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## Senate

The Senate met at 4 p.m. and was called to order by the President pro tempore (Mr. HATCH).

### PRAYER

The Chaplain, Dr. Barry C. Black, offered the following prayer:

Let us pray.

Eternal God, sovereign of nations, answer our lawmakers even before they call, and hear them even before they speak. Give them the wisdom today to commune with You. May this fellowship bring them Your gifts of knowledge, judgment, and wisdom for these turbulent times.

Lord, help them to yield their minds, hearts, and wills to the flow of Your Divine intelligence, using Your might to solve problems in our Nation and world. Give them the power to handle the pressures of legislative labor as they find fuel from a fresh flow of Your strength. May they think clearly, serve creatively, and endure consistently.

We pray in Your sacred Name. Amen.

### PLEDGE OF ALLEGIANCE

The President pro tempore led the Pledge of Allegiance, as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

### RECOGNITION OF THE MAJORITY LEADER

The PRESIDING OFFICER (Mrs. ERNST). The majority leader is recognized.

### BETTER CARE RECONCILIATION BILL

Mr. MCCONNELL. Madam President, 7 years ago, the Democrats forced an unfair healthcare system on our country that they called the Affordable Care Act. It turned out to be anything but that.

They told Americans that it would lower their premiums, but ObamaCare has increased premiums by an average of 105 percent in the vast majority of States on the Federal exchange since 2013. Unless we act, we can expect similar trends for years to come.

They told Americans that it would expand choice in the healthcare marketplace, but ObamaCare has left Americans in 70 percent of U.S. counties with little to no options for insurance this year. Unless we act, we can expect things to get worse.

They told Americans that it would allow them to keep their doctors, their plans, and their ability to make the smartest healthcare decisions for their families. Instead, ObamaCare forced millions off the plans they liked and forced millions into plans they either did not want or could not afford. Unless we act, more Americans will be left trapped, forced by ObamaCare to buy insurance but left without the means to actually do so.

This is the ObamaCare status quo as millions of Americans have come to know it. It is unacceptable. It is unsustainable. The American people need better care, which is exactly what we are working to bring them.

Through dozens of meetings and through conversations with every Member of our conference, we have had the opportunity to discuss many different ideas and approaches for bringing relief from ObamaCare. Ultimately, we found there were a number of areas in which we all agreed when it comes to what the critical issues we need to address are and how we can do that. Those solutions are what make up the draft legislation that was released last week and that we will continue working to consider now.

Better Care will preserve access to care for patients with preexisting conditions, strengthen Medicaid, and allow children to remain on their parents' insurance through the age of 26.

Better Care will lower costs from where they are under ObamaCare by,

among other things, eliminating taxes on the middle class, by giving Americans more power to control and reduce their medical costs and out-of-pocket expenses, and by giving States significant new tools to drive down premiums.

Better Care will free Americans from onerous mandates under ObamaCare by repealing the employer mandate that reduces hours and take-home pay for too many workers and by repealing the individual mandate that forces Americans to buy unaffordable ObamaCare insurance, freeing them to make the best healthcare decisions for their families on what types of plans they want and can afford.

Better Care will help stabilize insurance markets that are collapsing under ObamaCare by first implementing stabilization policies and then carefully transitioning away from ObamaCare completely so that more families are not harmed by its collapsing markets.

As one major insurer observed just today, this bill "will markedly improve the stability of the individual market and moderate premium increases." That is from a major insurer today.

We should keep working so that we can move forward with robust floor debate and an open amendment process here on the Senate floor. I would encourage all 100 Senators to participate because the American people need better care right now, and this legislation includes the necessary tools to provide it.

### RESERVATION OF LEADER TIME

The PRESIDING OFFICER. Under the previous order, the leadership time is reserved.

• This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.



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## EXECUTIVE SESSION

## EXECUTIVE CALENDAR

The PRESIDING OFFICER. Under the previous order, the Senate will proceed to executive session to resume consideration of the following nomination, which the clerk will report.

The senior assistant legislative clerk read the nomination of Kristine L. Svinicki, of Virginia, to be a Member of the Nuclear Regulatory Commission for the term of five years expiring June 30, 2022.

Mr. MCCONNELL. Madam President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The senior assistant legislative clerk proceeded to call the roll.

Mr. SCHUMER. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

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

## RECOGNITION OF THE MINORITY LEADER

The PRESIDING OFFICER. The Democratic leader is recognized.

## HEALTHCARE LEGISLATION

Mr. SCHUMER. Madam President, this week, the eyes of the American people should be and are on the Senate. The Republican majority endeavors to pass a massive remake of our Nation's healthcare system with the votes of only one party and the ideas of only one wing of one party in just 4 short days.

The Republican majority kept their healthcare bill shrouded in darkness for as long as possible, only dragging it into the light last Thursday morning after it was forced to because there was so much outcry over the secrecy. That was only a week before it was set for a vote. There are still no hearings and no opportunity for a robust discussion of amendments. Just a few hours ago, they released a revised version, which, at the moment, is what we will apparently consider on the floor.

There is a reason my Republican colleagues labored in secret. There is a reason they forsook the committee process and regular order and open debate. There is a reason they want to jam this bill through in just 1 week. They are ashamed of their bill. Now that we have seen it, we finally know why.

The Republican healthcare bill—this new TrumpCare—unwinds the healthcare protections and programs that are designed to help the Americans who need it the most in order to give a tax break to the Americans who need it the least.

The bill would gut Medicaid, making it harder for families with a loved one in a nursing home or for families with a disabled child to afford his care, so that they can give a massive tax cut to the wealthy.

This bill would defund Planned Parenthood, making it harder for millions of women to obtain care, so that they

can give people who make over \$1 million a \$57,000 tax cut, on average.

The bill would slash tax credits, which help families afford health insurance, in order to give a nearly \$1 trillion tax cut to the wealthiest Americans.

The bill would also punish any Americans who experience a gap in coverage, locking them out of health insurance for 6 months. Every year, tens of millions of Americans have a gap in coverage through no fault of their own. Some lose their jobs, and others have temporary financial problems. It is inhumane to say to those Americans: You now have to wait an additional 6 months without insurance.

Imagine someone who is struggling with cancer, and he has a lapse in coverage. The 6-month wait this Republican penalty imposes could well become a death sentence.

That is why Republicans are ashamed of this bill—it carries a staggering human cost. You do not have to take my word for it; the bipartisan National Association of Medicaid Directors came out today in opposition to the bill, saying it would “divert critical resources away from what we know is working today,” particularly for opioid treatment.

Madam President, I ask unanimous consent that their statement be printed in the RECORD.

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

[From the National Association of Medicaid Directors, June 26, 2017]

## CONSENSUS STATEMENT FROM THE NATIONAL ASSOCIATION OF MEDICAID DIRECTORS (NAMD) BOARD OF DIRECTORS ON THE BETTER CARE RECONCILIATION ACT OF 2017

WASHINGTON, DC.—The following statement represents the unanimous views of the National Association of Medicaid Directors (NAMD) Board of Directors. NAMD is a bipartisan, nonprofit, professional organization representing leaders of state Medicaid agencies across the country.

Medicaid is a successful, efficient, and cost-effective federal-state partnership. It has a record of innovation and improvement of outcomes for the nation's most vulnerable citizens.

Medicaid plays a prominent role in the provision of long-term services and supports for the nation's elderly and disabled populations, as well as behavioral health services, including comprehensive and effective treatment for individuals struggling with opioid dependency.

