Services a Deputy Secretary, the No. 2 person in the agency who will be the chief health care fraud prevention officer of the United States.

They will be responsible for only one job—to make sure we ferret out health care fraud. No. 2, we will bring predictive modeling to health care administration in this government. What is predictive modeling? An easy way to understand it is, it is the same way your credit cards work. If you make a credit card purchase and your credit card company thinks it is a questionable transaction, the computer has a model, and you get a phone call or an e-mail. If you don't call and validate that transaction, the vendor doesn't get paid. It happened to me a week or two ago. I went to buy a television. I am from Florida. I get an e-mail on my BlackBerrry before I walk out the door, saying: Did you authorize this purchase? We don't do that in health care. Instead, we chase the bad guys later and try to get the money back. That would stop the money from ever being paid.

The third thing it would do is require background checks for health care providers. The American people would be surprised to learn we don't do this right now. We have people ripping off Medicare and Medicaid, $10, $20 million a shot. My State, specifically in southeast Florida, is the health care fraud capital of the world.

We need to do a better job of spending the money of the people now before we embark upon new programs to spend trillions more. Senator KYL mentioned the Wall Street Journal's editorial of today. It called this bill the worst bill ever—that is a heck of a name—because it implements a spending surge to the tune of more than $1 trillion. It has $572 billion in new taxes, and it threatens to bankrupt the States. Senator JOHANNS mentioned this as a former Governor. I was the chief of staff to a Governor. I know how difficult it is to make ends meet in a State system where you actually have to balance budgets, not like the Federal Government where you can just spend more money and print more money. The States actually have to balance budgets. In Florida, we spend more than 30 percent on health care. If you spend more money on health care, specifically Medicaid, guess what you spend less money on. Education and other good programs. With these increased Medicaid obligations, the States will be in more of a difficult place. They will have to either cut other programs or raise taxes.

The Wall Street Journal said we can't regulate our way out of the reality that we live in a world of finite resources and infinite wants.

We should focus on the programs we have before we embark upon new programs. The majority wants to focus on new programs and not on effectively and efficiently running programs we have.

I hope my colleagues from both sides of the aisle will join me in supporting S. 2128, the Prevent Health Care Fraud Act of 2009.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from California.

HISTORY OF THE MEDICAL INSURANCE INDUSTRY

Mrs. FEINSTEIN. Mr. President, since most people have some form of health insurance, I decided, after many calls from constituents who have said to me: I can't afford a 20-percent increase in my medical health insurance premium; I had a 10-percent one last year, I began to look into the history of the medical insurance industry in America. I have come to the floor to discuss the current state of the private, publicly owned, for-profit health insurance industry and the ways this system must be changed during health care reform. Bottom line: Our country is the biggest health care spender in the world. In return, we get very average results.

It wasn't always this way in America. I wish, for a moment, to briefly review the history of health insurance in our country. Because understanding its development and its transition to the for-profit, commercial health insurance model is actually critical to this debate.

The story began to take shape about 90 years ago. There were very few health insurance plans before the 1920s. As a matter of fact, there was not much in the way of medical services to insure. Options for medical care were primitive by today's standards. In 1900, the average American spent $5 each year on health care-related expenses. This amounts to roughly $100 in today's dollars. Health insurance was not necessary because the cost of care was low. Over 90 percent of medical expenses were paid out of pocket. Most patients were treated in their homes, and medical technology and treatment options were very limited. The earliest private health insurance plans in the United States were fairly basic agreements, primarily sponsored through employers or unions. Employers deducted funds from participating workers' salaries and contracted with local physicians for treatment.

During the 1920s, medical technology was advancing and the treatment of acute illnesses shifted from homes to hospitals. But on the heels of the Great Depression, an increasing number of Americans were unable to afford medical services, which were becoming more costly. In 1929, the Baylor University Hospital developed a plan to guarantee affordable treatment options for patients while ensuring a steady stream of revenue for the hospital. According to author Paul Starr, the Baylor plan provided up to 21 days of hospital care and certain services to 1,500 local teachers in Dallas, TX, for $6 a year or 50 cents a month, if we can believe it.

A hospital official promoting the plan at the time said:

> We spend a dollar or so at a time for cosmetics and do not notice the high cost. The ribbon-counter clerk can pay 50 cents, 75 cents or $1 a month, yet it would take about 20 years to set aside [enough money for] a large hospital bill.

The Baylor plan proved popular and was soon expanded. It served as the foundation for what would become Blue Cross, the first example of a major, nonprofit medical insurance provider. Throughout the 1930s, the number of Blue Cross plans grew and enrollments expanded. By 1937, 1 million subscribers were covered.

