

1 EXECUTIVE BUSINESS MEETING TO CONSIDER AN ORIGINAL BILL
2 PROVIDING FOR HEALTH CARE REFORM
3 TUESDAY, OCTOBER 13, 2009
4 U.S. Senate,
5 Committee on Finance,
6 Washington, DC.

7 The meeting was convened, pursuant to notice, at
8 10:15 a.m., in room 216, Hart Senate Office Building,
9 Hon. Max Baucus (chairman of the committee) presiding.

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

14 Also present: Democratic Staff: Bill Dauster, Deputy
15 Staff Director and General Counsel; Russ Sullivan, Staff
16 Director; Liz Fowler, Senior Counsel to the Chairman and
17 Chief Health Counsel; Diedra Henry-Spires, Professional
18 Staff; Yvette Fontenot, Professional Staff; Shawn Bishop,
19 Professional Staff; Neleen Eisinger, Professional Staff;
20 Cathy Koch, Chief Tax Counsel; Kelcy Poulson, Tax
21 Research Assistant; Alan Cohen, Senior Budget Analyst;
22 Holly Porter, Tax Counsel; David Schwartz, Professional
23 Staff; Kelly Whitener, Fellow; and Andrew Hu, Health
24 Research Assistant. Republican Staff: Kolan Davis, Staff
25 Director and Chief Counsel; Andrew McKechnie, Health
26 Policy Advisor; Rodney Whitlock, Health Policy Advisor;

1 Michael Park, Health Policy Counsel; Mark Prater, Deputy
2 Chief of Staff and Chief Tax Counsel; Sue Walden, Health
3 Policy Advisor; Kevin Courtois, Health Staff Assistant;
4 Chris Condeluci, Tax Benefits Counsel; and Mark Hayes,
5 Republican Health Policy Director and Chief Health
6 Counsel.

7 Also present: Thomas Barthold, Chief of Staff of the
8 Joint Committee on Taxation; Douglas Elmendorf,
9 Congressional Budget Office; Mark Miller, Director of
10 MedPAC; Kate Massey, Unit Chief, Congressional Budget
11 Office; Josh Levasseur, Deputy Chief Clerk and Historian;
12 and Athena Schritz, Archivist.

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

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4 The Chairman. The committee will come to order.

5 Benjamin Franklin said, "Well done is better than
6 well said." Now pretty much everything has been said,
7 and now it is time to get the job done. The costs of
8 inaction are clear: Americans simply cannot afford the
9 status quo. Americans are looking for common-sense
10 solutions. Americans want a balanced plan that takes the
11 best ideas from both sides, and Americans want us to
12 craft a package that will get the 60 votes that it needs
13 to pass.

14 For two years now, that is exactly what we have been
15 doing in this committee. Over the last two years, we
16 have held 20 hearings on health care. Last June, we held
17 a health care summit at the Library of Congress. We held
18 three roundtable discussions with experts on each of the
19 three major areas of reform, health care delivery,
20 coverage, and how to pay for it. In connection with each
21 roundtable, we put out detailed option papers and then we
22 held three walk-throughs to hash out those options.

23 Six members of the committee, three Republicans and
24 three Democrats, held 31 meetings to try to come to a
25 consensus. We held exhaustive meetings. We met for more

1 than 61 hours. We went the extra mile. I want to
2 compliment those Senators, and I also especially want to
3 compliment my friend and colleague, Senator Grassley. He
4 has been very helpful in keeping a strong, good, civil,
5 often bipartisan tone to this committee.

6 Now we have held an open, exhaustive mark-up. I put
7 out the mark and posted it on the web September 16. That
8 was nearly a week before we started the mark-up. In a
9 first for this committee, we posted every amendment, all
10 564 of them, on the web.

11 Today's session to report out our bill is our eighth
12 day of meeting. Many of those days were long days. It
13 has been more than 22 years since the Finance Committee
14 met for 8 days on a single bill. Senators offered, and
15 the committee considered, 135 amendments. We conducted
16 79 roll call votes. We adopted 41 amendments.

17 Now the scores are in and I am proud to say that our
18 bill passes the test. Ours is a balanced package. It
19 starts reducing the deficit within 10 years. By the end
20 of the 10-year window, it is moving in the right
21 direction. It reduces the deficit by \$81 billion over 10
22 years.

23 And our package would control health care spending
24 in the long run. CBO has said in the second 10 years,
25 our bill would continue to reduce the deficit by a

1 quarter to a half a percent of GDP. That is roughly
2 another \$450 to \$900 billion in deficit reduction.

3 All Americans should have access to affordable,
4 quality health care coverage. Our bill would raise the
5 share of Americans with insurance coverage from about 83
6 percent to 94 percent. Our bill would deliver coverage
7 to 23 million Americans through new insurance exchanges,
8 and to 14 million more new enrollees through Medicaid.

9 Our bill would dramatically increase prevention and
10 wellness. It would begin shifting health care delivery
11 to the quality of care provided, not the quantity of
12 services rendered. It would lower prescription drug
13 costs dramatically for seniors. Folks who are satisfied
14 with their current health insurance coverage could keep
15 it. People would not be required to change health plans.

16 Our bill would reform the insurance market. No
17 individual could be denied insurance coverage or charged
18 more because of a preexisting health condition. Our bill
19 would prohibit insurance companies from discriminating on
20 the basis of gender or health status. Insurance
21 companies could no longer charge women more, or charge
22 more if someone has been sick. Our bill would require
23 insurance companies to renew policies as long as
24 policyholders paid their premiums, and no longer would
25 insurance companies be able to drop coverage when people

1 get sick.

2 In our plan, as amended, members of Congress would
3 be required to buy their health insurance through the
4 same exchanges that people in their own States would use.
5 Ours is a balanced plan that can pass the Senate. Our
6 bill should win the support of Republicans and Democrats
7 alike. Now the choice is up to Senators on this
8 committee.

9 My colleagues, this is our opportunity to make
10 history. Our actions here will determine whether we
11 extend better care to more Americans. Ben Franklin said
12 that "Well done is better than well said." Well,
13 Senators, now is the time that will tell whether things
14 are merely said or whether something is actually done.
15 Now is the time to get this done. Let us enact this
16 balanced common-sense plan to approve health care. Let
17 us reform the health care system to control costs and
18 premiums. Let us extend health care coverage to all
19 Americans.

20 I now recognize Senator Grassley for any statement
21 he may want to make.

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1 OPENING STATEMENT OF HON. CHUCK GRASSLEY, A U.S. SENATOR
2 FROM IOWA

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4 Senator Grassley. Yes. Thank you, Mr. Chairman.

5 I am going to put a very long statement in the
6 record, but I would like to hit some high points.

7 The first one is to commend you for bringing this
8 mark to where it is today. It has been a long time since
9 you and I first started talking back in November, and it
10 has been a long time since we started talking on this
11 bill on September 22 to where we are now. During the
12 committee mark-up, we have been able to air our
13 differences and we have been able to have votes. I thank
14 you for that process. It has been a very thorough
15 process.

16 I wish I felt better about the substance of the
17 bill--I do not mean all of the substance of the bill--
18 because there is a lot in this bill where it is not a
19 case of Republican, Democrat, or bipartisan. There is a
20 lot in this bill that is just a consensus that needs to
21 be done. But there are other provisions of the bill that
22 raise a lot of questions, and so those are the issues
23 that I am going to discuss here for just a few minutes.

24 The Chairman's mark, of course, has undergone many
25 changes during this process. I do not think, since we

1 have moved from bipartisan discussions to where this bill
2 will come out of committee, that that movement leftward
3 has been good. I hope we do not have the possibility of
4 further leftward movement when it is merged with the bill
5 coming out of the other Senate committee.

6 So I will highlight a few of these changes that I
7 find questionable and, to some extent, disturbing. As I
8 highlight these issues, it will be clear that this bill
9 is already moving on a slippery slope to more and more
10 government control of health care. We have the biggest
11 expansion of Medicaid since it was created in 1965. The
12 bill imposes an unprecedented Federal mandate for
13 coverage, backed up by enforcement by the authority of
14 the Internal Revenue Service. It increases the size of
15 government by at least \$1.8 trillion when fully
16 implemented.

17 It gives the Secretary of Health and Human Services
18 the power to define benefits for every private plan in
19 America and to redefine those benefits annually. That is
20 a lot of power over Americans' lives. It will cause
21 health care premiums for millions to go up, not down. It
22 tightens further the new Federal rating bands for
23 insurance rates. That means that millions who are
24 expecting lower costs as a result of health care reform
25 will end up paying more in the form of higher premiums.

1 The new rating reforms alone will raise premiums by
2 as much as 50 percent on millions of Americans. It
3 imposes new fees and taxes. These new fees and taxes
4 will total about a half a trillion dollars over the next
5 few years. On the front end, these fees and taxes will
6 cause premium increases as early as 2010, even before
7 most of the reforms take effect. Then after forcing
8 increased premiums to go up, this bill makes it mandatory
9 to buy insurance.

10 On several occasions, we on this side of the aisle
11 tried to take the Chairman's mark in a different
12 direction. We tried to ensure that the President's
13 pledge to not tax middle income families, seniors, or
14 veterans was carried out; we were rebuffed at every step.
15 Republican efforts to provide consumers with a lower-cost
16 benefit option were consistently defeated.

17 This means that despite the promises, a lot of
18 people are not actually going to be able to keep what
19 they have, as the President promised. It imposes higher
20 premiums for prescription drug coverage on seniors and it
21 creates a new Medicare commission with broad authority to
22 make further cuts in Medicare, and it makes that
23 commission permanent.

24 With this mark-up nearing its conclusion, we can now
25 see clearly that the bill continues its march leftward.

1 The broad bipartisan character of the reform proposal has
2 changed. The partisan change is precisely what I said
3 back in March, that anytime somebody other than Senator
4 Baucus wanted to pull the rug out from under us it could
5 be pulled out, and it was, so bipartisan talks stopped.

6 Today, we see that the fears that we had were
7 legitimate and justified. I still hold out hope that at
8 some point the doorway with bipartisanship will be opened
9 once again. I hope at some point the White House and the
10 leadership will want to correct the mistakes that they
11 made by ending our collaborative bipartisan work. I hope
12 that at some point they will want to let that bipartisan
13 work begin once again, and then they need to back that
14 effort of bipartisanship and give it the time needed to
15 get it right instead of to get it done right now.

16 But it is clear that today is not the day when that
17 is going to happen, and from that standpoint I do not
18 blame anybody on this committee, but I do blame people
19 outside of this committee for that process not working.

20 Thank you, Mr. Chairman.

21 [The prepared statement of Senator Grassley appears
22 at the end of the transcript.]

23 The Chairman. Thank you, Senator.

24 I will now recognize Senators for any concluding
25 remarks they may wish to make, including questions they

1 may want to ask of the Joint Committee on Taxation or the
2 Congressional Budget Office. Thank you, by the way, Dr.
3 Elmendorf and Mr. Barthold, for being here. We deeply
4 appreciate your presence here.

5 I would like each Senator to limit him or herself to
6 about five minutes in deference to other Senators. We
7 can always have another round, but let us kind of keep
8 things moving here.

9 I am going to recognize in order of appearance.
10 Next, is Senator Rockefeller.

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1 OPENING STATEMENT OF THE HON. JOHN D. ROCKEFELLER IV, A
2 U.S. SENATOR FROM WEST VIRGINIA

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4 Senator Rockefeller. Thank you, Mr. Chairman. I
5 echo Senator Grassley's appreciation for you in general
6 in terms of the hard work you have put into this. I have
7 never really seen such a complete commitment to hard
8 work, and that is impressive. A lot of people work hard
9 around here, but not as hard as you did.

10 This is a question on public option for Dr.
11 Elmendorf and for Dr. Miller, who I see not. Is Dr.
12 Miller here, of MedPAC?

13 The misleading and, to me, harmful claims made over
14 the weekend by the profit-driven health insurance
15 companies are politicking for corporate gain at its
16 worst. That is just my casual view. At a time when
17 millions are suffering every day in the hands of our
18 broken health care system, the idea that anyone's concern
19 be whether the insurance companies make enough money or
20 not is absurd, because they will.

21 Health insurance companies have been laughing all
22 the way to the bank for generations while people suffer--
23 harsh words, but it is what I feel. The industry stands
24 today as the greatest impediment to real health care
25 reform, and it chooses that path quite deliberately, and

1 it has over the years.

2 So, question number to Dr. Elmendorf and Dr. Miller.

3 In their industry report, insurance companies
4 essentially argue that health insurance premium increases
5 are beyond their control and an inevitable result of
6 health reform itself. The insurance industry is squarely
7 placing the blame for premium increases on health care
8 reform.

9 In the absence of comprehensive health reform, how
10 much have private insurance companies increased premiums
11 over the last decade?

12 Dr. Elmendorf. Senator, I do not have a number
13 about that. Certainly, as you are implying, private
14 insurance premiums have risen rapidly over the past
15 decade, but I do not have a number.

16 Senator Rockefeller. Does 131 percent sound pretty
17 good?

18 Dr. Elmendorf. I would have to take your word for
19 that, Senator.

20 Senator Rockefeller. Thank you. My word is good.

21 What has been the history of cost containment in the
22 private sector? Are there steps that private insurance
23 companies, health insurance companies can voluntarily
24 take, such as reducing executive compensation, improving
25 health care quality, and obtaining greater value,

1 reducing administrative overhead, greater bargaining for
2 prescription drugs in order to reduce their costs and
3 beneficiary premiums? Are these possibilities?

4 Dr. Elmendorf. I think there are a number of steps
5 that both private and public insurance managers could
6 take to restrain the growth of costs. Obviously a number
7 of those avenues have potential drawbacks of various
8 sorts, but there are a number of opportunities available,
9 yes.

10 Senator Rockefeller. Thank you.

11 With nearly half a trillion dollars in premium
12 subsidies going directly into the pockets of private
13 plans, is it fair to say that insurance companies simply
14 face no choice but to raise premiums?

15 Dr. Elmendorf. Economists are not good at the "do
16 you have a choice/do you not have a choice" sort of
17 language, I am afraid, Senator. We generally believe
18 that when costs rise, those costs are passed through to
19 prices. That is not always everywhere true 100 percent,
20 but it is generally true.

21 The implication of the question is, what happens
22 when certain fees are assessed on manufacturers or
23 providers of certain goods and services, what happens to
24 the prices they charge? Our assessment would be that the
25 prices generally rise by an amount that is roughly

1 corresponding to the increasing costs. Whether that is
2 as a matter of choice or not is a sort of judgment that
3 economists are just not well-equipped to make.

4 Senator Rockefeller. Well, let me get Dr. Miller
5 to comment, and then I may add in something.

6 Dr. Miller. I do not really have anything to add
7 to his answer. One thing I would point out, some data
8 that we went through in our last meeting. There have
9 been increases in provider consolidation, and that has
10 put some upward pressure on the prices that insurers have
11 to pay.

12 Senator Rockefeller. And so how would the
13 relationship between consolidation and raising premiums,
14 the choice to raise premiums, how would that work? I
15 mean, you can say, well, because people consolidate that
16 does not mean they are necessarily going to raise their
17 premiums, but they evidently made the choice to do that
18 as consolidation increased.

19 Dr. Miller. The data that was presented in our
20 last commission meeting by Dr. Gaynor from Carnegie-
21 Mellon and Paul Ginsberg from Health System Change,
22 suggest that there has been a lot of provider
23 consolidation on the hospital and physician practice
24 sides, and when that occurs, if they gain enough market
25 power in a given market, they can extract higher

1 payments, higher prices from the insurers.

2 The Chairman. I would like to go on to Senator
3 Hatch. We can come up.

4 Senator Rockefeller. Yes. I will wait for another
5 round.

6 The Chairman. All right. Thank you very much.

7 Senator Hatch, you are next.

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

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4 Senator Hatch. Thank you, Mr. Chairman. I could
5 be just a little bit over five minutes.

6 The Chairman. Well, not too many more.

7 Senator Hatch. I will try to keep it down.

8 The Chairman. All right.

9 Senator Hatch. Well, this is one-sixth of the
10 American economy. I think we ought to be able to say
11 what we want to.

12 I have taken a lot of votes in my Senate service, as
13 I have had the proud honor of representing my fellow
14 Utahans, and all Americans across this great Nation. I
15 do deliver these remarks with a heavy heart because what
16 could have been a strong bipartisan vote, reflecting our
17 collective and genuine desire for responsible reform, is
18 now ending as another divided vote as we take another
19 step forward towards the flawed solution of reforming
20 one-sixth of our economy with more spending, more
21 government, and more taxes.

22 Some of us have endured almost four weeks of debate
23 in the Health, Education, Labor & Pensions Committee, and
24 now all of us have gone through two weeks of strenuous
25 debate on a lot more than that in the Senate Finance

1 Committee. However, it almost seems like these hundreds
2 of hours of debate were almost all for naught. It is
3 important for Americans everywhere to understand that the
4 bills that we have spent hundreds of hours working on are
5 not the bills that will be discussed on the Senate floor.

6 The real bill is currently being written behind
7 closed doors in the dark corners of the Capitol and the
8 White House, and we can all only hope that all of us,
9 especially American families, will have ample
10 opportunity, at least 72 hours, to review the full bill
11 and its cost before we are asked to consider this on the
12 floor and vote on it as a bill that affects every
13 American life and every American business. This is too
14 big and too important to not have full public review.

15 I want to spend my time today talking about why this
16 bill fails President Obama's own test for responsible
17 health care reform. This bill is another example of
18 Washington once again talking from both sides of the
19 mouth and using technicalities and policy nuances to
20 evade the promises made to our seniors and middle class
21 families.

22 First, President Obama, in his own words, has
23 consistently stated, "If you like your current plan you
24 will be able to keep it." Let me repeat that: "If you
25 like your current plan, you will be able to keep it."

1 Well, the policies of this bill do not match this pledge.
2 One of the amendments I offered simply provided that if
3 more than one million Americans would lose the coverage
4 of their choice because of the implementation of this
5 bill, then the legislation would not go into effect.
6 This was a simple and straightforward amendment, no
7 nuance, no double talk. This amendment was defeated
8 along party lines.

9 It should come as no surprise to anyone on this
10 committee that in a recent Rasmussen poll, a majority of
11 Americans with health care coverage, almost 53 percent,
12 said that this bill would force them to change coverage.
13 This bill is rife with policies that will do anything but
14 allow you to keep your coverage. It cuts \$133 billion
15 out of the Medicare Advantage program, which will
16 adversely impact the availability of these plans for
17 millions of American seniors, especially in rural areas.

18 It is pushing for policies at a Federal level that
19 actuaries acknowledge could increase premiums for up to
20 one-third of the population by 35 percent, not to mention
21 the new insurance tax, which will cost families another
22 \$500 in higher premiums. This will make their current
23 coverage unaffordable for countless Americans.

24 American families are very smart, they are very
25 astute. They realize that there is no free lunch,

1 especially in Washington. They are being promised an
2 almost trillion-dollar bill that will not increase
3 deficits, not raise taxes, and not cut benefits. Only
4 Washington could try and sell a promise like this with a
5 straight face.

6 Second, the President has consistently pledged,
7 "We're not going to mess with Medicare." Once again,
8 this is another simple and straightforward pledge that
9 this bill now evades through Washington double-talk.
10 This bill strips \$133 billion out of the Medicare
11 Advantage program that currently covers 10.6 million
12 seniors, or almost 1 out of 4 seniors in the Medicare
13 program.

14 According to the Congressional Budget Office, under
15 this bill the value of so-called additional benefits like
16 vision care and dental care will decline from \$135 to \$42
17 by 2019. That is a reduction of more than 70 percent in
18 benefits. You heard me right: that is 70 percent. I
19 offered an amendment to protect these benefits for our
20 seniors, many of whom are low-income Americans and reside
21 in rural States. However, this amendment, too, was
22 defeated. The majority chose to skirt the President's
23 pledge about no reduction in Medicare benefits for our
24 seniors by characterizing the benefits being lost--vision
25 care, dental care, and reduced hospital deductibles--as

1 extra benefits, not statutory benefits.

2 Now, let me make this point as clearly as I can.

3 When we promise American seniors that we will not reduce
4 their benefits, let us be honest about that promise.

5 Benefits are benefits, so we are either going to protect
6 benefits or not. It is that simple. Under this bill, if
7 you are a senior with Medicare Advantage, the unfortunate
8 answer is no.

9 Third, the President has consistently stated, "I can
10 make a firm pledge, under my plan, no family making less
11 than \$250,000 a year will see any form of tax increase."

12 Now, let us examine the realities of this bill. As I
13 said before, there is no such thing as a free lunch,
14 especially when Washington is the one inviting you over.

15 According to the Joint Committee on Taxation, there are
16 more than \$400 billion in new taxes under this bill to
17 continue to fund Washington's insatiable appetite for
18 spending.

19 Here are some of the highlights: \$23 billion in new
20 taxes on employers through a mandate that will
21 disproportionately affect low-income Americans, and all
22 at a time when our unemployment is rapidly approaching
23 double digits.

24 The Chairman. Senator, I asked Senator Rockefeller
25 if he could suspend and so he could continue the next

1 round. There are a lot of Senators here. Senators are
2 going to have to wait a long, long time if we do not
3 abide by our five-minute limit. Now, you can more than
4 likely come back and finish up.

5 Senator Hatch. Well, let me finish this one part
6 and then I will finish the rest of my remarks afterward.

7 The Chairman. All right. Thank you. Thank you.

8 Senator Hatch. But I should be able to tie this
9 all together.

10 The Chairman. Thank you.

11 Senator Hatch. Some of the highlights are: \$23
12 billion in new taxes on employers through a mandate that
13 will disproportionately affect low-income Americans, and
14 all at a time when our unemployment is rapidly
15 approaching double digits; \$4 billion in new taxes on
16 Americans who fail to buy a Washington-defined level of
17 coverage; \$322 billion in new taxes on everything from
18 insurance premiums, to prescription drugs, to hearing
19 devices and wheelchairs.

20 Now, representatives from both the Congressional
21 Budget Office and the Joint Committee on Taxation
22 testified before the Finance Committee that these taxes
23 would be passed on to consumers, so even though this bill
24 tries to hide these costs as indirect taxes, average
25 Americans who purchase health plans, use prescription

1 drugs, and buy medical devices, everything from hearing
2 aids to crutches, will end up footing the bill.

3 By the way, it is interesting to note that although
4 these tax increases and Medicare cuts will start as early
5 as next year, subsidies to help people with their
6 premiums, which will skyrocket under this plan, will not
7 be available until July of 2013, three and a half years
8 later.

9 Now, I have some more things I would like to say,
10 but I will defer to the Chairman and say them in the next
11 round.

12 The Chairman. I appreciate that, Senator, very,
13 very much.

14 Next, is Senator Conrad.

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

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4 Senator Conrad. First of all, Mr. Chairman, I want
5 to join in thanking you for your extraordinary leadership
6 and dedication for well over a year on the question of
7 health care reform. In my 23 years in the Senate, no
8 chairman has made a more concerted effort to address the
9 policy concerns of the Nation or to make a more
10 determined effort to be fully bipartisan in the
11 deliberations. I think members on both sides of the
12 aisle, even those that disagree with the outcome, would
13 have to say, Mr. Chairman, you have been extraordinarily
14 fair, and I thank you for it.

15 The Chairman. Thank you.

16 Senator Conrad. We are in a circumstance as a
17 country where doing nothing is not an option. We are
18 already spending \$1 in every \$6 in this economy on health
19 care. If we fail to act very quickly, we will be
20 spending \$1 in every \$3 in this economy on health care,
21 and that is completely unsustainable.

22 As a Nation, we are also faced with a Federal debt
23 that is growing out of control. Again, if we fail to do
24 nothing, if we stay on the current trend line, we will
25 reach a debt in 2050 of approximately 400 percent of our

1 Gross Domestic Product. No one believes that that is a
2 sustainable course.

3 In addition, we see 46 million people uninsured
4 today. If we fail to act in the next decade, there will
5 be 54 million people uninsured, and tens of millions more
6 that will lack quality health care coverage. If we look
7 at this plan and the Congressional Budget Office scoring,
8 which is our objective, independent scorekeeper, they
9 tell us that this bill, over the first 10 years, will
10 reduce the deficit by \$81 billion.

11 Over the longer term, the Congressional Budget
12 Office has said this: "CBO expects that the proposal, if
13 enacted, would reduce Federal budget deficits over the
14 ensuing decade beyond 2019, relative to those projected
15 under current law with a total effect during that decade
16 that is in the broad range between one-quarter and one-
17 half percent of GDP." GDP during that period is forecast
18 to be \$260 trillion, so a reduction of one-quarter to
19 one-half of one percent over that period would be \$650
20 billion to \$1.3 trillion.

21 Further, the Finance Committee plan meets key health
22 reform benchmarks. As I have indicated, it is fully paid
23 for. It bends the long-term cost curve in the right way.
24 It expands coverage to 94 percent of the American people.
25 It contains major insurance market reforms and it

1 contains important delivery system reforms. It promotes
2 choice and competition.

3 This measure, if enacted, would prohibit insurers
4 from denying or rescinding coverage on the basis of
5 preexisting condition. It bans insurers from placing
6 annual or lifetime caps on health benefits. It prevents
7 insurers from charging more based on health status. It
8 creates nonprofit cooperatives to compete with for-profit
9 insurance companies.

10 The Finance plan improves the quality of care. It
11 covers preventive services, it provides incentives for
12 healthy lifestyles, it includes critical and important
13 delivery system reforms, encouraging quality over
14 quantity, and it promotes the adoption of best practices
15 using comparative effectiveness research, so doctors and
16 patients can evaluate what works best for them.

17 Finally, there are things that it does not do.
18 There is no government-run health care here. There are
19 co-ops that would be member operated and oriented. There
20 are no Medicare benefit cuts for seniors. There is no
21 coverage for those who are here illegally. There are
22 none of the rumored "death panels," and there is no
23 expansion of Federal funding for abortion services.

24 Mr. Chairman, again, I want to thank you and your
25 staff for your very diligent and important work.

1 The Chairman. Thank you, Senator, very much.
2 Next, Senator Snowe.
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1 OPENING STATEMENT OF HON. OLYMPIA J. SNOWE, A U.S.
2 SENATOR FROM MAINE

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4 Senator Snowe. Thank you, Mr. Chairman. I, too,
5 want to thank you for leading this committee through a
6 major issue and an undertaking commensurate with the
7 gravity of the circumstances we face in addressing this
8 transformational question for this country when it comes
9 to providing health security for all Americans.

10 I would like to pose several questions to Dr.
11 Elmendorf, if I could, because I think they are important
12 as the process moves forward.

13 Dr. Elmendorf, as you know, this is not going to be
14 the final bill. It will be merged with the Help bill
15 after this bill is reported out of the Finance Committee.
16 Of course, at that time it will be statutory language and
17 it should be scored, finally, by the CBO once again, a
18 final score before we consider it on the floor of the
19 Senate when we move to a vote on the motion to proceed.

20 What I would like to hear from you today are your
21 recommendations in terms of the drafting the statutory
22 language that will be consistent with the scores that you
23 have provided on the Finance portion of the merged bill.
24 How best do we go about that in terms of providing
25 instructions and recommendations to the drafting staff to

1 make sure that it is totally consistent with the
2 interpretations upon which you based your scores of this
3 package?

4 I mean, it is critically important because if there
5 are significant departures from the legislative
6 interpretation, that obviously could drive up the price.
7 I know from past experiences we have discussed there have
8 been some uneven experiences with other committees. I
9 would hope that we could maintain the integrity of the
10 score of this package, so how best can we do that, and
11 what instructions would be helpful in this process?

12 Dr. Elmendorf. Well, Senator, the process of
13 drafting legislative language and our producing an
14 official cost estimate of that language takes a good deal
15 of time, as I have said before here. That is partly
16 because of the intrinsic difficulty of writing in
17 legislative language to achieve the goals that are laid
18 out in the more conceptual language that we have seen so
19 far.

20 It is also the case that in the process of writing
21 out exactly what is to happen in legislative language, it
22 often turns out that our understanding of what a proposal
23 was intended to do does not exactly match the
24 understanding of the drafters of the proposal.

25 When we discover instances of that, our approach is

1 to point out to the drafters that this language does not
2 do what we thought they were trying to do. At that point
3 it is, of course, the drafter's choice whether to stick
4 with the language that they have, with their original
5 intent, and we will then factor that into our next score,
6 or they can respond that they are interested in following
7 what we believe their intent to be and adjusting the
8 language to meet our understanding of what they had in
9 mind in the conceptual language stage.

10 Then in that case, if the language can be drafted,
11 in fact, to do what we think it set out to do, then that
12 would not affect our score. I do not know procedurally
13 how that works, to tell you the truth, or what
14 instructions you might give, but that is the issue, that
15 often we find these cases where what we had in mind is
16 not exactly what the drafters had in mind.

17 Senator Snowe. Right. So there could be
18 potentially significant variances in interpretation, I
19 gather.

20 Dr. Elmendorf. There can be, Senator.

21 Senator Snowe. And is there a back-and-forth
22 between you and the staff on these issues?

23 Dr. Elmendorf. Yes. There is also involvement, of
24 course, of the people at the Centers for Medicare and
25 Medicaid Services that have expertise in how to

1 implement, and would be responsible for implementing much
2 of the language involved.

3 Senator Snowe. Well, I hope, Mr. Chairman, that
4 there would be consistency in that regard so there is not
5 a departure from the intent and the integrity of the CBO
6 scores as they have interpreted it in this mark, because
7 that is going to be critically important. We will have
8 to be vigilant in that regard.

9 The Chairman. You are right, Senator. In fact,
10 there are several stages there. There is one that is the
11 so-called merged bill, and that has to be scored before
12 it can go to the floor, and then afterwards when the bill
13 finally passes the Senate, along the lines that you
14 discussed with Dr. Elmendorf, to make sure the intent is
15 maintained in the actual language so the score reflects
16 the actual intent of it.

17 This is very important, the point you are making,
18 just to keep very vigilant and transparent about all of
19 this. As we all know, often sometimes when a bill is
20 finally written up, while talking with the government
21 agencies and who knows who else, that sometimes things
22 get changed, and not for nefarious reasons, but for
23 reasons that are different from what was intended by the
24 drafters of the legislation. So that is a very, very
25 good point. I am probably more vigilant about that point

1 now than I have ever been, and will keep the integrity.

2 Senator Snowe. I appreciate that.

3 The Chairman. Thank you.

4 Senator Snowe. Thank you.

5 The Chairman. All right. Next, is Senator
6 Bingaman.

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

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4 Senator Bingaman. Thank you, Mr. Chairman. I join
5 everyone else in congratulating you on your extraordinary
6 effort in getting us to this point, and also the
7 extraordinarily fair way you have proceeded in trying to
8 solicit input from Democrats and Republicans. I hope
9 that we are able to get this package passed out of the
10 committee and considered on the Senate floor and move
11 ahead.

12 I wanted to ask Dr. Elmendorf and Mr. Barthold, if I
13 could, just a question about one aspect of the bill. A
14 major purpose of our legislation has been to do this
15 bending of the cost curve, reducing the future growth in
16 the cost of health care in this country. One of the
17 provisions in the bill that I believe is significant in
18 that regard is the excise tax on high-cost health plans.

19 I guess my reading of the bill would lead me to conclude
20 that perhaps that is as important as any other provision
21 in the bill, maybe more important, in actually reducing
22 the cost curve.

23 Let me start and just ask if you would agree with
24 that conclusion. Dr. Elmendorf?

25 Dr. Elmendorf. Senator, CBO has not been able to

1 evaluate the effect of the proposal on national health
2 expenditures. The discussions that I have had here in
3 this room with Senator Conrad and others who have asked
4 have been focused on the effects of the proposal on
5 Federal budget deficits which of course is the heart of
6 our responsibility and has been the heart of our
7 estimating work this year.

8 In terms of the effects of the proposal on national
9 health expenditures, there are some conflicting forces.
10 The expansion of insurance to a larger share of the
11 population will lead to more spending on their health
12 care; I believe that is the intent of the committee.
13 That, by itself, will raise national health expenditures.
14 On the other hand, there are changes, such as the tax
15 provision you cite, changes in Medicare payments and so
16 on that would tend to push down national health
17 expenditures.

18 We have simply not done the analysis to net those
19 out, so I want to be clear about that to start with. In
20 terms of the factors that are pushing down national
21 health spending over time, the excise tax on high-premium
22 plans is certainly an important part of that. We have
23 not quantified that vis-à-vis the changes in Medicare,
24 say, but it is certainly a very important part of the
25 forces pushing down on health spending in this proposal.

1 Senator Bingaman. Mr. Barthold, did you have any
2 disagreement with that or anything to add?

3 Mr. Barthold. Senator, I also cannot comment on
4 trends in national health spending, but just to amplify
5 the point, we believe that the excise tax on high-cost
6 plans has the incentive for individuals and employers to
7 look to make smarter choices or different choices. So to
8 the extent that smart choices would damp down future
9 health spending, that would be a factor in that
10 direction.

11 Senator Bingaman. So is it fair to say that you
12 are assuming there would be substantial restructuring of
13 health benefits by employers if this excise tax provision
14 remains in the bill?

15 Mr. Barthold. Yes, Senator. As I think we
16 discussed in committee--I guess it was seven days ago--
17 the revenue estimate that we provided for this provision
18 assumes a lot of behavioral change. In fact, it assumes
19 that many employees and employers offering plans who
20 would otherwise see the plans subject to the excise tax
21 will reconfigure their plans and their compensation such
22 that we see that the bulk of the revenue raised by the
23 provision coming through income and payroll taxes, not
24 from people making excise tax payments. That is one
25 example of the behavior that we have built into the

1 analysis.

2 Senator Bingaman. Is it fair to say that any
3 analysis of this proposed legislation that tries to
4 assess the impact on premiums without taking into account
5 that expected restructuring would be significantly
6 deficient in that regard?

7 Mr. Barthold. Well, Senator, we always try to take
8 account of behavioral response in any estimate, every
9 economic analysis that the committee staff does for the
10 committee and for members, so we think it is a critical
11 part of the analysis. Yes, sir.

12 Senator Bingaman. And are you familiar with this
13 new report that PricewaterhouseCoopers has come out with?
14 My impression is that they did not assume that behavioral
15 change that you indicate is likely to be a significant
16 factor. Is that your understanding?

17 Mr. Barthold. Senator, I should not claim
18 familiarity with the report. I was busy yesterday doing
19 some work for the committee and some of the members and
20 did not get an opportunity to read it thoroughly. But
21 some of my colleagues are looking at it, and I will try
22 to follow up with you later, if that is all right.

23 Senator Bingaman. Thank you very much.

24 The Chairman. Thank you, Senator.

25 Next, Senator Kyl?

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

3

4 Senator Kyl. Thank you, Mr. Chairman.

5 Primarily, questions for you, Dr. Elmendorf. I have
6 a document here called "Technical Corrections to Redline
7 of the Chairman's Mark" dated October 5th. Are you
8 familiar with that document?

9 Dr. Elmendorf. Yes, Senator.

10 Senator Kyl. This was circulated three days after
11 the committee finished its work.

12 The document includes a requirement that the
13 individual mandate excise tax--in other words, the
14 penalty that Americans pay if they do not buy the
15 insurance policy mandated in the bill--and assumes that
16 this tax would be indexed to the CPIU, beginning in 2018.
17 Is that correct? In other words, to reflect the effect
18 of inflation?

19 Dr. Elmendorf. It is. I am looking, Senator, to
20 make sure that I am reading the right part of the
21 technical corrections.

22 Senator Kyl. It is down under "Clarifications",
23 page 35. The two page 35 references.

24 Dr. Elmendorf. Yes. The penalty amount, you were
25 saying, is indexed to the CPIU.

1 Senator Kyl. Right. And the affordability
2 exemption.

3 Dr. Elmendorf. The affordability exemption is
4 indexed at a faster rate, I believe, Senator, because
5 this is indexed in the same manner as the income caps in
6 the exchanges, and those are indexed to rise at a rate
7 that reflects what the premiums are relative to the --

8 Senator Kyl. And that latter provision means that
9 fewer people over time would qualify for the exemption
10 from the mandate due to not having access to an
11 affordable plan?

12 Dr. Elmendorf. Compared with a situation where the
13 cap was not indexed, yes, the indexing will push it up
14 over time.

15 Senator Kyl. Right.

16 And there are some other technical corrections that
17 are somewhat similar to the one that I just mentioned.
18 Is that correct?

19 Dr. Elmendorf. Yes, Senator.

20 Senator Kyl. Does the cost estimate that you
21 prepared assume that all of these provisions are part of
22 the mark that we have before the committee?

23 Dr. Elmendorf. Yes, Senator.

24 Senator Kyl. And do these changes have scoring
25 implications?

1 Dr. Elmendorf. Yes, they do.

2 Senator Kyl. So if the changes that CBO assumed to
3 be part of the bill are not actually in the bill if we
4 adopt it today, then that would affect the score of the
5 bill, is that correct?

6 Dr. Elmendorf. Yes, Senator. Can I just briefly
7 be clear, we are not trying ourselves to make up what is
8 in the bill. We are trying very hard not to do that. We
9 needed, in our work with the staff of the Joint Tax
10 Committee, to have a well-defined object that we could
11 score.

12 Senator Kyl. Right.

13 Dr. Elmendorf. We took that object to be, and we
14 communicated this to staffs on both sides of the aisle,
15 the materials posted by the committee staff, both the
16 original red-line version last Friday and this set of
17 corrections, and then additionally certain clarifications
18 that we have learned from the staff which we listed in
19 our letter.

20 Senator Kyl. Right.

21 Dr. Elmendorf. So we are trying to be very
22 transparent on what it was that we scored. Whether that
23 is what is in the bill in some legislative sense is out
24 of my purview.

25 Senator Kyl. Well, that is right. So then just to

1 summarize, the cost estimate that you prepared is not
2 based on the red-line of the Chairman's mark, as modified
3 by the committee itself, but rather is based on that
4 document plus the additional policy provisions that you
5 provided to the committee in this technical corrections
6 document. Is that correct?

7 Dr. Elmendorf. Additional provisions they provided
8 to us.

9 Senator Kyl. The staff provided to you.

10 Dr. Elmendorf. In this document.

11 Senator Kyl. Correct.

12 Dr. Elmendorf. Yes. And the additional
13 clarifications that we listed in our --

14 Senator Kyl. Exactly. And it could affect, for
15 example, as part of your estimate, the percentage of
16 Americans that will end up being insured by, say, 2019.

17 Dr. Elmendorf. Yes, Senator.

18 Senator Kyl. Mr. Chairman, the changes in the so-
19 called "Technical Corrections" document are substantive
20 changes. They were not adopted by the committee. They
21 were written by staff, provided to the CBO, as Dr.
22 Elmendorf just indicated. They are clearly amendments
23 that could not be made by the staff while the bill is
24 pending before the committee, but the CBO score assumes
25 that they have been adopted by the committee.

1 Since the committee has not, in fact, adopted these
2 changes, this means the CBO score we have does not
3 reflect the bill that we are about to vote on. Until the
4 committee debates these changes and decides whether to
5 adopt them, no one should pretend that what we are
6 looking at is a bill with a CBO score, as was promised,
7 before the final vote would occur.