Medicaid is complex and therefore demands thoughtful and deliberate discussion about how to improve it.

Medicaid Directors have long advocated for meaningful reform of the program. States continue to innovate with the tools they have, but federal changes are necessary to improve effectiveness and efficiency of the program. However, these changes must be made thoughtfully and deliberately to ensure the continued provision of quality, cost-effective care.

Medicaid Directors have asked for, and are appreciative of, improved working relationships with HHS and are working hard to streamline and improve the administration of the program. The Senate bill does formalize several critical administrative and

regulatory improvements, such as giving Medicaid Directors a seat at the table in the development of regulations that impact how the program is run, and the pathway to permanency for certain waiver programs. However, no amount of administrative or regulatory flexibility can compensate for the federal spending reductions that would occur as a result of this bill.

Changes in the federal responsibility for financing the program must be accompanied by clearly articulated statutory changes to Medicaid to enable states to operate effectively under a cap. The Senate bill does not accomplish that. It would be a transfer of risk, responsibility, and cost to the states of historic proportions.

While NAMD does not have consensus on the mandatory conversion of Medicaid financing to a per capita cap or block grant, the per capita cap growth rates for Medicaid in the Senate bill are insufficient and unworkable.

Medicaid—or other forms of comprehensive, accessible and affordable health coverage—in coordination with public health and law enforcement entities, is the most comprehensive and effective way address the opioid epidemic in this country. Earmarking funding for grants for the exclusive purpose of treating addiction, in the absence of preventative medical and behavioral health coverage, is likely to be ineffective in solving the problem and would divert critical resources away from what we know is working today.

Medicaid Directors recommend prioritizing the stabilization of marketplace coverage. Medicaid reform should be undertaken when it can be accomplished thoughtfully and deliberately.

Mr. SCHUMER. Madam President, the nonpartisan American Medical Association—a conservative organization—came out today in opposition to the bill, saying it “will expose low and middle income patients to higher costs and greater difficulty in affording care.”

I ask unanimous consent that their letter be printed in the RECORD.

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

AMERICAN MEDICAL ASSOCIATION,  
Chicago, IL, June 26, 2017.

Hon. MITCH MCCONNELL,  
Majority Leader, U.S. Senate,  
Washington, DC.

Hon. CHARLES SCHUMER,  
Minority Leader, U.S. Senate,  
Washington, DC.

DEAR MAJORITY LEADER MCCONNELL AND LEADER SCHUMER: On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to express our opposition to the discussion draft of the “Better Care Reconciliation Act” released on June 22, 2017. Medicine has long operated under the precept of *Primum non nocere*, or “first, do no harm.” The draft legislation violates that standard on many levels.

In our January 3, 2017 letter to you, and in subsequent communications, we have consistently urged that the Senate, in developing proposals to replace portions of the current law, pay special attention to ensure that individuals currently covered do not lose access to affordable, quality health insurance coverage. In addition, we have advocated for the sufficient funding of Medicaid and other safety net programs and urged steps to promote stability in the individual market.

Though we await additional analysis of the proposal, it seems highly likely that a combination of smaller subsidies resulting from lower benchmarks and the increased likelihood of waivers of important protections such as required benefits, actuarial value standards, and out of pocket spending limits will expose low and middle income patients to higher costs and greater difficulty in affording care.

The AMA is particularly concerned with proposals to convert the Medicaid program into a system that limits the federal obligation to care for needy patients to a predetermined formula based on per-capita-caps. At the recently concluded Annual Meeting of the AMA House of Delegates, representatives of more than 190 state and national specialty medical associations spoke strongly in opposition to such proposals. Per-capita-caps fail to take into account unanticipated costs of new medical innovations or the fiscal impact of public health epidemics, such as the crisis of opioid abuse currently ravaging our nation. The Senate proposal to artificially limit the growth of Medicaid expenditures below even the rate of medical inflation threatens to limit states' ability to address the health care needs of their most vulnerable citizens. It would be a serious mistake to lock into place another arbitrary and unsustainable formula that will be extremely difficult and costly to fix.

We are also concerned with other provisions of the legislation beyond those directly affecting insurance coverage. The Affordable Care Act's Prevention and Public Health Fund was, according to the Department of Health and Human Services, established to "provide expanded and sustained national investments in prevention and public health, to improve health outcomes, and to enhance health care quality." These activities are key to controlling health care costs and the elimination of support for them runs counter to the goal of improving the health care system. We also continue to oppose Congressionally-mandated restrictions on where lower income women (and men) may receive otherwise covered health care services—in this case the prohibition on individuals using their Medicaid coverage at clinics operated by Planned Parenthood. These provisions violate longstanding AMA policy on patients' freedom to choose their providers and physicians' freedom to practice in the setting of their choice.

We do appreciate the inclusion of several provisions designed to bring short term stability to the individual market, including the extension of cost sharing reductions payments. We urge, however, that these provisions serve as the basis of Senate efforts to improve the ACA and ensure that quality, affordable health insurance coverage is within reach of all Americans.

We sincerely hope that the Senate will take this opportunity to change the course of the current debate and work to fix problems with the current system. We believe that Congress should be working to increase the number of Americans with access to quality, affordable health insurance instead of pursuing policies that have the opposite effect, and we renew our commitment to work with you in that endeavor.

Sincerely,

*James L. Madara, MD.*

Mr. SCHUMER. Madam President, even several Republican Senators are expressing concerns.

Republican Senator HELLER said: "The bill doesn't protect the most vulnerable Nevadans—the elderly, Nevadans struggling with mental health issues, substance abuse, and people with disabilities."

He continued: "The goal of healthcare reform should be to lower costs here in Nevada, and I'm not confident—not confident—it will achieve that goal."

Republican Senator SUSAN COLLINS said about the bill: "I'm very concerned about the cost of insurance for older people with serious chronic illnesses, and the impact of the Medicaid cuts on our state governments, the most vulnerable people in our society, and health care providers such as our rural hospitals and nursing homes."

Even my friend the junior Republican Senator from Texas said that under this bill, "premiums would continue to rise."

My Republican friends are right to have these concerns. The bill will not lower costs for working families. It will leave the most vulnerable Americans out in the cold, devastate rural areas, and set us even further back in combating the opioid epidemic.

This week, the Senate will witness a political exercise in that the majority leader will attempt to coerce the votes of these Senators and any other hold-outs by adjusting the dials on the legislation a bit. There will be buyouts and bailouts and small tweaks that will be hailed as "fixes" by the other side.

The truth is that the Republicans cannot excise the rotten core at the center of their healthcare bill. No matter what tweaks they add, no matter how the bill changes around the edges, it is fundamentally flawed at the center. No matter what last-minute amendments are offered, this bill will force millions of Americans to spend more of their paychecks on healthcare in order to receive fewer benefits simply so that the wealthiest Americans can pay less in taxes. That is why our Republican colleagues are ashamed of this bill and are rushing it through in 4 short days.

Before we vote on the motion to proceed, I would ask my Republican friends to do one simple thing: Reflect on how this bill would impact your constituents. We are all sent here to serve the people of our States—to do right by them, to ease their burdens where possible and make sure our laws reflect a country that gives everyone an equal opportunity to succeed. The first rule of medicine is "do no harm." So it should be with government. So it should be with this healthcare bill.

But this bill will harm the middle-class family with a parent in a nursing home. It will harm the father whose son is struggling with opioid addiction and who is having trouble finding the money to put him through treatment. It will harm the child born with a pre-existing condition, who may hit the lifetime cap on healthcare coverage before he or she even enters kindergarten.

