

1 EXECUTIVE COMMITTEE MEETING TO CONSIDER  
2 HEALTH CARE REFORM  
3 TUESDAY, SEPTEMBER 22, 2009  
4 U.S. Senate,  
5 Committee on Finance,  
6 Washington, DC.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 taxes would go down for the people affected by this bill.

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

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

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

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

1 reduction.

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

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

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

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

24 And so let us begin our consideration of this bill.

25 Let us make this a time for progress, let us seize our

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

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

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

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

7 First of all--

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

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

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

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

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

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

25 I had a meeting, as five other members of this

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

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

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

25 But the American people have rejected that idea.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5           First, the amount of spending is a serious concern.

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

20          This bill has new taxes on everything from Q-tips to  
21          pacemakers and cancer screening to pregnancy tests.

22          There is even a \$60 billion across-the-board health plan  
23          tax. Experts and economists say that all of these health  
24          care taxes will be passed on to consumers.

25          When the focus of reform should be on reducing

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

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

16 In addition to concerns about cost to taxpayers and  
17 affordability for individuals, there are still some other  
18 serious outstanding issues that have yet to be resolved.

19 Preventing taxpayer funding of abortions, enforcement  
20 against subsidies for immigrants here illegally, medical  
21 malpractice reform--all unresolved.

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

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

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

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

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

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

25 Another area of concern is the individual mandate to

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

10 But the Federal mandate requires an extensive set of  
11 new enforcement tools housed in the Internal Revenue  
12 Service and backed by the full force of the Federal  
13 Government's enforcement powers. That combined with the  
14 magnitude of the penalties is cause for serious concern.

15 The further that we waded into this, the more concerned  
16 I became.

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

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

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

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

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

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

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

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

17 It is not too late to get it done right. We can  
18 stop at any time and refocus this effort. We can lower  
19 the spending in the bill. We can improve the quality of  
20 care with delivery system reforms that reward quality  
21 instead of quantity. We can focus on health care costs.

22 We can lower costs with medical liability reform. We  
23 can fix the insurance market.

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

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

9               Thank you, Mr. Chairman.

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

14              Senator Grassley. I know.

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

20              Next on the list 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.    Thank you, Mr. Chairman.  I want  
5       to first thank you for your leadership.  In my 23 years  
6       in the Senate, I have never seen any Committee Chairman  
7       dedicate himself as fully or as completely as you have to  
8       this effort, and I want to recognize you for that.

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

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

1 issues, although we did make enormous progress.

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

8 In 2009, a family of four faced, on average,  
9 premiums of \$13,000. By 2019, according to all  
10 projections, a family of four will face premiums of  
11 \$22,400. \$22,400 in premiums for a family of four by  
12 2019. And it is not just our families and businesses  
13 that face unsustainable increases in their premiums. It  
14 is the overall health care system.

15 Currently, we spend one in every six dollars in this  
16 economy on health care, but if we stay on the current  
17 trend line, by 2050 we will be spending one in every  
18 three dollars in this economy on health care. Clearly,  
19 that is unsustainable. And in the face of a Federal debt  
20 that is soaring, under the Congressional Budget Office's  
21 long-term budget outlook, we see that Federal debt is  
22 expected to go to more than 400 percent of GDP by the  
23 2050s on the current trend line.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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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. Let me  
5 begin this morning by first commending you and your staff  
6 for your sincere commitment to trying to find a  
7 bipartisan solution to reforming our health care system.

8 I can securely state that each of us on both sides of  
9 the aisle had hopes that we could be here today  
10 considering a health care reform bill that enjoyed wide  
11 bipartisan support.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 \$300 billion in new excise taxes on everyone from  
25 insurance providers to device makers to clinical labs,

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

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

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

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

19 I commend the President's commitment to only signing  
20 a bill that does not add a penny to our growing deficit.

21 I sincerely hope that we will apply the same standards  
22 of honesty on our accounting of this bill as we are now  
23 demanding from our families and businesses.

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

1       2013 and 2014--coincidentally, right after the  
2       Presidential election. So the initial 10-year price tag  
3       of \$856 billion is a significant underestimation. So, in  
4       reality, this is not a 10-year score. It is a 6- or 7-  
5       year best guess. The real 10-year costs for this bill  
6       will be significantly higher.

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

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

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

25              Thank you, Mr. Chairman.

1           The Chairman.    Thank you, Senator.  
2           Senator Kerry is next.  
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1 OPENING STATEMENT OF HON. JOHN F. KERRY, A U.S. SENATOR  
2 FROM MASSACHUSETTS

3

4 Senator Kerry. Mr. Chairman, thank you.

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

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

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

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

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

6 You know, when Teddy Roosevelt ran for President as  
7 the Progressive Party candidate in 1912, he pledged a  
8 system that would protect against just what I described.

9 He said "the hazards of sickness," and it did not  
10 happen.

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

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

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

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

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

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

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

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

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

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

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

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

14               Medical bills play a role in 62 percent of all  
15       bankruptcies in the United States, and as I mentioned, we  
16       have got 87 million Americans, one in three Americans  
17       went without health insurance for some period between  
18       2007 and 2008.

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

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

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

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

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

1           Secondly, I believe we have to pay attention--and I  
2 know others will talk about this--to the question of  
3 affordability on low- and moderate-income families. It  
4 is key when we finish this that we are lowering those  
5 costs in a way that makes this more affordable for them.

6           And I strongly support the efforts to strengthen  
7 Medicaid and improve the premium tax credits to the  
8 poorest families.

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

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

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

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

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

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

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

1 character of our country.

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

4 So I hope, Mr. Chairman, that together--I think we  
5 are going to do this. We are going to pass health care.

6 We are going to get this done. I have been confident of  
7 that all along. I am confident of it now. And we are  
8 going to do it because we have to and because it is the  
9 right thing to do. And in the end, I think we will show  
10 something about the character and the compassion of the  
11 American people. And I applaud you for helping to get us  
12 here this far.

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

20 Next, Mrs. Snowe.

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

3

4 Senator Snowe. Thank you, Mr. Chairman.

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

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

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

8 There are many miles in this journey with more than  
9 500 amendments that have enormous implication in both  
10 policy and financing, not to mention the process beyond.

11 And at the conclusion of this process, I hope, Mr.  
12 Chairman, that we will have the opportunity to review the  
13 final mark and revised CBO estimates on the bill as  
14 amended before we move to any final vote.

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

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

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

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

10 Already 81 percent of working Americans are uninsured.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3             Consider a family of four earning \$44,000 per year.

4       With tax credits on the exchange, their share of a  
5 \$15,000 cost of an exchange plan would be reduced to  
6 \$3,748. Yet if that same family is offered employer-  
7 provided coverage, before they would be permitted to  
8 access the exchange, they would have to spend 13 percent  
9 of their income on coverage. This amounts to an almost  
10 \$2,000 disparity per year for a lower-income family.  
11 That is wrong and it is unfair, and I will be introducing  
12 an amendment to scale the affordability test for those  
13 offered coverage with employers so that we do not create  
14 an impenetrable firewall that blocks affordable access  
15 and creates unacceptable inequity.

16             Finally, Mr. Chairman, let me just say the proposed  
17 expansion of Medicaid, which is the second largest  
18 component in this legislation, presents a challenge of  
19 affordability and fairness for our States, especially  
20 given the broad gap that currently exists in Medicaid  
21 eligibility from some at the deepest level of poverty to  
22 \$3,000, to others as high as \$48,000. We have heard--and  
23 we have discussed this with the Governors--not only about  
24 the equitable allocation of Federal assistance between  
25 those who have already expanded their Medicaid population

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

5           Considering that burden in conjunction with the  
6 impact of broadening Medicaid, I can well appreciate that  
7 States are truly concerned about the potential for  
8 unforeseen consequences on their budgets, especially in  
9 light of one study that reports that States' revenues in  
10 2014 will be the equivalent to the pre-recession levels  
11 of 2007.

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

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

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

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

5 Thank you, Mr. Chairman.

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

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

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

1       Senator Schumer for the moment and now go to Senator  
2       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 Congress needs to look  
6 at ways of reforming our health care system. Too many  
7 Americans are underinsured, uninsured, or cannot afford  
8 the health insurance they have. Reforming health care,  
9 which amounts to over 17 percent of our economy, is no  
10 easy task, and it is a process that should not be rushed.

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

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

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

25 I do not support the provisions in the bill that

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

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

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

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

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

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

7 A second promise the President made was that if you  
8 like the health care coverage you have, you can keep it.

9 Under the tax increases in this bill, health flexible  
10 spending accounts and health reimbursement accounts will  
11 likely disappear because of the high-cost-plan tax. And  
12 in another provision, taxpayers will lose health care  
13 coverage that allows them tax relief for the cost of  
14 over-the-counter medicine.

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

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

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

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

12 Thank you, Mr. Chairman.

13 The Chairman. Thank you very much, Senator.

14 Next on the list is Senator Menendez.

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

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

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

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

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

1 the budget deficit.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 I recognize Senator Kyl.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25           Another way to reduce cost, as I mentioned before,

1 is in the area of medical malpractice reform. As Ranking  
2 Member Grassley said, we do not need any more  
3 demonstration projects. We know what works. Look at the  
4 State of Texas, which has significantly reduced insurance  
5 premium costs for the medical practitioners in the State.

6 My understanding is they attracted 7,000 new physicians  
7 to that States as a result primarily of their malpractice  
8 reforms.

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

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

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

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

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

4 Mr. Chairman, the complete Government control  
5 through the individual mandate and insurance exchange  
6 regulations guarantees an end to innovation in insurance  
7 plans. Under this bill, they become little more than  
8 prepaid health administrators for the Federal Government.

9 And as experience in places like Massachusetts  
10 demonstrates, when costs soar, rationing of health care  
11 becomes the ultimate cost controller. This, I submit, is  
12 not reform.

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

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

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

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

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

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

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

5 And I also want to express my appreciation for your  
6 significant commitment to helping to work with the  
7 members of this Committee on trying to move forward with  
8 a strong product. And I hope that we will be able to  
9 achieve that.

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

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

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

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

3           The Chairman.   Well, we will work all night.

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

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

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

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

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

1       \$507 billion in cuts to Government health care programs  
2       and \$349 billion in new taxes. Most of the new taxes are  
3       going to be passed on to the consumers in the form of  
4       higher costs for everything from contact lenses and  
5       hearing aids to health insurance premiums. And the taxes  
6       are going to go into effect immediately, even though the  
7       other major provisions will not go into effect until 4  
8       years later.

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

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

1 would be assessed through the Tax Code and apply it as an  
2 additional amount of Federal tax owed. Yet the President  
3 is saying that there is no new tax in the bill, that his  
4 pledge to avoid increasing taxes for those who make under  
5 \$250,000 is honored. Yet last year, in September, he  
6 indicated that under his plan no family making less than  
7 \$250,000 a year will see any form of a tax increase, not  
8 your income tax, not your payroll tax, not your capital  
9 gains taxes, not any of your taxes. And yet we see this  
10 major new proposal for more taxes before us now.

11 The plan gives unprecedented power over reforming  
12 Medicare spending and benefits to an unelected board that  
13 would be given authority to determine payments to  
14 providers for Medicare with limited congressional review.

15 And there are those who already have raised significant  
16 concerns about that delegation of authority to manage  
17 Medicare.

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

25 The cuts to the Medicare Advantage plan are going to

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

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

12 The President has said many times and has promised  
13 the American people, if you like your health care  
14 coverage, the coverage you currently have, you can keep  
15 it. That will not apply under this plan. For those who  
16 have the flexible spending accounts, they will see their  
17 annual limits cut from \$5,000 to \$2,000. It will not  
18 apply to the millions of people on Medicare Advantage who  
19 will see their funding slashed by over \$123 billion. It  
20 will not apply to people who choose now to pay for their  
21 own health care and will be forced to pay--or exposed to  
22 \$20 billion in penalties. And it will not apply to those  
23 with health plans valued at more than \$8,000 for singles  
24 or \$21,000 for families, which includes many middle-class  
25 families who will then be facing the 35-percent excise

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

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

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

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

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

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

1 I thank you again for your effort on the issue.

2 The Chairman. Thank you very much, Senator.

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

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

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

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

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

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

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

1 to health care costs.

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

9 But too many Americans and more and more of them  
10 each year lack the fundamental reassurance they deserve,  
11 the peace of mind to know that if they or a loved one  
12 gets sick, they will get the treatment they need without  
13 being bankrupted in the process. We know the statistics,  
14 50 million people not covered. But I think it is the  
15 personal stories that I hear that affect me the most.  
16 When I go to Erie County or Onondaga County upstate, the  
17 suburbs in Nassau, Suffolk and Brooklyn, Queens, the  
18 Bronx. There is nothing worse than having a mom look you  
19 in the eye and say, "My son, my daughter has a terrible  
20 illness and I have no way to pay for his or her  
21 treatment."

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

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

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

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

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

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

5 You are going to have to pay the first \$5,000 or  
6 \$10,000 yourself and you are going to have to double your  
7 monthly payment for it. Or worse, Jim, Mary, you are a  
8 great worker, I want to keep you, but I can no longer  
9 give you health care insurance. That will happen if we  
10 do nothing inexorably. So act we must. Act we must.

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

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

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

1 based purchasing, integrated care.

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

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

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

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

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

1 do better on affordability in this bill.

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

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

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

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

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

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

3  
4 Senator Nelson. Mr. Chairman, thank you for  
5 bringing us to this point. Thank you, Senator Hatch for  
6 the continued input that you have and I look forward to a  
7 very substantive discussion. This Chairman's mark is a  
8 good starting place. I believe it needs to be massaged  
9 and then let us see if we can get something because after  
10 this long, hot summer where even violence got into the  
11 debate, it simply captures the passions, some political,  
12 some partisan, but some very substantive.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18           There are more Medicaid recipients than there are  
19 Medicare recipients. Roughly 49 million Medicaid,  
20 roughly 44 million Medicare. Now, that has been the law.

21           We get rebates. In other words, using the purchasing  
22 power of the federal government to get the cost of drugs  
23 lower to Medicaid. If that is good enough for Medicaid,  
24 why is not it good enough for Medicare to bring the cost  
25 of drugs lower?

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

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

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

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

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

6 The Chairman. Thank you. You have been very, very  
7 active and helpful in working with us to find a solution.

8 I compliment you for your constructive comments and hard  
9 work. Next, Senator Wyden.

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

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

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

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

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

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

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

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

25            So the fact is the way you have approached it trying

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

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

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

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

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

25 The second part of bipartisanship is acknowledging

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

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

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

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

25 First, the bill does not hold insurance companies

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

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

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

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

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

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

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

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

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

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

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

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

10 The Chairman. Thank you, Senator. Your statements  
11 indicates how long you have worked in health care reform.

12 I especially appreciate your comments about competition  
13 and choice and not being stuck with your employer if you  
14 want to go someplace else but you want to have good  
15 health insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

1 emergency.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25              This bill does not increase the deficit. In fact,

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

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

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

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

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

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

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

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

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

25 I like to paraphrase Churchill who used to say this

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

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

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

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

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

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

7 In light if Congress doesn't come through with  
8 sweeping health care reforms, that is the question, it  
9 goes on to answer, annual health care cost for business  
10 will soar 166 percent over the next decade, that is  
11 \$29,000 per worker says the business roundtable. That is  
12 even worse than the prior decade when costs shot up by  
13 131 percent.

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

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

25 It is not just big companies like GM and Chrysler

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

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

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

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

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

4 Issues like abortion, abortion is not provided for.

5 We do not fund abortions in this legislation. Some are  
6 saying that we are going to provide coverage for illegal  
7 aliens. We do just the opposite in this legislation.

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

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

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

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

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

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

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

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

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

25 What else works? Well, competition can work. I

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 percent we agree on.

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

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

17 Number three, if it is not perfect, make it better.

18 That applies to this legislation. It also applies to  
19 our health care delivery system. It is not perfect. We  
20 can make it a heck of a lot better.

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

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

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

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

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

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

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

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

18            The Chairman.   I heard three.   Is that right?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3  
4 Senator Enzi. Thank you, and I do appreciate you  
5 calling it the group of six rather than the gang of six  
6 because my mom told me never to join a gang. I want to  
7 thank you for your tremendous efforts. I think it is  
8 unprecedented and I will talk more about that in a few  
9 minutes. First I want to briefly discuss some of the key  
10 issues in the bill and what it will mean for every  
11 American.

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

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

1 option under this bill for 11 million working class  
2 Americans.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3  
4 Senator Cantwell. Thank you, Mr. Chairman. And Mr.  
5 Chairman, I want to say that you have proved that you are  
6 truly a distance runner because this process has been  
7 like a marathon and you have kept on pace and I guess my  
8 only request is I hope that the committee process will  
9 give the due kick to the system that we need to have at  
10 the end of this because I do think that we need to make  
11 some changes and I appreciate your willingness to make  
12 those changes.

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

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

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

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

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

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

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

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

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

6               The fact is that we waste about \$700 billion a year,  
7       30 percent of our health care on a system that is really  
8       not doing the service to our constituents. Our  
9       constituents want to know that when they go to see a  
10      physician that they have their full attention and many  
11      practicing physicians do the best they can under a system  
12      that rewards them for how many patients they see and how  
13      many procedures they order.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3  
4 Senator Ensign. Thank you, Mr. Chairman. The  
5 first thing I think we have to establish is that I think  
6 everybody here wants to improve the health care system.  
7 You know, sometimes in our partisan debates we question  
8 motives of each side of the aisle and I think that that  
9 is a mistake and that is where we get in some of the more  
10 rancorous type of debates.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 problem instead of going back more toward a market  
2 solution.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3

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

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

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

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

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

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

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

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

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

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

6 Several studies have shown that middle class  
7 families will see higher premiums because of the new  
8 taxes in the proposal. Premiums in the individual market  
9 would go up by 10 percent according to one study. In my  
10 state alone in Texas in the individual insurance market,  
11 91 percent of the current policies in place do not comply  
12 with the minimum actuarial value required under this  
13 bill. So again, their costs are gong to go up  
14 substantially.

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

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

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

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

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

18           We know that the proposal imposes a new tax for  
19 those who do not abide by the individual mandate. This  
20 new tax is as much as \$950 a year for an individual and  
21 \$3,800 for a family.

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

25           For businesses, the employer play or pay provision

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

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

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

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

25 With respect, Mr. Chairman, despite your outstanding

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

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

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

19 Senator Roberts. I think we had better go ahead and  
20 vote, Mr. Chairman. I do not mind riding drag in this  
21 posse and I appreciate your letting me ride in the posse.

22 But the last shall be first and the first shall be last.

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

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

4           Senator Roberts. 2:45?

5           Chairman Baucus: Yes.

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

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

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

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AFTER RECESS

[2:54 p.m.]

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

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

3  
4 Senator Rockefeller. Thank you, Mr. Chairman. I  
5 want to open my remarks by recognizing that we are moving  
6 forward in this process. We have enormous opportunity  
7 here to do something which is historic almost beyond  
8 imagination, the largest piece of legislation that I can  
9 remember, and all this within the context of never  
10 forgetting that we are here for the purpose of helping  
11 American families with their health care problems, and  
12 individuals.

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

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

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

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

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

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

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

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

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

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

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

1 movement long-term care. Less than 10 percent of  
2 Americans currently have long-term care insurance. That  
3 is something we actually did together in the Pepper  
4 Commission back in the late 1980s. So their only other  
5 option is the one that we discussed back in the late  
6 1980s, and that has not changed, which is part of our  
7 dilemma here, and that is that they spend down all of  
8 their assets, their income. They get rid of their car,  
9 they get rid of their house, they get rid of their  
10 clothes, they get rid of their toys, they get rid of  
11 their washing machines, and they go down to the level of  
12 impoverishment so that they can qualify for Medicaid and  
13 then they can get long-term care.

14 Is this what we choose to do to the American people?

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

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

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

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

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

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

1 public health insurance plan.

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

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

25 I do not think that the current bill does enough to

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

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

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

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

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

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

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

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

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

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

2 Thank you.

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

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

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

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

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

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

1 OPENING STATEMENT OF HON. PAT ROBERTS, A U.S.

2 SENATOR FROM KANSAS

3

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

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

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

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

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

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

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

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

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

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

25 In fact, all indications are that this bill will be

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

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

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

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

25 The reason for these opinions cannot be solely

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6           The annual fee on health insurance providers would  
7           be increased from \$6 billion in the Chairman's mark to  
8           \$6.7 billion in the modification, and the Chairman's  
9           modification also would repeal or eliminate the annual  
10          fee that was imposed on the clinical labs. There is an  
11          offsetting change in terms of Medicare lab fee schedule  
12          that Yvette will probably explain related to the lab fee  
13          proposal.

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

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

25          The other new item in the Chairman's modification is

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

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

11 That concludes my walk-through.

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

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

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

23 The third modification changes the effective date  
24 for the subtitle that contains the rating reform to July  
25 1, 2013. The fourth modification adds \$5 billion to the

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

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

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

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

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

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

1 exchanges.

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

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

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

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

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

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

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

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

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

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

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

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

4 The next modification eliminates annual and lifetime  
5 limits for all plans in the state exchanges beginning in  
6 2010 and precludes larger employers from imposing  
7 unreasonable annual and lifetime limits on coverage.

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

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

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

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

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

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

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

10              The Chairman.    What page are you on?

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

12              The Chairman.   Six of the modification.

13              Ms. Fontenot.   Right.

14              The Chairman.   Thank you.

15              Ms. Fontenot.   In the middle.

16              The Chairman.   Thank you.

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

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

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

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

1 Ms. Fontenot. All right.

2 The Chairman. Just hit the high points, summarize.

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

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

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

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

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

17 The Chairman. Are you still on page 7?

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

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

21 Ms. Fontenot. The penalty?

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

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

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

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

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

20 The Chairman. All right. Mr. Schwartz?

21 Mr. Schwartz. Thank you, Mr. Chairman.

22 The Chairman. Hit the high points.

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

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

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

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

9 Mr. Schwartz. That is correct.

10 The Chairman. Sometimes with modifications.

11 Mr. Schwartz. That is correct.

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

14 Mr. Schwartz. The great majority are.

15 The Chairman. Thank you.

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

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

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

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

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

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

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

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

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

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

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

24           Ms. Henry-Spires. Continuing at the bottom of page  
25 16 and to the top of page 17, the Kerry amendment, C-4,

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

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

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

14 Then, also, accepted in that section is amendment C-  
15 12, with modifications, a Hatch amendment, prohibiting  
16 federal funds from being used for assisted suicide and  
17 that offers contents protection to providers.

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

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

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

4 The Chairman. Thank you.

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

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

13 The modification accepts Bingaman amendment number  
14 D-9 to start community mental health centers in the mark.

15 The modification accepts, with modification, the Carper  
16 amendment C-1, provides \$200 million to the Secretary of  
17 HHS for up to five years to make grants to small  
18 businesses with less than 100 employees, to provide  
19 access to comprehensive, evidence-based, workplace  
20 wellness programs.

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

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

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

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

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

15 The Chairman. What page are you on?

16 Ms. Eisinger. The bottom of page 22.

17 The Chairman. Thank you.

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

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

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

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

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

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

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

23 The Chairman. You are on page 25.

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

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

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

6 Senator Bunning. Mr. Chairman?

7 The Chairman. Senator Bunning?

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

11 The Chairman. That makes good sense.

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

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

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

22 Dr. Elmendorf. We will stay for several hours.

23 The Chairman. All right. Thank you.

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

1 education slots and this relates to the funding level.

2 The Chairman. Where are you?

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

4 The Chairman. Speak up a little, please.

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

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

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

17 Turning to page 27, to accept, with modification,  
18 Stabenow number D-9 to clarify requirements in the  
19 quality infrastructure section. The next amendment, to  
20 accept, with modification, Nelson number D-6 to provide  
21 additional resources for the GME slot redistribution  
22 policies.

23 The bottom of 27, to correct drafting errors in  
24 Title III related to the low volume hospitals adjustment  
25 programs.

1           Turning to page 28, to clarify in Title III rules  
2 regarding payments for critical access hospitals. To  
3 accept, with modification, Rockefeller amendment D-7  
4 related to provisions in S.1634.

5           Mr. Dawe. Now, on page 31, the top, the first  
6 provision is a replacement for the clinical lab fee that  
7 Dr. Barthold referred to. This would create an  
8 additional payment reduction, a temporary additional  
9 payment reduction to the clinical lab fee schedule for  
10 the years 2011 through 2015.

11           The Chairman. What happened to the earlier pages?

12           Senator Conrad. We went from 28 to 31 there.

13           Ms. Bishop. We should not have switched these. So  
14 back to page 28, I am going to be brief. There is a list  
15 of amendments, modifications that were made to the mark  
16 related to Medicare Advantage and the prescription drug  
17 program.

18           The main amendment we accepted into the mark was an  
19 amendment filed by Senator Nelson that would create a  
20 grandfather program for Medicare Advantage plans that  
21 offer benefits in areas of the country where plans are  
22 bidding at 85 percent of fee-for-service cost or below.

23           They would be able to grandfather their current  
24 enrollees into their plans, but only in those areas of  
25 the country. The amendment would also eliminate the

1 efficiency bonus that was included in the competitive  
2 bidding program.

3 Senator Ensign. Mr. Chairman?

4 The Chairman. Can she just clarify that? Do you  
5 know what areas of the country that that affected and  
6 what areas it did not or at least a percentage of  
7 Medicare Advantage people that it affected and what it  
8 did not?

9 Ms. Bishop. I do not and the reason for that is  
10 the information that is used to calculate the bids that  
11 Medicare Advantage plans submit to CMS is proprietary.

12 So instead of being able to look and see which areas  
13 of the country the bids fall under a certain percentage,  
14 we basically chose the policy number of 85 percent  
15 because we felt that that would represent areas of the  
16 country that were efficient relative to fee-for-service,  
17 because there are some areas of the country that have  
18 relatively high fee-for-service costs that include high  
19 utilization or maybe even high amounts of fraud.

20 So we did not want to use just a 100 percent of fee-  
21 for-service. So we decided that efficient would probably  
22 be some level below fee-for-service cost. So we chose  
23 85, and we do not know what areas of the country that  
24 will include until CMS -- if this bill were to become  
25 law, CMS would have to identify what areas those were so

1 that plans could know what areas of the country they  
2 could be grandfathered into.

3 Senator Nelson. Mr. Chairman?

4 The Chairman. Yes, Senator Nelson.

5 Senator Nelson. We did a run on that and in  
6 Nevada, it would affect Nye, Clark, Pershing and  
7 Esmeralda Counties.

8 Senator Ensign. How can he have the information  
9 and they cannot?

10 The Chairman. I was asking myself the same  
11 question.

12 [Laughter].

13 Senator Ensign. If it's proprietary, how do you  
14 get it and they do not?

15 Senator Nelson. I got it from you all.

16 Ms. Bishop. No, no, no, no. Wait, wait, wait,  
17 wait. No, no.

18 [Laughter].

19 Ms. Bishop. We do not have the data. There is  
20 information that actuarial firms that prepared the bids  
21 for Medicare Advantage plans, they can share their sort  
22 of general information about where the bids are in the  
23 country. But there is no one actuarial firm that has all  
24 of the bids in the United States. The only entity that  
25 has all the bids are CMS, CBO, and MedPAC, and they are

1 not allowed to provide us with county-level, or even  
2 State-level, information.

3 Senator Nelson. Is it possible for MedPAC to  
4 answer that question? From what I understand, they have  
5 that information, and Mark Miller is in the audience.

6 The Chairman. Mr. Miller? You are in the audience  
7 somewhere. MedPAC? There you are. Thank you.

8 Mr. Miller. My understanding with the problem and  
9 doing the impacts, is that the data that we have does not  
10 conform to the areas that people will be bidding on, so  
11 we do not have the ability to estimate the impacts under  
12 the competitive option broadly, and this proposal  
13 specifically.

14 Senator Nelson. May I, Mr. Chairman, just put that  
15 into common street language? The data that they have now  
16 is broken out by counties what they anticipate in the  
17 future is going to be by metropolitan statistical areas.  
18 Is that correct?

19 Mr. Miller. It is very close. It is a little more  
20 complex than that. Currently, the data that we have is  
21 on service area. The counties will be the -- you could  
22 convert -- the current payment unit is counties, but  
23 under this rule those counties will be aggregated up to  
24 MSA. Our problem is, there is a mismatch between the  
25 bids by the geographic units, whether it is county or

1       whether it is MSA.

2               Senator Nelson.     During the mark-up, could we at  
3     least get the information so we know whether it affects  
4     what areas of the country, what counties, that kind of  
5     thing?

6               Mr. Miller.     That is the problem, you will not.  It  
7     does not tell you that.

8               Senator Nelson.     So we will have an amendment here  
9     that we do not know the effect.  Is that what I am  
10    understanding?  It sounds like it.

11              The Chairman.     You will know some effect.

12              So Ms. Bishop, could you explain what effect -- what  
13    will Senators know?

14              Ms. Bishop.     Right.  Just to give you a sense of  
15    the information that we received from a large actuarial  
16    firm, when we looked at the data, there were many States  
17    that would have areas that would be grandfathered.  So  
18    off the top of my head, we were just eyeballing which  
19    States would be affected.  Texas, Louisiana, Kansas,  
20    Tennessee, Nevada, Florida, New York, Georgia.  I am  
21    thinking of other places in the country.  Anyway, there  
22    were at least 15 or 20 States.  And like I said, we were  
23    not trying to --

24              Senator Ensign.     And they would be completely  
25    grandfathered in, all of those States?

1 Ms. Bishop. No. No.

2 Senator Ensign. The President has promised that  
3 anybody who has their health care coverage now will not  
4 lose their health care coverage. So when we have a  
5 senior ask us in our area, and this amendment may affect  
6 that, we kind of need to know whether or not we can  
7 answer them honestly and say, yes you are going to keep  
8 your coverage, or no you are not going to keep your  
9 coverage. It does not sound like to me we are going to  
10 have the information to be able to tell them that.

11 Senator Nelson. What this amendment does, the  
12 Chairman is willing to put into his package, it gets us  
13 part of the way there. It does not get us the whole way  
14 there. Now, I will offer another amendment that will get  
15 us the whole way there, but at least he is gracious  
16 enough to get us, for the counties -- and those four  
17 counties, you know them in your State that I just named,  
18 which is where they have the biggest differentials on  
19 Medicare Advantage.

20 The Chairman. Senator Conrad?

21 Senator Conrad. Can somebody help us understand,  
22 and I do not know if this is the appropriate place, Mr.  
23 Chairman, to ask this question.

24 The Chairman. Go ahead.

25 Senator Conrad. I know this was part of the

1 discussion yesterday or the day before. I thought I  
2 understood it then, but maybe it would be useful for  
3 others, and I think for me, too, to hear the explanation  
4 of the implications of this policy. You are saying that  
5 those who are below 85 percent of fee-for-service -- what  
6 would be the advantage to them?

7 Ms. Bishop. So, this is sort of getting at the  
8 question of, what is the policy rationale, this  
9 grandfather --

10 Senator Conrad. Right.

11 Ms. Bishop. [Continuing]. That would be limited,  
12 if you will, to areas of the country where plans are  
13 bidding at 85 percent or below fee-for-service. The idea  
14 there, the policy rationale for this, is that today, in  
15 those areas of the country where plans are bidding  
16 significant below fee-for-service costs--and there are  
17 lots of areas of the country where that is the case.

18 The Chairman. Like, what level?

19 Ms. Bishop. There are areas of the country where  
20 plans are bidding at 70 percent of local fee-for-service  
21 cost.

22 Senator Conrad. And it is because fee-for-service  
23 in those areas is very high.

24 Ms. Bishop. Right. Generally speaking--and just  
25 to clarify--when I mean that plans are bidding, what I

1 mean is that their estimates, their projections of their  
2 benefit costs, their profit, their marketing, and their  
3 broker fees are 70 percent of what it costs the Medicare  
4 program to provide benefits in that area, so their costs  
5 are significantly lower than fee-for-service. One of the  
6 reasons why plans are able to bid low in some areas of  
7 the country is because the fee-for-service costs in those  
8 locations are high relative to the national average.

9 Now, they could be high because there are high  
10 utilization patterns. They could be high because  
11 there is--and MedPAC has mentioned this in one of its  
12 meetings--more significant amounts of potential fraud in  
13 some areas of the Medicare program. So there are lots of  
14 reasons why an area of the country has high fee-for-  
15 service costs, but the implications to beneficiaries--I  
16 think this gets to your question--is that in those areas  
17 of the country where fee-for-service costs are high,  
18 plans are able to bid below those costs. It is  
19 relatively easy for them to bid below costs that are sort  
20 of inflated.

21 And so the current law allows the plans to keep 75  
22 percent of the difference between their bids and the fee-  
23 for-service costs. They get to retain that as an extra  
24 payment. The plan gets to retain that as an extra  
25 payment for themselves. They must provide extra benefits

1 to beneficiaries with those extra payments, so  
2 beneficiaries in areas of the country, by no fault of  
3 their own, have had relatively generous extra benefits  
4 because the law allows the plans to keep 75 percent of  
5 the difference.

6 But there is significant variation around the  
7 country in how much extra benefits beneficiaries have  
8 been able to retain under the current Medicare Advantage  
9 program. Competitive bidding is going to make consistent  
10 the amount of dollars that will be available for extra  
11 benefits across the country. It is going to be the same  
12 dollar amount, but plans have to earn it, it is not  
13 automatic. So in areas of the country where  
14 beneficiaries have been able to retain high amounts of  
15 extra benefits, this grandfathering provision will allow  
16 their extra benefits to --

17 Senator Conrad. Be stepped down.

18 Ms. Bishop. [Continuing]. To be stepped down  
19 slowly over time, whereas in other areas of the country  
20 where plans are bidding closer to fee-for-service,  
21 competitive bidding is not going to have a shock effect,  
22 if you will. So this is an opportunity, as we are  
23 calling it, the way it was presented in Senator Nelson's  
24 amendment, is just to kind of stabilize the benefits in  
25 areas of the country that have high costs so that there

1 is not a --

2 Senator Nelson. Shock effect.

3 The Chairman. All right.

4 Yes, Senator Hatch?

5 Senator Hatch. Mr. Chairman, I would just like to  
6 ask Mr. Barthold a question. In connection with the  
7 Chairman's modified mark, there is a new tax increase  
8 included on taxpayers who take advantage of the itemized  
9 deduction for medical expenses.

10 Now, Mr. Barthold, could you tell me what kind of  
11 taxpayers, both age and income, are most likely to be  
12 hurt by this increase, and would these likely be only  
13 those that are making more than \$200,000 as individuals,  
14 or \$250,000 as couples?

15 Mr. Barthold. Senator Hatch, any taxpayer who  
16 itemizes, if they have sufficiently high qualifying  
17 medical expenses, can claim that itemized deduction. So  
18 as you know, people may itemize with incomes of \$50,000,  
19 \$75,000, \$100,000. So it would affect taxpayers with  
20 incomes of less than \$200,000, \$250,000.

21 The profile tends to be where it picks up people  
22 with extraordinary medical expenses in any one year.  
23 That is what the floor has the effect of doing. If you  
24 have very unusually high medical expenses, the Internal  
25 Revenue Code has permitted individuals to reduce their

1 tax base to account for that unusual circumstance that  
2 applies in that one year.

3 You asked a little bit about age. I do not have, at  
4 the moment--I might in a couple of minutes--actual  
5 numbers, but approximately half of the dollar value of  
6 the revenue effect in the table that was provided to you,  
7 JCX-36, is from returns where either the taxpayer or the  
8 taxpayer's spouse is aged 65 or older. So I guess that  
9 is sort of disproportionate to the age distribution  
10 population.

11 Senator Hatch. Well, as I understand it, and I  
12 think it is true, that those who claim this deduction are  
13 mostly elderly people.

14 Mr. Barthold. I am sorry, I could not hear you.

15 Senator Hatch. They are mostly elderly people, or  
16 lower or middle income people. Does the current law's  
17 7.5 percent threshold not already pretty well guarantee  
18 that they are not getting a tax benefit now unless they  
19 have a lot of medical expenses relative to their income?  
20 Is there any reason to believe that the current law  
21 threshold is deficient or is being abused by people?  
22 This bill will raise this to 10 percent from the current  
23 threshold of 7.5 percent.

