and withdraw and speak

very briefly on it.

The Chairman. Sure.

Senator Menendez. It is C-11.

The Chairman. All right.

Senator Grassley. Senator, could I interrupt just for a second?

Senator Menendez. Yes.

Senator Grassley. To make a comment on what you just said. Now, some of our members are not here and we have got amendments in this area that we have to offer yet. And I do not know whether they are going to be here tonight or not.

The Chairman. I am sorry, which area?

Senator Grassley. Coverage. Yeah, before you will want to go to finance. So we have to have the right --

The Chairman. I am not going to close out amendments on coverage.

Senator Grassley. All right.

The Chairman. I just do not want to go to finance until tomorrow.

Senator Grassley. All right. Then we will have to have some amendments on coverage tomorrow.

The Chairman. All right. Whatever we get done tonight helps. Fine.

Senator Menendez. Sorry, you were speaking.

Senator Menendez. Thanks, Mr. Chairman. This is C-11. And since I am going to withdraw it, I guess it will be distributed.

But as you know, Mr. Chairman, under your mark there is a separate young invincible policy that is available both for those who are 25 years or younger. The plan would be for a catastrophic coverage only and would be exempt from having to meet minimum benefit standards. I understand the idea behind the proposal is to keep premiums low enough for young adults to buy these plans and meet the individual insurance mandate.

The amendment that I am talking about and hope to work with you as we move to the floor, would allow women, for example, who get pregnant while enrolled in a young invincible plan to access maternity care and switch to a more comprehensive plan.

If one could imagine a woman enrolls in this young invincible plan as she is healthy, newly married, does not think she will need anything more than the bare bones plan. But, as we all know, a life often has a different plan. She becomes pregnant, the open enrollment period is seven months away so she is caught in a catastrophic coverage until she can officially switch to a comprehensive plan. She is essentially without the coverage she needs for most of her pregnancy. And that

is by way of one example.

It is an amendment that is supported by a number of groups including the American College of Obstetricians and Gynecologists, the Association of Maternal and Child Health Programs, the March of Dimes, and a whole host of others.

Maternity coverage provides women with access to prenatal and post-partum care which we know improves the health of both mothers and infants. Women who receive prenatal care more likely to have access to screening and diagnostic tests that can help to identify problems early. Services to manage developing and existing problems, education, counseling and referral to reduce risky behaviors.

The reason that I am not moving forward is because my amendment is unable to be scored by CBO because the young invincible plans were not part of their preliminary analysis, so they are unable to provide an estimate for what this amendment would mean in the context of that maternity care. And pursuant to the Chairman’s rules about not being able to offer stuff that does not have a score I just wanted to put this out there. Hopefully when we do get a score on that section, that this can be addressed either in the merger or on the floor.

With that, Mr. Chairman, I withdraw the --

The Chairman. I think it is a good idea. I will just try to help get a score as soon as we can.

Senator Menendez. Thank you. I appreciate that.

The Chairman. Other amendments. Senator Kyl, you have one?

Senator Kyl. Mr. Chairman, I can discuss this. We are just waiting to get a score. I can discuss it now and then we can hopefully have the score tomorrow and vote on it tomorrow. I mean, whatever you want to do.

The Chairman. That is all fine. I just do not want to rehash the same arguments tomorrow again, all over again, after tonight.

And I am just curious, if we can have it tonight then vote --

Senator Kyl. I have one amendment that I am waiting to get an offset for. This amendment which I can discuss now or wait and get a score on.

The Chairman. I am sorry, I misunderstood the other one.

Senator Kyl. So there are two amendments. One which I could discuss now and then maybe with just a very short discussion of it tomorrow when everybody is here.

The Chairman. And the second one?

Senator Kyl. The second one we will have an offset for tomorrow morning. And I do not have an offset now.

The Chairman. Are there any amendments on this side? Coverage amendments? Coverage amendments. Any amendments on coverage? Because we are getting close to closing out coverage. We will not close it out tonight, but we will --

Participant. I think Senator Cantwell has one, maybe.

Senator Cantwell. Mr. Chairman?