8 In plain English, the estimated cost of the bill is
9 incorrect because the CBO assumed, based on changes
10 provided to them by the staff, that for example the fines
11 in the bill and the income percentages for people being
12 exempted from buying the insurance would be indexed for
13 inflation, but in fact in the mark, in the bill before us
14 that we are going to be voting on here, they are not
15 indexed for inflation.

16 It seems to me the committee has to make a decision
17 one way or the other: either we confirm the legislation
18 to the cost estimates and the other estimates that the
19 CBO has provided based on the technical corrections here,
20 or the CBO is going to have to modify its cost estimates
21 and other estimates, including percentages of people
22 covered, based on the fact that the committee has not
23 made the changes that the staff presented to the CBO in
24 the technical corrections document, one way or the other.
25 But we cannot pass the legislation as it is and know that

1 the score that we have reflects the policies in the
2 legislation.

3 The Chairman. Well, Senator, I had a hunch you
4 were going to make that statement. I also want to point
5 out that the implications of it are just not fair and
6 accurate. First of all, these are not changes to the
7 mark. These are simply clarifications. Frankly, they
8 are in the nature of what always happens with all
9 legislation, that is, when the legislation is written and
10 a neutral observer--in this case, the CBO and the Joint
11 Committee on Taxation--looks at it and sends us a note
12 back or questions back of, kind of, what is meant here.

13 Let me ask you, Dr. Elmendorf, do these
14 clarifications reflect the underlying mark, as amended?

15 Dr. Elmendorf. I am not sure of the question.

16 The Chairman. Do the clarifications reflect the
17 provisions in the underlying mark, as amended? That is,
18 when an index or no index is included, you go back and
19 look at the underlying mark to see whether that provision
20 was indexed or not. So my basic point is, is it not true
21 that these clarifications reflect the underlying mark, as
22 amended?

23 Dr. Elmendorf. Mr. Chairman, I am afraid I do not
24 think it is appropriate for me or for the CBO to judge
25 what the committee did or did not think it was agreeing

1 to. We needed some specific sets of provisions to work
2 from. Where there is legislative language, of course,
3 that is clear. When there is not, we need to define what
4 that set of things would be. We defined it to be the
5 information given to us by the committee staff. Again, I
6 am just not in a position to judge whether this
7 particular aspect of indexing was or was not what you and
8 other members of the committee thought you were voting
9 for or against during the mark-up process.

10 The Chairman. Is the underlying provision in the
11 mark, as amended? That is, is indexing on this provision
12 in the underlying mark, as amended? The nature of the
13 indexing.

14 Dr. Elmendorf. I can look at page 35 and see what
15 is there. I presume that its appearance on the technical
16 corrections sheet is implying that what is in page 35 is
17 not what your staff at least thought the committee had
18 decided to do, but that is the point that I think I just
19 do not have the competence or authority to be the judge
20 of.

21 The Chairman. Right. But you assumed it all
22 along, the indexing.

23 Dr. Elmendorf. Well, "all along" is a tricky
24 point.

25 The Chairman. Well, when you --

1 Dr. Elmendorf. The proposal has been evolving over
2 the course of the last several weeks and days.

3 The Chairman. When you were conducting your
4 analysis.

5 Dr. Elmendorf. When we conducted the analysis
6 underlying the letter we sent to you last Wednesday, we
7 assumed the technical corrections were in place along
8 with all of the other provisions in the red-lined
9 document, and the other clarifications. Whether this had
10 been in your or our understanding before this sheet came
11 out, I think, is not really relevant. We were trying
12 very hard not to go based on our memory of what had been
13 said to us at some point in the process, but just to go
14 off of what --

15 Senator Kyl. Mr. Chairman?

16 The Chairman. I might say, these are essentially
17 clarifications all made in good faith. There is no
18 intention here to do anything that is untoward or
19 unsavory or to change law in any way, just basically
20 reflecting the intention of the committee and the
21 amendments that the committee passed on some of these,
22 quite late in the morning, I might add.

23 Senator Kyl. Mr. Chairman, let me just make the
24 point to Dr. Elmendorf.

25 The Chairman. Briefly. Your time has expired,

1 Senator.

2 Senator Kyl. Yes. That is right. But you just
3 took 3 minutes and 43 seconds to respond to my exactly 5
4 minutes.

5 The Chairman. To a question you raised to me.

6 Senator Kyl. Yes. And the point is, Dr. Elmendorf
7 is correct. The language of the mark does not include
8 indexing. He had to assume that it was indexing because
9 the staff gave him a technical corrections document. But
10 the committee has never adopted this amendment. Indexing
11 is not just a minor matter. It will have profound
12 implications. The indexing in this case relates to the
13 fine that people have to pay if they do not buy
14 insurance. If it is indexed, then the fine amount will
15 remain the same relative to the cost of living. If it is
16 not indexed, over the course of 10 years or so, the fine
17 essentially goes away.

18 So, which policy is it that we want? The same thing
19 is true with respect to the income level for an exemption
20 at 8 percent. As Dr. Elmendorf said, the estimate of the
21 number of people who will be insured at the end of 10
22 years, let us say, will be changed depending upon whether
23 the bill is indexed or not. It is a significant matter.
24 It is not one that the staff can simply make by handing
25 Dr. Elmendorf a document. The committee has to make the

1 change if, in fact, we want to do that.

2 My question is, do we want to do that or not? Do we
3 want the fine to essentially go down to zero and do we
4 want the exempted amount to be such that there will be a
5 lot fewer people exempted from the mandate for coverage
6 or not?

7 The Chairman. Senator Kerry?

8 Senator Kyl. It is not just a technical
9 correction.

10 The Chairman. Senator Kerry? Senator Kerry is
11 recognized. Senator Kerry?

12 Senator Kerry. Is this for my time or is this on
13 this issue?

14 The Chairman. No, this is you. You are
15 recognized. You have the floor.

16 Senator Kerry. Well, I will come back to this
17 later.

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

3
4 Senator Kerry. Well, Mr. Chairman, first of all,
5 thank you for helping to get us to this point. I
6 appreciate, on a personal level, your listening to a
7 great number of concerns that were raised and working
8 with us to deal with them. I also appreciate your
9 working with us on an ongoing basis, particularly on the
10 threshold on the excise tax on the so-called Cadillac
11 plans, as well as on the medical devices component.

12 I am particularly concerned still about the lack of
13 an employer mandate and intend, if it does not become
14 part of the melded bill, to deal with that with respect
15 to an amendment on the floor. But I congratulate you on
16 what is in this bill. It is very, very significant and I
17 think we need to move forward.

18 Senator Bingaman mentioned a few minutes ago the
19 Pricewaterhouse study. I want to say a few words about
20 that because it is really an example of how Washington
21 works, or does not work, as the case may be. Frankly,
22 the insurance industry ought to be ashamed of this
23 report. It was commissioned from PricewaterhouseCoopers,
24 released on Monday. It is a powerful argument, frankly,
25 for why we ought to have a public plan. It is a powerful

1 argument for the attitude of an industry towards this
2 effort. There is an old saying that if you are not part
3 of the solution, you are part of the problem.

4 The fact is, the Pricewaterhouse analysis is
5 significantly flawed and the results are simply not
6 valid. PricewaterhouseCoopers admits that it has not
7 taken many of the reform provisions put in this
8 legislation into consideration. How do you put out a
9 study that does not take what the benefits of the reforms
10 will be?

11 The report does not take into consideration any of
12 the various cost containment provisions in this bill.
13 These other reform provisions would have the opposite
14 effect, lead to lower premiums, contrary to this report.
15 But those provisions were completely ignored by the
16 report--classic.

17 The report ignores the availability of tax credits
18 to small businesses. The report conveniently assumes
19 sizeable cost shifts, even though many have asserted that
20 Medicare cost shift is often exaggerated. MedPAC, for
21 instance, has noted this. The report is careful to only
22 talk about private premiums as opposed to household cost,
23 which would be lowered via premium credits and cost-
24 sharing assistance. Of course, they do not take that
25 into account.

1 The study assumes no reduction whatsoever in
2 administrative costs as a percentage of the premium.
3 Right now, for instance, individuals pay 25 to 40 percent
4 of their premiums on administrative costs in the non-
5 group market, and small businesses pay as much as 25
6 percent. Well, that ought to go down substantially due
7 to the elimination of most underwriting and the ability
8 to purchase via the exchanges. The reporting
9 requirements for medical loss ratio will further reduce
10 administrative costs. Do they take that into account?
11 No.

12 The PWC analysis states, "The new minimum benefit
13 requirements may require people to buy coverage that's
14 more expensive than the options to which they have
15 current access", and goes through a convoluted analysis
16 that is completely incorrect because, in fact, the
17 actuarial value of the bronze plan to which they refer in
18 Massachusetts is closer to 65 to 70 percent, not the
19 lower percentage that they refer to.

20 So it is extraordinary that in the final hours of
21 this effort, as we come to a vote, the industry remains
22 right where it has been all along. I listened to Senator
23 Rockefeller's comments earlier. The report estimates
24 that plans in the exchange will be subjected to the
25 excise tax on high-cost insurance as early as 2016.

1 There is absolutely no evidence whatsoever to back that
2 up. More importantly, however, is the fact that nearly
3 all of the coverage available under the exchange will be
4 exempt from the excise tax.

5 John Gruber, Professor of Economics at MIT,
6 concludes, "It is implausible that a bronze-like plan
7 could even approach the Cadillac tax threshold over the
8 foreseeable future." I have more, Mr. Chairman, and I
9 would ask unanimous consent that the full analysis be
10 placed in the record.

11 The Chairman. Without objection.

12 [The prepared statement of Senator Kerry appears at
13 the end of the transcript.]

14 Senator Kerry. But it is a disgrace that at the
15 last minute, obfuscation of a critical effort like this
16 is the choice of an industry that does not deliver health
17 care, it is just a middle person in this effort that
18 makes a lot of money being in the middle. What Americans
19 are interested in is getting decent health care. If
20 there wasn't a more powerful argument for why we need a
21 plan that is based on premiums, that operates by all of
22 the rules of the private sector, that is not subsidized,
23 lowers administrative cost and increases competition,
24 there is your argument right there and it is one we are
25 going to make on the floor.

1 Mr. Chairman, I thank you for an effort that will
2 significantly improve the coverage of Americans by
3 millions of people, that will avoid discrimination
4 against women, against elderly, that will avoid
5 increasing share of household income being dedicated to
6 health insurance as we go forward. We have work still to
7 do, we all know, but this mark is a significant beginning
8 in helping us to do something we have been trying to do
9 since Teddy Roosevelt, and that is going to make this a
10 very significant vote today.

11 The Chairman. Well, thank you, Senator. Thank you
12 for your efforts. You have been very faithful in trying
13 to address health care reform over the years, and I
14 deeply appreciate it.

15 Next, Senator Bunning.

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

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4 Senator Bunning. Thank you, Mr. Chairman.

5 I think everyone agrees that our health care system
6 is in desperate need of reform, but the bill before us
7 today that we will be voting on is clearly not the
8 answer. If this bill was the answer there would be no
9 need for the stunning lack of transparency that has
10 surrounded it, but the fact is, sunshine only reveals its
11 deep flaws.

12 First, under this bill, 25 million people will
13 remain uninsured. That is hardly universal coverage. I
14 suppose that this means that 46 million uninsured is a
15 moral outrage, but 25 million uninsured means the problem
16 is solved. For the millions who will be left uninsured,
17 this bill adds insult to injury by forcing them to pay a
18 penalty tax.

19 Second, compared to the starting point, this bill
20 now almost spends \$100 billion more and adds tens of
21 billions more in new taxes, all without insuring more
22 people. This package is going in the wrong direction,
23 spending more and taxing more without covering more
24 people. It is certainly not transparent about the true
25 cost of the bill. The actual cost is hidden by delaying

1 effective dates. Since most of this bill does not go
2 into effect until 2014, the true 10-year cost of the
3 fully implemented bill is approximately \$1.8 trillion.
4 Let me repeat that: the bill will cost \$1.8 trillion from
5 day of implementation until the next 10 years.

6 Third, CBO says that millions of people will lose
7 employer-based coverage under the bill, and 14 more
8 million people will have to rely on Medicaid, and CHIP
9 for coverage. Again, that is moving in the wrong
10 direction.

11 Fourth, this bill cuts \$517 billion from Medicare
12 and Medicaid, which certainly will have an impact on the
13 ability of Medicare beneficiaries to receive care. No
14 one can argue with a straight face that cutting hundreds
15 of billions will not affect patient care and seniors'
16 access to providers.

17 Finally, this bill breaks almost every promise
18 President Obama has made to the American people. He said
19 it will not raise taxes on individuals who earn less than
20 \$200,000 or couples who earn less than \$250,000, but the
21 tax increases in this bill will hit every American the
22 hardest. Speaker Pelosi got it right when she said, "The
23 savings come off the backs of the middle class."

24 President Obama also promised, "If you like your
25 coverage, you can keep it." This is true under this

1 bill, unless you are in an employer-sponsored plan,
2 Medicare Advantage, have a health savings account, a
3 flexible savings account, or a health reimbursement
4 account, buy over-the-counter medicines, have a generous
5 health care plan, or use medical expense deductions for
6 relief from your catastrophic health care expenses.

7 President Obama also promised that health care
8 reform will reduce cost. Where is the proof? We are
9 creating yet another entitlement program on top of the
10 other broken entitlement programs. We also know that
11 hundreds of billions of taxes in this bill will drive up
12 the cost of health care. In a recent study, it suggested
13 American families will pay more than \$4,000 in 2019
14 because of this bill.

15 Our CBO scorekeeper was not given enough time to
16 determine whether premiums will increase or decrease
17 under this bill or whether national health spending will
18 increase or decrease. Was that not the major selling
19 point in this bill, in the whole effort? Why do we not
20 know the true impact on the deficit? Because CBO was not
21 given statutory language or the time that it needs to
22 make a final cost estimate.

23 What is the big rush to pass something that will not
24 be fully implemented until 2014? The committee adopted
25 one of my amendments, to keep veterans' health care from

1 harm. This is a very serious concern because one of the
2 tax increases is specifically designed to allow drug
3 manufacturers to reduce their taxes by reducing or
4 eliminating their sales to the Veterans Administration.

5 At the time, Chairman Baucus said, "Frankly, I think
6 it is wise to make sure our veterans are protected here",
7 and my amendment was adopted unanimously. But in the
8 dark of night, my amendment was gutted without any notice
9 or consultation with me.

10 In a shocking betrayal of veterans, my amendment was
11 converted from a fail-safe program for the veterans into
12 a meaningless study. We did not protect the veterans.
13 It was like a family with a burning house calling the
14 fire department. How would you feel if you were told, I
15 am sorry, we cannot put out your fire, but we would be
16 happy to study it. Converting my veterans' protection
17 amendment into a study is just absurd.

18 I hope and pray that we do finally get a health care
19 system that will service the American people properly.
20 Thank you.

21 The Chairman. Senator Crapo, you are next. But
22 just very briefly, at the risk of inciting a discussion
23 here, Senator, let me just point out that after your
24 amendment was adopted, and you are correct in saying it
25 was agreed to unanimously. Then we went and asked the

1 Veterans Administration and the Treasury Department,
2 because your amendment was crafted that way, as well as
3 questions of CBO and Joint Tax, and they concluded that
4 they simply could not certify it. There is not data to
5 score it. It just cannot be done, one way or the other.

6 Then we asked the Congressional Budget Office, what
7 is the effect of that if they cannot certify because
8 there is no data one way or the other? What next? CBO
9 said that would mean we cannot score, we cannot give you
10 a decent score. But the main point being, we checked
11 with the relevant parties and they told us they just did
12 not have the data to make a reasonable certification.

13 Senator Bunning. Mr. Chairman, if all the things
14 you say are true, how can you study it? If everything
15 you said is true, all those things --

16 The Chairman. Well, I think it is worth studying.

17 Senator Bunning. How can a study come to a final
18 conclusion?

19 The Chairman. I think a study is going to be
20 helpful. But the main point I am just trying to explain
21 to you is, we just could not get the data--nobody could
22 get the data--to make a certification one way or the
23 other.

24 Senator Crapo?

25 Dr. Elmendorf. I am sorry. Can I just be clear?

1 Of course, CBO has no position about the way this
2 amendment should be drafted or not. It is the case that
3 when we look for triggers or fail-safes, we look hard at
4 whether there are measurable criteria, and we will often
5 speak to that. But I want to be clear, Senator, that we
6 are not against your amendment. We did not advocate the
7 amendment be altered. That would not be appropriate for
8 us.

9 Senator Bunning. Thank you.

10 The Chairman. Senator Crapo?

11 Senator Crapo. Thank you very much, Mr. Chairman.

12 I am going to use this round to ask some questions
13 of CBO and Joint Tax, and reserve until later my final
14 comments.

15 The Chairman. All right.

16 Senator Crapo. I would like to focus, first, Dr.
17 Elmendorf and Mr. Barthold, on the cost curve. We have
18 heard a lot of talk about the fact that this bill bends
19 the cost curve, but I would like to make sure we are
20 talking the same thing.

21 When my constituents--and I think most people in
22 America--talk about the need for health care reform, they
23 talk about the fact that the skyrocketing costs of
24 insurance and other health care costs have to be brought
25 under control. Has CBO scored that cost curve?

1 Dr. Elmendorf. No, Senator. I appreciate your
2 raising this issue. I think it is very important to be
3 clear about this. What we have written in our letter to
4 the committee is that we have evaluated the 10-year
5 budget effects, of course, and also the longer-term
6 effects on the Federal budget. We have not evaluated the
7 effects of the proposal on national health expenditures,
8 either within the 10-year budget window or beyond that
9 window.

10 Senator Crapo. Thank you.

11 And so those who say that this bill bends the cost
12 curve must be talking about something else. If they are
13 referring to your CBO score, that means that you are
14 talking about the cost to the Federal Treasury of the net
15 provisions in the bill, correct?

16 Dr. Elmendorf. I guess so, Senator. In my
17 experience, people use the term "cost curve" and "bending
18 the cost curve" as sometimes referring to the Federal
19 Government's situation and sometimes to refer to the
20 national situation, and we are trying to be as clear as
21 we can about one versus the other.

22 Senator Crapo. You have made no statement or
23 issued no conclusions about the impact on the national
24 health care cost curve?

25 Dr. Elmendorf. That is exactly right, Senator.

1 Senator Crapo. Could I ask you, with regard to the
2 cost of insurance -- I know you did not score that, and
3 that is not a part of your CBO letter. But I believe--
4 and I cannot recall whether this was you or Mr. Barthold,
5 but I believe in parts of the mark-up you indicated that,
6 although you hadn't scored it and do not have specific
7 numbers, that the overall impact of this bill on the cost
8 of health care insurance will be to drive the cost of
9 that insurance up. Is that correct?

10 Dr. Elmendorf. No, that is not a conclusion of
11 ours, Senator. What we have said in a separate letter to
12 Senator Baucus a few weeks ago is that there are a
13 variety of forces working on affecting private insurance
14 premiums and the amounts that people would pay for health
15 insurance, and some of the changes in the proposal would
16 tend to push down those premiums, some would tend to push
17 up those premiums.

18 Because there are so many conflicting forces, we
19 have not been able to assess the net impact on premiums.
20 I understand that our inability to do that is unfortunate
21 from the committee's perspective, it is unfortunate from
22 our perspective. The best we have been able to do is
23 list the factors, talk about the magnitude of some of
24 them, but not to draw an overall conclusion.

25 Senator Crapo. Thank you.

1 Mr. Barthold, have you reached a conclusion in that
2 regard?

3 Mr. Barthold. Senator Crapo, the Joint Committee
4 on Taxation does not analyze the totality of cost. The
5 limited areas in which we spoke over the past couple of
6 weeks related to the insurance industry fee that is in
7 the mark and the high-premium excise tax.

8 Senator Crapo. All right. Thank you. Because of
9 time, I want to keep going here.

10 Mr. Barthold. I am sorry, sir.

11 Senator Crapo. Let us go back to the Federal
12 Treasury and that which the CBO has scored. With regard
13 to that, there is spending and there are tax increases
14 and there are reductions in spending in this mark.
15 Correct?

16 Dr. Elmendorf. Yes. Increases and decreases in
17 both taxes and spending.

18 Senator Crapo. Correct. And let us just look at
19 the spending side of the ledger. Is it fair to say that
20 this mark will increase Federal spending by hundreds of
21 billions of dollars on health care?

22 Dr. Elmendorf. Yes, Senator, that is correct. If
23 I can just use a few seconds of your time to note that,
24 in the analysis that we have done with the Joint Tax
25 Committee, we have not broken out the effects in the

1 traditional way of the spending side and the revenue side
2 of the budget. We focused on the net effect on the
3 Federal deficit. We say in our letter there are some
4 further aspects of the bill that we would need to do, and
5 we will do in a formal cost estimate, to flesh out the --

6 Senator Crapo. I understand. But the point I am
7 getting at is this. For even those who want to talk
8 about the cost curve in the context of just the impact on
9 the Federal Treasury, would it not be accurate to say
10 that the net impact of the mark is to increase Federal
11 spending and to offset that spending by more taxes?

12 Dr. Elmendorf. I think so, Senator, but I want to
13 be a little careful. So what we have reported in our
14 letter is that Medicaid and CHIP outlays, what truly are
15 outlays, will be up by \$345 billion over the 10 years.
16 Then there is \$461 billion of exchange subsidies, some of
17 which would appear as reductions in revenue from lower
18 tax liabilities, some of which I believe would appear as
19 increases in spending because they would be refunded
20 parts of tax credits.

21 Senator Crapo. Correct.

22 Dr. Elmendorf. We have not broken that out, so we
23 are --

24 Senator Crapo. I understand. I am not asking you
25 to break out specific numbers. I am asking you to just

1 clarify that the net impact of the bill is to increase
2 Federal spending and to offset that spending by some cuts
3 in other areas, but cuts which are outstripped by
4 spending, and then making up that difference with tax
5 increases. Is that not a fair assessment?

6 Dr. Elmendorf. I believe that is right. But
7 again, just to be clear, there are \$345 billion of extra
8 Medicaid and CHIP outlays, and there is also about \$400
9 billion of reduced spending, mostly in Medicare. The net
10 of those two, the extra Medicaid outlays and the reduced
11 Medicare outlays, is actually a reduction in Federal
12 spending.

13 Senator Crapo. Well, wait a minute, though. The
14 net result of your letter, if I read your numbers
15 correct, is hundreds of billions of dollars of net --
16 when you net out everything on the spending side,
17 hundreds of billions of dollars of increased spending.
18 Is that not correct?

19 Dr. Elmendorf. Well, again, I am sorry, Senator,
20 but we have not really done that netting. So I am saying
21 that the large pieces that are clear, there is a
22 significant increase in Medicaid spending, significant
23 reduction in Medicare spending. Then there is the
24 exchange. In that case, the reduction in Medicare
25 spending more than offsets the increase in Medicaid

1 spending over the 10-year window. But there are also
2 these exchange subsidies, partly on the spending side,
3 partly on the revenue side. My guess is that there would
4 be enough extra spending there, there would be a net
5 spending increase. But I am afraid that we just have not
6 done that breakdown. I do not think that Joint Tax has
7 either.

8 Senator Crapo. Well, I see my time is up. I will
9 come back in the next round. But I think it is very
10 clear from the numbers in your charts, you can just do
11 the math.

12 The Chairman. Thank you, Senator.

13 Next on the list is Senator Roberts.

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

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4 Senator Roberts. Thank you, Mr. Chairman. I ask
5 permission to include my full statement in the record at
6 this point.

7 The Chairman. Without objection.

8 [The prepared statement of Senator Roberts appears
9 at the end of the transcript.]

10 Senator Roberts. It is my intent to ask Dr.
11 Elmendorf several questions in the next round, and also
12 ask unanimous consent he be awarded two Purple Hearts and
13 a Medal of Valor.

14 [Laughter].

15 Dr. Elmendorf. Thank you, Senator. It is the team
16 of people at CBO who deserve those awards, not me.

17 Senator Roberts. I see. That is exactly why we
18 are awarding you this award. Humbleness is a good thing.

19 Mr. Chairman, I am personally against the bill in
20 front of us today, but I know that many of my fellow
21 committee members will vote for it because they see it as
22 a moderate alternative to the Help and the House bills.
23 After my experience with the Help bill, I do have news
24 for my colleagues.

25 This bill, this so-called moderate health care

1 reform bill, will not be the bill that we will see in the
2 next few weeks that will come to the Senate floor. It
3 will not be the bill that comes out of the House Senate
4 Conference Committee. It is not even the bill that this
5 committee was considering last week, considering the
6 comments by my friend and colleague, Senator Kyl.

7 I refer to the carve-outs for Nevada, Oregon, Rhode
8 Island, and Michigan with regard to Medicaid costs to
9 States. The bill that comes to the Senate floor after
10 having been merged with the Help bill and the conference
11 report that comes out at the end of this process will be
12 radically different and it will contain all of the
13 policies that many--some--of you who may vote for this
14 bill today say you oppose: a government-run insurance
15 plan, higher taxes on American families and small
16 businesses, a job-killing employer play-or-pay tax,
17 costly insurance market rating restrictions, bloated
18 government entitlement programs, and robust tools for the
19 government to ration your health care. I know people say
20 that that is not there, but it is not prohibited.

21 Well, trust me, trust me, a vote for this bill will
22 be a vote for that bill. If you could but resist the
23 urge to play into the hands of those who would lead this
24 country down that path and instead take a thoughtful
25 step-by-step road that could result in at least a half a

1 dozen productive bipartisan reforms.

2 I know, Mr. Chairman and my colleagues, you are very
3 tired of hearing me repeatedly say in hearing after
4 hearing that we should have placed a big sign at the back
5 of our hearing room that says "Do No Harm". We should
6 have had it as a flashing light. With this ever-changing
7 bill, unfortunately we have failed that test.

8 As I have said before as well, I am terribly
9 concerned that we are riding hell-for-leather into a
10 health care box canyon full of spending quicksand, cactus
11 tax hikes, policy briar patches, complete with CMS
12 regulatory scorpions, rattlesnakes, and bad news bears.
13 Something like riding your pick-up over a whole tangle of
14 barbed wire and getting out of this, Mr. Chairman, and
15 back on solid ground to make Medicare solvent is going to
16 be a mighty rough and long ride.

17 So for all of these reasons, and for any of these
18 reasons, I would urge my colleagues to vote no on this
19 bill.

20 I yield back the balance of my time.

21 The Chairman. Thank you, Senator.

22 Senator Ensign, you are next.

23 Senator Ensign. Mr. Chairman, can I claim his
24 time? Just kidding.

25 [Laughter].

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

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4 Senator Ensign. Mr. Chairman, under this bill
5 there are winners and losers. I want to take some time
6 to talk about those who lose under this bill.

7 If you are currently on Medicare or hope to be so
8 one day, you lose. If you like your health care plan and
9 your doctor, but you are concerned about rising expenses,
10 you lose. If you are relying on a flexible spending
11 account to fill in the gaps in your coverage, you lose.
12 If you deduct catastrophic health expenses because you
13 have a chronic disease or a special-needs child with high
14 medical expenses, you lose. If you are from a State that
15 is in financial trouble, you lose.

16 President Obama has said, let me be exactly clear
17 about what health care reform means to you. First of
18 all, if you have got health insurance, you like your
19 doctors, you like your plan, you can keep your doctor,
20 you can keep your plan. Nobody is talking about taking
21 that away from you.

22 Mr. Chairman, under this bill that is not true.
23 There is no guarantee that you will be able to keep your
24 current health care plan and your doctor. We all agree
25 that we need health care reform. We want Americans with

1 preexisting conditions to get affordable coverage, and
2 Americans who lose their jobs to be able to keep their
3 affordable coverage. We just disagree on how to do it.

4 Mr. Chairman, let us look at Medicare. This bill
5 uses Medicare as a piggy-bank to pay for the uninsured.
6 Most Americans would agree that taking money from
7 Medicare, which is on the verge of bankruptcy, to fund a
8 huge expansion of health care benefits that we cannot
9 afford is wrong. This bill cuts Medicare by \$449 billion
10 for seniors under Medicare to pay for a new entitlement
11 program, even though Medicare will go bankrupt in 2017.

12 So how does this help millions of Americans
13 currently on Medicare, especially those on Medicare
14 Advantage? This committee passed my amendment to ensure
15 that if there are any Medicare savings in the bill, then
16 those savings will be kept in the Medicare program. In
17 looking at the CBO score, I am very disappointed to see
18 that the Medicare savings are being used to create and
19 fund new non-Medicare programs.

20 In addition, this bill does not protect seniors who
21 have Medicare Advantage plans. It is clear that some
22 Nevada seniors will lose benefits, and possibly even
23 their chance to be in a private Medicare plan, as a
24 result of the proposed cuts to Medicare Advantage.

25 The CBO estimates that the value of extra benefits

1 offered by Medicare Advantage plans will drop from \$1,600
2 a year to about \$500 a year. That is a real cut to
3 individuals. So even if seniors like their plans, they
4 may not be able to keep their plans and their values will
5 drop dramatically. President Obama also promised that he
6 would not raise taxes on families earning less than
7 \$250,000, not one single dime, he said. But that is
8 precisely what this bill does.

9 We are faced with a bill that, according to CBO, at
10 least 71 percent of the individual mandate penalties
11 would fall on those making less than \$250,000 a year.
12 Moreover, according to Joint Committee on Taxation,
13 almost 90 percent of the high-cost insurance plans, the
14 biggest tax in this bill, also falls on this group of
15 middle income families. This 40 percent tax does not
16 apply to high-cost plans, as the name suggests. It will
17 eventually be a tax on all health plans, since medical
18 inflation rises at a higher rate than the index in this
19 bill.

20 According to CBO's analysis of the various new fees,
21 these fees would increase costs for the affected firms,
22 which would be passed on to purchasers and would
23 ultimately raise insurance premiums by a corresponding
24 amount. If you have been using pre-tax dollars in the
25 flexible spending account to pay for services not covered

1 by your plan, like for speech therapy for a child with
2 autism, you are out of luck.

3 Flexible spending account are capped at \$2,500 under
4 this bill, so your income tax will rise as well as your
5 medical expenses. If you have been dealing with
6 extraordinarily high medical expenses and have counted on
7 your tax deduction for qualified medical expenses to pay
8 for care, or tuition for a special-needs school, you are
9 also out of luck. The bar has been raised from 7.5
10 percent to 10 percent of your income in this bill. In
11 other words, this bill hurts those who are being hit
12 hardest by medical catastrophes.

13 I took the President at his word when he said, "I
14 can make a firm pledge: under my bill, no family making
15 less than \$250,000 a year will see their taxes increase,
16 not your income taxes, not your payroll taxes, not your
17 capital gains taxes, not any of your taxes." This bill
18 violates that promise. There are seven brand-new taxes
19 in this bill. Count them: seven. And let us face it,
20 this is just the beginning.

21 Before the final bill is completed, you can be sure
22 that more taxes will be added. Already the news is
23 filled with talks about surcharges on high-income small
24 businesses, a value added tax which would be regressive,
25 a national sales tax on everyone, and a new windfall

1 profits tax on insurance companies that will do more to
2 raise the costs of insurance for Americans.

3 In addition, Mr. Chairman, I am concerned that
4 expanding the Medicaid program to new populations at 133
5 percent of poverty, as proposed under the Chairman's
6 mark, will ultimately begin to bankrupt my State of
7 Nevada, as well as other States. I recognize that the
8 Chairman's mark provides extra assistance to States like
9 Nevada to help defray the cost of covering newly eligible
10 beneficiaries. This is a major change in policy,
11 however, with Medicaid and will still, in the end, create
12 a new unfunded mandate on the States, many of which are
13 already severely strapped for cash. If we decide to
14 cover the cost for States, then it will balloon the
15 Federal deficit into the future.

16 So in conclusion, Mr. Chairman, as Americans we are
17 truly blessed. We typically do not usually have to wait
18 to get access to the health care services that we need.
19 Canadian and British patients often wait about twice as
20 long as Americans, sometimes more than a year to see a
21 specialist, especially if they want to have elective
22 surgery, like hip replacements, or to get radiation
23 treatment for cancer.

24 Unfortunately, our healthcare system as we know it
25 could drastically change as a result of this bill. Those

1 who have health insurance coverage today could end up
2 paying more and getting less. People could also lose the
3 ability to choose the health care that best meets their
4 needs. The financial well-being of future generations
5 will be compromised, given the \$1.8 trillion price tag on
6 this bill.

7 Mr. Chairman, no one knows what the 1,000 page-plus
8 bill will eventually do. Everyone was shocked when the
9 Joint Committee on Taxation reported that Americans who
10 cannot pay a fine on the mandate were originally subject
11 to a possible fine of \$25,000 and up to a year in jail.
12 We were able to address this as part of the amendment
13 process, but I am afraid that there may be other
14 unpleasant surprises as we go forward when the details
15 are released in this bill.

16 So, Mr. Chairman, I believe, for my State that is at
17 the forefront of the housing crisis, that is at over a 13
18 percent unemployment right now, our State cannot afford
19 this bill and that is why I will be voting against this
20 bill.

21 Thank you, Mr. Chairman.

22 The Chairman. Thank you, Senator.

23 Senator Wyden?

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25

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

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4 Senator Wyden. Thank you, Mr. Chairman.

5 Before I have questions for Dr. Elmendorf, Mr.
6 Chairman, just a couple of thank-yous to you. The
7 provisions in this bill are areas that reformers have
8 focused on for decades, like making sure our people do
9 not get hammered by insurance companies for having
10 preexisting conditions. I thank you for that, and I also
11 thank you for reaching out to me over the weekend to have
12 further discussions about issues that I feel strongly
13 about, like holding insurance companies accountable
14 through more choice and competition. I think we will
15 have more to talk about here in a few minutes about that
16 as well.

17 The Chairman. Senator, I do not know anybody who
18 has worked more for health care over the last several
19 years than you. You are a real stalwart, so I just thank
20 you. Many of your efforts are reflected in this bill,
21 and I thank you.

22 Senator Wyden. I thank you.

23 I do want to spend most of my time talking with Dr.
24 Elmendorf about a couple of his charts, particularly
25 issues relating to more consumer choice and

1 affordability. I have always felt that consumer choice
2 is how you hold insurance companies accountable. That is
3 how you make the system more competitive. I want to ask
4 you, first, about your chart in the letter you sent to
5 the Chairman October 7 on "Sources of Coverage".

6 With respect to that particular chart, it is page 1
7 of the charts relating to sources of coverage, it looks
8 to me like seven years after the legislation would take
9 effect, more than 90 percent of the American people still
10 would not have new choices in the exchanges, which will
11 be the new marketplace for insurance. Is that a correct
12 analysis of that chart, Dr. Elmendorf?

13 Dr. Elmendorf. Yes, Senator, that is correct. We
14 estimate that the number of people in the exchanges would
15 be about 23 million people in 2019, out of a total of 282
16 million people in the country.

17 Senator Wyden. And I know the Chairman and I, in
18 the second round, are going to get into this issue of
19 consumer choice. We have had some very constructive
20 conversations over the weekend, and we will continue them
21 in the second round.

22 The other question I wanted to ask you at this point
23 deals with affordability, because we all understand that
24 there are really three legs to this health care stool:
25 containing costs, making coverage more affordable, and

1 promoting choice, making the system more competitive. We
2 clearly have more to do in the area of consumer choice on
3 the basis of the question I just asked.

4 Now, on affordability, I would like to go to another
5 of your charts. It is entitled, "Analysis of Exchange
6 Subsidies and Enrollee Payments in 2016". As I read this
7 chart, if you have a middle class family of four with an
8 income of \$66,500, they would have to spend 12 percent of
9 their income, nearly \$8,000, on premiums before they got
10 any tax credits to buy coverage in the exchange.

11 Now, on top of those premiums, it appears that CBO
12 estimates that the cost of co-pays, deductibles, and
13 other expenses would be roughly \$5,000, on average, for
14 this family. So you have got a family looking at paying
15 close to \$13,000 before they really get any assistance,
16 the tax credits, to buy coverage. That would be more
17 than 19 percent of the typical middle class family's
18 income.

19 So my question is this, Dr. Elmendorf. It looks to
20 me as I read that analysis that a lot of those middle
21 class families are going to seek an exemption, given
22 those costs, and be uninsured. What was your judgment,
23 as you went forward in terms of your analysis, about how
24 many families would go that route, would seek an
25 exemption and be uninsured, largely because they would

1 say they could not afford the coverage?

2 Dr. Elmendorf. Senator, I am not sure I have an
3 answer about how many would seek the exemption. As you
4 know, we assume that a significant number of people would
5 choose not to take health insurance. There would be a
6 number of uninsured people at the end of the day. I do
7 not have--at least with me--an estimate of how many
8 people in that category who are in the lower income
9 brackets that might be eligible for Medicaid but are
10 choosing not to do that, versus higher income brackets
11 where they would not be getting the subsidies. I think
12 we can probably try to develop the details about the
13 distribution of the uninsured across income brackets, but
14 I do not have that in hand.

15 Senator Wyden. I would appreciate that. I will
16 close this round with this. There are not going to be
17 any rallies in America for Senators creating exemptions.
18 People want coverage. They want coverage to be
19 affordable. The example I gave suggests that we have got
20 a lot more work to do with respect to affordability. As
21 I have said, the Chairman has had a number of productive
22 conversations with me over the weekend, and we will look
23 at some ways to do that in the second round.

24 Thank you, Mr. Chairman.

25 Dr. Elmendorf. Actually, Mr. Chairman, I want to

1 clarify the statement I started with. I said there would
2 be 23 million people in the exchanges, in our estimate.
3 Those are the number of individuals or families going by
4 themselves to the exchanges. We also estimate--and this
5 was in a footnote in our letter to the committee--that 4
6 million people would be taken to the exchanges by their
7 employers. There will still be a total of 27 million
8 people who would be taking insurance through the
9 exchanges. That is still less than 10 percent of the
10 total population, as you said, Senator.

11 The Chairman. Thank you, Senator.

12 Senator Enzi?

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

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4 Senator Enzi. Thank you, Mr. Chairman. I do want
5 to thank you for all of the work that you have done on
6 health care. You are to be commended on the way that you
7 have gone about it. You started on it last year, not
8 just recently, and you had been working on it before
9 that, but you had a very active role in getting people
10 together at that point.

11 I still have a lot of people from my State that are
12 getting a hold of me and talking about health care
13 reform. Everybody is interested in it because it affects
14 everybody. I have never worked on a bill that affected
15 everybody before. My comments come in pretty much four
16 categories. One of them is the one that Senator Wyden so
17 excellently brings up, and that is choices. They want to
18 have more choices. They are looking for that in any way,
19 shape or form that they can get it. I think we missed
20 the boat on choices on this.

21 Of course, I would guess that most of my calls are
22 from people that are on Medicare. They are not
23 understanding our bill, because they say, let me see, we
24 are going to use a bunch of money from Medicare to pay
25 for a whole bunch of things, and then we are creating a

1 Medicare commission that is supposed to figure out how to
2 save Medicare? Somehow that does not ring true with
3 them. Spend money from Medicare for other things, then
4 create a commission to save money for Medicare so that it
5 does not go bankrupt. I understand their dilemma; I have
6 the same dilemma.