24 Mr. Barthold. Well, Senator, as I noted,  
25 approximately half of the revenue is related to taxpayers

1 where either the taxpayer or the taxpayer's spouse is  
2 aged 65 or over. In terms of numbers of returns, we  
3 estimate that in 2013, approximately 11.5 million  
4 taxpayers would be affected by this proposal. Of that  
5 amount--I am just quickly eyeballing it--about half of  
6 that number would have incomes less than \$75,000 and half  
7 would have incomes greater than \$75,000.

8 Senator Hatch. But not much more than \$100,000?

9 Mr. Barthold. I still could not hear you. I am  
10 sorry, Senator.

11 Senator Hatch. But not much more than \$100,000?

12 Mr. Barthold. Over about 2.2 million returns with  
13 incomes in excess of \$100,000 would be affected by the  
14 proposal.

15 Senator Hatch. So you would have about 9 million  
16 returns that would be under \$100,000?

17 Mr. Barthold. That is correct, sir.

18 Senator Hatch. Most of them would be under  
19 \$75,000.

20 Mr. Barthold. Roughly adding it here, roughly half  
21 would be under \$75,000.

22 Senator Hatch. Do you have a sense of whether most  
23 taxpayers who claim the medical itemized deduction do not  
24 really need this deduction or would they be made whole  
25 with other parts of the bill before us?

1           Mr. Barthold.    I could not make an assessment on  
2           the overall effect of the proposal since the committee is  
3           considering rather substantial changes in the overall  
4           health care system, sir.

5           Mr. Reeder.    I would like to point out that there  
6           are other aspects of the bill that will ameliorate the  
7           effect of this because all people will have access to  
8           insurance that will cover costs that are commonly claimed  
9           as excess medical deductions on Schedule A.

10          Senator Hatch.   But a lot of people today have  
11          insurance and they still use this faithfully.

12          Mr. Reeder.    There are other aspects of the bill as  
13          well: there are caps on the out-of-pocket costs under  
14          insurance; there is assistance with out-of-pocket costs  
15          for lower income folks.  So there are other aspects of  
16          the bill that will address the reasons why people use  
17          this deduction.

18          The Chairman.   Right.  And I think it is an  
19          important point to keep in mind.  The deduction, I would  
20          guess, is primarily taken for catastrophic costs.  We  
21          have a limit now of roughly \$6,000 per person so that the  
22          person will not have to pay more than \$6,000.  I would  
23          think that, therefore, the need for the early 7.5 percent  
24          deduction is not as great as it otherwise would be.  
25          Plus, the other provisions in the bill which give

1 economic benefits to people at middle income and lower  
2 income levels.

3 Senator Grassley. Mr. Chairman, that might be true  
4 for people that are not senior citizens, but senior  
5 citizens do not have catastrophic coverage through  
6 Medicare.

7 The Chairman. Well, that is right. I think that  
8 is a problem.

9 Senator Grassley. This would be particularly tough  
10 on senior citizens, it seems to me.

11 The Chairman. It could be. It could be. This is  
12 something that was, frankly, put together pretty quickly  
13 in order to satisfy other needs. But Senator, you make a  
14 good point. Let us see if we can modify it so that  
15 seniors are not hit by this, as a down point. As we work  
16 through this, let us see if we can find a modification.

17 Ms. Bishop, are you finished? Why do you not move  
18 on?

19 Ms. Bishop. All right. So, I just wanted to say  
20 one more thing about the amendments that were accepted  
21 related to Part D. We accepted several amendments  
22 related to the prescription drug program. One of them  
23 would equalized co-payments for dual eligibles that  
24 utilize home- and community-based services instead of  
25 residing in long-term care institutions. Another

1 modification--these are the major ones--was an amendment  
2 filed by Senator Stabenow that would allow prescription  
3 drug plans to waive Part D co-payments for the first fill  
4 for generic drugs.

5 Ms. Henry-Spires. Continuing on page 30 at the  
6 top, or one down, to accept, with modification, Lincoln  
7 Amendment Number D6 regarding rules for the calculation  
8 of the Medicare Hospital Wage Index. The next one, Wyden  
9 Amendment D1, would create a hospice concurrent care  
10 demonstration in Medicare. That was Wyden D1. The final  
11 one on the bottom of page 32, accept, with modification,  
12 Menendez Amendment D1 regarding, again, rules on Hospital  
13 Wage Index.

14 We are now turning to page 31.

15 Mr. Dawe. Modification accepts the Conrad  
16 Amendment D6, which eliminates the sunset on the Medicare  
17 Commission and sets the growth target beyond 2019 at GDP  
18 per capita, plus 1 percent. Also accepts, with  
19 modification, Lincoln Amendment D2. This provision  
20 temporarily reinstates reimbursement for certain bone  
21 density services, to 70 percent of their 2006 payment  
22 rates.

23 On the top of page 32, modification accepts Conrad  
24 Amendment D5. This extends, until January 1, 2012, the  
25 bonus payments under Medicare to ambulance service

1 providers in super-rural areas, as defined in the MMA.

2 Mr. Schwartz. Mr. Chairman, there is one  
3 modification in Title 4, "Transparency and Program  
4 Integrity". It is really just a clarification of the  
5 definition of "additional disclosable parties" under  
6 "Nursing Home Transparency". Then in Title 5, there is  
7 one clarification of exceptions that are available to the  
8 provider application fee. I believe that concludes the  
9 walk-through.

10 The Chairman. Very good.

11 Are there any questions from Senators on the mark or  
12 of Dr. Elmendorf, since we have him here? Senator  
13 Grassley?

14 Senator Grassley. Yes. I want to ask Joint Tax,  
15 it gets back to something that President Obama was  
16 speaking about on the Sunday talk shows, trying to say  
17 that it is not true that a penalty for not getting  
18 insurance is a tax, referring to the individual mandate.  
19 The mark before us makes it pretty clear that the penalty  
20 is a tax. It looks like the tax is now up to about  
21 \$2,000 a year. So Mr. Barthold, is the penalty here not  
22 an excise tax, and will it not affect people making under  
23 \$250,000 a year?

24 Mr. Barthold. Senator Grassley, the penalty  
25 proposed in the Chairman's mark is, as you observed,

1 structured as a penalty excise tax. We have other  
2 penalty excise taxes in the Internal Revenue Code. We  
3 have not separately analyzed. We have worked in  
4 conjunction with Dr. Elmendorf and his colleagues at the  
5 Congressional Budget Office in terms of the overall  
6 effects of what sort of people might purchase insurance  
7 through the exchange who would not have insurance  
8 provided by their employer, and where the individual  
9 mandate or the employer free rider penalty would arise.

10 We have not done a combined distribution analysis  
11 across income to specifically answer your question, but  
12 to the extent that, yes, we think that some people would  
13 be subject to the penalty excise tax when everything  
14 shakes out, we would expect that some would have incomes  
15 less than \$200,000.

16 The Chairman. Let me just say on that point, it is  
17 an interesting question. This is really a penalty that  
18 is being collected by the Internal Revenue Service. It  
19 could be collected by another body, another entity,  
20 another agency, perhaps HHS. I mean, HHS could set up a  
21 different apparatus. Maybe the Help bill has something  
22 similar, I do not know. That leads to all kinds of  
23 complications; they do not have the data, they are not  
24 efficient. But somebody is going to have to collect the  
25 penalty, to the degree to which a penalty is paid.

1           The modification, too, will reduce the penalty  
2 significantly, will cut it in half, so it is much smaller  
3 than it otherwise was. But somebody is going to have to  
4 collect it to the degree that there is one, and it is  
5 this committee's determination--at least it is my  
6 determination so far--that the better, more efficient is  
7 for the IRS, which is set up to collect these kinds of  
8 penalties. So it is really a penalty that we are talking  
9 about here, just the IRS, not HHS, is collecting the  
10 penalty.

11           Senator Wyden.    Mr. Chairman?

12           Senator Grassley.   I think the Chairman made the  
13 point that the IRS now is the one in this bill that is  
14 collecting this penalty or excise tax, or penalty excise  
15 tax, whatever you want to call it.

16           Senator Snowe.    Mr. Chairman?

17           Senator Grassley.   I am done.

18           The Chairman.    All right.

19           Senator Wyden?

20           Senator Wyden.    Thank you, Mr. Chairman.

21           Director Elmendorf sent you a letter today, Mr.  
22 Chairman, going through some of the payments that middle  
23 class folks would be paying in their subsidies. Director  
24 Elmendorf, if you could go to that letter, it is dated  
25 September 22. I just want to make sure I am reading the

1 chart right. The analysis looks to me like Americans at  
2 the exchange, middle class families with incomes between  
3 200 and 400 percent of the poverty line, would be paying  
4 19 or 20 percent of their incomes in premiums and cost-  
5 sharing for their health care.

6 Can you go to the back of that letter you sent to  
7 the Chairman and tell me if I am reading that chart  
8 right? Because it looks to me like that is in the  
9 outline for a family of four, and it looks like 250 to  
10 300 percent of poverty, they would be paying 20 percent  
11 of their income for one of the cheaper plans. Is that a  
12 correct analysis of that chart?

13 Dr. Elmendorf. That is the correct interpretation  
14 of that table. I should emphasize that this table and  
15 the letter are based on specifications as they were  
16 released last week, including income caps ranging from 3  
17 percent to 13 percent, and then would be indexed over  
18 time.

19 The Chairman. And that analysis was before the  
20 modification.

21 Dr. Elmendorf. Yes. And the modification today  
22 lowers those caps, so these numbers would be somewhat  
23 smaller given the modification. We have not recalculated  
24 them since we finished this at 11:00 this morning.

25 Senator Wyden. Give me a sense -- and I appreciate

1 that, because you dated the letter today, and that was  
2 what I was, in effect, responding to.

3 Is it likely to be 3 or 4 percentage points less?  
4 Because obviously the Federal Agency for Health Care  
5 Quality Research says if people are paying more than 10  
6 percent of their income, then it is a high financial  
7 burden for these kinds of families. So you have got it  
8 pegged on this chart, before the modifications, at 19 or  
9 20. Is it likely to go down even 3 or 4 percentage  
10 points? Because that would still be substantially over  
11 10 percent. Is it still likely to be, say, 15 or 16?

12 Dr. Elmendorf. No, I do not think so. The caps  
13 have been lowered by 1 percent of income, as I understand  
14 the modification. That will more or less reduce the  
15 amounts in the righthand column by about 1 percent of  
16 income. It was just lowering the caps, the share of  
17 income that families will have to pay, from 3 to 2, or 13  
18 to 12. That is indexed over time. Though I cannot do  
19 the precise math in my head, but I think basically it  
20 reduces those numbers by around 1 percentage point. So  
21 the ones that are 19 and 20 would be in the 18 to 19  
22 percent range.

23 Senator Wyden. So middle class families, with the  
24 modifications, would be paying about 18 or 19 percent of  
25 their income for health care?

1 Dr. Elmendorf. Those in the exchange.

2 Senator Wyden. Right.

3 Dr. Elmendorf. In 2016, buying the second-lowest  
4 cost, silver, plan. Yes, Senator.

5 Senator Wyden. Thank you, Mr. Chairman.

6 Senator Snowe. Mr. Chairman?

7 The Chairman. Senator Snowe?

8 Senator Snowe. Thank you, Mr. Chairman.

9 Dr. Elmendorf, how many people do you estimate would  
10 be captured by the individual mandate penalty?

11 Dr. Elmendorf. I am sorry, Senator. I did not  
12 hear that.

13 Senator Snowe. How many individuals would be  
14 captured by the individual mandate penalty?

15 Dr. Elmendorf. I do not think we have an estimate  
16 of the number of people, Senator. We did estimate that,  
17 given the way the penalty was constructed, again, in the  
18 original mark of last week, that the amount of money that  
19 would be collected by the government would be in the  
20 neighborhood of \$20 billion over the 10 years. But I do  
21 not think we have a number handy of the number of people.

22 Senator Snowe. How do you arrive at that  
23 calculation then?

24 Dr. Elmendorf. The modeling that we do  
25 incorporates people who would be charged a penalty, but I

1 do not have that number at hand. I think it is a number  
2 that we can look up, but it is not one that we reported  
3 in the letter and it is not one that I have with me.

4 The Chairman. And your analysis was since the  
5 modification. It was before the modification.

6 Dr. Elmendorf. This was before the modification.

7 The Chairman. And we have cut the penalty in half  
8 for those at 300 percent.

9 Dr. Elmendorf. That is right. But how much that  
10 changes the number of people, that is a little more  
11 complicated, because there is an incentive effect of  
12 reducing the penalty. So there are some offsetting  
13 pieces. We have not done this. Maybe I should just  
14 explain clearly that we have been spending our time,  
15 since last week, focusing on estimating the various  
16 modifications that the committee staff has put to us and  
17 the amendments that you all have put to us.

18 We received dozens of requests for modifications  
19 from the committee staff, and as you know, over 500  
20 amendments from members of the committee. Even when we  
21 asked for the priority list, there were nearly 200  
22 amendments that were viewed as high priorities. So we  
23 are delivering, I think, dozens of estimates and have  
24 dozens more on their way tonight, tomorrow, and the next  
25 day, but we decided it was more useful for you for us to

1 focus on working our way through the list of amendments  
2 rather than trying to collect the set of things that are  
3 part of the modification today, which does require extra  
4 work because there are interactions among the pieces that  
5 we do not estimate.

6 Of course, we have given you individual amendment  
7 scores. We will have to go back and do it eventually if  
8 the bill is adopted by the committee, but we thought,  
9 rather than spending the time to pull all those pieces  
10 together and re-do all the analysis from last week, we  
11 thought it was more useful for you to devote our energy  
12 to scoring your amendments. But I understand that  
13 creates some complication, in that some of the things  
14 that I will be saying refer to the bill as it existed  
15 before the release of the modification this morning.

16 Senator Snowe. Are you prepared to give us a final  
17 estimate on the bill, as amended, before we vote on it?

18 Dr. Elmendorf. It will take us some time to create  
19 a final estimate, an official CBO cost estimate of  
20 legislation. As you understand, this is very complicated  
21 legislation and the pieces do interact. So in the  
22 preliminary analysis that we provided last week, we tried  
23 to keep track of all those interactions and we will go  
24 back and do that again at such time as the committee  
25 adopts and settles on a particular piece of legislation.

1 But that takes some work. There are some things that  
2 were preliminary last week, and will still be preliminary  
3 until we have time to refine that. So our turning this  
4 preliminary analysis into a final estimate will take some  
5 time after the committee --

6 The Chairman. Dr. Elmendorf, this is a very  
7 critical question and it is one that is important to, I  
8 daresay, every single member of this committee. We need  
9 that final estimate, certainly the preliminary. In  
10 answer to Senator Snowe's question you said it takes some  
11 time, but you did then say we would get a preliminary  
12 estimate in the interim, if I heard you correctly.

13 Dr. Elmendorf. Well, again, I think it is a  
14 choice. We can respond to your preferences. If we did a  
15 preliminary analysis of the modification, that would take  
16 us the time that we would otherwise spend in estimating  
17 amendments that we have not yet gotten to score. There  
18 are only so many things -- we are working almost  
19 literally around the clock. But it is very important for  
20 us to maintain the quality of the analyses and estimates  
21 that we present, so we are moving at what I have  
22 described to the staff on some occasions as the "maximum  
23 safe speed".

24 The Chairman. Well, we want CBO to be relevant on  
25 the most important issues facing us, and certainly a

1 preliminary score and some of the most important  
2 amendments will make CBO relevant. I tell you, Dr.  
3 Elmendorf, this is a very serious concern of this  
4 committee and I would urge you to, with all deliberate  
5 speed, make sure that you address the scoring of this  
6 bill and the modification and give us a preliminary as  
7 soon as you can. But I cannot over-emphasize how  
8 important this point is.

9 Dr. Elmendorf. I understand, Mr. Chairman. Let me  
10 emphasize again, we have delivered estimates of dozens of  
11 amendments and modifications requested by the committee  
12 staff since the end of last week. The prioritized list  
13 of amendments arrived in our e-mail inboxes less than 48  
14 hours ago. We have turned around a vast amount of  
15 material for you, but there are limits. I think a  
16 crucial part of CBO's relevance over time has been its  
17 reputation for doing our work carefully, as well as  
18 quickly, and we will continue to proceed at maximum safe  
19 speed to serve you well.

20 The Chairman. And also, frankly, making judgments,  
21 exercising your discretion.

22 Dr. Elmendorf. I think a very important part of my  
23 judgment as Director, Mr. Chairman, is what that maximum  
24 safe speed is. We are not sitting around obsessing over  
25 the fine decimal places, if that is your concern, but to

1 get the analysis right we need to think about what is  
2 proposed in the amendments, the effects they would have.

3 The Chairman. I would be doing very little  
4 analysis on amendments that are incorporated in the  
5 modification because they have already been incorporated.

6 Dr. Elmendorf. Well, for us to put a cost on them,  
7 we need to do that analysis.

8 The Chairman. That is your scoring in the  
9 preliminary, not individually, separately.

10 Dr. Elmendorf. I am just saying, given the number  
11 of changes that have been made, the number of changes  
12 that were considered over the past week, that we are  
13 turning around estimates of those effects as rapidly as  
14 we can, considering --

15 The Chairman. I am not going to waste your time.  
16 I think you got the message.

17 On my list, I have Senator Bunning.

18 Senator Bunning. Thank you, Mr. Chairman.

19 Dr. Elmendorf, this is not contained in the  
20 modifications in the Chairman's mark, so CBO ought to  
21 have a very good handle on this. In the original  
22 Chairman's mark, the doc fix was for one year. Is that  
23 correct?

24 Dr. Elmendorf. Yes, Senator.

25 Senator Bunning. Over the additional 9 years of

1 the mark--10 years--how much would it cost if we flat-  
2 lined the doc benefits? How much additional costs would  
3 that be if it were flat-lined?

4 Dr. Elmendorf. I will stall for --

5 Senator Bunning. Stall for some help?

6 Dr. Elmendorf. While we find the number.

7 Senator Bunning. All right.

8 The Chairman. While he is stalling, I think it is  
9 important to remind ourselves that this Congress is paid  
10 for updating the SGR every year, but for one. I have  
11 forgotten what year it is. But a long time ago, we paid  
12 for it.

13 Senator Bunning. That is why I am trying to --

14 The Chairman. If you look at our history, if you  
15 look at --

16 Senator Bunning. That is why I am trying to get a  
17 handle on it.

18 The Chairman. If you look at our history, we have  
19 paid for it.

20 Senator Bunning. Mr. Chairman?

21 The Chairman. So it should not add to the deficit.  
22 We follow that customary practice.

23 Dr. Elmendorf. So, Senator, the cost of the  
24 additional nine years of the policy you described is  
25 about \$200 billion of extra spending relative to current

1 law.

2 Senator Bunning. Two hundred billion?

3 Dr. Elmendorf. Yes, Senator.

4 Senator Bunning. Have you done any possible  
5 estimates if there was an additional 1 percent increase  
6 in each of the nine years? In other words, how much --

7 Dr. Elmendorf. A growth rate of 1 percentage point  
8 higher each year over that period.

9 Senator Bunning. Correct. Because eventually we  
10 are going to have to do something other than just flat-  
11 line.

12 Dr. Elmendorf. I do not think we have that number  
13 at hand, but we have done many estimates of alternatives  
14 and we can certainly send that to you, Senator.

15 Senator Bunning. Just an additional \$200 billion.

16 Dr. Elmendorf. For the first policy you described.

17 Senator Bunning. All right.

18 Dr. Elmendorf. Yes, Senator.

19 Senator Bunning. One last question. Mr. Barthold,  
20 I want to follow up on Senator Hatch's question and ask  
21 you about a modification in the Chairman's mark which  
22 increases the threshold amount for itemized deductions  
23 for medical expenses from 7.5 of adjusted gross income to  
24 10 percent. Under current law, senior citizens with  
25 incomes of \$10,000 per year have to spend about \$751 out

1 of pocket for health care in order to get the first few  
2 cents of tax relief. Under the modification, however,  
3 how much will a senior citizen with an adjusted gross  
4 income of only \$10,000 have to spend before they get a  
5 few cents of tax relief?

6 Mr. Barthold. Senator, the way the floor works, is  
7 we take 10 percent of adjusted gross income. So you said  
8 \$10,000, \$1,000. If you have medical expenses,  
9 qualifying medical expenses in excess of \$1,000 claimed  
10 as a deduction, the excess over \$1,000. So if it were  
11 \$1,200, you could claim a \$200 tax deduction.

12 Senator Bunning. Would it be fair to say that  
13 taxpayers with high catastrophic health care costs  
14 relative to their income--let us say someone with a  
15 terminal illness--will have to experience even higher  
16 catastrophic health care costs before they can take this  
17 deduction?

18 Mr. Barthold. The effect of the floor is that, in  
19 order to claim an itemized deduction, you would have to  
20 have greater expenses to get over the floor.

21 Senator Bunning. In other words, there is a limit,  
22 also, is there not?

23 Mr. Barthold. Correct. And if you were over the  
24 floor, less of your expenses compared to present law  
25 would be allowed, the difference between 7.5 percent of

1 adjusted gross income and 10 percent. I should note, in  
2 your example, Senator, that an adjusted gross income of  
3 \$10,000, the individual is unlikely to have a tax  
4 liability and they would probably be claiming the  
5 standard deduction and the personal exemptions and would  
6 have a tax liability.

7 Senator Bunning. But if they had a catastrophic  
8 illness -- in other words, the standard deduction would  
9 be -- all that would be able to take --

10 Mr. Barthold. The standard deduction would wipe  
11 out their tax liability. Remember, this is an  
12 itemized --

13 Senator Bunning. They probably would not have a  
14 tax liability.

15 Mr. Barthold. That is correct, sir.

16 Senator Bunning. All right. Thank you.

17 Dr. Elmendorf. Senator, can I just add? About  
18 \$235 billion for the first proposal you mentioned, the  
19 flat line, and the 1 percent growth rate per year would  
20 be about \$280 billion.

21 Senator Bunning. Each of the 9 years, if you  
22 increased at a 1 percent fix, it would be 285?

23 Dr. Elmendorf. Total cost would be about \$280  
24 billion.

25 The Chairman. Thank you, Senator.

1           One point I would like to clear up a little bit,  
2           there is a big tax cut in this bill, which some do not  
3           like to remind us of, but I think is important to get out  
4           to the public.

5           Mr. Barthold, if you would tell me, with the tax  
6           credits that people receive, do you have any estimates as  
7           to the total number of dollars that would be tax cuts the  
8           American people would receive under this bill?

9           Mr. Barthold.    Mr. Chairman, I do have that.    But  
10          could you have another Senator inquire while I dig out  
11          the piece of paper?

12          The Chairman.    We will give you lots of time  
13          because this is a very valid point.

14          Mr. Barthold.    All right.

15          The Chairman.    All right.

16          Next on my list is Senator Ensign.

17          Senator Ensign.    Thank you, Mr. Chairman.

18          Just go back to what Senator Snowe talked about,    I  
19          think the bottom line is, and what Senator Snowe has been  
20          really pushing for, is that we have an estimate, as  
21          accurate as CBO can be--obviously there is a lot of  
22          guesswork in all of this--not only of the bill as  
23          modified, but the final bill that we are going to be  
24          voting on, which would include amendments.    I think the  
25          point that you were making is, you need the time to do

1 this thing right.

2 I think what Senator Snowe has been arguing for this  
3 whole time is that, because the implications -- President  
4 Obama said that he would not sign a bill that added one  
5 dime to the deficit. That was his promise in the speech  
6 before the Congress. Well, for us to know whether we are  
7 voting on a bill, the final bill, we have to have  
8 estimates from CBO that says whether we are in fact  
9 voting for a bill that increases the deficit or not. You  
10 had a preliminary estimate of the mark, but now it is  
11 modified.

12 Once we add amendments to it, there may be costs  
13 associated, significant costs, because, as you said, they  
14 interact--you adjust one part, it interacts. There may  
15 be significant cost to it. So I just wanted to make that  
16 point, that I believe, instead of artificial deadlines  
17 like we have already had set before us, we should have  
18 the time to get this thing right and know what we are  
19 voting on.

20 That is one of the reasons I think Senator Snowe has  
21 been asking for not only estimates, but legislative  
22 language, so we know exactly what we are voting on. The  
23 American people have been saying, are you going to read  
24 this bill? Well, we will not even have a bill to be able  
25 to read, from what I understand, before at least the

1 committee votes on it. So, I think those are legitimate  
2 points.

3 The question that I had, though, for Joint Tax was  
4 dealing with the excise tax. In the modification, from  
5 what I understand, it goes from 35 percent up to 40  
6 percent. In our preliminary discussions, I asked you  
7 all, between CBO and Joint Tax, this question. The major  
8 savings in the bill, from what I understand are in this  
9 excise tax, there are a couple hundred billion dollars in  
10 savings.

11 Is the major reason for the big savings because it  
12 is not indexed for medical inflation, it is only indexed  
13 for CPI, and now in the Chairman's modification it is  
14 indexed for CPI plus 1 percent? But in the out years and  
15 the second 10 years, we start picking up more and more of  
16 the people affected by this plan, is that not correct?

17 Mr. Barthold. Senator Ensign, as we discussed, I  
18 believe it was last Friday, the threshold imposes a tax  
19 and creates incentives for people to perhaps change the  
20 type of coverage that they have if they have an overall  
21 plan that is above the threshold amount. Under the  
22 Congressional Budget Office's baseline projections, the  
23 medical cost expenses, and thus, expenses of medical  
24 health plans, is growing more rapidly per year than the  
25 Consumer Price Index.

1           It is also growing more rapidly per year than the  
2           Consumer Price Index plus 1 percent. So that means the  
3           threshold is not growing as quickly as a plan's cost  
4           might increase, so year by year there would be more  
5           incentive to change the plan. And, as we discussed last  
6           Friday, more people with plans, if they did not change  
7           their plan, would find that their plan was now above the  
8           threshold.

9           Senator Ensign. If the business is going to be  
10          taxed at this, I mean, their effort is going to be to try  
11          to pass that cost on. I mean, that is what businesses  
12          do. When a tax is imposed on them, if possible--and most  
13          of the time they do that, they try to pass the tax on--so  
14          in effect, would we not be passing this tax on to more  
15          and more consumers into the future?

16          Mr. Barthold. Well, again, as we discussed on  
17          Friday, we have analyzed this as largely falling on the  
18          consumer. It could happen in a couple of different ways.  
19          It is noted, if consumers say we would not like to pay  
20          this excise tax, we will opt for a less expansive plan,  
21          or a plan that perhaps has higher co-pays so that they  
22          are below the tax threshold, that would result in them  
23          actually taking a greater income inclusion and there  
24          would be additional income tax and payroll tax receipts.  
25          That is part of the underlying revenue estimate.

1           Alternatively, if they are happy with their plan, do  
2 not want to change, or at least in the short run, there  
3 could be excise tax receipts as part of the revenue  
4 estimate, but we would expect that that would become part  
5 of the cost of the plan, which would raise their cost and  
6 there would actually be a little bit of an offset in  
7 terms of cash compensation effects.

8           Senator Ensign.   Mr. Chairman, I will close with  
9 this. I understand why the committee, and why you have  
10 decided to put this in the mark. With the "Cadillac"  
11 plans, there is the tendency for over-utilization in the  
12 health care field. But I keep going back to what  
13 President Obama has said, that if you like your plan you  
14 will be able to keep it. But if you are forcing people  
15 through taxes to change their plan, well, they may not  
16 have the option.

17           Their employer may decide to do something  
18 differently, because if these plans are passed on to  
19 basically the employers, because they pay most of the  
20 cost, then that, in fact, will cause people to not stay  
21 in their plans, not because of a choice that they are  
22 making, but because of a choice that the government has  
23 imposed a tax on that plan. I think it is important, at  
24 least, to be honest with the American people that that is  
25 the effect of what this excise tax, in effect, could do.

1           The Chairman.    If I might, just on this, I mean, we  
2   are going to hear a lot of this from a certain side of  
3   the aisle here.   I just think it is important to kind of  
4   clear the air a little bit.   What we hear is the promise,  
5   if you like what you have, you can keep it.   The fact is,  
6   currently, today, you cannot keep what you like in many,  
7   many cases by not passing any law.   That is because  
8   employers are changing plans all the time.   They are  
9   adding co-pays, they are adding deductibles, they are  
10   dropping.   You would not believe it.   I do not know the  
11   number.

12           Being very conservative, we hear that 14,000 people  
13   lose health coverage a day.   They have lost their plans.  
14   Fourteen thousand Americans have lost their plans.   They  
15   could not keep it.   That is the current, the status quo,  
16   as we all know.   A lot of people cannot keep the plans  
17   they want.   This bill goes a long way to provide  
18   stability so that people are more likely to -- first,  
19   they can choose the plans that they want, and they are  
20   more likely to keep them.   There are limitations on  
21   rescission here.   There are limitations on annual and  
22   out-of-pocket coverage caps that insurance companies  
23   have.   There is insurance market reform here.

24           So, two main points.   One, today, you cannot keep  
25   what you have now, you just cannot.   Now, some can, but

1 for those folks who find their employer has dropped their  
2 coverage, those folks are experiencing a dramatic change  
3 willy-nilly by their employer's insurance plan, they  
4 cannot keep what they have, and they sure do not want to  
5 keep what they have. They do not have any more.

6 The second point being, we are requiring a lot more  
7 stability here with this legislation so that people are  
8 more likely to like what they have, and if they want to  
9 move, they could more easily move to something that they  
10 like.

11 Another point I want to make with Tom Barthold,  
12 which is, it is my understanding, Mr. Barthold, that it  
13 is easier a Joint Tax analysis, or maybe it is CBO, that  
14 these higher-cost plans, the analysis is that because  
15 these plans do not go into effect, this law does not go  
16 into effect until 2013, that your analysis is that many  
17 insurance companies and employers will change their  
18 compensation packages, and as a result, wages and  
19 salaries will increase. That may increase taxes because  
20 salaries and wages are increasing, but on a net basis it  
21 is money in your pocket as compensation for not having,  
22 perhaps, the same high-value plan that you earlier had.

23 Mr. Barthold. That is correct, Mr. Chairman. As I  
24 was explaining to Senator Ensign, we view this as putting  
25 pressure on choices that people make. If they opt out of

1 their current plan by, as I said, perhaps choosing a plan  
2 with a higher co-pay rate, higher deductible rate so that  
3 it is no longer subject to the excise tax, that would be  
4 reflected in their compensation package in terms of more  
5 cash compensation.

6 The Chairman. Nothing is perfect here in their  
7 trade-offs, but does this not help bend the cost curve?  
8 Let me ask Dr. Elmendorf that question. I mean, if it is  
9 below medical inflation, the index, and some limit here,  
10 high-value plans, does that or does that not help bend  
11 the cost curve in the right way?

12 Dr. Elmendorf. So imposing this tax would, in our  
13 judgment, together with the Joint Tax Committee staff,  
14 reduce health spending over time by removing what is  
15 essentially a subsidy in the current Tax Code to buy more  
16 health insurance relative to buying things that you have  
17 to purchase with after-tax income, and by offsetting that  
18 subsidy, it puts the purchase of health insurance more on  
19 a level playing field with the purchase of other goods  
20 and services and would, in our judgment, reduce the  
21 purchase of health insurance.

22 Of course, CBO is not for or against any policies,  
23 but I think it is important to note that a very wide  
24 range of experts in health policy think that removing  
25 this subsidy, making people confront the true cost of the

1 extra insurance without the government subsidy, would  
2 lead to better choices over time.

3 The Chairman. All right.

4 Senator Kyl, you are next.

5 Senator Kyl. Thank you, Mr. Chairman.

6 Mr. Barthold. Mr. Chairman? I am sorry, Senator  
7 Kyl. I interrupted you. I did recover the piece of  
8 paper that the Chairman asked me to look for. I did not  
9 know if this might be a good point to --

10 The Chairman. Briefly, yes. Fine.

11 Mr. Barthold. Mr. Chairman, you had asked, just  
12 briefly, if we had done any analysis of looking at the  
13 low-income subsidies provided through the exchange and  
14 the cost-sharing subsidies for individuals purchasing  
15 insurance policies through the exchange in comparison to  
16 the high-premium excise tax.

17 Now, keeping in mind that we did this analysis based  
18 on the Chairman's mark and not as modified, to choose one  
19 calendar year, 2017, there are almost 45 million  
20 taxpayers who either receive a benefit or have income  
21 inclusion or experience a higher excise tax from the  
22 high-premium excise tax. But of those 45 million, on  
23 average, 25 million have a net tax reduction due to the  
24 subsidies available through the exchange and the cost-  
25 sharing subsidies for out-of-pocket medical expenses.

1           The Chairman.    But just to make it clear here, I  
2   grabbed my chart in front of me.  If I read the chart  
3   correctly, at the top it says, "Distributional Effects of  
4   Proposal", et cetera.  I have several charts.  One is  
5   2017.

6           Mr. Barthold.    I was looking at 2017.

7           The Chairman.    All right.  In 2017, my chart says,  
8   for all returns, total of all taxpayer, a tax reduction  
9   for all affected taxpayers of about \$38 billion?

10          Mr. Barthold.    That is correct.

11          The Chairman.    And roughly, round out, 45 million  
12   Americans will get a tax cut.

13          Mr. Barthold.    Well, I was breaking it down.

14          The Chairman.    And this is for all taxpayers.

15          Mr. Barthold.    That is overall.

16          The Chairman.    Yes.

17          Mr. Barthold.    Most of the tax cut, as you had  
18   noted earlier, occurs at incomes less than \$75,000.

19          The Chairman.    Right.  That is correct.  But for  
20   overall -- I am only able to do the grand total, not able  
21   to do the subtotals.  I cannot think that quickly.  But  
22   the grand total is, 44 million Americans get a tax cut in  
23   2017, and it is proportionately higher, and higher, and  
24   higher as each year goes by.

25          Mr. Barthold.    That is correct, sir.

1           The Chairman.    Thank you.

2           Senator Grassley.    But is it not true, Dr.  
3 Elmendorf, that CBO considers these refundable tax  
4 credits as outlays, which would be spending?

5           Dr. Elmendorf.    It is a longstanding budget  
6 convention.    I do not know who originally started it.  
7 The "refundable" part of refundable tax credits are  
8 reported on the outlay side of the budget, and on the  
9 part of the refundable tax credit that reduces tax  
10 liability, it is reported as a reduction in revenues.

11          The Chairman.    They are still tax cuts.

12          Senator Grassley.    The only thing I am saying is,  
13 he just got done saying it was an expenditure, an outlay.

14          Dr. Elmendorf.    The convention of how it is  
15 recorded in the budget and how one thinks about it is  
16 something that I will have to leave to you to discuss.  
17 Maybe I would just say, briefly, in the estimates that we  
18 have prepared, the preliminary analysis, we have,  
19 together with the Joint Tax Committee staff, have looked  
20 at the net effect on the budget deficit.    We have not yet  
21 broken that out into the way it would ultimately appear  
22 on the revenue and expenditure side of the budget, which  
23 involves working through issues like the one that you  
24 just raised, Senator Grassley.    That is part of moving  
25 toward a formal cost estimate that we have not yet

1 completed.

2 The Chairman. Senator Kyl has been very patient.

3 Senator Kyl. Thank you, Mr. Chairman. I would  
4 just note that a refundable tax credit, obviously, is  
5 money in excess of tax liability, and therefore it is  
6 hard to characterize that as a tax cut when you do not  
7 have any tax liability. But I appreciate your admonition  
8 that we do the characterization and you do the figuring.

9 Dr. Elmendorf. Thank you, Senator.

10 Senator Kyl. I have four quick questions. The  
11 first, is the Senate Budget Committee, using CBO scoring  
12 numbers, has estimated that the real 10-year cost of the  
13 bill, when fully implemented--in other words, when we  
14 have both the benefits and the taxes--is \$1.67 trillion.  
15 Do you know whether that is the correct number, or can  
16 you get us the correct number?

