SHERRIFF DELAYS AUCTION

Philadelphia’s Residential Mortgage Foreclosure Diversion Pilot Program began with a resolution passed by the City Council in March 2006. Sheriff John D. Hall then wrote to the owners of about $500 a month. But Mr. Hall’s inter- engage balance to $63,000. To renovate his home, expanding his mort- lons of households. At the recommendation of the sort of mistake that has upended mil-

Mr. THUNE. Mr. President, we now have a draft of the Senate majority’s health care reform bill, after spending sever- one-third of my remarks, the Senator from...

He had been raised by his grandfather in his neighborhood in Northeast Philadelphia. Ever since he was a teenager, he had attended St. Martin’s, the Catholic school around the corner, married his childhood sweetheart and still remained in his grandfather’s house, sending his own children—two boys (now in their 20s) and a 12-

Mr. Hall was struggling to come to terms with what he assumed was the end. “I put my whole life into this house,” he said. “After a while they want you to take it from me. You’ve got to regroup and move, but where? If I can’t pay my mort-

When he got the news that he had a few weeks’ reprieve, relief quickly gave way to what he assumed was the end. “I put my whole life into this house,” he said. “After a while they want you to take it from me. You’ve got to regroup and move, but where? If I can’t pay my mort-

When he got the news that he had a few weeks’ reprieve, relief quickly gave way to the worry that had dominated his thoughts for months. “It’s postponing the inevitable,” he said. “I’m a man,” he kept saying, trying to make sense of how a lifetime of working on other people’s homes had put him here, star-

In January, his truck was repossessed, leaving him to walk through the downtown to the union hall for his daily ritual of defeat. He watched the For Sale signs proliferating on his block, as mostly elderly neighbors tried to save their homes. “Number 27, Wachovia Mortgage versus . . . .” A girl no older than 6, with flower-shaped plastic bar-

Every day, he set the alarm clock and got up to go to work. His $800 monthly unemploy-

The PRESIDING OFFICER. Without objection, it is so ordered.
Committee in the Senate. He called the CLASS Act “a ponzi scheme of the first order, the kind of thing that Bernie Madoff would be proud of.” That is how he refers to this CLASS Act included in the bill and the savings that are associated with it. In fact, the bill in its present form shows a revenue in the first 10 years turns into a deficit in the second 10 years. So when you back out the $72 billion that it is assumed, would add to the revenues in the bill and you add to that cost, the $237 billion that would be required to fund the physician fee formula over a 10-year period, the so-called surplus that this bill generates actually turns into a deficit. It goes from a surplus of $130 billion to a deficit of $189 billion.

Again, a lot of gimmicks are being used to understate the true cost of the bill to the American people. All that being said, if you look at the overall cost, when fully implemented over 10 years, you come up with this: Remember, the Finance Committee passed its version of this bill out of committee, the 10-year, fully-implemented cost was $2.2 trillion.

When the Finance Committee passed its version of the health care reform bill out of the Finance Committee, then its fully-implemented cost of that bill was $1.8 trillion. So that is $1.8 trillion for the Finance Committee bill and $2.2 trillion for the Health, Education, Labor, and Pensions Committee bill. Guess what the Finance Committee version of that bill was that was merged together and has now been unveiled for all the world to see. It is $2.5 trillion in overall cost—10-year, fully-implemented cost. That is a $2.5 trillion expansion of the Federal Government in Washington, DC, associated with the fully implemented cost of the bill.

The point I am trying to make is this: The cost of the bill is being dramatically understated by the authors of the bill. It looks like it comes in under $1 trillion, when, in fact, when you back out the two components I mentioned, it is over $1 trillion in the first 10 years, and that is because they delay implementation of many provisions until January 1, 2014—a budgetary gimmick designed to understate the true cost of the bill.

When you look at the fully implemented, 10-year cost of the legislation, without the gimmick of the delayed implementation, and the other gimmicks in here, it is $2.5 trillion in additional costs to the taxpayers of this country. Of course, that $2.5 trillion has to be paid for somehow. The way it is paid for isn’t any different than in any of the other bills we have seen so far. It is paid for with higher taxes on small businesses and higher taxes on individuals. It is paid for with cuts to Medicare Programs that would impact senior citizens in this country, as well as medical providers, from hospitals, such agencies, to hospice—you name it—and medical device manufacturers get hit hard in this legislation. Everybody gets hit when it comes to the reimbursement side to pay for this.