7 We also, in that Medicare package, put it together
8 so that there is a deal with hospitals so that the
9 Medicare commission cannot consider them, which looks to
10 me like it just leaves doctors on the hook, which is the
11 reason I am getting a lot of calls from doctors, both
12 about that and about tort reform. They heard the
13 President, at their meeting, say that there was a need
14 for tort reform. They have emphasized the need for tort
15 reform. They are really not seeing us do anything on
16 tort reform.

17 Another big category that I am hearing from is the
18 average person. They say, well, it is nice that we are
19 watching out for a change about whether the Federal
20 Government is paying for what it is doing, but how about
21 what it is doing to us to pay for that? And they seem to
22 understand that. So I do not think they understand it in
23 the depth that they would if they actually saw
24 legislative language or understood the depth with which
25 we are going to on it, and as a result, I have a few

1 questions for CBO and Joint Tax.

2 I appreciate Senator Crapo's questions earlier that
3 pointed out that when we are talking about a cost curve,
4 we are talking about a Federal Government cost curve and
5 not the cost of the insurance cost curve, which is what
6 most of those people are talking about. But some more
7 details on this.

8 Could the new excise tax on medical devices be
9 passed through to purchasers and, therefore, cause an
10 increase in health insurance premiums?

11 Mr. Barthold. Senator Enzi, as an excise tax, it
12 depends on the market conditions. Generally, in
13 competitive markets we ultimately expect the excise tax
14 to be passed forward, at least in part. Where there is
15 not a lot of competition in the market, there can
16 sometimes be a different result with the manufacturer
17 bearing more, and in cases where the buyer is himself a
18 large buyer it is difficult to determine if prices
19 increase. So, for example, if the Federal Government
20 were a large purchaser, that can also affect the pricing,
21 and consequently who bears the tax.

22 But in terms of analyzing, we do assume that there
23 will be some effect on prices as a result of the proposed
24 excise tax.

25 Senator Enzi. Okay. How about--oh, go ahead, Dr.

1 Elmendorf.

2 Mr. Elmendorf. I agree.

3 Senator Enzi. Okay. Could the new excise tax on
4 drugs be passed through to the purchasers and, therefore,
5 increase health insurance premiums?

6 Mr. Barthold. The excise tax in the mark on drugs
7 falls into the last category that I mentioned as sort of
8 causing--or making it difficult to analyze in that the
9 proposal in the Chairman's mark is restricted to drugs
10 that are related to Federal programs. And so that makes
11 it not a purely competitive market analysis, and it is
12 harder to say.

13 In our analysis for the purpose of creating the
14 revenue estimate, we did assume that there would be an
15 effect on prices.

16 Senator Enzi. So would you have the same answer
17 for the excise tax on health insurance plans that have a
18 lot of benefits?

19 Mr. Barthold. Well, they are all a little
20 different, and as I think the Committee discussed last
21 week, the excise tax on the health insurance--you mean
22 the health insurance fee or the industry fee or the high
23 premium excise tax?

24 Senator Enzi. The high premium excise tax.

25 Mr. Barthold. The high premium excise tax, as we

1 talked about earlier today, Senator, we expect there to
2 be a number of effects on consumers. We expect that it
3 creates an incentive for a number of employers on behalf
4 of their employees and for employees to demand different
5 types of coverage. That leads to income inclusions as
6 the compensation mix changes, and so in that sense, the
7 consumer is bearing part of that burden of the tax,
8 although it is not necessarily reflected in the price
9 that he or she pays for the insurance that they receive.

10 But, again, on affected plans we anticipate that it
11 will lead to an increase in the price of those plans.
12 That is part of the price incentive that leads to these
13 behavioral changes that we are talking about.

14 Senator Enzi. Thank you. I have more questions.
15 I will save them for the next round.

16 The Chairman. Thank you, Senator.

17 Next, Senator Nelson.

18 Senator Nelson. Well, while we are talking about
19 taxes, let us remember the hidden tax that we are paying.

20 If we do not do anything like this bill, if we do not do
21 health reform, every one of us paying our health
22 insurance premiums pay for the people who are uninsured
23 that end up going to the emergency room and get free
24 care, which that cost is passed back on us. And if I
25 recall, Dr. Elmendorf, isn't that something on a national

1 average around--for a family policy, isn't that hidden
2 tax somewhere around \$1,000 a year?

3 Mr. Elmendorf. So, Senator, that number does not
4 come from us. I do not have a number like that. I think
5 I would just say the extent of cost shifting in the
6 economy, in the medical system, is very unclear. It is
7 certainly true that certain payers pay less than others.

8 Whether that means that their costs are shifted to
9 others and other people's costs are thereby higher is a
10 more complicated question, and I think there is more
11 disagreement about that.

12 Senator Nelson. Well, I have seen that number over
13 and over on a national average of about \$1,000, and just
14 common sense would tell you, if people do not have
15 insurance and they are getting health care at the most
16 expensive place at the most expensive time, when the
17 preventable disease has turned into an emergency, and
18 those costs are absorbed in the system, then it is the
19 rest of us that pay. And the figure that I have seen
20 over and over is about \$1,000 for a family policy, and
21 the figure that I have seen in my State of Florida is
22 even higher than that.

23 So, clearly, that is one of the main things that we
24 are trying to address here, is to bring down the cost of
25 health insurance to make it more affordable and also to

1 make it available to people.

2 Mr. Chairman, I would add my kudos to you. You have
3 singularly been dogged and have brought us to this point,
4 and I thank you for that.

5 I just want to say that I am really surprised at
6 this, the insurance industry's report, and I would like
7 to ask Mr. Miller of MedPAC, I would like to ask him a
8 question.

9 This study identifies Medicare provider cuts in this
10 legislation as a driver of increased premiums. What is
11 your opinion about those cuts, those reductions in this
12 legislation? Is it going to lead to significant cost
13 shifting and increased premiums that this insurance
14 industry report says?

15 Mr. Miller. In MedPAC, we do Medicare, and I
16 cannot necessarily address the relationship between cost
17 shifting and private insurance premiums. But I think the
18 question you are getting at is that in the context of our
19 update work that we do each year to make recommendations
20 to Congress, we have looked at the issues of cost
21 increases among providers. And our concern is that those
22 cost increases have been going much faster than might be
23 expected given their input costs. So costs for wages,
24 costs for rents, that type of thing.

25 So we started to look into this issue, and what we

1 have come up with is that we disagree with the argument
2 that there is the general understanding on cost shifting.

3 Put differently, when we looked at hospitals, for
4 example, we found that hospitals that are under fiscal
5 pressure, so are not getting very high payments on the
6 private side, do not have large endowments, tend to have
7 lower costs. And so we organized--we looked at the data
8 more completely and found that what is happening is
9 hospitals' costs in particular seem to be following
10 private-payer payments, which have been very rapid in the
11 last decade, and those costs have followed those
12 payments.

13 And when you classify hospitals into hospitals who
14 are getting very high private payments and have large
15 endowments versus hospitals who have low payments from
16 private payers, you find that their costs per case are
17 about 10 percent different; that hospitals under fiscal
18 pressure tend to have lower costs.

19 So a basic argument is that the cost-shifting
20 argument assumes that costs are fixed and that any
21 payment that does not meet those costs is inadequate. We
22 make the argument that costs for providers tend to follow
23 what is paid, and the more you pay, the higher costs that
24 you tend to get.

25 Senator Nelson. Okay. That is a very detailed way

1 of saying that this is wrong, and I think--Mr. Chairman,
2 I see my time is up. I will talk more in a second round.

3 But I just can tell you, I had the privilege or the
4 burden, whichever way you look at it, of being the
5 elected insurance commissioner of Florida for 6 years.
6 And insurance companies want to make a profit,
7 understandably. But in doing so, they want to cherrypick
8 the least risk, the healthy people, and that is
9 understandable. But when you to take that mind-set on a
10 population that you want to take care of their health, it
11 does not work.

12 And so is it any wonder that now that they see there
13 is going to be a bite on them to look out after the
14 overall health, they come out at the 11th hour with a
15 report that says, oh, this thing is all flawed.

16 Thank you, Mr. Chairman.

17 The Chairman. Thank you, Senator.

18 Senator Cornyn, you are next.

19 Senator Cornyn. Thank you, Mr. Chairman.

20 Dr. Elmendorf, I want to just go back to the
21 question that Senator Crapo was asking you about the
22 scope of your review and just ask you to answer this
23 question. Do you expect that the United States will
24 spend more or less of our gross domestic product on
25 health care as a result of this bill?

1 Mr. Elmendorf. We have not formed an estimate to
2 answer that question, Senator. I do not know.

3 Senator Cornyn. You have not been asked, and you
4 have not provided an answer to that question yet?

5 Mr. Elmendorf. Well, certainly many people are
6 curious, including ourselves, but we have not had an
7 opportunity to develop an answer to that question.

8 Senator Cornyn. I would like to go back to some of
9 the discussion about the PricewaterhouseCoopers study
10 that was released and which has been criticized because
11 it was paid for by the insurance industry, but just to
12 ask you this, Dr. Elmendorf: CBO has in the past scored
13 legislation related to premium increase impact, has it
14 not?

15 Mr. Elmendorf. Yes, Senator, we have spoken to
16 that question for some previous legislation.

17 Senator Cornyn. And so CBO is certainly competent
18 and qualified to take a look at the
19 PricewaterhouseCoopers report and to confirm that it is
20 correct or to say it is correct in part and wrong in part
21 or that it is completely wrong? CBO can do that if given
22 an opportunity to do that review, correct?

23 Mr. Elmendorf. Yes, Senator, I think we can. It
24 is a complicated question, and it would take us some
25 time.

1 Senator Cornyn. I would suggest it is an important
2 question, but I appreciate your answer. I hope we can
3 get that information from you before we have to vote on
4 this legislation, certainly.

5 As advertised, we have been talking about reducing
6 costs for consumers of their health insurance coverage,
7 and it would be a cruel outcome indeed if, in fact,
8 unintentionally we actually increased their health
9 insurance costs.

10 I would like to also ask, Mr. Chairman, there is an
11 article that I want to refer to by Peter Suderman that
12 was published October 6, 2009, Wall Street Journal called
13 "Lessons of State Health Care Reforms" and ask that this
14 be made a part of the record after my comments.

15 The Chairman. Without objection.

16 [The article appears at the end of the transcript.]

17 Senator Cornyn. Thank you very much.

18 I would just ask, Dr. Elmendorf, certainly with the
19 provisions in this bill that have to do with community
20 rating, the provisions of the bill that have to do with
21 guaranteed issue, with the new taxes that Mr. Barthold, I
22 believe, responded to Senator Enzi on that would be
23 passed, in whole or in part, down to policyholders, would
24 you agree with me it is certainly no surprise that those
25 would have an impact on health care premiums,

1 individually and cumulatively?

2 Mr. Elmendorf. I think it is certainly no surprise
3 that those fees that you have discussed would tend to
4 push up premiums. It is no surprise that community
5 rating and other aspects of insurance market reforms
6 would affect premiums. But whether they increase or
7 decrease them on net and on whom they increase or
8 decrease them is much less clear.

9 In general, an effort to have everybody pay the same
10 price for insurance will tend to raise premiums for
11 people who are healthy and have been able to achieve
12 lower prices because of that, and it will tend to lower
13 premiums for people who are sicker and have paid higher
14 prices because of that.

15 So no doubt that the move toward community rating
16 very much affects the distribution of premiums paid
17 across a group. The extent to which it raises or lowers
18 them on net is more subtle.

19 Senator Cornyn. As part of CBO's analysis, when
20 you have an opportunity to analyze the impact of these
21 various provisions on premiums and on costs to consumers,
22 would you be interested in the experience of the States
23 that have tried various initiatives like community
24 rating, guaranteed issue, and the like, including an
25 individual mandate like Massachusetts has? Would you be

1 interested in that experience as opposed to just an
2 academic model about what it may or may not turn out to
3 be?

4 Mr. Elmendorf. Yes, Senator, we take those real-
5 world experiences very seriously. Of course, no
6 individual State has done the set of things that this
7 proposal would do, so the analogies can be at best
8 imperfect. But we certainly give them--but they are
9 among the best evidence available, and we certainly take
10 it very seriously in our--

11 Senator Cornyn. I would commend to you the article
12 I referred to by Mr. Suderman on October 6, 2009, in the
13 Wall Street Journal that is going to be part of the
14 record for some discussion of that. But I am sure that
15 that will be a starting place perhaps, but not a
16 finishing place.

17 Mr. Chairman, may I conclude with just a question
18 for you? I am advised by my staff that once the
19 Committee votes on the conceptual language, there will
20 actually be report language that the Committee will
21 provide as part of its product. Is that correct?

22 The Chairman. The Senator is correct.

23 Senator Cornyn. And will that report language
24 include legislative language?

25 The Chairman. The Senator is correct.

1 Senator Cornyn. And may I ask when the members of
2 the Committee will be allowed to look at the legislative
3 language?

4 The Chairman. As soon as possible.

5 Senator Cornyn. I would hope so, but I would
6 assume that you are saying after we vote on the
7 conceptual language. Is that correct?

8 The Chairman. The Senator is once again correct.

9 Senator Cornyn. Well, I am on a roll, Mr.
10 Chairman.

11 The Chairman. You are doing well.

12 Senator Cornyn. Well, let me ask you: Why
13 wouldn't it make sense then for it to be made public--or
14 made available to all members of the Committee so we
15 could actually see not just the conceptual language but
16 also the legislative language, since the legislative
17 language is what actually becomes law? And wouldn't it
18 make sense to provide it, as Senator Bunning has said, to
19 the American people so they can look at it and see how
20 this will impact them?

21 The Chairman. The Senator is correct, as soon as
22 possible.

23 Senator Menendez, you are next.

24 Senator Menendez. Mr. Chairman, first let me join
25 my colleagues in recognizing your leadership and your

1 stewardship during this long and intense debate. I know
2 you have worked hard to make this a good bill and how
3 hard you have worked to make this as fair a proceeding as
4 possible. And now it is time to vote.

5 It is a historic vote, one of those occasions when
6 each of us must weigh any lingering concerns against our
7 responsibility to act and to act wisely, for the lives
8 and livelihood of the American people literally lie in
9 the balance. I will vote for this bill because it goes a
10 long way in the right direction. I will vote to move it
11 out of the Finance Committee with the hope that it will
12 continue to improve, especially making health care more
13 affordable and providing choice with a strong public
14 option.

15 The amendments we passed have made this a better
16 bill. It protects consumers by providing insurance
17 market reforms to help rein in costs and expand coverage.

18 It includes amendments I sponsored to help families
19 fighting health insurance bureaucrats who deny them
20 coverage when they need it the most; amendments to
21 provide coverage for behavioral health treatments,
22 including for children with autism and support services
23 for women suffering from postpartum depression. It
24 protects federally qualified health centers so they can
25 continue to provide much needed care to families in our

1 communities. And it contains necessary changes to the
2 excise tax recognizing that retirees and high-risk
3 workers have additional health costs, changes that raise
4 the thresholds more generously to save millions of family
5 policies from being hit. And we look forward to doing
6 more.

7 Overall, Mr. Chairman, this bill is now, in my view,
8 a fairer bill for families. It protects children and
9 families facing hardships or who are unable to afford
10 coverage, children growing up with grandparents, children
11 who may be aging out of foster care, children with
12 parents whose employers do not provide dependent
13 coverage. It includes my amendments to provide consumers
14 with assistance when they feel they have been unfairly
15 denied a claim from their insurance company or charged
16 outrageous rates when they are rushed, often unconscious,
17 to a hospital. These amendments, among others, have
18 strengthened the bill.

19 Now, I would have liked to see the bill go further
20 on affordability. I fundamentally believe that if we
21 place a mandate on families to purchase coverage, we have
22 to ensure that that coverage is truly affordable.

23 Mr. Chairman, I know you made every effort to
24 incorporate my amendment on lowering premium caps, and I
25 want to commend you for that, and I look forward to going

1 further as we bring a final bill to the floor.

2 For families across America, including families in
3 the territories, accessing affordable coverage is, in my
4 view, a critical part of any health care reform package,
5 and we have to make sure we get it right.

6 But the bill we will vote out today does not include
7 a strong public option, one that will provide consumers
8 the real choice they need. I know there are those who
9 say we do not want Government involved in health care.
10 Well, I would remind them to look around. The health
11 care system we have in America is a private system
12 without Government oversight, and it is not working.

13 This weekend, we not so coincidentally hear that the
14 insurance industry suddenly claims or, more accurately,
15 threatens that under this legislation premiums could rise
16 faster and higher. How convenient that they came forward
17 at the 11th hour. After all the negotiations and
18 discussions, after all the hard-fought debate, after all
19 the study in and out of industry, suddenly insurers have
20 trumped up a deeply flawed report, contradicted by more
21 thorough studies, claiming costs that are increased, yet
22 admitting that they did not consider all the reforms
23 included in the bill before us.

24 The simple truth is this bill requires every
25 American to have health insurance. It could not be

1 clearer. More people will come into the system, but that
2 is apparently not enough for insurance executives.

3 In my view, Mr. Chair, if the insurance industry is
4 making bogus claims in one last effort to sink health
5 care reform by playing yet another fear card to scare
6 average, hard-working families, then it is one more
7 indication that we are on the right track, one more
8 indication this legislation is the right legislation at
9 the right time for all the right reasons.

10 The truth about the insurance industry in the
11 present system is that they are coming between doctors
12 and patients. Insurance executives are making medical
13 decisions based on the bottom line. Costs are
14 increasing, the quality of care is decreasing, options
15 are being limited, reliability fleeting. The truth is
16 the public option would not be Government-run insurance.

17 It would be self-financed and self-sustaining. To me,
18 that is not a Government-run insurance program.

19 Most importantly, instead of rewarding risk
20 management, it would reward good work and innovation. It
21 would promote performance incentives, just as Medicare
22 promotes quality care while keeping costs down. So I
23 hope we will get to see a public option in the final bill
24 that comes before the Senate.

25 Finally, it seems to me that the fact is to vote

1 against the bill before us is to do nothing. It is a
2 vote to stay the course and let market forces continue to
3 treat the health of the American people as an investment,
4 minimizing risks, maximizing profitability. A vote
5 against the bill is to be for the status quo, for the
6 insurance companies to continue to commit the constant
7 denial of health care when you need it, rising double-
8 digit premium increases, and for millions to continue to
9 have no health insurance whatsoever.

10 The status quo that some of our colleagues are
11 trying to protect is a health insurance Ponzi scheme
12 where insurers collect ever increasing premiums from
13 families, then do everything in their power to minimize
14 their own risk by denying them claims while finding a way
15 to pay benefits only when absolutely necessary. That is
16 fundamental wrong, Mr. Chairman. That is what we are
17 trying to change. That is what your bill does, and that
18 is why I will be voting for it.

19 The Chairman. Well, thank you, Senator, very, very
20 much.

21 Next, Senator Carper, you are next.

22 Senator Carper. Thanks, Mr. Chairman. I want to
23 commend and thank you for your leadership. I want to
24 especially commend those who spent--what was it?--61
25 meetings with you in trying to find a way to a bipartisan

1 proposal. I want to express my thanks to all of our
2 colleagues on this Committee--

3 The Chairman. In the interest of accuracy, 61
4 hours.

5 Senator Carper. Sorry. All right.

6 The Chairman. But it felt like many, many more.

7 [Laughter.]

8 Senator Carper. I am sure it did.

9 I want to especially thank our staff, Finance
10 Committee staff, Democrat and Republican, as well as our
11 personal staff, for the enormous effort and time that
12 they have invested in this process and all those that
13 have come before us in the course of this year and last
14 year before I joined the Committee to give us the benefit
15 of their input.

16 I believe that with the passage of this bill, or
17 something close to it, we will begin to move to transform
18 the health care system today that costs more than any on
19 Earth, does not provide better outcomes, results in some
20 14,000 people losing coverage every day, leaves over 40
21 million people without coverage, and puts American
22 companies at an enormous competitive disadvantage with
23 their business rivals around the world.

24 There are many facets of health reforms that are
25 necessary and integral in adopting sound health reform

1 policy, but I want to make, if I could today, special
2 reference to three that have been major priorities for me
3 and I know for some of our colleagues.

4 One of those was reining in the growth of health
5 care costs. The second is moving away from a fee-for-
6 service delivery system. And the third is encouraging
7 wellness and incentivizing healthy behaviors, more
8 healthy behaviors.

9 I believe that July 16, 2009, was a game changer in
10 the debate on health care reform. From that date,
11 Senator Conrad, as Chairman of the Budget Committee of
12 the Senate, asked CBO Director Doug Elmendorf if any of
13 the health care reform bills up to that point reined in
14 the growth of health care costs. As I recall, Dr.
15 Elmendorf replied, "No," and went on to say that health
16 care bills up to that point significantly expanded the
17 Federal responsibility for health care costs.

18 On that day in July, we did not yet have a Finance
19 Committee package to examine. We now have a Finance
20 Committee package. We have heard back from CBO on that
21 package. We have heard that our package would expand
22 health insurance coverage to 94 percent of Americans, up
23 from 83 percent today. We have heard that our package as
24 a whole costs some \$829 billion over the next 10 years,
25 significantly lower than the other reform proposals in

1 Congress, and, I might add, fully offset, fully paid for.

2 In fact, it provides a net surplus, I believe, of \$81
3 billion over the next 10 years, and over the next 10
4 years beyond that, a surplus added of as much as \$800
5 billion.

6 I have made it clear to my colleagues and to all who
7 will listen that I am not interested in voting for a bill
8 that increases our national debt and does not begin to
9 rein in the growth of health care costs.

10 Over the last several months, I have become
11 convinced that one key piece of reforming our health care
12 system is moving away from our current pay such of fee-
13 for-service, a view that I think is widely shared by
14 others on this Committee. The current payment structure
15 of paying health providers for each health service that
16 they provide stifles collaboration and suppresses
17 efficient care management in many instances.

18 During the visit that I shared with all of our
19 colleagues about a month ago to the Cleveland Clinic, a
20 nonprofit health care delivery system that has moved away
21 from fee-for-service and now pays its doctors a salary, I
22 saw firsthand what can be accomplished when we move away
23 from fee-for-service, when we create a patient-centered
24 model of care that focuses on primary care, prevention
25 and wellness, managing chronic diseases, and harnessing

1 information technology for the delivery of health care.
2 Although we can do more, our Finance Committee bill takes
3 a number of important first steps in moving away from our
4 current payment structure.

5 One of the provisions in our Finance package that
6 many of us believe can be a game changer in this regard
7 is the creation of CMS' Innovation Center, and later
8 today I will ask Dr. Elmendorf to talk with us a bit more
9 about that. But the Innovation Center's purpose will be
10 to test, evaluate, and expand different payment
11 structures and models which aim to foster patient-
12 centered care and to improve quality.

13 In addition to reining in the growth of the health
14 care costs and moving away from fee-for-service, I
15 believe that encouraging wellness and incentivizing
16 healthy behaviors are critical to reform. We know that
17 if we incentivize people to take better care of
18 themselves, we can rein in the growth of our health care
19 costs as well, and recent findings have shown us that the
20 biggest factor contributing to most people's health
21 status is their behavior, our behavior. And roughly 40
22 percent of our health status, I am told, is a direct
23 result of our choices about food and physical activity.
24 Another 20 percent is a direct result of social and
25 physical environments, such as our homes and the places

1 where we work.

2 That means for most people the way that we eat, the
3 way we drink, the way we exercise, or do not, as well as
4 our work and home environments shape as much as 60
5 percent of our underlying health status today.

6 I was pleased to work during the markup with Senator
7 Ensign to fashion a bipartisan amendment that will better
8 enable employers to incentive employees to address some
9 of the major causes of poor health that lead to higher
10 health care costs. What are they? Smoking, obesity,
11 high cholesterol, high blood pressure, among others.

12 Let me conclude by saying none of us is suggesting
13 that our Committee's proposal is perfect, but I do
14 believe it represents an important next step, and today I
15 hope that we will report out of Committee a Finance
16 package that will provide us with the foundation as we
17 move forward and merge two health care bills in the
18 Senate. The American people are counting on us. We
19 cannot afford to let them down.

20 Thank you.

21 The Chairman. Thank you, Senator.

22 Next, I will turn to Senator Lincoln, and for the
23 interest of those who might wonder what my intentions are
24 for the rest of the day, Senator Lincoln is at the end of
25 my list. There are some Senators who clearly are not

1 here who will come later. I intend to keep moving on
2 this bill. We will just keep working. We are getting
3 close to a vote, so I think it is in the best interest of
4 all of us that we just keep going ahead to our vote.

5 So after Senator Lincoln, I am next on the list, but
6 I will defer to Senator Grassley and then Senator
7 Rockefeller and Senator Hatch in that order.

8 Senator Lincoln?

9 Senator Lincoln. Thank you, Mr. Chairman. As is
10 often the case, much has been said, but not everyone has
11 said it, and it is now my turn.

12 I want to say a very special thanks to you, Mr.
13 Chairman, and to all of our colleagues for the incredible
14 hard work over these weeks and certainly months on the
15 America's Healthy Future Act legislation that I do
16 believe builds on what works in health care, makes it
17 better, and also works to create greater efficiencies.

18 You know, I hope that we will look at the title of
19 this bill and remind ourselves that we are not going to
20 be able to take a pill and wake up tomorrow if we are
21 able to pass a bill and to see that everything has been
22 cured. This is the future, and it is going to take us
23 time and devotion, not only in terms of what we do here
24 today and what we do in the continued process in trying
25 to improve upon what many have said is not perfect--and

1 it is not. But it is our responsibility to continue in
2 this democratic process of moving forward to start with
3 what we feel like is the best work we could have done and
4 then to move to that next step.

5 I am very encouraged that the Congressional Budget
6 Office in their analysis confirms we have achieved one of
7 our goals, and certainly my principle, of a bill that is
8 deficit neutral and reduces the growth of health care
9 spending over the long term, particularly for Government.

10 I for one agree that preserving the status quo in
11 health care is simply not sustainable. We must continue
12 to work to get it right, and we can. But to continue in
13 the direction on the trajectory that we are on right now
14 is not going to be meaningful to anyone.

15 Our current health care system, while we have the
16 best doctors and facilities, medical technologies,
17 nurses, caregivers in the entire world, it still--our
18 current health care system still leaves millions of
19 Americans without any coverage and millions more
20 underinsured.

21 The current system is one in which health insurance
22 premiums are rising many times faster than wages. In our
23 own State of Arkansas, it is five times faster. And
24 Americans pay higher premiums, as much as--several of my
25 colleagues have asked the question if it is noted by the

1 CBO, but in Arkansas, we find that our premiums are as
2 much as \$1,500 higher in Arkansas to cover the bills of
3 uninsured individuals, most of which get their care in
4 emergency rooms because there is nowhere else to go.

5 It is one in which insurance companies are allowed
6 to deny coverage based on an illness you may have had 5
7 years ago, to increase your rates or drop you from their
8 policy if you become sick, and to charge significantly
9 more if you are older or because you happen to be a
10 woman.

11 If nothing changes, the Medicare Part A trust fund
12 will be insolvent in just 8 years. If this bill does not
13 pass, Medicare doctors will receive a 21-percent
14 reduction in Medicare payments in 2009, which could
15 significantly hinder seniors' ability to find physicians
16 who are willing to see Medicare patients. We must solve
17 that problem.

18 We have crafted a bill and worked hard to ensure
19 that seniors will not see a reduction in the Medicare
20 benefit they have always relied upon. And I will
21 continue to ensure that remains the case as we move
22 forward in this process.

23 Seniors know--they know, most of them, like my mom,
24 who is a Depression baby, they know that businesses and
25 households nor can our health care system continue to

1 operate with as many inefficiencies as there are in our
2 current system. And without eliminating those
3 inefficiencies, we will no longer be able to depend, nor
4 will they, on a health care system that they desperately
5 need.

6 Furthermore, this legislation contains provisions
7 that I have worked on for many years with my colleague
8 Senator Hatch, as well as the Chairman and Ranking
9 Member, designed to prevent, detect, and prosecute abuse,
10 neglect, and exploitation perpetrated against our elders.

11 Elder abuse is a national disgrace, and this bill would
12 make huge strides in coordinating efforts at the national
13 and local level to combat this problem once and for all.

14 It has already been said in this room, Mr. Chairman,
15 but it is worth repeating, that according to the
16 Congressional Budget Office, about \$700 billion are spent
17 each year in our health care system on activities that do
18 not improve health, whether we are talking about wellness
19 and prevention, whether we are talking about
20 inefficiencies in delivery systems, or shifting our
21 system to a system that is based on volume to a system
22 that is based on value. The bottom line is there are
23 inefficiencies that exist, and without tackling those
24 inefficiencies, we will no longer have a system that is
25 going to be able to provide for so many Americans that

1 need it.

2 These inefficiencies include fraud, abuse,
3 administrative costs, paying providers and facilities
4 based on that volume of services rather than the quality
5 of care provided--inefficiencies that we target in this
6 bill through common-sense reform. Many make them out to
7 simply be cuts, arbitrary cuts. They are not at all.

8 Mr. Chairman, we have worked hard to eliminate these
9 inefficiencies. For example, the Finance Committee has
10 established a CMS Center on Innovation that Senator
11 Carper mentioned that can rapidly test models that would
12 improve efficiencies in health care delivery, such as my
13 Realigning Care Act, a model that would coordinate the
14 caregiving teams of health care providers for seniors
15 with multiple chronic conditions and especially those
16 with dementia, to improve their lives and reduce the
17 costs associated with duplicative tests and duplicative
18 services and rehospitalization.

19 We have found in Arkansas, with our Center on Aging
20 that works in tandem with UAMS, our medical school, and
21 our Center on Aging, we now have outsourced into
22 different small communities the fact that we have not one
23 single senior in Arkansas that lives more than 50 miles
24 from a Center on Aging. It is critical for us to get
25 this type of care and this kind of consultation out to

1 our seniors so that we can eliminate those inefficiencies
2 that put at jeopardy their access to the kind of health
3 care that they need.

4 There is no doubt in my mind that the cost of doing
5 nothing is simply too high. It is too high for working
6 families. It is too high for small businesses. It is
7 too high for States and too high for the Federal
8 Government and too high for the seniors in Medicare who
9 trust and rely upon the promise that Medicare will be
10 there for them in their golden years.

11 This bill covers 94 percent of Americans and will
12 provide stability for those who currently have coverage,
13 whether or not they choose to keep it. It is not
14 perfect. We all know that. But the America's Healthy
15 Future Act is a great step in the right direction.

16 We still have a number of steps to take, and we must
17 stick with it, Mr. Chairman, and I know through your
18 leadership and others on the Committee, as we move
19 towards the floor, we are going to do just that.

20 This bill builds on programs that work, like
21 Medicaid and CHIP, to ensure our most vulnerable and our
22 children are taken care of. Similar to the Small
23 Business Health Options Program, or the SHOP Act, that I
24 introduced with Senators Snowe and Durbin, the bill
25 allows small businesses, the self-employed, and other

1 individuals the ability to shop for coverage among a
2 number of health insurance plans and co-ops that compete
3 against one another. And I want to again thank you, Mr.
4 Chairman, for working with me on the small business
5 provisions and for continuing to work with me to improve
6 the small business tax credit.

7 This bill changes the status quo so that insurance
8 companies work for the consumer and not the other way
9 around. It prohibits insurance companies from denying
10 coverage based on pre-existing conditions. It prevents
11 them from increasing your rates just because you get sick
12 and from imposing arbitrary lifetime and annual limits on
13 coverage. And it ensures that health insurance
14 executives at these companies will not see any personal
15 windfall from a Government mandate.

16 The 11th hour attempt by the health insurance
17 industry to discredit this bill should be proof enough to
18 the American public that this reform is about the
19 American people who need relief and not about the
20 industry.

21 We know that this historic moment is but one step in
22 a long process that began in this Committee nearly 22
23 months ago, and that it will continue for weeks and
24 months to come before a bill can be signed into law.
25 Rest assured, Mr. Chairman, my support for a health

1 reform package at each step in this process will depend
2 on how it benefits Arkansans, and my support today does
3 not ensure my support for a final product that strays far
4 from the good work from the leadership of Chairman Baucus
5 and the Committee and what we have done here. And the
6 questions I will ask to determine my support about the
7 future versions is going to be: Does it increase the
8 deficit? Does this legislation promote choice and
9 competition, quality and lower cost, as my colleague
10 Senator Wyden has worked so hard for?

11 Does the legislation protect our seniors? And does
12 it curb the rising costs of health insurance coverage in
13 the long term?

14 And, finally, I have heard from many of our
15 constituents in Arkansas who have good ideas and they
16 want to be a part of this process. They would like the
17 opportunity to see this legislation both in our plain
18 English version and in its entirety in the form of full
19 legislative language. And I, along with seven other of
20 our colleagues in the Senate, have requested that Leader
21 Reid ensure the complete bill language and CBO scores are
22 available online before we proceed to the vote on the
23 bill and before its final passage, and that all
24 amendments be made publicly available.

25 Mr. Chairman, in closing--

1 The Chairman. I am going to have to ask you wrap
2 up.

3 Senator Lincoln. Certainly. In closing, I just
4 hope that we will remember that Americans out there are
5 frightened. I know in my home State during the month of
6 August in those town hall meetings, it was clear they are
7 alarmed. They are alarmed about our deficit in this
8 country, as they should be. And they are alarmed about
9 big bills that are difficult for them to understand, and
10 they need to have time to look at them, just as we do, to
11 take our time and to ensure that we get it right.

12 Mr. Chairman, I applaud you for your commitment to
13 health care reform and look forward to continuing to work
14 with you to make sure this bill ultimately does what we
15 set out to do: create stability in our health care
16 system with better quality and lower costs for families,
17 businesses, and our seniors.

18 Thank you, Mr. Chairman.

19 The Chairman. Thank you, Senator.

20 Okay. That completes our first round. Next,
21 Senator Grassley.

22 Senator Grassley. For CBO, I want to refer to
23 Senator Conrad pointing out that CBO's analysis says that
24 the Committee bill "if enacted, would reduce Federal
25 budget deficits over the ensuing decade relative to those

1 projected under current law," that is, in a broad range
2 between one-quarter percent and one-half percent. So
3 could you please tell us whether this projected deficit
4 reduction includes the interest on the national debt?
5 And if so, how much of the total is attributable to
6 interest savings and how much is attributable to
7 increased taxes or further Medicare cuts?

8 Mr. Elmendorf. So, Senator, that number, like all
9 of our cost estimates, is about the non-interest
10 components of the Federal budget. We do not incorporate
11 in our cost estimates the effects on interest payments.
12 We do include those, of course, in new baseline
13 calculations and so on. But this figure was--like our
14 cost estimates--about the non-interest components.

15 Senator Grassley. Okay. Dr. Elmendorf, rather
16 than having you answer what I think would be short
17 answers, I am going to give you my figure of the question
18 I have and only interrupt me if I am wrong, would you?
19 Because I think I know what the answers are, but I have
20 got some things I want to point out.

21 Mr. Elmendorf. Okay, Senator.

22 Senator Grassley. Based on your September 15th
23 analysis prior to the beginning of the markup, what was
24 the gross cost of coverage provisions of the Finance
25 Committee proposal and what percentages of legal

1 residents were covered? I think those numbers are \$774
2 billion and 94 percent.

3 Then going on, based on your most recent analysis,
4 what is the gross cost of the coverage provisions of the
5 Finance Committee proposal now? And what percentage of
6 legal residents are covered? I believe the answer is
7 \$829 billion and 94 percent.

8 So the coverage portion of the bill costs about \$55
9 billion more now than it did a few weeks ago, but the
10 same amount of people would still not have insurance. So
11 based upon the most recent analysis, how many total
12 people in the United States are still uninsured by 2019?

13 And I believe that is about roughly 25 million people.

14 Mr. Elmendorf. Yes, Senator.

15 Senator Grassley. Okay. So after spending close
16 to \$1 trillion, we see only about a 10-percent increase
17 in the number of people insured. But, put another way,
18 we still have about 25 million people living in the
19 United States 10 years from now not insured.

20 Question: What is the total amount of Federal
21 subsidies going to pay for private health insurance? I
22 believe \$461 billion. Okay. What is the income limit
23 for subsidies under the amended mark? I believe 400
24 percent.

25 Mr. Elmendorf. Of the Federal poverty level, yes,

1 Senator.

2 Senator Grassley. So that is about \$88,000 for a
3 family of four today rising to close to \$100,000 in
4 income in 2016. What is the total amount of fines
5 imposed as the excise tax is paid by people who do not
6 buy insurance? And I believe that is about \$4 billion.

7 Mr. Elmendorf. Yes, over the 10-year window,
8 Senator, yes.

9 Senator Grassley. Okay. Thank you. What is the
10 total amount of fines imposed as an excise tax paid by
11 employers from the free rider proposal? I believe that
12 is about \$23 billion.

13 Mr. Elmendorf. The penalty payments will be \$23
14 billion.

15 Senator Grassley. Okay. What is the total cost of
16 the Medicaid expansion under the amended mark? I believe
17 that is about \$345 billion.

18 Mr. Elmendorf. Yes, the increase in Medicaid and
19 CHIP outlays.

20 Senator Grassley. Okay. In comparing current law
21 to the amended mark, how many more people are in the
22 Medicaid and CHIP program? And I believe that that is
23 about 14 million when it is implemented. So about half
24 of the newly insured people under the Chairman's mark are
25 in taxpayer-funded Government programs. What is the

1 total amount of cuts in Medicare and Medicaid in the
2 amended mark? And I believe that is about \$404 billion.

3 Mr. Elmendorf. Yes, Senator.

4 Senator Grassley. The total amount of cuts in
5 Medicare Advantage is \$117 billion. The new tax on high-
6 cost plans will raise \$201 billion. And so how much of
7 this most recent score was based on legislative language?

8 And you have told us that you cannot do that until you
9 get the legislative language. So none has been based
10 only on the legislative language.

11 So my last statement, because my time is up, would
12 be to say for everyone paying attention to this meeting
13 that we are having, just to repeat from what I heard,
14 none of this score is based on legislative language, but
15 if CBO interpreted the conceptual language correctly, we
16 are spending \$829 billion to increase coverage and paying
17 for it with increased taxes and the largest cuts to
18 Medicare in history. By 2019, we are providing Federal
19 subsidies to families with an income of almost \$100,000.
20 And we are proposing the largest single expansion of
21 Medicaid in history, even though States cannot afford
22 what they already have and have to cover. We are fining
23 people who do not buy insurance with excise taxes to the
24 tune of \$4 billion, and when it is all said and done, 25
25 million people will still not have any insurance.

1 I yield the floor.

2 The Chairman. Thank you, Senator.

3 Senator Rockefeller, you are next.

4 Mr. Chairman, you and I have worked out an
5 agreement, and that is that my closing statement is a
6 little bit longer than some of the others, and so what I
7 am going to do is I am going to divide it in half, which
8 is a bit awkward. It is not the Wyoming way. But,
9 nevertheless, that is the way it has to be.