17 Dr. Elmendorf. I cannot speak to that one way or  
18 the other, Senator. We are not trying to estimate the  
19 bill on the impossible supposition that it would be  
20 implemented right away. What we have done instead, to  
21 offer you and the other members of the committee and the  
22 Congress a sense of the long-run effects of the bill, is  
23 to talk in vague, but the most precise terms we think we  
24 can about the effect in the second 10 years. We have  
25 said we view that, if the law is implemented as written

1 and not changed, would be a reduction in the Federal  
2 budget deficits in the second 10 years.

3 The Chairman. About \$800, \$900 billion.

4 Senator Kyl. Well, but if you take the first 10  
5 years in which it is fully implemented when you have both  
6 sides of the equation, what is the amount of money? That  
7 is what I am asking about. According to this  
8 calculation, using CBO numbers, it is \$1.67 trillion.

9 The Chairman. What is the net? What is the net?

10 Dr. Elmendorf. So if you did it for the first 10  
11 years in which it was implemented --

12 Senator Kyl. Yes.

13 Dr. Elmendorf. Maybe you are referring to the 2013  
14 to 2022 period.

15 Senator Kyl. Exactly. Yes, exactly.

16 Dr. Elmendorf. So we have not done that estimate.  
17 We think that the crystal ball is hazy enough for the  
18 first 10 years, and beyond that becomes hazier still to  
19 the point where doing a cost estimate of the sort we  
20 normally deal with, all the interacting pieces carefully  
21 traced and so on, it just gives you an unrealistic sense  
22 of our powers as forecasters. So we really do draw the  
23 line on that sort of detailed cost estimate at 2019, the  
24 end of the 10-year budget window. For the following  
25 decade, all we think we can do is to give you a ballpark

1 sense of the effects of the legislation by extrapolating  
2 some of the key components.

3 Senator Kyl. Well, let me follow up on that then,  
4 because you do predict the long-term deficit reductions.  
5 You note, and I think you are absolutely correct on this,  
6 that they depend on Congress repeatedly approving cuts  
7 year after year, for example, to Medicare providers, an  
8 assumption which you say "is often not the case with  
9 major legislation", and you cite the SGR for doctors as  
10 the example for that.

11 So the score would depend on Congress doing  
12 something that we may well not do, or to use your  
13 language, that we often do not do. Is that correct?

14 Dr. Elmendorf. The one change I would make in what  
15 you said is that Congress does not have to approve future  
16 cuts in payments, they have to not act to disapprove.

17 Senator Kyl. Right.

18 Dr. Elmendorf. So I think that is important. We  
19 scored the legislation as it is written. If the  
20 legislation required future congressional action, we  
21 would not score that now. We would score it as part of  
22 future legislation. The reason we score it here is  
23 because it will take effect unless you --

24 Senator Kyl. Yes. And that is a perfectly  
25 appropriate way to do it. I am not arguing with that.

1 But you also make the point that, citing the physician  
2 SGR, we often do make the adjustment for political  
3 reasons or other reasons that we deem important. So in  
4 making an estimate like this, I think it is appropriate  
5 to note the reality of what we usually do rather than  
6 just the way the bill happens to be written right now.

7 Dr. Elmendorf. So you understand, Senator, our job  
8 is to project the effect of the bills as written, not to  
9 second-guess what you do. But in general, we tried very  
10 hard here to be transparent about the assumptions that  
11 underlie those projections so you and your colleagues can  
12 form your own judgments.

13 Senator Kyl. And I do appreciate your observation  
14 about our tendencies. That helps, at least in the  
15 debate.

16 Third, let me just read something that you wrote in  
17 a brief entitled, "Effects of Changes to the Health  
18 Insurance System on Labor Markets". This pertains to the  
19 so-called "freerider" provision in the mark.  
20 "Supporters of such surcharges often refer to them as  
21 free rider penalties. Although the surcharges would be  
22 imposed on the firms, workers in those firms would  
23 ultimately bear the burden of those fees, just as they  
24 would with pay-or-play requirements." This also relates  
25 to something Senator Ensign was talking about earlier, in

1       which you noted that the excise tax would fall mostly on  
2       the consumer.

3               Here, you note "employer surcharges tend to be more  
4       targeted. Many of those workers are more likely to have  
5       earnings at or near the minimum wage, and the signs of  
6       such surcharges, if based on actual costs imposed on  
7       government programs, could be larger per affected worker  
8       than the assessments being considered in many pay-or-play  
9       requirements." So the bottom line, I gather, is that  
10      this kind of surcharge, or so-called free rider penalty,  
11      does disproportionately affect the low-income workers.

12             Dr. Elmendorf. Yes. I think that is right,  
13      Senator. As we wrote in the brief, economists believe,  
14      through theory and evidence, that charges of this sort  
15      tend to be passed through to workers' wages, and where  
16      those wages are fixed in some way and cannot be passed  
17      through--for example, by minimum wage--then in those  
18      cases they may have employment effects.

19             Who is affected is a complicated business to keep  
20      track of, beyond the generalities that you have quoted  
21      correctly and I have just said, because it depends a lot  
22      on what those workers do, whether a worker decides, for  
23      example, to get insurance through a spouse's policy and  
24      so on. There is tremendous diversity in the country, so  
25      it is hard to make general characterizations beyond what

1 we have said here.

2 Senator Kyl. Yes. And I appreciate that.

3 Finally, after Senator Nelson's grandfathering  
4 provision on Medicare Advantage--you know what I am  
5 speaking of--have you done the analysis of what effect  
6 that would have on enrollment since then or do you just  
7 have the analysis of the original Chairman's mark?

8 Dr. Elmendorf. On Senator Nelson's amendment, I  
9 believe that our very preliminary analysis of the  
10 amendment is that it would add about \$10 billion to the  
11 cost of the legislation. I do not know if we have  
12 numbers on people affected. So I am told there is very  
13 little effect on enrollment in the program, Senator.

14 Senator Kyl. All right.

15 And do you recall what the reduction in enrollment  
16 was under the original Chairman's mark? My recollection  
17 was that it was around \$3 million, but I am not sure over  
18 what period of time. But you should have the number  
19 there, I think.

20 Dr. Elmendorf. Senator, I believe I have it here  
21 in the stack, and I think my colleagues have it as well.

22 Senator Kyl. All right. They are nodding as if  
23 that may be ballpark. I am not sure.

24 Dr. Elmendorf. I believe, Senator, that the  
25 reduction in enrollment that we project for 2019 is about

1 2.7 million people, or 20 percent of the baseline level  
2 of enrollment.

3 Senator Kyl. All right. About 20 percent of the  
4 baseline enrolled, and not much change, you think, as a  
5 result of the Nelson proposal?

6 Dr. Elmendorf. That is right, Senator.

7 Senator Kyl. All right.

8 And this is just a subset, but do you have a  
9 breakdown between urban and rural? If you do and could  
10 get that to us later, that is fine. I do not mean to use  
11 the time right now.

12 Dr. Elmendorf. We do not have that with us, but we  
13 will see what we can do about that for you.

14 Senator Kyl. All right. If you already have it,  
15 fine. I am not asking you to do extra work.

16 Dr. Elmendorf. Thank you, Senator.

17 Senator Kyl. I agree with your maximum safe speed  
18 proposition. Thank you.

19 Dr. Elmendorf. Thank you, Senator.

20 The Chairman. Thank you very much.

21 Senator Conrad?

22 Senator Conrad. Dr. Elmendorf, unfortunately I was  
23 called away to take a call that has significant effects  
24 on my State, so I apologize that I was not here.

25 Dr. Elmendorf, I would be interested to know, your

1 assessment has been that the Chairman's mark, as  
2 originally put out, was paid for and actually reduced the  
3 deficit by \$49 billion over the first 10 years.

4 Dr. Elmendorf. Yes, Senator.

5 Senator Conrad. Your further analysis was that it  
6 bent the cost curve in the right way, that is, reduced  
7 long-term costs from what they would otherwise be by one-  
8 half of 1 percent of GDP.

9 Dr. Elmendorf. Yes, Senator. That is correct.

10 Senator Conrad. And our analysis of GDP over the  
11 second 10 years, is we are looking at roughly \$260  
12 trillion of Gross Domestic Product over that period, so  
13 one-half of 1 percent would be roughly \$1.3 trillion. Is  
14 that math correct?

15 Dr. Elmendorf. The calculation sounds right. I  
16 cannot vouch for the GDP number. We deliberately  
17 presented our answer as a percentage of GDP for two  
18 reasons. One, because I think it is hard for people to  
19 understand what a dollar in 2029, say, is worth today,  
20 given inflation that will ensue over that time. Second,  
21 because the dollar figure has the risk of looking too  
22 precise when, in fact, as I have said, we are looking  
23 through a pretty hazy crystal ball at that point. So we  
24 think it is most useful for you and for others to think  
25 about this as a percentage of GDP, and you quoted our

1 conclusion correctly.

2 Senator Conrad. Yes. Fair enough. I think you  
3 have done it in a very professional way.

4 With respect to the issue of when scoring might be  
5 available, because this is obviously a sensitive matter,  
6 it is critically important that we have scoring before a  
7 final vote is cast in the committee and it is obviously  
8 critically important that we have your best assessments  
9 on the costs of amendments as we consider them -- and I  
10 know, and I want to applaud you and your staff, for the  
11 extraordinary personal and professional commitment that  
12 all of you have made at CBO to this effort, because I  
13 know that you and your staff have been working not only  
14 nights, but weekends, for months. It is deeply  
15 appreciated by this committee, and it is certainly  
16 appreciated by the committee that I had.

17 With that said, it is important for us to know, once  
18 there is a package after the amendment process here, can  
19 you give us some rough estimate in days of how long it  
20 would take to have a CBO score?

21 Dr. Elmendorf. First of all, thank you for your  
22 appreciation for our work. I will pass that along to my  
23 colleagues at the office, and that will cheer them  
24 greatly. I think we can update our preliminary analysis,  
25 give you something comparable to what we gave you last

1 week, for the bill, including the amendments that are  
2 adopted, within a few days of the package actually being  
3 set.

4 A formal cost estimate would require--and we have  
5 said this to people on the House and Senate side--two  
6 weeks of work by us once the package is settled. And  
7 that may seem like a long time, but there are a lot of  
8 complications in doing this right, as you need it to be  
9 done. It is the interaction effects among the  
10 provisions. It is reading the legislative language. Our  
11 official cost estimates are based on reading of actual  
12 language. It is very complicated to write this language  
13 and to interpret it correctly, and that often involves a  
14 certain amount of iteration between us and the staff of  
15 the relevant committees.

16 We also need to develop a more complete budget  
17 presentation rather than just the effects on the deficit,  
18 which is the way we have been summarizing for you so far.

19 So we have told all the people who have asked that it  
20 will take us about two weeks to do a formal cost estimate  
21 after we have a full bill, but as I said, we can do an  
22 updated preliminary analysis more quickly than that.

23 Senator Conrad. And that preliminary analysis, if  
24 it tracks what you did for us in the preliminary analysis  
25 done thus far, would include effects on the deficit in

1 this 10-year period, as well as whether or not we  
2 successfully bend the cost curve thereafter.

3 Dr. Elmendorf. Yes, that is right, Senator.

4 Senator Conrad. And those conclusions by you,  
5 preliminary though they may be, would be of enormous  
6 importance to this committee, certainly to this member  
7 before I cast a vote, because I want to be absolutely  
8 assured that we are going to have this paid for, and  
9 better than that, that we are going to bend the cost  
10 curve in the long term in the right way. I think many of  
11 us would not be able to support legislation that did not  
12 accomplish those very important objectives. The  
13 President has made clear he would not sign legislation  
14 that did not meet those objectives. So that part of the  
15 analysis would take several days after the package is  
16 complete here, as I hear you say it.

17 Dr. Elmendorf. Yes. That is right, Senator.

18 Senator Conrad. I think that is extremely  
19 important and very helpful.

20 I thank the Chairman. Again, I want to thank you,  
21 Dr. Elmendorf, and your team. This has been an  
22 extraordinary effort by you and your staff, and we  
23 appreciate it.

24 Dr. Elmendorf. Thank you, Senator.

25 The Chairman. That is an interesting conversation,

1 but the real question is: how do we get ourselves out of  
2 this box? I would like your help to get us out of this  
3 box. What is the box? The box is, let us say we pass  
4 legislation. Let us say we put out a bill, just for sake  
5 of discussion, Thursday. As I understand your answers,  
6 you are saying only then could you start to do a  
7 preliminary analysis. And if I understood you correctly,  
8 you said it would take a few days, and if I understood  
9 you further, you said two weeks after that to do a final.

10 So the box we are in, if we pass legislation, we  
11 have got to cool our heels here for up to two to three  
12 weeks before we know the final. That is unacceptable,  
13 clearly. We cannot operate that way. So you have got to  
14 help us get out of this box somehow. It seems to me  
15 that, to the degree that you could tell us the  
16 preliminary -- I have a hard time seeing why it takes  
17 that long to do a preliminary, because you are probably  
18 doing it as we go along each day with amendments.

19 Let me finish. Let me finish. Let me finish.

20 I have got to think that the final could not be that  
21 different from the preliminary, so long as the  
22 description of what we do accurately represents what we  
23 are doing, so in good faith, the legislative language  
24 does reflect what we are doing, and that would seem to me  
25 that therefore, if that is the case when we write this up

1 that this is actually what this really does do, that that  
2 should be sufficient to give you a pretty good indication  
3 of what the scoring will be, and that the final, which as  
4 you say we get two weeks later, is not going to be very  
5 much different from a good-faith preliminary.

6 Dr. Elmendorf. I think, Senator, one of the  
7 crucial parts of this long period--which I understand may  
8 seem very surprising to you--is the drafting and review  
9 of legislative language. It is not a matter of our  
10 doubting anybody's faith, it is simply hard to write down  
11 in law, translate into law, what is in specifications.  
12 The experience of people who have been at CBO much longer  
13 than I have and have seen much more of this happen is  
14 that that process invariably takes more time than people  
15 like me and you guess it will up front. It is hard to  
16 predict how long that is.

17 I assure you, Senator, we will be working as fast as  
18 we can, while maintaining our quality. But the  
19 experience has been--and I want to be honest about that  
20 up front--that it takes a long time to turn a bill of  
21 this complexity into legislative language. I am not a  
22 lawyer, so I cannot even really explain that to you, but  
23 that is the --

24 The Chairman. Let me ask the question again.  
25 Assuming good faith in the drafting of the mark, the

1 modified mark and amendments, we are going the extra mile  
2 to make sure that the language adequately reflects what  
3 we are intending here and so forth, my question is, if  
4 that is the case--and that will be case, as far as I am  
5 concerned. This will be a good-faith drafting. We are  
6 not trying to fuzz anything--that when the actual  
7 legislative language is written, this committee does not  
8 do legislative language. The tradition, the history is  
9 not to do legislative -- let me finish. To do  
10 legislative language while we are debating, while we are  
11 offering amendments and so forth. I have been on this  
12 committee for 30 years and that has been the case. Only  
13 later is the legislative language actually written.

14 But my question is this: assuming good faith and the  
15 actual descriptive language, for want of a better  
16 expression, what would the final-final--two weeks later,  
17 however long it takes--be pretty close to what you  
18 preliminarily determined?

19 Dr. Elmendorf. If your question is, if the  
20 legislative language implements the specifications --

21 The Chairman. Accurately.

22 Dr. Elmendorf. [Continuing]. As we understood  
23 them.

24 The Chairman. Accurately reflects.

25 Dr. Elmendorf. Then that simplifies the process.

1           The Chairman.    Yes.

2           Dr. Elmendorf.    But just the discovery of that will  
3    take some time.  Again, it is not a matter of anybody  
4    acting in bad faith, it is just a matter of the  
5    difficulty, the number of pages of legislation that will  
6    need to be written.  I am not even sure how far along  
7    your staffs will be on that process.  I am not sure even  
8    what legislation we will be asked to do an official cost  
9    estimate of because there are multiple committees.  We  
10   have not done a final cost estimate of the Help  
11   Committee's bill.  So I am not sure when this process  
12   will even start formally.  It depends on what it is that  
13   is most useful for the members of the Senate for us to  
14   devote our attention to.

15          The Chairman.    All right.  But you only estimate  
16   our bill, in a preliminary fashion, at least, very  
17   quickly?

18          Dr. Elmendorf.   As I understand your request, once  
19   the committee has finished adopting or rejecting a set of  
20   amendments so that there is a well-defined bill, we know  
21   what is in it and what is out of it, then we will turn to  
22   estimating, to doing a preliminary analysis of that bill.

23          The Chairman.    Well, we have got a lot of work to  
24   do, I can tell right now.  We will figure a way out of  
25   this box together, but we need your good-faith help to

1 get us out of this box. All right.

2 Senator Rockefeller, you are next.

3 Senator Rockefeller. Thank you.

4 David Schwartz, under this mark, would all  
5 individuals in Medicaid and the Children's Health  
6 Insurance Program be able to keep the coverage that they  
7 currently have?

8 Mr. Schwartz. No, Senator, they would not. For  
9 kids who are in CHIP today, which you well know could  
10 take different forms depending on how the State has  
11 structured its program, they would not all necessarily be  
12 able to stay in because the provision in the Chairman's  
13 mark would be to transition from the current structure of  
14 CHIP to a different structure where what we have referred  
15 to as the core benefits would be provided through an  
16 exchange plan with a wrap-around done by the State to the  
17 full extent of EPSDT or the Medicaid package.

18 Senator Rockefeller. It is incredibly important to  
19 me that the Children's Health Insurance Program, which  
20 represents children, they have specific benefit  
21 requirements. It has been a defined benefit package, now  
22 it is going to the exchange and who knows what it will  
23 be. You talk about wrap-around. Can you give me an  
24 example recently of a State which has effectively worked  
25 a wrap-around?

1           Mr. Schwartz.    To be honest, I am less familiar  
2 with individual State plans and how they --

3           Senator Rockefeller.   Well, to be honest, I cannot.  
4 So the wrap-around argument, I think, becomes a way of  
5 trying to get out of the perils of putting children in  
6 the health exchange, which I find unacceptable, and a  
7 wrap-around is not going to do it.

8           Second, under current laws, States have the option  
9 to provide flexible benefits through a State plan  
10 amendment. This simply means that they can offer less  
11 generous coverage to new employees. So, Mr. Schwartz, it  
12 is my understanding that this flexibility provision would  
13 become mandatory for newly-eligible populations in  
14 Medicaid, like parents and childless adults, under the  
15 mark. Is that correct?

16          Mr. Schwartz.    That is correct.

17          Senator Rockefeller.   Mr. Schwartz, would new  
18 enrollees be in less need or greater need of Medicaid  
19 benefits than current enrollees?

20          Mr. Schwartz.    I am not sure that there is an  
21 answer. I think it would vary based on the individuals.  
22 In some cases it could be greater, in some cases it could  
23 be less, and in some cases it could be the same.

24          Senator Rockefeller.   Well, and I think what you  
25 are saying, therefore, is that you are creating--and this

1 is my point--a two-tiered Medicaid system, which I think  
2 a lot of people are just going to be getting less  
3 benefits, which you answered, in response to my first  
4 question and I think is buttressed by this flexibility.  
5 Some governors love flexibility, like Medicaid waivers,  
6 because they do not have to do as much and they can cut  
7 people off of CHIP and whatever they want. And that is  
8 just the nature of governors; I know, I was one.

9 The next question. On the flexibility, Mr.  
10 Schwartz, what is the origin of this benefit flexibility  
11 language?

12 Mr. Schwartz. It is codified as Section 1937, as  
13 you said, of the Social Security Act.

14 Senator Rockefeller. Which is called the Deficit  
15 Reduction Act.

16 Mr. Schwartz. It originally passed Congress as  
17 part of the Deficit Reduction Act.

18 Senator Rockefeller. Now, my understanding is--and  
19 this is going to sound political, and I guess it is--that  
20 it was passed without a single Democratic vote.

21 Mr. Schwartz. I believe that is correct, Senator.

22 Senator Rockefeller. Under Republican control. It  
23 was passed under something called "reconciliation". Am I  
24 correct?

25 Mr. Schwartz. You are correct, Senator.

1           Senator Rockefeller.    Thank you, Mr. Schwartz.  You  
2   are outstanding.

3           [Laughter].

4           Senator Rockefeller.    What has been the impact of  
5   this so-called flexibility on States like West Virginia?

6           Mr. Schwartz.    States like West Virginia have used  
7   the flexibility available in Section 1937 to provide --  
8   the language in the Act is "a benchmark or benchmark  
9   equivalent" benefit package and they have scaled back the  
10   benefits that were available prior to creating that  
11   flexibility.

12          Senator Rockefeller.    Thank you.

13          I want to go on just for a moment to Medicare  
14   sustainability and MedPAC.  We skirt around this issue,  
15   but I want to confront it directly.  Under the Medicare  
16   Commission proposal, I see that Congress still has the  
17   opportunity to vote recommendations down.  That is not my  
18   choice, but that is in the mark.  As you know, this is  
19   not what I want.

20          Actually, I am going to ask this to Mr. Dawe.  Is it  
21   possible, under this proposal, for Congress to block the  
22   recommended Medicare reforms just as they do today?

23          Mr. Dawe.    Under the Chairman's mark, Congress  
24   would have an opportunity to come up with an alternative  
25   proposal between January 1 when the Commission's proposal

1 is due to Congress and August 15. They would have an  
2 opportunity to pass an alternative proposal that would  
3 achieve the same amount of budgetary savings. If  
4 Congress failed to act, then the Medicare Commission's  
5 proposals would take effect automatically.

6 Senator Rockefeller. I very much doubt that the  
7 Congress would fail to act, and I very much fear that the  
8 Congress would turn them down. The reason for that is  
9 that MedPAC, which is official but has no authority,  
10 created in 1997, makes their recommendations based on  
11 evidence-based outcomes, et cetera.

12 In other words, it is not just the power of a  
13 lobbyist to persuade somebody to do more for oxygen or  
14 less for something else, medical equipment, and that kind  
15 of thing. It is evidence-based. All of it is evidence-  
16 based and it is very specific and it is very nuanced and  
17 very complicated, and not always politically correct, but  
18 is accurate.

19 Now, my proposal would not allow that to happen  
20 because I do not want Congress to be able to vote on it  
21 because I do not want lobbyists to be able to vote on it,  
22 if I make myself clear.

23 I mean, how are we going to improve the accuracy of  
24 what we do in Medicare? How are we going to make it  
25 better for seniors if we are literally, with 14,000

1 health care lobbyists wandering around in Washington, DC,  
2 each with one particular service or one particular client  
3 that they need to show that they have earned their money  
4 in carrying out their efforts towards Congress, how are  
5 we going to make Medicare more efficient, more  
6 accountable, more explainable, and more beneficial to  
7 seniors if we allow Congress to act as they have been  
8 over these recent years?

9 Mr. Dawe. Well, I can only speak to what is in the  
10 mark. The Chairman's mark would create an independent,  
11 15-member commission. The mark lays out that the members  
12 of the commission should have similar qualifications to  
13 the members of MedPAC. So the intent of the provision is  
14 to establish an independent body that would be expert-  
15 based and evidence-based to create proposals and then  
16 give Congress an opportunity to review those and act on  
17 its own. If Congress fails, then the commission would  
18 take effect.

19 Senator Rockefeller. Right. And so you would have  
20 to believe that Congress was not going to fail to sustain  
21 MedPAC's proposals. I think MedPAC is tremendously  
22 misunderstood. Congress is fundamentally offended by the  
23 fact that it cannot make all of those decisions. If you  
24 accept the fact, as I do, that there is a relatively  
25 small percentage of people in Congress who really

1 understand the nuances of Medicare--health care in  
2 general, but Medicare, let us say--and how to adjust  
3 that, how to give updates, how to recognize that rural  
4 health care centers have to be given more -- we have the  
5 problem of pediatricians going through medical school and  
6 doing their residencies, and they practice for a couple  
7 of years, but they cannot make enough money, so off they  
8 go into some other specialty.

9 As the Nation gets older, the doctors that treat  
10 them get fewer. That can be adjusted, and would be  
11 adjusted by MedPAC, to reimburse geriatricians more in  
12 their practices so they would be less likely to leave  
13 them. I mean, that is just as an example of the kinds of  
14 things which affect seniors better in health care.

15 Now, the health care trust fund in Medicare is set  
16 to start declining in 2017. This proposal, however it  
17 comes out, will not take effect until 2013 and it is  
18 sunsetted, I think, although that has been cleared up  
19 now, thankfully. But I just do not understand how we can  
20 make proper Medicare decisions without professional  
21 analysis and the accepting of that professional analysis  
22 over extremely nuanced conditions across a country full  
23 of MSAs, rural, urban, and all kinds of geographic  
24 differences that make Medicare very, very complicated.

25 Mr. Dawe. The intent of the proposal is to strike

1 a balance between preserving a role for Congress and  
2 empowering an independent group to make the nuanced  
3 proposals that you speak of, and then again to allow  
4 Congress to have its opportunity, but to have some  
5 accountability built in by allowing the commission's  
6 proposals to take --

7 Senator Rockefeller. No. I think we understand  
8 each other. I would just hope that my colleagues would  
9 think seriously about the year 2017 when the Medicare  
10 trust fund begins to go down and the need, therefore, to  
11 make the best evidence-based Medicare decisions that we  
12 possibly can, which has to be done, I think, through  
13 professionals. I hope they would think about that, not  
14 as taking away from their power, but would add to the  
15 health of the seniors that they represent.

16 I thank the Chair.

17 The Chairman. Thank you, Senator Rockefeller.

18 Next on my list is Senator Crapo.

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

20 Dr. Elmendorf, I want to start out with you and go  
21 back to the Medicare Advantage question. I would just  
22 like you to help me work through that a little bit so we  
23 understand exactly what the proposal in the mark does and  
24 how the change that was made in the Chairman's  
25 modifications to the mark impact that.

1           If we start on the original mark, which had  
2           approximately \$123 billion of reduction in Medicare  
3           Advantage programs under Medicare, can you explain to me  
4           what the impact of that provision was in terms of how it  
5           would change the provision of health care through  
6           Medicare Advantage?

7           Dr. Elmendorf.    In our estimate, Senator, the  
8           effect of the original Chairman's mark on Medicare  
9           Advantage enrollment in 2019 would be a reduction of  
10          roughly 2.7 million people, or 20 percent of the  
11          enrollment that we project under current law.

12          Senator Crapo.    And what would be the reason for  
13          that reduction?

14          Dr. Elmendorf.    Because the competitive bidding  
15          process would reduce the extra benefits that would be  
16          made available to beneficiaries through Medicare  
17          Advantage plans, fewer of them would end up choosing  
18          Medicare Advantage and more would choose the fee-for-  
19          service part of Medicare.

20          Senator Crapo.    So in effect, I think you said the  
21          number was about 20 percent of the enrollee who would  
22          then choose to leave Medicare Advantage.

23          Dr. Elmendorf.    That is right.

24          Senator Crapo.    The effect then is that the reason  
25          they are going to choose to leave Medicare Advantage is

1 because their Medicare Advantage plan is less beneficial  
2 to them under the proposal than it is today, and  
3 therefore they would have to choose some other option.

4 Dr. Elmendorf. They would not receive as much  
5 additional benefits today in the current Medicare  
6 Advantage system. Beneficiaries who choose Medicare  
7 Advantage receive benefits that beneficiaries in the fee-  
8 for-service system do not receive.

9 Senator Crapo. Well, I understand --

10 Dr. Elmendorf. And additional benefits would be  
11 smaller. I want to be sure I am clear about something.  
12 This reduction in enrollment is not necessarily people  
13 who are in who would leave. It may be others who would  
14 not join at all. So it is not the number who are leaving  
15 Medicare Advantage, but a fewer number who would be  
16 there. Some of them may leave, and some may be ones that  
17 just will not join.

18 Senator Crapo. But there would be a loss of  
19 enrollment.

20 Dr. Elmendorf. There would be less enrollment  
21 overall by about 20 percent. Yes, Senator.

22 Senator Crapo. So are you saying that people would  
23 not leave Medicare Advantage?

24 Dr. Elmendorf. No. What I wanted to clarify was  
25 that this 20 percent is not all people who are leaving.

1 Some might be those who leave, others would be those who  
2 just would not join.

3 Senator Crapo. Do you have an understanding of  
4 what ratios it would be as to those who simply do not  
5 join versus those who leave?

6 Dr. Elmendorf. It is almost all not joining. I  
7 think the logic here is, the people who are in a plan  
8 that they are happy with are likely to stay. There is a  
9 great deal of inertia in people's choices. Even new  
10 people choosing what to do will come at this with a  
11 different set of choices than people would under current  
12 law.

13 Senator Crapo. My understanding is that, under  
14 your analysis, the value of the additional benefits that  
15 those in Medicare Advantage today receive would end up  
16 being reduced to about \$46 per member, per month in 2019.  
17 That is a little more, but not too much more than half of  
18 what it is today. Is that correct?

19 Dr. Elmendorf. My notes say \$42 of additional  
20 benefits per month in 2019, and I am told it is a little  
21 less than half of what we would project under current  
22 law.

23 Senator Crapo. So approximately half of the  
24 additional benefit would be lost to those current  
25 Medicare Advantage policyholders?

1           Dr. Elmendorf.    For those who would be enrolled  
2 otherwise under current law, yes.

3           Senator Crapo.    Is it true that part of the  
4 decrease in the enrollment could result from plans that  
5 are just leaving different areas and no longer offering  
6 Medicare Advantage to current enrollees?

7           Dr. Elmendorf.    I am relying again on my expert  
8 colleagues.    The competitive bidding system would, in our  
9 judgment, keep the plans essentially in the same place as  
10 they would be under current law.  It is just that new  
11 people joining Medicare and deciding what to do are less  
12 likely to choose a Medicare Advantage plan.  The  
13 competitive bidding process should enable these plans to  
14 continue to operate where they are, just with a lower  
15 level of additional benefits than would be the case under  
16 current law.

17          Senator Crapo.    About half the level of current  
18 benefits.

19          Dr. Elmendorf.    Yes, that is right.

20          Senator Crapo.    So the current plan holders would  
21 recognize about half the benefits that they see today  
22 under the current law?

23          Dr. Elmendorf.    Yes, that is right.

24          Senator Crapo.    All right.  Thank you.

25          I would like to shift gears, quickly, just to one

1 other area. That is on the excise tax on premiums. The  
2 Chairman's mark adjusts it from a CPI adjustment to a CPI  
3 plus one adjustment. I am interested in how that relates  
4 to the health care inflation rate as opposed to the CPI  
5 inflation rate. If you add one percentage to it, does it  
6 get you a close approximation? What is the approximate  
7 differential there in terms of the actual inflation rate  
8 of health care versus what is now included in the  
9 modified Chairman's mark?

10 Dr. Elmendorf. Adding 1 percent moves it closer to  
11 health care spending, but it is still less than we think  
12 the rate of increase in health care spending will be.

13 Senator Crapo. Do you have any estimates as to  
14 what you believe that rate will be?

15 Dr. Elmendorf. Our 75-year estimates of budget  
16 outcomes include numbers for a lot of decades, but I  
17 would not want to, as we have in general in talking about  
18 the budget effects of this legislation, put a lot of  
19 weight on those specific numbers. We do have some  
20 slowing in excess cost growth in health care over the  
21 subsequent decades because we think that the pressures of  
22 the rising health spending will affect more firms',  
23 individuals', State and local governments' behavior.

24 But I do not want to put much emphasis on those  
25 numbers. What I would say is that we, just to give you a

1       ballpark, think that excess cost growth in health care,  
2       the rate by which health spending rises per capita above  
3       the rate of GDP growth per capita, would be between 1.5  
4       and 2 percent over the 2020 to 2029 decade. So that 1.5  
5       to 2 percent, you can see that raising the indexing mark  
6       for the tax provision moves toward that, but not all the  
7       way to that.

8             Senator Crapo. All right. Thank you very much. I  
9       see that my time is up.

10            The Chairman. Senator Nelson is next on the list.  
11       I have Senator Nelson, Senator Snowe, and Senator Cornyn,  
12       and Senator Enzi following you, and Cantwell is following  
13       Enzi.

14            Senator Nelson. Senator Crapo, there would not be  
15       that cut in Medicare Advantage if the Nelson amendment is  
16       adopted.

17            Senator Crapo. I did not have time, but I was  
18       then going to ask, what would the impact be of the Nelson  
19       amendment. I would love to hear you inquire about that,  
20       Senator.

21            Senator Nelson. Well, as a matter of fact, I am  
22       going to ask Dr. Elmendorf. Let me get his attention.

23            Dr. Elmendorf. I am sorry. I am sorry, Senator.

24            Senator Nelson. You are doing a great job and you  
25       have got a lot on your plate to know, so let me just add

1 one other. I am not going to ask you about Medicare  
2 Advantage because we have already gotten into that, and  
3 your problem would be taken care of by my amendment.

4 I want to ask you about an amendment I am  
5 considering offering which would close the donut hole by  
6 requiring the Medicaid drug rebates to be available for  
7 dual eligible--Medicaid and Medicare eligibles--under  
8 Part D of the Medicare prescription drug benefit. Do you  
9 have a revenue estimate for that amendment that I am  
10 considering? I might say that you gave a revenue  
11 estimate in the House of \$86 million over 10 years that  
12 that amendment would cover. Now, we have got a little  
13 bit different proposal here.

14 Dr. Elmendorf. Right. So we are still working on  
15 that amendment, Senator. Certainly we think the effects  
16 would be in the tens of billions of dollars, but the  
17 actual number, we cannot reason very directly from the  
18 House number because the policy interacts a lot with  
19 other parts of the health reform proposal here. So we  
20 really need to do the estimate, essentially from scratch,  
21 on its own. I do not want to predict where that will  
22 come out, but it is in the tens of billions of dollars.

23 Senator Nelson. Right. Is it true--and I want the  
24 Chairman to hear this--that it was an accurate figure of  
25 \$86 million of additional revenue with regard to the

1 Waxman provision in the House bill? This is dual  
2 eligibles, Mr. Chairman, the amendment I am considering  
3 offering.

4 Dr. Elmendorf. So I think, Senator, the number  
5 that you have in mind from our analysis of the House bill  
6 includes several provisions. The particular piece that  
7 you are focused on, I cannot separate out while sitting  
8 here. I am sorry, it is one of those things that we just  
9 have not yet had time to do, but we are working on it and  
10 we will try to complete that estimate for you as quickly  
11 as we can.

12 Senator Nelson. All right.

13 Mr. Chairman, do you not allow us to offer an  
14 amendment unless we have a revenue estimate?

15 The Chairman. It can be allowed. It has to be  
16 offset. It should be offset.

17 Senator Nelson. Well, this does not need an  
18 offset. This is producing tons of revenue.

19 The Chairman. If you can add revenue, then we are  
20 fine with that.

21 [Laughter].

22 Senator Nelson. All right. Glad to know that. I  
23 just did not want to get caught in the things getting  
24 slowed down in your shop. All right.

25 Let me ask Mr. Barthold, I am considering an

1 amendment that would impose an excise tax on a patent  
2 challenge settlement under the Hatch-Waxman Act. Orrin  
3 Hatch and Henry Waxman have a law and it required  
4 something to do with generic drug companies challenging a  
5 patent of a brand-name drug company. When they have  
6 these big settlements, they are not taxable. So I am  
7 considering an amendment that would make that taxable.  
8 Do you have a revenue estimate for that?

9 Mr. Barthold. Senator Nelson, I do not have an  
10 estimate at the present time. I do have a couple of my  
11 colleagues who have been researching the case law. The  
12 Federal Trade Commission maintains a record base of these  
13 settlements. We have been using that to try and develop  
14 a baseline to have an idea of the scale of which this  
15 excise tax might apply, and I hope to have a response to  
16 you sometime tomorrow.

17 Senator Nelson. Would it be safe to say that that  
18 revenue estimate would be a substantial additional new  
19 revenue?

20 Mr. Barthold. I do not want to prejudge the  
21 magnitude and then have my colleagues prove me wrong and  
22 put you and me in a difficult position.