In response to the lack of coverage by Blue Cross for physician services, in 1939, the precursor to Blue Shield, called the California Physicians Service, was developed. This plan reimbursed physicians for the cost of services based on negotiated payment schedules. According to the Congressional Research Service, in 1945, nonprofit Blue Cross and Blue Shield plans had expanded to cover 19 million subscribers nationally in most States. These nonprofit Blue Cross and Blue Shield plans dominated the health insurance industry. At this same moment, Congress was reviewing the matter of insurance regulation, generally. In 1945, after significant lobbying by the industry, the McCarran-Ferguson Act was enacted. By passing this law, the Federal Government committed to a hands-off approach to insurance regulation, generally, including the regulation of for-profit, commercial health insurance companies.

This is where things began to change. The McCarran-Ferguson Act gave States, not the Federal Government, primary responsibility for overseeing the insurance business. It meant, as a practical matter, that whether insurance companies would be regulated forcefully or with little care would be left up to individual insurance commissioners in each of the 50 States. Additionally, the McCarran-Ferguson Act included a specific antitrust exemption for the business of medical insurance. As a result, practices such as price fixing, bid rigging, and market allocation, prohibited by Federal law in every other industry, were left up to the States and their enforcement mechanisms.

If insurance companies colluded to raise prices above competitive levels, Federal officials would not and could not investigate or intervene. All regulation was up to the States and, in fact, very little regulation has taken place.

During World War II, for-profit, employer-based health insurance plans expanded rapidly and took a firm hold in our country. Due to price and wage controls, employers competed for workers by offering health insurance benefits. In 1944, the unemployment rate was 2 percent. Additionally, unions were able to collectively bargain health insurance benefits and employer contributions for health insurance which were excluded from a worker's taxable income. By the 1950s, for-

profit commercial health insurers, such as Aetna and the Connecticut General Life Insurance Company, known now as CIGNA, became very active. Then things started to change. The market share of Blue Cross and Blue Shield was significantly reduced in many parts of the country. As of 1953, commercial insurers provided hospital insurance to 29 percent of Americans versus Blue Cross's 27 percent.

The widespread entry of commercial insurance into the health insurance market had a dramatic impact. First, the commercial health insurers did not operate under the same rate restrictions as Blue Cross. Second, Blue Cross premium rates were based on the average cost of medical services in a defined geographic area or community. Commercial insurers, on the other hand, calculated premiums based upon the claims of particular groups or individuals and adjusted these premiums each year depending on their health status. This also allowed commercial insurers to evaluate coverage on an individual rather than use the community rating system of Blue Cross. Therefore, commercial insurers were able to underbid Blue Cross for firms with very healthy workers who were cheaper to insure.

Right then and there, we begin to see the skewing of the system away from a community rate toward an individual assessment; whereby companies could cherry-pick only the healthiest and, therefore, make more money.

The loss of these healthier groups then raised average costs among the remaining employees, placing Blue Cross at a competitive disadvantage with commercial insurers. This competition from commercial insurers eventually resulted in Blue Cross changing the way its premiums were calculated. The single, community-wide premium pricing model was replaced in favor of the commercial approach. This shift toward charging premiums based on claims of particular groups or individuals changed the nature of competition in the health insurance market. Insurers could reduce costs by shifting risk and recruiting employers with healthier workers, and they did. Furthermore, because they could choose whom to insure, many large, for-profit commercial insurers left the individual market altogether in favor of large-scale employers because they carried lower operating costs.

Where does that leave us today? Today we have a health insurance industry where the first and foremost goal is to maximize profits for shareholders and CEOs, not to cover patients who have fallen ill or to compensate doctors and hospitals for their services. It is an industry that is increasingly concentrated and where Americans are paying more to receive less.

Here is the bottom line: According to the Kaiser Family Foundation, in the last 9 years, American families have seen their health insurance premiums more than double, while benefits have been getting worse and the industry has been growing less competitive.

A snapshot of the American health insurance industry today presents an alarming picture.

As of 2007, just two carriers—WellPoint and UnitedHealth Group—had gained control of 36 percent of the national market for commercial health insurance. Both these companies had more than doubled since 2000. Since 1998, there have been more than 400 mergers—that is in 11 years—400 mergers of health insurance companies, as larger carriers have purchased, absorbed, and enveloped smaller competitors.

In 2004 and 2005 alone, this industry had 28 mergers, valued at more than $53 billion. That is more merger activity in health insurance than in the 8 previous years combined.

Today, according to a study by the American Medical Association, more than 94 percent of American health insurance markets are highly concentrated under U.S. Department of Justice guidelines. This means these companies could raise premiums or reduce benefits with little fear that consumers will end their contracts and move to a more competitive carrier.