Of course, the American taxpayer gets hit hard when it comes to the tax increases included in there—$2 trillion in tax increases and $3 trillion in Medicare tax. This 1.5 trillion expansion of the Federal Government to create a new entitlement program.

The other thing this bill does, which wasn’t included in a previous version, is it has an increase in the payroll tax on Medicare. The argument is, it only applies to people in the higher income categories. They tried to carve out people under $200,000 a year. Remember, the Medicare tax—and the payroll tax that every employee in this country pays, which is 1.45 percent on their income, matched by their employer, for a total of 2.9 percent—is increased. It gets increased to pay for not reforming or making Medicare more sustainable, a program we all know is destined to be bankrupt.

The increase in the Medicare tax will fund a whole new entitlement program unrelated to Medicare. The argument will be it is a health care program. But the fact is, the Medicare payroll tax was put into place to fund Medicare, a program people would pay into so that when they retire, they would have the security of health care coverage.

The payroll tax included in this bill, first off, will hit a lot of people. If you are a couple who both make a hundred—or $100,000 a year, you are already into the category where you are going to be hit by the tax. One of my main objections—and I am not for this tax increase—one of my main objections is the majority has chosen to use that tax increase not to make Medicare more sustainable but to create a whole new entitlement program with this bill.

The other thing I wish to point out, because it has come up in the last day or two, is there has been all this discussion about mammograms, this U.S. Preventive Services Task Force that came out with a recommendation that women under 40 should not go through mammogram screening; and, of course, a few years ago they made the opposite recommendation—back in 2002—when the U.S. Preventive Services Task Force made the recommendation that women 40 and older should undergo annual mammogram screening. That recommendation was completely reversed earlier this week.

The 16-member task force ruled that patients under 50 or over 75, without special risk factors, do not need mammograms. It is a de facto rule, and under national health care these kinds of cost analyses will inevitably become more common as government decides where the government-run health care. When you start down that path—and we have seen the model in Europe and Canada—where the government imposes cost control measures, that leads to rationing. Pretty soon, people are denied care, and care is delayed when people want to get a particular procedure. It has been concluded that this is not cost-effective, and some of these decisions that have traditionally been made between patients and doctors are made by the government.

I will read for you something that was in an editorial in the Wall Street Journal today. It gets at the very heart of what I am talking about. It says:

More important for the future, every Democratic version of ObamaCare makes this task force an arbiter of the benefits that private insurers are required to cover as they are converted into government contractors. What are now merely recommendations will become de facto rules, and under national health care these kinds of cost analyses will inevitably become more common as government decides where the government dollars where finite tax dollars are allowed to go.

In a rational system, the responsibility for health care ought to reside with patients and their doctors. James Thral, a Harvard medical professor and chairman of the American College of Radiology, tells us that the breast cancer decision shows the dangers of medicine being reduced to “accounting exercises subject to interpretations and underlying assumptions,” and based on costs and large group averages, not individuals.

He goes on to say:

I fear that we are entering an era of deliberate decisions where we choose to trade people’s lives for money.

What is important about that observation is that he is pointing out what a lot of people will be very concerned about. If you are a woman in my home State of South Dakota, and let’s say you are 42 years old, the recommendation made by this task force which everybody is now dismissing and saying is about insurance and not about imaging—under legislation such as this, where you create a board that actually does have statutory powers and is enabled to make many of these decisions based on what is cost-effective, you could have someone in a State such as mine, or any woman in any State in this country who would be in their forties—because they said 50 should be the baseline now, the age at which you get mammograms or breast cancer screening done—that you could actually have a woman in your country who would be denied the opportunity to do that.

Of course, we all know and everybody can relate to people in this country...
who, by virtue of that screening process and that test, have been detected early and able to beat breast cancer, which is something that afflicts a great number of women across this country. That is one example. I use this as an example of how we ought to be about driving down costs, it ought to be about providing more access to Americans, it ought to be about maintaining that important relationship between a physician and their patient and not getting to where we have the government making those decisions, where we are actually bending the cost curve up rather than driving it down.