As the American Medical Association said today, this bill violates the "do no harm" standard on many levels. I believe my friends and colleagues on the other side of the aisle are men and

women of good conscience. I would ask that they think with their conscience before they vote on the motion to proceed on Wednesday.

Any bill that does this much harm to the American people ought to receive a "no" vote.

#### RUSSIA SANCTIONS

Finally, Madam President, I have a word on Russia sanctions. President Trump has spent the last few days firing off tweets that point fingers at President Obama's handling of Russia's interference in our election. It is good that the President has finally acknowledged—albeit implicitly—that Russia interfered in our election, something that the intelligence community has long agreed upon.

Let me give the President some heartfelt advice. Mr. President, you have to stop the name-calling, finger-pointing, and deflection when it comes to something as serious as Russia's meddling in our democracy. This is very, very serious stuff.

Whatever President Trump thinks of President Obama's actions during the election is moot. Mr. Trump is now President, not Barack Obama, and the Russian threat is still there. If President Trump is concerned by Russian interference in our election, he can step up to the plate and try to stop it. Blaming Obama is not going to solve the problem, even though that blame may be wrongly placed.

The best thing President Trump can do is to support the Russia sanctions bill the Senate passed 2 weeks ago by an overwhelming, bipartisan, 98-to-2 vote—a bill that is currently languishing at the clerk's desk in the House, at what appears to be, at least, the request of the White House.

It would be unconscionable—unconscionable—to let sanctions stay where they are or, worse, to weaken them, when Russia has interfered with the wellsprings of our democracy and, if not punished, will likely do so again.

If President Trump doesn't support the bill and tries to block it or water it down, Americans are going to be asking: What is his motivation? What is the reason President Trump is afraid to sanction Russia after they interfered in our elections? The American people are going to ask a lot of questions.

I would advise the President to stop casting blame and step up to protect the vital interests of this country, to get tough on Russia, get serious about safeguarding our elections, and tell Speaker RYAN to pass our Russia sanctions bill so that President Trump can sign it.

Otherwise, President Trump is going to be in an even deeper hole with the public on the matter of Russia.

Thank you, Madam President.

I yield the floor.

The PRESIDING OFFICER. The Senator from Vermont.

Mr. LEAHY. Madam President, I thank the distinguished Democratic leader for his comments. I ascribe to them.

## TRUMP ADMINISTRATION CUBA POLICY

Madam President, on June 16, in a campaign-style speech glorifying the failed Bay of Pigs invasion of Cuba in 1961, President Trump spoke of freedom and democracy for the Cuban people.

Those are goals every one of us in this body shares, not only for the people of Cuba but for people everywhere. But the hypocrisy of the President's remarks in Miami, where he announced his decision to roll back engagement between the United States of America and Cuba, was glaring, if not surprising.

This is a President who has praised, feted, and offered aid and weapons to some of the world's most brutal despots. A President who, when he was in Saudi Arabia, never uttered the words "freedom" or "democracy" or "women's rights." In fact, he said he did not believe in lecturing other governments about such things. Freedom House ranks Saudi Arabia as less free than Cuba.

This is a President who welcomed at the White House President Erdogan, who has imprisoned tens of thousands of teachers, journalists, and civil servants as he dismantles the institutions of secular democracy in Turkey.

President Trump praised Philippine President Duterte, who brags of committing murder and who defends a policy of summarily executing, without any legal process, thousands of suspected petty drug users.

President Trump says he admires President Putin, and he acts like a soulmate to President El-Sisi, both of whom show no reluctance to order the imprisonment and, in Russia, even the assassination, of critics of their autocratic rule.

Despite all of this—praising these tyrants around the world—President Trump has decided to make a point of going after tiny Cuba, whose government, for all its faults, doesn't hold a candle to these other autocracies.

If the hypocrisy were not enough, it gets a whole lot worse, because in doing so he is trampling on the rights of Americans—of the Presiding Officer, of me, and of everybody else in this country.

I wonder how many, if any, Members of Congress have read the details of the President's announcement in Miami, other than the couple of Cuban-American Members of Congress—neither one of whom has ever set foot in Cuba—even though it is only a few miles off our coast. They publicly took credit for writing the new White House policy.

Now, that, in and of itself, speaks volumes about the administration's so-called policy review. That turned out to be largely a sham. Apparently, every Federal agency recommended continuing down the path of engagement begun by President Obama, as did the U.S. business community and the rapidly growing number of private Cuban entrepreneurs who are benefiting from U.S. engagement.

It is especially ironic that those hard-working Cubans and private

American citizens are the ones who will be hurt by this change in policy. Instead, the President decided to toss a political favor to a tiny minority of the President's supporters in Miami.

Now, the President's party has long claimed to be a party devoted to individual freedom, as we all should be. But let me give my colleagues a few examples of what his policy means for the freedom of individual Americans.

First, remember that Americans can travel freely to any of the other countries I have mentioned, despite the repressive policies of their governments. Americans can travel to Saudi Arabia, the Philippines, Turkey, and Egypt, as well as to Iran, Vietnam, and China. We can go to any of those countries without restriction.

Of course, Americans can travel freely to Russia, Cuba's former patron. I would note that Russia is now investing heavily in Cuba's transport sector and, taking advantage of the fact that we are turning our back on Cuba, they are seeking a military base there. And Americans can travel freely to the dictatorship of Venezuela, Cuba's source of cheap oil. In fact, Americans can travel freely to any country they want, provided that country will let them in, no matter how undemocratic, no matter how tyrannical, no matter how repressive. Apparently, President Trump could care less about that. But not to Cuba, whose people have far more in common with us than those of any of the other countries I named.

No, President Trump says you can go to Iran, you can go to Vietnam, you can go to Russia, you can go to Turkey, and you can go to Saudi Arabia. You can go anywhere you want, but you can only go to Cuba under conditions that the White House and bureaucrats in the Treasury Department, who have never been to Cuba, permit.

Rather than make your own decision about where to take your family for a vacation or to experience a foreign culture, the White House will make that decision for you.

You must be a part of an organized group, and the purpose of your trip must fit within 1 of 12 licensing categories determined by bureaucrats at the Treasury Department. I suspect they have never been to Cuba.

You must have a designated chaparrone to verify that, Heaven forbid, you do not stray from the program submitted to and approved—you hope—by the Treasury Department, whose employees and bureaucrats you have never met. If your application is interminably delayed or denied—for whatever reason—you are out of luck. There is no appeal.

Now, that is how the White House says that Cuba will become a democracy. By curtailing the freedom of Americans to travel and spend their hard earned money there. By behaving the way we would expect of a communist dictatorship—not of the world's oldest democracy, where the government's job is to protect individual free-

dom, not trample on it. The example we set for Cuba is by trampling on the rights of our own people.

How well did restricting travel by Americans to Cuba work from 1961 until 2014, when President Obama relaxed those Cold War restrictions, decades after the Russians had abandoned the island and Cuba no longer posed any threat to us? It failed miserably. At the same time, it treated the Cuban and American people as pawns in a political game.

Throughout those many years, the Castro government had a ready excuse for its own failings and repressive policies. They could blame it on the United States, and for many years, the Cuban people believed it because we, with our embargo, wouldn't let Americans travel to Cuba or do business there. But with the possible exception of the Pope, I don't think any foreigner has been received as warmly or engendered as much hope for the future as President Obama did when he and First Lady Michelle Obama visited Havana. It was amazing to watch the reaction of the people in Cuba.