The Chairman. Senator Cantwell.

Senator Cantwell. Mr. Chairman, if I could bring up Cantwell amendment number C-9.

The Chairman. C-9.

Senator Cantwell. Primary care, medical home coverage.

The Chairman. Okay.

Senator Cantwell. Mr. Chairman, as you know, and Committee members the northwest has been an area for innovative models for providing high quality and cost-effective care. And one of these models is the direct primary care medical home. Under this model patients have unlimited access to primary care medical home so that primary care doctors coordinate all of their health care needs and cover all their costs for preventive care with a set monthly fee of $50 to $80.

So the underlying mark of the Chairman requires

individuals to have coverage and we want to make sure that this type of innovative model would also be eligible as coverage provided under the plans required for individuals.

This would require the Secretary of DSHS to set up standards under which insurance coverage requirements in the mark can be met by having a direct primary medical home coverage and combined with non-primary care, wrap-around insurance. And it will require this coverage model be counted as a minimal, credible coverage plan before the coverage requirements in the mark take effect.

I know that my colleagues are considering many innovative ways to drive down costs. Small versions of this coverage model already exist in 29 states. Not as big as the scale that we have in the northwest, but those states include Arizona, Florida, Michigan, and New York, and Oregon, and Texas. And the combination of this direct primary care and insurance to cover all primary -- non-primary care needs offers an excellent model for coverage at a very affordable price.

The cost savings of this model, direct primary care, can save businesses and individuals 20 to 50 percent on their comprehensive care coverage and so I hope that the underlying bill will allow this kind of innovation to take place.

Senator Ensign. Mr. Chairman, is this amendment modified? We just do not have the language. Is it modified?

The Chairman. Senator, is this modified?

Senator Cantwell. Yes, it has been.

The Chairman. It has been modified. Yes, we need language. I do not know where the language is. Do you have language, Senator?

Senator Cantwell. We do.

The Chairman. Can we distribute it?

Senator Cantwell. Yes.

The Chairman. Good.

Senator Cantwell. Mr. Chairman, I am happy to hold off so members can see this. But given your request to have all coverage amendments tonight, we thought we would throw it up for consideration.

The Chairman. My sense is though we really cannot -- it would be difficult to consider this and take action on it without seeing it and digesting it.

Senator Cantwell. I am happy to set it aside, Mr. Chairman, for tomorrow or whatever you would like.

The Chairman. Let me consult with -- Senator Grassley is not here. But are there -- the Senators have not had a chance to see this. It is going to be hard to get their reaction.

I frankly think we are going to have to defer this until tomorrow.

I think we are going to have to defer it to tomorrow.

Senator Cantwell, has this been scored; do you know?

Senator Cantwell. I know that our staffs have been working on this and we made suggested changes and the amendment is revenue neutral.

The Chairman. All right. And I see there is nodding affirmatively. Do you believe it is revenue neutral?

Ms. Fontenot. I believe that is correct.

The Chairman. Okay. We are at the stage where, I do not know, nobody is really ready. I do not think we can act on this tonight yet. We have to review it a bit more thoroughly.

Senator Cantwell. I am happy to set it aside for tomorrow, Mr. Chairman.

The Chairman. All right. The amendment is set aside.

Senator Kyl, are you ready yet?

Senator Kyl. Yes, as I said, I do not have the score here.

The Chairman. Well, go ahead because nobody has an amendment.

Senator Kyl. Okay. This is amendment number C-17.

Senator Conrad. Has that been modified?

Senator Kyl. No. This is as filed. It is amendment number C-17 and what it would do is increase the annual -- this relates to health savings accounts. It probably would have been better to follow -- we had an amendment earlier and directly follow that because some of the discussion would be similar.

But in any event, this amendment would increase the annual HSA contribution limits to equal the amount of the individual HDHP out-of-pocket maximum which is currently in the law. And let me explain what the positive effect of that would be.

Currently contributions to health savings accounts are limited annually under a formula specified in statute and they are adjusted annually for inflation by IRS.