By the way, the CBO said in response to the majority’s bill that was unveiled yesterday that it actually increases costs by $160 billion. To me, the fundamental goal of health care reform for most Americans, the key concern is how we have health care today, is its costs. Everything we have seen so far, including the worst recent version which we are going to have at some point on the floor of the Senate, probably sometime after the Thanksgiving holiday, increases costs, drives the cost curve up.

How can you be for something that cuts Medicare to providers and seniors across this country, that raises taxes on small businesses, the economic engine that creates jobs in this country, raises taxes on middle-income Americans and which also, ironically, raises the cost of health care, increases the cost of health care? I am not saying this is the CBO. That has been consistent through all the bills that have been produced. It is consistent with this idea that the government making those decisions, which also, in my view, will lead to a massive bill, just in terms of its volume. It also includes a massive expansion of the Federal Government in health care. It simply increases it and does not do anything to drive down the cost of health care. It simply increases it and puts more cost on all of us.

The Wall Street Journal’s editorial page was the one that I think best know the medical literature—did decide to re-analyze the data with health-care spending as a core concern. The task force concluded that the tests for the first group aren’t valuable, while also noting that screening younger women results in more false positives that lead to interventions. The CBO sent to have printed in the RECORD a Wall Street Journal editorial. Nicholas Kristof did a column today in the New York Times, dueling newspapers on the floor. This is an interesting column today in the New York Times. We can have competing newspapers, dueling newspapers on the floor. Nicholas Kristof did a column called “The Wrong Side of History.” I quote:

Critics storm that health care reform is “a cruel hoax and delusion.” Ads in 100 newspapers thunder that reform would mean “the beginning of socialized medicine.”

The Wall Street Journal’s editorial page predicts that the legislation will lead to “deteriorating service.” Business groups warn

More important for the future, every Democrat version of ObamaCare makes this task force an arbiter of the benefits that private insurers will be required to cover as they are converted into contractors. What are now merely recommendations will become de facto rules, and under national health care these kinds of cost analyses will inevitably become more common as government decides where finite tax dollars are allowed to go.

In a rational system, the responsibility for health care ought to reside with patients and their doctors. James Thrall, a Harvard medical professor and chairman of the American College of Radiology, tells us that the breast cancer decision shows the dangers of medicine being reduced to “accounting exercises subject to interpretations and underlying assumptions,” and based on costs and large group averages, not individuals. “I fear that we are entering an era of deliberate decisions where we choose to trade people’s lives for money,” Dr. Thrall continued. He’s not overstating the case, as the 12% of women who will develop breast cancer during their lifetimes may now better appreciate.

More spending on “prevention” has long been a cry of health reformers, and President Obama has been especially forceful. In his health speech to Congress in September, the President made an analysis—“routine checkups and preventative care” like mammograms and colonoscopies because “there’s no reason we shouldn’t be catching diseases like breast cancer and colon cancer before they get worse.”

It turns out that there is, in fact, a reason: Screening for breast cancer will cost the government too much money, even if it saves lives.

Mr. THUNE. Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Michigan.

Ms. STABENOW. Mr. President, I ask unanimous consent to speak for up to 20 minutes in morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

HEALTH CARE REFORM

Ms. STABENOW. Mr. President, first, it is a good thing our health care reform doesn’t do the kinds of things the Senator is talking about. I wouldn’t support it either, and I trust the Chair would either. It is a good thing that is not what we are doing. With respect to my friend from South Dakota, we have a different view of this bill.

Let me first start by saying, as the Chair knows, and as you’ve heard, this bill saves lives and saves money, and particularly protects Medicare and stops insurance abuses. That is what we are about.

Before going through the specifics of the bill, I wish to read from a very interesting column today in the New York Times. We can have competing newspapers, dueling newspapers on the floor. Nicholas Kristof did a column called “The Wrong Side of History.” I quote:

Critics storm that health care reform is “a cruel hoax and delusion.” Ads in 100 newspapers thunder that reform would mean “the beginning of socialized medicine.”

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