In 10 States—Alabama, Alaska, Arkansas, Hawaii, Iowa, Maine, Montana, Rhode Island, Vermont, and Wyoming, these 10 States—two health insurance companies control 80 percent or more of the State market. So 10 States, 2 health insurance companies control more than 80 percent of the statewide market.

In my State of California—nearly 40 million people—just two companies—WellPoint and Kaiser Permanente—control more than 58 percent of the market. The market presence of these two companies is up a combined 14 percent in 1 year. Let me repeat that. The market presence of two companies in California is up 14 percent in 1 year.

When you look at specific health markets, the situation is even worse. In 2007, the two largest health insurance companies in Bakersfield, CA, controlled 76 percent of the market there. In Salinas, the top two controlled 65 percent. In Los Angeles, the top two carriers controlled 51 percent of the market. This is a huge market. It is a 12-million-person market, and two companies control over half of that insurance market.

The American Medical Association described it this way:

> The United States is headed toward a system dominated by a few publicly traded companies that operate in the interest of shareholders and not primarily in the interest of patients.

I think that is a very sobering statement.

The effects of this market concentration are being felt by consumers and families. They are being felt by American businesses. They are being felt by doctors and health care providers.

Premiums are skyrocketing for employers and for individuals trying to buy health insurance. According to the Kaiser Family Foundation, since 1999, the average health insurance premium has more than doubled, rising 119 percent. That is an increase of four times the national wage growth over the same period and more than four times the rate of inflation. So it is ''open sesame.''

This is an amazing factor. Between 1999 and 2007, the average American worker saw his wages increase 29 percent. His insurance premiums rose more than 120 percent during that same period. This is how disproportionate it is, and it is wrong.

For some people, this means their employer is paying more and struggling more to stay in business. For some, it means they are personally paying more and struggling to make ends meet. For some, it means they have been forced to join the ever-growing group of 47 million Americans who simply cannot afford health insurance coverage today.

While premiums are going up, there is no evidence coverage is improving. We have heard countless stories from consumers about the way insurers are cutting costs and saving money by denying coverage to people with preexisting conditions, rescinding care when people fall ill and haggling administratively over coverage and benefits.

These stories come from health care providers too. When just a few companies control the market, physicians and hospitals have fewer places to turn when they believe they are not being reimbursed fairly. Just as American families and their employers have fewer choices for purchasing insurance, health care providers have less bargaining power over reimbursement rates. The net result is, consumers and health care providers are losing out, while health insurance companies and their shareholders are bringing in record profits.

According to Health Care for America Now, between 2000 and 2007, profits at the 10 largest publicly traded health insurance companies soared up 428 percent, from $2.4 billion in 2000 to $12.9 billion in 2007.

The CEOs of these companies took in record earnings. In 2007, these 10 CEOs made a combined $118.6 million. The CEO of CIGNA took home $25.8 million. The CEO of Aetna took home $23 million. The CEO of UnitedHealth took home $13.2 million. The CEO of WellPoint took home $9.1 million.

This history, and this failed market, is a uniquely American story. I recently read ''The Healing of America'' by T.R. Reid. He is a former Washington Post journalist who has a bum shoulder. So he decided he would go from country to country and go to doctors in that country, examine their health care sector, see what would help him, what they recommended, and it is a very interesting book. He writes about the health care systems of the countries he visits.

A few things are clear. First, as Reid says:

The United States is the only developed country that relies on profit-making health insurance companies to pay for essential and elective care.

So in every country that has health care reform—the United Kingdom, France, Switzerland, Germany, Canada—the United States is the only one that allows this open, ribald, for-profit health insurance industry that we do in this country.

Profit-seeking motives do influence insurance companies. Today, insurance companies have a financial reason to deny coverage to people who may actually get sick, so they exclude people with even the most minor preexisting conditions.

Secondly, if you get sick, insurance companies will comb through past records to find a reason to retroactively deny coverage. This means people lose their health coverage when they need it the most.

In other nations, with not-for-profit insurance, there is no motivation for companies to engage in these practices. Everyone is covered regardless of his or her health history. This allows risk to be effectively spread across the entire population.

Other countries accomplish this with employer responsibility and an individual requirement to become part of the insurance system.

A few examples: In Germany, most people enroll in sickness funds, with premiums split between workers and employers. Only the very wealthy can opt out to buy separate insurance.

In Switzerland, everyone must purchase basic, nonprofit insurance. Companies can only make a profit on the extra benefits they sell, such as for cosmetic surgery or a private room in a hospital, but not by providing basic coverage.

In France, everyone is enrolled in one of several large health insurance funds, which are closely regulated by the federal government.

In the United Kingdom, everyone is automatically covered by the National Health Service.

Americans like to criticize other nations' systems as bureaucratic. But in truth, it is our system that is wasteful and inefficient. Many other countries are able to deliver better health care for lower prices than we do currently. I wish to point this out.