President Trump claims President Obama got a bad deal when our flag went up at the U.S. Embassy a little less than 2 years ago, after more than half a century. But President Trump has yet to say what the deal he believes he could obtain would look like. His so-called deal could be described in one word, "capitulation," which hasn't worked for over 50 years.

The White House decries the decrepit Cuban military's role in the economy, as if it poses a threat to us or is somehow an aberration. They should look at the role of Egypt's military and Russia's and Indonesia's and Pakistan's. They have their hands in all kinds of business and real estate ventures.

They point out the number of people arrested in Cuba has increased. I have condemned the arrests of peaceful protesters. These arrests are wrong, but they are also wrong in the countries whose repressive governments the President has praised, some of which he regards as close allies of the United States.

Now, like Americans, the Cuban people know that fundamental change will not happen quickly and that the revolutionaries who overthrew one dictator only to be replaced by another will hold on to power while they can. But they also know that their time is ending, that Cuba is changing, and that the American people can support them best by engaging with them.

Secretary of State Tillerson says the administration is "motivated by the conviction that the more we engage with other nations on issues of security and prosperity, the more we will have opportunities to shape the human rights conditions in those nations." Apparently, this administration should have added: "except for Cuba."

On May 25, Senator FLAKE and I, along with 53 Democratic and Republican cosponsors, introduced the Freedom for Americans to Travel to Cuba

Act. It is, frankly, absurd that such legislation is even necessary to restore the American people's freedom to travel that the Federal Government should never have taken away.

Fifty-five Senators of both parties are on record in support of doing away with the restrictions in law that even President Obama could not fix; and, frankly, if there is a vote on this bill, it will pass overwhelmingly. I hope the majority leader will strike a blow for democracy and actually let us have that vote so we can show the Cuban people what real democracy looks like when people are allowed to vote.

We support freedom not only for the people of Cuba, we support it for the American people because we reject the idea that any government should deny its citizens the right to travel freely, least of all our own government. We actually believe Secretary Tillerson's rhetoric. We believe that restoring the punitive policy of the past is little more than a misguided act of vengeance rooted in a half-century-old family feud that will do nothing to bring freedom to Cuba.

Who do we see now coming to Cuba to build a railroad? The Russians. Who do we see as we turn our back on Cuba planning to invest there? The Chinese. Let's not repeat the mistake we made for 50 years.

The Cuban people and the American people want closer relations. Every single poll shows that. I wish President Trump would listen to the American people rather than to a tiny minority who want to turn back the clock.

If we really care about freedom in Cuba, we should flood Cuba with American visitors and make it possible for American farmers and American companies to compete there as they would in any other country.

If we really care about freedom, our government should stop playing Big Brother with the lives of Americans. It doesn't work. It has never worked. Frankly, it is wrong.

I yield the floor.

THE PRESIDING OFFICER (Mr. MORAN). The Senator from Rhode Island.

#### HEALTHCARE LEGISLATION

Mr. REED. Mr. President, I come to the Senate floor, once again, to urge my colleagues to work in a bipartisan, transparent fashion to improve our healthcare system and help bring down costs.

Over the weekend, members of the American Medical Association—the Nation's largest organization of doctors—had a chance to finally read the proposed Republican bill and found it violates their “do no harm” principle. According to a letter they wrote to Leaders MCCONNELL and SCHUMER, “Medicine has long operated under the precept of *Primum non nocere*, or, ‘first do no harm.’ The draft legislation violates that standard on many levels.”

That is the conclusion of the American Medical Association, and they are

correct. This bill will not lower costs, and it will not improve our healthcare system. Instead, it will remove health insurance coverage for millions of Americans. Indeed, the CBO has just released their estimate that 22 million Americans will lose their health insurance coverage. It will increase costs for everyone and decimate State budgets, creating a ripple effect throughout our economy.

The bill my colleagues worked in secret to craft is, in a sense, a sham. It will not lower costs, and it will not improve our healthcare system, as they insist. Instead, it will remove health insurance coverage for millions of Americans—22 million, according to the CBO—increase costs for everyone, as I said, and decimate State budgets. In fact, their bill essentially is a huge tax cut for the wealthiest 2 percent of Americans at the expense of everyone else.

If you need any further proof of the real driver of this bill, one of its biggest giveaways is a retroactive tax break on investment income for people making at least a quarter of a million dollars. Dozens of leading economists, including six Nobel laureates, have criticized this plan as, in their words, a “giant step in the wrong direction” that prioritizes tax breaks averaging \$200,000 annually per household in the top 0.1 percent of Americans over the well-being of working families. In fact, President Trump himself will get an estimated \$2 million tax break each year from the giveaways in this bill. Let's call this bill what it is: a massive giveaway to the wealthiest Americans. Meanwhile, the rest of the country—all of our constituents—will be the ones paying the price for these tax breaks for those well-off. So much for the President's claim that he would end a rigged system.

Now, how do Republicans pay for these tax breaks? For starters, they are proposing to end the Medicaid expansion under the Affordable Care Act, which is providing health insurance to nearly 15 million Americans, but then they go even further by effectively block-granting Medicaid, cutting hundreds of billions of dollars from the program over the next decade. These are not reforms designed to lower costs. This is a cut, pure and simple, which will sharply curtail and eliminate needed healthcare services to many across this country. In fact, the Center on Budget Policies and Priorities published data that shows a stark contrast of who gains and who loses under this bill. The 400 households in the country with the highest incomes will get tax breaks totaling \$33 billion because of the Senate TrumpCare bill. As a result, over 725,000 Americans will lose Medicaid coverage in just four States to equate to that \$33 billion: Alaska, Arkansas, Nevada, and West Virginia. That doesn't even scratch the surface as to who will lose access to care in the remaining 46 States.

Medicaid has played a critical role in ensuring access to care for millions of

Americans, including children, seniors, and people with disabilities. In fact, across the country, and in my home State of Rhode Island, about half of all Medicaid funding is spent on nursing home care. Over 60 percent of nursing home residents access care through Medicaid. If you think nursing home care will be protected, you are in for a rude awakening because the math just doesn't work. It will be impossible to cut Federal funding for State Medicaid programs by hundreds of billions of dollars and not impact the most significant Medicaid expenditures, which are nursing homes.

I would also like to talk about the role Medicaid plays in emergencies like a recession or public health crisis. We know all too well how an economic downturn impacts communities. With job loss, comes loss of health insurance, pensions, and other benefits. The tax base shrinks, and State budgets suffer. Medicaid, as currently structured, is able to adapt to this. As the need increases, the program grows to cover everyone who is eligible, including those who have just lost jobs. This saves families from having to choose whether to take their kids to the doctor or put food on the table.

Under the Senate TrumpCare bill, States will be hamstrung by arbitrary caps and limits on Medicaid. In fact, States will be unable to expand coverage during a recession to those in need, and they will likely have to make cuts across the board, from healthcare and education to transportation infrastructure, to make up for the lost tax revenues. This is not strictly going to be an issue of healthcare policy in States. The cuts are so dramatic that after they have taken all they can from other healthcare programs, they will inevitably go to education funding—the biggest expense most States have—and then to transportation and then to public safety. Even then, I don't think they can keep up with these cuts.

Like most of the country, Rhode Island was hard hit by the recession. It took many years for the economy to even begin to turn around in the right direction. It seemed my colleagues are forgetting how Medicaid has been a critical safety net through tough economic times.