23 Senator Nelson. All right.

24 Again, Mr. Chairman, I pose to you, since this would  
25 be a proposed amendment that would not have a cost

1 consequence but would in fact produce new revenue, I  
2 would not have to have this estimate by the time that I  
3 would offer this amendment.

4 The Chairman. It would be in order.

5 Senator Nelson. All right.

6 Mr. Barthold, let me ask you just one more question.  
7 The Chairman's modification increases the excise tax  
8 threshold on the Cadillac plans for retirees up to \$8,750  
9 from \$8,000 for individuals, and to \$23,000 from \$21,000  
10 for families. How much does that specific change cost?

11 Mr. Barthold. I do not have a line-item breakout  
12 on that. I can get that for you, Senator. I will get  
13 that for you later this evening.

14 Senator Nelson. It is in the Chairman's  
15 modification.

16 Mr. Barthold. Oh, no. I understand. The reason  
17 is, I do not have the breakdown of that one piece --  
18 holding everything else constant at it. We worked it  
19 through the model where the Chairman's modification had  
20 proposed four different changes, and we worked those  
21 through the model at once. So I will ask one of my  
22 colleagues if we can re-run our model holding the three  
23 modifications as it, and looking at the incremental  
24 effect of the one change. I will see if I can get that  
25 response to you yet this evening, sir.

1 Senator Nelson. All right.

2 And Mr. Barthold, I am considering an amendment that  
3 has been filed that, for retirees now--this is retirees  
4 under these health insurance plans--that it would  
5 increase it to \$10,000 for individuals and \$25,000 for  
6 families, and only above that figure would the excise tax  
7 come in. If you could also offer how much it would cost  
8 for that, would you oppose the amendment? I sure would  
9 be appreciative.

10 Mr. Barthold. Senator, if I could ask, would your  
11 preference be to have the second estimate first?

12 Senator Nelson. Well, since I am going to be  
13 offering that amendment, possibly, yes.

14 Mr. Barthold. All right. Thank you, sir.

15 Senator Nelson. Thank you.

16 Mr. Barthold. We will get it to you.

17 The Chairman. Thank you, Senator.

18 Next, Senator Snowe.

19 Senator Snowe. Thank you. I just have a couple of  
20 questions, one of Dr. Elmendorf, and then one of the  
21 staff.

22 I just want to be clear. How much of the  
23 legislative language have you received regarding the  
24 Chairman's mark at this point?

25 Dr. Elmendorf. We have been working our way

1 through pieces of it, Senator. But of course, the  
2 provisions are changing rapidly and we have been trying  
3 mostly to focus on estimates of the specifications as  
4 they have arrived for the Chairman's mark, for the  
5 amendments that are part of the modification, or for  
6 other amendments that may be introduced.

7 So we have made some progress, and we have worked  
8 with the staff on some of this, but I think there is  
9 still a good deal to go, even for the mark itself. Then,  
10 of course, the amendments that are adopted will require  
11 additional work.

12 Senator Snowe. I know that you have offered  
13 important caveats in the preliminary analysis about the  
14 impact on a comprehensive cost estimate, and that the  
15 legislative specifications and legislative language is  
16 very important and can have a significant effect on the  
17 final cost and the final analysis. I was just wondering  
18 if you have received a lot of the language or you have  
19 not, and whether or not that would really have a material  
20 impact on the bottom line.

21 Dr. Elmendorf. I am told that we have received a  
22 good deal of language in terms of covering the pieces of  
23 the Chairman's mark, but that a lot of it requires a good  
24 deal of further iteration between us and the committee  
25 staff, and I think to some extent CMS, in an effort to

1 make sure that it actually achieves what the  
2 specifications are trying to achieve.

3 Senator Snowe. Right.

4 Dr. Elmendorf. That is the iterative process that  
5 I have described. It is not a matter of anybody trying  
6 to do anything wrong, it is just the difficulty of  
7 actually doing it right.

8 Senator Snowe. Well, especially if there is a  
9 calculation with a surplus in the mark, if that is  
10 affected in some way, and significantly. It is possible,  
11 is that not correct?

12 Dr. Elmendorf. It is possible, Senator. I mean,  
13 we have worked very carefully to try to understand the  
14 specifications, and I know the staff are working very  
15 hard to translate that into legislative language. But it  
16 is a complicated business and it is hard.

17 Senator Snowe. Right. And you made that clear  
18 many times within the group of six in wanting the  
19 legislative language for that purpose, so I really  
20 appreciate it, and that of the staff's hard work.

21 I just want to confirm my reading of the Chairman's  
22 modifications. Are all of the offsets within health  
23 care? Are there any offsets that are outside health  
24 care?

25 Dr. Elmendorf. On the tax side --

1           Senator Snowe.    No.   Within the Chairman's  
2   modification.

3           The Chairman.    No.

4           Senator Snowe.    The amendments that you have  
5   accepted.

6           The Chairman.    My staff tells me, within the  
7   modification, no. All within health care.

8           Senator Snowe.    Right. Right.

9           The Chairman.    In the mark, there is corporate --

10          Senator Snowe.    The corporate. But in the  
11   modifications.

12          The Chairman.    In the mark itself.

13          Senator Snowe.    Because I noticed, when some of the  
14   amendments were accepted, that there were offsets outside  
15   health care. So I am presumably looking at this list, if  
16   this is accurate in terms of --

17          The Chairman.    Well, let me double check. I am  
18   informed that it is, but let me double check.

19          Mr. Barthold.    In terms of the financing title, all  
20   of the changes in your modification have a health angle.  
21   The two new starters were the Indian Health Services, the  
22   itemized deduction, AGI, floor. Then you modified the  
23   high-premium excise tax. You had modifications to the  
24   effective date on the HSA penalty on improper  
25   distributions, and you had a change in the limitation and

1 the effective date on the flexible spending accounts.  
2 You made a modification to the medical definition of the  
3 base for medical devices. So, all, arguably, a health  
4 connection.

5 Senator Snowe. All right. Thank you.

6 The Chairman. All right. Are you through,  
7 Senator?

8 Next, Senator Cornyn.

9 Senator Cornyn. Thank you, Mr. Chairman.

10 I just want to make sure, Dr. Elmendorf, as I  
11 understand your desire to achieve the fastest safe speed  
12 of your work, being a new member of the committee, I  
13 understand this committee, unlike any other committee in  
14 the Congress, deals with concepts rather than legislative  
15 language. So I just want to understand, once the  
16 committee reduces its product to legislative language, my  
17 understanding is, then, you said it will take some time--  
18 obviously as quickly as you can do it safely--to score  
19 it.

20 But let me ask you this next wrinkle. My  
21 understanding is that the Help Committee product, the  
22 Health, Education, Labor and Pensions Committee, and the  
23 product of this committee will then be merged at some  
24 point. Presumably there will then be a new legislative  
25 product. Will you then have to score that product in

1 order for us to know what we are voting on when the bill  
2 comes to the floor and how much it will cost?

3 Dr. Elmendorf. We will try to focus our energy.

4 The Chairman. The answer is yes. The answer is  
5 yes. We are going to score it. It is very simple.

6 Dr. Elmendorf. We will try to focus our energy on  
7 whatever piece of legislation is most relevant for the  
8 Congress, and if that means completing a full analysis  
9 and the formal score for the committee bill, we will do  
10 that. If it means, instead, shifting our focus to  
11 scoring some combined bill that goes to the floor of the  
12 Senate, we will focus on that. So I am not clear whether  
13 we will actually do both of these things in order or  
14 whether, in fact, we will move on to address whatever is  
15 the more pressing need of the Senate.

16 Senator Cornyn. I appreciate the Chairman's  
17 response. I think, Mr. Chairman, the answer is--if I  
18 heard him correctly--yes, that whatever we are going to  
19 be voting on, we ought to be able to read and understand  
20 how much it is going to cost.

21 Dr. Elmendorf. The only point I was trying to  
22 clarify was that I am not sure that the most productive  
23 use of our time in helping you is to spend several weeks  
24 on your bill and then several weeks on the bill for the  
25 Senate as a whole, because it may be that the better use

1 of our time is to shift to the bill that the Senate as a  
2 whole will consider.

3 Senator Cornyn. I heard from my constituents in  
4 August, and I think we all heard from our constituents,  
5 their sense of growing concern, is a nice way to put it--  
6 outrage would perhaps be more accurate--that Congress is  
7 voting on legislation that we have not had a chance to  
8 read. Certainly, I think that would include voting on  
9 legislation that we do not know how much it will cost and  
10 what its impact will be on the budget.

11 So I would associate myself with the concerns  
12 expressed by Senator Conrad and Senator Snowe, and I  
13 think the Chairman -- we appreciate the difficulty of  
14 your job and we want you to get it right, but I need to  
15 know, and I think others need to know, what it is we are  
16 voting on, what is in the bill, how much it is going to  
17 cost before we can intelligently exercise the duties, the  
18 fiduciary duty, that we have as an elected member  
19 representing our States. So, I appreciate that.

20 Let me ask you, in that vein, I understand in  
21 response to Senator Kyl's questions, that you explained  
22 the complexities of projecting out a 10-year full  
23 implementation of this proposal by the Chairman. But  
24 would it not be true to say that in 2019, which is the  
25 final year of the budget window when the new programs are

1 fully implemented, that the annual spending under the  
2 Chairman's mark, according to the CBO, would be \$154  
3 billion?

4 Dr. Elmendorf. The problem with answering that  
5 question directly is that we, in the announcements we  
6 have done with staff of the Joint Tax Committee, we have  
7 looked at the net impact on the deficit and we have not,  
8 in fact, broken this down entirely in terms of what would  
9 appear on the revenue side and what would appear on the  
10 spending side.

11 Senator Grassley noted just one of the many issues  
12 that raises, which is the extent of the refundability of  
13 tax -- how much of they money that goes out in these tax  
14 credits would be for people who have no tax liability,  
15 and thus appear on the expenditure side versus how much  
16 is a reduction in tax liability and would appear on the  
17 revenue side.

18 So there are a host of other issues. We mentioned  
19 another one in our letter, I think, which was that the  
20 risk-adjusted payments among plans and insurance  
21 exchanges would appear, in matching magnitude on the  
22 revenue and spending side of the budget, money that would  
23 be collected from plans with healthier-than-average  
24 enrollees and directed to those with sicker-than-average  
25 enrollees.

1           So we do not have a total of spending and a total of  
2           the revenue, we have some revenue pieces. There are some  
3           pieces that are clearly changes in spending, but there  
4           are others floating around we have not estimated  
5           separately. So, I do not have a total spending effect or  
6           a total revenue effect.

7           The Chairman. But you have a net. You do have a  
8           net.

9           Dr. Elmendorf. We have the net effect, and that is  
10          what we focused on.

11          The Chairman. That is positive.

12          Dr. Elmendorf. Which is the reduction of deficits  
13          of \$49 billion over the 10 years.

14          The Chairman. Thank you.

15          Senator Cornyn. I am looking at a document. It  
16          says the source is the Congressional Budget Office, and  
17          the staff of the Joint Committee on Taxation, which is a  
18          preliminary analysis of the insurance coverage  
19          specifications provided by the Senate Finance Committee.

20                 It talks about the effect on the Federal budget  
21          deficit, starts at 2010, and goes to 2019. But there is  
22          a figure of \$154 billion there for Medicaid, CHIP  
23          outlays, exchange subsidies, and associated effects on  
24          tax revenues. Am I not reading that correctly? Is that  
25          not the estimated cost of the bill during all these new

1 programs, fully implemented --

2 Dr. Elmendorf. The table you are reading from,  
3 Senator, is the effect of insurance coverage  
4 specifications, but that number is a combination of  
5 increases in outlays and reductions in revenues. That  
6 number is the net effect on the budget deficit of the  
7 Federal deficit of that part of the coverage provisions.  
8 So I am sorry, it is just part of the complexity of  
9 putting this together; we have a number of tables and  
10 they interact in complicated ways. That is a piece of  
11 the net effect on the deficit, of the coverage provision.

12 Senator Cornyn. Let me ask it another way and see  
13 if I can --

14 Dr. Elmendorf. I am sorry.

15 Senator Cornyn. No. I appreciate the complexity  
16 that you are speaking to. Can you tell the committee  
17 what the cost of the Chairman's mark will be in 2019, the  
18 final year of the budget window in which the new programs  
19 are fully implemented?

20 Dr. Elmendorf. Our estimate, with the staff of the  
21 Joint Tax Committee, is that in 2019, the Chairman's  
22 mark, at least last week, would reduce the budget deficit  
23 by \$16 billion, on net, taking into account the insurance  
24 coverage provisions, the changes in Medicare, the other  
25 revenue provisions, and so on. But the cost estimate,

1 there is an issue we discussed last week, which is what  
2 counts as the cost.

3 We talked last week about a 10-year total, the gross  
4 cost, if you will, of the insurance coverage pieces, as  
5 being \$774 billion. I think that is the number which the  
6 154 that you mentioned is the number for the tenth year.

7 But that is just the gross cost of the insurance  
8 coverage expansions, and there are a set of other pieces  
9 that affect the deficit in different ways. The net of  
10 all of that is the \$16 billion reduction in the deficit.

11 Senator Cornyn. Let me ask you about your letter  
12 of September 22 to the Chairman where you talk about the  
13 fees--really, taxes--on manufacturers of brand-name drugs  
14 and medical devices, on health insurance providers, and  
15 on clinical laboratories. You say these fees would  
16 increase costs for the affected firms, which would be  
17 passed on to purchasers and which would ultimately raise  
18 insurance premiums by a corresponding amount.

19 So it is true that these additional fees ultimately  
20 would be passed down to the health care consumer and be  
21 reflected and not lower insurance premiums, but higher  
22 insurance premiums?

23 Dr. Elmendorf. As you have read from the letter,  
24 Senator, our judgment is that that piece of the  
25 legislation would raise insurance premiums by roughly the

1 amount of the revenue collected.

2 Senator Cornyn. And at the same time, the premiums  
3 in the new insurance exchanges would tend to be higher  
4 than average premiums under current law for the  
5 individual market. Again, all other factors being  
6 equal--you say this, I think, on page 6--because the new  
7 policies would have to cover things that they do not  
8 currently cover, which is pre-existing medical conditions  
9 and the insurance companies could not deny coverage to  
10 people with high expected costs for health care.

11 Dr. Elmendorf. As you say, Senator, in the letter  
12 we note that that piece of the legislation would raise  
13 premiums, on average. Of course, people who are sicker  
14 than average would experience a reduction in premiums,  
15 those who are healthier than average would experience an  
16 increase in premiums from bringing these sicker people  
17 into the pool and covering their medical expenses. But  
18 that is only a piece.

19 One of the things I think it is probably  
20 disappointing to the readers, we list on pages 5 and 6 of  
21 this letter today a collection of factors pushing in  
22 different directions in the comparison of premiums in the  
23 proposed insurance exchanges and under current law, and  
24 we have not been able to quantify all of these factors at  
25 this point, but we are not able to produce a net

1 comparison, which I know many members, and we, are  
2 interested in knowing.

3 It is a bit of a laundry list, but there are a lot  
4 of differences, as we explained here, about the ones that  
5 you have mentioned, but also issues about differences in  
6 the actuarial value of the policies, the amount of total  
7 health expenses that are covered that are different that  
8 affects premiums in one way and cost-sharing expenses in  
9 a different way.

10 It is a different group of people who would be  
11 enrolled in insurance coverage because of the mandate and  
12 other features. So it is just very difficult to assess,  
13 at the end of the day, how these factors shake out.  
14 Unfortunately, the best we can do for you at this point  
15 is to help you think through the different pieces,  
16 pushing in different directions, but we cannot actually  
17 sum them up in a quantitative way for you.

18 Senator Cornyn. But just in terms of the  
19 additional taxes being put on drug companies, device  
20 manufacturers and the like, your opinion is, those will  
21 ultimately be reflected in the insurance premiums paid by  
22 the consumer?

23 Dr. Elmendorf. Yes. That is right, Senator.

24 Senator Cornyn. And then let me, finally, ask you  
25 for right now--because there is a lot more I would like

1 to ask you, but time is short, at least for now--about  
2 the excise tax for failure to maintain insurance. The  
3 Chairman's modified mark imposes a penalty of up to \$950  
4 for individuals and \$1,900 for families on those who do  
5 not get coverage. Maybe this is a question for Mr.  
6 Barthold, maybe for you. Does the Joint Tax Committee  
7 predict that this excise tax will have an impact on  
8 families making less than \$250,000 a year?

9 Mr. Barthold. Senator Cornyn, as I believe I told  
10 Senator Ensign, or it was Senator Grassley who asked a  
11 similar question, we have worked on this jointly with the  
12 Congressional Budget Office. It, in combination with the  
13 free rider penalty, helped determine who purchases  
14 insurance through the exchange, what employers may  
15 provider or not provide in employer-provided insurance.

16 What we have not done is tried to do a complete  
17 distribution analysis of the whole package, breaking out  
18 the individual components and saying, ah, there are X  
19 number of people, by category, paying the penalty, buying  
20 insurance. But we do think that some individuals will  
21 pay and will be subject to the penalty under the mandate.  
22 It basically follows from that that some of those  
23 individuals, since we think those individuals will not  
24 all be high-income individuals, would earn less than  
25 \$250,000. But we have not done a formal analysis that

1 says it is a substantial number or a modest number.

2 Senator Cornyn. I appreciate your answer, and Dr.  
3 Elmendorf's. I think what your answers demonstrate, at  
4 least to me, is this is incredibly complex and  
5 interactive. That is the reason why I think it is so  
6 important we not only have final legislative language,  
7 but we actually have a CBO score so we know what we are  
8 voting on and what it costs before we are required to do  
9 so.

10 Thank you very much.

11 The Chairman. Thank you, Senator. You are  
12 correct, this is exceedingly complex and interactive.  
13 For example, I might also read from the same letter that  
14 you were quoting, which goes in the other direction and  
15 shows some of the benefits. On a net basis, the letter  
16 is pretty inconclusive.

17 I would just ask, Dr. Elmendorf, on page 5 down near  
18 the bottom, is it not correct that you write, "CBO  
19 currently estimates that about 23 percent of premiums for  
20 policies that are purchased in the non-group market under  
21 current law go toward administrative costs and overhead,  
22 but under the proposal, that share would be reduced by 4  
23 or 5 percentage points, and that reduction reflects a 7  
24 or 8 percentage points decrease in the types of  
25 administrative costs that are currently borne by non-

1 group insurers, offset partly by a surcharge that  
2 exchange plans would have to pay to cover operating costs  
3 of the exchanges, which would add about 3 percent." So  
4 on a net basis, there are benefits there, too.

5 Dr. Elmendorf. Yes. I think that is a very  
6 important aspect of the bill. As I said, there are  
7 pieces blowing different directions, but this reduction  
8 in administrative costs stems, I think, most importantly  
9 from insurers not spending the time trying to figure out  
10 whether certain medical expenses are due to pre-existing  
11 conditions or not, and that turns out to be, from our  
12 discussions with insurance companies, an important  
13 expense that they would not have to pay under the  
14 proposal.

15 The Chairman. Thank you.

16 Next, Senator Enzi.

17 Senator Enzi. Thank you, Mr. Chairman.

18 Thank you, Dr. Elmendorf. I appreciate the volume  
19 of work that you have had to do in the short period of  
20 time you have to do it in, and all of the different  
21 committees that are asking for your help. I appreciate  
22 you being here.

23 Last week in the closed-door walk-through, you  
24 commented that the Chairman's mark does not solve the  
25 Medicare sustainability problem and that it does not

1 solve the long-term deficit problem. Do today's changes  
2 in the mark solve these problems?

3 Dr. Elmendorf. I do not recall saying, Senator,  
4 that it did not solve the long-term deficit problem.  
5 What we said in the letter, and what I tried to say in  
6 the session last week, was that as the legislation is  
7 written, if it is not overturned by subsequent  
8 legislation and is implemented as written, then we expect  
9 it would reduce budget deficits by \$49 billion in the  
10 first decade and by about half a percent of GDP in the  
11 second decade. That was our understanding of the effects  
12 of the mark. We have not worked that out even in the  
13 first 10-year estimate for the modification today, and  
14 that would be a precondition for looking at the second 10  
15 years beyond that. So, we have not updated that overall  
16 description.

17 Senator Enzi. Thank you.

18 Going to the actuarial value of the different plans,  
19 if the value of the bronze plan was decreased from 65  
20 percent to 60 percent, what direction and kind of impact  
21 do you estimate that it would have on premiums?

22 Dr. Elmendorf. A few thoughts, if I understand  
23 your question correctly. If you reduce the actuarial  
24 value from 65 to 60 percent, then the percentage  
25 reduction in the medical costs covered is 5/65ths,

1       essentially, so on the order of 7 percent or so.  
2       Premiums do not fall quite as much because there is  
3       administrative loan that does not change when you do  
4       that. So maybe premiums fall on the order of 5 percent  
5       or so, I do not know.

6               But the other thing to remember--and I am not sure  
7       where you are going with the question--but in the  
8       legislation that has been proposed, people in lower  
9       income brackets would receive cost-sharing subsidies that  
10      would raise the actuarial value, essentially, of their  
11      plans at 90 percent or 80 percent, depending on just how  
12      long their income was. So reductions in actuarial value  
13      may not affect the net benefits received or the net cost  
14      of the government or categories of people because of the  
15      way the cost-sharing subsidies were constructed.

16             Senator Enzi. All right.

17             I did note in your estimate that capped premium  
18      costs at 13 percent of individual income for individuals  
19      earning less than 400 percent of poverty, that it would  
20      translate to \$1,900 in Federal Government subsidies for  
21      families that are earning \$90,100 a year. Is that  
22      correct?

23             Dr. Elmendorf. I am sorry, Senator. What was the  
24      number that you --

25             Senator Enzi. The premium cost of 13 percent of

1 income for a person earning less than 400 percent of  
2 poverty would translate to \$1,900 in subsidies for a  
3 family earning \$90,100 a year.

4 Dr. Elmendorf. Yes, I think that is correct. This  
5 is the category of people earning between the mid-point  
6 of the 350 to 400 percent of poverty range in 2016, where  
7 the middle of that range is about \$90,000.

8 Senator Enzi. All right. Thank you.

9 Dr. Elmendorf. Yes, Senator.

10 Senator Enzi. That just seems to me like a lot of  
11 taxpayer money to spend on somebody making \$90,000 a  
12 year.

13 For Medicaid counsel, is there greater access to  
14 care in the private sector than in Medicaid? Are  
15 individuals more likely to receive the preventive care  
16 that we talk about? Why would Medicaid beneficiaries not  
17 be better off in the same system as everyone else?

18 Mr. Schwartz. Senator Enzi, the first question  
19 that you asked, typically most people would say that  
20 access to specialists and individual physicians is  
21 probably a little bit greater in the private sector.

22 The Chairman. Mr. Schwartz, could you speak up,  
23 please? Maybe pull the microphone a little closer.

24 Mr. Schwartz. I am sorry. Is that better?

25 The Chairman. That is much better, thank you.

1           Mr. Schwartz.    I was saying that access to  
2           specialists and individual physicians is probably a  
3           little bit greater in the private sector, but that  
4           hospital access is pretty much equal across the board.

5           Senator Enzi.    All right.

6           Mr. Schwartz.    And -- oh, go ahead.

7           Senator Enzi.    In the Help Committee mark-up we  
8           were told by CBO that it cost 20 percent more to cover a  
9           person in the exchange than through Medicaid.  Is that  
10          true?  If so, why is it more expensive in the exchange  
11          and less expense in Medicaid?  Can you tell us what the  
12          trade-offs are for a person going into one versus the  
13          other such that it would be more costly for a person in  
14          the insurance than where they would have the enhanced  
15          access?

16          Mr. Schwartz.    Sure.  We heard a similar number  
17          from CBO, and I do not know if Doug--he is shaking his  
18          head--stands by it.  There are big differences,  
19          obviously, between a Medicaid operation and a private  
20          insurer.  There are different costs, and then there are  
21          also different reimbursement rates that Medicaid and a  
22          private insurer might pay to a hospital or a doctor who  
23          provides services.

24          So typically a private payor would pay an individual  
25          physician or a specialist more than Medicaid would pay

1       them. Hospital payment rates seem to be closer together,  
2       but still probably Medicaid coming in a little bit lower.  
3       So the cost of actually providing care will be different,  
4       and that, in part, contributes, I think, to the 20  
5       percent difference. But that is not my number, so I do  
6       not know if CBO wants to explain it in more detail.

7               Senator Enzi. If we went to the private sector  
8       instead of to Medicaid, what would that mean for States  
9       regarding the costs?

10              Mr. Schwartz. Well, of course, States today can  
11       leverage the private sector through Medicaid managed  
12       care, so financially States are still responsible for  
13       paying for the care for that beneficiary, but it is  
14       delivered through a private model. But I think you may  
15       be asking, if Medicaid played no role, then there would  
16       be, in theory, no State contribution.

17              Senator Enzi. I have got a lot of other questions,  
18       but I am out of time, Mr. Chairman. I appreciate your  
19       indulging me.

20              The Chairman. You bet. Thank you, Senator.

21              Senator Cantwell?

22              Senator Cantwell. Thank you, Mr. Chairman.

23              Dr. Elmendorf, we had a conversation on the briefing  
24       of the previous draft of the bill. I know, since our  
25       meeting this morning, the Chairman's modification has

1 made some changes to bending the cost curve in Medicare.  
2 Mr. Chairman, I very much appreciate the adoption of that  
3 language, which helped us put a stake in the heart, if  
4 you will, of fee-for-service and really start to focus on  
5 a value index. My colleague Senator Klobuchar, who  
6 worked very diligently on this as well and who introduced  
7 original legislation, very much appreciates that this  
8 language is now included in the modification.

9 So if I could, Dr. Elmendorf, I think we were  
10 looking at and discussing this bending the cost curve of  
11 Medicare. The baseline growth rate that we all have been  
12 talking about, the doubling of Medicare, 89 percent,  
13 something like 6 percent a year, or a little more than  
14 that, the previous mark estimates were that, instead of  
15 that doubling, it would be something like a 61 percent.  
16 I think that was a conservative increase. Is that right?  
17 A 61 percent increase in the Medicare growth rate.

18 Dr. Elmendorf. Senator, I actually do not know  
19 offhand what the growth rate was of incorporating the  
20 Chairman's mark. But, yes. The mark and the  
21 modification, of course, maintains a very substantial  
22 reduction in Medicare payments relative to what would  
23 happen under current law.

24 Senator Cantwell. And I am just trying to get an  
25 idea of what substantial is from this perspective. I

1 think inflation is 48 percent, is that right? So if we  
2 were looking at Medicare and we were looking at a 48  
3 percent increase, that is what we think general inflation  
4 is?

5 Dr. Elmendorf. I am sorry, Senator. I understand  
6 this is a useful line of inquiry for you, but you have me  
7 at a disadvantage in terms of the cumulative growth rates  
8 of these things over the 10-year window, which I just do  
9 not know offhand.

10 Senator Cantwell. All right. Well, we are not  
11 trying to stump you, for sure.

12 Dr. Elmendorf. Well, you are doing all right at  
13 that.

14 [Laughter].

15 Senator Cantwell. We are just trying to get to the  
16 point of the change that we have been able to make and  
17 how substantive it is. I would love to ask you that just  
18 right out, but I am assuming you will tell me you do not  
19 know what the impact of that is. So I am trying to --

20 Dr. Elmendorf. Well, I have better days and worse  
21 days. My hypothesis--but I will wait for my colleagues  
22 to stop me if I am wrong--is that the reduction in  
23 Medicare payments relative to the baseline, by 2019, is  
24 on the order of 10 percent of baseline Medicare spending.

25 So if you picture baseline spending rising like

1 this, being brought down like this, there is a growing  
2 wedge. The wedge, by the end of the 10-year window,  
3 looks to be in the neighborhood of 10 percent of baseline  
4 spending. That is quite significant. Many of the  
5 proposals that are in this legislation to explore value-  
6 based purchasing, to look at different ways of  
7 structuring accountable care organizations, all these  
8 sorts of changes that experts talk about need to be  
9 experimented with, and discovered, and worked with. So  
10 it is difficult to achieve very large savings overnight.

11 Senator Cantwell. Well, I guess that is the  
12 difference. The language that probably is still in the  
13 modification, but in the previous draft, yes, we had  
14 accountable care organizations and global budgeting,  
15 which will definitely move us towards this goal of really  
16 driving down costs. But I fail to see that as  
17 substantive.

18 I mean, I do not see we are going to see a huge  
19 migration to accountable care organizations. I would  
20 love to accelerate that. Some of the other value-based  
21 purchasing and some of the other things were pilot  
22 programs. So to me, I think this is the most substantive  
23 reduction to Medicare that has been introduced.

24 Dr. Elmendorf. Let me make sure I am clear.  
25 Quantitatively, in terms of the reductions in Medicare

1 spending relative to current law, by far the largest  
2 piece are reductions in payment rates under the existing  
3 structure, that the changes that are made to the  
4 structure of payments are there and matter, but are much  
5 less important quantitatively in our estimates than  
6 simply the reduced payment rates for services under  
7 current law. So again, I think this should not be, in  
8 some sense, surprising. If providers and beneficiaries  
9 were pushed into new systems, more savings might be  
10 achievable more quickly. But in fact, experts generally  
11 agree that a lot of work is needed to develop just what  
12 those new systems would be.

13 Senator Cantwell. But we are saying something  
14 different. In the modification today, we are saying  
15 that, no, you are going to change. You are going to  
16 change to a value index, and that we are going to steer a  
17 way of doing things just on volume.

18 Dr. Elmendorf. So I think we are still looking at  
19 the pieces of the changes in the modification released  
20 today, and maybe I will have a more developed view of  
21 this down the road. But I think it would be difficult to  
22 change the system so aggressively as to match over the  
23 next few years, or several years, the reductions, the  
24 savings from just lower payment updates. But I will take  
25 a close look at what is in the modification.

1           Senator Cantwell.    You are saying more than the  
2           payment updates, is what you are saying?

3           Dr. Elmendorf.    Yes.  I think payment updates are  
4           so important quantitatively.

5           Senator Cantwell.    Yes.  I would definitely like to  
6           see, and I know the Chairman has been pounding on, when  
7           are we going to get numbers.  But the reason this is so  
8           important is because this is about also reducing the cost  
9           of health care for the 90 percent of Americans who have  
10          care, and we should be spending far more time on the  
11          discussion of which of the policies that we are proposing  
12          or are in the draft are going to affect that number,  
13          because I do not think we are doing that.

14          We are spending a lot of time talking and debating  
15          about what we are going to do about the uninsured  
16          population, which I care very much about too, in covering  
17          them.  But this is the measure, I think, of this bill, is  
18          how much we are reducing those costs.  So I would be very  
19          curious, and obviously disappointed, to also find out  
20          that this would result in a very go-slow approach.  I  
21          think we know what is working.  We know where cost-  
22          effective coordinated care is delivering better care, and  
23          we ought to migrate.  We should not walk, we should not  
24          skip, we should run towards that model if we want to have  
25          the most savings and also deliver the best care.  But I

1 look forward to your numbers.

2 Another one. Not, again, trying to stump you, but  
3 looking for the same kind of numbers and analysis also in  
4 the modification proposal to transition long-term care,  
5 which is about \$100 billion of our Medicaid spending--of  
6 course, that is a split number--to try to focus on  
7 community-based care. Again, the notion that it is 70  
8 percent per-person cheaper to do community-based care --  
9 our Federal system is still very oriented towards nursing  
10 home care and this moves an incentive program. So,  
11 thoughts on how we can get some numbers on the impact of  
12 that as well.

13 Dr. Elmendorf. Senator, I am told that the net  
14 effect of the puzzle that you are discussing, which we  
15 have been working on, is to increase Federal spending,  
16 but that will seem counterintuitive. Let me try to  
17 explain. For a given set of people --

18 Senator Cantwell. It is not counterintuitive.  
19 Sorry.

20 Dr. Elmendorf. [Continuing]. It can be much  
21 cheaper to treat them in a home or community setting than  
22 in some institutional facility, but providing Medicare  
23 support for that kind of service in a more generous way  
24 will tend to draw more people in to take that service.  
25 So that is why, for a given individual currently

1 receiving care in an institutional setting, this might be  
2 a saving to the government and obviously can be an  
3 improvement in the lives of those people. It is likely  
4 to be a cost on net because of the extra people who are  
5 drawn in to take that service and receive that benefit.

6 Senator Cantwell. Certainly the State of  
7 Washington has served more people and covered a larger  
8 population, but the per-individual savings is, instead of  
9 spending \$42,000 on the health care of these individuals,  
10 it is only \$2,400 per individual. So, that is the  
11 different and that is the migration we hope the Federal  
12 Government, with the baby boom population reaching  
13 retirement age, we hope that they will do the same and  
14 move towards it because this policy of focusing on long-  
15 term care is just unsustainable. So, we will look  
16 forward to those numbers.

17 I am aware that part of the proposal is to incent  
18 States to move to the model, so we are putting a little,  
19 if you will, sugar out to get States to migrate. But the  
20 savings are for us in the long run, and a policy that  
21 keeps people in their homes, which I think America will  
22 respond very positively to.

23 Dr. Elmendorf. Well, we look forward to that. We  
24 will keep working on those amendments and get back to  
25 you, Senator.

1           Senator Cantwell.    Thank you.   Thank you.

2           Thank you, Mr. Chairman.   And thanks for including  
3 both of those proposals in the modification.   I think  
4 they will help us in reducing the costs for Medicare and  
5 make substantial progress for us as a Nation.   Thank you.

6           The Chairman.    You are very welcome.

7           There is a vote going on--two votes, I am told.   We  
8 have roughly, I am guessing, five minutes left on the  
9 vote.   Senator Stabenow, you are next on the list.   So, I  
10 suggest you go --

11          Senator Stabenow.   Mr. Chairman, I have two quick  
12 questions.

13          The Chairman.    Right now?   Just do it.   Ask those  
14 two questions.   It is my intention to come back and get  
15 to amendments right after we return.

16          Senator Stabenow.   I simply would like--and I am  
17 not sure if anybody has the answer now--but again,  
18 realizing all of the challenges you have on scores, this  
19 is critical for us to make decisions.   I am very  
20 interested in having more information, scores, as it  
21 relates to a range on the tax credits and subsidies in  
22 terms of affordability so that we would look at a range  
23 below 10 percent, and hopefully we will have that.

24          Dr. Elmendorf.    Yes, Senator.   So working on  
25 amendments of that sort is a very high priority for us

1 and we will give you some alternatives.

2 Senator Stabenow. Terrific.

3 And the other is raising the threshold on which the  
4 excise tax would begin on insurance plans from 21 percent  
5 to 25 percent. It is my understanding, I believe Senator  
6 Nelson asked for that number as it related to retirees.  
7 I would like to know that number as it relates to all  
8 plans in terms of the cost of that.

9 Mr. Barthold. We will get a response to you soon,  
10 Senator.

11 Senator Stabenow. Thank you.

12 Thank you, Mr. Chairman.

13 The Chairman. All right. It is my intention to  
14 recess until 6:45. That is going to be the dinner hour,  
15 now until 6:45. At 6:45, we are just going to wrap up a  
16 couple of questions. Senator Kyl said he would like to  
17 ask a couple of questions. Then I want to get to  
18 amendments and we will just keep going well into the  
19 evening.

20 Dr. Elmendorf. Mr. Chairman, as I said, we need to  
21 get back and continue these estimates.

22 The Chairman. I want you to go back to go to work.

23 Dr. Elmendorf. We will have somebody here who can  
24 field questions and get them back to us. Thank you very  
25 much.

1           The Chairman.   Thank you.   Very good idea.   Thank  
2    you.

3           The committee is in recess until 6:45.

4           [Whereupon, at 6:03 p.m. the meeting was recessed.]

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1 done thus far of the Chairman's modification is to  
2 estimate the revenue consequences of the combined four  
3 changes he made.

4 I did report to the Chairman earlier while I believe  
5 that you were out of the room, he had asked about some  
6 distributional analysis that we had prepared under the  
7 original mark. So I have done some distributional  
8 analysis of some of the original marks.