As T.R. Reid points out, our system, with for-profit insurance and medical underwriting, has some of the highest administrative costs in the world because, in the United States, roughly 20 percent of every premium dollar is spent on administration. This includes advertising, profits, and paperwork—20 percent goes to this.

Let's compare this: Canada, on the other hand, spends about 6 percent. France spends about 5 percent. One of France's advantages comes from an electronic form, a personal health record. It is called the Carte Vitale. Here is a picture of it I have in the Chamber. I had actually asked some of my family, newly returned from living in France for a long time, if they would send me their actual Carte Vitale, which I have seen. Unfortunately, they have not arrived. But, as shown in this picture, this is what they look like.

As shown on this part of the picture, this is a small chip. In this chip is the entire medical history of a patient—every shot received, every diagnosis made, everything about the patient. So the patient goes in for a physician's visit, which costs about $27 in France today, and the doctor takes the Carte Vitale, puts it into his computer, and the entire background of the individual pops up.

Let's say he prescribes certain medication. That then goes into this small chip. Every French citizen over the age of 15 carries a Carte Vitale, which has taken the place of the walls of paper records we see at our physicians' offices in this country.

Also, this system allows French physicians to bill automatically for the care they provide without paperwork or bureaucracy. The Carte Vitale has helped the French achieve what many consider to be the world's best health care system.

As we have seen, other industrialized nations spend less on administrative costs. They have nonprofit insurance. They use employers and individual responsibility to provide basic health care to everyone. This structure does, by independent analysis, provide better results because, whatever the indicator, the United States lags behind the rest of the industrialized world.

This is painful, but I believe we have to look at it. According to the World Health Organization, France leads the world in overall system performance, followed by Italy. America is 37th. These are the top health care systems: France, Italy—and, as you can see, the rest. We are No. 37.

In avoidable mortality, which measures a system's effectiveness in caring for people who contract a potentially serious medical condition, again, France tops the list, again, followed by Japan. The United States is 15th.

The United States lags other developed nations in infant mortality. Here it is, as shown on this chart. This is according to the Commonwealth Fund. The leader is Japan, with 3 deaths per 1,000 births. We are No. 22 on that list.

This is surprising because you would think, particularly with infant mortality, we would be a real leader, but we are not.

To summarize, I think action is needed.

Other countries are far from perfect, and I am not saying anything other than that. But these lessons show that high-quality health care can be delivered for less than we currently spend. Our system of relying on for-profit medical insurance, I believe, is broken. We are spending more for worse results than the rest of the world. That is what I hope to show.

That is why it is essential that we take action, and take action now. I basically believe the medical insurance industry should be nonprofit, not profit-making. There is no way a health reform plan will work when it is implemented by an industry that seeks to return money to shareholders instead of using that money to provide health care. This is difficult to accomplish today, but there are a number of steps that can be taken in this direction.

The first is to repeal the antitrust exemption. I believe we must take strong action to stop illegal, anti-competitive activity in the industry. The Justice Department currently has authority to review certain health insurance mergers. But although almost 400 health insurance mergers took place during the past administration, the Department brought challenges to only two of those mergers. Even those that were challenged were later allowed to proceed with relatively minor adjustments.

When a dominant market player tries to subsume a smaller competitor, the Justice Department should review the acquisition carefully to ensure that consumers, employers, and health care providers still have bargaining power. We should also repeal the antitrust exemption for health insurance companies. This exception is a relic of the past, and it has no current justification.

The Justice Department should be able to investigate and sue health insurance companies when they engage in price fixing, bid rigging, or market allocation. These kinds of collusive activities are not fair play. They are not allowed in other industries, and they should not be allowed in this one.

I also believe a public option is an essential piece of any effort. It will provide robust, nonprofit competition for an industry that is broken and profit-ridden. In concentrated markets, the public option will provide consumers with real choice. Remember, the largest market in America is the Los Angeles market, and a majority of that market is controlled by two health insurance companies.

Because it will not attempt to make a profit, the public option will not turn anyone away. It may be able to charge lower premiums because its goal will be to provide health care coverage, not to return profits to shareholders. Whether it is opt-in or opt-out, States that strongly object to providing nonprofit competition to residents should have the opportunity not to participate. But make no mistake; the public option alone will not solve our Nation's problem with health care. It will be available to a relatively few Americans at first. Only those who will purchase insurance in newly created exchanges will have the opportunity to buy it. But I believe it is a building block as we work to construct a new system.

In addition to creating a public option, we must put health insurance companies on a path toward more responsible behavior. That is why I am

proposing a Federal medical insurance rate authority.