I am also concerned that my colleagues are not aware of the impact Medicaid has on our Nation's veterans. The uninsured rate among veterans has dropped by 40 percent since implementation of the Affordable Care Act. Nationwide, nearly 1 in 10 veterans is covered by Medicaid, including approximately 8,000 veterans in my home State of Rhode Island. The cuts to Medicaid that have been proposed by my Republican colleagues put the care of our veterans at risk. We have all promised to provide the best care possible to our brave men and women when they leave the service, but the Senate TrumpCare bill would do the opposite.

That is not the only way this bill would damage veterans' care. Many

veterans seek help for mental health care by going outside of the VA system. TrumpCare puts mental health and substance abuse treatment at risk by saying insurance companies no longer need to cover these services. For the over 15,000 veterans in Rhode Island who access mental and behavioral healthcare outside of the VA, they would be out of luck. For all the bipartisan work in this Chamber to increase veterans' access to these services, it would all be for naught if Senate Republicans pass their TrumpCare bill.

These are just some of the things Republicans are sacrificing in the name of tax breaks for the wealthy. It is, frankly, unconscionable. More importantly, this will not be lost on the American people. I have heard from thousands of my constituents since the beginning of this year, and if Senate Republicans press forward with this legislation, I think we will all hear from many more of these constituents for many years to come.

TrumpCare is fundamentally flawed and cannot be fixed. We would welcome the opportunity to work across the aisle on improvements to the Affordable Care Act, like those to lower costs, especially prescription drug costs, any time.

I, once again, urge my colleagues to drop their efforts and to work with us to instead make improvements to the ACA.

I yield the floor.

**THE PRESIDING OFFICER.** The Senator from Florida.

**Mr. NELSON.** Mr. President, last week, I spoke with a very brave mother. She had endured what not one of us ever wants to have to endure while she watched her child go through cancer, over and over and over again. That mother is Elaine Geller from my State of Florida. I want to show you her daughter. This is her daughter Megan. She was working as a kindergarten teacher when she was diagnosed with leukemia in 2013 at the age of 26. At the time Megan was admitted to the hospital, her blood count was four. She had pneumonia, and she had water on her heart.

She ultimately checked into one of the very good cancer centers at the University of Miami, and she stayed there for 7 months. She went through the regimen of chemo. She spent months in the hospital, receiving multiple rounds of chemo, biopsies, and various other treatments. Eventually, Megan's doctor told her she had to have a transplant, which required a \$150,000 upfront payment. I think you see where I am going with this story. Very few families would be able to afford a 150-grand payment, especially a single mother.

I heard this story last week from Megan's mother. She said that thanks to the Affordable Care Act, she didn't have to write a check for the transplant. In fact, she didn't have that money. Because that transplant was provided for under the Affordable Care

Act coverage, she knew that was one worry that could be taken off of her mind. She had enough to worry about as a mother, what she should be doing in such a situation, and of course she wanted to give all of her attention to her daughter.

The cancer went into remission after the transplant; however, after leaving the hospital, 63 days later, the cancer came back. This time, they went to MD Anderson Cancer Center in Houston. I asked the mom why she wanted to do that. She said: "When your child is dying, there's nothing that you won't do." I think all of us as parents can identify with that, but we are so very fortunate that we haven't had to go through it.

Maybe, as we get ready to vote on this healthcare bill, on the Republican alternative—which, by the way, just came out of CBO today—the Congressional Budget Office—and they said that if the Senate bill were enacted, 22 million people would lose health insurance coverage. Remember, that is not too much different from what CBO said when the House bill was passed a couple of months ago, the bill to which there has been such a negative reaction. CBO said that 23 million people in this country would lose their coverage as a result of the House bill. We just got the score from CBO minutes ago. Twenty-two million people. Is that the direction we want to be going in?

Megan is still going through treatment, and the cancer was only in remission for 32 days before it came back again. Megan received multiple blood transfusions. Remember, this is a single mom trying to keep her daughter, a schoolteacher in her twenties, alive. This time, all of the blood transfusions started to take another toll on Megan. She became so weak. When trying to walk, she faltered, she fell, she hit her head, and at age 28, she passed away.

Let's get to the bottom line of this discussion, other than that our hearts go out to all the Megans all across America. The bottom line is, that whole treatment over 2 years cost \$8 million. There was not a cap on the total amount of money that could be paid under the existing law, the Affordable Care Act. An insurance company cannot put a cap on the amount of your medical bills that can be reimbursed. Suppose before the ACA that cap was \$50,000. This single mom could not even have come up with money for the initial transplant, which looked as though it worked and did work for several months. In fact, \$8 million over time—2 years—how in the world could any one of us afford that?

A lot of people say: Well, the ACA isn't doing it. Well, why don't we all get together in a bipartisan way and fix it? And one of the fixes would be, because certain healthcare problems, like Megan's, cause the insurance company to pay out a lot of money—do you know what we can do about it? We can create a reinsurance fund, which is a bill that I had filed, and it is to rein-

sure against that catastrophic healthcare problem like Megan's of \$8 million, to reinsure the insurance company. Do you know what that would do in the State of Florida, if we passed this as a fix to the ACA? It would lower the premiums in the ACA in Florida 13 percent. That is reinsurance.

It is not unlike what we have done for hurricanes. A catastrophic hurricane could cost so much more than the insurance company has assets for, and therefore they buy insurance from a company like Lloyd's of London or other reinsurance companies. They buy insurance in case of a catastrophe—the insurance company does that. If an insurance company did not have to pay out this \$8 million because it had insured against that kind of catastrophic loss, everybody else's premiums are going to come down. Otherwise, they have to make premiums actuarially sound, and they have to raise them in order to take care of the cases that are prohibitively expensive.

All of this sounds down in the weeds, but the bottom line is this: If we want to fix the ACA, we can fix it, but we can't do it one party against the other. We have to have the will to come together in a bipartisan agreement to fix it.

Of course, if the mom of this girl had been faced with this without insurance coverage, she would be bankrupt. She wouldn't have been able to even afford the first transplant, much less the 2 years of extra life her daughter had while fighting for her life. Anybody who goes through something like Elaine and her daughter Megan did knows that every second counts.

That is what this healthcare debate is about—giving people peace of mind, giving them that financial security, that certainty, putting people's health ahead of other things, such as company profits. You can do it all and solve everybody's problem, including the insurance company's, which obviously is in business to make a profit. You can do it.

Elaine said her daughter would be proud to know that we are telling that story today. It matters. It matters to her, albeit deceased. It certainly matters to her mom. It matters to their Senator. It matters to a lot of other people.

The ACA, the existing law—the one there was such a fractious fight over 5 to 7 years ago—is working. Here is a good example. Then we see that the aim of our friends on that side of the aisle is—they want to repeal it. They don't want anything that has the taint of ObamaCare, and so they concoct something in the House. You see what kind of greeting that has gotten in the country. I think it was in the upper teens—a poll that showed it was viewed favorably. In other words, it is viewed very unfavorably.

In order for the Senate majority leader to come up with something that he can repeal ObamaCare with, in the dead of night, in secret—even the Republican Senators didn't know what it



was until they hatched it in the public last Friday. This bill is just as bad as the House bill.

They will claim, in trying to stand up this bill—by the way, it is going to wither, the more it is examined in the glare of the spotlight. They claim that it maintains the ACA's protections for those with preexisting conditions. Can anybody really say that with a straight face? It leaves it up to the States.