Although some high deductible health plans cover 100 percent of expenses after the deductible is met, many plans charge a co-insurance until a higher limit on out-of-pocket expenses is met. That might include deductibles, co-payments, and co-insurance. Out-of-pocket limits for high-deductible health plans are limited and they are adjusted annually for inflation but are higher than the contribution limits for health savings accounts.

My amendment would conform the two. It would allow individuals to contribute money to the health savings accounts equal to the amount of the out-of-pocket limits for the high-deductible health plans. What would this do? It would give chronically ill people a way of paying for all of their out-of-pocket expenses with tax-free dollars. That is the primary effect of it. And it would give everyone else the flexibility to save enough money to be prepared in the case of a serious medical event, but also have enough money to provide for routine medical expenses.

Obviously these are both very good results. It provides more personal responsibility for payment for medical care. It does not require taxpayers to support folks. It is common sense and I think it provides people with an incentive for future care.

Mr. Chairman, there are some general talking points on health savings accounts that I would like to discuss here. I am sensing that the Chairman would like to just perhaps get these amendments laid down so that when we have the score tomorrow we can discuss them in more detail. But that is what this amendment would do. I think it is a very good amendment.

The Chairman. Okay. Any discussion?

[No response.]

The Chairman. We will wait for a score tomorrow?

Senator Kyl. Yes. Thank you Mr. Chairman.

Incidentally, Mr. Chairman, I know I said I would set in, but let me just get a little statistical information out for my colleagues to chew on over night.

There is kind of a sense that well these are just for the young, more wealthy, young folks that figure they do not have to buy insurance and so on. We got some statistics which I think are very interesting. Forty-six percent of people with health savings accounts in the year 2008 lived in low or middle income neighborhoods; 34 percent lived in middle income neighborhoods; 53 percent of all individual market enrollees were aged 40 or older. In other words, over half were over 40.

Small employers were one of the fastest growing markets for these high-deductible, health plan HSA products, rising 34 percent between the year 2008 and 2009. And according to a recently released Kaiser annual survey of employee health benefits, the average annual premium for a family with a high-deductible health plan with a health savings account is $11,100 versus the average employer-sponsored family premium of $13,375 for all plans.

I think the bottom line here is that there are a lot of different kind of folks who are using these plans,

they are growing in popularity. A lot of folks who do not have that much money live in a lower or lower middle-class neighborhoods. So it is kind of a myth to suggest that the folks that take advantage of these policies are young, rich folks. That just is not the case. And I think we want to do everything we can to preserve their effectiveness. And that could be enhanced with the amendment that I have offered.

Senator Conrad. Mr. Chairman.

The Chairman. Senator Conrad.

Senator Conrad. Mr. Chairman, might I ask the staff? It is my understanding that there is nothing in the Chairman's mark that changes HSA contribution levels as they are under current law.

Mr. Reed. That is correct.

Senator Conrad. So, for 2009, those limits are 3,000 for individual coverage and 5,950 for family coverage?

Mr. Reeder. That is correct. Plus a $1,000 catch-up if you are over 55.

Senator Conrad. For those over 55 a $1,000 catch-up. So there is nothing in the Chairman's mark that alters those numbers?

Mr. Reeder. That is correct.

Senator Conrad. And as I understand it, Senator

Kyl would increase those numbers; is that correct?

Mr. Reeder. That is correct.

Senator Conrad. And he would make them as high as 5,800 for a single and a 11,600 for a family in 2009?

Mr. Reeder. Up to that amount. As I read the amendment it would be dependent upon whatever the out-of-pocket limit was in the plan.

Senator Conrad. Do you have any rough estimate of what that would cost?

Mr. Reeder. We do not.

Senator Conrad. Joint Tax?

Mr. Barthold. We have not had an opportunity to estimate this yet, Senator Kyl, Senator Conrad.

The Chairman. I might ask if they will get a score by tomorrow? Do we know? Will we try to get one?

Mr. Barthold. We will do our best, sir.

The Chairman. All right. Thank you.

Senator Kyl. The one fact that might make it -- all those answers are exactly correct. It is the equal amount to the individual’s high deductible out-of-pocket maximum and that differs for different people. So I suspect you can give some kind of a ballpark, but that does create a variable that you cannot probably know for certain.