My proposal for a medical insurance rate authority builds on the successful and well-accepted model of utility commissions. Throughout this country, providers of gas, water, and electricity need to justify any proposed rate increase. This is required because the services they provide—water, gas, and power—are considered necessities for life.

Well, are they more a necessity for life than health insurance? I don't think so. Health insurance should be no different. Access to affordable medical care is certainly a necessity of life.

Under my proposal, the Federal Government would be required to establish a medical insurance rate authority which would oversee premiums charged by the for-profit medical insurance industry. Premium increases above a certain threshold would need to be approved. The medical insurance rate authority would conduct basic oversight insuring that premium funds are spent on medical care and not for profit or overhead.

These safeguards will ensure that the health insurance industry does not continue their pattern of astronomic premium increases. It is fair for the price of insurance to reflect the actual price of medical care, but it is not fair for insurance companies to increase their profits while Americans pay higher and higher premiums.

It has taken many decades for our health system to evolve and break down as it has, and we cannot expect to fix it overnight. We need to remember what health insurance originally was in this country, nonprofit; and what it is around the world, nonprofit; and a way to ensure that people can get basic care to stay healthy and they are protected from financial ruin when they get sick. I believe strongly this must be the underlying goal of any health reform the Senate approves this year.

Mr. President, I ask unanimous consent that a list of sources be printed in the RECORD.

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

SOURCES

1. Congressional Research Service, The Market Structure of the Health Insurance Industry, 10/21/09.

2. Congressional Research Service, Health Care Reform: An Introduction, 8/31/09.

3. Alex Blumberg, All Things Considered, National Public Radio, October 22, 2009, ''Accidents of History Created U.S. Health System.''

4. Paul Starr, The Social Transformation of American Medicine, 1982.

5. Melissa Thomasson, ''The Importance of Group Coverage: How Tax Policy Shaped U.S. Health Insurance.'' American Economic Review, 2003.

6. Blue Cross and Blue Shield, A Historical Compilation. Accessed 10/30/09 at www.consumersunion.org.

7. Kaiser Family Foundation & Health Research and Education Trust, ''Employee Health Benefits: 2008 Annual Survey.''

8. American Medical Association, Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2007.

9. American Medical Association, Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2008.

10. David Balto, Testimony Before the Senate Judiciary Committee Subcommittee on Antitrust, July 31, 2008, Hearing on ''The Right Prescription? Consolidation in the Pennsylvania Health Insurance Industry.''

11. Corporate Research Group, The Managed Care M&A Explosion, 2005.

12. Health Care for America Now, Premiums Soaring in Consolidated Health Insurance Market, May 2009, citing U.S. Securities and Exchange Commission filings.

13. T.R. Reid, The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care, 2009.

Mrs. FEINSTEIN. I thank the Chair and I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Iowa is recognized.

Mr. GRASSLEY. Thank you, Mr. President.

Mr. President, I come to the floor to address the issue of health care reform. In order to demonstrate the complicated issues that face us, I have with me the House of Representatives health care reform bill, approximately 2,000 pages; I have over here the Senate HELP Committee bill, approximately 1,000 pages; and over here, the Senate Finance Committee bill, approximately 1,500 pages.

Some on the other side of the aisle are saying their bills do not represent a government takeover of the health care system. I want to believe that. I would really like to believe it, but the facts seem to tell a different story. If we look at the specifics of the bill reported by the Senate HELP Committee or the House bill released last week, I don't see how one could call it anything but a government takeover.

So I wish to start with the Senate HELP Committee bill.

On September 17, the HELP Committee finally released what I previously said was a bill containing about 1,000 pages—more accurately, 839 pages—over 2 months after the majority party on the HELP Committee voted to report it. When I was back in my State of Iowa for the August recess, I held 17 townhall meetings. Due to the controversial health care bill the HELP Committee and the three House committees had just voted on, the attendance was the highest I have seen in the 2,871 townhalls I have held during my years in the Senate.

Many of the people who attended were citing sections from the health reform bills. They had good questions. I heard repeatedly about the new powers being granted to the government in these bills. So I decided we should have a catalog of how many times these bills grant new powers to the Secretary of Health and Human Services.

Well, I have the HELP Committee bill with me today, and there is a lot going on in the 839 pages of that bill. We have gone through the 20,725 lines of legislative text just to see how many new government authorities it creates, and here is what we found: This bill creates a total of 87 new government programs.

In addition to the 87 new government programs created by this legislation, a substantial amount of new regulatory authority has been granted to the Secretary of Health and Human Services. I know the other side doesn't like to hear that this bill calls for a government takeover of our health care system, but let's let the facts speak for themselves. If it isn't a government takeover of our health care system, why does the word ''Secretary''—meaning Secretary of HHS—appear 982 times in this bill? Maybe the other side needs a reminder that the Secretary of Health and Human Services is an agent of the Federal Government appointed by the President, confirmed by the Senate.