Before I came to Washington and the Senate service, I was the elected insurance commissioner, State treasurer of Florida. It was my job to regulate the insurance companies—all kinds of insurance companies, including health insurance companies. I can tell you that I have seen some insurance companies use asthma as a preexisting condition, and therefore that was the reason they would not allow the person who needed insurance to be covered. They said: If you have a preexisting condition, we are not going to insure you. I have even seen insurance companies use as an excuse a rash as a preexisting condition, and that means they are not going to insure you. Under the existing law, the ACA, they can't do that. You are going to have the security of knowing you are going to have coverage.

Do you know something else you are going to have the security of knowing? You are not going to deal with some of those insurance companies that I regulated. Of your premium dollar for health insurance, they would spend 40 percent of that dollar not on your healthcare, but they would take 40 cents of that premium dollar that you paid and that was going to executive salaries. It was going to administrative expenses. It was going to plush trips. Don't tell me that is not a true story. I saw it over and over in the 1990s as the elected insurance commissioner of Florida.

You know what the existing law says? It says that of every premium dollar you pay, 80 cents of that premium dollar has to go into healthcare. It can't be commissions. It can't be executive salaries. It can't be the executive jets for the corporate executives. Eighty cents of that premium dollar has to go into healthcare so you get what you pay for in that premium dollar. At some point there is going to be an attempt to undo that. If you start leaving things up to the States, watch out.

When Megan was in the ICU, she had a respiratory failure that cost thousands of dollars more, and thanks to the ACA, her insurance carrier covered it. But under the Republican bill that has been now released, States could let their insurance companies pocket more of those premium dollars to pay for those things I just shared, which I had seen back in the decade of the 1990s as the insurance commissioner. Well, we shouldn't be padding their pockets. The premium dollar for health insurance ought to go to healthcare.

The Senate bill cuts billions in Medicaid. We haven't even talked about

that. Who gets Medicaid? Millions of people in this country do. It is not only the poor. It is not only the disabled. It is 65 to 70 percent of all seniors in nursing homes who are on Medicaid, and it is also some children's programs. Let me just give you one example. I went to the neonatal unit at Shands Hospital in Jacksonville, a hospital affiliated with the University of Florida, but in Jacksonville. The doctors and nurses were showing me how miracles occur for premature babies; they keep them alive.

Then what they wanted to show me was—with the opioid epidemic, which has hit my State just like all the other States, they wanted me to see and understand that when a pregnant mom is addicted to opioids, she passes that on in her womb to her unborn child. When born, that baby is opioid-dependent. The doctors showed me the characteristics—that high, shrill cry, the constant scratching, the awkward movements. Do you know what they use to wean those little babies off opioids over the course of a month? They use doses of morphine.

Do you want to devastate Medicaid? Do you want to take over \$800 billion over 10 years out of Medicaid? What about those single moms? The only healthcare they get is Medicaid. And what about those babies I just described, who are also on Medicaid? If you start capping the amount of money that goes to the States on a Federal-State program for healthcare—Medicaid—you are going to throw a lot of people off any kind of healthcare, including senior citizens in nursing homes.

A Medicaid block grant, or a cap, would end the healthcare guarantee for millions of children, people with disabilities, pregnant women, and seniors on long-term care. There are 37 million children in this country who rely on Medicaid for care. The seniors, the poor, the disabled, the children—they are all vulnerable to the cuts that would occur.

If that is not enough to vote against this bill that is coming to the floor this week, the Senate bill actually imposes an age tax for older Americans, allowing insurance companies to charge older Americans up to five times more for coverage than a young person. You say: Well, older people have more illnesses and ailments; older people ought to cost more. If that is your argument, well, that is true.

The age rating in the existing law, the ACA, is three to one. This changes it to five to one, and five to one means one thing: higher premiums for senior citizens—I am talking about all insurance policies—until they reach that magic age of 65 and can be on Medicare. Do you want an age tax on older Americans as a result of this bill? I don't think so. But that is what is in there.

Fixing our Nation's healthcare system shouldn't be a partisan issue. That is why I have joined—bipartisan—with colleagues to introduce a bill that I de-

scribed a moment ago, which would lower healthcare premiums by 13 percent. That bill would stabilize the ACA's insurance marketplace through the creation of a permanent reinsurance fund. I have seen the policies work, as I described, with catastrophic hurricane insurance. There is nothing magic about my idea. It is just an obvious fix to the existing law, and ideas like that can bubble forth in a bipartisan way to make the existing law that we have sustainable.

What we ought to be doing is trying to look for ways to help people like that single mom Elaine and her daughter Megan. We should be working together to make the ACA work better. We shouldn't be plotting behind closed doors in the dead of night with a secret document—a secret document that we now know will make it worse.

I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. CARPER. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

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

Mr. CARPER. Mr. President, it is good to see you this afternoon.

I rise in support of the nomination of Kristine Svinicki to hold a third term as a member of the Nuclear Regulatory Commission, known as the NRC. Many Senators heard from our chairman on the Environment and Public Works Committee in support of this nominee last week, just prior to our cloture vote. I want to add my voice in support of her nomination as well.

Since joining the Environment and Public Works Committee, I have worked closely with my colleagues to strengthen what we call the "culture of safety" within the U.S. nuclear energy industry. In part, due to our collective efforts and the NRC leadership and the Commission's dedicated staff, the NRC continues to be the world's gold standard for nuclear regulatory agencies. However, as I say time and again, that does not mean we can become complacent when it comes to nuclear safety and our NRC oversight responsibilities, a perspective that I am certain is shared by every Member of this body.

Ensuring that the Nuclear Regulatory Commission continues to have experienced and dedicated leadership is one of the most important things that our committee, the Committee on Environment and Public Works, and the Senate can do to maintain a high level of safety and excellence in our Nation's nuclear facilities.

I am quite impressed with our NRC Commissioners, and I am encouraged with their ability to work cooperatively with each other. Each Commissioner, including our current chair, Kristine Svinicki—let me say her name again: Svinicki. People have a hard time saying her name. It is Svinicki.

She brings a unique set of skills to the table—something that has served the Commission and our country well.

I continue to have ongoing discussions with our friend, the chairman of the committee, Senator JOHN BARRASSO, about the strong interest I and our minority members of the committee have with ensuring parity, as the Senate looks to confirm other nominees to the NRC. This is in order to ensure that we have a balance of Democratic and Republican members on the Commission for years to come. It continues to be a priority for me and our Democratic colleagues.

At this time, I support moving Chairman Svinicki through the confirmation process. I do so out of respect for her long service to the NRC and for the need to ensure certainty and predictability within the NRC and its leadership. I hope my colleagues will join me in supporting her nomination.

Mr. President, as to this particular nominee, not everybody on the committee or probably in the Senate will support the nomination of Kristine Svinicki. They could have held her up. No one has, and she has moved through our committee expeditiously. She, in my view, should have moved through expeditiously and will be coming before us for an up-or-down vote in a few minutes.

#### HEALTHCARE LEGISLATION

Mr. President, I want to suggest, as we approach our business later this week with respect to healthcare legislation, that maybe the way we have handled this nomination might be a little bit of a model for the way we can actually work together.

We need to. People in this country say to me all the time and people in my State say to me all the time: Just work together. Get something done.

I know the Presiding Officer and the Senator from West Virginia, who has just entered the Chamber, want to work that way, too, and so do I. What I think we ought to be doing on healthcare in this body is to look at the ACA and study it up and down. God knows we had enough hearings, roundtables, opportunities to debate it, vote for it, and amend it—over 80, I think, or maybe over 400 amendments, all told, and 80-some days of working on it in 2009.