9 Senator Kyl. Well, I will go ahead and ask these  
10 questions and you can caveat it if that is necessary. So  
11 the primary impact of this provision with respect, well,  
12 what were the primary impacts as you analyzed with the  
13 new 40 percent number?

14 Mr. Barthold. Well, the 40 percent number is the  
15 same basic structure obviously as the 35 percent number.  
16 So the basic analysis is that for plans for employers and  
17 employees with plans above the threshold, there is an  
18 incentive to change behavior or pay the excise tax.

19 Now, ways to change the behavior could be to go to a  
20 less costly plan. Plans can be made less costly by  
21 either shrinking the scale of benefits so if, for  
22 example, you had a plan that offered dental coverage --

23 Senator Kyl. I understand.

24 Mr. Barthold. You understand. Or to change of  
25 course copayments, coinsurance rates. When that occurs,

1 our view of the economics of this type of proposal is  
2 that the employer and the employee are then agreeing to  
3 change the compensation package.

4 So under present law, the compensation package when  
5 there is health care, that is excludable from income for  
6 both the income and payroll taxes. If we make a change  
7 to go to a less costly plan by any of the methods that I  
8 sketched out, we would expect that the compensation  
9 package changes so that the employee receives more cash  
10 compensation.

11 So one of the effects is that there can be greater  
12 income inclusions for both income tax and the payroll  
13 tax. Now of course if the employee and the employer  
14 still think that this is a good plan, a good benefit even  
15 with the excise tax in place raising the cost on the  
16 incremental part, then there would be some excise tax  
17 payments made.

18 We view the excise tax as ultimately being born by  
19 the employee in the form of higher premiums essentially  
20 grossed up to reflect the excise tax in terms of the  
21 economic analysis of the revenue, that means that in fact  
22 there is a higher compensation component that would be in  
23 terms of health care insurance and would be excludable,  
24 so there would be a little bit of an offset of the excise  
25 tax receipts for a reduced income and payroll taxes as

1 the compensation makes changes.

2 Senator Kyl. Well, did you do either for the  
3 previous 35 percent rate or the 40 percent rate an  
4 estimate of what percentage of the revenue would come  
5 from the collection of the tax, the new excise tax, and  
6 what percent would come from the increased income tax and  
7 payroll tax revenues that you anticipate would occur?

8 Mr. Barthold. Let me give a qualified yes to that.

9 I do not have hard numbers. Again, I will tell you sort  
10 of our process on this.

11 Through time as was noted in response to a question  
12 from Senator Ensign, the excise tax applies to  
13 potentially more plans. There is more cost pressure,  
14 there is more potential for income inclusion and we think  
15 as employees and employers learn about the plan, you  
16 know, if you try and shift the cost of the excise tax  
17 forward onto the premium maybe employees think well, if  
18 that plan is not worth this incremental cost so I am  
19 going to change my mind back again and I want to do  
20 something to reduce it so that we think through time we  
21 will see growing income inclusions which means growing  
22 receipts from income and payroll tax relative to excise  
23 tax receipts.

24 So sort of the short summary is initially there is  
25 excise tax receipts and some income and payroll tax

1 receipts. Through time, the income and payroll tax  
2 receipts grow relative to the excise tax.

3 Senator Kyl. Would you anticipate that after, that  
4 in the 10<sup>th</sup> year let us say that the majority of the  
5 revenue, that more than half of the revenue would be from  
6 the income payroll tax side as opposed to the receipts  
7 from the excess tax?

8 Mr. Barthold. I will say yes if you let me qualify  
9 that. I would want to double check it with my couple of  
10 economist colleagues who have been doing the modeling on  
11 it.

12 But we do view it as growing through time and the  
13 income conclusions becoming more significant.

14 Senator Kyl. Got it. Do you think you will  
15 actually have some, and you do not need to have them  
16 right now, but do you actually have numbers that you  
17 could supply to us on that at some point?

18 Mr. Barthold. I can at least give you some rough  
19 trends.

20 Senator Kyl. Yes, that would be good. With  
21 respect to the number of, I think you referred to them as  
22 units, tax units, whether it is an individual filed or a  
23 family filed, so the number would be understated I guess.

24 But my understanding is that you estimated under the  
25 35 percent that about 13.8 million policy holders would

1 be affected in 2013, rising to 39.1 million in 2019.

2 Now, obviously there have been some changes in, I  
3 gather that was before the transition provisions and it  
4 was before the 40 percent, the increase in the rate to 40  
5 percent I presume. You can tell me whether that is  
6 correct or not.

7 Mr. Barthold. If you can give me a couple of  
8 seconds to shuffle some papers here. The figures that  
9 you are referring to were an analysis that we did and it  
10 was based on 35 percent excise tax for thresholds again,  
11 8,000, 21,000, which were indexed by the CPI. The  
12 Chairman's modification of CPI plus one.

13 It provided the high state transition relief but did  
14 not have the additional provisions about over age 55  
15 retirees or high risk, deemed high risk occupation.

16 Senator Kyl. Okay. In fact --

17 Mr. Barthold. The figures you read were just a  
18 report from our table.

19 Senator Kyl. Yes. And this is in the letter to  
20 Senator Ensign which I just was handed, you have the  
21 estimate of in the year 2019 39.1 million tax filing  
22 units would be affected. That is to say, well, let me  
23 ask you.

24 Mr. Barthold. Well, that would mean either they  
25 are indirectly paying the excise tax by having a higher

1 premium or they have chosen to have an increased cash  
2 comp at the expense of a less costly plan, or both.

3 Senator Kyl. Do you break that down and get those  
4 numbers to us later? Or is that, or do you not do that?

5 Mr. Barthold. Well, if later can count tomorrow.

6 Senator Kyl. Yes. And it is true that actually  
7 the number of people impacted would be more because like  
8 if you have a family of five or four, that counts as one  
9 tax unit, correct?

10 Mr. Barthold. Presumably a family of four would be  
11 filing a joint return or head of household. Yes, sir,  
12 that would be one tax filing unit.

13 Senator Kyl. So the number of people would  
14 actually be more than that. Did you calculate the number  
15 of plans or did you estimate the number of plans you  
16 believe will exceed the threshold and either continue to  
17 offer or not continue to offer that plan after the tax  
18 takes effect?

19 Mr. Barthold. On a plan, we did not do it on a  
20 plan basis. We have tried to impute information about  
21 value costs of health care packages to our individual tax  
22 model and then we have estimated the proposals on the  
23 individual tax model.

24 We have not actually on the individual tax model  
25 assigned specific plans to specific individuals. So the

1 short answer is no.

2 Senator Kyl. I wasn't speaking specific plans, but  
3 simply to get an idea of how many plans --

4 Mr. Barthold. Well, it is for the reason that we  
5 have not imputed from the universe of plans to, we have  
6 imputed dollar values to people, but not plans. So while  
7 I could, to make up a number while I could say, well,  
8 there are 13 million tax filing units have a plan value  
9 above that threshold, I could not say for time how many  
10 plans that might represent.

11 Senator Kyl. I wasn't sure of the answer to  
12 Senator Ensign's question. He was getting at the  
13 difference between the CPI and the medical inflation  
14 index and I think his question was is that one of the  
15 reasons why the number of the people was going to rise,  
16 the number of tax units would rise from 13.8 to 39.1 over  
17 time. You just assigned another reason for it, but how  
18 significant a factor is the factor that he was referring  
19 to?

20 Mr. Barthold. Well, that's the main, I would say  
21 that is the primary factor driving them. Again, just to  
22 review, remember the Congressional Budget Office baseline  
23 and essentially all outside people who study this are  
24 projecting that health care costs will rise at a rate in  
25 excess of the general inflation rate.

1           So that, without making changes, the cost of any one  
2 given plan will grow through time. So that means if we  
3 are not moving the threshold at which the tax applies,  
4 not at the same rate, and we are not, that more plans  
5 will cross that threshold, more people will cross it.

6           Senator Kyl. So you would say the majority of the  
7 increase is attributable to that factor, is that  
8 accurate?

9           Mr. Barthold. I would say a substantial majority.

10          Senator Kyl. Substantial majority? Okay. Final.

11          My understanding is that the mark before us has a  
12 provision that requires an employer to calculate and  
13 report the amount of tax owed by each insurance company  
14 with which it does business whether or not the insurer  
15 offers one of these high cost plans.

16          A, is that correct? B, are there any other taxes  
17 that you know of or any other provision of the tax code  
18 where they, where somebody other than the taxpayer or IRS  
19 is calculating taxes owed by another taxpayer?

20          Mr. Barthold. Well, the first answer is the mark  
21 contemplates that employers will report to the insurance  
22 company if they are purchasing insurance or the plan  
23 administrator if they are using either an outside  
24 administrator or some large firms actually have a captive  
25 in-house plan administrator. So in a sense in that case

1 they would be reporting to themselves the value of the  
2 health care provided.

3 Now, the reason that the mark and the modified mark  
4 went that way is an employer might provide health care  
5 from multiple sources. You could buy a basic health plan  
6 from Company A and you might buy either a supplemental  
7 health plan or you might buy a vision plan from Company  
8 B.

9 Our understanding of the basic policy is if you are  
10 spending a lot under excludable income, so if you are  
11 above this threshold if you wanted to have people  
12 essentially think about it and maybe, you know, think  
13 about the income inclusion and make a different cost  
14 trade off decision.

15 Since the employer is buying from potentially two  
16 different sources, you would get the same result as if  
17 you had bought all those same services from one source,  
18 you had to have a mechanism of reporting that back and  
19 treating different plans that are otherwise equal but  
20 structured differently, consistently.

21 So there is this reporting mechanism. That was a  
22 long answer to your basic question to which I apologize.

23 It is somewhat unique, yes, but there are other  
24 circumstances where the taxes collected and all the  
25 recordkeeping is done by a person who is not liable for

1 the tax.

2 An example of that is the communications excise tax.

3 The liability is actually on me and my local and line  
4 phone. The telephone company does all the reporting.

5 Senator Kyl. But here is what I do not quite  
6 understand. Take the example where you have two  
7 companies.

8 The question is what exceeded the \$21,000? Was it  
9 Company A or the benefits from Company B?

10 Mr. Barthold. That is obviously a critical  
11 question, Senator Kyl, and the mark envisions that it is  
12 a pro rata treatment. I mean, you could come, your  
13 question seemed to suggest should I stack one policy  
14 first and lay all the excise tax on the second policy,  
15 but the mark envisions pro rata.

16 Senator Kyl. So it really does have the employer  
17 then doing the calculations?

18 Mr. Barthold. That is fair, yes.

19 Senator Kyl. And then that information is  
20 submitted to IRS?

21 Mr. Barthold. For tax administration and tax  
22 enforcement, there has to be reporting to the IRS. So  
23 the amount would be reported to the IRS and it would be  
24 reported to the insurance company or the insurance  
25 companies in the case that you posit.

1           Senator Kyl.    So the companies find out after April  
2 15<sup>th</sup> what their liability is based on information that  
3 they had no reason to necessarily know.  I guess they  
4 could adjust --

5           Mr. Barthold.  In practice, yes, that is possible.  
6 But in practice I think what I would imagine would happen  
7 is first of all you often have people bidding with  
8 different employees and so they ask what terms, you know,  
9 is this going to be in conjunction with something else.  
10 So it might have sort of an idea of what the employer is  
11 trying to do.

12           Then it would not be unusual, you actually see this  
13 in some, in cross-border financial transactions all the  
14 time.  There can be tax indemnity clauses to the  
15 contract that should a tax amount arise under the  
16 contract that I am writing, that the contract price is  
17 then grossed up by the amount of the tax liability.

18           That would be sort of a very simple contractual  
19 arrangement that the two insurance companies who might be  
20 bidding to provide basic health and dental would contract  
21 the employer.

22           Senator Kyl.    Let me get down to the legislative  
23 language here.  We might want to be pretty careful.

24           The Chairman.   You ask the questions.

25           Senator Kyl.    If this stays then we are going to

1 have to be really careful how this particular provision  
2 is implicated. I think we can all see the potential  
3 dangers involved.

4 The Chairman. Thank you, Senator. Both sides have  
5 agreed to our first round amendments and I would like to  
6 just give the list right now, the Senators whose names I  
7 read to come so they can offer their amendments. We are  
8 going back and forth, Republic and Democrat.

9 Bunning on transparency language, Conrad, CMS  
10 Invasion Center, Senator Kyl, strike Title 3, Kerry, Home  
11 Health Payment Reform, Roberts, strike Title 3E, Wyden,  
12 Independence at Home, Hatch, MA Cuts Require CBO  
13 Certification, Schumer, Part B Drug Reimbursement for Bio  
14 Similar, Grassley, MA Access for World Beneficiaries,  
15 Rockefeller, Modifying Medicare Provision, Roberts,  
16 strike Home Health Nursing Home Hospital Cuts, Stabenow,  
17 Emergency Care Doctors, Ensign, Apply Medicare Savings to  
18 Solvency, Cantwell, Physician Work Force Enhancement,  
19 Cornyn, Strike Medicare Commission, Nelson, Donut Hole  
20 Eligible Rebate -- DHS provision or DSH provisions, and  
21 then there is Urban Medical Hospitals.

22 Kyl, partial strike of Medicare Commission, Carper,  
23 Medicaid Overpayments, Kyl or Hatch, strike MA Cuts,  
24 Bingaman, Federally Qualified Health Centers.

25 Next on my list to ask questions is Senator Hatch.

1           Senator Hatch.    Thank you, Mr. Chairman.  I have a  
2   number of questions.  Can you hear me all right?

3           Mr. Barthold.    Yes, Senator.

4           Senator Hatch.    I would like to talk about the  
5   transition relief for a few minutes.  I have quite a few  
6   questions.

7           Let me just ask you, why is a -- increase of 20  
8   percent when it is obvious that each of the high cost  
9   states are not the same?  Why isn't that based on the  
10  various factors of affordability?

11          And also, if this is a good idea, why phase it out?

12          And most importantly, why just 17 states?  Why not 10 or  
13  why not 25?

14          Mr. Barthold.    Those are all questions that I am  
15  really not in a position to answer.

16          Senator Hatch.    Who is in the position to answer?

17          Mr. Barthold.    I think they are policy decisions  
18  that grew out of discussions in part from the group of  
19  six and there is certainly some ease of administration in  
20  terms of having a fixed percentage increase rather than  
21  going state by state and having a finely tuned  
22  calculation.

23          One certainly could conceive and try to move the  
24  proposal in that direction.  As to number of states, a  
25  reason that you might limit to a certain number of states

1 is if there are some studies, there is the NEPS  
2 statistics for example give a rough distribution of costs  
3 of different states. So you might look at the NEPS  
4 distribution and say well how many states are more than  
5 one standard deviation away from the mean?

6 If that came out to be 10 or 15 or whatever, that  
7 could be a rational basis for saying how you wanted to  
8 set up some of the --

9 Senator Hatch. Let me get into it a little bit  
10 more. On page 199 of the Chairman's mark, it imposes an  
11 excise tax on insurers if the aggregate value of employer  
12 sponsored health coverage for an employee exceeds a  
13 certain threshold amount.

14 So the employee picks his coverage, the employer  
15 submits the information to the insurer and the insurer  
16 pays the tax, correct?

17 Mr. Barthold. Yes. That's the point that Senator  
18 Kyl just discussed.

19 Senator Hatch. Okay. And this tax is based upon  
20 the aggregate value coverage for an employee on an  
21 individual basis, correct?

22 Mr. Barthold. Yes, that's correct.

23 Senator Hatch. Okay. Now, looking at the  
24 transition relief provided on page 201 of the Chairman's  
25 mark, it states that a transition -- apply to 17 states

1 determined by the Secretary in which health care was  
2 least affordable for the year ending December 31<sup>st</sup>, 2012,  
3 correct?

4 Mr. Barthold. It was highest cost.

5 Senator Hatch. Okay. This transition rule raises  
6 the threshold amount to 20 percent. Is the District of  
7 Columbia considered as one of those states?

8 Mr. Barthold. We have, in terms of estimating the  
9 proposal, Senator, we have not tried to identify any  
10 specific set of 17 states. That doesn't mean we are not  
11 cognizant of existing data, but the mark envisions that  
12 the Secretary of the Treasury in 2012 will look at data  
13 available in 2011 and 2012.

14 Senator Hatch. Would you expect the District of  
15 Columbia --

16 Mr. Barthold. The District of Columbia would count  
17 as a state.

18 Senator Hatch. That is my point. Now, is the  
19 transition determined by the state of residence of the  
20 policy holder, employer or the insurer?

21 Mr. Barthold. The employer, sir.

22 Senator Hatch. Okay. So if I am an employer  
23 living in DC which is determined to be a least affordable  
24 state where the transition rule applies and I work in  
25 Virginia which is determined not to be a least affordable

1 state --

2 Mr. Barthold. Actually it is the location of where  
3 the, when you said employer, it is the employers, where  
4 the employer has the employee.

5 Senator Hatch. Okay. Well, let me go through  
6 that.

7 Mr. Reeder. There is a clarification in the  
8 modified mark.

9 Senator Hatch. Okay. Let me go through this  
10 again. If I am an employee living in DC which is  
11 determined to be a least affordable state where the  
12 transition rule applies and I work in Virginia which is  
13 determined not to be a least affordable state and my  
14 employer buys insurance from an insurance company located  
15 in Maryland, also not determined to be a least affordable  
16 state, I will be able to get higher cost coverage through  
17 my employer than a coworker that lives in Virginia, is  
18 that correct?

19 Mr. Barthold. I believe that is correct under the  
20 modification, the state of the individual.

21 Senator Hatch. Now, Article 1 Section 9 of the  
22 Constitution requires that direct taxes be apportioned  
23 among the states on the basis of the population. In  
24 contrast, the tax imposed under the Chairman's mark upon  
25 the sale of certain -- expensive health insurance plans

1 would be a true excise tax required by Article 1, Section  
2 8 to -- throughout the Unites States.

3 We are not talking about a defined geographic region  
4 in the Unites States versus Susinski. We are talking  
5 about states, right?

6 Mr. Barthold. The transition is defined by states.

7 Senator Hatch. Because this relief is limited to  
8 certain states. Is the transition related to  
9 geographically -- throughout the United States as  
10 provided by the Constitution? You know what the answer  
11 to that is.

12 Mr. Barthold. Well, I cannot really comment about  
13 the Constitution.

14 Senator Hatch. The answer is no.

15 Mr. Barthold. It is, as you observed --

16 The Chairman. If I can. The point here is where  
17 the insured lives. That is the employee because that is  
18 the person who is affected.

19 Senator Hatch. That is not what he said.

20 The Chairman. Well, the intent is where the  
21 employee or the insured lives.

22 Senator Hatch. Let us go further. While we are on  
23 the topic of upholding the Constitution, the --  
24 legislation would require all U.S. citizens and legal  
25 residents to purchase a certain level of health insurance

1 coverage.

2 They must record qualified coverage on the federal  
3 income tax return. Failure to do so would result in an  
4 excise tax of \$750 on individuals applied as an  
5 additional amount of federal tax owed. Would that be a  
6 direct tax?

7 Mr. Barthold. If we applied an excise tax on all  
8 individuals --

9 Senator Hatch. But you are not. I am told that  
10 this would be the first time in our history that  
11 Americans would be faced with the situation where they  
12 were ordered to do some specific act by the federal  
13 government which if they refuse to do it they would be  
14 subject to a tax. Is that correct?

15 Mr. Barthold. I do not know, Senator.

16 Senator Hatch. I think it is.

17 Mr. Reeder. If I could jump in here and just add  
18 that the code, the Internal Revenue code is replete with  
19 excised taxes that are applies as penalties.

20 Senator Hatch. Well, this is on a person, not a  
21 service or product.

22 Mr. Reeder. There are lots of excised taxes that  
23 are applied to an individual.

24 Senator Hatch. I guess I'm asking do you believe  
25 this individual mandate raises possible Constitutional

1 issues as I have been told? It sure seems like it to me.

2 Mr. Barthold. Senator, it is just not something  
3 that I am qualified to answer. An excise tax applied on  
4 activities by all individuals would not seem to be beyond  
5 the flush of the Constitution's authority for the  
6 Congress to assess a tax. But I am not the right person  
7 to engage in a Constitutional discussion. I'm sorry.

8 Senator Hatch. It would be a tax on a person for  
9 doing absolutely nothing. I mean, can anyone on the  
10 panel say whether the mandate of excise tax would be  
11 constitutional? Anybody?

12 The Chairman. Well, I will. This is an equally  
13 applied penalty for all persons meeting a certain  
14 category. I think it is a stretch to say this is  
15 unconstitutional. I will take that argument any day that  
16 it is not constitutional. It is constitutional.

17 Mr. Reeder. We did refer this to CRS and we got  
18 guidance from them that it is.

19 Senator Hatch. To be honest with you, I do not  
20 think it is at all. Let me move on.

21 The Chairman's mark provides a tax credit for  
22 qualified small employers with no more than 25 full time  
23 equivalent employees. These employees have annual full  
24 time equivalent wages that average no more than \$40,000.

25 Moreover, the full amount of the credit would be

1 available only to the employer with ten or fewer  
2 employees and whose employees have an average full time  
3 equivalent wages of less than \$20,000.

4 What economic disincentives do these requirements  
5 create for growing a business beyond 10 or 20 employees  
6 or increasing wages beyond \$20,000 or \$40,000?

7 Mr. Barthold. Well, Senator, this was partially  
8 addressed by Dr. Elmendorf when he was here, the  
9 Congressional Budget Office has written a paper on some  
10 of the employment effects from health care reform.

11 One of the points that Doug made when he was here  
12 and Sandy Davis may want to follow up with his colleagues  
13 at the CBO because I do not want to misstate their  
14 results, but as a subsidy phases out, it essentially  
15 makes the next worker a higher cost worker than the  
16 preceding worker.

17 I think that was the point that you were raising,  
18 and that goes into employment decisions. It is a  
19 consequence in part of the phase out of the subsidy that  
20 is being offered.

21 Senator Hatch. What is bothering me a great deal  
22 about this whole exercise is that there is such a rush  
23 in just a few months to get done 1/6 of the American  
24 economy on a conceptual bill, which is what we do in this  
25 committee, that has to be finally put into final language

1 and then that has to be scored so at least we know what  
2 we are doing and so the American people at least can look  
3 at it and see if they agree with it.

4 I know how long it takes to put really important  
5 health care legislation through because I have put a lot  
6 through with my friends on the other side. We seem to be  
7 rushing very hard. But let me just ask you this.

8 According to the Chairman's mark, the individuals  
9 who failed to maintain health insurance are subject to an  
10 excise tax, right?

11 Mr. Barthold. It is the penalty, excise tax  
12 penalty.

13 Senator Hatch. The penalty for excise tax. The  
14 excise tax would be assessed with a tax code and applied  
15 as an additional amount of federal tax owed. However,  
16 there are various rules protecting those who are  
17 uninsured for less than three months or to the extent  
18 that the cost of the health insurance premium exceeds 10  
19 percent of adjusted gross income.

20 Are there any excise taxes in the current tax system  
21 that are treated this way? And are there any other  
22 excise taxes that vary based on the taxpayer's income?  
23 Are there any other taxes at all in our current tax  
24 system that are furthered by the failure of the taxpayer  
25 to take some action?

1           Mr. Barthold.   Well, as Mr. Reeder noted, there are  
2           some penalty excise taxes that apply to individuals for  
3           either actions that they take or in some instances for  
4           not having taken an appropriate action.

5           We have penalty excise taxes on excess distributions  
6           or premature distributions from qualified retirement  
7           plans. There is excise taxes in the tax exempt  
8           organization area for, I guess for lack of a better term,  
9           for inappropriate activities or decisions made by  
10          management of the tax exempt order.

11          Senator Hatch.   But are they based on the  
12          taxpayer's income?

13          Mr. Barthold.   None of those are based on  
14          taxpayer's income. The excise taxes on the distribution  
15          indirectly are based on income in the penalty taxes for  
16          early withdrawals for example key off of the size of the  
17          withdrawal.

18          Senator Hatch.   Well, this excise tax is imposed  
19          upon the insurer for which plan it offers which exceeds a  
20          threshold amount. When the insurer --

21          Mr. Barthold.   That is a different excise tax.

22          Senator Hatch.   Okay. I understand that. I'm  
23          moving on. When the insurer pays this tax, it is likely  
24          that the insurer will pass the cost along to the employer  
25          who purchased the high cost insurance? And do you

1 believe that this would result in less revenue for the  
2 employer in which it can hire more employees and provide  
3 higher salaries?

4 Mr. Barthold. As I was discussing with Senator Kyl  
5 a few moments ago, the way we analyze this is the excise  
6 tax itself essentially sets up a question of do I want to  
7 pay more for this current health care benefit or would I  
8 potentially like to reallocate my compensation by perhaps  
9 choosing a lower cost plan either through accepting  
10 higher deductibles, higher copays, perhaps less coverage  
11 of certain items that may be deemed non essential.

12 When I do that, I receive greater cash income. I am  
13 trading in excludable compensation benefits in the form  
14 of health care and receiving more cash income.

15 In that analysis and in the way we have analyzed  
16 this and I believe the Congressional Budget Office has  
17 largely concurred with our analysis, we view the tax as  
18 being born ultimately by the employee, by the policy  
19 holder.

20 From the business side, whether the business  
21 compensates its employees with cash, with retirement  
22 benefits, with health care benefits, they are somewhat  
23 indifferent. It all adds up and it is all the  
24 compensation cost. It is the price, sort of the expanded  
25 concept of the wage that they are paying the employee.

1           So our view of the excise tax is that it essentially  
2 just works to change the compensation package decision.  
3 Some employees in negotiation with their employer may  
4 choose to keep a plan that is subject to the excise tax.  
5 We believe that the premium will increase to reflect the  
6 tax as partly the point we were discussing earlier in  
7 which case we have essentially chosen to have a little  
8 bit more of their compensation being the form of health  
9 care premium and less wage compensation. But we do not  
10 view it as impeding, as raising the price of labor and  
11 impeding the business's choice to hire additional workers  
12 as it might expand given a positive outlook for market  
13 conditions.

14           Senator Hatch. Let me ask you, what are the  
15 implications suggesting CPI-U plus one as the index of  
16 the threshold as opposed to some other index? Would this  
17 index cause a growing number of plans to be cut? I would  
18 like to at least know the answer to that.

19           Mr. Barthold. The original Chairman's mark -- the  
20 thresholds by the CPI. The modification index is the  
21 threshold by CPI plus one. So the modification will  
22 cause fewer plans to be potentially subject to the excise  
23 tax and will be underlying mark.

24           Senator Hatch. Okay.

25           The Chairman. Okay.

1           Senator Hatch. I am not through yet.

2           The Chairman. We have five minutes and we can come  
3 back to you. If you could wrap up, that would be  
4 helpful.

5           Senator Hatch. Well, let me just ask one last  
6 thing. I thought we were going to just be able to finish  
7 what our line of questions are.

8           Can you share the CRS report with us that you said  
9 you were relying on for the constitutionality of this? I  
10 would like to have a copy of it.

11          Mr. Reeder. I'm sorry. It was an oral conversation  
12 where they recited some case law which I can --

13          Senator Hatch. Well, did not they put that in  
14 writing? Usually CRS will put a --

15          Mr. Reeder. We can ask them.

16          Senator Hatch. Well, again, we are missing this  
17 bill without answering questions that are really  
18 important like the constitutionality of some of the  
19 provisions. These are important issues. They are not  
20 just itty bitty issues.

21          I do not understand why the rest of them when it  
22 involves 1/6 of our American economy and people all over  
23 this country are up in arms about it because they do not  
24 understand it and we do not understand it.

25          It is pretty hard to understand when you are looking

1 from a conceptual plan without scoring except preliminary  
2 type scoring that may or may not be accurate.

3 I have lot of confidence in Dr. Elmendorf. I think  
4 he is an honest man, I think he is trying to do a good  
5 job and he has been honest in telling us it is pretty  
6 hard to get all the scoring done on this in the limited  
7 time that we are given for this.

8 It just seems to me, Mr. Chairman, I do not blame  
9 you for this. I know there is a lot of pressure on you.  
10 But it seems to me that we ought to take our time on this  
11 and make sure we get it right.

12 If I am right, then a number of these things are  
13 unconstitutional. This could wind up being not only an  
14 exercise in futility but one that really costs our  
15 country an undue amount of money that could really hurt  
16 our country and our economy in the end.

17 I will reserve my time to ask more questions later.

18 Mr. Reeder. If I might add that the CRS does have a  
19 report on their website addressing the constitutionality  
20 of these provisions.

21 The Chairman. We are going to get a CRS report.  
22 Senator Grassley?

23 Senator Grassley. My first question would be to  
24 finance staff. Preliminary to it which by I would not  
25 expect any of you to know, but in 1995 I got a bill

1 passed called the government accountability Act which  
2 applied all the laws from the 1930s that Congress had  
3 exempted itself from that they had applied to Congress.

4 So I am concerned about your modified amendment C3.

5 The amendment that I put in would require that all  
6 members of Congress and federal employees get their  
7 health coverage through the exchanges when they are up  
8 and running. This is something that we not only need but  
9 I think in a lot of other states people heard in their  
10 town halls because many people at the grass roots believe  
11 that members of Congress should get the same coverage  
12 that we are coming up with for everyone else.

13 So that is what my amendment was intended to do and  
14 this amendment will not only hold us accountable, but  
15 will also help improve the Chairman's' mark by creating a  
16 more vibrant market by adding more people to it.

17 But in the modification, my amendment was modified  
18 to say that elected officials and federal employees may  
19 purchase their coverage in the exchange. It appears to  
20 make it optional for members to go into the exchange, and  
21 is that right, and if it does let me say that part of  
22 this is to get members of Congress to understand what the  
23 average citizen does navigating the exchange and having  
24 the same thing that other people have.

25 Ms. Fontenot. You are right, Senator. The

1 modification to the amendment gives federal employees the  
2 option to enroll the way that any private sector employee  
3 would have the option to enroll.

4 Senator Grassley. Okay. Well, I have explained  
5 where I am coming from on that and I will probably  
6 proceed with my original amendment. I appreciate the  
7 consideration you gave it by including it, but it just  
8 goes in the opposite direction that I was intending to  
9 go.

10 I want to speak about immigrants who are here  
11 illegally. This is based, if anybody on the finance  
12 staff wants to respond, but I just want to point out some  
13 things that bother me.

14 There is almost no topic that generates more  
15 controversy. Despite the controversy, the committee has  
16 responsibility to consider the impact on immigrants here  
17 illegally on our health care system.

18 So last week I sent a letter to CBO requesting more  
19 information on this issue. Earlier today I received a  
20 response from CBO which states I part, we do not have a  
21 detailed estimate you requested.

22 Since I didn't get a complete response to my earlier  
23 questions, I would like to take a moment to focus on what  
24 the letter says.

25 According to the letter, CBO assumes there will be

1 14 million unauthorized immigrants residing in the United  
2 States in 2019. CBO assumes 8 million will be uninsured,  
3 4 million will have employer-based coverage, one million  
4 would have Medicaid coverage and one million would have  
5 other coverage.

6 With respect to Medicaid, the letter says that this  
7 coverage primarily reflects emergency care services. The  
8 letter also states that some unauthorized immigrants will  
9 obtain full year Medicare coverage even though they do  
10 not qualify for it. However, we believe state agencies  
11 successfully screening out most ineligible individuals.

12 I am not sure what the statement is based on,  
13 whether CBO is aware of any statistically valid audit to  
14 determine the reliability of the state's citizenship  
15 verification procedures or not.

16 The letter says CBO assumes that the enforcement  
17 mechanisms in the bill would be highly effective in  
18 keeping ineligible individuals from receiving tax  
19 credits.

20 Although the bill requires the exchange to verify  
21 the Social Security numbers and the legal status of  
22 participating individuals, there is no provision in the  
23 bill to prevent anyone from using somebody else's Social  
24 Security number.

25 I will say this parenthetically. That is something

1 that we were working on as we ended our bipartisan  
2 negotiations and I was hoping that we would arrive at  
3 some sort of a consensus on that, but we did not.

4 Lastly I want to say small business with low wage  
5 workers who provide insurance in 2011 and 2012 would be  
6 eligible to receive temporary credits to purchase  
7 insurance. There is no provision in the bill to verify  
8 the legal status of workers employed by these small  
9 businesses.

10 Now, that is my analysis of that letter. If anybody  
11 on the Finance Committee staff wants to comment on it,  
12 otherwise I will go onto another question. Is there any  
13 rebuttal you need to give on that?

14 The Chairman. I want to ask Mr. Klouda to comment  
15 on the degree of how robust is the screening right now  
16 and what are the different screens?

17 Mr. Klouda. Senator, right now the way the  
18 Chairman's mark is structured, people applying to the  
19 exchange or seeking a tax credit, their name, date of  
20 birth and social security number is verified with the  
21 Social Security Administration.

22 If those individuals assert that they are citizens  
23 of the United States, that is checked with the SSA  
24 records as well. For individuals who are not citizens of  
25 the United States, then they --

1           The Chairman.    But who are here legally.

2           Mr. Klouda.    But, well, are here legally, their  
3 information would be checked with the records at DHS to  
4 see if their claim of lawful status is what their DHS  
5 records reflect.

6           Senator Grassley.   That still does not cover though  
7 what I said about people that could steal Social Security  
8 numbers.

9           Mr. Klouda.    Yes, Senator.   Well, people who are  
10 applying for exchange are going to put their income  
11 information and that will be verified with the IRS as  
12 well.

13          The Chairman.    So if someone stole a social  
14 security number, what?   What would happen?

15          Mr. Klouda.    Well, they also have to have the other  
16 pieces of that person's identity information.   We check  
17 to see if there is a concern with identify theft in some  
18 of our other health care programs.

19          We contacted the National Association of Medicaid  
20 Fraud Units, and they mentioned that there is a minor  
21 degree of identity theft in Medicaid, but it is very  
22 small.   It is not one of their main concerns in terms of  
23 Medicaid fraud issues.

24          So we feel that someone committing identify theft  
25 through this system, not only would they have to get all

1 the information, have it verified, but then they would  
2 have to actually present themselves at a health care  
3 center or doctor's office and collect benefits.

4 Some people that we have talked to are experts in  
5 identify theft and just feel that is unlikely that people  
6 would want to enter the system that way and have to sort  
7 of maintain the fraud.

8 Senator Grassley. You know one instance that you  
9 do not cover is the fact that if you steal a social  
10 security number and you have that number, you can write  
11 and get income information based upon that number.

12 Mr. Klouda. I am not sure what you are referring  
13 to.

14 Senator Grassley. I am referring to the fact that  
15 if you have a social security number, you can write to  
16 Social Security and get pay records for what has been  
17 paid in under that number.

18 In other words, I could write in and ask Social  
19 Security for my record.

20 Mr. Klouda. That may be true. I just wanted to  
21 point out that the IRS would not pay a credit for the  
22 same person twice. So if I were to luck out and find  
23 the, somebody who is eligible for the credit and steal  
24 their identity, the IRS would only pay that credit once.

25 Senator Grassley. I will go onto another question

1 for joint tax. You have hit some of this a couple of  
2 times already, but I want to hit it from another angle.

3 In regard to employers who are less than 500  
4 employees are less likely to self-insure their employee's  
5 medical claims under the proposal to impose a fee on  
6 health insurance providers, employers who are self-  
7 insured are exempt from the fee. This means only  
8 insurance companies that sell health insurance policies  
9 to, for example, small businesses would be required to  
10 pay the fee.

11 This would also include self-employed who purchased  
12 individual health insurance. Does this mean that the  
13 premiums for small business and the self-employed will go  
14 up? And how many years will the costs seem to go up?

15 Mr. Barthold. Yes, Senator Grassley, I guess we  
16 haven't spoken about this industry wide fee which --  
17 modification would be \$6.7 billion allocated across the  
18 industry.

19 As you observed, it does not apply to self-insurers  
20 and you also stated that generally you are less likely to  
21 self-insure if your employer is under 500 individuals.  
22 That is certainly the case. Self-insurers tend to be  
23 larger companies.

24 We, and again the Congressional Budget Office is in  
25 concurrence with this, believe that these fees will

1 generally be reflected in premium costs. As you  
2 observed, it is people purchasing group insurance so it  
3 would be smaller employers.