10 I want to start out my remarks by saying something
11 which is so simple, but I think it has the necessary
12 clarity. Bluntly stated, health reform is about making
13 people's lives better. It is about people's lives,
14 making them better, and it is about providing all
15 families tangible solutions that make a difference in
16 their day-to-day lives through good times and bad.

17 Health care reform is about the everyday folks of
18 West Virginia and Arkansas and all the other States
19 around this table, and many that are not. And they are
20 expecting us to fight for them. This is not sort of a
21 tricky little exercise. And health care reform is about
22 eliminating once and for all that horrifying feeling that
23 so many people live with when they go to bed and wake up
24 each day, that feeling of walking a tightrope, fearing
25 that one accident, one illness, one misstep could send

1 them over the edge without any support. That is the
2 reality of so many of the people that I represent.

3 The status quo every American knows to be in our
4 broken system is not what we must do. The status quo is
5 sending us backwards, and the status quo is going to get,
6 I suppose, plenty of votes here today. But it is not the
7 best we can do. It is not even close.

8 So over the last 3 weeks, we have considered scores
9 of amendments, engaged in hours of debate. That is in
10 itself progress, I suppose. But as we all know, our
11 success will not be measured in terms of time and effort.

12 It will be measured in terms of what the American people
13 will be in terms--as our real judges of how well we have
14 done or not done, and that is the way it should be.

15 I have made no secret of the fact that I think we
16 could have dug deeper, gone more creative, and worked
17 together much better. It is regrettable to say so, but I
18 believe the bill before us still falls short of what
19 people need and what people expect from us.

20 Mr. Chairman, allow me to expand just a bit on some
21 areas of concern and pleasure.

22 Some will point to the 29 million people that we do
23 insure as strong evidence that this is a good bill. And
24 I cannot argue with that because we are constrained by
25 money. But I am constrained to point out that 29 million

1 that have not been covered that are now covered is not
2 45, much less the 25 that are underinsured. So that
3 needs to be said.

4 Would I want to spend the money? Of course I would.

5 But we cannot do that, and I understand that, but it
6 needs to be said that we are not doing what we set out to
7 do. It is a step in the right direction, but it is not
8 enough.

9 Universal coverage has always been the goal of
10 health reform, and leaving 16 million men and women and
11 children uninsured is wrong, to me, as the Senator from
12 West Virginia.

13 Public programs. With respect to Medicaid and CHIP,
14 these are two public programs that work and work well. I
15 am appreciative of the Committee's support for preserving
16 CHIP for children; however, I remain very concerned about
17 the benefit levels for children in the State exchanges
18 and about many of the changes to Medicaid included in
19 this bill.

20 For children, the HELP bill requires insurance
21 offered in the exchange to cover preventive services and
22 full pediatric health services, including oral and vision
23 care, new child health quality measures, and coverage of
24 dependent children up to the age of 26. The HELP bill
25 also provides a full Medicaid expansion to 150 percent of

1 poverty.

2 Unlike the HELP bill, this bill does not go far
3 enough to protect vulnerable populations. We need to
4 move away from provisions that create a two-tiered
5 Medicaid program and put low-income people at the mercy
6 of private plans. Medicaid should be the foundation of
7 care for our most vulnerable citizens, not a political
8 bargaining chip for insurance companies--or for
9 Governors, for that matter.

10 Despite the improvements made--Mr. Chairman, my time
11 is up.

12 The Chairman. Thank you, Senator.

13 Next I have--let me see. Senator Hatch, you are
14 next.

15 Senator Hatch. Well, thank you, Mr. Chairman, and
16 I want to compliment you on the graciousness and kindness
17 you have had throughout this whole process, and it has
18 been a very difficult one for you. I know that. I know
19 those long debates and long meetings were very, very
20 difficult. But I am appreciative of you.

21 Dr. Elmendorf, I appreciate you, too. I believe you
22 are a very honest man and a very good leader for our
23 Committee. But let me just say this: We have all heard
24 the alarming statistics on the skyrocketing health
25 insurance premiums. This is one of the main reasons

1 behind the call for health care reform.

2 Now, as you can imagine, there is a significant
3 overhaul of the health insurance market in this bill, and
4 the impact on premiums is a crucial and significant area
5 of concern for members of this Committee. Hopefully I am
6 speaking for members of both sides of the aisle that no
7 one would want health insurance premiums to rise more
8 dramatically under this bill than they are doing now and
9 make coverage unaffordable for certain portions of
10 Americans.

11 I would think we would all like to honor the
12 President's pledge that you get to keep what you have.
13 In the past, in several prominent health care bills CBO
14 has provided Congress with an analysis of premium impact
15 of those policies, just to mention a few: in 1994, the
16 Health Security Act; in 1999, the Patients' Bill of
17 Rights; the 2001 bipartisan Patients' Bill of Rights Act;
18 the 2001 Mental Health Equitable Treatment Act; the 2006
19 Small Business Health Plan Act; in 2007, the Mental
20 Health Parity Act of 2007, just to mention a few of them.

21 Now, here we have a bill that will affect one-sixth
22 of our entire economy along with every American life and
23 business. It is probably bigger than the entire list I
24 just read to you. In your most recent analysis of this
25 report, there was one very, very important piece missing,

1 and that was the impact of these policies on premiums.

2 Now, I know that this is not a matter of oversight
3 on your behalf but, rather, a function of time. At least
4 that is my belief.

5 Now, the process is moving too fast and the demands
6 on your were too high for you to give us a clear
7 understanding of what we are going to do to premiums of
8 millions of Americans who have coverage. Now, if I could
9 just get yes or no answers to these, if you can, I would
10 appreciate it.

11 Has CBO done a premium impact analysis on this bill?

12 Mr. Elmendorf. No, Senator.

13 Senator Hatch. Okay. Has it done a premium impact
14 analysis in the past on these other bills?

15 Mr. Elmendorf. I do not know the whole list, but
16 we have certainly done that sort of analysis in the past,
17 yes, Senator.

18 Senator Hatch. All right. But you have not done
19 it here.

20 Mr. Elmendorf. No, we have not.

21 Senator Hatch. Okay. If you were given more time
22 to truly inform the members of this Committee about the
23 premium impact of these policies on our constituents,
24 would you be able to provide it for them as you have done
25 in the past for legislation?

1 Mr. Elmendorf. With sufficient additional time,
2 yes, Senator. As you noted, the scope of this bill is so
3 much broader, and that is precisely why that sort of
4 analysis is much more difficult than it has been for CBO
5 for some of the previous legislation that we have done.

6 Senator Hatch. But if you had more time, you would
7 be able to--

8 Mr. Elmendorf. With sufficient time, yes, Senator.

9 Senator Hatch. See, one of the gripes that we have
10 on this side is that we have just been ramming this
11 through no matter what. Now, I understand why the
12 majority is trying to do that, because this does contain
13 a lot of--you know, it is a very, very complex and very,
14 very difficult matter to put forward. But I think we
15 ought to at least have that type of information, and I
16 certainly think you certainly have the capability of
17 giving it to us if you had the time to do it.

18 Mr. Elmendorf. Yes.

19 Senator Hatch. Now, Mr. Barthold, I understand
20 that the Joint Committee on Taxation staff has prepared
21 an analysis of the effect of marginal tax rates under the
22 Chairman's mark. Based on a table showing the marginal
23 tax rates for a family of four under the mark in 2013,
24 the combined effective income, payroll, and premium
25 marginal tax rate would be 59 percent on those making 150

1 percent of the Federal poverty level.

2 Now, so that I understand, does this mean that if a
3 family is making around \$34,000 per year, the marginal
4 effective tax rate would be almost 60 percent?

5 Mr. Barthold. Senator Hatch, some staff had asked
6 us to make some calculations of effective marginal tax
7 rates due to phase-outs of provisions. As you are aware,
8 in the mark there is a phase-out of the subsidies, the
9 exchange subsidies. Under present law, there is a phase-
10 out of the earned income credit. In addition, there is
11 the regular statutory tax rates for both the payroll tax
12 and the income tax.

13 Senator Hatch. So what would the effective
14 marginal tax rate be?

15 Mr. Barthold. The effective marginal tax rate for
16 a person--a family of four with a wage income of \$34,200
17 would be 59 percent.

18 Senator Hatch. Almost 60 percent.

19 Mr. Barthold. I just wanted to be clear on what
20 the components of that were and that it arises from the
21 phase--

22 Senator Hatch. In other words--

23 Senator Rockefeller. [Presiding.] The Senator's
24 time is up.

25 Senator Hatch. All right. I would be happy to

1 quit. I would ask unanimous consent that my full remarks
2 be placed in the record since I did not have time to give
3 them.

4 Senator Rockefeller. It will be done.

5 [The prepared statement of Senator Hatch appears at
6 the end of the transcript.]

7 Senator Rockefeller. Senator Conrad?

8 Senator Conrad. Again, I want to thank not only
9 the Chairman, I would also like to thank the staff on
10 both sides because as I look back on this process of over
11 a year, staffs have spent many, many weekends working,
12 many, many nights working until late. Our Group of Six,
13 I am told, met 61 times. Many of those times the staff
14 had to rearrange their schedules in order to accommodate
15 the work of the members of that group. I do not think
16 they get enough credit for the extraordinary effort that
17 they -- both Republican and Democratic staffs -- have
18 made on this legislation, and they should be thanked.

19 I would like to talk for just a minute about the
20 question of public option and the effect of public option
21 when it is tied to Medicare levels of reimbursement.

22 My State has the second lowest level of Medicare
23 reimbursement, and so if one ties public option to
24 Medicare levels of reimbursement, which is what the
25 committee of jurisdiction did in the House, which some of

1 the amendments considered here would do as well, that has
2 very serious consequences for not only my State, but for
3 other low-reimbursement States, as well. And I have had
4 the continuing dialogue with people back in my home
5 State, and I have had people tell me, well, you ought to
6 support public option because the Medicare levels of
7 reimbursement can be changed.

8 I would just ask them to consider that Medicare
9 levels of reimbursement and the current formulas have
10 been in place for many years, and there is a reason that
11 they are the way they are. The House of Representatives
12 is based on population. The membership is based on
13 population. And so the big-population States have a
14 disproportionate number of members in the House of
15 Representatives.

16 For anyone to say, well, Senator, just change
17 Medicare levels of reimbursement: I have been here 23
18 years, and I have managed to get them changed once in 23
19 years. The opportunity I had to get them changed was in
20 the Medicare prescription drug bill debate when there was
21 new money on the table, and in that circumstance of the
22 \$20 billion that was available for allocation over and
23 above what was required for Medicare prescription drugs,
24 there was about \$20 billion left available for
25 allocation, and rural areas got a disproportionate share

1 of that amount to try to narrow the gap between where we
2 were compared with the higher-population States.

3 Let me just say that these changes still leave us
4 with an extraordinary disparity. My State gets one-half
5 as much in Medicare reimbursement as some of the highest
6 population States in this country to treat people with
7 the exact same illnesses, the exact severity of illness.

8 Our State gets one-half as much. The same is true of
9 Senator Enzi's State, Senator Roberts' State, maybe true
10 of others' as well.

11 And so when people tell me they are going to have a
12 public option and it is going to be tied to Medicare
13 levels of reimbursement, that has got very significant
14 consequences for the State that I represent. Very
15 significant. Because if all of our reimbursement was
16 tied to what is the second lowest level in the country,
17 the continuing operation of our hospitals would be at
18 risk. Every hospital administrator in my State who has
19 talked to me about this issue has said this would
20 threaten the viability of their institutions. Every
21 single one.

22 The medical association at home has told me it would
23 be a significant threat to doctors and attracting doctors
24 to our State. Attracting doctors to a rural State like
25 mine is already a significant challenge. In fact, MedPAC

1 says it takes more money to attract doctors to my State
2 than to the more populous States on the east and west
3 coast.

4 It is also true that in my State, when we go to buy
5 technology, we do not get a rural discount. They do not
6 say, "Gee, we see you only get half as much under
7 Medicare, so we will give you a discount."

8 The same is true when we go to attract a doctor or
9 nurse. They do not say, "Gee, we see you get half as
10 much, so we are going to be glad to come there for half
11 as much money." It does not work that way.

12 So I just want to enter this into the record and
13 make very clear that public option tied to Medicare
14 levels of reimbursement is a non-starter for me because I
15 represent North Dakota. I do not represent some other
16 State. I represent--and I am proud to do so--the State
17 of North Dakota. And they did not send me here to come
18 back with a result that would fundamentally threaten the
19 health care system of my State.

20 I thank the Chairman.

21 The Chairman. Thank you, Senator.

22 Senator Snowe.

23 Senator Snowe. Thank you, Mr. Chairman. I first
24 want to thank you for guiding a process which has enabled
25 us to examine and to consider what may be the most

1 complex issues to come before this Committee. This
2 Committee has gone further than ever before in attempting
3 to blaze a pathway towards affordability for all
4 Americans that has eluded us for decades, if not a
5 century.

6 To your credit, Mr. Chairman, you have predicated
7 this process on substance rather than politics, and it
8 has been remarkable for the absence of rancor, and that
9 is a tribute to you and to Senator Grassley, who also
10 shares an abiding concern for health security for
11 Americans and who has thoughtfully and constructively
12 offered myriad approaches to the bill before us.

13 Indeed, the last 2 weeks we have considered more
14 than hundreds of amendments. We have heard legitimate
15 proposals from both sides about the proper role of
16 Government in providing the answers. I think it is clear
17 we all struggle with the appropriate equilibrium. But I
18 do not think that there is any doubt that everyone here
19 is sincere in the solutions that they espouse and that we
20 all recognize that there is a problem.

21 In that light, as we contemplate the course of our
22 action here today, we should also contemplate the decades
23 of inaction that have been brought us to this crossroads.

24 Indeed, with one in four Americans either uninsured or
25 underinsured, the track record is clear. The status quo

1 approach has produced one glaring common denominator, and
2 that is that we are having a problem that is growing
3 worse, not better.

4 Skyrocketing health care costs have driven up
5 premiums, having the potential to send the entirety of
6 our health care system into a death spiral because costs
7 are outpacing inflation two to three times. We are
8 seeing employer-provided coverage is predicted to reach
9 \$30,800 a decade from now. We can anticipate spending
10 \$33 trillion over this next decade.

11 It is really akin to the Titanic, and turning the
12 Titanic around before it hits an iceberg. But the
13 difference is that the captain did not know there was an
14 iceberg, but we do.

15 At the same time, people are duly apprehensive about
16 what Congress will do in reforming a system that provides
17 the best-quality care in the world. They are concerned
18 it might result in Government takeover of health care.
19 They are understandably troubled about what reform will
20 mean to them. And they also rightly question as to
21 whether or not this is the appropriate point in time
22 given our state of the economy to take this undertaking.

23 They also question Congress' ability to get it right.

24 And that is why I have argued vehemently,
25 consistently, and persistently, as the Chairman knows,

1 against arbitrary deadlines, and I have communicated that
2 to the President as well, because I think that we
3 understand that these issues are complex, and most
4 certainly the American people intuitively understand that
5 this issue is not only complex, it is costly; and given
6 the enormity of the task, that it should take time. And
7 that is exactly what we should give it.

8 And if there is anything that I have learned over my
9 more than 30 years of legislative experience, the best
10 way to allay people's concerns is to systematically
11 address these issues, their views, their viewpoints, and
12 the alternatives.

13 Now, the mark before us produces some bipartisan
14 landmark reforms, which is to end the unfair, flagrant
15 insurance practice policies that have devastated
16 Americans for decades. We are familiar with them:
17 rescinding policies when people get ill, rating premiums
18 on the basis of health status or gender, or not providing
19 coverage to Americans and denying that Congress so that
20 not every American has the ability to access affordable
21 health care.

22 This bill also does navigate ideologies. It
23 bolsters what works in the system and engenders quality
24 and competition, lowering premiums, achieving savings,
25 which is critically important, as well as changing the

1 accelerating cost curve of health spending.

2 In addition, it creates individual and small
3 business exchanges, which Senator Lincoln and I have
4 worked on, along with Senator Durbin, in creating small
5 business health insurance reform. This is critical
6 because it will create a powerful marketplace for
7 creating that competition and lowering premiums, which is
8 so critical, by providing access for the very first time
9 to national plans that will be offered across all State
10 lines and all 50 States, which I proposed because I think
11 that that is going to be so important in injecting
12 competition in the marketplace.

13 I am also pleased that this mark includes a
14 provision to expand low-income affordability for people
15 in the exchanges, adding significant numbers of small
16 businesses that will have access to the exchanges
17 immediately, which is also going to be critical in
18 creating and enhancing the power of these exchanges. As
19 CBO has indicated, these exchanges will help tens of
20 millions of Americans to have insurance and to achieve
21 savings in coverage.

22 At the same time, I have shared my Republicans'
23 concerns about vast governmental bureaucracies and
24 governmental intrusions. That is why I opposed the
25 amendment for the so-called public option. I co-authored

1 an amendment with Senator Schumer regarding reducing the
2 threshold for the individual mandate penalty and
3 requiring Congress to review and reassess that mandate
4 altogether. I happen to think that is an issue we should
5 continue to revisit because the onus should be on the
6 Government to achieve and accomplish the primary goal of
7 this legislation, which, of course, is affordability.

8 Undeniably, affordability remains and continues to
9 remain my paramount concern. I think that if there is
10 anything that we have to do, Mr. Chairman, it is to
11 continue to wrestle with that issue to absolutely ensure
12 that all Americans have access to affordable health
13 insurance plans and that we absolutely know that they are
14 affordable. And I know the charts that the CBO has
15 produced demonstrates that if you start to compare the
16 different plans and what people will be able to access
17 for affordable health insurance with the tax subsidies
18 and the tax credits. Absolutely imperative, and it will
19 produce change. But we have to make sure that it is
20 absolutely guaranteed.

21 Other concerns I have is Medicaid expansion, its
22 implication for future State budgets; Medicare
23 reimbursement, particularly as it affects home health
24 care; nursing homes, they do not realize the benefits
25 that other providers will do because of the reduction of

1 the number of uninsured and uncompensated care. And I
2 have other issues as well. It is not an exhaustive list.

3 So is this bill all that I would want? Far from it.

4 Is it all that it can be? No. But when history calls,
5 history calls, and I happen to think that the
6 consequences of inaction dictate the urgency of Congress
7 to take every opportunity to demonstrate its capacity to
8 solve the monumental issues of our time.

9 As I have said throughout this process and through
10 the Group of Six, there are many, many miles to go in
11 this legislative journey. As one national story
12 characterized it recently, people do have concerns about
13 what we will do with reform; but at the same time, they
14 want us to continue working. And that is what my vote to
15 report this bill out of Committee here today represents.

16 It is to continue working the process.

17 I do it with reservations because I share my
18 Republican colleagues' trepidation about what will
19 transpire on the Senate floor, what will emerge in the
20 House-Senate conference, and how indeed the Finance
21 Committee bill will be merged with the HELP bill. And on
22 that point I want to be perfectly clear, Mr. Chairman. I
23 happen to believe that as the Finance bill is integrated
24 with the HELP bill, we have to absolutely be sure that it
25 is done in strict accordance with the CBO's

1 interpretation of the Finance Committee's provisions.
2 That is absolutely essential so that we maintain the
3 integrity of the score of the mark before us and on those
4 provisions that are part of that legislation.

5 Secondly, before I vote on a motion to proceed to
6 consider the unified bill, the merged bill between HELP
7 and the Finance Committee, I certainly think we should
8 have a final CBO score on the statutory language that is
9 available on public websites so everybody has a chance to
10 review it. That is consistent with what my Republican
11 colleagues have argued for. It is what Senator Lincoln
12 initiated in a letter to the Senate Majority Leader,
13 along with seven other Democratic Senators. It is
14 certainly my bottom line as well.

15 Finally, I say that my vote today is my vote today.
16 It does not forecast what my vote will be tomorrow. As
17 Henry Wadsworth Longfellow said, a fellow Mainer, he
18 said, "Great is the art of the beginning, but greater is
19 the art of the ending."

20 So as this process goes forward, I hope that we give
21 due deference to the scope and the complexity of the
22 issue before us and that we do everything possible to
23 develop a greater propensity for bipartisanship and
24 achieving broader support for this legislation and resist
25 the temptations and the impulses to retreat into

1 partisanship.

2 The majority has the votes. It has the votes in the
3 House. It has the votes in the Senate. So it should not
4 be about the mathematics of vote counting but, rather,
5 the mechanics of getting the best policy, because, after
6 all, one-sixth of our economy, the health security and
7 the financial well-being of all Americans, should not be
8 at the mercy of a one-vote-margin strategy. I happen to
9 believe the credibility of the process will dictate the
10 credibility of the outcome.

11 I recall, Mr. Chairman, when you convened this
12 Committee early on this year on the first meeting
13 regarding health care reform and you indicated it was
14 your foremost priority, you also expressed a desire to do
15 everything we could to achieve broad bipartisan support.

16 And I know that that goal has eluded us here today, but
17 it is something that we should continue to make it
18 happen. I think that it would certainly engender the
19 confidence of the American people.

20 Thank you, Mr. Chairman.

21 The Chairman. Well, thank you, Senator, for that
22 very thoughtful statement. It will be well remembered,
23 and I thank you for it.

24 I might also say that your admonition and your
25 persistence in many, many areas, but one on process, is

1 one that I plan to adhere to when we move forward trying
2 to merge the bills together and also before we have a
3 vote, before we move to proceed. I think you are
4 absolutely correct. The Senate deserves and the American
5 people deserve to have a score on the final bill before
6 we proceed to vote on the floor, and I just thank you
7 very much for heightening that need for transparency and
8 due diligence to make sure we are doing the right thing
9 here. So thank you very, very much for that.

10 Senator Kyl, you are next.

11 Senator Kyl. Mr. Chairman, all of us here support
12 health care reform, but the bill we have before us is not
13 one that I can support. Americans have real concerns,
14 and we should listen to what they are saying. Americans
15 are concerned about the cost of their health care
16 premiums, and yet according to studies, including
17 estimates of the Congressional Budget Office, new
18 Government-forced mandates in this bill will raise
19 premiums on American families.

20 They are worried about the exploding debt, a new
21 record deficit, and out-of-control spending, and yet this
22 bill spends nearly \$1 trillion on a massive new
23 entitlement that we cannot afford.

24 Americans like the wide variety of health care
25 choices they have now, and the overwhelming majority are

1 happy with their current plans. But this bill eliminates
2 many of those choices, including seniors' choices because
3 of deep Medicare cuts, and it violates the President's
4 pledge that happily insured Americans get to keep what
5 they have.

6 It also violates the President's pledge not to
7 increase taxes on middle-income families. Many middle-
8 income families, including the chronically ill, will see
9 a tax increase under this bill.

10 Finally, the bill leads to the rationing of health
11 care, something all Americans, but especially seniors,
12 have told us they are worried about. Because our time
13 today is limited, I cannot discuss each of these concerns
14 and why they are all so important, but let me at least
15 discuss two in particular: the effects of Medicare cuts
16 and rationing.

17 Seniors are very worried about Medicare cuts, and we
18 should take their concerns seriously. CBO estimates this
19 bill cuts Medicare spending by \$449.4 billion over 10
20 years. Hundreds of billions of dollars will be cut from
21 hospitals, nursing homes, home health providers, and
22 hospice care. Nearly \$120 billion would be slashed from
23 Medicare Advantage. You cannot make such massive cuts
24 without limiting seniors' care. Seniors like the choices
25 they now have, and they do not deserve to have them

1 ripped away to help pay for this bill.

2 This bill, in fact, leads to rationing in several
3 ways. It sets up a Medicare Commission which would have
4 the power to automatically cut Medicare spending unless
5 Congress acted to stop the cuts. Arbitrary payment cuts
6 to already low provider reimbursements create shortages
7 and, therefore, result in the delay and denial of care.

8 One of the ways this will occur is explained in the
9 Wall Street Journal. Beginning in 2015, Medicare would
10 rank doctors against their peers based on how much they
11 cost the program, and then automatically cut payments by
12 5 percent to anyone who falls into the 90th percentile or
13 above.

14 So every year, one in ten physicians would be
15 punished for ordering what the Government says is too
16 many tests, treatments, or medications for their
17 patients. This provision applies immense pressure on
18 physicians to cut costs and provide less care rather than
19 provide the care that leads to the best outcomes.

20 Specialists who make use of the more expensive procedures
21 and technology to treat seniors and the chronically ill
22 would be most affect. This is rationing, and it is
23 wrong.

24 Direct rationing can occur when the HHS Secretary
25 uses comparative effectiveness research to make coverage

1 decisions, as the bill directs. Nothing in the bill
2 protects Americans against this rationing, despite the
3 fact, I would add, that there were numerous Republican
4 amendments to ensure such a protection were defeated.

5 Republicans believe Americans deserve a better
6 approach to health care reform. We want to address the
7 problems of cost and access with a patient-centered
8 approach that targets solutions to specific problems.
9 Many of our proposals to drive down costs and increase
10 access, including medical malpractice reform, association
11 health plans, and allowing people to buy health care
12 policies across State lines, would not cost a dime. I
13 had hoped such sensible measures would be included in the
14 final bill, but our amendments were rejected on party-
15 line votes.

16 The whole point of health care reform is to make
17 things better for Americans. The bill fails that test
18 while imposing huge costs and limiting choices, and that
19 is why it should be rejected.

20 Mr. Chairman, there is a final reason that we should
21 not support the bill right now, and that is because the
22 bill that the CBO has scored is not the Chairman's mark
23 but, rather, it is based on assumptions that the staff
24 has made and on a technical corrections list that the
25 staff has presented to the CBO which this Committee has

1 never voted on. So my suggestion would be at the
2 appropriate time that we take the technical corrections
3 list and vote on it, just like we do on the floor, and if
4 it passes, it then becomes part of the bill and would be
5 scored by the CBO. If it does not pass, then the CBO, as
6 acknowledged by Dr. Elmendorf here this morning, would
7 have to revise its estimates. Until we know whether or
8 not the technical corrections are, in fact, adopted by
9 the Committee, we will not know what the estimate of the
10 CBO is, and, therefore, it would be inappropriate for us
11 to vote on the bill.

12 So, again, I hope that at the appropriate time the
13 Committee will at least have an opportunity to vote up or
14 down on the so-called technical amendments, which could
15 have a significant result on the analysis of the
16 Congressional Budget Office.

17 The Chairman. Thank you, Senator.

18 Senator Cantwell is here. We welcome the Senator.
19 You are next to be recognized, but I think it is only
20 appropriate that, in the tradition of this Committee, we
21 honor you by singing you "Happy Birthday."

22 [Singing.]

23 Senator Cantwell. Thank you. Thank you, Mr.
24 Chairman. I thought for a while there that maybe
25 everybody on this Committee would celebrate their

1 birthday as we walked through health care reform.

2 [Laughter.]

3 Senator Cantwell. But I am glad it has only been
4 three or four of us.

5 I do want to thank you, Mr. Chairman, for your hard
6 work and diligence on this legislation. As I have said
7 before, you are a distance runner, and not only does the
8 movement of this legislation to the floor show that you
9 know how to get over the finish line, that you are
10 persistence will help us continue to improve this bill,
11 so I thank you for that.

12 I want to thank your staff as well for their hard
13 work in including many provisions that we fought for from
14 the Northwest, and also my staff member Mark Iozzi, who
15 has worked very hard on this, who I have tried to
16 convince that--I think he is going to go join the Peace
17 Corps after this, but passing memorable health care
18 legislation is also a way to change the direction of
19 lives of many Americans and people, so I hope he thinks
20 about that.

21 Mr. Chairman, there has been a lot lately in the
22 newspaper that somehow there is surprising new
23 information about the rising cost of health care or
24 trying to paint this bill as a bill that is going to
25 increase the cost of health care. The big secret around

1 here that enough people do not dwell on is the fact that
2 these costs are going to go up 7.9, 8 percent a year in
3 premiums if we do nothing. And while I want to work for
4 further changes on the floor, more competition, like the
5 Leahy bill that allows cross-State premiums without
6 slashing the benefits, or looking at expanding public
7 option or looking at ways to expand the basic health plan
8 provisions that I put into the bill, the bottom line is
9 that this bill does make significant changes to the way
10 we are going to control costs moving forward.

11 For the first time in 2013, instead of seeing that
12 number of increase go from 7.9 percent in premiums, we
13 are going to see the premium increase be kept close to
14 the rate of inflation. That is quite significant. For
15 the first time in decades, instead of seeing premiums go
16 through the roof, they will be kept more in line with the
17 rate of inflation.

18 Now, the question for all of us is how do we improve
19 on that so that that trend continues beyond 2013 and that
20 we continue to make the improvements to reduce costs.
21 But this legislation with the Medicare reforms--and one
22 of every \$5 health care is Medicare spending, so we are
23 going to have a 5-percent reduction in the first 10 years
24 of this bill and a 15-percent reduction for every year--
25 15 percent savings every year in the second 10 years of

1 this plan under Medicare. I cannot emphasize enough how
2 important that is in reducing the health care cost curve.

3 There are long-term care reforms in here that I have
4 spoken to and sponsored. The fact that just deferring 5
5 percent of the American people off of nursing home care
6 and into community-based care can save \$10 billion in a
7 10-year window, or the idea of the basic health plan that
8 I know for sure in the State of Washington, because of
9 negotiation by the State, has driven down the cost of
10 health care by between 35 and 40 percent for the people
11 in that plan.

12 So these are the things that are in this proposal
13 that are the start of reforms that can help us in saving
14 health care costs for Americans. But the issue is that
15 there is a lot of discussion by the insurance industry,
16 and I believe the insurance industry has a right to make
17 a profit. And, in fact, they have made a pretty good
18 profit. They have made something like a 428-percent
19 increase in the last 10 years. And I know that they are
20 used to making that profit, but there is nothing that
21 says that that industry has to continue to make that
22 level of profit because we have not enforced the kind of
23 competition that will help Americans receive affordable
24 health care.

25 The fact is that this industry profit has grown to

1 \$200 billion, \$3.5 billion of which they have spent on
2 lobbying Members of Congress. In fact, according to a
3 Vanity Fair article, they have spent \$263 million in the
4 first 6 months of this year. That is six lobbyists for
5 every Member of Congress and millions of dollars spent on
6 lobbying them.

7 So we can decide we are going to let the trend
8 continue of increased premiums and let the industry have
9 its way in fighting against this bill, or we can decide
10 to do something to move ahead on those comprehensive
11 reforms that I just discussed that are part of getting
12 the costs down in the future. I think that we should
13 move ahead.

14 I know that there was a resident of my State, Bo
15 Melman, in Spokane, Washington, who had a heart condition
16 at 23 years old and could never get insurance. In fact,
17 he ended up getting \$893,000 in medical bills for his two
18 heart surgeries taken care of by an organization called
19 Project Access. But what has happened since he got his
20 care is that Project Access, because it had both State
21 and county funding and private sector nonprofit funding,
22 they have all canceled their commitment to Project
23 Access.

24 My point is the safety net that we have looked for
25 to help these people is falling apart. We have seen a

1 21-percent increase in the uninsured in Washington State,
2 and so to stand here and do nothing is not an option. In
3 fact, it reminds me of an ancient proverb that says, "Do
4 not stand still in a place of danger expecting miracles."

5 Well, there is going to be no miracle if we stand here
6 and do nothing. And I would like to see from the other
7 side--I applaud the Senator from Maine, but I would like
8 to see more comprehensive proposals from the other side
9 on controlling the cost of health care. That is what
10 this is all about.

11 And so I know if we do nothing, we are going to have
12 more Bo Melmans like the constituent in Spokane,
13 Washington. We are going to see that doubling of
14 Medicare. We are going to see that continued premium
15 increase. And so by adopting these reforms today, we can
16 at least put a downpayment on the changes that we expect
17 to see in controlling costs and get out colleagues on the
18 floor to help us double down on cost containment and
19 affordability so we can really give the American people
20 the change that they deserve.

21 Mr. Chairman, thank you, and thank you for honoring
22 me on my birthday.

23 The Chairman. You are very, very welcome. A big
24 day for you in many ways.

25 Senator Bunning?

1 Senator Bunning. Thank you, Mr. Chairman. I have
2 a couple questions I would like to ask Joint Tax, Mr.
3 Barthold, about the health care tax provisions in the
4 bill, which the Chairman has described as a major tax
5 cut.

6 First, can you tell me what portion of this so-
7 called tax cut will go to taxpayers with income tax
8 liability and what portion will actually go to people
9 with no income tax liability and, therefore, is
10 classified as a spending outlay?

11 Mr. Barthold. Senator Bunning, we have estimated
12 that the percentage of--I assume you are referring to the
13 exchange subsidy.

14 Senator Bunning. Yes.

15 Mr. Barthold. We have estimated that the
16 percentage of the exchange subsidy that is in excess of
17 income tax liabilities is approximately 75 percent.

18 Senator Bunning. 75? That means that 25--

19 Mr. Barthold. That is the average across the
20 budget period, and it is pretty much the same--

21 Senator Bunning. In other words, that would be
22 more of a spending outlay.

23 Mr. Barthold. Mr. Elmendorf can confirm, but the
24 Congressional Budget Office usually accounts those
25 portions of subsidies on the outlay side of the ledger.

1 Senator Bunning. Thank you. So a large portion is
2 actually spending and not tax reduction. And this health
3 care tax credit, is this money that families get back in
4 their pockets, they can spend on their own priorities?
5 In other words, can families use this tax relief to put
6 food on the table, increase their savings, or pay their
7 children's tuition?

8 Mr. Barthold. Well, Senator Bunning, that is
9 actually a complicated question. As the mark lays out,
10 of course, the payment is made through the exchange for
11 health insurance, but that, of course, means that there
12 is a change in the overall budget possibilities for the
13 consumer that would allow them to make decisions with the
14 remainder of their cash if they now have a different
15 health care outcome. But in terms of the direct payment,
16 the mark would direct the payments go directly to the
17 insurance provider.

18 Senator Bunning. Okay. I have another question.
19 This is for CBO. The bill includes a savings of \$6.1
20 billion for long-term care pharmacies. Does the CBO
21 score of \$6.1 billion in savings of this provision
22 include the reduction in medication waste in dispensing
23 in both community pharmacies as well as long-term care
24 pharmacies? If so, could you provide the breakout for
25 each sector?

1 Mr. Elmendorf. Give me one moment, Senator.

2 [Pause.]

3 Senator Bunning. Does this count? Because I am
4 worried about my time.

5 Mr. Elmendorf. I am sorry, Senator. I believe the
6 correct answer is that we only looked at the long-term
7 care pharmacies, not the community-based pharmacies that
8 you just mentioned.

9 Senator Bunning. How did CBO estimate the savings
10 to be achieved in the long-term care settings? Do not be
11 bashful, because I have only got 5 minutes. Speak.

12 Ms. Massey. Okay. What we basically did was we
13 looked at the decrease in the ingredient cost and then
14 we--

15 The Chairman. Use the microphone, please.

16 Senator Bunning. Go ahead. I do not mean to run
17 you out of your seat, Dr. Elmendorf.

18 Ms. Massey. I am sorry. We received some
19 information from CMS that indicated that there would be
20 savings from moving from a 30-day blister pack to daily
21 dispensing, so we captured those savings and then took
22 into account that long-term care pharmacies would receive
23 kind of additional costs.

24 Senator Bunning. Was Medicare Part D
25 beneficiaries, was that savings also included?

1 Ms. Massey. The savings were really from moving
2 from a different method of dispensing the drug.

3 Senator Bunning. That is all.

4 Ms. Massey. That is all.

5 Senator Bunning. Okay.

6 Ms. Massey. That was the main thrust.

7 Senator Bunning. That is \$6.1 billion?

8 Ms. Massey. In the modified mark as amended, I
9 believe the savings over 10 years were closer to three,
10 and I can double-check that.

11 Senator Bunning. Well, according to the
12 preliminary scorecard, it is \$6.1 billion. So unless
13 that is incorrect--thank you. You are taking all my
14 time, and I want to say something. Thank you very much.

15 I wish I could vote for this bill, but it does not
16 correct the problem that we have in our health care
17 system, and with the two answers I received on just two
18 individual things, I am going to vote no on final
19 passage. Thank you.

20 Mr. Elmendorf. I would just add--I am sorry,
21 Senator. We think--the answer is \$6 billion. You were
22 reading the table correctly. We have not changed that
23 number.

24 Senator Bunning. I appreciate that. Thank you,
25 Doctor.

1 The Chairman. Thank you, Senator.

2 Senator Crapo?

3 Senator Crapo. Thank you very much, Mr. Chairman.

4 Dr. Elmendorf, I am going to come back to you.

5 Sorry if I was a little too pushy the first time around.

6 Mr. Elmendorf. I am sorry for fumbling around. I
7 think I can now answer your question more coherently,
8 Senator.

9 Senator Crapo. I think we will get there. What I
10 want to do is simply try to go through with you the cost
11 side and then the savings side of what is happening with
12 the mark. And as I understand it--and I am going to read
13 directly from the charts and from the information in your
14 letter. But as I understand it, on the effects on the
15 Federal deficit in terms of what I will call the cost
16 side, you have predicted--or projected that the Medicaid
17 and CHIP outlays will increase by \$345 billion; that
18 exchange subsidies and related spending will increase by
19 \$461 billion; and that the small-employer tax credits
20 will result in another outlay of \$23 billion, for a total
21 of \$829 billion in new outlays. Correct?

22 Mr. Elmendorf. In new increase in the Federal
23 deficit. My fumbling before was because I recognized
24 that part of the exchange subsidies would, in fact, be
25 outlays and part would be reductions in tax revenue and

1 would appear on the revenue--

2 Senator Crapo. All right. And I think that is
3 where you and I were not connecting before. And
4 recognizing that and going back to what Senator Bunning
5 just said, about 75 percent of those exchange subsidies
6 are, in fact, spending and about 25 percent are tax
7 relief. Is that correct?

8 Mr. Elmendorf. Yes, that is correct. That was a
9 fact I did not know when we talked--

10 Senator Crapo. All right. And using that
11 clarification, then we get to a total cost of coverage of
12 \$829 billion. Then that \$829 billion is offset in some
13 way to result ultimately in an \$81 billion reduction to
14 the deficit. The offsets I would like to go through with
15 you to see what they are.

16 My understanding is that the first and probably most
17 significant offset is a \$404 billion net reduction of
18 Medicare spending. Correct?

19 Mr. Elmendorf. Yes, Senator.

20 Senator Crapo. There is a gross number and a net
21 number there, isn't there? What is the gross number of
22 Medicare cuts?

23 Mr. Elmendorf. We have not reported them that way.

24 I should say there is also some other Medicaid money in
25 there. There are a number of positive and negative rows

1 in our table, and even individual rows in the table are
2 often nets of different provisions that we have estimated
3 together.

4 Senator Crapo. All right. In the interest of
5 time, I will just take the net number of \$404 billion of
6 Medicare and other related cuts, but mostly Medicare
7 cuts. And then there will be, as I read your charts, a
8 number of reductions in revenue--excuse me, reductions in
9 the impact in terms of taxes and penalties that are paid,
10 a \$4 billion penalty by uninsured individuals, the
11 penalty payments by employers resulting in \$23 billion of
12 taxes, the excise tax on high-premium insurance plans of
13 \$201 billion in taxes--and, by the way, let me stop
14 there. Of that \$201 billion, isn't it the assumption
15 that much of that is in payroll taxes? Mr. Barthold?