Rather than have legislation that just Democrats or just Republicans vote to put on the table and to try to push through here on Thursday, my hope is that we will hit the pause button. My hope is that we will hit the pause button, and we will focus—Democrats and Republicans—on trying to figure out what in the Affordable Care Act needs to be fixed and fix it, and figure out what needs to be maintained and preserved and preserve it. That is what I think we should do.

Lo and behold, if we were to do those things, I think we would end up with a better healthcare system with better healthcare coverage and maybe actually make true of the word of the Pres-

idential nominee, Donald Trump, who said he favored healthcare legislation that would actually cover everybody and get better results for less money. That is not a bad goal for us to shoot for. What I have laid out here just very briefly is this: Figure out what needs to be fixed in the Affordable Care Act and fix it, figure out what needs to be preserved and preserve it, and do it not just as Democrats or Republicans, but do it together. I think if we would do that, in the words of Mark Twain, we would confound our enemies and amaze our friends.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. MANCHIN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

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

All time has expired.

The question is, Will the Senate advise and consent to the Svinicki nomination?

Mr. MANCHIN. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The clerk will call the roll.

Mr. CORNYN. The following Senators are necessarily absent: the Senator from Arizona (Mr. FLAKE), the Senator from Georgia (Mr. ISAKSON), and the Senator from Alabama (Mr. STRANGE).

The PRESIDING OFFICER (Mr. LANKFORD). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 88, nays 9, as follows:

(Rollcall Vote No. 154 Ex.)

#### YEAS—88

Alexander	Fischer	Paul
Baldwin	Franken	Perdue
Barrasso	Gardner	Peters
Bennet	Graham	Portman
Blumenthal	Grassley	Reed
Blunt	Hassan	Risch
Boozman	Hatch	Roberts
Brown	Heinrich	Rounds
Burr	Heitkamp	Rubio
Cantwell	Hirono	Sasse
Capito	Hoeven	Schatz
Cardin	Inhofe	Schumer
Carper	Johnson	Scott
Casey	Kaine	Shaheen
Cassidy	Kennedy	Shelby
Cochran	King	Stabenow
Collins	Klobuchar	Sullivan
Coons	Lankford	Tester
Corker	Leahy	Thune
Cornyn	Lee	Tillis
Cotton	Manchin	Toomey
Crapo	McCain	Udall
Cruz	McCaskill	Van Hollen
Daines	McConnell	Warner
Donnelly	Menendez	Whitehouse
Duckworth	Moran	Wicker
Durbin	Murkowski	Wyden
Enzi	Murphy	Young
Ernst	Murray	
Feinstein	Nelson	

#### NAYS—9

Booker	Harris	Merkley
Cortez Masto	Heller	Sanders
Gillibrand	Markey	Warren

#### NOT VOTING—3

Flake Isakson Strange

The nomination was confirmed.

The PRESIDING OFFICER. The majority leader.

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the motion to reconsider with respect to the Svinicki nomination be considered made and laid upon the table and the President be immediately notified of the Senate's action.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

#### LEGISLATIVE SESSION

#### MORNING BUSINESS

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Senate be in a period of morning business for debate only and with Senators permitted to speak therein.

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

The Senator from Hawaii.

#### HEALTHCARE LEGISLATION

Ms. HIRONO. Mr. President, we are all one diagnosis away from having a serious illness. Lots of us believe that getting a serious illness is something that happens to other people. I was one of them.

My moment of reckoning came 2 months ago. During a routine physical, my doctor told me I have kidney cancer. It is a moment everyone dreads. Thankfully, I had health insurance. I was able to sit down with my doctors and decide how I would fight my cancer, not how I would pay for treatment.

No one should have to worry about whether they can afford the healthcare that one day might save their life. Healthcare is personal, and it is a right, not a privilege reserved only for those who can afford it. It is why we are fighting so hard against TrumpCare.

Thirteen of our male colleagues spent weeks sequestered away, literally plotting how to deny millions of people in our country the healthcare they deserve. They spent these weeks figuring out how to squeeze as much as they could out of the poorest, sickest, and oldest members of our society so they could give the richest people in our country a huge tax cut. This is not a healthcare bill. This is a tax cut for the rich bill.

Last week, the majority whip looked the American people in the eye from his desk and accused us of denouncing TrumpCare before we had a chance to read it. Well, read it we did, and it is as bad as we thought.

The Congressional Budget Office is estimating that 22 million people will lose their insurance under TrumpCare. Its draconian cuts to Medicaid would have a devastating impact on our seniors—our kupuna, as we refer to them



in Hawaii—who depend on the program for long-term nursing care. It imposes an age tax on people 50 to 64 that allows insurance companies to charge them five times more for insurance. It fulfills the Republican Party's cherished goal of defunding Planned Parenthood. It undermines protections for Americans living with serious and chronic diseases who could face the reimposition of yearly and lifetime caps on their care.

For millions of people in our country, TrumpCare is not some abstract proposal that has no relevance to their lives. Last week, Senator MURRAY, Senator VAN HOLLEN, and I joined three advocates—Ian, Marques, and Jill—who told us their stories about how TrumpCare would impact them.

Ian grew up in Fond du Lac, WI. During his sophomore year in high school, Ian discovered he had bone cancer after suffering an injury playing football. He has been cancer-free for 6 years and is now pursuing a career in medical research, in large part, because of his experience in fighting this cancer. Although Ian has been cancer-free for some time now, he is very concerned about what TrumpCare could mean for him if his disease comes back. He has a preexisting condition.

Marques lives in Richmond, VA. He was diagnosed with multiple sclerosis when he was only 27 years old. He has three young daughters and faces a lifetime of extensive treatment for his disease. Because of the Affordable Care Act and the guarantee of coverage it affords every American, Marques did what he never thought he would be able to do with MS, he started his own business.

Jill is from Hillard, OH. Her daughter Alison was born with cystic fibrosis. Alison endured a lot at a very young age. When she was only 7, Alison had part of her lung removed because of the damage her disease caused. Because she has health insurance, which makes paying for expensive CF drugs more affordable, Alison is a happy teenager planning eagerly for her future. Jill made clear what would happen if TrumpCare passes: Alison's CF medication would become prohibitively expensive. Under TrumpCare, Jill would have to make decisions about which drugs she could afford for Alison, not which would work best to fight her disease.

Annual or lifetime limits on healthcare coverage will mean constant worry about paying for the life-saving care that Ian, Marques, Jill, and their families need—not starting a business, not living like a normal teenager or young adult with dreams for the future. They will spend practically every waking moment just worrying about how they are going to pay for the care they need to live.

TrumpCare would be a disaster for the American people, and we are going to fight against it tooth and nail, but I also want to be clear about what we are fighting for. We are fighting for universal healthcare that is a right,

and not a privilege, for every American.

Tomorrow, I am going in for surgery to remove the lesion I have on my rib, but I am going to be back as quickly as I can to keep up the fight against this mean, ugly bill. The stakes are too high to stay silent. We need everyone in this fight because we are all in it together.

Millions of people across the country are mobilizing against TrumpCare because healthcare is personal. I am encouraged that so many people have been calling all of us and making their voices heard. The majority leader and Donald Trump can try to jam this bill down our throats, but we aren't going to let them succeed, and we are going to hold them accountable.

The fight continues.

I yield the floor.

The PRESIDING OFFICER. The Democratic leader.