Iowans keep telling me that Congress needs to just slow down, consider all ideas, and, of course, common sense tells us to actually read the legislation. But the HELP Committee bill makes it clear that the majority leadership and the White House would rather push something through quickly and leave the important decisions to an unelected, unaccountable government official.

The long list of new powers granted to the Secretary begin on page 11 of the HELP Committee bill, and I quote:

> The Secretary shall by regulation establish a minimum size for community ratings areas.

So let me put it in common language rather than statutory language.

This bill includes a number of controversial rating reforms, and one of those reforms would set a 2-to-1 age rating band. That means premiums for the oldest person could be no more than twice the cost of the premiums to the youngest person. Now, that is going to reduce premiums substantially for older people, and that is a fine goal, but the money has to come from somewhere. So to pay for those lower premiums for older people means much higher premiums for younger people. It is a new hidden tax being imposed on young people. It will increase premiums for young people by at least 50 percent.

This bill would give the Secretary the regulatory power to draw the map in each State for these rating areas, and that is where we go back to the quote I just cited:

> The Secretary shall by regulation establish a minimum size for community rating areas.

Keep in mind, under current law this sort of policy is presently decided by 50 different State legislatures or by 50 different insurance commissioners. But some in Congress want to take this responsibility away from the States and turn it over to unelected bureaucrats in Washington, DC.

I spoke on the Senate floor earlier last week about how the Democratic proposals for health care will increase premiums and overall health care spending. Quite the opposite: I think to most people hearing us talk in Washington, DC, about health care reform, the word ''reform'' would mean to

them not increasing premiums and overall health care spending.

To offset the increase in premiums, they say they will subsidize them using taxpayer dollars. But guess who is given the power to decide what benefits are eligible for these new subsidies? I will read the answer straight from the bill on page 90, line 11. It says:

> The Secretary shall establish . . . the essential health care benefits eligible for credits. . . .

My friends on the other side of the aisle claim their proposal will increase choice and competition in the health insurance industry. But after reading this bill, it is clear that only 1 percent will have a choice, and that person is the Secretary of HHS.

On page 74, line 17, the Secretary is given the power to regulate what type of health plan works best for you and your family. I will read that quote:

> The Secretary shall, by regulation, establish criteria for certification of health plans as qualified health plans.

After the Secretary chooses what plan works best for you and your family, the Secretary can choose what conditions your doctor must meet in order to contract with the plan chosen for you.

On page 80, line 14, it says that a qualified health plan may contract with " . . . a health care provider if such provider implements such mechanisms to improve health care quality as the Secretary may by regulation require."

That means if you want to purchase coverage through a new exchange established by this bill, the Secretary of HHS will be deciding what health plan and what doctor is best for you and your family.

This bill also extends the Secretary's influence into classrooms, where our future doctors are being trained. On page 685 of the bill, line 10, it says:

> The Secretary shall support development, evaluation, and dissemination of model curricula for . . . use in health professions schools . . . and for other purposes determined appropriate by the Secretary.

That is a lot of power in a sentence of the law that says "and for other purposes determined appropriate by the Secretary."

Are all of these new requirements and regulations going to help our health care system? Will they make Americans healthier? The truth is, we have no way of knowing since so much in this bill, including what I have highlighted, is left to the regulatory decisions of an unelected government bureaucrat.

The proponents of this bill say it isn't a government takeover of health care. But after reading only a fraction of the bill out loud, as I have done, it is hard to argue the fact that the Secretary of HHS is granted a lot of power over our health care system.

The Secretary will determine the size of new rating areas. The Secretary will decide what benefits health care plans have to cover. The Secretary will decide what health plan works best for you and your family. The Secretary will decide what conditions your doctor must meet to be included in your plan. The Secretary will decide what curriculum should be taught in our medical schools.

You may be tired of hearing me say "Secretary," because I am tired of saying it. I have only said it 25 times in this speech. But this bill uses the word "Secretary" another 957 times, which is an indication that the HELP Committee bill is moving control of our health care system in what many people in this country consider the wrong direction.

That brings me to the House bill that was released last week. The House bill, right here—2,000-some pages—seems to be heading in the wrong direction also. In fact, a spokesman for the small business industry said to the Hill newspaper:

> [The House bill] is a "how to" on how not to do health care reform.

That is pretty disappointing, since the bill costs about $2.2 million per word. You would think we would be getting something for that kind of investment.

The Wall Street Journal today calls the House bill "the worst bill ever." Quoting, "Epic new spending and taxes, pricier insurance, rationed care, dishonest accounting: the Pelosi bill has it all."

Again, that was from the Wall Street Journal.

Let's start with what is in the 2,000 pages and $1 trillion in spending in this new bill.