4 The small employer market, individual market would  
5 be included. We think we'd have some of the economic  
6 effect of making it more likely that some modest size  
7 employers might consider self-insuring. It would make it  
8 less likely that some of the larger firms would choose to  
9 opt out of self-insurance into the purchased group  
10 insurance market. I hope that's responsive to you.

11 Senator Grassley. You responded to the fact that  
12 the costs would go up, but you didn't say how long. How  
13 many years did you expect them to go up? I would expect  
14 them to go up at least three to five years until the  
15 health insurance reforms kicked in. Would that be fair  
16 to say?

17 Mr. Barthold. The proposal is a permanent  
18 proposal. We would expect that it would have, I mean,  
19 the analysis would hold year by year, so we would expect  
20 it to have an impact in each year.

21 Now, I guess I cannot answer on my own without  
22 checking how we have coordinated this with the  
23 Congressional Budget Office because we do expect  
24 insurance market reforms in other changes in the broader  
25 goal to have effects on premiums in the group market.

1           So if your question is would this feed the totally -  
2           - or not totally offset by the other changes in the bill,  
3           I don't have an answer for that at the present time.

4           Senator Grassley.    The fee is an excise tax?

5           Mr. Barthold.    It is not a normal structure one,  
6           but we analyze it as an excise tax.  It is essentially  
7           saying if you based on the volume of your business there  
8           is a tax imposed.

9           Now, that tax varies by the overall volume of  
10          business in the marketplace and that of your competitors.  
11          So it is a different sort of variable rate excise tax.  
12          We do see it as an excise tax.

13          Senator Grassley.   Under the Chairman's mark, the  
14          insurance company is required to report to Treasury the  
15          net premiums written by a company in the previous year.

16          Based on this information, Treasury will determine a  
17          company's market share.  Has a tax ever been based on  
18          market share?

19          Mr. Barthold.    I believe that the Chairman in his  
20          mark based this structure and the structure on medical  
21          devices and also to a degree the industry fee on the  
22          branded pharmaceuticals on the tobacco settlement.  The  
23          tobacco settlement does collect fees from each company  
24          based on the company's market share as it evolves.

25          There is a precedent out there.  There may be some

1 other precedents as well.

2 Senator Grassley. I guess my other questions were  
3 CBO and they are not here. So did anybody on your, he  
4 asked me to call on somebody. Senator Kyl?

5 Senator Kyl. I just had one question of staff.  
6 There is an indication in the modification of the  
7 Chairman's mark on page 2 at the very top of the page it  
8 is described as an amendment to accept the modification -  
9 - and related amendments, Grassley 15 and 16, Hatch 4,  
10 Kyl amendment number 6 and Cornyn number 10.

11 I just wanted to disassociate myself with this  
12 because I do not think my amendment has anything to do  
13 with what this does.

14 As I understand it, well, my amendment which is  
15 referred to as number six there allows states to opt out  
16 of all of Title 1, meaning the insurance reforms, the  
17 exchange, the subsidized mandate, the coop, Medicaid  
18 expansion and so on which of course is not what the  
19 modification does.

20 I understand the modification would simply allow  
21 states to apply for a waiver on just the insurance  
22 reforms if the state and only if the state provides, and  
23 I am quoting now, coverage that is at least as  
24 comprehensive as required under the mark.

25 So I just want to make it clear in indicating that

1 it is adopted at least in part, my amendment, I don't  
2 think it does any such things. I want the record to be  
3 clear on that point.

4 Senator Grassley. Senator Hatch?

5 Senator Kyl. And if any staff would like to  
6 contradict that, please do.

7 Senator Grassley. I'm sorry. You didn't get an  
8 answer.

9 Senator Kyl. No, I guess it is a comment. But if  
10 any staff thinks I am incorrect on that, then please say  
11 so.

12 Senator Grassley. Let me ask one more question and  
13 then I will call on Senator Hatch. To the staff. The  
14 Chairman's mark explains that for purposes of determining  
15 eligibility for premium credit, individuals must submit  
16 personal information to the state exchange.

17 The mark also states that the eligibility  
18 determinations will be conducted by a federal agency. So  
19 the state would seem contradictory.

20 Will the state exchange or a separate federal agency  
21 be responsible for verifying the income and legal status  
22 of an individual and his or her family?

23 Ms. Fontenot. Senator, the state exchanges will  
24 have to interface with the IRS in order to confirm income  
25 levels. So it will be an eligibility determination that

1 is based on information submitted to the state exchanges  
2 that has been verified by the IRS.

3 Senator Grassley. Well, the mark doesn't describe  
4 the federal agency. Which federal agency would be  
5 responsible?

6 Ms. Fontenot. We anticipate it would be the IRS.  
7 They hold the income verification information. They hold  
8 the tax filings where they can verify the income.

9 Senator Grassley. You anticipate it, but it seems  
10 to my staff that it is not firmly stated in the mark. Or  
11 is it your intention that that will be the case?

12 Ms. Fontenot. It is our intention that IRS will  
13 continue to hold the income information and the  
14 verification will be done with IRS records.

15 Senator Grassley. I am sorry. Senator Hatch, I  
16 forgot that I was going to call on you. You are next.

17 Senator Hatch. We have been looking over the CRS.  
18 We did get the CRS language and it does not specifically  
19 mean what I think you have interpreted it to mean. But I  
20 will try and get that prepared for us by tomorrow or even  
21 later tonight.

22 Mr. Reeder. And we will follow-up, as well.

23 Senator Hatch. Because I am very concerned about  
24 that. Let me just ask a couple of more questions on  
25 this. In connection with determining the amount of

1 employer-provided health insurance coverage that exceeds  
2 the threshold, for determining the new excise tax, why  
3 would the aggregate include the amount of the employee's  
4 flexible spending arrangements?

5 After all, are these not the employee's dollars and  
6 not dollars provided by the employer? It seems strange  
7 and wrong to me to treat these amounts as employer-  
8 provided health insurance.

9 Likewise, does not this proposal also include toward  
10 the threshold the employee's portion of health insurance  
11 premiums? Is it not true then that this is not just a  
12 tax on employer-provided health insurance, but also a tax  
13 on employee contributions, some of which have already  
14 been taxed once?

15 Mr. Barthold. Senator Hatch, you are correct. To  
16 go to the second question, the mark would provide that in  
17 aggregating the value of health care benefits that might  
18 be subject to the excise tax, it would include benefits  
19 that were paid with employee after-tax dollars.

20 Now, as to the point on, I guess, the policy of  
21 including an FSA, a health flexible spending arrangement,  
22 the effect of the flexible spending arrangement is to  
23 permit the employee to make payments for certain health-  
24 related expenditures with pre-tax dollars.

25 Now, that has the same effect as complete employer-

1 provided health insurance. It has the extra effect, I  
2 think, in the context of the Chairman's mark, and I will  
3 not --

4 Senator Hatch. But the difference is --

5 Mr. Barthold. -- the Chairman as to motivation,  
6 but it does essentially mean that you could pay with pre-  
7 tax dollars the deductible, and I believe the Chairman's  
8 intention with the excise tax was he wanted to create  
9 some cost consciousness.

10 Senator Hatch. That is fine, but these are  
11 employee dollars, not employer dollars.

12 Mr. Barthold. The flexible spending account --  
13 well, our view and most economists' view is that all the  
14 dollars are employee dollars. It was the point that we  
15 were talking about before about the mix of the  
16 compensation.

17 Senator Hatch. But there is no question that  
18 flexible spending accounts are employee dollars.

19 Mr. Barthold. They are pre-tax employee dollars,  
20 just as the purchased health insurance policy can be with  
21 pre-tax employee dollars. But on the point that you are  
22 making that the flexible spending account represents  
23 dollars only until they are spent, whereas the health  
24 insurance policy is a policy that is agreed to at the  
25 beginning, that, of course, is true.

1           Senator Hatch.    All right.  Now, there are many  
2   employers who provide basic health care coverage to their  
3   employees.  Employees sometimes purchase supplemental  
4   coverage that goes beyond what the employer-provided  
5   health insurance coverage, such as coverage for cancer.

6           In calculating the threshold amount, will employers  
7   be less likely to offer supplemental coverage to  
8   employees exceeding the threshold a month, in your  
9   opinion?  Is that possible?

10          Mr. Barthold.  Well, the calculation is based upon  
11   what the employees are choosing, what they are offering.  
12   As we discussed before, there would be incentives for  
13   employees and employers to say "I do not want the overall  
14   benefit package to exceed these thresholds" and, as you  
15   were observing, one way to do that would be not to offer  
16   or not to purchase certain supplemental policies.

17          Senator Hatch.  Mr. Chairman, your own Chairman's  
18   mark recognizes the differences between employer-provided  
19   contributions and employee-funded FSA, or flexible  
20   spending account, contributions.

21          On page 202, the reporting requirement excludes FSA  
22   contributions.  Likewise, on page 23 of the mark, the  
23   small employer tax credit does not allow FSA  
24   contributions to count toward amounts paid by employers  
25   for purposes of determining the credit.

1           Is this not a "heads I win, tails you lose" approach  
2 as far as FSA users are concerned?

3           Mr. Barthold. I misunderstood your question,  
4 Senator. I am sorry.

5           Senator Hatch. Let me state it again. The  
6 Chairman's mark does recognize the difference between  
7 employer-provided contributions and employee-funded FSA  
8 contributions. Yet, on page 202, the reporting  
9 requirement excludes FSA contributions.

10           Likewise, on page 23 of the mark, the small employer  
11 tax credit does not allow FSA contributions to count  
12 towards amounts paid by employers for purposes of  
13 determining the credit. That is why I ask if it is a  
14 "heads I win, tails you lose" approach as far as FSA  
15 users are concerned. Does that make it more clear?

16           Mr. Barthold. I am wasting your time, which is  
17 counting down, by not understanding. I will have to  
18 think about it. Maybe we can speak separately.

19           Senator Hatch. We will submit that question to  
20 you, then.

21           The Chairman. If I might, Senator, just a proposal  
22 here so we can take some action here tonight. I have  
23 consulted with Senators and I suggest -- including at  
24 least your staff, maybe you, too -- we take up your  
25 amendment, Senator, the one with regard to MA cuts that

1 require CBO certification; the Conrad amendment, CMS  
2 Innovation Center; the Nelson amendment to the dual  
3 eligibles; and, I suggest we take those three up, we  
4 debate them, and then we will vote on those tomorrow when  
5 we come back.

6 Senator Hatch. That would be fine. But can I  
7 finish my questions?

8 The Chairman. Sure. Senator Schumer? Let us kind  
9 of get the sense here of what is going on first, Senator.  
10 Let me see what Senator Schumer has in mind.

11 Senator Schumer. After Senator Hatch finishes with  
12 his line, I have one question I would like to ask before  
13 we stop.

14 Senator Hatch. I have a few now. The CRS report  
15 concludes the government can require individuals to  
16 obtain health insurance and penalize you if you do not.  
17 However, the penalty must be something the government has  
18 already given you and can take away, such as the right to  
19 a deduction.

20 Now, this is an excise tax imposed on you,  
21 regardless of if you have a tax liability or not. I  
22 think the CRS has not analyzed the Chairman's proposal.  
23 So I want you to really look at that, because the CRS has  
24 not concluded that this is constitutional and I think we  
25 can make a case that it is not, and you ought to at least

1 get that right before we proceed with this bill and I  
2 think that would be a very, very important thing to do.

3 Now, let me go back to where I was and that is  
4 regarding the distribution of taxes and whether the mark  
5 will raise taxes on middle income families. What are the  
6 distributional effects of this excise tax on high-cost  
7 insurance plans? The distributional effects.

8 Mr. Barthold. The distributional effects, as we  
9 were discussing earlier, Senator, we review the  
10 economics, leading to a couple of possible outcomes. One  
11 is that employees and their employers may decide that  
12 they want to reconfigure their compensation plans to  
13 offer a less expensive health care package, which could  
14 be achieved by a number of different means.

15 When that happens, they would be receiving more cash  
16 compensation, leading to increased income and payroll  
17 taxes. Another possibility is that the employees like  
18 the package, the fact that the price has increased, they  
19 may make some changes, but we expect that the tax will  
20 increase the cost of the policy. In that case, there is  
21 some direct excise tax payment made.

22 The price has gone up to the employee. Again,  
23 because it is part of the compensation package, there  
24 would be some offset in terms of by having more expense  
25 in health care, there would be less wage cash

1 compensation. So there would be some modest offset to  
2 the excise tax receipts from reduced income and payroll  
3 taxes.

4 Distributionally, as we discussed earlier, this is  
5 on the employee basis. Since plans often cover employees  
6 of many different income levels, the income inclusions or  
7 the higher premium from the excise tax would be reflected  
8 in the tax payments or premium payments of individuals of  
9 many different income levels.

10 Senator Hatch. In connection with the \$2,500 FSA  
11 threshold, how many families would find themselves  
12 limited in the amount they wish to contribute to their  
13 flexible spending account?

14 I note that this threshold does not appear to be  
15 indexed for inflation and my question is is that an  
16 oversight. Given CBO inflation forecasts, how many  
17 families would be limited in their FSA funding, let us  
18 say, in five years, in 10 years?

19 I think it is a legitimate question, because that is  
20 a very important part of our tax code right now and I  
21 personally appreciate FSAs and I think most people do.

22 Mr. Barthold. Senator, as you know, the FSA  
23 proposal in the Chairman's original mark was to limit it  
24 to \$2,000. In the modification, it increases that  
25 limitation to \$2,500. But as you observed, in neither

1 the mark nor the modification does it index that  
2 threshold amount.

3 We don't have a very good projection on the number  
4 of families for which this would be binding. I think  
5 some of the available statistics are that it is really  
6 only about 20 percent of employees of whose employers  
7 offers the possibility of a flexible spending arrangement  
8 choose to set one up for health.

9 Our data is really kind of thin going beyond that.  
10 So I cannot give you much more of an answer.

11 Senator Hatch. I saw an estimate of 35 million  
12 Americans who use flexible spending accounts, but I do  
13 not know that that is --

14 Mr. Barthold. Well, the flexible spending  
15 accounts, remember, are not all health. There can be  
16 dependent care flexible spending accounts.

17 Senator Hatch. It is estimated that in --

18 Mr. Barthold. The cap on attentive care flexible  
19 spending accounts is a non-indexed cap under present  
20 policy.

21 Senator Hatch. It is estimated that in 2008, the  
22 average FSA participant earned approximately \$55,000 per  
23 year. Many individuals use FSAs to seek the services or  
24 prescriptions for chronic conditions that require ongoing  
25 care and medical supplies.

1           Looking at the provision that would conform the  
2 definition of medical expenses for health savings  
3 accounts, it appears that under the mark, employees can  
4 no longer use pre-tax dollars to pay for over-the-counter  
5 medicine, such as aspirin, or any other over-the-counter  
6 medicine.

7           In addition, there is a proposal in the Chairman's  
8 mark to increase the penalty for nonqualified health  
9 savings account distributions to 20 percent.

10           Now, assuming you are in the top tax bracket, would  
11 you see up to a 55 percent tax increase on a bottle of  
12 aspirin? A 35 percent increases in taxes and 20 percent  
13 penalty is the way I look at it. Am I off on that?

14           Mr. Barthold. Senator, if someone were in the 35  
15 percent tax bracket and used their HSA in a nonqualified  
16 distribution, there would be now a 20 percent penalty on  
17 that distribution.

18           If you say the income that was -- there is also the  
19 income inclusion. So, yes, it would be 55 percent.

20           Senator Hatch. Has Congress ever enacted a tax on  
21 an entire industry segment that is then allocated among  
22 the segment's companies based on their portion of the  
23 total sales and does this not introduce new kinds of  
24 complexity into the tax system?

25           What about predictability? Should not business

1 enterprises be able to reasonably compute what their tax  
2 liability should be without waiting to see how the rest  
3 of the industry segment did for the year?

4 Now, you answered that, in part, with Senator Kyl, I  
5 believe. But these questions, I think, are legitimate  
6 questions.

7 Mr. Barthold. The base question of have we imposed  
8 something like this before, I believe the Chairman stated  
9 that you saw, as a model of this, the tobacco settlement.  
10 So the tobacco settlement does allocate a certain amount  
11 of dollars as a fee on manufacturers of tobacco based on  
12 their sales.

13 Now, as the administrability and predictability, you  
14 are correct, it is not as precise and predictable as, for  
15 example, the cigarette excise tax of \$1.01 per pack. But  
16 in practice, many of the businesses that would be subject  
17 to the tax have projections of what their sales are  
18 likely to be over the coming year.

19 They have projections of their market, market share.  
20 So they would have a reasonable projection of what their  
21 tax liability might be. Now, those are only projections.  
22 It is not certainty.

23 Senator Hatch. The tobacco settlement was a  
24 settlement with the states, not individuals, and it was  
25 not part of the tax code.

1           Mr. Barthold.    You are correct, sir.  The tobacco  
2           settlement is not part of the Internal Revenue Code, but  
3           the model of the tobacco settlement is that payments are  
4           made based upon an overall dollar value which is  
5           allocated across the manufacturers and importers of  
6           tobacco products and that is really the same kind of  
7           model that you can see in these proposals that are in the  
8           Chairman's mark.

9           Senator Hatch.    Now, would these things be placed  
10          in the Internal Revenue Code and would the IRS be the  
11          agency that collects and enforces these fees and, if so,  
12          would these not more properly be called taxes?

13          Mr. Barthold.    I am not the person to make a  
14          judgment of what names -- whether to call something a tax  
15          or a fee or an assessment.  I can tell you, economically,  
16          we have modeled the effect of being like an excise tax.

17          As I think I was noting to Senator Grassley, we view  
18          it as a variable rate excise tax.  The rate varies across  
19          different companies, but it is basically a tax that  
20          depends upon the amount of production or the amount of  
21          sales that you, the business, undertake during the  
22          taxable period.

23          Senator Hatch.    It also seems to me that these fees  
24          are going to be due even if the entire segment loses  
25          money or has zero profit.  Am I correct on that?

1           Mr. Barthold.    As an excise tax, Senator, that is  
2 always the case. It is also the case, of course, for the  
3 payroll tax. The employer's share of payroll tax  
4 liabilities is due regardless of whether the employer is  
5 operating a profitable enterprise or not.

6           So the excise taxes on alcoholic beverages or the  
7 excise taxes are due even if the brewer, the winery or  
8 the distiller is not profitable in that year.

9           Senator Hatch.   This set of industry fees covers  
10 four different segments of the health care industry.

11          Mr. Barthold.    Actually, I believe the Chairman's  
12 modification strikes the clinical laboratory fee. So it  
13 is branded pharmaceuticals, medical devices, and  
14 insurance.

15          The Chairman.    Senator, how much longer are you?  
16 We have got to get some amendments here.

17          Senator Hatch.    Well, I have got a lot of  
18 questions.

19          The Chairman.    Well, at some point, we are going to  
20 have to get to amendments.

21          Senator Hatch.    Well, at some point, we ought to  
22 understand what is in this doggone bill.

23          The Chairman.    That bill has been out there a week,  
24 Senator.

25          Senator Hatch.    No, it has not. You have got a

1 conceptual bill that really does not even have the final  
2 language. It does not have a score to it.

3 The Chairman. This committee, as you know,  
4 Senator, you have been on this committee many, many  
5 years, only because conceptual --

6 Senator Hatch. I understand that we use conceptual  
7 language in this, but let us understand it is just  
8 conceptual.

9 The Chairman. That is what we have always done.

10 Senator Hatch. Well, fine. I do not have any  
11 problem with that, except it is strange compared to --

12 The Chairman. We are going to get to amendments  
13 pretty soon now.

14 Senator Hatch. You what?

15 The Chairman. We are going to get to amendments  
16 pretty soon.

17 Senator Hatch. Well, let me ask you, Mr. Chairman.  
18 Are we going to be serious about really understanding  
19 this bill or are we just going to move ahead and just  
20 roll on everybody without understanding it?

21 These are legitimate questions. These are not a  
22 bunch of make-work questions. And I have a pile of  
23 questions that I think we have got to have answers to  
24 before we vote on this or before we even do amendments to  
25 this conceptual bill.

1           Now, I am not trying to be a problem here. I think  
2 I have always cooperated, but golly, we are talking about  
3 one-sixth of the American economy and we are not going to  
4 do what we should to ask appropriate questions.

5           What really bothers me more than anything else is  
6 that I do not blame the CBO. They have been under the  
7 gun like you cannot believe. I have asked them to do  
8 work for the bill that we have come up with and I cannot  
9 get anything done there and to send it on time.

10           So I can imagine they are just inundated with this  
11 particular bill, but it is bothering me that we have to  
12 just push forward on this bill even without asking the  
13 questions that really ought to be asked.

14           This is a complex bill. This will be over 1,000  
15 pages when it is done. It is going to involve somewhere  
16 between, over a 10-year period, \$1.5 trillion to \$2  
17 trillion on top of our \$2.4 trillion that we already  
18 spend.

19           It seems to me we ought to get it right. We ought  
20 to at least know what it is all about. These are our  
21 experts and they are doing a darn good job, in my  
22 opinion, of answering these questions, at least as far as  
23 I am concerned.

24           I certainly do not want to be a clog or obnoxious  
25 about this, but I do think these are legitimate

1 questions. They are questions that ought to be asked,  
2 and I have got plenty of questions that I think are  
3 legitimate, important, will help us to understand this  
4 better and may help the public to understand it better  
5 and may actually be fruitful to us if we take the time to  
6 go through them.

7 I know what you are trying to do and I know you have  
8 got lots of pressure on you from the White House and  
9 elsewhere, from the administration, but this is the  
10 United States Senate and this is the most important  
11 committee in the United States Senate, and we ought to  
12 look at these things seriously and we ought to be able to  
13 ask all the questions that we have if they are legitimate  
14 questions. If they are not, tell me and I will withdraw  
15 them.

16 But these questions I have asked here this evening  
17 are very, very important and they are on and they are a  
18 very limited part of the bill.

19 The Chairman. I will make a proposal Senator, a  
20 suggestion, which is let us bring up and debate some of  
21 these amendments and then we can set a time tomorrow when  
22 we vote on amendments.

23 Senator Hatch. Can I ask my questions tomorrow  
24 morning?

25 The Chairman. No, no. I will stay here all night

1 long while you are asking your questions of staff. I  
2 will just sit here and be here and all the staff will  
3 stay here so you can ask questions and get answers to all  
4 your questions.

5 I will be here as long as you want to ask questions  
6 tonight and all the staff will be here.

7 Senator Hatch. I would rather treat staff a little  
8 more --

9 The Chairman. They want to answer your questions.  
10 I know they want to answer your questions.

11 Senator Hatch. I think we ought to ask the  
12 questions before we vote. I think it is very, very  
13 important to do that. I think it is critical to the  
14 understanding of this issue.

15 If this was some itty-bitty bill, I could back off  
16 very easily on this and just say, "Look, all right, I  
17 agree." This is not some itty-bitty bill. This could  
18 wreck the country.

19 The Chairman. Let us do this. Let us debate the  
20 amendments and also --

21 Senator Hatch. Why do that before you know what in  
22 the world we are talking about?

23 The Chairman. Some of these amendments are on  
24 different subjects than your questions. Let us debate  
25 the amendments. Then we will be here to ask -- so we

1 will be able to listen to questions and answer the  
2 questions that you have.

3 Senator Hatch. Well, I would rather ask the  
4 questions now so that we know where we are going.

5 Senator Kyl. Mr. Chairman, might I just interpose  
6 a question?

7 The Chairman. Yes, sure.

8 Senator Kyl. I have a related, but separate  
9 concern. It has been hard for me to get from my staff an  
10 analysis of the mark, the substitute mark that you just  
11 filed.

12 We are keeping staff here for a long time. They  
13 have got to hang around here and I do not know when they  
14 have time to analyze the mark. For example, and I will  
15 mention one thing in particular, I am very intrigued by  
16 the language that is described for Senator Cantwell's  
17 amendment.

18 I do not understand it and my staff was not able to  
19 figure it out. I do not know whether they were able to  
20 visit with your staff yet or not. But it looks to me  
21 like it is a very thorough amendment; that is to say it  
22 is not a little thing. It is a big thing, it looks like  
23 to me, and I really think we need some time and our staff  
24 needs some time to evaluate these things.

25 So as you figure out the schedule here -- we work

1 our staff hard, they work all weekend, they work at night  
2 and so on. We may go home, but then they are expected to  
3 keep on working. So I do think we need to have some time  
4 for them to give us the advice we need.

5 The Chairman. Well, we will have ample opportunity  
6 tomorrow or the next day to debate Senator Cantwell's  
7 amendment. We could stay an hour, two hours on her  
8 amendment, to understand her amendment when it comes up,  
9 whenever it comes up.

10 Senator Kyl. And I appreciate that, but it would  
11 be nice to have some feeling of these things before the  
12 debate starts.

13 The Chairman. Well, I do not know when she is  
14 going to offer her amendment. I mean, she will wait for  
15 a day or two --

16 Senator Kyl. Well, I am not trying to pick on  
17 Senator Cantwell, of course.

18 Senator Cantwell. Mr. Chairman, just a  
19 clarification. I think Senator Kyl is talking about in  
20 the modification, the language that was adopted on the  
21 value index.

22 Senator Kyl. Correct.

23 Senator Cantwell. Thank you.

24 Senator Kyl. Yes.

25 The Chairman. Let me ask this, Senator Hatch. Why

1 do you not ask questions for maybe another 15-20 minutes?  
2 Then we will go to the amendments and we will debate  
3 those amendments and put the vote for the amendment off  
4 to tomorrow. Then we will get to the rest of your  
5 questions tonight.

6 Senator Hatch. Let me just say that some of my  
7 questions have to do with the amendments that are going  
8 to be called up.

9 The Chairman. Well, we could ask your questions  
10 when the amendment is called up.

11 Senator Hatch. Ask them after the amendments have  
12 been passed.

13 The Chairman. Not passed. The amendment is called  
14 up and you ask your questions on that amendment and we  
15 vote on that amendment that tomorrow.

16 Senator Schumer. He is just commenting how good  
17 you are at this, Orrin.

18 Senator Hatch. Well, I am glad to be called good  
19 at something, I will tell you. But let me just tell you,  
20 it is not just a matter of being good. These are tough  
21 questions.

22 I will do one thing before I take my 15 or 20  
23 minutes. You had a question that you wanted to ask. I  
24 feel guilty not letting you ask your question. If you  
25 have more, I will even wait until after you ask more.

1           Senator Schumer.    I am sure you will.

2           Senator Hatch.    Because I recognize the importance  
3 of this body as a deliberative body, not as one that just  
4 rushes things through, especially one-sixth of the  
5 American economy.

6           Again, Mr. Chairman, I do not blame you.  I think  
7 you have got an inordinate push from the White House and  
8 others who know that they are trying to push something on  
9 the American people that they otherwise would not be for,  
10 and I just want to make sure that the American people  
11 know what they are getting pushed on.

12           I will be happy to yield for the purpose of one  
13 question, two questions.

14           The Chairman.    Senator, I am setting my own agenda.  
15 As Chairman of this committee, I am setting my own  
16 agenda.  I am not going to be told --

17           Senator Hatch.    Then this is the first time in all  
18 my time in the Senate with you, as a dear friend, where  
19 you have tried to cut off questions.  I have never seen  
20 it before, never.

21           The Chairman.    I am trying to encourage things  
22 along here.  My agenda is to act fairly, expeditiously,  
23 but fairly.

24           Senator Hatch.    Well, that has always been your  
25 way.

1           The Chairman.    So that Senators have an opportunity  
2 to ask all their questions.

3           Senator Hatch.    I will yield to the Senator for his  
4 two questions.

5           Senator Schumer.   Is that all right, Mr. Chairman?

6           The Chairman.    You bet.

7           Senator Schumer.   Thank you.

8           Senator Hatch.    But I want it back as soon as he is  
9 through.

10          Senator Schumer.   I just had a question on one  
11 amendment.  This deals with new physicians.  Senator  
12 Nelson and I worked on an amendment that would address  
13 the critical workforce shortages.

14          We are going to need more doctors if we are going to  
15 have more insured people.  There were two things that we  
16 wanted to do.  The second and more important which I am  
17 not going to discuss now, we will debate that amendment,  
18 is adding 10,000 newly funded slots that, accordingly to  
19 researchers, are desperately needed, with a slant to  
20 having those slots go into primary care.

21          But the first is the pooling of unused residency  
22 positions and reallocating them to hospitals that want to  
23 create or expand their primary care programs.  As I read  
24 the amendment, I do not know which staff member is in  
25 charge of this, Ms. Eisinger, the way they are

1 reallocated -- and it is a big, complicated formula which  
2 is sort of outcome determinative.

3 New York, which trains one out of every six, one out  
4 of every seven of the nation's doctors does not get any  
5 of them. The original amendment did, because it was the  
6 top 25 states. By this formula, which is -- I am not  
7 saying it is not meritorious, but you can cut the formula  
8 any way you want, and now we are cut out, as are some  
9 other states.

10 I was wondering what is the logic of that other than  
11 politics. Mr. Chairman, I would like to be able to work  
12 with you and the staff to correct it.

13 The Chairman. Do not say politics.

14 Senator Schumer. No. Preferences, preferences.

15 The Chairman. Policy.

16 Senator Schumer. Policy.

17 Ms. Eisinger. The logic was a combination of  
18 policy and dollars, actually, not politics, per se. But  
19 the amendment you are referring to is one that was filed  
20 by Senator Bingaman.

21 Just to step back, there are basic ways that these  
22 training slots are getting redistributed. One has to do  
23 with the amount of people living in a health professional  
24 shortage area, in a state relative to the population.

25 So in other words, states with more underserved

1 areas would be prioritized, and that is the list you are  
2 referring to, where I think New York was number 18 in  
3 terms of the number of underserved areas relative to  
4 population.

5 Then the other criteria had to do with the number of  
6 medical residents in training relative to population.  
7 That one, obviously, you are, I think, 50th on the list  
8 of the most medical residents.

9 Senator Schumer. But most of the residents go  
10 elsewhere and do medicine.

11 Ms. Eisinger. Right. So in terms of the Bingaman  
12 amendment, stepping back, right now, there are 1,100  
13 unused slots in the system when you carve out certain  
14 states and certain situations.

15 One of the carve-outs we did, there is actually a  
16 total of 1,800 slots available, but 300 of those are  
17 slots that were not filled because in the Balanced Budget  
18 Act, there was an incentive given to certain facilities,  
19 and most of these were New York facilities, not to fill  
20 those slots, because at the time, back in 1997, there was  
21 thought to be an oversupply of physicians.

22 So those 300 or so slots that are primarily in New  
23 York would not be subject to this policy. In other  
24 words, they would not lose those slots. So that is the  
25 first thing. So New York is protected in that sense.

1           But of the pool that is left once you do these  
2 carve-outs, it is 1,100, as I said. We had hoped to be  
3 able to afford to fill all of those slots.  
4 Unfortunately, our resources were limited. We ended up  
5 spending or allocating \$750 million, which would get us  
6 900 of those 1,100 slots.

7           So on the first question, we did not have enough  
8 resources in the package to get all of the remaining  
9 available slots into the system. That is the first  
10 thing.

11           Then the Bingaman amendment, recognizing that,  
12 proposed to constrict where the slots could go to the top  
13 10 states that had the most need. So given the interplay  
14 between limited dollars and a question between do we  
15 target it to the most need and do more or spread it thin  
16 and go further, the Bingaman amendment pushed to limit it  
17 and that was an amendment that we accepted. Clearly,  
18 this could be revisited.

19           Senator Schumer. Mr. Chairman, I would just ask  
20 that we be able to work with the staff and try to work  
21 something out.

22           The Chairman. Absolutely, absolutely.

23           Senator Schumer. I am finished.

24           Senator Conrad. Mr. Chairman?

25           The Chairman. Senator Conrad?

1           Senator Conrad.   Mr. Chairman, I would just go back  
2           to the conversation you were having with Senator Hatch  
3           and I would ask Senator Hatch to accept the what seems to  
4           me a very generous offer of the Chairman, which is to  
5           allow us to proceed to amendments.

6           There are a number of us that have amendments  
7           pending. Allow us to debate those amendments, including  
8           any questions that you have got, and then let the rest of  
9           us go so that we can do the work that you were talking  
10          about.

11          We have got lots of analysis to do in preparation  
12          for tomorrow, and let you go on and answer any question  
13          that you have got of the staff. The Chairman has said he  
14          would stay here to listen to those questions.

15          But you going forward before we call up the  
16          amendments is holding all kinds of staff here who need to  
17          be working on preparation for tomorrow. I have been on  
18          the committee for 15 years. I have never seen a  
19          circumstance where any member just got unlimited  
20          questions. I have never seen that.

21          Senator Hatch.   Well, have you ever seen a bill  
22          that was one-sixth of the American economy, which the  
23          Chairman described as the most important welfare bill  
24          since --

25          Senator Conrad.   Yes, I did. I saw it with the tax

1 cuts in the Bush administration and I had lots of  
2 questions. It affected 100 percent of the economy and we  
3 were not given unlimited questions. You talk about a  
4 disaster for the country, that turned out to be.

5 The Chairman. I must add, just for the information  
6 of the committee, the 2001 tax cut bill was, I guess, a  
7 \$1.3 trillion bill. We spent I do not know how many days  
8 on that, not too many days. This is a \$900 billion bill.

9 Senator Kerry. The 1986 tax reform bill, and then  
10 we can find a few of them.

11 The Chairman. I agree, Senator Hatch, this is a  
12 big bill. It takes time.

13 Senator Hatch. It is a big bill.

14 The Chairman. It is complex. But this committee  
15 has not spent actually more than two days in markup for  
16 10 years. But this is a big bill and we are just trying  
17 to find a way to find the right balance here, the balance  
18 between understanding the bill, on the one hand, and  
19 acting, on the other.

20 My sense is that the right balance is along the  
21 lines that we have now been discussing; namely, maybe 10  
22 or 15 minutes more of some questions, then we get to  
23 amendments, and you can clearly ask questions on those  
24 amendments. Then we vote on those amendments tomorrow.

25 Senator Hatch. Well, I do not intend to keep

1 anybody here forever nor do I intend to ask unlimited  
2 questions.

3 I might add there is a difference between the tax  
4 bills and even in the current tax situation we are living  
5 under, because it sunsets in 10 years. This bill, if it  
6 passes, would be on our backsides the rest of our lives  
7 and it is going to be in a way that could be very  
8 detrimental to the country if we do not get it right.

9 Now, if we get it right, it could be a tremendous  
10 boom to our society. I am just interested in trying to  
11 get it right, but, look, I am not going to keep my  
12 colleagues here. But I do think that it is outrageous  
13 that we have to do this in two or three days when we have  
14 got some time to do it, and I think we ought to all be  
15 able to ask whatever questions we want to ask, certainly,  
16 within reason and I will try to be reasonable about it.

17 The Chairman. I appreciate that very much. Thank  
18 you, Senator.

19 Senator Hatch. I understand you have a tough job.  
20 I have been there, too, in a number of committees and it  
21 is difficult. But this is a very, very important bill.  
22 Once this bill becomes law, if it becomes law, and I hope  
23 that the current bill does not, we are going to be stuck  
24 with it the rest of our lives. Our children will be  
25 stuck with it, our grandchildren are going to be stuck

1 with it, and, in Elaine and my case, our great-  
2 grandchildren.

3 Let me just take a second to dissociate my Hatch  
4 coverage amendment number four from the Chairman's  
5 modified mark, where it has been grouped with the Wyden  
6 coverage amendment, C-8. My amendment is a very  
7 straightforward amendment. It is a straight strike at  
8 the new individual mandate tax proposed in this bill.

9 It reverts to current law, wherein the decision on  
10 this issue falls back on the state. So Massachusetts,  
11 for example, can have a mandate, but Utah does not have  
12 to because the state does not want to.

13 The federal government should not be in this  
14 business. It does not require the state that decline to  
15 have an individual mandate to still meet all the  
16 requirements imposed under this bill or go to a Medicaid  
17 or CHIP-like waiver process to get out of this mandate to  
18 have a state referendum.