16 Mr. Barthold. It is not just payroll taxes. It is
17 income inclusion, so there is income and payroll taxes.

18 Senator Crapo. You are right. I am sorry. I
19 misspoke there. But it is a result of increased income
20 taxes and/or increased payroll taxes--

21 Mr. Barthold. And payroll taxes, as well as some
22 excise tax payments.

23 Senator Crapo. But the vast majority is the
24 increase in income and--

25 Mr. Barthold. The vast majority is income and

1 payroll taxes.

2 Senator Crapo. All right. And then there is also
3 an \$83 billion other impact of tax increases, which I
4 understand relate also to the increased taxes on wages.
5 Is that correct?

6 Mr. Elmendorf. Yes, but I think that is
7 principally an increase in taxable income as related to
8 the reduction in employer-sponsored insurance coverage
9 and workers then getting taxable cash--

10 Senator Crapo. They are getting taxable cash in
11 their wages, which is then an income tax increase.

12 Mr. Elmendorf. Income and payroll tax as well.

13 Senator Crapo. And payroll, okay. Then, finally,
14 there is another line on page 3 of \$196 billion of
15 changes in revenues, all of which appear to me, with the
16 exception of a few that are fraud, waste, and abuse,
17 about \$2 billion of it, and a little other on the CER of
18 about \$2 billion. The rest of that is also tax
19 increases. Is that not correct?

20 Mr. Barthold. The tax increases are all--the tax
21 changes, I should say, are all detailed on the table that
22 we have provided to the members related to the financing
23 title, Title 6 of the mark. It is in our document JCX-
24 41, and so that is the other industry fees that we have
25 talked about, the change in the AGI threshold for

1 Medicare, the FSA changes and the like.

2 Senator Crapo. And this is probably for you, Dr.
3 Elmendorf--

4 Mr. Elmendorf. In terms of our table, \$196
5 billion, correct, Senator. That is essentially--that is
6 nearly all tax increases.

7 Senator Crapo. All right. And then that gets us
8 to a net reduction of the deficit of \$81 billion. But to
9 summarize, let me just ask you if this is a correct
10 summary, there is \$829 billion of increased cost to the
11 Treasury, and that is offset by approximately \$404
12 billion of cuts, most of it to Medicare, and the rest
13 mostly tax increases to get to a net increase in the
14 reduction of the deficit of \$81 billion.

15 Mr. Elmendorf. That is correct, Senator.

16 Senator Roberts. And could I also ask you, is that
17 \$81 billion on or off budget?

18 Mr. Elmendorf. It is entirely off budget.

19 Senator Crapo. Which means that it is primarily
20 related to Social Security tax receipts?

21 Mr. Elmendorf. The net effect is additional Social
22 Security tax receipts.

23 Senator Crapo. And were we to not take into
24 account the increase in the Social Security tax receipts,
25 would there be a reduction in the deficit?

1 Mr. Elmendorf. I should just say be careful, there
2 is a little bit of extra Social Security spending
3 included in that line, but essentially all tax receipts,
4 and without those parts of those receipts turning up
5 there, then the net effect would be what we show for the
6 on-budget balance, which is essentially a zero effect on
7 the deficit.

8 Senator Crapo. So there would be no impact on the
9 deficit unless we take the funds dedicated toward the
10 Social Security trust fund.

11 Mr. Elmendorf. I am not sure what--unless you
12 include in the calculation additional receipts received
13 by the Social Security trust fund.

14 Senator Crapo. Do those receipts indicate that
15 there will be ultimate increased Social Security outlays
16 at some point in the future?

17 Mr. Elmendorf. Yes, there will be additional
18 outlays over time, Senator.

19 Senator Crapo. And are those included in your
20 score?

21 Mr. Elmendorf. Yes, they are, Senator. The extra
22 spending--the benefits lag considerably, so the amount
23 that appears in the 10-year budget window is quite small,
24 but it is in our numbers.

25 Senator Crapo. All right. Thank you.

1 Mr. Chairman, I see I am out of time again. I have
2 still got some more questions, but I will wait for the
3 next round.

4 The Chairman. You bet.

5 Senator Roberts, you are next.

6 Senator Roberts. Thank you, Mr. Chairman.

7 Page 12 of the October 7 CBO letter says, "These
8 projections assume that the proposals are enacted and
9 remain unchanged throughout the next two decades." And
10 my question of the distinguished gentleman on the far
11 side of the panel: Have you factored in the likelihood
12 that future Congresses will refuse to allow these cuts to
13 go into effect? Obviously, we have a different
14 disciplinary situation with the Medicare Commission, but
15 just as an observation, at least as long as I have had
16 the privilege of public service, we have always proposed
17 to cut the level of increase in regards to Medicare to
18 the various providers only to catch unmitigated you-know-
19 what at the end of the year and only to pass a
20 supplemental. I think it went from 2003 to date. Those
21 were cuts or a cut in the level of increase, finally
22 described as strengthening and preserving Medicare of 2,
23 3, 4 and percent, always brought back at least to last
24 year's levels.

25 What on Earth is to prevent us from--well, I guess

1 the discipline is the Medicare Commission. Is that how
2 you factor that in?

3 Mr. Elmendorf. So, Senator, as you know, our
4 estimates have to follow the law as it is written. We
5 were very explicit in our letter of these projections.
6 Discussed in the long run in particular, these
7 projections assume that the proposals are enacted and
8 remain unchanged throughout the next two decades, which
9 is often--

10 Senator Roberts. My point is I do not think that
11 is very realistic. I do not mean to quarrel with you,
12 but I just do not think that has happened, at least in my
13 memory. I will refer to the Commission, which will be
14 composed of 15 members, would be appointed by the
15 President and confirmed by the Senate. That does not
16 give me any sense of confidence regardless of who is in
17 the White House.

18 But at any rate, if a package that meets the level
19 of Medicare savings described is not enacted into law by
20 August 15, 2014, the Chairman's mark would require the
21 Commission's or Secretary's original proposal to go into
22 effect automatically. Is that not the case?

23 Mr. Elmendorf. Yes, Senator, and we do think that
24 the Medicare Commission will produce additional savings
25 beyond--

1 Senator Roberts. No, I do not--

2 Mr. Elmendorf. --what is specified.

3 Senator Roberts. --but there are people here that
4 do.

5 Mr. Elmendorf. I am sorry, Senator--

6 Senator Roberts. So that is the extra discipline
7 that we have, the thought meaning that we cannot do it
8 ourselves, so it is sort of a Medicare BRAC, if you will,
9 or some have referred to it as "MedPAC on steroids."

10 Mr. Elmendorf. Again, the analogies are not
11 perfect, but we do think that that is--that is part of
12 our score, includes the effects of the actions of the
13 Commission.

14 Senator Roberts. Well, you have got \$1.5 billion
15 the first year of cuts, 2015; \$7.5 billion in 2019; and
16 in 2019, the Medicare Commission will change in terms of
17 who they can cut and how much.

18 On page 11 of the October 7th CBO letter, it says,
19 "With regards to the cuts to Medicare, Medicaid, and
20 CHIP, savings from these provisions are estimated total
21 \$93 billion in 2019. CBO projects that in combination
22 they will increase by 10 to 15 percent per year in the
23 next decade."

24 Why do you expect such a large acceleration of cuts
25 in the second decade?

1 Mr. Elmendorf. The cuts are relative to a
2 baseline, and the way the--for example, if one slows the
3 rate of increase of provider payments by some percentage
4 each year, then the gap relative to current law widens
5 over time so that the amounts of savings relative to
6 current law, assuming the proposals are allowed to unfold
7 as written would increase over time, and the savings are
8 growing rapidly within the 10-year budget window and will
9 continue.

10 Senator Roberts. I got it. How will these
11 reductions affect Medicare beneficiaries' access to care,
12 and let me just say that this is, I think, where the big
13 shell game comes in. Those on the other side--and I
14 respect what they are saying--saying we are not going to
15 cut anybody's Medicare. What we are going to do is take
16 a Lizzie Borden ax from CMS and take a good whack at
17 every provider out there that provides the Medicare, of
18 course, and that is where you get the savings.

19 And so, consequently, sooner or later you find
20 doctors and you find hospitals, specialty hospitals, and
21 you find pharmacists and you find home health care people
22 saying, I am sorry, I am not going to treat any more
23 Medicare patients.

24 Have you factored that in, in regards to--I mean,
25 that is a wonderful way to cut Medicare, just shut people

1 off.

2 Mr. Elmendorf. The effect of those provisions on
3 access to care is very uncertain, we believe, Senator.

4 Senator Roberts. To say the least.

5 Mr. Elmendorf. We have not estimated that effect.

6 We have focused on the budgetary effects. I think there
7 are different views among health experts as to what level
8 of efficiencies can be achieved to buy providers over the
9 period of time in which this proposal would be changing
10 from current law.

11 Senator Roberts. Mr. Chairman, I am 21 seconds
12 over, but I just want to report that the renowned Mayo
13 Clinic is no longer accepting some Medicare and Medicaid
14 patients, and they have singled out Medicaid patients
15 from Nebraska and Montana. That is only because they
16 will accept the contiguous States, and then in Arizona,
17 where Senator Kyl is from, sorry, no more Medicare or
18 Medicaid patients. But you can get it for a \$250 fee
19 plus fees of \$175 to \$400 per visit.

20 I think that does not augur well to where we are
21 headed and the point I was trying to make. And I thank
22 the Chair.

23 The Chairman. Thank you very much, Senator.

24 I see the arrival of Senator Schumer and Senator
25 Stabenow, so I will recognize Senator Schumer. I do not

1 think today is his birthday, so we are not going to wish
2 him Happy Birthday.

3 [Laughter.]

4 The Chairman. You are next, Senator, unless you
5 wish to defer. Or Senator Stabenow. Whatever works.

6 Senator Stabenow. Thank you, Mr. Chairman. This
7 is a very important day, and I want to thank you, I want
8 to thank everyone that has been involved in working so
9 hard to get us to this point. It is not just about the
10 last year's worth of work, but really, when we look at
11 it, we are looking back at a process that started over
12 100 years ago when President Teddy Roosevelt first called
13 for a national commitment on health care coverage for all
14 Americans. And today is a critically important step in
15 making that a reality for all those we represent.

16 This bill closes the gaps in coverage that have left
17 millions of Americans without health care they
18 desperately need. From prenatal care to childhood to
19 young adulthood, through the working years, early
20 retirees, into older age, this bill covers every stage of
21 life with quality, affordable health care coverage, and
22 it makes Medicaid a real safety net for low-income
23 Americans so that if you lose your job, you do not lose
24 your health insurance.

25 We know that 60 percent of insurance plans in the

1 individual market create a situation where a woman cannot
2 buy maternity care for any amount of money. I am proud
3 that this bill will change that, giving a woman the care
4 she needs so her baby can have a chance at a healthy
5 start in life.

6 In 2030, when that baby turns 21, she will be close
7 to graduating from college. I got a letter from a mom in
8 Marshall, Michigan, whose son, Justin, is today in the
9 same boat. Justin is a smart young college student with
10 a bright future ahead of him, but a few years ago, he was
11 diagnosed with leukemia. He is doing great now. His
12 doctors say there is a 90-percent certainty his leukemia
13 will not come back, and that is a blessing. But his
14 family is worried about how he will get insurance when he
15 graduates. This bill will give him a new start in
16 expanded choices, and unlike now, he will not be denied
17 or charged more because of pre-existing conditions.

18 In 2039, that baby that is born will turn 30 and
19 hopefully will be starting their own family. If she has
20 insurance through her job, she will have better insurance
21 than we have now. She will not have to worry about pre-
22 existing conditions. She will have a health plan that
23 focuses on prevention and keeping her healthy. If she
24 does not have insurance through work and if she is self-
25 employed, she will be able to shop around for the best

1 coverage on the new exchange where the information will
2 be presented clearly and transparently to help her select
3 the best policy for her needs and her family's needs.

4 In 2064, that baby will be 55 and might decide to
5 retire early or, frankly, be forced to retire early. For
6 her and for the millions of Americans who have taken
7 early retirement, this bill creates a new reinsurance
8 plan to cover the few individuals who get very sick so it
9 does not push up premiums and eat away her retirement
10 savings.

11 Less than half of people age 55 to 64 have full-time
12 jobs, and for many of these people, their golden years
13 have become golden arches years where they are working
14 minimum wage jobs trying to pay for rising health care
15 costs. This bill will help bring down those costs and
16 give older Americans real help.

17 Finally, in 2074, a little girl or a little boy born
18 this year will be able to get Medicare because this bill
19 makes the right investments in quality and cost savings
20 to protect and secure Medicare for years to come. We are
21 changing the payment incentives to reward quality of
22 care, prevention, primary care, and to help close the
23 prescription drug doughnut hole.

24 Every child in America deserves a healthy start in
25 life and a healthy future, and I believe that this bill

1 makes that a closer reality for each American child.

2 Thank you, Mr. Chairman.

3 Senator Grassley. Senator Schumer, you are next.

4 Did you want to speak? Then I call on Senator Ensign.

5 Senator Ensign. Thank you, Senator Grassley.

6 Mr. Barthold, a couple of questions for you on the
7 distribution of the effects of the tax increases, the 40-
8 percent excise tax. According to your distribution
9 tables, it looks like that about 70 percent of the taxes
10 are paid by people making less than--or about 70 percent
11 are people making under \$250,000. Is that about right?

12 Mr. Barthold. Well, Senator, in the short run, I
13 will trust your arithmetic. I did not break it out. We
14 have it broken out by different income groups.

15 Senator Ensign. I just did that broadly, because, I
16 mean, it is even higher than that. I just said it is at
17 least 70, 71 percent because you did break it out a
18 little differently. But I did not even go up to--your
19 tables do not go up. They break it out a little
20 differently, but it is at least 70 percent of the taxes
21 are paid by those families making less than \$250,000.

22 In your chart also, it looks like the 40-percent
23 excise tax will hit in 2013, family plans about 14
24 percent of the plans, single plans about 19 percent, and
25 in 2019, it will actually be over a third of the single

1 plans and almost a third of the family plans. Is that
2 correct?

3 Mr. Barthold. That is correct, Senator.

4 Senator Ensign. And then in the future--

5 Mr. Barthold. If I could qualify what that means,
6 that calculation of--let's call it roughly 14 percent
7 rising to roughly one-third, is under the baseline
8 projections of premium costs for plans, these are plans
9 that would be subject to the--it would be above the
10 excise tax threshold. Now, that does not mean that they
11 are paying the excise tax, as we have discussed, because
12 we expect that there will be behavioral changes by both
13 employees and employers.

14 Senator Ensign. Right. They will either get a
15 less generous benefit and you are expecting them to--

16 Mr. Barthold. Right, I just--

17 Senator Ensign. You are expecting them then to get
18 more wages, then they would pay taxes, and that is where--
19 -I know you get a lot of your revenue--

20 Mr. Barthold. That is correct, Senator.

21 Senator Ensign. --from this bill. I just wanted
22 to make it clear that about a third of the plans--because
23 it is not indexed for medical inflation. It is only
24 indexed for CPI plus 1 in this bill. And, therefore, it
25 gets more and more of the plans as we go into the future,

1 and I just think that point needs to be re-emphasized.

2 Mr. Barthold. One other point of just
3 clarification is we are not making any statement about
4 what happens two or three decades off.

5 Senator Ensign. Right. I know.

6 Mr. Barthold. And my colleague Doug Elmendorf and
7 his colleagues have written about longer-term
8 projections, and they project in some of their other work
9 that there would be a slowing in the rate of increase of
10 the cost of premium and medical costs.

11 Senator Ensign. Okay. Dr. Elmendorf, you have
12 said that this bill will save \$81 billion to the deficit,
13 but as far as overall health care spending, does it slow
14 overall health care spending?

15 Mr. Elmendorf. We have not estimated that effect,
16 Senator, as we said in our letter.

17 Senator Ensign. I think that is important because
18 it is--you know, the American people are not just the
19 American Government. So I think that we all have to
20 realize that. We are talking about health care costs in
21 the United States. We have not brought health care costs
22 down with this bill.

23 You did say one place--you know, the other side
24 says, well, how are you going to control costs? You did
25 write a letter to Senator Hatch about tort reform saying

1 that it would save about \$54 billion. Is that correct?

2 Mr. Elmendorf. Yes, Senator.

3 Senator Ensign. That is just the Government cost,
4 right? It would save \$54 billion to the Government. Do
5 you have any calculations on how much it would also save
6 private citizens, the private sector?

7 Mr. Elmendorf. No. In that letter, we reported
8 that we think this package of proposals would reduce
9 total national health care spending by about half a
10 percent.

11 Senator Ensign. Right.

12 Mr. Elmendorf. But we have not tried to--and we
13 did a more careful calculation of the various ways in
14 which the Federal budget would be affected.

15 Senator Ensign. Right. Getting back to tort
16 reform, if about half of the medical costs today are paid
17 for by the Federal Government, wouldn't it be at least
18 ballpark that if it saves the Federal Government \$54
19 billion if tort reform was enacted, it is probably going
20 to have a good chance of saving somewhere near that
21 number at least to the private sector? So we could have--

22 Mr. Elmendorf. Reasonable, very rough
23 approximation, yes.

24 Senator Ensign. Very rough, I realize, but a
25 reasonable approximation of \$100 billion. So if we want

1 to actually decrease some costs, tort reform. Does a
2 sense of the Senate on tort reform, would that score as
3 saving costs in yours?

4 Mr. Elmendorf. No, Senator.

5 Senator Ensign. Okay. I just wanted to point that
6 out, because that is all we have in this mark, is a sense
7 of the Senate on tort reform, where we should be lowering
8 the cost of health care by enacting a true medical
9 liability reform, and I hope we can do that when this
10 bill gets to the floor.

11 Thank you, Mr. Chairman.

12 The Chairman. Thank you, Senator, very much.

13 Senator Wyden?

14 Senator Wyden. Mr. Chairman, would you like to
15 hear from Senator Schumer and then I will go after that?

16 The Chairman. Whatever you want to do.

17 Senator Schumer. Whichever you prefer.

18 Senator Wyden. I think Senator Schumer has yet to
19 get in his first round, and if I could right after that,
20 Mr. Chairman.

21 The Chairman. Senator Schumer, then Senator Wyden.

22 Senator Wyden. Thank you.

23 Senator Schumer. Thank you, Mr. Chairman. And,
24 first, I want to join my colleagues on both sides of the
25 aisle in saluting you for your hard work, your tenacity,

1 your thoughtfulness, and your fair-mindedness in moving
2 this bill forward. You work here is a legislative tour
3 de force the likes of which we have rarely seen in these
4 halls. We know how important this is. Thanks to your
5 hard work, we stand on the cusp of doing something that
6 Congress has been trying to achieve but not succeeded at
7 for half a century--real health care reform.

8 This is clearly not anyone's ideal bill, but it is a
9 good bill. It will certainly make health care a whole
10 lot better than it is today. There are ways that this
11 bill, of course, can be improved, and I plan to fight for
12 those improvements as we move to the floor.

13 First and foremost, we must continue in the
14 direction of cutting the cost of health care while
15 preserving its quality. If we do not cut costs, Medicare
16 will go broke. If we do not cut costs, private insurers
17 will continue to raise premiums and drop millions of
18 beneficiaries. If we do not cut costs, we will cover
19 fewer people tomorrow than we do today, despite our best
20 efforts. We can cut costs and still preserve quality
21 health care for everybody given the waste, duplication,
22 and inefficiency in the system.

23 So there is no question that one of the most
24 important ways to reform our health care system is
25 cutting costs. I want to say, Mr. Chairman, this bill,

1 due to your efforts and those of many others--Senator
2 Cantwell--does more than any of the other four bills to
3 do that. The reforms on bundling, value-based
4 purchasing, and integrated care are all important
5 changes. For the first time, we are beginning to move
6 away from the fee-for-service model that drives too much
7 of the waste and inefficiency in our health care system,
8 and that is the fundamental reason people are paying more
9 and getting less back.

10 To cut costs, we must have a public option in the
11 final bill. It is the most effective way to cut
12 insurance costs, period. The health insurance industry
13 is one of the least competitive industries in the
14 country. That is why they are so opposed to a public
15 option, because the clearest, most effective way to lower
16 premiums going forward is to create competition in the
17 health care industry, and that is just what a public
18 option will do.

19 A level playing field public option, one that has no
20 built-in Government advantages, will keep the feet of
21 insurers to the fire because it will operate with only
22 one thing in mind: delivering the best care at the
23 lowest cost. Nothing else, not profits, not share price,
24 not executive salaries, will come between patients and
25 doctors. Again, we must have a public option.

1 Second, while I think it is important to bring high-
2 cost insurance plans into line, I think we need to make
3 changes to the excise tax provisions on the floor. I
4 believe we need to ensure, as we do that, that we create
5 the appropriate safeguards for the middle class,
6 especially those who are in high-risk professions--
7 firefighters, coal miners, telephone line workers--whose
8 benefits are a result of their dangerous occupations or
9 their choice.

10 There are those who make modest salaries, they have
11 opted to make modest salaries, and instead opt for full
12 and complete health care coverage. They should not be
13 punished. We have moved some in that direction. We have
14 to move further.

15 Finally, we need to make sure that health care
16 reform does not require people to pay what they cannot
17 afford. The insurance companies have already made their
18 position abundantly clear in their report yesterday.
19 They want people to buy their insurance regardless of
20 cost. In their report yesterday, insurance companies
21 showed they are even using health care reform as a cover
22 for increasing profits by jacking up premiums on middle-
23 class families that cannot afford it. We have to make
24 sure we balance the goal of getting everyone insured with
25 the reality that insurance must be affordable, and we

1 cannot punish people if it is not. With Senator Snowe's
2 help, I think we have gotten closer by allowing people to
3 avoid a penalty of premiums of more than 8 percent of
4 their income.

5 If insurance companies will price their plans so
6 they do not cost more than 8 percent of a person's
7 income, no one will be left uncovered. That is what the
8 CBO report found last week. Decreasing the affordability
9 threshold had the effect of forcing the insurance company
10 to a price at an affordable level, not leaving people
11 out.

12 Mr. Chairman, the burden should be on insurance
13 companies to make insurance affordable or else miss out
14 on customers, not on middle-class families to pay for
15 insurance at any cost. Middle-class family affordability
16 should always trump insurance company profits. As we
17 move forward, I will continue to work with Senator Snowe
18 and others to make sure that insurance is affordable and
19 we are not asking people to do more than they are able.

20 In closing, Mr. Chairman, this is not a perfect
21 bill. It needs further changes on the floor and in
22 conference. But it goes a long way in the right
23 direction towards real reform, and you are to be
24 commended for moving us down this road so that we can
25 accomplish something that we can all be proud of:

1 providing the American people with health care that they
2 can afford and will work for all of them.

3 Mr. Elmendorf. Mr. Chairman?

4 The Chairman. Thank you, Senator.

5 Mr. Elmendorf. I am sorry. Mr. Chairman?

6 The Chairman. Dr. Elmendorf.

7 Mr. Elmendorf. I am loath to do this, but I just
8 want to be clear here. Senator Schumer made a reference
9 to something that I think is your interpretation of our
10 report not something that we--we wrote the report the
11 exact week--

12 The Chairman. I do not think that would be the
13 first time a Senator has misinterpreted your report.

14 Mr. Elmendorf. No, but I think I want to be clear
15 about this, that increasing the ability of people to
16 avoid paying penalties for not having health insurance
17 reduces insurance coverage, in our estimates. That
18 particular change was one of many changes made from our
19 previous estimates to this one, and that is why there is
20 not a net reduction in insurance coverage of any
21 significance that shows through. But I want to be clear
22 that people understand this, but I know this issue will
23 continue to be discussed.

24 Senator Schumer. But you are saying there was no
25 net decrease in coverage. That is what the amendment on

1 our score showed. That is what you--

2 Mr. Elmendorf. If I understand the provision that
3 you are talking about, when you open the door for people
4 to not pay the penalties--

5 Senator Schumer. No. I was talking about the 8-
6 percent affordability waiver.

7 Mr. Elmendorf. The 8-percent waiver for the
8 penalties, or are we talking about--

9 Senator Schumer. The 8-percent affordability
10 waiver that you did not have to buy insurance if you
11 could not get it at 8 percent of your income. That would
12 show a decrease in the number of people covered.

13 Now, you can argue why or why not, but you said that
14 in your letter to us.

15 Mr. Elmendorf. What we said is that provision by
16 itself decreases the number of people who have insurance
17 coverage. There are other changes that were made from
18 the previous analysis to this one that pushed coverage
19 up, and that is why the net effect is--

20 Senator Schumer. How much did it decrease it?

21 Mr. Elmendorf. I think our analysis of that--did
22 we do that separately or with other provisions? Yes, we
23 said a few million people--fewer people would be insured
24 through opening that escape hatch.

25 Senator Schumer. I thought that was 5 percent, not

1 8 percent.

2 Mr. Elmendorf. It is more, I think, if you go down
3 to 5 percent.

4 Senator Schumer. But it was 8 percent, as I
5 understand it--and we can check the record. But you did
6 not find any decrease to the--

7 Mr. Elmendorf. I am sorry. We will check,
8 Senator. I do not believe that is right. Certainly
9 there is a larger decrease as the level is moved down
10 further.

11 The Chairman. Senator Wyden?

12 Senator Wyden. Thank you, Mr. Chairman.

13 Mr. Chairman, let me start this round by expressing
14 my thanks to you and your staff for working with us
15 during the markup on this question of free choice and by
16 engaging you for a couple of minutes on a colloquy about
17 how to proceed. I think you and colleagues here know
18 that I think this is an extraordinarily important issue
19 because with choice the consumer is in a position to hold
20 insurance companies accountable and get more affordable
21 coverage. If anything, my concerns were reaffirmed this
22 morning when Dr. Elmendorf told us that 7 years into the
23 legislation, more than 90 percent of the public would not
24 be able to get access to the exchanges. And if you do
25 not have a significant number of people in the exchange,

1 you cannot spread cost, you cannot spread risk, you
2 cannot keep coverage affordable.

3 So you have been very constructive, it seems to me,
4 in working with us over the last week or so on it, on an
5 acceptable free choice proposal. It would focus on two
6 areas: making sure that workers who, in effect, are in
7 what I call an "affordability doughnut hole" would be
8 able to shop for coverage in the exchange, and also
9 provide States with the opportunity to go even further in
10 promoting choice and competition if they choose to
11 provide their citizens with that option. And I think for
12 purposes of this colloquy, if we can agree, as we have in
13 our discussions, about working together to ensure that we
14 can address this question of more choice and more
15 affordability in a way that brings bipartisan support,
16 works with business and labor and a variety of
17 organizations, I think that would be real progress, and I
18 thank you for the very constructive talks we have had.

19 The Chairman. You bet. You have been a tireless
20 worker for health care, a tireless promoter of choice and
21 affordability. We all are very much, but I especially
22 appreciate your efforts. And as we move to the floor, I
23 want to work to try to find some way to achieve that even
24 more. And you have always been the vanguard, Senator, in
25 pushing for that, and I think all Americans are very

1 thankful for that.

2 Senator Wyden. As you acknowledge, Mr. Chairman, I
3 have long been working on fundamental health reform that
4 would provide expanded choice to all Americans including
5 employees who have group coverage at their workplace.
6 Today, almost half of the workers who are fortunate
7 enough to have employer-sponsored health care don't have
8 any choice of health plans. I believe that providing
9 workers choice -- just like we have as members of
10 Congress -- will both improve the quality of health plans
11 and lower costs by encouraging health insurers to compete
12 for consumers' business. Choice and competition are
13 fundamental to comprehensive health reform.

14 I offered an amendment during the mark up that would
15 have ensured every American would be guaranteed a choice
16 of health plans. Unfortunately, it was clear that my
17 proposal would not have been approved by the Committee,
18 so I withdrew the amendment. Since then, our staffs have
19 been working to come up with a workable choice proposal
20 that will enable employees to shop for the coverage that
21 most efficiently meets their needs and ensure that
22 workers who are not offered affordable coverage by their
23 employer would have the ability to shop for coverage in
24 their local insurance exchange. It also would provide
25 states with the opportunity to go even further in

1 promoting choice and competition if they choose to
2 provide their citizens with that option. I hope that you
3 will join me in working to include this idea as health
4 reform moves forward.

5 The Chairman. Thank you, Senator Wyden, for your
6 tireless work over the past years in health reform and,
7 most of all, promoting choice for American workers and
8 their families. I too believe in choice, and I believe
9 the most recent version of your proposal could help
10 achieve our mutual goals of ensuring affordable coverage
11 for all Americans and injecting competition into the
12 health care system. We need to be sure that the proposal
13 achieves our goals without unexpected consequences, but I
14 believe it is a promising approach that could be included
15 in the health reform bill that the Senate takes up. I
16 look forward to working with you on this proposal.

17 Senator Wyden. That is very helpful, Mr. Chairman,
18 and with your leave, if I could perhaps take a couple of
19 minutes just to wrap up in terms of any closing remarks.

20 I know the prospect of having third and fourth rounds
21 meant that you would be bringing out supper, and I do not
22 want to inflict that on colleagues.

23 The Chairman. Go ahead.

24 Senator Wyden. Thank you, Mr. Chairman. I will be
25 brief.

1 Mr. Chairman and colleagues, I think we all
2 understand that health reform legislation is unlike any
3 other bill. Apart from the fact that it affects all
4 Americans and our entire economy, writing a health reform
5 bill is fundamentally different than anything else the
6 Congress does.

7 For example, in an appropriations bill or a tax
8 bill, these kinds of bills are largely collections of a
9 variety of different provisions, some of which are so
10 important to a particular State or a particular Senator
11 that he or she votes for it. But I think the Chairman
12 knows through all of the long hours that we have put in
13 here, health reform is about fitting the pieces together
14 in a way that works for the American people and does not
15 upset the whole. And certainly health reform is like an
16 ecosystem. The organisms are hardly independent. A
17 change in one area leads to changes in another area,
18 which leads to changes in yet still other areas. So you
19 cannot do health reform piecemeal. You have got to find
20 a way to fit all the pieces together.

21 I made it clear--and the Chairman and I have talked
22 about it--that there are a variety of very constructive
23 provisions in this legislation, and as far as I am
24 concerned, leading the way is making sure that the
25 American people do not go to bed at night thinking that

1 they are going to get hammered in the morning because
2 they have got a pre-existing condition. And there are
3 other important provisions as well that I know colleagues
4 on both sides of the aisle are concerned about.

5 I do have an enduring concern that more has to be
6 done to fit the pieces together, and Chairman Baucus has
7 just indicated in our colloquy that he will work with me
8 and other colleagues to try to get that done, to create
9 exchanges where Americans can shop for coverage, like a
10 Member of Congress does, and are part of a large group
11 with new bargaining power, low administrative costs for
12 their health plans and where they can get a good deal.

13 I will close, Mr. Chairman, by saying that I have
14 had a chance, I think, to meet with almost every member
15 of this Committee and every member of the Senate in their
16 office just to listen to them, to hear what they think
17 needs to be done to promote good-quality, affordable
18 coverage for all Americans. And I am convinced every one
19 of those colleagues is anxious to get real health reform
20 while we have spirited debates about how to actually get
21 it done.

22 But there are some in this country whose primary
23 goal, unfortunately, is to defeat real health reform. I
24 do not want to do anything to advance that cause. I want
25 to continue to work with colleagues on both sides of the

1 aisle to make progress on making the pieces of real
2 health reform fit together, and I think we can get that
3 done.

4 My vote today to advance this bill forward is a
5 judgment that there is enough good will in this Committee
6 and in the Congress to move forward in a bipartisan way.

7 We are going to have to do it because then, otherwise,
8 the American people will not believe our legislation is
9 affordable. They will be concerned about restricting
10 choice, and none of us want that. We want to move
11 forward in a fashion that puts the pieces of health care
12 reform together. With the start that we are making here
13 today, it is my intention when we call the roll to vote
14 to move this legislation forward, and I thank you, Mr.
15 Chairman, for your cooperation.

16 The Chairman. Senator Bingaman, do you wish to
17 speak in another round?

18 Senator Bingaman. I do not, Mr. Chairman. I am
19 ready to vote whenever you are ready.

20 The Chairman. I think that depends on a few other
21 Senators here. But we are getting there.

22 Senator Enzi?

23 Senator Enzi. Mr. Chairman, I thank you for the
24 opportunity. I asked questions with my last round, and,
25 again, I commend you for your work to try and craft a

1 bipartisan bill. We do need health care reform, but we
2 have to get it right. And despite your best efforts, I
3 think this bill fails to address the most important issue
4 in the entire health care debate, which is lowering the
5 costs for working Americans.

6 Increasing health care costs is the issue I hear
7 most about from my constituents. They want to see real
8 reforms enacted to make health care more affordable for
9 them.

10 Now, I know in here we are going to be putting some
11 requirements and saying what minimum credible coverage
12 is. I think that is a decision that people ought to be
13 able to make on their own, and I have tried to lower the
14 bar that Washington is going to tell them is the minimum
15 credible coverage. So rather than making health care
16 more affordable, this bill will actually increase the
17 costs that millions of Americans will pay for their
18 health care.

19 In the name of covering some of the uninsured, the
20 bill imposes new policies that will ultimately drive up
21 costs and reduce choices for consumers. The combined
22 impact of the new taxes, the mandates and the entitlement
23 expansion in this bill will substantially increase the
24 price that many Americans and most Wyomingites will pay
25 for their health insurance.

1 The bill will also force an estimated 14 million
2 Americans into an already failing Medicaid program that
3 does not provide adequate care for its current enrollees
4 because they cannot see a doctor, not to mention the
5 stigma. Advocates for this expansion argue that
6 enrolling more people in Medicaid is actually cheaper
7 than helping them to purchase private insurance. They
8 are correct. Medicaid pays rates significantly below the
9 rest of the market. That is why the doctors are not that
10 interested.

11 Government dictates prices, and they call it
12 negotiating costs. Because of these inadequate payments,
13 40 percent of the physicians now refuse to take Medicare
14 patients. If you cannot see a doctor, you do not have
15 health care. And we are starting to see a similar thing
16 with Medicare.

17 That is why I and some of my colleagues fought to at
18 least give working class Americans the choice to enroll
19 in either Medicaid or private health insurance.
20 Unfortunately, we did not succeed, and this bill still
21 denies real choices to the millions of Americans who will
22 otherwise be trapped in a health program that fails to
23 meet their needs and delivers inadequate care.

24 Earlier I asked about increased taxes, and I have
25 got to tell you, my constituents in Wyoming know that

1 companies do not pay the taxes, that they pass them on.
2 And I appreciate Senator Conrad's comments about rural
3 hospital payments called DSH because this bill phases out
4 that payment and will put hospitals out of business in
5 Wyoming, with people being hundreds of miles from care.

6 In the coming weeks, after this bill is merged with
7 the HELP Committee bill, we will have another chance to
8 revisit many of these issues. I plan to work with
9 Republican and Democratic Senators to modify this bill to
10 actually lower costs and provide more choices so that it
11 addresses the real needs of the American people.

12 I thank you, Mr. Chairman.

13 The Chairman. Thank you, Senator, very much.

14 Senator Nelson?

15 Senator Nelson. Mr. Chairman, I want to use this
16 remaining time--of course, I have already said that I am
17 going to vote for the bill, and I am so proud of the way
18 you have conducted this Committee.

19 If you listen to our people, you know the panic, the
20 fright that can set in when they have the fear of not
21 having insurance or having it taken away. Each of us has
22 gotten thousands of communications, either e-mail,
23 personally talking to people, telephone calls, letters.
24 We are averaging on the average of 10,000 to 15,000 a
25 week. So I just randomly picked out four, and I want to

1 tell you their story.

2 This is from Joanne. "My husband has been in very
3 bad health for the last 6 years, and for 15 years he has
4 been covered by my health insurance through my employer.

5 He started using the insurance in 2000, and I was told
6 this week that he had been dropped due to him reaching
7 his lifetime limit of \$1 million. The insurance is Blue
8 Cross of South Carolina, and my problem is that I can
9 find no insurance that will insure him due to the fact
10 that he is currently receiving dialysis treatments. I
11 was told if he had any other health insurance issues such
12 as TB, et cetera, he would be insurable, but because he
13 receives dialysis, he is not. I have tried at least
14 seven different insurance companies, and they all give me
15 the same answer."

16 That was Joanne.

17 This is from a preacher, a pastor. "I had two
18 stents put in my heart 3 years ago, and at the time I had
19 insurance. The insurance company refused to pay and said
20 it was a pre-existing condition. Now I am stuck with a
21 \$50,000 hospital bill that I have been paying on. I have
22 been having chest pain again lately and need more to be
23 done. The stress of racking up more hospital bills is
24 overwhelming. Is there not a program that will aid in
25 paying some of these bills?"

1 This is from Elizabeth. "I was accepted by Humana
2 last July. In the middle of August, my daughter had to
3 call 911 for me. Once in the hospital, they found a
4 collapsed lung, and the next day, after some tests, they
5 also found bronchial cancer. And everything the hospital
6 did, Humana gave permission to do. Now, it is 9 months
7 later, and still with chemotherapy treatments to go, and
8 Humana says they are dropping me, and they refuse to pay
9 the past bills. I still need chemo. What insurance
10 company will pick me up?"

11 And the last one I picked out just at random, Mr.
12 Chairman. This is for Anonymous. "I am 49 years old. I
13 pay health insurance. Notice that I did not say I have
14 health insurance. There is a very real difference. The
15 insurance company that I have is Mega Life and Health. I
16 cannot change companies because in 2007 I was designated
17 with a sarcoma, and they said it was a pre-existing
18 condition. The salesperson who sold me this policy
19 deceived me, used terminology that led me to believe I
20 was buying coverage that, in fact, I was not. This
21 company makes a habit of denying everything and only pays
22 sometimes and only after multiple phone calls and
23 requests for audits, et cetera. I currently am in
24 remission, but that is not going to last. I am unable to
25 afford my prescription medication to keep this cancer at

1 bay. My medicine after the insurance coverage is \$1,500
2 for a 90-day supply. I cannot afford it. So I forego
3 the medicine to keep a roof over my head." And Anonymous
4 ends with the follow: "Maybe you and everyone else on
5 Capitol Hill could quit with all the hoopla and just let
6 all of America buy into a health insurance program."

7 And that is what we are starting right here, the
8 first step.

9 Thank you, Mr. Chairman.

10 The Chairman. Thank you, Senator.

11 Senator Cornyn, you are next to be recognized.

12 Senator Cornyn. Thank you, Mr. Chairman.

13 Mr. Chairman, all of us recognize the importance of
14 health care reform. American families have seen their
15 costs skyrocket. Seniors are concerned about the long-
16 term sustainability of Medicare. Young people realize
17 that with the spending and the debt we are racking up and
18 the failure to deal with the entitlement crisis in this
19 country, their future may be less well off than indeed
20 ours is and our parents before us.