The bill includes a government-run insurance provision. All the caveats aside, it is still a government insurance plan—or let me say government insurance company, plain and simple.

Interestingly, after all the promises about lower costs, the Congressional Budget Office has said that premiums in the government-run plan would be more expensive than premiums in the private market. That report just came out within the last couple of days.

The bill also locks every American with an income below 150 percent into Medicaid. Today, a family of 4 with an income of $33,000 is at 150 percent of the poverty level. Under this new House bill, that family would not get any assistance to get private health coverage. In other words, they would not have choice.

Let me point out that Medicaid is already financially unsustainable in its current form. This is the biggest expansion of Medicaid in its history. With this Medicaid expansion, the new House bill continues to leave States liable for a significant share of that new spending—a share States cannot afford. Ultimately, that will force States to raise taxes to pay for their share of this expansion of Medicaid. That is a hidden tax, although it will come separately among the 50 States.

The bill also proposes a host of new Federal insurance market reforms that will actually raise costs for most individual Americans.

With the creation of a new unelected Federal bureaucrat, called the "health choices commissioner," the Federal Government will now be in charge of deciding what insurance you have to buy.

If this isn't a government takeover of health care, I don't know what it is. If you don't like what the new health choices commissioner comes up with or you cannot afford it, you will be hit with a new individual mandate tax penalty, and that will be enforced by the IRS.

Despite all the promises about being able to keep what you have, the bill cuts more than $150 billion from Medicare Advantage plans, endangering the existing coverage for millions of seniors.

Don't take my word for it, because the Office of the Actuary—that is a professional office, not a political office—at the Department of Health and Human Services said that with this level of cuts "enrollment in [Medicare Advantage] plans would decrease by 64 percent."

The CBO has taken a look at some of the changes in the Medicare Part D drug benefit and concluded that the changes will actually raise premiums.

So whether you are in Medicare Advantage, Medicare Part D, or private insurance, this new House bill means higher costs, more government interference, and less choice. I don't think that is what people in my State of Iowa have in mind when they ask us to fix the health care system.

The House bill also includes a part that is called the CLASS Act, which creates a new long-term care entitlement. I happen to be very supportive of taking steps to improve long-term care for Americans. But the CLASS Act is fiscally irresponsible. I am not going to name the prominent Senate Democrat, but one has been quoted as calling the CLASS Act a Ponzi scheme that Bernie Madoff would have been proud of.

Finally, I hope everyone out there pays special attention to what House Democrats call "shared responsibility."

If you make money in America, the House Democrats expect you to do some extra sharing. Lots. The bill includes a massive tax increase to pay for it.

Now I wish to go to what is not in the bill. Even though President Obama continues to support medical liability reform, as I do, the House still refuses to consider it. In the "devil's in the details" category, I find it particularly worrisome that the House bill failed to include a prohibition on rationing that was in their original discussion draft. The discussion draft of H.R. 3200 stated that the committee should "ensure that essential benefit coverage does not lead to rationing of health care."

Every time you get the government more involved in health care, the issue at grassroots America comes up: Will

we have rationing? A lot of committees have tried to say that there would not be any rationing coming from this, and that was in the original House bill. But as it is put together as one final package, as it is here, that section, unfortunately, was dropped. In other words, the prohibition on rationing is not in this bill.

This is what the latest House bill proposes: more taxes, more spending, higher premiums, fewer choices, a government-run plan, the biggest Medicaid expansion in history, unsustainable new entitlement programs, and 2,000 pages.

Despite all the promises, the facts don't lie. The House bill and the HELP Committee bill I referred to during these remarks represent an unprecedented government takeover of our Nation's health care system—a takeover that this country cannot afford, and a takeover that the American people don't want.

I thank my colleagues for giving me this time beyond the hour of 4, when the unemployment compensation bill was to be taken up, so I could keep another obligation.

I yield the floor.

CONCLUSION OF MORNING BUSINESS

The PRESIDING OFFICER. Morning business is closed.

UNEMPLOYMENT COMPENSATION EXTENSION ACT OF 2009

The PRESIDING OFFICER (Mr. MERKLEY). Under the previous order, the Senate will resume consideration of H.R. 3548, which the clerk will report.

The bill clerk read as follows:

A bill (H.R. 3548) to amend the Supplemental Appropriations Act, 2008, to provide for the temporary availability of certain additional emergency unemployment compensation, and for other purposes.

Pending:

Reid (for Baucus/Reid) amendment No. 2712, in the nature of a substitute.

Reid amendment No. 2713 (to amendment No. 2712), to change the enactment date.

Reid amendment No. 2714 (to amendment No. 2713), of a perfecting nature.

Reid amendment No. 2715 (to the language proposed to be stricken by amendment No. 2712), to change the enactment date.