19 It is simply a straight strike and simply makes it a  
20 state option with no preconditions. So I would like to  
21 dissociate my amendment C-4 from being grouped with Wyden  
22 C-8 and direct our respective staffs to work on it to  
23 reach a resolution that expresses the true intent of my  
24 amendment.

25 The Chairman. You want the portion that is your

1 amendment to be stricken.

2 Senator Hatch. Yes.

3 The Chairman. You have the right to do so, if you  
4 wanted to strike that portion.

5 Senator Hatch. Mine is simply a straight strike.  
6 It simply makes it state option with no preconditions.

7 The Chairman. Could someone on the staff who knows  
8 this subject comment? What portion?

9 Senator Hatch. Just to come out of the modified  
10 mark.

11 The Chairman. One portion of Senator Hatch's  
12 amendment is in. What would happen if we could just  
13 delete Senator Hatch's portion from the modified mark?

14 Ms. Fontenot. Senator, there were a number of -- I  
15 apologize. I did not want to interrupt you.

16 Senator Hatch. Go ahead. No, I did not want to  
17 interrupt you.

18 Ms. Fontenot. There were a number of amendments  
19 that were filed that dealt with state options, whether it  
20 be in terms of allowing states the option to waive the  
21 individual mandate, allowing states the option to waive  
22 the rating rules, allowing state the option to not  
23 participate in federal health care reform in some way.

24 One of those included an amendment from Senator  
25 Wyden that required states to file a waiver and meet

1 certain requirements and then would allow them, if they  
2 met certain requirements, to waive out of all the federal  
3 health care reform legislation.

4 So we were trying to accommodate all of the various  
5 amendments that were seeking some sort of state option  
6 with regard to how they comply with this legislation.

7 Senator Hatch. I understand you are diligently  
8 trying to do this. I just want to make it clear that my  
9 amendment should not be lumped with the Wyden amendment  
10 and it is a straight strike with no preconditions. As  
11 long as I can present it that way, I will be happy.

12 Let me just take a few more minutes on just a few  
13 more questions and then I will honor my distinguished  
14 Chairman and the rest of my colleagues on the other side,  
15 even though I have all kinds of questions that I think  
16 need to be answered.

17 Now, President Obama has said over and over again  
18 that no one will lose their health benefits or their  
19 current health coverage, while the Finance mark includes  
20 \$113 billion in reductions for the Medicare Advantage  
21 program.

22 Is it not true that if these cuts go into effect,  
23 Medicare beneficiaries who have their health care  
24 coverage through Medicare Advantage plans are going to  
25 lose benefits? Does anybody want to answer that? You

1 are the lucky one.

2 Ms. Bishop. Let me see if I can answer that  
3 question. I would like to try to draw a distinction  
4 between Medicare covered benefits, which are benefits  
5 that beneficiaries are entitled to in the statute, to  
6 draw a distinction between those benefits and the extra  
7 benefits that beneficiaries have available to them  
8 through Medicare Advantage, and we tend to use the same  
9 word for both of those benefits.

10 We use the word "benefit," but they are really  
11 different. The one set of benefits, the covered benefits  
12 are the ones that the statute and the Congress makes  
13 available to every Medicare beneficiary no matter where  
14 they decide to get their care, whether it is in the  
15 traditional program or whether it is through Medicare  
16 Advantage.

17 The extra benefits that are available in Medicare  
18 Advantage are available because the law allows Medicare  
19 Advantage plans to offer them, first of all, to Medicare  
20 Advantage beneficiaries and, also, the statute provides  
21 for extra funds that are paid to Medicare Advantage plans  
22 and they use those funds to cover the costs of providing  
23 those extra benefits.

24 So earlier today, when there was a Q-and-A with Doug  
25 Elmendorf, the question came up about are Medicare

1 Advantage beneficiaries going to lose benefits under  
2 competitive bidding. We actually went back and looked at  
3 the transcript, because we wanted to make sure that we  
4 had this exactly right.

5 The answer is that Medicare Advantage beneficiaries  
6 are not going to lose any covered benefits under  
7 competitive bidding. It is unlawful.

8 Senator Hatch. My question is this. Will Medicare  
9 Advantage beneficiaries lose their current Medicare  
10 Advantage benefits? The answer has to be yes.

11 Ms. Bishop. I am going to go there. I am almost  
12 there.

13 Senator Hatch. Well, take \$113 billion out of the  
14 program.

15 Ms. Bishop. Right. I am going to just make the  
16 distinction between they are not losing any of their  
17 Medicare covered benefits; that Medicare Advantage plans  
18 are never allowed to not cover the Medicare statutory  
19 benefits.

20 The \$113 billion is a reduction in the extra  
21 benefits, the added additional benefits that Medicare  
22 Advantage enrollees have available to them and those  
23 benefits come in the form of vision, dental, reduced  
24 hospital deductible.

25 It is unstatutory, it is unlawful for any Medicare

1 Advantage plan to reduce the A/B covered benefits that  
2 they provide. That is by statute. They have to provide  
3 that.

4 They are going to have a reduction in the added  
5 benefits that they have in Medicare Advantage. So it is  
6 a reduction in benefits, but it is additional extra  
7 benefits that they have above what they are entitled to  
8 by law on the fee-for-service side.

9 Senator Hatch. I guess what I am getting to us  
10 under the competitive bidding model, how will Medicare  
11 Advantage beneficiaries living in rural states like Utah  
12 and Montana be impacted? Will the number of Medicare  
13 Advantage plans offered in those states be reduced once  
14 this legislation is enacted?

15 In addition, how will beneficiaries living in states  
16 with a high concentration of seniors participating in  
17 Medicare Advantage plans, Florida, California, Oregon,  
18 Washington, be affected by these reductions?

19 Ms. Bishop. Well, to be honest, CBO has provided,  
20 on a few occasions since we have been looking into this  
21 issue, they have provided some analysis. They provided  
22 the provided the letter to Senator Crapo and a letter to  
23 Senator Kyl over the last couple of months and I will  
24 just describe that, because I know that they are not at  
25 the table here.

1           There is distributional impacts of competitive  
2 bidding and they are going to differ by areas of the  
3 country that you just described. In areas like Montana  
4 and Utah and rural states, mainly rural states,  
5 competitive bidding is going to, to a large extent, keep  
6 the program and the number of plans relatively stable as  
7 they are today.

8           So there will be plans available in rural areas. In  
9 some of the rural states, there will be more dollars  
10 available for the extra benefits than there is today. So  
11 to a certain extent, competitive bidding has an  
12 advantage, if you will, in rural areas, because it makes  
13 the level of extra benefits consistent across the  
14 country.

15           Where there is going to be more of an effect from  
16 competitive bidding is going to be in the large urban  
17 areas where today the level of extra benefits are very  
18 high and those level of extra benefits are determined  
19 solely based on whether or not the plan can bid below an  
20 external benchmark.

21           So in other words, urban areas that have high levels  
22 of extra benefits today, in some areas of the country,  
23 beneficiaries receive \$250 per member per month in extra  
24 benefits through the Medicare Advantage program, and  
25 those are free dollars, if you will. Those are taxpayer-

1 funded dollars.

2 In other areas of the country, in rural states, the  
3 level of extra benefits is about \$25 or \$30 per month.  
4 So there is a wide variation. So what we are going to do  
5 is we are going to equalize the amount of extra benefits  
6 that are available to Medicare beneficiaries. So that  
7 means there are going to be distributional impacts of  
8 those changes.

9 Senator Hatch. Well, I do not know how you do that  
10 and take \$113 billion out. Also, competitive bidding has  
11 not worked in these rural areas.

12 Be that as it may, let me go to the next question,  
13 because --

14 Senator Schumer. Would my colleague yield? I just  
15 had a question along these lines, a serious question.

16 Senator Hatch. Sure.

17 Senator Schumer. Would it make sense -- you said  
18 they could cut the extra benefits or I suppose they could  
19 raise the premium, right?

20 Ms. Bishop. They could.

21 Senator Schumer. Which is probably the thing they  
22 are more likely to do. But would it be possible to --  
23 Senator Nelson has been leading the charge on the  
24 grandfather and we have not been able to fully do that in  
25 the bill, although we have made efforts.

1           What about limiting the premium increase to a  
2           certain percent and keeping the benefits so people are  
3           not clobbered? They are paying \$30 a month and it goes  
4           up to \$150. Have you considered that? It is along the  
5           lines of what you are talking about, Orrin.

6           Ms. Bishop. I think that is a very interesting  
7           idea, because the -- but I am wondering if the potential  
8           -- there are two answers to that.

9           One is when you increase the amount of dollars  
10          available for extra benefits, you obviate the need for  
11          plans to charge higher premiums. So in areas where there  
12          is going to be more consistent, higher levels of extra  
13          benefits available, there is not a need for them to raise  
14          their premiums.

15          In urban areas, where we are going to be lowering  
16          the amount of funds available for extra benefits, in  
17          high-cost urban areas, the plans are going to be  
18          compelled, if you will, to charge a premium for those  
19          extra benefits because they are no longer going to get  
20          paid for those extra benefits from the Medicare program.

21          So they are going to do two things. They are going  
22          to want to reduce the amount of extra benefits that are  
23          available or they are going to want to charge a premium  
24          for those things.

25          Now, that already happens today in a lot of areas of

1 the country. A lot of beneficiaries in Medicare  
2 Advantage pay premiums for extra benefits, but it does  
3 not happen in urban areas, because the level of subsidy,  
4 if you will, of the extra benefit is very, very high.

5 So once competitive bidding starts to shrink the  
6 pie, there will be pressure, if you will, on the plans to  
7 raise their premiums. In an area that could be eligible  
8 for a grandfather, what we have done is the grandfather  
9 freezes the amount that is available for extra benefits.  
10 It freezes it. It does not index it.

11 So that it kind of holds it constant over time.  
12 That is going to reduce and, in some instances, obviate  
13 the need for those plans, plans that get to grandfather  
14 those from charging a premium, because we are holding  
15 constant the amount of money that they are going to get  
16 paid for extra benefits.

17 Remember, plans only charge premiums for extra  
18 benefits. They do not charge premiums to provide the A/B  
19 benefit. The Medicare program pays 100 percent of that.  
20 So they are charging premiums for extra benefits. We are  
21 going to hold that constant and there is no need for them  
22 to charge a premium.

23 So in a sense, even though we are grandfathering the  
24 extra benefits, it is like grandfathering premiums. It  
25 has that secondary effect of grandfathering premiums.

1           Senator Schumer.    But there are large areas in many  
2 of our states that are not included in the grandfather  
3 here, that are 90 percent or 95 and not at 85.  Some of  
4 them are urban areas.  So that is why I am saying a limit  
5 on how much the premium could go up.

6           Ms. Bishop.    Right.  And you could accomplish that  
7 -- there was not an amendment to do that and that was not  
8 included in the Chairman's mark.  One way to accomplish  
9 that would be to require the Secretary of HHS, when they  
10 are reviewing the bids, to deny a bid of a plan that  
11 raises their premiums by some amount.

12          The Chairman.   Well, look at that.

13          Ms. Bishop.    All right.

14          The Chairman.   Just an idea, just look at it.

15          Senator Kerry.   Mr. Chairman, could I ask a  
16 question?

17          The Chairman.   Sure.

18          Senator Kerry.   Could you tell me, for the \$118  
19 billion, how many people are we talking about, number  
20 one?

21                 Number two, is there any analysis about the  
22 difference in the quality of care between those higher  
23 benefits and what you are going to reduce them to?

24          Ms. Bishop.    Can I just pull out a table from CBO?  
25 You can see that.  This is a letter that was written to

1 Senator Kyl on May 8, 2009. Then we actually have a more  
2 recent table. I wanted to read from that.

3 The Chairman. Another question. She can be  
4 looking at that if that might help, Senator, but give her  
5 time to look it up, if you have another question.

6 Senator Kerry. No. I just wanted to pursue that.  
7 That is fine.

8 The Chairman. She has it.

9 Senator Hatch. Have you noticed, just on this  
10 itty-bitty question here, that my colleagues had  
11 questions? You can imagine, if I could ask all my  
12 questions, how much it would, I think, really help all of  
13 us.

14 Now, you are a good person and I know that, but you  
15 have to --

16 The Chairman. We missed you in our group of six.

17 Senator Hatch. There are so many of these kinds of  
18 questions. You have got to admit that there are issues  
19 with competitive bidding in rural states. I think you  
20 would admit that. It is not as simple as it sounds.

21 Ms. Bishop. We thought about this a lot and my  
22 honest view, my honest -- as a policy analyst, my view is  
23 that competitive bidding would be good for rural areas.

24 That is my honest view, because they are going to  
25 get paid their bids and they are going to have more funds

1 available to provide extra benefits.

2 Senator Hatch. It has not been good in the past, I  
3 will tell you, where they have tried it. Let me just ask  
4 one more question. I do want to cooperate with my  
5 colleagues, even though I feel like we ought to be able  
6 to submit questions to somebody in the White House to  
7 answer that we do not have time to ask here, because  
8 these are important.

9 I have got a raft of important questions that would  
10 help us to understand this bill a lot more and maybe help  
11 us not to make a lot of mistakes that are going to cost  
12 the American taxpayers dearly.

13 But let me just ask this question, because it is one  
14 that concerns a lot of people in this country. I do not  
15 know who will answer this, but I will just throw it out  
16 there.

17 How does this mark ensure that federal taxpayer  
18 dollars would not be used to pay for abortions? Will  
19 health care plans offered through the co-op be able to  
20 include abortion services as a benefit? That is a  
21 question some people have.

22 How does the mark treat medical providers who do not  
23 want to offer abortions? Are they going to be treated  
24 fairly or are they going to be pushed into positions that  
25 they really cannot ethically do?

1 Under the Baucus language, it says -- and I do not  
2 mean to blame you for this language, except I do not know  
3 how to call it other than the Baucus language. It says,  
4 quote, "Abortion cannot be a mandated benefit as part of  
5 a minimum benefits package, except in those cases for  
6 which federal funds appropriated for the Department of  
7 Health and Human Services are permitted," unquote.

8 Now, as we all know, currently, the federal  
9 appropriations rider, known as the Hyde amendment, which  
10 must be renewed annually, allows only three types of  
11 abortion -- rape, incest and to save the life of the  
12 mother.

13 Mr. Chairman, if the fiscal year 2011 appropriations  
14 bill, for example, did not include the Hyde amendment and  
15 allowed federal funding for abortion on demand, is it not  
16 true that your bill would then also allow and, in fact,  
17 could mandate health care plans to cover abortion on  
18 demand?

19 The Chairman. All right.

20 Senator Hatch. I would like to know the answer to  
21 that.

22 The Chairman. I will have Ms. Henry-Spires answer  
23 that question. Before I do, though, just to remind all  
24 of us, it is my intent and I think the intent of most of  
25 us in this committee that this be a health care reform

1 bill and not be an abortion bill.

2 Senator Hatch. Fine, but that is --

3 The Chairman. If I may continue. That the goal  
4 here is for this committee to be neutral on that subject  
5 and to respect the status quo and, also, not allow  
6 federal funds for abortions.

7 Let me ask Ms. Henry-Spires to give a little more  
8 sophisticated answer.

9 Senator Hatch. Well, if I could just ask the last  
10 part of my question here before you do. Under the  
11 Chairman's mark, as I view it, the Secretary of HHS must  
12 ensure that each state exchange has, quote, "at least one  
13 plan that provides coverage of abortions beyond those for  
14 which federal funds appropriated for the Department of  
15 Health and Human Services are permitted," unquote.

16 If that state has no or few abortion providers, it  
17 would seem the coverage of abortion would be meaningless.  
18 Right? So how would this provision work for a state that  
19 has no or a small number of abortion providers?

20 How will the Secretary ensure that there are plans  
21 to cover abortion in those that do not?

22 The Chairman. Ms. Henry-Spires, could you answer  
23 that question, Deirdre?

24 Ms. Henry-Spires. Sure. To your first question,  
25 Senator Hatch, the language that you refer to was

1 stricken in the Chairman's modification. So the language  
2 that says -- and I can pull it up for you. On page 26 of  
3 the modification, it strikes the reference to the Hyde  
4 exceptions, meaning then that the Chairman's mark ensures  
5 that no federal funds -- there is no mandate for  
6 abortions by private insurance companies. It means there  
7 are no mandates for abortions by private insurance  
8 companies.

9 Senator Hatch. Can they do abortions?

10 Ms. Henry-Spires. Excuse me?

11 Senator Hatch. Can they do abortions beyond those  
12 three exceptions?

13 Ms. Henry-Spires. They are allowed to do them now  
14 under current law. Any private plan can offer abortion.  
15 Many do. Some do not. But the Chairman's mark in no way  
16 tries to make law that exceeds what is allowable under  
17 current law now.

18 To your second question, one that does not, the  
19 provision that says one plan must cover abortion and one  
20 plan must not, it is left to the Secretary to ensure that  
21 within an exchange, a state exchange, that there is a  
22 plan that does one of each.

23 However, there are some states that do not allow for  
24 the coverage of abortion in their private plans. In  
25 those states, the provision that no state law is

1 preempted would trump that.

2 So your question is -- so it leaves current law  
3 stable in states and for the federal government. Your  
4 question to how would the Secretary ensure this, the  
5 Secretary could use the free market to ensure, then  
6 FEHBP.

7 For the two years that abortions were permitted  
8 under FEHBP, about half the plans, 178 of them, offered  
9 abortion and the rest of them did not. So it seems that  
10 the free market manages to sort this out for itself.

11 However, the Secretary would also have at her  
12 disposal regional exchanges. So that you would not  
13 overstep the laws in any given state, but state are  
14 allowed to band together across territories to offer  
15 coverages that are necessary. But she is not allowed to  
16 require abortion coverage.

17 Senator Hatch. I guess the final thing I would  
18 like to ask about this, in addition to the ethical  
19 question that I raised, as well, whether health care  
20 people are going to have to participate in abortions.

21 May federal dollars be used to pay for abortions  
22 under this mark?

23 Ms. Henry-Spires. No, not beyond the Hyde  
24 exceptions, which you yourself brought up. So it makes  
25 no change to federal law.

1           Senator Hatch.    What about the ethical question,  
2    though?

3           Ms. Henry-Spires.    The ethical question, all  
4    conscience protections are left in place.    Some of them  
5    are actually even extended.    So Weldon, for example, is  
6    extended to include private insurers.

7           Before folks had providers and plans had -- well,  
8    providers, not plans, had protection, federal and state  
9    and local governments had protection, conscience  
10   protection, they could be willing to provide a service or  
11   not willing to provide a service.

12          This expands that to include private insurers who  
13   would be willing to provide a service or not willing to  
14   provide a service.    So current law is expanded in that  
15   way.    There are increased protections.

16          Senator Hatch.    Thank you.

17          The Chairman.    Now, is any Senator ready to offer  
18   his or her amendment?

19          Senator Kyl.    Mr. Chairman, might I just ask one  
20   follow-up question to the staff.

21          The Chairman.    Sure.

22          Senator Kyl.    I am sorry, I do not know your name.

23          Ms. Henry-Spires.    Henry-Spires.

24          Senator Kyl.    Could you later, you do not have to  
25   do it right now, point to the language in the -- I know

1 it is conceptual language, not legislative language, but  
2 point me to the language in the Chairman's mark that does  
3 ensure that no federal funds here can be used to purchase  
4 abortion coverage?

5 Ms. Henry-Spires. Gladly.

6 Senator Kyl. Thank you.

7 The Chairman. Senator Conrad?

8 Senator Conrad. Mr. Chairman, I call up my  
9 amendment D-3. This amendment would expand the list of  
10 criteria for care coordination models to be tested by the  
11 CMS Innovation Center to include the following: to  
12 facilitate inpatient care, including intensive care of  
13 hospitalized Medicare beneficiaries at their local  
14 hospitals through the use of electronic monitoring by  
15 specialists, including intensivists and critical care  
16 specialists based in integrated health systems.

17 Colleagues and Chairman, the evidence demonstrates  
18 that the application of best practices, including the use  
19 of intensivists, application of standardized protocols  
20 and 24/7 response capability reduces cost, saves lives,  
21 and improves outcomes.

22 Despite these advancements, 50 percent of ICUs in  
23 the country lack intensivist coverage and less than 26  
24 percent meet the leapfrog group standard in this area.  
25 The proposed system by Geisinger Health Systems, who came

1 before the committee, is to incorporate centralized  
2 monitoring of ICU beds from a command center with  
3 continuous real-time monitoring of the status of each  
4 patient, intelligence software, and real-time clinical  
5 alerts.

6 Adoption of this technology would allow one or two  
7 intensivists, two to three critical care nurses, and two  
8 to three clerical staff to monitor 50 to 100 ICU beds in  
9 a shift.

10 Implementation of this system in rural areas has  
11 resulted in significant reductions in ICU mortality,  
12 hospital mortality, ICU length of stay and hospital  
13 length of stay, as well as lowering costs in both larger  
14 and smaller community hospitals.

15 So I hope my colleagues would support this  
16 amendment. Again, it comes directly from the Geisinger  
17 experience that was shared by all members of the  
18 committee when the Geisinger representatives were here to  
19 testify before the committee.

20 It is basically to use telemedicine to link up  
21 intensive care units that do not have the most advanced  
22 specialists available 24/7 to monitor on a real-time  
23 basis the patients who are in those ICUs and the results  
24 of the application of this principle in hospitals and  
25 ICUs run by Geisinger was to reduce mortality, to reduce

1 length of stay, to save money, and to get better hospital  
2 outcomes.

3 I think it is left out of the CMS Innovation Center  
4 language perhaps inadvertently, but I think it would be  
5 unfortunate to not include it.

6 The Chairman. Well, Senator, I think it is a great  
7 idea. I, at least speaking for myself, have been very  
8 impressed with the Geisinger and other integrated systems  
9 in the country and, as I recall, a lot of people were  
10 part of the Geisinger system.

11 It is sub-rural, urban and some rural settings and  
12 some rural settings, as well. Frankly, I think this is  
13 the direction health care is headed in this country. It  
14 is more toward these kinds of integrated systems, which  
15 both cut costs and increase value, save time.

16 It is really astounding what they have done and it  
17 is basically because they are integrated and because  
18 their focus, therefore, is on the patient. It is care  
19 coordination and it is much more focused on the patient  
20 than some other delivery systems.

21 I understand this amendment has no cost and if there  
22 is not further debate on this, I see no reason why we  
23 just do not accept it.

24 Senator Rockefeller?

25 Senator Rockefeller. I support this amendment, but

1 I just need to -- I am going to worry a little bit about  
2 it and I am going to assume that it is going to be worked  
3 out well.

4 This is a very hands-on process when you are dealing  
5 with more than one individual and when you have tele-  
6 health, which I think is the future of all of this. The  
7 hands-on with multiple individuals in a state where only  
8 4 percent of the land is flat, are we at that point yet?  
9 I am not willing to bet that we are not. So I support  
10 the amendment.

11 The Chairman. Great. If there is no further  
12 objection, the amendment is adopted.

13 Senator Kerry. Mr. Chairman?

14 The Chairman. Senator Kerry?

15 Senator Kyl. Mr. Chairman?

16 The Chairman. Senator Kyl?

17 Senator Kyl. I am sorry. I wanted to discuss this  
18 amendment, if I could.

19 The Chairman. I am sorry. Without objection,  
20 adopted, and gives you a chance to --

21 Senator Kyl. I asked Senator Conrad for a little  
22 bit more of an explanation of what he was trying to get  
23 at here and I think what he was talking about has the  
24 potential to provide a new kind of service particularly  
25 in communities where you would have either a very small

1 hospital or perhaps it is a rural hospital and you would  
2 not have access to the kind of people who might be  
3 available in a bigger hospital setting.

4 The problem that I have, and I mentioned this to  
5 him, is that it amends a provision in your mark that I  
6 think has provisions that are not adequately restricted  
7 or, to put it another way, are too broad in the authority  
8 that is given to the Secretary.

9 Perhaps the best way to deal with that is to seek to  
10 amend the provision more broadly, which would have an  
11 impact on what Senator Conrad is seeking to do here, but  
12 it does not go directly to what he is trying to add to  
13 the provision in your mark.

14 The Chairman. I would suggest those are two  
15 separate concepts.

16 Senator Kyl. They are.

17 The Chairman. I would suggest that we adopt the  
18 Conrad amendment and then later on you can offer an  
19 amendment that addresses the breadth of the concept,  
20 which would necessarily -- yes.

21 Senator Kyl. What I gather we will need to do is  
22 to modify language of an amendment that we have already  
23 offered or do a second degree or something.

24 So I would not be precluded from doing that later. I  
25 could do a second degree to Senator Conrad.

1           The Chairman.   Well, let us not get tangled up like  
2 that.

3           Senator Kyl.    That is fine, as long as I can do  
4 that, then.

5           The Chairman.   Sure.

6           Senator Kyl.    Thank you very much, appreciate it.

7           Senator Conrad.   Mr. Chairman, might I just note --  
8 Senator Kyl asked me, because I constructed this, in my  
9 own mind, with respect to rural areas. I represent a  
10 rural area. It is really not limited to that, because  
11 the 50 percent of ICUs that do not have intensivists  
12 coverage are not exclusively in rural areas.

13           They disproportionately are, but the Geisinger folks  
14 told us that our hospitals in urban settings that do not  
15 have 24/7 intensivists coverage and by telemedicine you  
16 can extend that kind of specialist care via telemedicine  
17 to those who are providing the hands-on coverage in those  
18 intensive care settings.

19           So I really do think it is an idea that has merit,  
20 certainly, first and foremost, for rural areas, but not  
21 exclusively.

22           Senator Kyl.    Mr. Chairman, to be clear, it would  
23 not be my intention to try to make that distinction. I  
24 was simply inquiring of that. That is not the point of  
25 the problem that I raised.

1 I appreciate, Mr. Chairman, that we can get back to  
2 this at a different time.

3 The Chairman. So, Senator, I presume you do not  
4 object to adopting his amendment. Without objection, the  
5 amendment is adopted.

6 Are there further amendments?

7 Senator Kerry. Mr. Chairman?

8 Senator Kerry. Senator Kerry?

9 Senator Kerry. Thank you very much, Mr. Chairman.  
10 I was pleased to support that amendment. I think it is a  
11 good amendment by Senator Conrad.

12 Mr. Chairman, I would like to call up amendment 29,  
13 Kerry D-2. This is an amendment that is designed to ease  
14 the impact on homebound seniors of home health cuts that  
15 are proposed in the Chairman's mark.

16 Senator Stabenow has joined me in cosponsoring this  
17 amendment. I have some modifications to the amendment  
18 which are at the desk and I ask that those modifications  
19 might be distributed to the members.

20 As we all know, home health care is a key part of  
21 our health care delivery system for Medicare  
22 beneficiaries. It is cost-effective, it is high quality,  
23 and it fulfills one of the greatest desires of all  
24 patients, which is to be able to be treated at home.

25 Currently, over three million Medicare beneficiaries

1 receive home health services across the country. These  
2 are people with acute illnesses, injuries or numerous  
3 chronic conditions.

4 Mr. Chairman, I understand that your mark will  
5 reduce the Medicare payments to home health providers by  
6 about \$43 billion over 10 years. These cuts come, I want  
7 to emphasize, through some things that we all support.  
8 They are through re-basing payments to home health  
9 agencies, providing a cap on outlier payments and  
10 instituting productivity adjustments. We want those and  
11 I respect the provisions in the mark that are targeted to  
12 improve payment accuracy.

13 But I am concerned that the overall impact of these  
14 reductions would negatively impact access to home health  
15 care.

16 So my amendment would reduce those cuts to home  
17 health agencies by about \$5 billion from the \$43 billion  
18 to \$38 billion over a 10-year budget window and it  
19 achieves this reduction by ensuring that re-based  
20 payments to home health providers are reduced by no more  
21 than 3 percent in a given year versus the 3.5 percent  
22 that is set forward in the mark.

23 I believe this amendment will encourage the  
24 efficiencies that we want, while, at the same time,  
25 ensuring that Medicare beneficiaries have access to home

1 health care.

2 Home health agencies will still face significant  
3 rate cuts, far greater proportionately, incidentally,  
4 than any other provider group. But I think the amendment  
5 will help to preserve the ability of agencies to continue  
6 to serve a very vulnerable segment of the population.

7 I might add, Mr. Chairman, the President has  
8 promised that Medicare provider cuts will not impact  
9 Medicare beneficiaries' access to any Medicare services  
10 and I think if we did this adjustment, we would, in fact,  
11 help the President to keep that promise.

12 I know, Mr. Chairman, that you have worked very,  
13 very closely with the home health sector to target  
14 delivery payment reforms within the payment system. I  
15 just feel we need to do a little more to make sure that  
16 those who are homebound get the skilled nursing and the  
17 therapy services which are so critical.

18 So I would ask, Mr. Chairman, if we could even agree  
19 to work on this in the next days, I would certainly take  
20 a good faith effort to do that and not necessarily have  
21 to have a vote on this, if we could do that.

22 I do not know if Senator Stabenow wants to say  
23 anything.

24 Senator Stabenow. Mr. Chairman?

25 The Chairman. Senator Stabenow?

1           Senator Stabenow. Thank you. I appreciate Senator  
2 Kerry putting forward this amendment and am pleased to  
3 join him in it. We all recognize that home health care  
4 is critical both in being able to support people to have  
5 the kinds of care that they want in the community and at  
6 home and, also, in reducing costs as it relates to moving  
7 from institutional care to giving people the kind of care  
8 that they would like at home in the community and the  
9 difference in both quality and cost is measurable.

10           What Senator Kerry and I are doing is basically  
11 proposing to go back to the level that the President  
12 proposed when he was putting forward his recommendations  
13 on provider cutbacks, and I would hope that we would be  
14 able to remain at that level, because even at that level,  
15 I believe that is still going to cause some real  
16 challenges for home health care providers.

17           Certainly, I know in Michigan, there are more and  
18 more people relying on home health care providers. I  
19 think as we baby boomers are retiring, as people are  
20 living longer and are in a position where they can be at  
21 home rather than in a nursing home, it is going to become  
22 greater -- greater and greater demand will be on home  
23 health care services.

24           So I would hope, Mr. Chairman, that we could work  
25 with you and have this amendment adopted. Thank you.

1           Senator Nelson.    Senator Kerry, I support your  
2 amendment.

3           Senator Kyl.    Mr. Chairman?

4           The Chairman.    Senator Kyl?

5           Senator Kyl.    Thank you.   Mr. Chairman, I gather it  
6 was Senator Kerry's intention to not call for a vote  
7 right now, but to discuss this later.   But I have a  
8 question that pertains to this amendment and would also  
9 perhaps pertain to some others.

10           I gather that the reference to an offset by closing  
11 corporate tax loopholes is accompanied by something more  
12 specific than that and that there is some kind of score  
13 for this.

14           I am just wondering how we will deal with offsets as  
15 we proceed through this mark.

16           The Chairman.    That is a very good question.

17           Senator Kerry.   Mr. Chairman, first of all, it is a  
18 placeholder, but we have been informed that it scored at  
19 \$5 billion.

20           Senator Kyl.    \$5 billion.

21           Senator Kerry.   \$5 billion.

22           Senator Kyl.    And my question really is -- I  
23 gather, by placeholder, there is a specific provision in  
24 that.

25           Senator Kerry.   There is not a specific provision

1 yet. That is what we want to work with the Chairman on.

2 Senator Kyl. I see. So the idea will be that as  
3 amendments are offered, before we vote on them, there  
4 will be a specific offset that would be identified.

5 Senator Kerry. Absolutely. Of course, I am  
6 awaiting the Chairman's reply to my inquiry here with  
7 respect to what we can do in the next days, in which case  
8 I would not ask for a vote at this time.

9 Senator Kyl. Thank you.

10 Senator Kerry. And consider withdrawing the  
11 amendment.

12 The Chairman. There are really two issues here.  
13 The first issue is the one called for by this amendment;  
14 that is, should there be a reduction. The second issue  
15 is the one raised by Senator Kyl more generally, when  
16 offsets are recommended, that we know what the offsets  
17 are, not just this amendment, but future amendments.

18 Clearly, it makes sense to work with Senators who  
19 would like a reduction here. It is important to remind  
20 us, though, that MedPAC has made this recommendation,  
21 that is, the cut that is in the modified mark.

22 I might also add the home health industry has profit  
23 margins about 16 percent, but in this mark here, based on  
24 the MedPAC recommendations, would re-base home care  
25 provider payments to improve advocacy, to perform home

1 health outlier payments, and, also, to cover costs of  
2 treating higher cost patients.

3 But the main point is clearly we will work with the  
4 Senator on his amendment, because we have got to find the  
5 right balance here between the recommended cuts and what  
6 makes sense here.

7 Senator Schumer. Mr. Chairman, in New York, and I  
8 am fully supportive of this, we are not even for-profit.  
9 It is visiting nurse service, Visiting Nurse Association  
10 that does all this, and they are really getting clobbered  
11 and they are not a for-profit.

12 The Chairman. We will work with you. The  
13 amendment is withdrawn.

14 Other amendments?

15 Senator Stabenow. Mr. Chairman?

16 The Chairman. Senator Stabenow? There was an order  
17 here and the order I have, which is probably dated -- you  
18 are right, Senator.

19 Senator Hatch, actually, if he wants to offer his  
20 amendments. He is not here at the moment. Senator  
21 Conrad, number three was -- you are right, Senator  
22 Nelson. You are next.

23 Senator Nelson. Thank you, Mr. Chairman. Mr.  
24 Chairman, this involves the fact that Medicare pays more  
25 for its prescription drugs than does Medicaid.

1           As a matter of fact, the law used to read that if  
2 you were a dual eligible, that you were eligible for  
3 Medicaid and you were also eligible for Medicare, you got  
4 your drugs at the cheaper price of Medicaid.

5           But that was reversed when we passed the Medicare  
6 Part D prescription drug benefit by saying, no, that the  
7 lower cost of drugs on Medicaid could not be transferred  
8 on behalf of that Medicaid eligible who was also getting  
9 Medicare. The result is that there are seven million low  
10 income seniors who are dual eligible for both Medicare  
11 and Medicaid who no longer receive drugs that were paid  
12 for by the Medicaid program at a lower negotiated rate.

13           Medicare now pays on the average of 30 percent more  
14 for its drugs than Medicaid. So low income seniors  
15 receive their drugs through Medicare now as a result of  
16 the prescription drug bill and, therefore, these higher  
17 prices have resulted in, in just two years, \$3.7 billion  
18 more for the pharmaceutical companies.

19           Now, I think we ought to revert back to what the law  
20 used to be, that we should not be charging the government  
21 the higher price drugs for dual eligibles, drugs that  
22 otherwise under Medicaid we would get at the lower price.

23           Today, seven million low income seniors receive  
24 their drugs, they are dual eligible, seven million, they  
25 receive their drugs through Medicare Part D. They are

1 just one-fourth of the Medicare drug beneficiaries, but  
2 they represent one-half of Medicare drug expenses.

3 So what this amendment does is requires  
4 pharmaceutical companies to pay rebates on prescriptions  
5 for low income seniors, the same rebates that they pay on  
6 Medicaid folks, they will pay those same rebates for the  
7 dual eligible Medicaid recipient who is getting their  
8 drugs under Medicare and it will lower drug costs over  
9 \$86 billion over 10 years.

10 Now, I asked earlier of Dr. Elmendorf. That price  
11 of \$86 billion was the price that they had estimated to  
12 Chairman Waxman in his House committee-passed bill, \$86  
13 billion. We do not have an exact figure, as Dr.  
14 Elmendorf said, but we know he said it is going to be  
15 tens of billions of dollars.

16 So let me suggest to you what you can do with \$86  
17 billion, new found money. First of all, you can  
18 completely close the donut hole with it and, over and  
19 above that, you can have another \$30 billion of surplus.  
20 \$86 billion of revenue, what can you do with it? You can  
21 totally close the donut hole on prescription drug  
22 benefits for seniors, all seniors, not just dual  
23 eligibles, all seniors on Medicare prescription drug Part  
24 D and you can have another \$30 billion left over.