21 In fairness, I do think that this bill does take
22 some steps in the right direction by realigning
23 incentives for providers, by creating incentives for
24 patients. But I must say that it could do so much more
25 that it does not do to make things better. Indeed, I

1 think in some ways it makes things worse.

2 We need to deal with things like encouraging greater
3 competition. We need to help small businesses and retain
4 flexibility that comes from dealing with these issues at
5 the State level, if possible, rather than a command and
6 control program dictated out of Washington. We need to
7 do more about cutting the \$70 to \$120 billion in waste,
8 fraud, and abuse from our current entitlement programs,
9 and as we have learned, this bill does nothing to deal
10 with the phenomenon of defensive medicine or to save the
11 estimates \$54 billion that a reasonable medical liability
12 reform legislation like that we have in my State of Texas
13 would provide to taxpayers.

14 People are understandably anxious about what we are
15 doing here, and they are hoping we will make things
16 better, but they are beginning to see that we could, in
17 fact, make things worse. The Congressional Budget
18 Office, of course, reports the bill will cost taxpayers
19 \$829 billion over the next 10 years. But when it is
20 fully implemented over a 10-year window, that figure
21 grows to about \$1.8 trillion. And we have seen that the
22 pay-for, the partial pay-for is Medicare cuts, taking
23 money out of the Medicare program, which is already
24 unsustainable, in order to pay for this new entitlement
25 program.

1 And we have seen that this bill is likely because of
2 the mandates includes in it to increase premiums for
3 people who already have insurance. According to one
4 study, 91 percent of Texans who buy their insurance on
5 the individual market will see their premiums go up
6 because they are below the minimum actuarial value
7 mandated by the State.

8 And then there are new unfunded mandates for the
9 States. Because of the expansion of Medicaid in this
10 bill, the estimate of the Health and Human Services CMS
11 in Texas estimates that Texas taxpayers will be forced to
12 fund \$20 billion in additional Medicaid expenses over the
13 next 10 years, crowding out other priorities, like
14 education and law enforcement.

15 And then, of course, there is the unsustainability
16 of the Medicare program as currently enacted and
17 operating. Future generations are going to have to
18 figure out a way to pay for that, too, in addition
19 everything else.

20 And, of course, the bill does not solve the access
21 problem, and it does jeopardize current health benefits.

22 We know that the bill would leave 25 million people
23 uninsured. The bill would make Medicaid the only health
24 care option for 14 million Americans. In Harris County,
25 Texas, where Houston is located, 42 percent of physicians

1 will not see a new Medicaid patient because of low
2 reimbursement rates, yet we are forcing 14 million new
3 Americans on Medicaid.

4 And we know that according to CBO, about 3 millions
5 Americans will lose their employer-sponsored coverage.
6 And CBO has said those who are on Medicare Advantage,
7 which are half a million people in the State of Texas
8 alone, that their benefits will be cut by approximately
9 one-half. This will stifle innovative Medicare Advantage
10 plans like HealthSpring and WellMed in Texas, which have
11 kept seniors healthier and saved money by focusing on
12 value instead of volume.

13 And, of course, this bill would lay the foundation
14 for Government coverage decisions based upon comparative
15 effectiveness research. When you combine both the
16 provider and the payer and the coverage determiner in
17 one, it will inevitably lead to rationing.

18 And so I cannot support a bill that will increase
19 the costs of health care, which will not bend the cost
20 curve, and which does not give the American people or
21 Members of Congress adequate time to understand the full
22 impact of this legislation. We have talked about the
23 importance of transparency. I can see the Chairman has
24 taken what he believes to be steps in that direction, but
25 I think there is so much more that needs to be done. And

1 I hope the full Senate will have the benefit of what
2 Senator Snowe talked about, which is a complete bill
3 language and a score telling us what this bill will cost
4 before we will be asked to vote on the motion to proceed
5 on the combined HELP Committee and Finance Committee
6 bills on the floor. I do not know how we could in good
7 conscience do anything less.

8 Thank you.

9 The Chairman. Thank you, Senator.

10 Senator Kerry, you are next.

11 Senator Kerry. Mr. Chairman, I will try to be
12 fairly quick, and I want to kind of have a little
13 colloquy with you on a couple of things. I know we want
14 to vote soon.

15 I spoke during the course of the amendments, and I
16 withdrew my amendment, and we really never had a debate
17 about it, and I did not get a chance to follow up with
18 you because there was a vote that took place on the
19 floor. And that, Mr. Chairman, is on the whole subject
20 of the employer mandate issue.

21 I am very, very concerned that we have not looked at
22 that carefully enough and, frankly, taken even sort of a
23 minimalist approach to it. This issue would guarantee
24 greater strength in the provision of health care to a lot
25 of people in the country. And I say that because you

1 have 160 million people who get health insurance today
2 through their employers, but that number is going down.
3 And among employers there has been an incentive, because
4 of the costs and other things, to shift costs to workers
5 and even drop that kind of insurance. And the fact is
6 that today there is about an \$1,100 additional cost to
7 everybody else's insurance to pay for those who cannot
8 get coverage through their jobs and receive charity care.

9 As a result, the people who do have coverage see their
10 premiums rise. And as that tension increases, there is a
11 greater pressure for employers to drop coverage. There
12 is a greater pressure to move in a different direction.

13 So if we are going to keep the employer-sponsored
14 system -- which we all decided, the Committee, frankly,
15 by consensus, was the cornerstone of what we are building
16 on. If we are going to hang onto that, I think you want
17 to do what we did in Massachusetts. We have a mandate,
18 and we have a penalty, which is a fairly small penalty,
19 assessed against people and a free-rider provision in
20 addition to it.

21 I would like to see us try to meld what we have here
22 as we go forward because it seems to me that if we do, we
23 are going to have a much stronger guarantee of spreading
24 risk, spreading cost, providing more affordable insurance
25 to more people. And, interestingly enough, in

1 Massachusetts after the mandate was put in place,
2 coverage went up. Everybody predicted, oh, my God, they
3 are not going to be able to do it, they will drop. We
4 have more people covered through their employers as a
5 result of that, and it has been affordable. So I really
6 hope that when we get to the floor, Mr. Chairman, we can
7 look at that.

8 Then just two other quick issues I would like you to
9 comment on. One is the medical devices. I believe it is
10 fair to ask the medical device manufacturers to bear some
11 of the burden here. We are all sharing that burden among
12 everybody. But right now I fear that we have not
13 adequately taken into account the cost savings that come
14 to patients and to the whole system through many of those
15 devices. And if we ask them to do more than a fair
16 share--and I think it is today--I think we are going to
17 curb some of the innovation which actually winds up
18 making savings in the long run. So I would like to ask
19 if we can continue to visit on that as we go to the floor
20 and go forward.

21 And the final thing Senator Schumer raised, and
22 others have, is just I am confident we can find something
23 more to try to adjust to a fairer level on that threshold
24 on the high-cost plans. I know we cannot get to the
25 level that some of us have asked for, but I do believe we

1 could get to a median somewhere in between what we have
2 asked and where we are, and I would ask for your
3 continued efforts to try to see if we could address that
4 and those other two.

5 The Chairman. Well, Senator, you have raised some
6 of the main questions that all of us have been wrestling
7 with over and over and over again, and there are trade-
8 offs here. On the one hand, we want coverage so all
9 Americans have health insurance. We also want it to be
10 affordable, that people can afford it. We want to keep
11 premiums going down, not up. We want to bend the cost
12 curve. We have an obligation, I believe, in legislation
13 we enacted this year to set in place provisions that will
14 not raise health care costs. We have got to have some
15 control there.

16 You mentioned several provisions. One is the
17 employer mandate. That is in the HELP bill, as you know,
18 so when we go to merge the two bills, that may or may not
19 be in the final product.

20 Clearly, in all our efforts throughout, including
21 providers providing their fair contribution to health
22 care reform, we want to make sure that we are fair, that
23 everyone pays--every group pays its fair share.

24 The whole standard benchmark here is evenhandedness,
25 everybody is part of this, we are all Americans, we all

1 be part of the solution, and clearly that is an approach
2 that has to be continued and maintained. But I would
3 thank you very much, though, for those comments because
4 it helps us remember again that we have to go the extra
5 mile to try to find the right way to thread those
6 needles, because they are very important and very
7 difficult issues, and I thank you for raising them.

8 Senator Menendez, do you wish to--Senator Carper?

9 Senator Carper. Yes, sir. Thank you.

10 We have reached a point in our deliberations where I
11 think people are looking forward to the vote. I am going
12 to ask a question of three of our folks at the head table
13 that I hope will help us on our path forward to the
14 floor. I think the three things that we are trying most
15 to do is: trying to make sure we do not increase the
16 budget deficit, in fact, try to rein it in over time; try
17 to extend coverage to those who do not have it; and also
18 try to rein in the growth of health care costs.

19 If all we do is extend coverage to the people who do
20 not have and we do not rein in the growth of health care
21 costs, we are not going to extend that coverage for very
22 long. And I have telegraphed a pitch to Drs. Barthold
23 and Elmendorf and Miller and told them I want to ask them
24 just to--rather than focus so much on what is in this
25 bill that is especially helpful in reining in the growth

1 of health care costs, as we move from here to the merge,
2 trying to merge the bills between now and the floor, and
3 we actually get to the floor and take up the final bill
4 in the Senate, what are some additional steps that we
5 should be taking to rein in, further rein in the growth
6 of health care costs, to build on what I think are some
7 very good steps that are in this bill already?

8 Mr. Miller. Senator, as you said, there are a
9 number of things in the bill that MedPAC has recommended,
10 so a lot of our stuff is in here. I guess what I would
11 urge attention to is building for the future. There are
12 many things in the bill where we are testing ideas--
13 bundling, accountable care organizations, that type of
14 thing.

15 I would also put special attention--again, which
16 some of this is in the bill--on building Medicare's
17 capacity to test new ideas so that in the future, as we
18 come back time and time again to Medicare we have new
19 ideas to put in place on delivery reform and the
20 structure of the benefit and that type of thing. So that
21 is the emphasis I think I would say.

22 Senator Carper. All right. Thank you, Doctor.

23 Dr. Elmendorf?

24 Mr. Elmendorf. So, Senator, as you know, CBO does
25 not make policy recommendations. We have evaluated--

1 Senator Carper. But if you did--

2 Mr. Elmendorf. --a number of alternative proposals
3 that would have effects on costs. One thing I can do is
4 to refer you to a recent set of recommendations from a
5 bipartisan group of health experts, published by the
6 Engleberg Center at Brookings Institutions, including
7 Mark McClellan, who used to run CMS, and a number of
8 experts.

9 They talk about the aspects of this bill that they
10 view as being useful in affecting costs and talk about
11 provisions that they wish were included in this bill.
12 Again, these are not my recommendations, but to give you
13 a sampling of the sorts of things that they talk about.

14 They talk about reducing payment updates in Medicare
15 in regions with high cost growth, especially if those
16 regions do not adopt payment reforms. They talk about
17 medical malpractice reforms. They talk about expanding
18 the scope of the Medicare Commission to include not just
19 Medicare but also Medicaid, and to permit proposals on a
20 broader set of changes in Medicare. They talk about
21 giving more authority to HHS and CMS to expand successful
22 demonstration projects along the lines of what Mark was
23 talking about.

24 Senator Carper. Good. Thanks very much.

25 Dr. Barthold?

1 Mr. Barthold. Senator, the tax instrument often is
2 a fairly blunt instrument, so I do not know that I have
3 much to recommend by way of specifics. But let me just
4 offer two general thoughts.

5 One, when we provide tax benefits, we are usually
6 encouraging use. So if there is certain use that we want
7 to discourage or we think that increased demand has led
8 to higher costs, we might examine if there are tax
9 benefits that maybe are no longer needed or not
10 appropriate in terms of the overall policy that the
11 Congress is adopting.

12 Oppositely, of course, the tax instrument will
13 discourage use, and some people have advocated that in
14 some situations.

15 Senator Carper. All right. The last question, if
16 I could, again for you, Dr. Elmendorf and Dr. Barthold.
17 In your opinion, has the Finance bill, the bill that we
18 are about to vote on here, preserved the role of health
19 savings accounts as part of our health care delivery
20 system?

21 Mr. Barthold. Health savings accounts are not
22 precluded under the mark.

23 Senator Carper. So the answer is they have been
24 preserved.

25 Mr. Barthold. Yes, sir.

1 Senator Carper. Thank you very much.

2 Thank you, Mr. Chairman.

3 The Chairman. Thank you, Senator.

4 I get the sense here we are getting close to a vote.

5 Any Senators have anything they urgently must--

6 Senator Crapo. I have a couple more questions, and
7 then I am ready to make a final statement.

8 The Chairman. Okay. Senator Crapo.

9 Senator Crapo. All right. Thank you very much.

10 Mr. Barthold, this first question is for you, I
11 believe, and my understanding is, as we have talked
12 already, that the \$201 billion tax on high-cost plans was
13 primarily, I think you said 73 percent, going to be in
14 the form of income and payroll taxes. Again, is that
15 correct?

16 Mr. Barthold. Let me see. Over the period 2009 to
17 2019, of the \$201 billion that we estimate would be
18 raised from this provision, the net excise tax receipts
19 are approximately \$40 billion.

20 Senator Crapo. Which translates to about 27--well,
21 that would be only about 20 percent, wouldn't it?

22 Mr. Barthold. That is correct, around 20 percent.

23 Senator Crapo. So about 80 percent would be in the
24 form of income tax or payroll tax?

25 Mr. Barthold. Income and payroll tax.

1 Senator Crapo. So that would be 80 percent, not 73
2 percent?

3 Mr. Barthold. Yes.

4 Senator Crapo. Approximately. And am I correct in
5 my understanding that Joint Tax has also estimated that
6 of that portion that is going to be paid is income tax
7 and payroll tax increases, about 90 or 91 percent of that
8 will be paid by people who make less than \$200,000?

9 Mr. Barthold. We have done a distribution analysis
10 of the proposed excise tax, and for calendar year 2019,
11 we have estimated that--I guess that is approximately 60
12 percent of the taxes would be--and that includes the
13 income inclusions--would be borne by individuals with
14 incomes under \$200,000.

15 Senator Crapo. And that is just for the year 2019
16 or throughout the full 10 years?

17 Mr. Barthold. Well, we did the analysis for 10
18 years. Since the threshold is changing, Senator, the
19 calculation changes year by year.

20 Senator Crapo. Thank you.

21 Then, Dr. Elmendorf, the same kind of question with
22 regard to the \$83 billion figure in your numbers on page
23 3, I believe it is--no, page 5 of your report. This \$83
24 billion is mostly tax on revenues associated with the
25 expansion of federally subsidized insurance. Isn't that

1 \$83 billion also mostly income and payroll tax increases?

2 Mr. Elmendorf. Yes, Senator, it is mostly income
3 and payroll tax increases.

4 Senator Crapo. And so you have a breakdown as to
5 what percentage of that \$83 billion would be paid by
6 those earning less than \$200,000 a year?

7 Mr. Elmendorf. No, Senator. Actually, that part
8 of our estimate comes from our colleagues at the Joint
9 Tax Committee as well, so that question is back to Tom.

10 Senator Crapo. Mr. Barthold, did you hear the
11 question?

12 Mr. Barthold. I am sorry. I was double-checking--

13 Senator Crapo. I have moved to the \$83 billion tax
14 figure on CBO's page 5, which is, as Mr. Elmendorf has
15 said, also mostly payroll and income taxes. And my
16 question is, if you do have it: What portion of that tax
17 is paid by those making less than \$200,000?

18 Mr. Barthold. I do have some information related
19 to that, if you will let me fumble here with my folders
20 for a few seconds.

21 Senator Crapo. While you are looking, Mr.
22 Chairman, that will be my last--I have a lot more I would
23 love to ask, but that will be my last question, and then
24 I would like to make a closing statement at some point.

25 The Chairman. You can take the time now because--

1 Senator Crapo. All right. I will be glad to.
2 Thank you.

3 Mr. Barthold. Senator, we did try to do some
4 analysis of the distribution of the outlay portions of
5 the bill, which I think goes in part to what you are
6 asking. Or is it you really just want to know the direct
7 payroll piece?

8 Senator Crapo. The payroll and income taxes.

9 Mr. Barthold. The indirect effects are included in
10 the distribution that I reported on in your prior
11 question.

12 Senator Crapo. So that would be 60 percent,
13 approximately?

14 Mr. Barthold. It should be, yes.

15 Senator Crapo. All right. Thank you.

16 The Chairman. Senator, you might as well give your
17 statement.

18 Senator Crapo. All right. Thank you very much,
19 Mr. Chairman, and I appreciate your allowing several
20 rounds of questions here because we do need to get the
21 details of the report understood and to evaluate them
22 carefully.

23 I would just like to start by indicating that many
24 have said that those who do not support the bill are
25 simply supporting the status quo or that a vote against

1 this bill is a vote for the status quo, and I could not
2 disagree more. There is a robust debate here among all
3 of us about what we need to do to reform health care in
4 our country, but I do not know of a single member of this
5 Committee, frankly, nor a single member of the United
6 States Senate who believes we should not do anything.
7 And I agree with you and others who state that we need
8 dramatically to place the reform of our health care
9 system in our country on the front burner and to move
10 aggressively forward to find workable solutions.

11 The issue that I believe most Americans are crying
12 out for resolution to is the skyrocketing increasing
13 costs of health care that they face every year, often--in
14 fact, probably primarily--in the form of skyrocketing
15 insurance premiums that go up in double-digit amounts
16 often year after year.

17 And it has been said here that this proposal
18 addresses that issue by bending the cost curve down. As
19 has been testified here by Dr. Elmendorf, the CBO did not
20 score that, and, in fact, much of the analysis that I
21 have seen indicates that, in fact, just the opposite is
22 true--that, in fact, the cost of insurance is going to go
23 up above what it would have gone up if we enact this
24 legislation, and that we are not really taking the kinds
25 of aggressive steps that are going to address the things

1 that are driving cost increases in our health care
2 economy. And it is for that reason, among the others
3 that I will mention, that I have a very difficult time
4 supporting this measure as the one we should enact in
5 order to address the issue.

6 In fact, even if you define the cost curve as simply
7 the Federal budget, I think the answers to my questions
8 today indicate that that does not drive down the cost
9 curve either if you define it as the impact on spending
10 at the Federal level. I believe it is pretty clear from
11 CBO's analysis and the answers to my questions today that
12 there will be--and these are approximate numbers--about
13 \$829 billion of new spending, which itself is a little
14 bit misleading because the spending in this bill does not
15 really start in its full form for 4 years. And if you
16 get a full 10-year look at what the numbers are, it is
17 going to be greater than \$829 billion.

18 That \$829 billion of new spending on health care by
19 the Federal Government is offset by about \$400 billion of
20 Medicare cuts and about \$506 billion of taxes and
21 penalties. Again, these are rough numbers, but I think
22 that they are pretty accurate given CBO's score.

23 Of that \$506 billion of taxes and penalties, I am
24 going to have to work on this better before we get to the
25 floor for the full debate, but a huge portion of that is

1 going to be paid by people who make less than \$200,000
2 individual or \$250,000 for a couple. And squarely this
3 will place about half a trillion dollars of new taxes on
4 the backs of the American people and our economy, a huge
5 portion of which will be on the middle class and lower-
6 income categories.

7 And what do we get in return for it? Well, as I
8 have already indicated, we do not, in my opinion, reduce
9 the cost curve. We do not bend the cost curve, which is
10 the number one reason that most Americans think we should
11 address the issue.

12 Number two, we do increase coverage, although with a
13 very, very heavy hand of the Federal Government, and we
14 will end up--though this particular bill does not have a
15 Government option in it, this bill has very extensive new
16 increase and control of the health care economy by the
17 Federal Government. And that will drive some increase in
18 coverage, but even in the coverage area, we will still
19 see, of that 47 million uninsured number, about 25
20 million of them still uninsured. And I recognize and I
21 will acknowledge that about 8 million of those, according
22 to CBO's numbers, I believe, are those who are not
23 citizens and who are not legally here. But even that
24 leaves us--if you agree that we should not insure those
25 who are not citizens of this country, legally present in

1 the country, you would still be left with about 15 or 16
2 million people uninsured. So the bill does not achieve
3 one of the other major objectives that those calling for
4 reform in our country request.

5 What does it do? As I have indicated, it imposes a
6 massive new amount of Federal control over the health
7 care economy. It increases taxes by about half a
8 trillion dollars, as I have already indicated. It cuts
9 Medicare by a net amount of \$404 billion. And we debated
10 earlier in the mark about the impact of those cuts
11 primarily falling upon Medicare Advantage that
12 dramatically reduce the availability of Medicare to those
13 who are seeking to use it. And, in fact, while we have
14 Medicare and Medicaid, two major Federal entitlement
15 programs, both of which are going to go off the cliff
16 financially soon, instead of taking those Medicare
17 savings to try to address and shore up Medicare, we
18 instead are going to put those into a new Federal
19 entitlement program and an expansion of Medicaid, which,
20 in my opinion, will not really address once again the
21 pressing issues that our Nation faces with regard to
22 health care.

23 Then the bottom line is--I could go on with other
24 reasons, but the bottom line is when you look at the
25 deficit reduction that the bill contains, it is about \$81

1 billion, the entirety of which is off-budget, meaning
2 that it is Social Security trust fund dollars. If you
3 take the Social Security trust fund dollars out of this
4 analysis, the CBO score would be approximately balanced,
5 zero, which means that you have cut Medicare and
6 increased taxes enough to pay for about \$829 billion of
7 new spending. And like I say, that \$829 billion is
8 actually a much larger number because it does not count
9 for the full 4 years of the--or for the first 4 years of
10 the first 10 years of the program.

11 So, Mr. Chairman, we do want to work toward
12 meaningful health care reform, but the health care reform
13 our Nation needs is health care reform that will reduce
14 the cost curve for our health care economy, and health
15 care reform that will not come at the cost of massive new
16 taxes and massive new Government control over the
17 economy.

18 Thank you very much, Mr. Chairman.

19 Senator Wyden. Mr. Chairman, just a housekeeping
20 matter?

21 The Chairman. Sure, go ahead.

22 Senator Wyden. Mr. Chairman, I would just like to
23 put into the record the charts that I used with respect
24 to choice and affordability and the written colloquy that
25 we worked out over the weekend.

1 The Chairman. Thank you. Without objection, it
2 will be included.

3 Senator Wyden. Thank you.

4 [The information appears at the end of the
5 transcript.]

6 The Chairman. Without objection, all statements
7 will be included in the record.

8 Senator Grassley?

9 Senator Grassley. I just have two short questions
10 for Dr. Elmendorf.

11 According to the letter that you provided for your
12 most recent score, the Medicare Commission is limited in
13 a number of areas, but it was given specific authority to
14 reduce expenditures under Medicare Part D to help come up
15 with \$22 billion in cuts. In fact, the amendment that
16 was approved specifically mentioned "reductions in
17 Federal premium subsidies to Medicare Part D plans."

18 I know that you cannot predict what the Commission
19 will recommend, but if the Medicare Commission chose the
20 one example offered in the amendment and reduced Federal
21 premium subsidies in order to cut \$22 billion, is it
22 reasonable to conclude that this could result in an
23 increase in premiums for Medicare beneficiaries?

24 Mr. Elmendorf. Yes, Senator. If I understand your
25 question correctly, if that is the way, the direction

1 that the Commission chooses to go to achieve the savings
2 that we project will be needed under the legislation,
3 then that reduction in subsidies would raise the costs to
4 beneficiaries.

5 Senator Grassley. Then my last question is
6 somewhat repetitive. I do not know whether it is has
7 been discussed today, but it has been discussed before,
8 so I want to bring it up today to get it on the record
9 for today's record.

10 President Obama said, "People currently signed up
11 for Medicare Advantage are going to have Medicare on the
12 same level of benefits."

13 CBO has said that benefits in Medicare Advantage
14 plans, which can include hearing aids, eyeglasses, and
15 routine physicals, will drop from an average of \$87 to an
16 average of \$42. Is it reasonable to assume that some
17 seniors will see a reduction in benefits?

18 Mr. Elmendorf. Senator, the numbers that I have in
19 front of me suggest a reduction from \$135 a month in 2019
20 to about \$42 a month in 2019. And the reduction will be
21 somewhat smaller in some areas for which there are
22 special provisions in the proposal. But, yes, for those
23 seniors that would be a reduction not in the standard
24 Medicare benefits but in the additional Medicare benefits
25 provided through the Medicare Advantage plans.

1 Senator Grassley. Okay. Thank you.

2 Thank you, Mr. Chairman.

3 The Chairman. I would like just to read into the
4 record a portion of the CBO letter analyzing the
5 Chairman's mark. There has been a lot of discussion here
6 and a lot of opinions on many, many different subjects--
7 coverage, affordability, tax, et cetera--and I want to
8 just focus on one here. This is the CBO letter dated
9 October 9th, page 11, stating that, "All told, the
10 proposal"--and this is CBO, the bipartisan--nonpartisan
11 Congressional Office, just analyzing proposals that the
12 House presents them, that the Senate presents them, and
13 which I think frankly they--no one faults them for not
14 being objective or somehow biasing their statements. No
15 one does. Totally objective.

16 Anyway, the statement says, "All told, the proposal
17 would reduce the Federal deficit by \$12 billion in 2019.

18 That is a CBO and JCT estimate." And I might add that I
19 think over the 10-year period the tables show that the
20 reduction is about \$81 billion over that 10-year period.

21 It is a reduction in the deficit.

22 I might also add that there has been some talk about
23 what is the level of the Federal Government's overall
24 commitment to health care, and I might read a portion:
25 "Under the proposal, projected effects on the Federal

1 budget deficit also represent a change in the Federal
2 Government's overall commitment of resources to health
3 care because essentially all the spending and tax
4 elements contained in the proposal are related to health
5 care. Thus, the proposal would reduce the Federal
6 budgetary commitment to health care relative to that
7 under current law during the decade following the 10-year
8 budget window."

9 Senator Rockefeller?

10 Mr. Elmendorf. Mr. Chairman, can I just say that
11 this term, "the Federal budgetary commitment to health,"
12 is one that I think is not immediately obvious what its
13 meaning is. We introduced this in our letter to Senator
14 Conrad and Senator Gregg earlier in the year. But just
15 to be clear, what we are looking at there, at least at
16 the time, was the current commitment. We included the
17 spending in Medicare and Medicaid, the tax exclusion for
18 employer-sponsored health insurance, those three large
19 areas in which the Federal Government was using resources
20 on the health area, and there are smaller areas as well.

21 That is the set of provisions of the Government's budget
22 that we are talking about.

23 So this language here is a reference to the
24 Government's net use of resources in the health area. As
25 various Senators have noted, this proposal has a

1 combination of increases and decreases, and this is a
2 reference to the net effect of those.

3 The Chairman. Thank you. Before I turn to Senator
4 Rockefeller, do you have statements or--

5 Senator Stabenow. Mr. Chairman, I had just a quick
6 comment, if I might be able to make a comment.

7 The Chairman. If you might, because I was going to
8 call on Senator Rockefeller.

9 Senator Stabenow. Thank you. Well, Mr. Chairman,
10 I think it is important, given the comments that we have
11 been hearing today, just to add to the record a couple of
12 things.

13 I wanted to pull from the AARP website--they have
14 "Facts and Myths." "Myth: Health care reform will hurt
15 Medicare," they say, not us.

16 "Fact: None of the health care reform proposals
17 being considered by Congress would cut Medicare benefits
18 or increase your out-of-pocket costs for Medicare
19 services."

20 "Fact: Rather than weaken Medicare, health care
21 reform will strengthen the financial status of the
22 Medicare program."

23 And I do also want to say, as we are coming to a
24 close, we have all worked very hard, we have all been
25 here, we have all been slogging through over 500

1 amendments and so on. I think it is important and fair
2 to note that from friends on the other side of the aisle,
3 we have heard basically three themes: Wait, wait, wait.

4 Secondly, business as usual for insurance companies is
5 okay for families and businesses. And, thirdly, that
6 higher costs for middle-class families and small
7 businesses are okay when we are looking at how we pay for
8 health insurance. And I think we reject that.

9 Thank you, Mr. Chairman.

10 The Chairman. Okay. Senator Rockefeller?

11 Senator Rockefeller. Thank you, Mr. Chairman. I
12 am somewhat embarrassed that I am closing this, but let
13 me just say a couple things.

14 One is that I had dinner last night at our house, my
15 wife, Sharon, and I with about six or seven hospital
16 administrators, big ones, little ones--more big than
17 little. And they cried out to me to say, "Why do you let
18 us keep on doing what we have to do?" And I am going to
19 vote for this bill coming out of Finance this afternoon
20 because I think that, in spite of a lot of problems that
21 I have with it, I think that the dialogue is now for
22 real. I think the dialogue has been set in place. I
23 think that is partly because of the Chairman and his
24 patience. And the time has come. The time is right for
25 it.

1 So I said to them, "Why is it our responsibility to
2 stop you from doing what you are doing if you think it is
3 wrong?" And the said, "Well, because you give us the
4 opportunity to do that." And it was not a hostile
5 conversation. It was a very constructive one, and it
6 describes really where we are. We are in a system which
7 is leading us all down strange paths.

8 Now, you understand--and I gave the first half of
9 this a couple hours ago--I do think the insurance
10 industry gets too sweet a deal in this. They get half
11 the money, and yet no real responsibility to put it into
12 medical care, which is why I do favor the minimum medical
13 loss ratio of 85 percent. It has not been brought up
14 particularly today, but I think that is important as we
15 go on through the process.

16 I do think that a public option is necessary, and I
17 think so for two reasons:

18 One, because the insurance industry does not know
19 how to stop itself. They are a train which just gathers
20 speed, and with no impediments. So what you have to do
21 is put up an impediment--not to stop them because nobody
22 ever will do that, but to slow them down, make it more
23 rational, more reasonable. And that is the public
24 option. If the word "public" were not in there, maybe it
25 would be more acceptable. I do not see it as a

1 Government takeover. I see it as Government assistance
2 to people who are getting killed by premium increases.
3 And I say it also because I do not know what the
4 alternative could be to a public option. Co-ops have
5 been discussed, but, interestingly enough, we have never
6 had in all the history of these Finance Committee
7 hearings--that I am aware of, anyway--a discussion on co-
8 ops. They are in the mark. They are meant to do the
9 job. But mostly people who have looked at this, myself
10 included, CBO and others, have concluded they will not
11 slow the train down. Not big enough to compete.

12 I do think that employers have a responsibility and
13 large employers ought to be under the same kind of
14 discipline that our Chairman has imposed on smaller
15 employers in the insurance market. You know, restraints
16 in insurance, I think that is a fair thing to do. And if
17 we do not do that, then 46 to 55 percent of Americans
18 will be using health insurance plans that have no
19 constraints at all on insurance, and I think that is
20 wrong.

21 Briefly, on the Medicare Commission, I really
22 believe in that. I think it is the only long-term way to
23 do what needs to be done to save Medicare and to unfetter
24 us from our clinically proven bad habits of behavior. I
25 do think that it should not be done by the Congress, but

1 that is not the will of this Committee. But having said
2 that, I really would hope that it would be less than the
3 6-month look-over by the Congress, because that means
4 that every lobbyist will be able to earn his or her pay
5 again and again and again.

6 I will end on this: End-of-life care. I feel very
7 sad we have not talked about that, for two reasons:
8 because it affects--I had it in my own family; many
9 people have had it. I just talked with the Chairman
10 about a situation. I mean, it affects everybody. But we
11 have not talked about it because the screamers took hold
12 of this briefly, and they are not meant to take hold of
13 us. They can break up our town meetings, but they cannot
14 break up our proper decisionmaking. And we all know that
15 anywhere between 40 to 50 to 60 percent of Medicare is
16 spent in the last 6 months of life, and I think it is
17 fair to give people options. I wish my mother had had an
18 option. They kept her alive, I think--for 12 years, but
19 I think 6 or 7 years were doing her harm, and the
20 Hippocratic oath says, "Do no harm." It does not say,
21 "You must cure." It says, "Do no harm."

22 So that is just a personal note. I do not expect it
23 to get anywhere. But because of this new atmosphere, we
24 are free to talk about everything in a positive, useful
25 way, and I like that. I loved the speech that Senator

1 Cantwell gave because it was just heartfelt, succinct,
2 and very, very helpful.

3 So, Mr. Chairman, I will vote yes. I am ambitious
4 for this package as it goes on down the road, and I thank
5 you.

6 The Chairman. Senator Grassley?

7 Senator Grassley. I wanted to suggest one--go
8 ahead.

9 The Chairman. There is another matter I would like
10 to raise at this point and accomplish, and that is the
11 point raised by Senator Kyl earlier today. He raised a
12 question of whether the Committee has adopted the
13 corrections and clarifications posted on the Internet on
14 October 5th. Frankly, I do not believe that we need to
15 vote to adopt those corrections and clarifications
16 because, in my opinion, they are already incorporated in
17 the Chairman's mark as amended. However, in the spirit
18 of fairness and transparency and going the extra mile, I
19 ask consent that the corrections and clarifications be
20 adopted.

21 Senator Kyl. Mr. Chairman?

22 The Chairman. The Senator from Arizona.

23 Senator Kyl. If you are asking for that in the
24 form of a motion--or an amendment, rather, to the mark,
25 could we have a roll call vote on that?

1 The Chairman. Absolutely. I move that the
2 corrections and the clarifications be adopted. All those
3 in favor will say aye?

4 [A chorus of ayes.]

5 Senator Kyl. Mr. Chairman, a roll call vote?

6 The Chairman. A roll call vote is requested. The
7 Clerk will call the roll.

8 The Clerk. Mr. Rockefeller?

9 Senator Rockefeller. Aye.

10 The Clerk. Mr. Conrad?

11 Senator Conrad. Aye.

12 The Clerk. Mr. Bingaman?

13 Senator Bingaman. Aye.

14 The Clerk. Mr. Kerry?

15 Senator Kerry. Aye.

16 The Clerk. Mrs. Lincoln?

17 Senator Lincoln. Aye.

18 The Clerk. Mr. Wyden?

19 Senator Wyden. Aye.

20 The Clerk. Mr. Schumer?

21 Senator Schumer. Aye.

22 The Clerk. Ms. Stabenow?

23 Senator Stabenow. Aye.

24 The Clerk. Ms. Cantwell?

25 Senator Cantwell. Aye.

1 The Clerk. Mr. Nelson?
2 Senator Nelson. Aye.
3 The Clerk. Mr. Menendez?
4 Senator Menendez. Aye.
5 The Clerk. Mr. Carper?
6 Senator Carper. Aye.
7 The Clerk. Mr. Grassley?
8 Senator Grassley. No.
9 The Clerk. Mr. Hatch?
10 Senator Hatch. No.
11 The Clerk. Ms. Snowe?
12 Senator Snowe. No.
13 The Clerk. Mr. Kyl?
14 Senator Kyl. No.
15 The Clerk. Mr. Bunning?
16 Senator Bunning. No.
17 The Clerk. Mr. Crapo?
18 Senator Grassley. No.
19 The Clerk. Mr. Roberts?
20 Senator Roberts. No.
21 The Clerk. Mr. Ensign?
22 Senator Ensign. No.
23 The Clerk. Mr. Enzi?
24 Senator Enzi. No.
25 The Clerk. Mr. Cornyn?

1 Senator Cornyn. No.

2 The Clerk. Mr. Chairman?

3 The Chairman. Aye.

4 The Clerk will tally the vote.

5 The Clerk. Mr. Chairman, the final tally is 13
6 ayes and 10 nays.

7 The Chairman. The motion is adopted.

8 Senator Grassley?

9 Senator Grassley. Go ahead.

10 The Chairman. Okay. I will just make a statement
11 here.

12 One is I very much appreciate the cooperation of
13 this Committee. We started on this endeavor a couple of
14 years ago and held many, many hearings, some of them
15 formal hearings, some of them informal, many discussions,
16 sat down with experts, the CBO, Joint Committee on Tax,
17 and many others. The Group of Six met. My goal from the
18 outset was for us as a Committee to very proudly report
19 out a bill that we could virtually carry and get passed
20 and that would be the foundation and the basis for health
21 care reform that is so needed in this country.

22 Even though we do not have quite the degree of
23 bipartisan support as I would have hoped for, I still
24 very much appreciate the good-faith effort that everyone
25 has undertaken, and I might say especially you, Senator

1 Grassley, because it has meant a lot to me personally.

2 For more than 2 years, we have dedicated ourselves
3 to crafting that solution to our health care crisis, and
4 I think today's vote is a culmination of our hard work
5 and commitment to fixing this crisis.

6 We all understand we cannot afford the status quo.
7 We all understand Americans are looking for common-sense
8 solutions. That is what they elected us to do: find a
9 common-sense, balanced solution to this. And I think
10 that is exactly what we have achieved in this Committee.

11 Ours is a balanced bill that does bend the cost
12 curve, that does lay the foundation for continued
13 progress. It lowers the Federal deficit, ends insurance
14 industry discrimination, expands coverage, and improves
15 quality. It also guarantees that in the United States of
16 America no person will go broke just because he or she
17 gets sick.

18 My colleagues, let us put an end to the status quo.

19 Let us enact real reform that lowers costs, expands
20 affordable, accessible coverage for millions of
21 Americans. Now is the time to act.

22 Now I will entertain a motion to report the bill.

23 Senator Rockefeller. Move we report the bill.

24 The Chairman. The motion has been made and
25 seconded. A recorded vote is automatic. The Clerk will

1 call the roll.
2 The Clerk. Mr. Rockefeller?
3 Senator Rockefeller. Aye.
4 The Clerk. Mr. Conrad?
5 Senator Conrad. Aye.
6 The Clerk. Mr. Bingaman?
7 Senator Bingaman. Aye.
8 The Clerk. Mr. Kerry?
9 Senator Kerry. Aye.
10 The Clerk. Mrs. Lincoln?
11 Senator Lincoln. Aye.
12 The Clerk. Mr. Wyden?
13 Senator Wyden. Aye.
14 The Clerk. Mr. Schumer?
15 Senator Schumer. Aye.
16 The Clerk. Ms. Stabenow?
17 Senator Stabenow. Aye.
18 The Clerk. Ms. Cantwell?
19 Senator Cantwell. Aye.
20 The Clerk. Mr. Nelson?
21 Senator Nelson. Aye.
22 The Clerk. Mr. Menendez?
23 Senator Menendez. Aye.
24 The Clerk. Mr. Carper?
25 Senator Carper. Aye.

1 The Clerk. Mr. Grassley?
2 Senator Grassley. No.
3 The Clerk. Mr. Hatch?
4 Senator Hatch. No.
5 The Clerk. Ms. Snowe?
6 Senator Snowe. Aye.
7 The Clerk. Mr. Kyl?
8 Senator Kyl. No.
9 The Clerk. Mr. Bunning?
10 Senator Bunning. No.
11 The Clerk. Mr. Crapo?
12 Senator Grassley. No.
13 The Clerk. Mr. Roberts?
14 Senator Roberts. No.
15 The Clerk. Mr. Ensign?
16 Senator Ensign. No.
17 The Clerk. Mr. Enzi?
18 Senator Enzi. No.
19 The Clerk. Mr. Cornyn?
20 Senator Cornyn. No.
21 The Clerk. Mr. Chairman?
22 The Chairman. Aye.
23 The Clerk will tally the vote.
24 The Clerk. Mr. Chairman, the final tally is 14
25 ayes and 9 nays.