Reid amendment No. 2716 (to amendment No. 2715), of a perfecting nature.

Reid motion to commit the bill to the Committee on Finance, with instructions to report back forthwith, with Reid amendment No. 2717, to change the enactment date.

Reid amendment No. 2718 (to the instructions (amendment No. 2717) of the motion to commit), of a perfecting nature.

Reid amendment No. 2719 (to amendment No. 2718), of a perfecting nature.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, I yield to the Senator from Illinois such time as he desires.

Mr. DURBIN. Mr. President, I thank the chairman of the Finance Committee. He will be discussing a matter of grave importance in Illinois and all across the Nation, the extension of unemployment benefits, which we have been trying to bring to the floor for 27 days. Our Republican colleagues have opposed it, stopped it, delayed it, and demanded every vote they can think of to stop the extension of unemployment benefits, even though there are millions of Americans out of work and desperately looking for jobs. Many of them have exhausted their family savings trying to avoid foreclosure, to feed their families, and they need these benefits desperately. But we have been held up time and again because several Republican Senators have insisted on amendments that have nothing to do with unemployment and nothing or little to do with the economy. I hope today we can break through that. I hope we can find bipartisan support to extend the unemployment benefits.

I thank the Senator from Montana for yielding a moment to me.

I wish to respond to my friend—and he is my friend—my colleague, Senator GRASSLEY of Iowa, my neighboring State. He and I have worked on many things together. Our political views differ, that is for sure, but I believe he is a hard-working, good representative of his State. In fact, when I said that once on the floor, he ended up quoting it in one of his campaign brochures, which got me in trouble with the Iowa Democratic Party. But so be it. I like him, and I hope he feels the same.

We have worked together on many issues, but for the Senator from Iowa to come to the floor and be critical of a bill saying it is too many pages—that is what I have heard over and over again from the Republican side. They have argued that health care reform in the Senate is going to run over 1,000 pages in length, and they say it over and over again.

I don't know historically what major legislation considered on the Senate floor is comprised in the number of pages, but we have had some pretty big bills in the past—in the Senate Appropriations Committee and other places—because those bills take on big issues and big subjects. Nothing is bigger than our health care system in America. To talk about 1,000 pages really does not do justice to the enormity of the task we are tackling, to try to bring costs under control so people and businesses across America have secure and stable health care.

We ought to make sure as well that the health insurance companies stop exploiting those who have health insurance policies. We want to eliminate preexisting conditions as an exclusion. We want to make sure when you are sick, your health care will be there; that when you change jobs, you can take your health care with you. We want to make sure your children are covered for longer periods of time than they are now under current law. It takes a few pages to put that together. You cannot put it in a few sentences if you want to change the law and make it work.

So to come here and criticize the bill which has not been presented in a final form as I stand here I don't think makes a very strong case.

I asked the other day for the Republicans to tell me how many pages their health care reform bill is. The Senator from Tennessee said they were working on several different bills but they would be shorter in length. The closest we can come to the Republican health care reform bill I hold in my hand. It is 2½ pages long, and it consists of a press release from MITCH MCCONNELL, the Senate Republican leader. That is as far as the Republicans have gone in writing health care reform for the American people. It is a press release. In this press release, there are no positive things they stand for, only criticisms of our efforts to write a health care reform bill.

To my right is the Senator from Montana, the chairman of the Senate Finance Committee. He has spent the better part of a year—at least a year—trying to put together a health care bill. He has engaged others in trying to bring them into this conversation. Unfortunately, at the end of the day, only one Republican Senator, Ms. SNOWE of Maine, joined Senate Democrats in voting for health care reforms. So far, she is the only Republican in the House or the Senate who has voted for health care reform even at the committee level. The Republicans have been standing on the sidelines while we have been trying our best to put together good legislation which will bring the cost of health care down, protect those beneficiaries who are denied coverage under their health insurance plans, and extend the reach of competition and choice so more Americans have places to turn. When the Senator from Iowa complains about so-called rationing, I think he overstates the case.

We know there is too much money spent on the current health care system. There is duplication, waste, and fraud, and we want it to come to an end. If Medicare is going to be on sound financial footing, if we can say to seniors today and for years to come that they can count on Medicare being there when they need it, we have to cut out unnecessary spending.

One of the areas in that particular program that is highly controversial is called Medicare Advantage.

Medicare Advantage was proposed by the insurance industry. They said years ago: The government has tried to run Medicare for 40 years, but they haven't done a very good job. Why don't you let the private insurance companies offer a Medicare plan. We will show you what you can do when you use the genius of the insurance industry in America to offer Medicare.

We took them up on their challenge and said to them: Present the insurance policy to seniors that will provide Medicare benefits.