25 Now, needless to say, this is going to be a hard

1       fought amendment. I do not come to this emotionally. I  
2       come to this to say that I really want to revert back to  
3       the law and what it was before.

4             And I will conclude with this, Mr. Chairman. I  
5       remind everybody, the law said before that if you were  
6       dual eligible, you are a low income senior, Medicaid, the  
7       Federal government, got your drugs cheaper. It said if  
8       you were dual eligible, Medicaid and also receiving  
9       Medicare, you got your drugs at that same low price,  
10      because of the discounts.

11            I want to revert back to what the law was before it  
12      was superseded by the prescription drug bill passed five  
13      years ago.

14            Senator Grassley. Well, then why do you not do it  
15      by just putting Medicare people or dual eligibles back  
16      into Medicaid then? Why do you not do it that way  
17      instead of this way?

18            Senator Nelson. Well, why should we when the law  
19      was that they were eligible to begin with? We expanded  
20      the benefit to them. We expanded that they could get  
21      their drugs under Medicare.

22            So why should they not be able, Medicaid eligible,  
23      to be able to get the lower priced drugs like they used  
24      to instead of having to pay higher prices for their drugs  
25      in Medicare Part D?

1           Senator Kerry.    Mr. Chairman?

2           The Chairman.    Senator Kerry?

3           Senator Kerry.    Mr. Chairman, this is really an  
4           excellent amendment.  I think it is a very important  
5           amendment and I would like to be added as a cosponsor to  
6           it.

7           I can remember when Part D was established and the  
8           donut hole was created and, ever since then, we have  
9           always been looking for a way to close it.  This is  
10          really a common sense, fair-minded way to restore a  
11          benefit that existed for our seniors.  In Medicaid, dual  
12          eligibles received a better price on drugs.  Restoring  
13          this rebate and closing the donut hole would deliver  
14          savings at a time when we are struggling.

15          For instance, I just offered an amendment to reduce  
16          home health cuts by \$5 billion.  Here is an offset.  We  
17          have a huge ability to do well by seniors, to do good for  
18          the overall reform effort and to be fair in the process  
19          and I think it makes all the sense in the world and I  
20          hope the colleagues will support it.

21          The Chairman.    Senator Rockefeller?

22          Senator Rockefeller.  Thank you, Mr. Chairman.  I  
23          am a cosponsor of this and it is, in a sense, like a  
24          dream come true to me.  I do not want to wax too  
25          emotional, because Senator Schumer may start sobbing.

1           But I have always had this incredible instinct that  
2 dual eligibles should not be treated as second class  
3 citizens. That is number one. I feel really  
4 passionately about that. I spoke up to President Bush  
5 very passionately about that.

6           The other thing is that every single meeting that I  
7 have had with seniors, this donut hole has always come up  
8 and I have always felt that I was inadequate in being  
9 able to respond to that question of why can you not do  
10 this, and then they would talk about the F-22 or  
11 something of this sort.

12           But the point is we can do it. So if you want to  
13 talk about improving services for senior citizens in  
14 America, this is the way to do it. I think they are  
15 going to be shocked and happy that you have taken a  
16 problem which they considered insoluble, which was this  
17 band, a period where they got no benefits and had to pay  
18 the premiums, nevertheless, which is patently unfair and  
19 along comes the Senator from Florida with this amendment,  
20 which I think solves this problem in a way which is fair.

21           Again, dual eligibles cannot be treated as second  
22 class citizens. It is not your fault if you are poor.  
23 At least in West Virginia, it is not.

24           I think it is an excellent amendment and it does  
25 something which I think is going to be astoundingly

1 popular and deservedly so for seniors.

2 The Chairman. Senator Stabenow?

3 Senator Stabenow. Thank you, Mr. Chairman. I  
4 would also ask my friend from Florida add me on as a  
5 cosponsor, as well. When the original Medicare bill  
6 passed, one of my biggest concerns was low income  
7 seniors.

8 We certainly do not want to take people who are low  
9 income seniors out of Medicare, but we know that when  
10 someone qualifies as a senior for Medicaid, they are  
11 probably in a nursing home, which has been the most  
12 challenging part of the prescription drug bill effort.

13 In talking to folks working with seniors in nursing  
14 homes, they will tell you that. One of the most  
15 challenging parts of not having a public option kick in  
16 in terms of competition under the prescription drug bill  
17 is that those who are poor seniors have not had the same  
18 kind of choice in competition as other areas.

19 They have gotten the worst situation, I believe. So  
20 I strongly support this. There are nearly three million  
21 Medicare Part D beneficiaries that are going to fall in  
22 this gap which we now call the donut hole this year and  
23 it will force them to spend over \$4,000 for medications.

24 Would it not be terrific if we could indicate to  
25 those folks that they will be covered and to be able to

1 do it in a way that would also make sure that our poor  
2 senior citizens, most of whom are in nursing homes, will  
3 have the opportunity to go back to a system that worked  
4 so much better for them?

5 I am very hopeful that we will join together and  
6 support this and have the opportunity then to have some  
7 resources to address other critical parts of the bill.

8 The Chairman. Senator Schumer?

9 Senator Schumer. I would also like to be added as  
10 a cosponsor. This amendment is one of the early  
11 amendments, but it is going to show the direction we are  
12 headed. There is almost no argument against this.

13 If you are below a certain age, you get the Medicaid  
14 reimbursement rate. Why, if you are older and poor, do  
15 you change it simply to put money in the pharmaceutical  
16 industry's pocket.

17 Now, we are asking everyone to make sacrifices here.

18 This is a huge amount of money. It closes the donut  
19 hole, something, as my colleague from West Virginia so  
20 beautifully put it, will really -- it does bring tears to  
21 one's eyes to just recall the speech.

22 But it will really help seniors who need it. It  
23 will create \$30 billion. We are scrounging for \$2  
24 billion here, \$4 billion here, \$3 billion here to do all  
25 the things we want to do, and, frankly, most people would

1 say the so-called deal that pharma cut with whomever was  
2 pretty lenient, more lenient than just about what any  
3 other industry did.

4 So we hear a lot of talk here, the government is  
5 doing this. This is not the government. This is the  
6 government saving money. Which side are you on? The  
7 senior citizen who needs help saving money in this bill  
8 on one side, pharma on the other. It is hard to imagine  
9 an argument against it that could be made publicly.

10 So I hope we unanimously pass this amendment and  
11 show where we are. This amendment, in a certain sense,  
12 is a metaphor for where this bill is headed.

13 Senator Grassley. Mr. Chairman?

14 The Chairman. Senator Grassley? Senator Carper,  
15 you wanted to speak.

16 Senator Carper. Let me yield to Senator Grassley  
17 and then I will go.

18 Senator Grassley. Well, what do you mean, Senator  
19 Schumer, whomever cut the deal? You know who cut the  
20 deal. Do not fool anybody. We all know what pharma did.  
21 They made a deal and that deal is going to stick.

22 Senator Schumer. Not if we vote against it.

23 Senator Grassley. Pardon?

24 Senator Schumer. Not if we overturn it here  
25 tonight. If we overturn it here tonight, if we all vote

1 here for this amendment.

2 Senator Grassley. If it is such a good principle,  
3 Senator Nelson, it seems to me that you would want to  
4 apply Medicaid to doctors and everybody else, health care  
5 professionals. Then where are you going to get?

6 You cannot get anybody to take care of Medicaid  
7 people now and if you want those low rates of Medicaid,  
8 apply it across the board. You will really save a lot of  
9 money, but you are not going to have any services either.  
10 So I think that it is a poor idea.

11 Senator Kerry. Would the Senator yield for a  
12 question? I would ask you, is there a distinction  
13 between a service and a product?

14 Senator Grassley. It is a principal that you can  
15 save money because it is Medicaid. I do not know what  
16 the principal is. It does not do any good to have the  
17 product and the service kind of go together, it seems to  
18 me.

19 Senator Nelson. Why were you doing it before?

20 Senator Grassley. You understand that before, 30  
21 percent of the senior citizens never had pharmaceuticals.  
22 Why do you think we passed the bill?

23 Senator Nelson. Well, the Medicaid folks certainly  
24 did and, I am telling you, we are not talking about a few  
25 people. We are talking about several million, eight

1 million low income seniors, Medicaid, also receive their  
2 drugs through Medicare because they are dual eligible,  
3 eight million.

4 Senator Kyl. Mr. Chairman, while we are just  
5 having a pause here, could I ask Senator Nelson a  
6 question? Maybe it was answered before. That is, what  
7 is the cost of this, what is the score in here?

8 Senator Nelson. It will produce \$86 billion.

9 Senator Kyl. \$86 billion.

10 Senator Nelson. That is correct. It is not a  
11 cost. It will produce \$86 billion of revenue.

12 Senator Kyl. Because if I could--and maybe I  
13 missed this. Because this is a proposal to impose a new  
14 tax?

15 Senator Nelson. This is a proposal that Medicare  
16 pays less for its drugs by getting the same discount on  
17 the Medicare drugs for only dual eligibles that it gets  
18 already in discount for Medicaid recipients.

19 Senator Kyl. Thank you. And the method by which  
20 that is done is? Is that spelled out in your amendment?

21 Senator Nelson. That is correct. And this used to  
22 be the law, Senator. This was the law before the passage  
23 of the Medicare prescription drug benefit. Dual  
24 eligibles, Medicare and Medicaid dual-eligible  
25 recipients, they got the discount that Medicaid

1 recipients got on their drugs--

2 Senator Schumer. Would the Senator yield for a  
3 second? Just in reference to what Senator Kyl is getting  
4 at here, and Senator Grassley, Medicaid recipients now  
5 who are not 65 get these drugs. They just get them at a  
6 lower price. It does not really hurt the availability.  
7 It relates to what Senator Kerry was saying, difference  
8 between a service and a good, and a product.

9 And, furthermore, I do not believe there is any  
10 evidence that before we change the law that senior  
11 citizens suffered in any way when they got the Medicaid  
12 rate.

13 So this is just a win-win-win. I did not understand  
14 why we did this in the Part D bill other than to--you  
15 know, maybe there were some compromises that had to be  
16 made to win PhRMA over or something. But they did pretty  
17 well in the Part D bill, and it was sort of piling on in  
18 a certain sense.

19 If you believe--whatever side you are on, you are  
20 conservative, you want to save the Government money, you  
21 should be for this; if you are a liberal, you want to  
22 fill the doughnut hole or everyone wants--I do not know  
23 if that is liberal or conservative; we all want to fill  
24 the doughnut hole--you should be for this. If you want  
25 to reduce the deficit, you should be for this, because

1 even after you fill the doughnut hole, you have got \$36  
2 billion extra. And it does not reduce services to the  
3 recipient in any way.

4 The Chairman. Okay. Senator Kyl is--

5 Senator Snowe. Mr. Chairman, I just would like to  
6 ask a question of the sponsor, Senator Nelson. Does this  
7 take into account the 50-percent reduction in the  
8 doughnut hole on brand-name drugs as a result of the  
9 agreement with the pharmaceuticals?

10 Senator Nelson. No, ma'am.

11 Senator Snowe. It does not. So this is in  
12 addition to that.

13 The Chairman. That is my understanding.

14 Senator Kyl?

15 Senator Kyl. Mr. Chairman, just a question maybe  
16 to staff, maybe to Joint Tax. I am not sure. Maybe CBO  
17 would be the one. Is there an understanding of whether  
18 or not the cost--I presume this is paid for by a cost  
19 shift to private insurance, and I am just wondering if  
20 there is any analysis of that by staff. Money has to  
21 come from somewhere. It does not come out of--

22 Senator Grassley. It is going to raise prices for  
23 people--

24 Senator Kerry. It comes from the drug industry.

25 Senator Grassley. It is going to raise prices for

1 people with private insurance.

2 Senator Kyl. Yes. Thank you.

3 Senator Grassley. It is going to raise prices on  
4 early retirees. It is going to raise prices on children.  
5 It is going to mean higher prices for people that are  
6 fighting cancer.

7 Senator Kyl. The money has to come from somewhere.

8 Senator Grassley. Absolutely. There is no free  
9 lunch. But these people talk like there is a free lunch.

10 Senator Kyl. So presumably the private sector  
11 would have to charge that to the private sector patients  
12 that already have insurance.

13 Senator Grassley. Of course. We discussed this 3  
14 years ago with a Yale professor named Dr. Morton, and she  
15 told us--this is her quote: "Tying the price of a large  
16 government customer to a reference price is poor policy  
17 because the effect on government sales is so large, the  
18 firm prefers to distort its choices for the rest of the  
19 market."

20 Senator Kyl. Meaning cost shifting.

21 Senator Grassley. Yes.

22 The Chairman. Wait, slow down here. Senator  
23 Carper sought recognition some time ago.

24 Senator Carper. Thanks very much. A question, if  
25 I could, for staff. Let me kind of go back in time. I

1 am trying to recall the Medicare Part D debate. My  
2 recollection when we were debating Part D, the  
3 prescription drug program under Medicare, is we said that  
4 for folks who signed up for the Medicare Part D program,  
5 the first \$2,000 of prescriptions that they bought in a  
6 particular year, they roughly paid for maybe a quarter of  
7 the cost of that, and Medicare bore the cost for the  
8 other 75 percent. I think that is correct. But once  
9 their purchases exceeded roughly \$2,000, most seniors had  
10 to bear up until maybe \$5,000 in annual purchases,  
11 between \$2,000 and \$5,000, seniors for the most part bore  
12 all of those costs.

13 And then when a person's purchases, a senior  
14 citizen's purchases exceeded \$5,000, my recollection is  
15 that Medicare picked up maybe 90 percent of the cost,  
16 something like that. And except if the person was low  
17 income, and if the senior participating in the Part D  
18 program is low income, I do not think they had to bear  
19 the first 25 percent of the cost. I think they got a  
20 pretty good deal, in the first 25 percent up to \$2,000.

21 As I recall, the low-income Medicare Part D  
22 participants did not fall into the doughnut hole. They  
23 basically got a pretty good deal right through the  
24 doughnut hole up to \$5,000, and at \$5,000 Medicare picks  
25 up 90 percent of the cost.

1           Let me just ask staff, do I have that right?

2           Senator Grassley.    95 percent.

3           Senator Carper.    Is it 95 percent?  Basically is  
4   that the right--

5           Ms. Bishop.    Yes, that is correct.  We have folks  
6   here from CMS, too, if you want to be more precise, but  
7   that is basically right.  And those levels have changed  
8   over time because they have been indexed.  But basically  
9   that is right.  There is the low-income subsidy folks.  
10   The folks who are dual eligible, who are eligible for  
11   Medicare and Medicaid, have larger subsidies than folks  
12   who are not on those programs, so they do not pay the  
13   full price in the doughnut hole.

14          Senator Carper.    Okay.  When I have described this  
15   program to folks back in Delaware, over the last 4 or 5  
16   years, I have said if you happen to not use somewhere  
17   between \$2,000 and \$5,000 worth of medicines a year, if  
18   you are below \$2,000 or over \$5,000, it is actually a  
19   pretty good deal, the Medicare Part D program.  If you  
20   happen to be fairly low income, it happens to be a pretty  
21   good deal as well.  If you are not low income and you do  
22   not use more than \$5,000, but use somewhere between the  
23   \$2,000 and \$5,000, it is maybe not such a great deal, but  
24   it could be okay for you.

25          So I just want to set that premise.  The program is

1 set up to actually treat low-income seniors very  
2 favorably. I just kind of want to put that on the  
3 record.

4 The second point I would like to make in this regard  
5 is I was not involved in negotiations with PhRMA, but I  
6 believe that the administration was, obviously PhRMA was,  
7 and I presume this Committee was involved in some way in  
8 those negotiations. And what PhRMA agreed to do through  
9 those negotiations is to pay about \$80 billion over 10  
10 years to help fill up half the doughnut hole. That is my  
11 understanding. And they are prepared to go forward and  
12 to honor that commitment.

13 As I understand it, the amendment from our colleague  
14 Senator Nelson would basically double what was negotiated  
15 with PhRMA, and whether you like PhRMA or not--we talked  
16 earlier today in our opening statements, I talked about  
17 four core values and one of those is the Golden Rule:  
18 Treat other people the way I want to be treated. I tell  
19 you, if somebody negotiated a deal with me and I agreed  
20 to put up, let us say, \$80 or \$80 million or \$80 billion,  
21 and then you came back and said to me a couple of weeks  
22 later, Oh, no, no, I know you agreed to do \$80 billion,  
23 and I know you are willing to help support through an  
24 advertising campaign this particular--not even this  
25 particular bill, just the idea of generic health care

1 reform, no, we are going to double what you agreed in  
2 those negotiations to do, that is not the way--that is  
3 not what I consider treating people the way I would want  
4 to be treated. That just does not seem right to me. And  
5 whether you like PhRMA or not, we have a deal. I think  
6 they are willing to abide by the deal. They are willing  
7 to put up their money. They are willing to put up their  
8 money to help encourage people in this country to support  
9 health care reform. And now we are going to say we want  
10 to double the amount you committed to contribute? That  
11 just does not seem fair.

12 Senator Stabenow. Mr. Chairman?

13 The Chairman. Senator Stabenow.

14 Senator Stabenow. Thank you, Mr. Chairman.

15 There are a lot of ways why I hope this bill will be  
16 fair when we get done, and I am not going to debate the  
17 larger Medicare prescription drug bill right now, which  
18 we could. But I think the way I would look at this  
19 really is that if this saves \$86 billion, then that means  
20 that prior to the Medicare prescription drug bill  
21 passing, the poorest seniors in the country over a 10-  
22 year period were paying \$86 billion less. That is what  
23 that means. They already had good coverage, with all due  
24 respect; they were the ones who were already being  
25 covered under Medicaid. They went into a different

1 system that has increased those costs \$86 billion.

2 They were not the ones originally that we were  
3 focusing on in terms of needing help with prescription  
4 drugs. They already had help through Medicaid.

5 So my concern is I guess I would view this as  
6 returning to where we were before with the poorest  
7 seniors in the country who were paying \$86 billion less  
8 before this bill passed over a 10-year period. I do not  
9 see any rationale for continuing to charge them \$86  
10 billion more when we can take those dollars and put them  
11 into other areas of increasing services for people.

12 I would really, I would strongly support the Nelson  
13 and others' amendment in which I am very pleased to join,  
14 and hopefully we will be able to use those resources in a  
15 way that will actually expand more coverage for people.

16 The Chairman. Senator Schumer?

17 Senator Schumer. Yes, just two quick points. To  
18 Tom, if you think the original deal was fair, yes, you  
19 should not break it. But it is not unfair--I was not at  
20 the table. None of us were at the table. And if you  
21 think the deal was too fair to PhRMA and not fair enough  
22 to citizens, there is nothing unfair about breaking it.  
23 That is a value judgment.

24 And the only other thing I would say, Mr. Chairman,  
25 this is going to be a constant debate when we come to

1 this bill, and it is a difficult--I do not disagree. It  
2 is a difficult balance. But how often do we side with  
3 one of the interest groups? And some of those interest  
4 groups could be interest groups Democrats like; some of  
5 them could be interest groups Republicans like. And how  
6 often do we side with the average citizen? And the  
7 further away we get from siding with the average citizen,  
8 the less good this bill is going to be for the people.

9 Senator Grassley. If this is a bad deal, you ought  
10 to be embarrassed for your President for sitting down  
11 with these folks. It did not come from anybody on this  
12 side making that sort of a deal?

13 Senator Kerry. Mr. Chairman?

14 The Chairman. Senator Kerry.

15 Senator Kerry. I do not know if the President  
16 personally sat down with them or if the White House staff  
17 did.

18 Senator Grassley. Well, the President had the new  
19 conference with them.

20 Senator Kerry. I understand, but the Congress is  
21 the Congress, and we do not have to abide by every single  
22 decision that has been made. And the people who head up  
23 PhRMA understand that, particularly their chief lobbyist  
24 used to be a Chairman up here. He understands that.

25 Congress has the right and the ability to make a

1 different decision. I listened to the explanation a few  
2 minutes ago about the subsidy process, and Senator Nelson  
3 talked about how they get a fairly good deal. You know  
4 who pays for that deal? The taxpayers. The taxpayers  
5 are paying for that. The taxpayers are covering the  
6 difference because PhRMA will not.

7 Now, hospitals are taking a \$155 billion cut here.  
8 A \$155 billion out of the hospitals, and we are quibbling  
9 about \$80 billion out of PhRMA? Please. PhRMA sets the  
10 price. PhRMA says we are going to give you a 50-percent  
11 deduction. Well, they set the price. They could raise  
12 the price and give you a 50-percent deduction and still  
13 walk off with enormous sums of money.

14 Look at all those advertisements on television  
15 today. It is stunning, which is another mistake that was  
16 made a number of years ago.

17 Doctors will tell you that advertisements are  
18 driving the cost of health care because people come in  
19 and say, "I saw this on TV. You have got to give me  
20 this." And they are all afraid to say no.

21 So PhRMA is driving a lot of these costs in a lot of  
22 ways that are not even fully measured here. And I think  
23 it is entirely appropriate for us to question going back  
24 to a law that was more fair. These are dual-eligible  
25 people who once upon a time had the benefit of this lower

1 cost. It was taken away from them and entirely went into  
2 the pockets of PhRMA. It did not come to the Government.

3 It did not pay for some additional care. It did not pay  
4 for another benefit. It went to PhRMA.

5 The President, incidentally, sent a message to the  
6 Congress recently saying he wants to close the doughnut  
7 hole. Well, here we have an opportunity to close the  
8 doughnut hole, provide a lower price, and I think wind up  
9 with a much more fair allocation of the pain that has got  
10 to be shared in this effort to try to reduce the costs.

11 So, you know, Mr. Chairman, we are not talking about  
12 private insurance, as Senator Grassley said. Children  
13 would not be adversely affected by this policy. Children  
14 do not manufacture the drugs, and private insurance  
15 companies do not manufacture the drugs. PhRMA  
16 manufactures them, and PhRMA sells them, and PhRMA sets  
17 the price. And if they decide to pass it on, that is  
18 because we have not set up a structure that fairly  
19 protects people. And what this amendment by Senator  
20 Nelson seeks to do is protect people. And I think it is  
21 appropriate.

22 The Chairman. Senator Carper?

23 Senator Carper. Mr. Chairman, again, another  
24 question for staff. Help me on this if you will. The  
25 question is--and it is a reasonable question that Senator

1 Kerry suggests. What is a fair contribution by PhRMA, if  
2 you will, to this agreement? And the administration  
3 negotiated, I think with involvement by our Committee,  
4 \$80 billion over 10 years. And the hospitals have  
5 negotiated--what is it, \$150 billion? Is that it?--over  
6 the same period of time.

7 I do not recall exactly what--when you look at the  
8 total amount of money that we are spending for health  
9 care in this country, what percentage can be attributed  
10 to pharmaceuticals, for some reason I think that it is 10  
11 percent or so. Is it a little less than 10? Right  
12 around 10? People are nodding their heads, about 10  
13 percent.

14 Ms. Bishop. Of medical expenditures, not of total  
15 expenditures in the U.S. but of medical expenditures.

16 Senator Carper. So 10 percent. And if you look at  
17 hospital expenditures as a percentage, if you can give me  
18 apples to apples to apples, what would hospitals be? Is  
19 it 10 percent? Is it less than 10 percent? Is it more  
20 than 10 percent?

21 Mr. Clapsis. I would double check, but we think it  
22 is around 30 or 40 percent.

23 Senator Carper. It is 30 or 40 percent for  
24 hospitals? So we are saying--well, we will say it is 35  
25 percent then, 35 percent for hospitals, roughly 10

1 percent for pharmaceuticals. Pharmaceuticals are asked  
2 to give \$80 billion to make this deal work, and hospitals  
3 \$150 billion.

4 Now, when I look at 35 percent versus 10 percent,  
5 that is three and a half times more. And when I look at  
6 \$150 billion to \$80 billion, that is less than 2:1. The  
7 argument here, if we are going to try to do something  
8 that is comparable between what the hospitals are  
9 donating, are giving, and what PhRMA is, under that  
10 agreement either the hospitals should be doing close to--  
11 I think close to about \$250 billion, or maybe closer to  
12 \$300 billion, and PhRMA should be doing maybe less. That  
13 is the logical conclusion that one would get to.

14 Let me just ask the staff. Am I totally off base  
15 here? If you have got the hospitals--let me just finish.

16 If you have got the hospitals, they are 35 percent of  
17 the cost, and they only have to contribute \$150 billion,  
18 and PhRMA is about 10 percent and they have to contribute  
19 \$80 billion--

20 Senator Kerry. Would the Senator yield just for a  
21 moment? Isn't there a distinction, though, that a lot of  
22 teaching hospitals and children's hospitals are not-for-  
23 profit? That is a very different animal from a for-  
24 profit company.

25 Senator Nelson. If the Senator would yield--

1           Senator Kerry.    It is just a huge distinction.

2           Senator Nelson.    I will ask the staff in that  
3   answer that you provide to talk about profit margins,  
4   hospital profit margins and the pharmaceutical industry  
5   profit margins.

6           Mr. Clapsis.    Sure, Senator, certainly a lot of  
7   perspectives, I think, and ways to approach the issue.

8           In terms of hospitals, I think one of the  
9   sensitivities is around their margins, specifically  
10   Medicare margins.  MedPAC has found over the last few  
11   years that Medicare margins are typically negative, so  
12   obviously you approach, I think, hospital reimbursement  
13   with some trepidation.

14          On the flip side, hospitals are probably the  
15   industry that has the most to gain out of health care  
16   reform broadly, and just to give you the context,  
17   sometimes about 15 to 20 percent of hospital revenues go  
18   towards their uncompensated care costs.  This is a  
19   combination of bad debt, things they write off, the free  
20   care that hospitals actually give away.

21          So if you look out over the next 10 years and look  
22   at some of the AHA data, it suggests hospitals have  
23   possibly \$300 or \$400 billion in uncompensated care costs  
24   that they are going to see.  So, clearly, reform for a  
25   hospital is a very different equation than almost any

1 other industry sector because there is such a significant  
2 benefit from having that uncompensated care cost--so,  
3 again, not getting paid anything, and now actually  
4 getting revenue for those uninsured patients that they  
5 did not get before.

6 So that is why hospitals, I think, are a little bit  
7 different, negative Medicare margins, but the flip side,  
8 they have a significant benefit coming from reform, and I  
9 think those are just some of the factors you have to look  
10 at, I think, when you are looking at the hospital side.

11 Senator Schumer. What percentage of hospitals are  
12 nonprofit? And then what percentage of PhRMA is  
13 nonprofit?

14 [Laughter.]

15 Mr. Clapsis. A little more than half of hospitals  
16 are nonprofit.

17 Senator Grassley. And every hospital in the State  
18 of Iowa is a nonprofit.

19 Senator Schumer. And they are now in the red--  
20 overall, hospitals are in the red. They are losing  
21 money. Is that right? What is their profit margin?

22 Mr. Clapsis. I think MedPAC's data--and I think  
23 Mark Miller is still here--suggests their Medicare  
24 margins are negative, but not necessarily hospitals'  
25 overall margins.

1           Senator Schumer.    I think in my State 85 percent of  
2   the hospitals are in the red.

3           Mr. Miller.    The overall Medicare margin for  
4   hospitals is about negative 6.  The overall margin across  
5   all payers is about positive 4 or positive 5.

6           Senator Schumer.    And what is PhRMA?

7           Mr. Miller.    I have no idea.

8           Senator Schumer.    I think it is like 15 or 18.  I  
9   do not know.  I think it is about that.

10          The Chairman.    Senator Rockefeller?

11          Senator Rockefeller.  Mr. Chairman, this is a  
12   stunning argument that we are listening to here.  Let me  
13   say something which may seem a bit odd.

14                I remember when George Mitchell was Leader in the  
15   Senate, and we had the majority, and President Clinton  
16   had just been elected.  And President Clinton typically  
17   came to our caucus thinking that he kind of belonged  
18   there, you know.  And George Mitchell said, "Mr.  
19   President, we respect your office greatly.  There are  
20   times when the executive branch is fully in control.  
21   There are times when the legislative branch needs to do  
22   its policy discussions."  And we had this rather  
23   extraordinary sight of the President of the United States  
24   and the Secret Service being ushered out of the  
25   Democratic Caucus.

1           Now, why do I make that point? I make that point  
2 because you were talking about a deal. I am talking  
3 about a deal, too. You are talking about a deal that we  
4 made with pharmaceuticals--we, somebody, made with  
5 pharmaceuticals, primarily the executive. And I am  
6 talking about a deal that we failed to make, promised to  
7 make and then failed to make with the senior citizens of  
8 the United States of America on the doughnut hole. A  
9 painful deal in which 8 million of them, at least, have  
10 to cough up between \$2,700 and \$5,800, whatever that span  
11 is, over a period of months, they have to cough up  
12 enormous sums of money in premiums while they are  
13 receiving nothing in the way of coverage.

14           Now, that is a deal, too. That is a deal with real  
15 people. And you are talking about a deal--this is not a  
16 nonprofit thing for them. This is a huge loss for them,  
17 for the seniors, 8 million of them.

18           PhRMA is an association of companies that make a lot  
19 of money. They invest in clinical trials and with  
20 research institutes, and then they will pull out of them  
21 when they realize they are not going to bear fruit. That  
22 is part of the way they do deals. So there is nothing  
23 sacred about that deal.

24           There is something sacred about the deal that we  
25 thought we were going to make and did not make, did not

1 honor our original commitment to seniors on the doughnut  
2 hole.

3 Now, people feel good because we have done half of  
4 that. Well, that is fine, but there are still 8 million  
5 people out there having to pay premiums when they are  
6 getting no services, no benefits, nothing. Nothing.

7 I just think it is one of the most one-sided--you  
8 are worried about the deal with the pharmaceuticals.  
9 Well, I mean, there may come a day when I am, too, but it  
10 is not going to be when it is compared to 8 million  
11 seniors and the doughnut hole that has not been filled  
12 up, and they are doing something which ought to be  
13 illegal in this country: paying premiums when they are  
14 receiving no services, which is the opposite of  
15 everything that we do in this country.

16 So I think it is a very good amendment, and it keeps  
17 Medicare honest, and it does right by dual eligibles.  
18 And I do not know what this comparison between the deal  
19 with pharmaceuticals and the deal with 8 million  
20 Americans--it is just not a close argument.

21 Senator Nelson. Senator Rockefeller, it is a deal  
22 with 44 million Americans in Medicare Part D prescription  
23 drug benefit. That will fill the doughnut hole not just  
24 for the dual eligibles; it will be enough money to fill  
25 the doughnut hole for the entire Medicare prescription

1 drug benefit D.

2 Senator Rockefeller. So it is a much bigger deal.

3 Senator Nelson. Forty-four million.

4 Senator Grassley. What do you mean? Twelve  
5 percent of the 44 million. Twelve percent of the 44  
6 million.

7 Senator Nelson. No.

8 Senator Grassley. Twelve percent are in the  
9 doughnut hole.

10 Senator Nelson. I take it that you tend to  
11 disagree with my numbers.

12 [Laughter.]

13 Senator Grassley. There are 44 million people on  
14 Medicare. There is 12 percent that are in the doughnut  
15 hole. And none of the dual eligibles are in the doughnut  
16 hole, because they do not have a doughnut hole.

17 Senator Nelson. The government is paying more for  
18 their drugs. They are paying at rates that are offered  
19 higher under Medicare than what they used to have as dual  
20 eligibles where they were paying lower rates because of  
21 greater rebates under Medicaid.

22 Now, the facts are the facts. You can disagree,  
23 most agreeably, Senator, but the facts are the facts.  
24 This is reverting to what the law used to be before it  
25 was changed under the prescription drug bill that was

1 passed about 5 years ago.

2 The Chairman. Okay. I think we have had a good  
3 debate here. We will vote on this amendment tomorrow,  
4 and I am wondering--we have had a good debate here. We  
5 will vote on this tomorrow, and I am wondering if any  
6 other Senators have other amendments they wish to offer.  
7 Maybe they can offer and we can accept.

8 Senator Stabenow?

9 Senator Stabenow. Mr. Chairman, I like that  
10 possibility. Thank you, Mr. Chairman.

11 Mr. Chairman, to change the debate just a little  
12 bit, one of the very positive things in the bill is  
13 moving towards primary care, and--or let me say first I  
14 would call up amendment D-7 to Chairman's mark.

15 In the legislation, we are moving towards primary  
16 care to move people out of emergency rooms. We provide a  
17 10-percent bonus for primary care doctors, which is a  
18 very positive step forward in moving people from  
19 emergency rooms and encouraging more primary care doctors  
20 and more people having the opportunity to see their  
21 family doctor.

22 But before we get to that system, we are still  
23 confronted over the next few years, between now and 2014,  
24 with the fact that our emergency rooms are dramatically  
25 overcrowded, and we are having difficulty in finding on-

1 call specialists to serve in the emergency rooms right  
2 now.

3 And so this particular amendment, for the period  
4 until we get the exchange up and going and until we are  
5 fully focused on primary care, would give a 5-percent  
6 Medicare reimbursement bonus for emergency room  
7 physicians and on-call specialists that are performing  
8 services in an emergency room.

9 Mr. Chairman, I would reference a GAO report  
10 commissioned by yourself that was released in June. GAO  
11 found that patients in need of immediate care between 1  
12 minute or 14 minutes time frame response waited an  
13 average of 28 minutes and exceeded the recommended wait  
14 almost 75 percent of the time.

15 The report cited a lack of inpatient beds as the  
16 largest contributor to overcrowded emergency rooms and,  
17 of course, inadequate access to primary care was also a  
18 factor.

19 I am very pleased that in the HELP bill they  
20 included a version of another amendment that I will not  
21 offer today that would establish guidelines for critical  
22 issues such as boarding that are overcrowding our  
23 emergency rooms, and I am going to work very hard, Mr.  
24 Chairman, and I want to work with you when the two bills  
25 are merged to take this provision from the HELP Committee

1 and put it into the final bill.

2 One of the other issues identified by a report by  
3 the respected Institute of Medicine is that we have a  
4 lack of specialists right now that are willing to be on  
5 call in emergency rooms. Specifically, the IOM noted  
6 that one of the most troubling trends is the increasing  
7 difficulty of finding specialists to take emergency  
8 calls, providing emergency calls become unattractive in  
9 many specialties, including neurosurgery, orthopedics.  
10 Specialists have difficulty collecting payment for on-  
11 call services, in part because many emergency and trauma  
12 patients are uninsured. Nearly 80 percent of specialists  
13 in one survey had difficulty obtaining payment for those  
14 services.

15 And so, Mr. Chairman, my goal would be to just  
16 recognize between now and when we, in fact, have an  
17 exchange running and a focus on primary care, during this  
18 short window to allow some ability to provide relief to  
19 emergency rooms, emergency room physicians, and address  
20 what is currently a crisis, as we all know, in our  
21 emergency rooms, help them get through this period until  
22 health care reform takes effect.

23 The Chairman. Well, I appreciate that, Senator.  
24 You make some good points. Clearly, the goal here is to  
25 encourage people not to go to emergency rooms, but have

1 the insured see maybe an internist or primary care  
2 doctor, and there is such a shortage of primary care  
3 doctors.

4 On the other hand, there is generally a significant  
5 workforce shortage in this country, including specialists  
6 to provide emergency care. I think you have a good idea  
7 here. Let us see if we can work something out here. Let  
8 us see what we can do.

9 Senator Stabenow. Thank you, Mr. Chairman. I  
10 would just emphasize again, this is a stop-gap to get us  
11 to the point where hopefully the goals of the bill will  
12 be able to be realized in terms of increased primary  
13 care. But we have a serious crisis occurring in  
14 emergency rooms across the country right now.

15 The Chairman. Okay. I do not see any more  
16 Senators seeking recognition to offer amendments. This  
17 has been a good first day, a good, productive day for  
18 amendments, and I thank all staff and everyone else who  
19 has been here for working so diligently here today.

20 We will continue tomorrow, and the Committee will  
21 recess until 9:30 tomorrow morning.

22 [Whereupon, at 9:55 p.m., the Committee was  
23 adjourned, to reconvene Wednesday, September 22, 2009, at  
24 9:30 a.m.]

25

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