The Chairman. All right. Well, we are kind of

reaching an actual stopping point here.

Senator Stabenow.

Senator Stabenow. Mr. Chairman, I just wanted to ask for some of us working on affordability issue which has been listed under coverage, we are not yet ready to offer something. So I would ask that we have the opportunity even if we go forward to financing to offer something at a later point?

The Chairman. Oh, yes, the coverage amendments will still be in order.

Senator Stabenow. Thank you.

The Chairman. The main point is I just do not want to take up financing amendments until tomorrow.

Senator Stabenow. Right.

The Chairman. And if we have coverage tonight, fine. But we will also have some more coverage tomorrow.

All right. Seeing no active interest here in amendments at this point --

The Senator would like a 15-minute break.

[Laughter.]

The Chairman. He can take it.

[Laughter.]

The Chairman. All right. We will recess until 9:30 tomorrow.

[Whereupon, at 10:36 p.m., the session was recessed to be reconvened at 9:30 a.m., September 30, 2009.]

Barack Obama

October 14, 2008

Alan Morgan, Chief Executive Officer
National Rural Health Association
1108 K Street NW, Second Floor
Washington, DC 20005

Dear Friends,

Thank you for the invitation to share a few thoughts with you during your Annual Rural Health Clinic Conference in Savannah this week. I'm sorry I can't be here with you, but I do want to wish you well and hope you have a productive conference.

I also want to applaud you and your Association for the important work you do on behalf of rural America. Rural Americans have been overlooked for too long, and that's one thing we're going to change in an Obama-Biden administration.

I don't have to tell you that rural America faces many challenges, and many opportunities as well. That's why I've proposed a comprehensive rural plan to address those challenges and take advantage of those opportunities by working with local leaders and empowering you to create positive, substantive change for your communities. We can revive rural economies, improve education, and bring broadband Internet access to everyone. But we must also make our healthcare system work if we really want rural areas to thrive for generations to come.

Affordable, accessible healthcare is essential to the 62 million Americans who call rural America home, and it is an important engine of the economy. In many rural communities, the hospital or health sector is the largest single employer, providing numerous employment opportunities..

My comprehensive plan will cover the uninsured by building on the existing health care system, and using existing providers, doctors and insurance plans. It will strengthen employer coverage, makes insurance companies accountable and ensure patient choice of doctor and care without interference from government, or insurance company bureaucrats. And I've laid out the steps we'll take to increase efficiency and lower costs by up to $2,500 per year for the typical family. For more details on my plan, please go to BarackObama.com/Healthcare

However, I am also acutely aware that extending insurance coverage is a hollow victory if there are no facilities and providers available. That's why I will take concrete steps to address this geographic inequity. I will work to fix the historical disparity in Medicare and

Barack Obama

Medicaid reimbursement rates in which rural providers often get paid less than their urban counterparts when they perform the same procedure. I will create loan forgiveness and related types of incentive programs to help attract health care providers to rural areas. I will increase the federal capital available to build start up community health centers, many of which are in underserved rural areas. And I will also increase access to health care in rural areas by promoting the wider adoption of effective telecommunications and health information technologies. My administration will invest $10 billion a year over the next five years to move the U.S. health care system toward broad adoption of standards-based electronic health information systems.

Finally, we must not forget our rural veterans who have served our country so bravely. The Obama-Biden administration will increase the number of Veterans Affairs (VA) centers serving our rural veterans. We will also fight efforts to weaken the VA by outsourcing critical competencies, while ensuring that we give the VA the tools and flexibility to contract with other health care providers in remote areas where there is inadequate access to a VA medical center or it is impractical to build one.

As your President, I will need the best information and counsel available. Organizations such as yours are an important source of the counsel and support needed to improve health care in rural America. I hope I can count on you and your 18,000 members to help me create a quality of life for rural America that is the envy of the rest of the world.

Sincerely,

Barack Obama

Obama'08
BarackObama.com

Obama for America • 233 N. Michigan Ave • Chicago, IL 60601