1 The Chairman. The ayes have it, and the mark is
2 ordered reported.

3 I now ask consent that staff be granted authority to
4 make technical, conforming, and budgetary changes.
5 Without objection, it is so ordered.

6 I thank all Senators.

7 [Applause.]

8 The Chairman. The hearing is adjourned.

9 [Whereupon, at 2:54 p.m., the hearing was
10 adjourned.]

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Markup of the America's Healthy Future Act

Senate Finance Committee

Statement by Senator Chuck Grassley, Ranking Member

October 13, 2009

Mr. Chairman, first of all, I want to commend you for bringing this markup to where it is today.

It seems like a long time since we started on September 22nd.

We've been able to air our differences and have the votes.

Mr. Chairman, I wish I felt better about the substance of the bill.

The Chairman's Mark has undergone many changes during this process and they are not to the good.

I'll highlight a few of the changes I find most disturbing. As I highlight these issues, it will be clear that this bill is already sliding rapidly down the slippery slope to more and more government control of health care.

It has the biggest expansion of Medicaid since it was created in 1965.

It imposes an unprecedented federal mandate for coverage backed by the enforcement authority of the Internal Revenue Service.

It increases the size of the government by at least \$1.8 trillion when fully implemented.

It gives the Secretary of Health and Human Services the power to define benefits for every private plan in America and to redefine those benefits annually. That's a lot of power over people's lives.

It will cause health care premiums for millions to go up, not down.

It tightens further the new federal rating bands for insurance rates. That means that millions who are expecting lower costs as a result of health reform will end up paying more in the form of higher premiums. The new rating reforms alone will raise premiums by as much as 50% on millions.

It imposes new fees and taxes. These new fees and taxes will total about a half trillion dollars over the next few years. On the front end, these fees and taxes will cause premium increases as early as 2010 even before most of the reforms take effect.

Then after forcing health premiums to go up, this bill makes it mandatory to buy it.

On several occasions, Republicans tried to take the Chairman's Mark in a different direction. We tried to insure that the President's pledge to not tax middle-income families, seniors, or veterans was carried out. We were rebuffed every step of the way.

And Republican efforts to provide consumers with a lower cost benefit option were consistently defeated – this means that despite the promises, a lot of people aren't actually going to be able to “keep what they have.”

It imposes higher premiums for prescription drug coverage on seniors and the disabled.

And it creates a new Medicare Commission with broad authority to make further cuts in Medicare and it makes that Commission permanent.

In our Group of Six negotiations, I resisted making the Commission permanent. And I certainly wasn't going to agree to target prescription drug premiums.

But this bill now requires the Medicare Commission to continue making cuts to Medicare forever. The damage this group of unelected people could do to Medicare is unknown.

What's more alarming is that so many providers got exempted from the cuts this Commission would make that it forces the cuts to fall directly on seniors and the disabled.

The Congressional Budget Office has confirmed that the Commission structure requires it to focus it's budget axe on the premiums seniors pay for Part D prescription drug coverage and for Medicare Advantage.

Sooner or later, it has to be acknowledged that, by making the Commission permanent, those savings are coming from more and more cuts to Medicare.

Finally, I can't help but note the incredible cynicism in an amendment that took benefits away from children. That amendment was offered and passed because the Chairman's Mark had the audacity to let children get covered through private insurance.

In 41 states, children would have received access to the EPSDT benefit.

EPSDT benefits cover vitally needed services for children such as rehabilitation services, physical, occupational and speech therapy particularly for children with developmental disabilities.

But those benefits were deleted by Rockefeller Amendment C21. Now children in 41 states won't have access to health care and they'll be left in a grossly underfunded public program. And they lost these important benefits.

What this mark up has shown is that there is a clear and significant philosophical difference between the two sides.

Throughout the markup, we have focused on trying to reduce the overall cost of the bill. We were told 'no'.

We focused on trying to reduce the pervasive role of government in the Chairman's Mark. We were told 'no'.

We tried to make it harder to for illegal immigrants to get benefits. We were told 'no'.

We tried to guarantee that federal funding for abortions wouldn't be allowed under this bill. We were told 'no'.

We tried to allow alternatives to the individual mandate and harsh penalties. We were told 'no'.

We tried to reward states with extra Medicaid dollars if they passed medical malpractice reform. We were told not just 'no' but shockingly we were told Medicaid isn't even in the Committee's jurisdiction.

We have watched while the other side has expanded public coverage.

We saw Democrat amendments move millions from private coverage into public coverage.

We saw Democrat amendments create new government programs that cover families making close to 90 THOUSAND dollars.

And at the end of the day, after raising billions in new taxes, cutting hundreds of billions from Medicare, and imposing stiff new penalties for people who don't buy insurance, and increasing costs for those that do ... 25 million people will still not even have health insurance.

I don't think this is what the American people had in mind when we promised to fix the health care system.

As I said when this process started, the Chairman's mark that was released 6 days ago was an incomplete, but comprehensive, good faith attempt to reach a bipartisan agreement.

But then the Modification pulled that attempt at bipartisan compromise very far towards a partisan approach on several key issues.

With this markup nearing its conclusion we can now see clearly that the bill continues its march leftward.

The broad bipartisan character of the reform proposal has changed.

This partisan change is precisely what Republicans feared would occur at later stages in the legislative process.

Today we see that those fears were legitimate and justified.

Nevertheless, I still hold out hope that at some point the doorway to bipartisanship will be opened once again.

I hope that at some point the White House and Leadership will want to correct the mistake they made by ending our collaborative bipartisan work.

I hope at some point they will want to let that bipartisan work begin again. And then, they need to back that effort and give it the time needed to get it right.

But it is clear that today is not the day when that is going to happen.

Statement by Senator John F. Kerry
United States Senate Committee on Finance
October 13, 2009

Mr. Chairman, first of all I have to commend you for your commitment to health care reform. For years, you have worked diligently on this issue. The mark before us not only reflects your hard work, but also accomplishes exactly what you set out to do.

The mark spends less than \$900 billion on health care reform and actually lowers the deficit. But more importantly, it makes health care affordable for the millions of uninsured Americans and will result in 94 of them having health insurance.

A year ago June, this Committee started its work in earnest, with a day-long summit with experts. Many of the ideas we discussed that day shaped the mark before us.

At the summit, we learned the value of our employer based system and how important it is that we not weaken it. But we also learned from Massachusetts that coverage can be improved significantly. In fact, the exchanges in the mark are modeled somewhat after the Connector in Massachusetts.

Our votes on this mark are among the most important we will ever take, and I think it's vital that not only my colleagues but also the American public fully understand what we are voting on today.

So, my colleagues on the opposite side of the dais, let me ask you this: Should we add another 20 million Americans to the ranks of the uninsured over the next decade? Because if we fail to act now, that's exactly what will happen. Today, 46 million Americans go without health insurance. That number will grow to 66 million by 2019 unless we pass the Chairman's Mark. The Mark will extend coverage to 94 percent of Americans by 2019. But if you want to increase the number of uninsured Americans, then you should oppose the Chairman's Mark.

And let me ask you this: If you want health care costs to consume an ever increasing share of household incomes, forcing an increasing number of Americans to file for bankruptcy due to medical bills? If so, then you should vote against the Chairman's Mark today. Because the Chairman's Mark goes a long way toward helping make coverage more affordable for Americans. It provides premium and cost-sharing assistance to families living moderately above the poverty line. It expands Medicaid to provide quality health care coverage to our most vulnerable Americans. And it requires insurance companies to limit out-of-pocket expenses to all consumers and requires them to cover preventive care for free.

And let me ask you this: If you want insurance companies to continue to deny coverage to Americans based on pre-existing conditions? If you think so, you should definitely vote against the Chairman's Mark. And if you believe women should continue being charged about 40

percent for the exact same insurance coverage as men, then the Chairman's Mark isn't for you, because the Chairman's Mark prohibits these outrageous practices.

And let me ask you this: If you believe we should continue spending nearly 50 percent more per person on health care than any other country – without actually getting any healthier? If so, then by all means oppose the Chairman's Mark because it contains a host of provisions designed to improve the quality of care provided to patients while realigning payment systems to reward high quality care.

And let me ask you this: If you believe the government should just stand by and do nothing as the number of small businesses offering health benefits continues to decline? Well, if so, the Chairman's Mark isn't for you. The Mark includes important provisions to help small businesses provide health insurance to their employees. It would allow small business owners to join together to purchase insurance and enhance their buying power. And it includes \$23 billion in small business tax credits to help small businesses provide affordable health insurance.

I am pretty certain that if each of us on the dais put together our own health care bill, we would have a different result than what is before us now. I would have included a public option, and I will continue to support the efforts of my friends Senator Rockefeller and Senator Schumer to do just that. A public plan is essential if we want to lower costs and increase choice and competition in the health insurance market.

The mark is not perfect, but the good far outweighs the bad. It reflects numerous hours of grueling work and hard-fought compromises. There are still a few issues that I will continue to work on as this mark makes its way through the legislative process. For example, I am concerned that the threshold on the high cost insurance tax is too low and the provision impacts more policies than intended. But I'm confident we can work together to strike the right balance of lowering health care spending without harming middle class families.

Make no mistake, though. What is before us is a solid proposal that meets our requirements. We should be proud of the work we've done, because this Mark provides a good starting place for health care reform.

Back in July, our former colleague Ted Kennedy wrote a magazine article titled "The Cause of My Life." Ted made the point that in reforming our health care system, "incremental measures will no longer suffice. We need to succeed where Teddy Roosevelt and other since have failed. If we don't reform the system, if we leave things as they are, health-care inflation will cost far more over the next decade than health-care reform. We will pay far more for far less, with millions more Americans uninsured or underinsured. This would threaten not just the health of Americans, but also the strength of the American economy."

So let me ask you, my colleagues on the opposite side of the dais: Will you reflect on the words of our friend Ted Kennedy? He devoted his career to health care reform. And he, more than anyone, understood what is at stake.

And let me ask you: Will you keep an open mind as the process moves forward? We should not let ourselves become caught up in process arguments. We should stay focused on the task at hand and not forget the price of failing to act.

STATEMENT OF SEN. PAT ROBERTS
SENATE FINANCE COMMITTEE
HEALTH CARE REFORM MARKUP
10.13.09

Although I am personally against the bill in front of us today, I know that many of my fellow Committee Members will vote for it because they see it as a moderate alternative to the HELP and House bills.

Well, after my experience with the HELP bill, I have news for you: this bill, this so-called “moderate” health care reform bill, will NOT be the bill that we will see in the next few weeks coming to the Senate floor. It will NOT be the bill that comes out of the House-Senate Conference Committee.

It is not even the bill that this committee was considering last week!

I refer to the changes— if not marching orders— from the majority leadership. The carve outs for Nevada and then Oregon, Rhode Island and Michigan with regard to Medicaid costs to states, and the carve out for states like New York that get a higher threshold for so-called “Cadillac Plans” along with 16 other states.

As I have stated, the bill that comes to the Senate floor after having been merged with the HELP bill, and the conference report that comes out at the end of this process will be radically different, and it will contain all of the policies that many of you who may vote for this bill today say you oppose:

a government-run insurance plan, higher taxes on American families and small businesses, a job-killing employer pay-or-play tax, costly insurance market ratings restrictions, bloated government entitlement programs, and robust tools for the government to ration your health care.

Trust me, a vote for this bill will be a vote for that bill. If you could but resist the urge to play into the hands of those who would lead this country down that path and instead take a thoughtful, step-by-step road that could result in at least a half dozen productive bi-partisan reforms.

I know, Mr. Chairman, my colleagues, you are tired of hearing me repeatedly say in hearing after hearing that we should place a big sign at the back of our hearing room wall that says, “Do No Harm!”

With this ever-changing bill, we have failed that test. And, as I have said before as well, I am terribly concerned that we are riding hell for leather into a health care box canyon. Like riding your pickup over a whole tangle of barbed wire. Getting out of this mess and back on solid ground to make Medicare solvent is going to be a mighty rough and tough ride.

For all of these reasons— for any of these reasons— I urge my colleagues to vote NO on this bill.

[Submitted by Senator Cornyn]

Peter Suderman: The Lesson of State Health-Care Reforms

October 6, 2009

The Wall Street Journal

The Lesson of State Health-Care Reforms

The major provisions of ObamaCare already have been tried. They've led to increased costs and reduced access to care.

By PETER SUDERMAN

Supreme Court Justice Louis Brandeis famously envisioned the states serving as laboratories, trying "novel social and economic experiments without risk to the rest of the country." And on health care, that's just what they've done.

Like participants in a national science fair, state governments have tested variants on most of the major components of the health-care reform plans currently being considered in Congress. The results have been dramatically increased premiums in the individual market, spiraling public health-care costs, and reduced access to care. In other words: The reforms have failed.

New York is exhibit A. In 1993, the state prohibited insurers from declining to cover individuals with pre-existing health conditions ("guaranteed issue"). New York also required insurers to charge those enrolled in their plans the same premium, regardless of health status, age or sex ("community rating"). The goal was to reduce the number of uninsured by making health insurance more accessible, particularly to those who don't have employer-provided insurance.

It hasn't worked out very well, according to a Manhattan Institute study released last month by Stephen T. Parente, a professor of finance at the University of Minnesota and Tarren Bragdon, CEO of the Maine Heritage Policy Center. In 1994, there were just under 752,000 individuals enrolled in individual insurance plans, or about 4.7% of the nonelderly population. This put New York roughly in line with the rest of the U.S. Today,

that percentage has dropped to just 0.2% of the state's nonelderly. In contrast, between 1994 and 2007, the total number of people insured in the individual market across the U.S. rose to 5.5% from 4.5%.

The decline in the number of people enrolled in individual insurance plans, the authors say, is "attributable largely to a steep increase in premiums" because of the state's regulations. Messrs. Parente and Bragdon estimate that repeal of community rating and guaranteed issue could reduce the price of individual coverage by 42%.

New York's experience with guaranteed issue and community rating is not unique. In 1996, similar reforms in Washington state preceded massive premium spikes in the individual market. Some premiums increased as much as 78% in the first three years of the reforms-or 10 times medical inflation-according to a study presented at the annual meeting of the Association for Health Services Research in 1999. Other results included a 25% drop in enrollment in the individual market, and a reduction in services offered. Within four years, for example, none of the state's major carriers offered individual insurance plans that included maternity coverage.

A 2008 analysis by Kaiser Permanente's Patricia Lynch published by Health Affairs noted that in addition to Washington and New York, the individual insurance markets in Kentucky, Maine, Massachusetts, New Hampshire, New Jersey and Vermont "deteriorated" after the enactment of guaranteed issue. Individual insurance became significantly more expensive and there was no significant decrease in the number of uninsured.

Supporters of federal health-care reform argue that the problems associated with these regulations can be addressed with the addition of an individual mandate, which is part of every ObamaCare bill in Congress. This would require every individual to purchase health insurance.

Guaranteed issue alone, the argument goes, results in slightly more expensive premiums, which drives healthier individuals out of the risk pool, which in turn further drives up premiums. The end result is that many healthy people opt out, leaving a small pool of sick individuals with very high premiums. An individual mandate, however, would spread those premium costs across a larger, healthier population, thus keeping premium costs down.

The experience of Massachusetts, which implemented an individual mandate in 2007, suggests otherwise. Health-insurance premiums in the Bay State have risen significantly faster than the national average, according to the Commonwealth Fund, a nonprofit

health foundation. At an average of \$13,788, the state's family plans are now the nation's most expensive. Meanwhile, insurance companies are planning additional double-digit hikes, "prompting many employers to reduce benefits and shift additional costs to workers" according to the Boston Globe.

And health-care costs have continued to grow rapidly. According to a Rand Corporation study this year, the growth now exceeds state GDP by 8%. The Boston Globe recently reported that state health-insurance commissioners are now worried that medical spending could push both employers and patients into bankruptcy, and may even threaten the system's continued existence.

Meanwhile, survey data from the Massachusetts Medical Society indicate that the state's primary-care providers are being squeezed. Family doctors report taking fewer new patients and increases in wait time.

Reform measures in other states have proven to be expensive duds. Maine's 2003 reform plan, Dirigo Health, included a government insurance option resembling the public option included in the House health-care bill. This public plan, "DirigoChoice," was supposed to expand care to all 128,000 of Maine's uninsured by 2009. But according to the U.S. Census Bureau, the 2007 uninsured rate remained roughly 10%-essentially unchanged. DirigoChoice's individual insurance premiums increased by 74% over its first four years-to \$499 a month from \$287 a month-according to an analysis of Dirigo data by the Maine Heritage Policy Center. The cost of DirigoHealth to taxpayers so far has been \$155 million.

Tennessee's plan for universal coverage, dubbed TennCare, fared even worse in the 1990s. The goal of the state-run public insurance plan was to expand coverage to the uninsured by reducing waste. But the costs of expanding coverage quickly ballooned. In 2005, facing bankruptcy, the state was forced to cut 170,000 individuals from its insurance rolls.

Despite these state-level failures, President Barack Obama and congressional Democrats are pushing forward a slate of similar reforms. Unlike most high-school science fair participants, they seem unaware that the point of doing experiments is to identify what actually works. Instead, they've identified what doesn't-and decided to do it again.

- *Mr. Suderman is an associate editor at Reason magazine.*

CLOSING REMARKS OF HON. ORRIN HATCH
ON AMERICA'S HEALTHY FUTURE ACT OF 2009
October 13, 2009

I have taken a lot of votes in my Senate service as I have had the proud honor of representing Utahns and Americans all across this great nation. I deliver these remarks with a heavy heart because what could have been a strong bipartisan vote reflecting our collective and genuine desire for responsible reform is now ending as another partisan vote as we take another step forward towards the flawed solution of reforming one-sixth of our economy with more spending, more government and more taxes.

Some of us have endured almost four weeks of debate in the Health, Education, Labor and Pensions Committee and now all of us have gone through two weeks of strenuous debate in the Senate Finance Committee. However, it almost seems like these hundreds of hours of debate were almost all for naught.

It is important for Americans everywhere to understand that the bills that we have spent hundreds of hours working on are NOT the bills that will be discussed on the Senate floor.

The real bill is currently being written behind closed doors in the dark corners of the Capitol and the White House and we can all only hope that all of us, especially American families, will have ample opportunity, at least 72 hours, to review the full bill and its cost before we are asked to consider this on the floor and vote on it. As a bill that affects every American life and every American business – this is too big and too important to not have a full public review.

I want to spend my time today talking about why this bill fails President Obama's own test for responsible health care reform.

This bill is another example of Washington once again talking from both sides of the mouth and using technicalities and policy nuances to evade the promises made to our seniors and middle class families.

First, President Obama in his own words has consistently stated: If you like your current plan, you will be able to keep it. Let me repeat that: if you like your plan, you will be able to keep it. Well, the policies of this bill do not match this pledge.

One of the amendments I offered simply provided that if more than 1 million Americans would lose the coverage of their choice because of the implementation of this bill, then this legislation would not go into effect. This was a simple and straightforward amendment – no nuance, no double talk.

This amendment was defeated along party lines. It should come as no surprise to anyone on this committee that in a recent Rasmussen poll a majority of Americans with health care coverage, almost 53 percent, said that this bill would force them to change coverage.

This bill is rife with policies that will do anything but allow you to keep your coverage. It cuts \$133 billion out of the Medicare Advantage program, which will adversely impact the availability of these plans for millions of American seniors, especially in rural areas. It is pushing for policies at a federal level that actuaries acknowledge could increase premiums for up to one third of the population by 35 percent. Not to mention the new insurance tax which will cost families another \$500 in higher premiums. This will make their current coverage unaffordable for countless Americans.

American families are very smart and very astute. They realize there is no free lunch, especially in Washington. They are being promised an almost trillion dollar bill that will not increase deficits, not raise taxes and not cut benefits. Only Washington could try to sell a promise like this with a straight face.

Second, the President has consistently pledged: *We're not going to mess with Medicare*. Once again, this is another simple and straightforward pledge that this bill has now evaded through Washington doubletalk.

This bill strips \$133 billion out of the Medicare Advantage program that currently covers 10.6 million seniors or almost one out of four seniors in the Medicare program. According to the Congressional Budget Office, under this bill the value of so-called additional benefits like vision care and dental care will decline from \$135 to \$42 by 2019. That is a reduction of more than 70 percent in benefits. You heard me right – 70 percent.

I offered an amendment to protect these benefits for our seniors, many of whom are low-income Americans and reside in rural states. However, this amendment too was defeated. The majority chose to skirt the President's pledge about no reduction in Medicare benefits for our seniors by characterizing the benefits being lost – vision care, dental care and reduced hospital deductibles – as extra benefits, not statutory benefits.

Let me make this point as clearly as I can – when we promise American seniors that we will not reduce their benefits, let us be honest about that promise. Benefits are benefits. So we are either going to protect benefits or not – it is that simple and under this bill, if you are a senior with Medicare Advantage, the unfortunate answer is NO.

Third, the President has consistently stated: I can make a firm pledge. Under my plan no family making less than \$250,000 a year will see any form of tax increase.

Now let us examine the realities of this bill. As I said before, there is no such thing as a free lunch, especially when Washington is the one inviting you over. According to the Joint Committee on Taxation, there are more than \$400 billion in new taxes under this bill to continue to fund Washington's insatiable appetite for spending.

Here are some of the highlights:

- \$23 billion in new taxes on employers through a mandate that will disproportionately affect low income Americans and all at a time when our unemployment is rapidly approaching double digits.
- \$4 billion in new taxes on Americans who fail to buy a Washington-defined level of coverage.
- \$322 billion in new taxes on everything from insurance premiums to prescription drugs to hearing devices and wheelchairs

Representatives from both the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) testified before the Finance Committee that these taxes will be passed on to the consumers. So even though this bill tries to hide these costs as indirect taxes, average Americans who purchase health plans, use prescription drugs and buy medical devices – everything from hearing aids to crutches – will end up footing the bill. By the way, it is interesting to note here that although these tax increases and Medicare cuts will start as early as next year, subsidies to help people with their premiums, which will skyrocket under this plan, will not be available until July of 2013 – three and a half years later

So what about the promise of no taxes on families making less than \$250,000? Well look at the evidence. According to data from the Joint Committee on Taxation and former CBO Director Douglas Holtz-Eakin, 89 percent of these new taxes will be paid by taxpayers making less than \$200,000 a year. The insurance excise tax alone will cost families up to \$500 more in premiums. That's not all. The Joint Committee on Taxation also found that at least 71 percent of all penalties collected from the individual mandate will also come from those making less than \$250,000. Like I said, there is no free lunch in this town.

So based on my count this bill already has three strikes against President Obama's own pledges to the American people.

Lastly, let me talk a little bit about the myth of this proposal actually reducing the deficit by \$81 billion over 10 years. Here is the harsh reality – Congressional Budget Office recently reported that our national deficit for fiscal year 2009 alone was a shocking \$1.4 trillion.

Let me put this in perspective. This was the largest yearly deficit since 1945. It is more than THREE times our deficit from last year and almost 10 percent our ENTIRE economy. This should send shivers down the spine of every American out there. We are literally drowning the future of this nation in a sea of red ink.

But the biggest bait and switch on the American people about this bill's impact on deficit is a simple math trick. If something is too expensive to do for a full 10 year period, just do it for 6 years. Most of the major spending provisions of the bill do not go into effect until 2013 or later – coincidentally after the 2012 Presidential elections. So what we are seeing is not a full 10 year score but rather a 6 year score.

According to the Senate Budget Committee, the full 10 year score of this plan will easily surpass \$1.8 trillion.

In our current fiscal environment, where the government will have to borrow nearly 43 cents of every dollar it spends this year, let's think hard about what we are doing to our country and our future generations. Our national debt is on a path to double in the next five years and triple in the next 10 years. There is still time for us to step back, press the reset button and write a bill that all of us can support and be proud of.

Wyden-Baucus Colloquy on Working on Choice Proposals

Senator Wyden. As you know, Mr. Chairman, I have long been working on fundamental health reform that would provide expanded choice to all Americans including employees who have group coverage at their workplace. Today, almost half of the workers who are fortunate enough to have employer-sponsored health care don't have any choice of health plans. I believe that providing workers choice -- just like we have as members of Congress -- will both improve the quality of health plans and lower costs by encouraging health insurers to compete for consumers' business. Choice and competition are fundamental to any comprehensive health reform.

I offered an amendment during the mark up that would have ensured every American would be guaranteed a choice of health plans. Unfortunately, it was clear that my proposal would not have been approved by the Committee, so I withdrew the amendment. Since then, our staffs have been working to come up with a workable choice proposal that will enable employees to shop for the coverage that most efficiently meets their needs and ensure that workers who are not offered affordable coverage by their employer would have the ability to shop for coverage in their local insurance exchange. It also would provide states with the opportunity to go even further in promoting choice and competition if they choose to provide their citizens with that option. I hope that you will join me in working to include this idea as health reform moves forward.

The Chairman. Thank you, Senator Wyden, for your tireless work over the past years in health reform and, most of all, promoting choice for American workers and their families. I too believe in choice, and I believe the most recent version of your proposal could help achieve our mutual goals of ensuring affordable coverage for all Americans and injecting competition into the health care system. We need to be sure that the proposal achieves our goals without unexpected consequences, but I believe it is a promising approach that could be included in the health reform bill that the Senate takes up. I look forward to working with you on this proposal.

[The charts referred to in the transcript, submitted by Senator Wyden, follow:]



CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

October 7, 2009

Honorable Max Baucus
Chairman
Committee on Finance
United States Senate
Washington, DC 20510

Dear Mr. Chairman,

The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) have completed a preliminary analysis of the Chairman's mark for the America's Healthy Future Act of 2009, incorporating the amendments that have been adopted to date by the Committee on Finance. That analysis reflects the specifications posted on the committee's Web site on October 2, 2009, corrections posted on October 5, and additional clarifications provided by the staff of the committee through October 6. CBO and JCT's analysis is preliminary in large part because the Chairman's mark, as amended, has not yet been embodied in legislative language.

Among other things, the Chairman's mark, as amended, would establish a mandate for most legal residents of the United States to obtain health insurance; set up insurance "exchanges" through which certain individuals and families could receive federal subsidies to substantially reduce the cost of purchasing that coverage; significantly expand eligibility for Medicaid; substantially reduce the growth of Medicare's payment rates for most services (relative to the growth rates projected under current law); impose an excise tax on insurance plans with relatively high premiums; and make various other changes to the Medicaid and Medicare programs and the federal tax code.

CBO and JCT's preliminary assessment of the proposal's impact on the federal budget deficit is summarized below. The enclosures with this letter provide estimates of the resulting changes in the number of nonelderly people in the United States who would have health insurance, present the primary budgetary effects of the proposal's major provisions related to insurance coverage, display detailed estimates of the cost or savings from

other proposed changes (primarily to the Medicare program) that would affect the federal government's direct spending, and describe the major additional corrections and clarifications provided by the committee staff.

Estimated Budgetary Impact of the Amended Chairman's Mark

According to CBO and JCT's assessment, enacting the Chairman's mark, as amended, would result in a net reduction in federal budget deficits of \$81 billion over the 2010–2019 period (see Table 1). The estimate includes a projected net cost of \$518 billion over 10 years for the proposed expansions in insurance coverage. That net cost itself reflects a gross total of \$829 billion in credits and subsidies provided through the exchanges, increased net outlays for Medicaid and the Children's Health Insurance Program (CHIP), and tax credits for small employers; those costs are partly offset by \$201 billion in revenues from the excise tax on high-premium insurance plans and \$110 billion in net savings from other sources. The net cost of the coverage expansions would be more than offset by the combination of other spending changes that CBO estimates would save \$404 billion over the 10 years and other provisions that JCT and CBO estimate would increase federal revenues by \$196 billion over the same period.¹ In subsequent years, the collective effect of those provisions would probably be continued reductions in federal budget deficits. Those estimates are all subject to substantial uncertainty.

Specifications Regarding Insurance Coverage

The amended mark would take several steps designed to increase the number of legal U.S. residents who have health insurance. Starting in July 2013, the proposal would establish a requirement for such residents to obtain insurance and would in many cases impose a financial penalty on people who did not do so. The proposal also would establish new insurance exchanges and would subsidize the purchase of health insurance through those exchanges for individuals and families with income between 100 percent and 400 percent of the federal poverty level (FPL).

¹ The \$196 billion figure includes \$180 billion in additional revenues (estimated by JCT) apart from receipts from the excise tax on high-premium insurance plans and \$16 billion in additional revenues from certain Medicare and Medicaid provisions (estimated by JCT and CBO).

TABLE 1. PRELIMINARY ESTIMATE OF THE EFFECTS ON THE DEFICIT OF THE CHAIRMAN'S MARK, AS AMENDED, FOR THE AMERICA'S HEALTHY FUTURE ACT OF 2009

	By Fiscal Year, in Billions of Dollars											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019	
NET CHANGES IN THE DEFICIT FROM INSURANCE COVERAGE PROVISIONS ^a												
Effects on the Deficit	*	3	5	-7	30	78	96	101	104	107	32	518
NET CHANGES IN THE DEFICIT FROM OTHER PROVISIONS AFFECTING DIRECT SPENDING ^b												
Effects on the Deficit of Changes in Outlays	9	-1	-11	-21	-42	-47	-55	-66	-78	-93	-65	-404
NET CHANGES IN THE DEFICIT FROM OTHER PROVISIONS AFFECTING REVENUES ^c												
Effects on the Deficit of Changes in Revenues ^d	-11	-13	-15	-19	-20	-21	-22	-23	-25	-26	-78	-196
NET CHANGES IN THE DEFICIT ^a												
Net Increase or Decrease (-) in the Budget Deficit	-2	-11	-20	-47	-32	10	20	13	1	-12	-111	-81
On-Budget	-2	-11	-20	-41	-24	20	31	26	16	6	-98	*
Off-Budget ^e	*	*	*	-6	-8	-9	-11	-13	-16	-18	-13	-81

Sources: Congressional Budget Office and staff of the Joint Committee on Taxation (JCT).

Notes: This estimate reflects the specifications posted on the Senate Finance Committee's Web site on October 2, 2009, corrections posted on October 5, and additional clarifications provided by the staff of the committee through October 6.

Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.

Components may not sum to totals because of rounding; * = between \$0.5 billion and -\$0.5 billion.

- a. Does not include effects on spending subject to future appropriations.
- b. These estimates reflect the effects of interactions between insurance coverage provisions and other Medicare and Medicaid provisions.
- c. The changes in revenues include effects on Social Security revenues that are classified as off-budget.
- d. The 10-year figure of \$196 billion includes \$180 billion in additional revenues (estimated by JCT) apart from receipts from the excise tax on high-premium insurance plans and \$16 billion in additional revenues from certain Medicare and Medicaid provisions (estimated by JCT and CBO).
- e. Off-budget effects include changes in Social Security spending and revenues.

Policies purchased through the exchanges (or directly from insurers) would have to meet several requirements: In particular, insurers would have to accept all applicants, could not limit coverage for preexisting medical conditions, and could not vary premiums to reflect differences in enrollees' health. The proposal also would provide start-up funds to encourage the creation of cooperative insurance plans (co-ops) that could be offered through the exchanges; existing insurers could not be approved as co-ops.

Starting in 2014, nonelderly people with income below 133 percent of the FPL would generally be made eligible for Medicaid; the federal government would pay a share of the costs of covering newly eligible enrollees that varies somewhat from year to year but ultimately would average about 90 percent. (Under current rules, the federal government usually pays about 57 percent, on average, of the costs of Medicaid benefits.) In addition, states would be required to maintain current coverage levels for children under Medicaid and CHIP through 2019. Beginning in 2014, states would receive higher federal reimbursement for CHIP beneficiaries, increasing from an average of 70 percent to 93 percent. CBO estimates that state spending on Medicaid would increase by about \$33 billion over the 2010–2019 period as a result of the specifications affecting coverage. That estimate reflects states' flexibility to make programmatic and other budgetary changes to Medicaid and CHIP.

The amended proposal contains a number of other key provisions. Although it would not explicitly require employers to offer health insurance, firms with more than 50 workers that did not offer coverage would be subject to a penalty for full-time workers who obtained subsidized coverage through the insurance exchanges. As a rule, full-time workers who were offered coverage from their employer would not be eligible to obtain subsidies via the exchanges. However, an exception to that "firewall" would be allowed for workers who had to pay more than a specified percentage of their income for their employer's insurance—10 percent in 2013, indexed over time—in which case the employer could also be penalized. Under certain circumstances, firms with relatively few employees and relatively low average wages would also be eligible for tax credits to cover up to half of their contributions toward health insurance premiums. Beginning in 2013, insurance policies with relatively high total premiums would be subject to a 40 percent excise tax on the amount by which the premiums exceeded a specified threshold. In general, that threshold would be set initially at \$8,000 for single policies and \$21,000 for

family policies (although a number of exceptions would apply); after 2013, those amounts would be indexed to overall inflation plus 1 percentage point.

On a preliminary basis, CBO and JCT estimate that the proposal's specifications affecting health insurance coverage would result in a net increase in federal deficits of \$518 billion over fiscal years 2010 through 2019. That estimate primarily reflects \$345 billion in additional federal outlays for Medicaid and CHIP and \$461 billion in federal subsidies that would be provided to purchase coverage through the new insurance exchanges and related spending.² The other main element of the coverage provisions that would increase federal deficits is the tax credit for small employers who offer health insurance, which is estimated to reduce revenues by \$23 billion over 10 years. Those costs would be partly offset by receipts or savings, totaling \$311 billion over the 10-year budget window, from four sources: net revenues from the excise tax on high-premium insurance plans, totaling \$201 billion; penalty payments by uninsured individuals, which would amount to \$4 billion; penalty payments by employers whose workers received subsidies via the exchanges, which would total \$23 billion; and other budgetary effects, mostly on tax revenues, associated with the expansion of federally subsidized insurance, which would reduce deficits by \$83 billion.³

By 2019, CBO and JCT estimate, the number of nonelderly people who are uninsured would be reduced by about 29 million, leaving about 25 million nonelderly residents uninsured (about one-third of whom would be unauthorized immigrants). Under the proposal, the share of legal nonelderly residents with insurance coverage would rise from about 83 percent currently to about 94 percent. Roughly 23 million people would purchase their own coverage through the new insurance exchanges, and there would

² The subsidies reflect the administrative costs of establishing and operating the exchanges. Related spending accounts for \$5 billion for high-risk pools, about \$3 billion for insurance co-ops, and the net budgetary effects of proposed reinsurance fees and payments.

³ Changes in the extent of employment-based health insurance affect federal revenues because most payments for that coverage are tax-preferred. If employers increase or decrease the amount of compensation they provide in the form of health insurance (relative to current-law projections), CBO and JCT assume that offsetting changes will occur in wages and other forms of compensation—which are generally taxable—to hold total compensation roughly the same. Such effects also arise with respect to specific elements of the proposal (such as the tax credits for small employers), and those effects are included within the estimate for those elements.

be roughly 14 million more enrollees in Medicaid and CHIP than is projected under current law.⁴ Relative to currently projected levels, the number of people either purchasing individual coverage outside the exchanges or obtaining coverage through employers would decline by several million.

The proposed co-ops had very little effect on the estimates of total enrollment in the exchanges or federal costs because, as they are described in the specifications, they seem unlikely to establish a significant market presence in many areas of the country or to noticeably affect federal subsidy payments. As a result, CBO estimates that of the \$6 billion in federal funds that would be made available, about \$3 billion would be spent over the 2010–2019 period.

Specifications Affecting Medicare and Medicaid

Other components of the proposal would alter spending under Medicare, Medicaid, CHIP, and other federal health programs. The proposal would make numerous changes to payment rates and payment rules in those programs (the budgetary effects of which are shown in Table 1 and detailed in the enclosed table). In total, CBO estimates that enacting those provisions would reduce direct spending by \$404 billion over the 2010–2019 period.⁵ The provisions that would result in the largest budget savings include these:

- Permanent reductions in the annual updates to Medicare’s payment rates for most services in the fee-for-service sector (other than physicians’ services), yielding budgetary savings of \$162 billion over 10 years. (That calculation excludes interactions between those provisions and others—namely, the effects of those changes on payments to Medicare Advantage plans and collections of Part B premiums.)

⁴ Under the proposal, certain employers could allow all of their workers to choose among the plans available in the exchanges, but those enrollees would not be eligible to receive subsidies via the exchanges (and thus are shown in the enclosed table as enrollees in employment-based coverage rather than as exchange enrollees). CBO and JCT estimate that approximately 4 million people would obtain coverage in that way in 2019, bringing the total number of people enrolled in exchange plans to about 27 million in that year.

⁵ In addition, the Medicare and Medicaid provisions would increase federal revenues by approximately \$16 billion over the 2010–2019 period.

- Setting payment rates in the Medicare Advantage program on the basis of the average of the bids submitted by Medicare Advantage plans in each market, yielding savings of an estimated \$117 billion (before interactions) over the 2010–2019 period.
- Reducing Medicare and Medicaid payments to hospitals that serve a large number of low-income patients, known as disproportionate share (DSH) hospitals, by almost \$45 billion—composed of roughly \$22 billion each from Medicaid and Medicare DSH payments.

The proposal also would establish a Medicare Commission, which would be required, under certain circumstances, to recommend changes to the Medicare program to limit the rate of growth in that program's spending. Those recommendations would go into effect automatically unless blocked by subsequent legislative action. For fiscal years 2015 through 2018, such recommendations would be required if the Medicare trustees projected that the program's spending per beneficiary would grow more rapidly than a measure of inflation (the average of the growth rates of the consumer price index for medical services and the overall index for all urban consumers). The proposal would not set a target for spending in 2019; after 2019, recommendations would be required if projected growth exceeded the rate of increase in gross domestic product (GDP) per capita plus 1 percentage point. The proposal would place a number of limitations on the actions available to the commission, including a prohibition against modifying eligibility or benefits, so its recommendations probably would focus on:

- Reductions in subsidies for non-Medicare benefits offered by Medicare Advantage plans;
- Reductions in subsidies of premiums charged by Part D plans; and
- Changes to payment rates or methodologies for services furnished in the fee-for-service sector by providers other than hospitals, physicians, hospices, and suppliers of durable medical equipment that is offered through competitive bidding.⁶

⁶ The proposal would authorize the Medicare Commission to recommend changes that would affect hospitals and hospices beginning in 2020.

The commission would develop its first set of recommendations during 2013 for implementation in 2015. CBO estimates that—given all of the reductions that would result from other provisions—this arrangement would reduce Medicare spending by an additional \$22 billion over the 2015–2019 period.

“Failsafe” Budgeting Mechanism

An amendment adopted by the committee would require that, beginning in 2012, the Director of the Office of Management and Budget (OMB) certify annually whether or not the provisions of the legislation are projected to increase the budget deficit in the coming year. If the Director determined that they were projected to increase the deficit, he or she would be required to notify the Congress, and exchange subsidies would be automatically adjusted to avoid the estimated increase in the deficit for that year.

The estimates presented in this preliminary analysis do not incorporate the potential effects of using this proposed failsafe mechanism, although CBO and JCT estimate that the amended mark would increase the deficit in fiscal years 2015 through 2018. Many of the budgetary effects of this proposal would appear as part of larger aggregates in the budget and would not be readily observable. Consequently, its overall budgetary impact could not be identified, and OMB’s estimating assumptions and procedures would determine whether and how this failsafe procedure was implemented. It is therefore difficult to predict whether the proposed failsafe mechanism would result in a budget-neutral impact in each year. If the mechanism was implemented to reduce exchange subsidy rates in some years, it would probably result in significant reductions to the dollar volume of such subsidies and associated reductions in coverage. Under CBO and JCT’s estimates of the deficit impact for the proposal, the failsafe provisions would require a reduction in exchange subsidies averaging about 15 percent during the years 2015 through 2018.

Important Caveats Regarding This Preliminary Analysis

There are a number of key reasons why the preliminary analysis that is provided in this letter and the enclosures does not constitute a final cost estimate for the proposal:

- The Chairman’s mark, as amended, has not yet been converted into legislative language. The review of such language could lead to

significant changes in the estimates of the proposal's effects on the federal budget and insurance coverage.

- The budgetary information shown in the above and enclosed tables reflects many of the major cash flows that would affect the federal budget as a result of implementing the specified policies and provides a preliminary assessment of the net effects on the federal budget deficit. However, some cash flows (such as risk adjustment payments) would appear in the budget but would net to zero and thus would not affect the deficit; CBO and JCT have not yet estimated all of those cash flows. Furthermore, CBO and JCT have not yet divided all of the estimated cash flows into spending and revenue components.
- Federal spending that would be funded by future appropriations is not reflected in these estimates. For example, implementation costs for operations of the Internal Revenue Service and the Centers for Medicare and Medicaid Services are not included. Those discretionary costs could total several billion dollars over the 10-year period, but CBO has not yet completed an estimate of the appropriations that would be necessary. (In contrast, administrative costs for establishing and operating the exchanges, largely funded through a premium surcharge, are included in Table 1.)

CBO's Previous Estimate

On September 16, 2009, CBO transmitted a preliminary analysis of specifications for the Chairman's mark as provided by staff of the Finance Committee. Those earlier estimates differ from the estimates provided here for two primary reasons:

First, the proposal has been changed in a number of significant ways. For example, the subsidies that would be provided through the insurance exchanges were made larger, the penalties for not having insurance were reduced, and more people would be exempt from those penalties. Furthermore, the provisions of the excise tax on high-premium insurance plans were changed in ways that would reduce the amount of revenues collected. In addition, states would now be required to maintain current coverage levels for children under Medicaid and CHIP through 2019. Although CBO and JCT were able to provide estimates for many amendments, the agencies are not in a position to assess the impact of

individual policy changes now that they have been combined in the amended mark.

Second, CBO and JCT have made some technical refinements in their estimating procedures, including a revised assessment of the impact of the proposed changes on premiums for employer-sponsored health insurance and the resulting effects on tax revenues.

Effects of the Proposal Beyond the First 10 Years

Although CBO does not generally provide cost estimates beyond the 10-year budget projection period (2010 through 2019 currently), Senate rules require some information about the budgetary impact of legislation in subsequent decades, and many Members have requested CBO analyses of the long-term budgetary impact of broad changes in the nation's health care and health insurance systems. However, a detailed year-by-year projection, like those that CBO prepares for the 10-year budget window, would not be meaningful because the uncertainties involved are simply too great. Among other factors, a wide range of changes could occur—in people's health, in the sources and extent of their insurance coverage, and in the delivery of medical care (such as advances in medical research, technological developments, and changes in physicians' practice patterns)—that are likely to be significant but are very difficult to predict, both under current law and under any proposal.

CBO has therefore developed a rough outlook for the decade following the 10-year budget window by grouping the elements of the proposal into broad categories and assessing the rate at which the budgetary impact of each of those broad categories is likely to increase over time. Under this proposal, the major categories are as follows:

- The gross cost of the coverage expansions, consisting of exchange subsidies, the net costs of expanded eligibility for Medicaid, and tax credits for employers: Those provisions have an estimated cost of \$180 billion in 2019, and that cost is growing at about 8 percent per year toward the end of the 10-year budget window. As a rough approximation, CBO assumes continued growth at about that rate during the following decade.

- The excise tax on high-premium insurance plans: JCT estimates that the provision would generate about \$46 billion in additional revenues in 2019 and that receipts would grow by roughly 10 percent to 15 percent per year in the following decade.
- Other taxes and the effects of coverage provisions on revenues: Increased revenues from those provisions are estimated to total about \$52 billion in 2019 and are growing at about 10 percent per year toward the end of the budget window. As a rough approximation, CBO assumes continued growth at about that rate during the following decade.
- Changes to the Medicare program and changes to Medicaid and CHIP other than those associated directly with expanded insurance coverage: Savings from those provisions are estimated to total \$93 billion in 2019, and CBO projects that, in combination, they will increase by 10 percent to 15 percent per year in the next decade.

All told, the proposal would reduce the federal deficit by \$12 billion in 2019, CBO and JCT estimate. After that, the added revenues and cost savings are projected to grow more rapidly than the cost of the coverage expansion. Consequently, CBO expects that the proposal, if enacted, would reduce federal budget deficits over the ensuing decade relative to those projected under current law—with a total effect during that decade that is in a broad range between one-quarter percent and one-half percent of GDP. The imprecision of that calculation reflects the even greater degree of uncertainty that attends to it, compared with CBO's 10-year budget estimates.

Many Members have expressed interest in the effects of reform proposals on various other measures of spending on health care. Under the Chairman's proposal, the projected effects on the federal budget deficit also represent the change in the federal government's overall commitment of resources to health care because essentially all of the spending and tax elements contained in the proposal are related to health care. Thus, the proposal would reduce the federal budgetary commitment to health care, relative to that under current law, during the decade following the 10-year budget window. Members have also requested information about the effect of proposals on national health expenditures (NHE). CBO does not analyze NHE as closely as it does the federal budget, however, and at this point the

agency has not assessed the net effect of the current proposal on NHE, either within the 10-year budget window or for the subsequent decade.

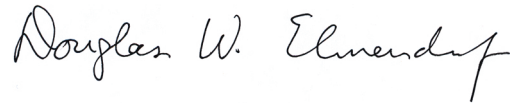
These projections assume that the proposals are enacted and remain unchanged throughout the next two decades, which is often not the case for major legislation. For example, the sustainable growth rate (SGR) mechanism governing Medicare's payments to physicians has frequently been modified (either through legislation or administrative action) to avoid reductions in those payments. The projected savings for the proposal reflect the cumulative impact of a number of specifications that would constrain payment rates for providers of Medicare services. In particular, the proposal would increase payment rates for physicians' services for 2010, but those rates would be reduced by about 25 percent for 2011 and then remain at current-law levels (that is, as specified under the SGR) for subsequent years. Under the proposal, increases in payment rates for many other providers would be held below the rate of inflation (in expectation of ongoing productivity improvements in the delivery of health care). The projected longer-term savings for the proposal also assume that the Medicare Commission is relatively effective in reducing costs—beyond the reductions that would be achieved by other aspects of the proposal—to meet the targets specified in the legislation. The long-term budgetary impact could be quite different if those provisions were ultimately changed or not fully implemented. (If those changes arose from future legislation, CBO would estimate their costs when that legislation was being considered by the Congress.)

CBO has not extrapolated estimates further into the future, because the uncertainties surrounding them are magnified even more. However, in view of the projected net savings during the decade following the 10-year budget window, CBO anticipates that the proposal would probably continue to reduce budget deficits relative to those under current law in subsequent decades. Therefore, pursuant to section 311 of S. Con. Res. 70, CBO estimates that enacting the proposal would not cause a net increase in deficits in excess of \$5 billion in any of the four 10-year periods beginning after 2019.

Honorable Max Baucus
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I hope this preliminary analysis is helpful for the committee's deliberations. If you have any questions, please contact me or CBO staff. The primary staff contacts for this analysis are Philip Ellis, who can be reached at 226-2666, and Holly Harvey, who can be reached at 226-2800.

Sincerely,

A handwritten signature in cursive script that reads "Douglas W. Elmendorf".

Douglas W. Elmendorf
Director

Enclosures

cc: Honorable Chuck Grassley
Ranking Member

Preliminary Analysis of the Insurance Coverage Provisions Contained in the Amended Chairman's Mark

EFFECTS ON INSURANCE COVERAGE /a		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
(Millions of nonelderly people, by calendar year)											
Current Law	Medicaid/CHIP	40	39	39	38	35	34	35	35	35	35
Coverage /b	Employer	150	153	156	158	161	162	162	162	162	162
	Nongroup	13	12	12	12	13	14	14	14	14	15
	Other /c	14	14	14	14	14	15	15	15	15	16
	Uninsured /d	<u>50</u>	<u>51</u>	<u>51</u>	<u>51</u>	<u>51</u>	<u>51</u>	<u>52</u>	<u>53</u>	<u>53</u>	<u>54</u>
	TOTAL	267	269	271	273	274	276	277	279	281	282
Change (+/-)	Medicaid/CHIP	*	-2	-2	-1	6	10	13	13	14	14
	Employer	*	2	2	3	4	*	-2	-2	-3	-3
	Nongroup/Other /c	*	*	*	*	-3	-4	-4	-4	-5	-5
	Exchanges	0	0	0	4	15	22	21	22	23	23
	Uninsured /d	*	-1	-1	-6	-22	-27	-28	-29	-29	-29
<u>Post-Policy Uninsured Population</u>											
	Number of Nonelderly People /d	51	50	50	45	28	24	24	24	24	25
	Insured Share of the Nonelderly Population /a										
	Including All Residents	81%	81%	81%	84%	90%	91%	91%	91%	91%	91%
	Excluding Unauthorized Immigrants	83%	83%	83%	85%	92%	94%	94%	94%	94%	94%
<u>Memo: Exchange Enrollees and Subsidies</u>											
	Number w/ Unaffordable Offer from Employer /e				*	1	1	1	1	2	2
	Number of Unsubsidized Exchange Enrollees				1	3	5	5	5	5	5
	Average Exchange Subsidy per Subsidized Enrollee						\$4,600	\$4,800	\$5,000	\$5,200	\$5,500

Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Note: CHIP = Children's Health Insurance Program; * = fewer than 0.5 million people.

a. Figures for the nonelderly population include only residents of the 50 states and the District of Columbia.

b. Figures reflect average annual enrollment; individuals reporting multiple sources of coverage are assigned a primary source.

c. Includes Medicare and other sources; the effects of the proposal are almost entirely on nongroup coverage.

d. The count of uninsured people includes unauthorized immigrants as well as people who are eligible for, but not enrolled in, Medicaid.

e. Workers who would have to pay more than a specified share of their income (10 percent in 2013) for employment-based coverage could receive subsidies via an exchange.

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Preliminary Analysis of the Insurance Coverage Provisions Contained in the Amended Chairman's Mark

EFFECTS ON THE FEDERAL DEFICIT / a,b,c (Billions of dollars, by fiscal year)	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
Medicaid/CHIP Outlays /d	-1	-2	-3	-1	25	44	61	69	74	80	345
Exchange Subsidies & Related Spending /e	1	2	3	7	29	68	80	84	90	98	461
Small Employer Tax Credits /f	<u>0</u>	<u>2</u>	<u>4</u>	<u>3</u>	<u>3</u>	<u>3</u>	<u>2</u>	<u>2</u>	<u>2</u>	<u>2</u>	<u>23</u>
Gross Cost of Coverage Provisions	*	2	4	8	56	115	143	155	166	180	829
Penalty Payments by Uninsured Individuals	0	0	0	0	0	*	-1	-1	-1	-1	-4
Penalty Payments by Employers /f	0	0	0	0	-1	-3	-4	-5	-5	-5	-23
Excise Tax on High Premium Insurance Plans /f	0	0	0	-10	-18	-23	-30	-35	-40	-46	-201
Other Effects on Tax Revenues and Outlays /g	<u>*</u>	<u>1</u>	<u>2</u>	<u>-6</u>	<u>-8</u>	<u>-11</u>	<u>-12</u>	<u>-13</u>	<u>-16</u>	<u>-20</u>	<u>-83</u>
NET COST OF COVERAGE PROVISIONS	*	3	5	-7	30	78	96	101	104	107	518

Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Note: CHIP = Children's Health Insurance Program; * = between \$0.5 billion and -\$0.5 billion.

a. Does not include several billion dollars in federal administrative costs that would be subject to appropriation.

b. Components may not sum to totals because of rounding; positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.

c. Estimates could change based on review of legislative language.

d. Under current law, states have the flexibility to make programmatic and other budgetary changes to Medicaid and CHIP. CBO estimates that state spending on Medicaid and CHIP in the 2010-2019 period would increase by about \$33 billion as a result of the coverage specifications.

e. Includes \$5 billion in spending for high-risk pools, about \$3 billion in spending for insurance co-ops, and the net budgetary effects of proposed reinsurance fees and payments.

f. The effects on the deficit of this provision include the associated effects of changes in taxable compensation on tax revenues.

g. The effects are almost entirely on tax revenues. CBO estimates that outlays for Social Security benefits would increase by about \$3 billion over the 2010-2019 period, and that the coverage provisions would have negligible effects on outlays for other federal programs.

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Preliminary Estimate for Title I, Subtitle F, Through Title V of the Chairman's Mark, as Amended, for the America's Healthy Future Act of 2009
Estimates reflect specifications and are subject to revision upon review of legislative language.

By fiscal year, in billions of dollars.

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
Changes in Direct Spending Outlays												
TITLE I-HEALTH CARE COVERAGE												
SUBTITLE F-TRANSPARENCY AND ACCOUNTABILITY												
Ombudsmen Program												
Transparency												
Health Insurance Consumer Assistance Grants	0	0	0	0	0	0	0	0	0	0	0	0
Standardization												
SUBTITLE G-ROLE OF PUBLIC PROGRAMS												
PART I-MEDICAID COVERAGE FOR THE LOWEST-INCOME POPULATIONS												
Eligibility Standards and Methodologies												
Medicaid Program Payments												
Medicaid and Employer-Sponsored Insurance												
Treatment of the Territories	0	0.1	0.1	0.1	0.7	0.7	0.8	0.8	0.9	1.0	1.0	5.3
Medicaid Improvement Fund	0	0	0	0	-0.1	-0.2	-0.2	-0.2	-0.2	0	-0.1	-0.7
PART II-CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)												
included in estimate for expanding insurance coverage												
PART III-IMPROVEMENTS TO MEDICAID												
Enrollment Coordination with the Exchange												
Presumptive Eligibility												
Waiver Transparency	0	0	0	0	0	0	0	0	0	0	0	0
PART IV-MEDICAID SERVICES												
Free-Standing Birth Centers	*	*	*	*	*	*	*	*	*	*	*	*
Curative and Palliative Care for Children in Medicaid	*	*	*	*	*	*	*	*	*	*	0.1	0.2
Long-Term Services and Supports												
Aging and Disability Resource Center funding	*	*	*	*	*	*	*	*	0	0	*	0.1
Community first choice option	0	0	0	0	0.1	0.2	0.4	0.9	1.2	0	0.1	2.9
Spousal impoverishment	0	0	0	0	0.2	0.2	0.2	0.3	0.3	0	0.2	1.2
Home- and community-based services	*	0.2	0.2	0.2	0.3	0.4	0.4	0.5	0.6	0.6	1.0	3.4
Money Follows the Person Rebalancing Demonstration	0	0	0	*	0.1	0.2	0.3	0.4	0.3	0.3	0.2	1.7
Family Planning Services	0	0	0	0	0	0	0	0	0	0	0	0
Definition of Medical Assistance	0	*	*	*	*	*	*	*	*	*	*	*
School-Based Health Centers	0.1	0.1	*	*	0	0	0	0	0	0	0.2	0.2
Repayment of Medicaid Overpayment	0.1	*	*	*	*	*	*	*	*	*	0.1	0.1
PART V-MEDICAID PRESCRIPTION DRUG COVERAGE												
	-0.6	-1.4	-1.7	-1.8	-1.9	-2.0	-2.3	-2.4	-2.5	-2.7	-7.4	-19.4
PART VI-MEDICAID DISPROPORTIONATE SHARE PAYMENTS												
	0	0	0	*	-2.2	-2.9	-4.1	-4.2	-4.3	-4.5	-2.2	-22.2

Preliminary Estimate for Title I, Subtitle F, Through Title V of the Chairman's Mark, as Amended, for the America's Healthy Future Act of 2009
Estimates reflect specifications and are subject to revision upon review of legislative language.

By fiscal year, in billions of dollars.

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
PART VII-DUAL ELIGIBLES												
Waiver Authority for Dual Eligible Demonstrations	0	0	0	0	0	0	0	0	0	0	0	0
Federal Coordinated Health Care Office	0	0	0	0	0	0	0	0	0	0	0	0
PART VIII-MEDICAID QUALITY												
Medicaid Quality Measures	*	*	*	0.1	0.1	*	*	*	*	0	0.2	0.3
Medicaid Reimbursement for Health-Care Acquired Conditions	0	0	*	*	*	*	*	*	*	*	*	*
Medicaid Bundled Payments Demonstration Project	0	0	0	0	0	0	0	0	0	0	0	0
Medicaid Global Payments Demonstration Project	*	*	*	0	0	0	0	0	0	0	0.1	0.1
Medicaid Accountable Care Organizations Demonstration Project	0	0	0	0	0	0	0	0	0	0	0	0
Medicaid Emergency Psychiatric Care Demonstration Project	0	*	*	*	*	*	*	*	0	0	0.1	0.1
PART IX-MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION												
	*	*	0	0	0	0	0	0	0	0	*	*
PART X-AMERICAN INDIANS AND ALASKA NATIVES												
Premiums and Cost-Sharing	included in estimate for expanding insurance coverage											
Payer of Last Resort	0	0	0	0	0	0	0	0	0	0	0	0
Eligibility Determination	0	0	0	0	0	0	0	0	0	0	0	0
Indian Providers and Medicare Part B	0	*	*	*	*	*	*	*	*	*	0.1	0.2
Other Policies Related to Exchange Coverage	0	0	0	0	0	0	0	0	0	0	0	0
Indian Tribe Health Benefits	included in JCT estimates											
SUBTITLE H-ADDRESSING HEALTH DISPARITIES												
Standardized Collection of Data	0	0.1	0.1	0.1	0	0	0	0	0	0	0.2	0.2
Sufficient Disparities Data	0	0	0	0	0	0	0	0	0	0	0	0
Data Sharing	0	0	0	0	0	0	0	0	0	0	0	0
Privacy and Security	0	0	0	0	0	0	0	0	0	0	0	0
Medical Power of Attorney for Foster Care Children	0	0	0	0	0	0	0	0	0	0	0	0
Therapeutic Foster Care	*	*	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.6
SUBTITLE I-MATERNAL, INFANT, AND EARLY CHILDHOOD VISITATION												
Home Visitation Grants Program	*	0.2	0.3	0.4	0.4	0.2	*	*	0	0	1.3	1.5
Support Services for Women Suffering from Postpartum Depression	0	0	0	0	0	0	0	0	0	0	0	0
Elder Justice	0	0	0	0	0	0	0	0	0	0	0	0
VA and TRICARE Protections	0	0	0	0	0	0	0	0	0	0	0	0
Assisted Suicide	0	0	0	0	0	0	0	0	0	0	0	0
Abstinence Education and Personal Responsibility Education for Adulthood Training	*	0.1	0.1	0.1	0.1	0.1	0.1	*	*	0	0.4	0.6

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TITLE II-PROMOTING DISEASE PREVENTION AND WELLNESS												
SUBTITLE A-MEDICARE												
Risk Assessment, Personalized Prevention Plan, and Wellness Visit	0.2	0.3	0.3	0.3	0.4	0.4	0.4	0.4	0.5	0.5	1.6	3.7
Removing Barriers to Preventive Services	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.4	0.8
Evidence-Based Coverage of Preventive Services	*	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.3	-0.7
Study on Beneficiary Access to Immunizations	0	0	0	0	0	0	0	0	0	0	0	0
Incentives for Healthy Lifestyles	*	*	*	*	*	*	0	0	0	0	0.1	0.1
SUBTITLE B-MEDICAID												
Improving Access to Preventive Services for Eligible Adults	*	*	*	*	*	*	*	*	*	*	*	0.1
Tobacco Cessation	0	0	0	*	*	*	*	*	*	*	*	-0.1
Incentives for Healthy Lifestyles	*	0.1	*	*	0	0	0	0	0	0	0.1	0.1
Medicaid State Plan Option Promoting Health Homes and Integrated Care	*	*	*	*	*	*	*	*	*	*	*	0.1
Appropriations for Childhood Obesity Demonstration Project	*	*	*	*	*	0	0	0	0	0	*	*
SUBTITLE C-WORKPLACE WELLNESS												
Incentives for Participation in Voluntary Wellness Programs	included in estimate for expanding insurance coverage											
TITLE III-IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE												
SUBTITLE A-TRANSFORMING THE HEALTH CARE DELIVERY SYSTEM												
PART I-LINKING PAYMENT TO QUALITY OUTCOMES IN THE MEDICARE PROGRAM												
Hospital Value-Based Purchasing	0	0	0	0	0	0	0	0	0	0	0	0
Physician Quality Reporting Initiative	0	0.1	*	-0.1	-0.1	-0.2	-0.2	-0.1	-0.2	-0.2	-0.1	-0.8
Expansion of Physician Feedback Program	0	0	0	0	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.1	-0.9
Value-Based Modifier for Physician Payment Formula	0	0	0	0	0	0	0	0	0	0	0	0
Medicare Inpatient Rehabilitation Facility, Long-Term Acute Care Hospital, and Hospice Quality Reporting	0	0	0	0	*	*	*	*	*	*	*	-0.2
Medicare PPS-Exempt Cancer Hospital Quality Reporting	0	0	0	0	0	0	0	0	0	0	0	0
Medicare Home Health Agency and Skilled Nursing Facility Value-Based Purchasing Implementation Plans	0	0	0	0	0	0	0	0	0	0	0	0
Reducing Health-Care Acquired Conditions	0	0	0	0	0	-0.3	-0.3	-0.3	-0.3	-0.3	0	-1.5
PART II-STRENGTHENING THE QUALITY INFRASTRUCTURE												
Quality Infrastructure	*	0.1	0.1	0.1	0.1	*	0	0	0	0	0.2	0.3
Health Information Technology for Free Clinics	0	0	0	0	0	0	0	0	0	0	0	0

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PART III-ENCOURAGING DEVELOPMENT OF THE NEW PATIENT CARE MODELS												
Accountable Care Organizations	0	0	*	-0.1	-0.3	-0.6	-0.7	-0.9	-1.0	-1.2	-0.5	-4.9
CMS Innovation Center												
Funding for Center (including noncovered benefits)	0.1	0.2	0.4	0.6	0.7	0.8	0.9	1.0	1.0	1.0	1.9	6.6
Effect on Medicare spending for benefits	0	-0.1	-0.2	-0.4	-0.5	-0.6	-0.9	-1.3	-1.8	-2.3	-1.1	-8.0
National Pilot Program on Payment Bundling	0	0	0	*	*	*	*	*	*	*	*	*
Reducing Avoidable Hospital Readmissions	0	0	0	-0.3	-0.3	-0.3	-0.3	-0.3	-0.3	-0.3	-0.5	-2.1
Transitional Care Program to Reduce Preventable Readmissions	0	0.1	0.2	0.2	0.1	0	0	0	0	0	0.5	0.5
Extension of Gainsharing Demonstration	*	*	*	*	*	0	0	0	0	0	*	*
Home-Based Chronic Care Management Program	*	*	*	*	*	*	*	*	*	*	*	*
PART IV-STRENGTHENING PRIMARY CARE AND OTHER WORKFORCE IMPROVEMENTS												
Primary Care/General Surgery Bonus	0	0.2	0.3	0.3	0.3	0.3	0.1	0	0	0	1.1	1.6
Graduate Medical Education Provisions	*	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.4	1.0
Proposal on Development of a National Workforce Strategy	0	0	0	0	0	0	0	0	0	0	0	0
Demonstration Project to Address Health Professions Workforce Needs	*	*	0.1	0.1	0.1	0.1	*	*	*	0	0.3	0.4
Extension of Family-to-Family Health Information Centers	*	*	*	*	*	*	0	0	0	0	*	*
Teaching Health Centers	0	*	*	*	*	*	*	*	*	*	0.2	0.2
Advanced-Practice Nurse Training	0	0.2	0.2	0.2	0.2	0.2	*	0	0	0	0.8	1.0

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SUBTITLE B-IMPROVING MEDICARE FOR PATIENTS AND PROVIDERS												
PART I-ENSURING BENEFICIARY ACCESS TO PHYSICIAN CARE AND OTHER SERVICES												
Sustainable Growth Rate	7.0	3.9	0	0	0	0	0	0	0	0	10.9	10.9
Extension of Floor on Medicare Work Geographic Adjustment	0.3	0.5	0.2	0	0	0	0	0	0	0	1.1	1.1
Practice Expense Geographic Practice Cost Index	0.2	0.6	0.3	0	0	0	0	0	0	0	1.1	1.1
Misvalued Relative Value Units	0	0	0	0	0	0	0	0	0	0	0	0
Therapy Caps	0.7	0.9	0.2	0	0	0	0	0	0	0	1.8	1.8
Extension of Treatment of Certain Physician Pathology Services	0.1	0.1	*	0	0	0	0	0	0	0	0.2	0.2
Extension of Increased Payments for Ambulance Services	*	*	*	0	0	0	0	0	0	0	0.1	0.1
Extension of Long-Term Care Hospital Provisions	0	0.1	0.1	*	*	*	0	0	0	0	0.2	0.2
Extension of Payment Adjustment for Mental Health Services	*	*	*	0	0	0	0	0	0	0	0.1	0.1
Permit Physician Assistants to Order Post-Hospital												
Extended Care Services and to Serve Hospice Patients	*	*	*	*	*	*	*	*	*	*	*	*
Medicare Diabetes Self-Management Training	*	*	*	*	*	*	*	*	*	*	*	*
Medicare Improvement Fund	0	0	0	0	-16.7	-5.6	0	0	0	0	-16.7	-22.3
Medicare Part B Special Enrollment Period for Military Retirees	0	0	*	*	*	*	*	*	*	*	*	*
Federally Qualified Health Centers PPS	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.4	0.9
Guidelines to Ensure Emergency Room Access	0	0	0	0	0	0	0	0	0	0	0	0
Medicare Payment for Biosimilar Products	0	0	0	0	0	0	0	0	0	0	0	0
Access to Critical Lab Tests	0	*	*	*	0	0	0	0	0	0	0.1	0.1
Report on Payment for New Clinical Lab Tests	0	0	0	0	0	0	0	0	0	0	0	0
PART II-RURAL PROTECTIONS												
Extend Medicare Rural Hospital Flexibility Program	0	0	0	0	0	0	0	0	0	0	0	0
Extend HOPD Hold Harmless for Small Rural Hospitals	*	*	*	0	0	0	0	0	0	0	0.1	0.1
Extend and Expand HOPD Hold Harmless for												
Sole Community Hospitals	0.1	0.2	*	0	0	0	0	0	0	0	0.3	0.3
Extend Reasonable Cost Payment for Laboratory Services												
in Small Rural Hospitals	*	*	*	0	0	0	0	0	0	0	*	*
Extend Rural Community Hospital Demonstration Program	0	0	0	0	0	0	0	0	0	0	0	0
Extend Medicare Dependent Hospital Program	0	0	*	*	*	0	0	0	0	0	0.1	0.1
Payment Adjustment for Low-Volume Hospitals	0	0.1	0.1	*	0	0	0	0	0	0	0.3	0.3
Demonstration Project on Community Health Integration Models												
in Certain Rural Counties	0	0	0	0	0	0	0	0	0	0	0	0
Study on Adequacy of Medicare Payments in Rural Areas	0	0	0	0	0	0	0	0	0	0	0	0
Technical Correction Related to Critical Access Hospitals	0	0	0	0	0	0	0	0	0	0	0	0
Payment for Dual-Energy X-Ray Absorptiometry Services	0.1	0.1	*	0	0	0	0	0	0	0	0.1	0.1
Super Rural Ambulance Payments	*	*	*	0	0	0	0	0	0	0	*	*

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PART III-MEDICARE PART D IMPROVEMENTS												
Improving Coverage in the Part D Coverage Gap	0.3	1.3	1.2	1.4	1.6	1.8	2.2	2.3	2.5	3.2	5.7	17.7
Improving the Determination of Part D Low-Income Benchmarks	0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.7
Voluntary De Minimis Policy for Low-Income Subsidy Plans	0	*	*	*	*	*	*	0.1	0.1	0.1	0.1	0.4
Special Rule for Widows and Widowers Regarding Eligibility for Low-Income Assistance	0	*	*	*	*	*	*	*	*	*	0.1	0.2
Facilitation of Reassignments of Beneficiaries in Low-Income Subsidy Plans	*	*	*	*	*	*	*	*	*	*	*	*
Funding Outreach and Education of Low-Income Programs	*	*	*	0	0	0	0	0	0	0	*	*
Strengthening Formularies with Respect to Certain Categories or Classes of Drugs	0	0	0	0	0	0	0	0	0	0	0	0
Reducing the Part D Premium Subsidy for High-Income Beneficiaries	0	-0.4	-0.5	-0.7	-0.9	-1.1	-1.3	-1.6	-2.0	-2.4	-2.4	-10.7
Simplifying Part D Plan Information	0	*	0	0	0	0	0	0	0	0	*	*
Limitation on Removal or Change of Coverage of Covered Part D Drugs	0	0	0	0	0	0	0	0	0	0	0	0
Medicare Part D Copayment Equity	0	0.1	0.1	0.1	0.1	0.1	0.2	0.1	0.1	0.2	0.4	1.2
AIDS Drug Assistance Programs and Indian Health Service Generic "First Fill"	0	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.6
Generic "First Fill"	0	-0.2	-0.3	-0.3	-0.3	-0.3	-0.4	-0.4	-0.4	-0.4	-1.1	-3.0
Long-Term Care Pharmacy	0	-0.1	-0.2	-0.4	-0.6	-0.8	-1.0	-1.0	-0.9	-1.1	-1.3	-6.1
Pharmacy Benefit Manager Transparency	0	0	0	0	0	0	0	0	0	0	0	0
Office of the Inspector General	0	0	0	0	0	0	0	0	0	0	0	0
Study on Coverage for Dual Eligibles	0	0	0	0	0	0	0	0	0	0	0	0
SUBTITLE C-MEDICARE ADVANTAGE												
Medicare Advantage Payment (Including Grandfathered and Transitional Benefits)	0	-6.2	-6.6	-10.3	-11.0	-12.2	-13.9	-16.7	-18.9	-21.5	-34.1	-117.4
Benefit Protection and Simplification	0	0	0	0	0	0	0	0	0	0	0	0
Simplification of Annual Beneficiary Election Periods	*	*	*	*	*	*	*	*	*	*	*	*
Extension for Specialized MA Plans for Special Need Individuals and for Erickson Demonstration Plans	0	0.2	0.2	0.2	0.1	0.1	*	*	*	*	0.7	0.9
Extension of Reasonable Cost Contracts	0	*	*	*	0	0	0	0	0	0	*	*
MA Private Fee-for-Service Plans	0	*	1.0	0.7	0.5	0.5	0.5	0.4	0.4	0.4	2.1	4.3
Medigap	0	0	0	0	0	*	*	*	*	*	0	-0.1
Extend Changes for Coding Intensity Through 2013	0	-0.6	-0.8	-0.5	0	0	0	0	0	0	-1.9	-1.9

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SUBTITLE D-IMPROVING PAYMENT ACCURACY												
Home Health Payment Changes	-0.1	-0.3	-0.3	-0.9	-2.0	-3.3	-5.1	-6.2	-6.8	-7.5	-3.6	-32.5
Hospice Payment Reforms	0	*	*	*	*	*	*	*	*	*	*	-0.1
Hospice Concurrent Care Demonstration Project	0	*	*	*	*	0	0	0	0	0	*	*
Medicare DSH Changes	0	0	0	0	0	-4.0	-4.3	-4.7	-4.6	-4.9	0	-22.5
Plan to Reform Medicare Hospital Wage Index	0	0	0	0	0	0	0	0	0	0	0	0
Geographic Hospital Wage Index Provisions	0	0	0	0	0	0	0	0	0	0	0	0
Extend Section 508 Reclassifications	0.2	0.3	*	0	0	0	0	0	0	0	0.5	0.5
Imaging Use-Rate Assumption	-0.1	-0.2	-0.2	-0.2	-0.3	-0.3	-0.4	-0.4	-0.5	-0.5	-0.9	-3.0
Durable Medical Equipment												
Elimination of additional payment in 2014	included in estimate of market basket cuts and productivity adjustments for durable medical equipment											
Power wheelchairs	0	-0.4	-0.1	*	*	*	*	-0.1	-0.1	-0.1	-0.6	-0.8
Accreditation Exemption for Certain Pharmacies	0	0	0	0	0	0	0	0	0	0	0	0
Treatment of Certain Cancer Hospitals	0	0	0	0	0	0	0	0	0	0	0	0
Nurse Midwifery Payments	*	*	*	*	*	*	*	*	*	*	*	*
SUBTITLE E-ENSURING MEDICARE SUSTAINABILITY												
Market Basket Cuts and Productivity Adjustments												
Hospitals paid under the inpatient PPS	-0.3	-0.8	-2.9	-5.5	-8.1	-10.9	-13.8	-17.2	-21.1	-25.9	-17.6	-106.3
Skilled nursing facilities	0	0	-0.3	-0.7	-1.1	-1.5	-1.9	-2.4	-3.0	-3.7	-2.1	-14.6
Hospice	0	0	0	-0.3	-0.5	-0.8	-1.0	-1.4	-1.7	-2.1	-0.8	-7.8
Home health	0	-0.2	-0.4	-0.5	-0.5	-0.8	-1.2	-1.7	-2.3	-3.1	-1.6	-10.6
Part B fee schedules, except physicians' services	0	-0.4	-0.8	-1.3	-1.9	-2.5	-3.1	-3.7	-4.4	-5.1	-4.4	-23.1
Temporary Adjustment to the Income-Related Part B Premium	0	-0.7	-1.2	-1.5	-2.0	-2.4	-2.8	-3.3	-4.0	-4.9	-5.4	-22.8
Medicare Commission	0	0	0	0	0	-1.5	-3.1	-4.3	-6.2	-7.1	0	-22.2
SUBTITLE F-PATIENT-CENTERED OUTCOMES RESEARCH												
Comparative effectiveness (Medicare components)	0	*	*	*	*	*	*	*	-0.1	-0.2	*	-0.3
Comparative effectiveness (Non-Medicare components)	*	*	0.1	0.1	0.2	0.3	0.4	0.4	0.4	0.5	0.4	2.5
SUBTITLE G-ADMINISTRATIVE SIMPLIFICATION												
Effects on Medicaid Spending	*	*	-0.1	-0.2	-0.3	-0.4	-0.5	-0.6	-0.8	-0.9	-0.5	-3.7
SUBTITLE H-SENSE OF THE SENATE REGARDING MEDICAL MALPRACTICE												
	0	0	0	0	0	0	0	0	0	0	0	0

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TITLE IV-TRANSPARENCY AND PROGRAM INTEGRITY												
Limitation on Medicare Exception to the Prohibition on Certain Physician Referrals for Hospitals	*	*	*	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.8
Physician Payment Sunshine	0	0	0	0	0	0	0	0	0	0	0	0
Prescription Drug Samples	0	0	0	0	0	0	0	0	0	0	0	0
Nursing Home Transparency	0	*	*	*	0	0	0	0	0	0	0.1	0.1
Imaging Self-Referral Sunshine	0	0	0	0	0	0	0	0	0	0	0	0
Hospital Average Charge Information	0	0	0	0	0	0	0	0	0	0	0	0
TITLE V-FRAUD, WASTE, AND ABUSE												
Fraud, Waste, and Abuse	*	*	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.4	-1.3
Accelerate Implementation of the Competitive Acquisition Program for Durable Medical Equipment	*	*	*	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-1.4
Medicaid National Correct Coding Initiative	0	*	*	*	*	*	*	*	*	*	-0.1	-0.3
INTERACTIONS												
Medicare Advantage Interactions	0	1.6	-0.6	-1.3	-2.0	-2.1	-2.4	-2.7	-2.9	-3.8	-2.4	-16.1
Premium Interactions	0	-1.4	-0.1	0.7	5.7	4.2	3.9	4.8	5.6	6.7	4.9	30.1
Implementation of Medicare Changes for 2010	*	0	0	0	0	0	0	0	0	0	*	*
Medicaid Interactions with Part D Provisions	*	*	*	*	*	0.1	0.1	0.1	0.1	0.2	0.1	0.6
TRICARE Interaction	0.1	0.1	-0.1	-0.2	-0.2	-0.3	-0.5	-0.6	-0.8	-0.9	-0.3	-3.4
Total, Changes in Direct Spending	9.0	-0.6	-10.9	-21.0	-41.7	-46.7	-54.7	-66.0	-78.1	-93.5	-65.1	-404.1

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Changes in Revenues												
Fraud, Waste, and Abuse (CBO Estimate, On-budget)	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.9	2.0
Premium Taxes for Patient-Centered Outcomes Research (JCT estimate, on-budget)	0	0	0	0.1	0.3	0.3	0.4	0.4	0.5	0.7	0.4	2.6
Effect on Revenues of Changes in Health Insurance Premiums as a Result of Comparative Effectiveness Research, Administrative Simplification, and Changes in the Medicaid Drug Program (JCT and CBO estimates)												
Income and Medicare payroll taxes (on-budget)	*	-0.1	-0.1	0.1	0.5	1.0	1.6	2.2	2.2	2.2	0.4	9.5
Social Security payroll taxes (off-budget)	*	*	*	*	0.1	0.2	0.3	0.5	0.5	0.5	0.1	2.1
Subtotal, on-budget revenues	0.1	0.1	0.1	0.4	1.0	1.5	2.2	2.9	2.9	3.1	1.7	14.2
Total, unified budget revenues	0.1	0.1	*	0.4	1.1	1.7	2.5	3.3	3.4	3.6	1.7	16.3

Changes in Deficits												
Changes in on-budget deficits	8.9	-0.7	-10.9	-21.3	-42.7	-48.2	-56.9	-68.8	-81.1	-96.5	-66.8	-418.3
Changes in unified budget deficits	8.9	-0.6	-10.9	-21.3	-42.8	-48.4	-57.2	-69.3	-81.6	-97.0	-66.8	-420.4

Memorandum:

Non-scoreable savings from increased HCFAC spending	0	*	*	*	*	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.4
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NOTE: * = between -50 million and \$50 million.

CMS = Centers for Medicare & Medicaid Services; DSH = disproportionate share hospital; GME = graduate medical education; HCFAC = Health Care Fraud and Abuse Control; HOPD = hospital outpatient department; JCT = Joint Committee on Taxation; MA = Medicare Advantage; MA-PD = Medicare Advantage prescription drug plan; PPS = prospective payment system; VA = Department of Veterans Affairs.