#### WISHING THE SENATOR FROM HAWAII WELL

Mr. SCHUMER. Mr. President, I just want to salute, on behalf of all of us in the Senate, our great, great Senator from Hawaii. Her courage, her strength, her conviction to help people who need help is just inspiring—that is the only word I could think of, “inspiring”—to every one of us.

We love you, MAZIE. We wish you well, and we can't wait for you to come back and rejoin the fight doubly invigorated.

I yield the floor.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. MERKLEY. Mr. President, I extend to my colleague from Hawaii every blessing for her successful health treatment. I know the thoughts and prayers of every Member of the Senate are with her tomorrow and beyond as she undertakes that healing path.

#### HEALTHCARE LEGISLATION

Mr. MERKLEY. Mr. President, I appreciate the comments of the Senator from Hawaii tonight. They are certainly very relevant to the issue of healthcare here in America because each of us hopes that if a loved one gets ill, they will have the peace of mind that they know they will be able to get the healthcare they need and they will not go bankrupt in the process. Yet here we are tonight debating a bill titled “Better Care Act.”

Better Care, has ever there been a bill in the history of the United States of America so more perversely named than this Better Care Act which strips care from 22 million Americans?

I was very struck by one equation of this bill; that is, that it provides to the richest 400 Americans \$33 billion over a 10-year period. That is enough to pay for healthcare under Medicaid for 700,000 individuals—700,000 individuals. It rips the healthcare away from them to give \$33 billion to the richest 400

families. That is obscene. That is certainly not better care.

It is hard for me to imagine that a single Member of this body would vote to proceed to this bill, but here we are. Until we get agreement that we are not going to proceed, we have to continue to carry on this fight.

We know that 15 million people, CBO estimates, will lose healthcare in the next 12 months. That is even worse than the House bill. Last week, I came to this floor to call the Senate draft mean and meaner. The House bill was mean. The Senate's is meaner. Now we have the CBO estimate that says, yes, it is worse. One million more people would lose healthcare in a short period of time.

Furthermore, the rate at which standard Medicaid is compressed—Medicaid, as it existed before ObamaCare, that rate has increased to further diminish healthcare, having nothing to do with ObamaCare, just to add to the cruelty of this bill. So millions lose, but we deliver billions of dollars to the richest Americans.

In my home State of Oregon, just the elimination of the expansion of Medicaid, the Oregon health plan—just that would eliminate 400,000 Oregonians off healthcare.

Imagine those individuals holding hands, 400,000 Oregonians, stretching from the Pacific Ocean to the State of Idaho. Anyone who has driven across Oregon would realize it is 400 miles across Oregon. If you are driving it, it is 7 hours of driving. For 7 hours, at 50 miles an hour, 60 miles an hour, you are passing a stream of people who would lose their healthcare just from the elimination of the expansion of Medicaid.

My colleagues across the aisle have crafted this so as to put it beyond the next Presidential election, beyond the 2018 election and beyond the 2020 election. Why? They are so terrified of the impact of this on the election they decided to postpone it until after 2018 and 2020, as if that makes it acceptable to rip healthcare from millions of people. That type of cynical, cynical act, purely political, is not going to be viewed well by the American public.

If you are so ashamed of this bill, if someone is so ashamed that they want to postpone the effects beyond the next Presidential election 3½ years from now, then maybe you should be so ashamed as not to vote to move to the bill here in the short term.

One of our colleagues across the aisle noted today: I can't imagine—not quite the exact word-for-word, but it is close. I can't imagine that anyone in America would have a chance to review this bill and truly understand it in time to proceed to it this week, including myself.

Well, that is certainly true. Has there ever been a case where a bill profoundly affecting so many has not had the benefit of committee deliberation here in the Senate? Are we a legislative body or are we a dictatorship where everything is done behind closed doors

and then rammed through? That is not the American way, and that is not the constitutional vision for how the Senate should work. There is supposed to be time to consult healthcare experts and time to go home to consult our constituents and find out how they feel.

If one is so terrified of this bill that you are afraid of your constituents, then you shouldn't vote to proceed to the bill. If one is so terrified you don't want to consult the experts, you shouldn't proceed to this bill. If you are so terrified that the reaction from the public will be so strong that it will put you in an awkward spot, then you shouldn't proceed to this bill—because you have the responsibility to consult with your folks back home, a responsibility to consult with healthcare experts, to understand every nuance of this bill.

One of those facts is going to have a devastating impact on those who would go to nursing homes. Folks who are under Medicaid and in a nursing home have given up their entire income and assets before they can get Medicaid support.

I was in Klamath Falls the weekend before this last weekend, went to a nursing home, and they said: Senator, almost 100 percent of the folks here on long-term care are paid for by Medicaid. I thought they were going to say 60 percent or two-thirds, because that is the national statistic. No, in rural Oregon, in Klamath Falls, almost 100 percent.

Then we had the CEO of the Oregon Health Association reach out and address this issue of how it is going to affect seniors. Here are his exact words:

I was on a call early today looking at some projections of how hard Oregon and Medicaid-funded long-term care service would be hit. If this bill passes, it literally could force the closure of the majority of nursing facilities in Oregon by 2025.

One thing I can't get out of my mind. At another nursing home I went to is a woman named Deborah. I explained I was coming by to talk to people because I wanted to understand better the impact of this bill on long-term care.

She said: Senator, I am paid for by Medicaid. If Medicaid disappears, I am on the street, and that is a problem because I can't walk.

That is exactly what Deborah said. And, of course, it is a problem, not only because she can't walk but because she needs extensive care, which is why she is in long-term care to begin with.

The anxiety was palpable among the nursing home residents, among the long-term care residents, because they have no backup plan, because they had to spend down their assets before they qualified for Medicare. Don't think of this just as ripping healthcare away from millions of working families, millions of struggling families, millions of children, but also from our seniors who are in long-term care, who need exten-

sive care, and who have given up their assets in order to qualify for Medicaid. They used those assets to pay for it as long as they could, and now they are on Medicaid. We are prepared to take those folks, many of them in wheelchairs—like Deborah, unable to walk—and throw them into the street and say: too bad.

The President called the House bill mean and indicated he wanted a bill with more heart. This is not a bill with more heart. We should not move to proceed to this bill.

The PRESIDING OFFICER. The Senator from Minnesota.

Ms. KLOBUCHAR. Mr. President, I thank my colleague from Oregon for his words.

I rise today to give voice to the concerns I am hearing from so many people in my State and across the country about this repeal bill.

First, I want to recognize my colleague from Hawaii, Senator HIRONO, who spoke earlier tonight about her personal battle with kidney cancer, as she is an example to all of us of determination and grit when the going gets tough. She not only is going to the hospital for surgery tomorrow—which isn't an easy surgery—but she decided she wanted to spend the night before she went into the hospital here because she is so passionate about this issue.

I know she is going to fight this disease and win and come out stronger than ever. I have been so moved by how she has taken on her personal fight against cancer at the same time that she has kept this fight going in the Senate. She is doing it not just for herself or for her State but for people all over the country.

As Senator HIRONO has said, her experience shows how quickly a routine visit to the doctor can turn into a serious diagnosis—a diagnosis that becomes a preexisting condition.

Everyone who faces a serious illness, no matter who they are, should be able to focus all of their energy on getting better, not on how they are going to pay their medical bills. Unfortunately, the bill we are considering doesn't allow everyone to do that.

As the nonpartisan Congressional Budget Office noted earlier today, this bill could mean the return of annual or lifetime limits on what insurance would cover for people with expensive conditions like cancer or Alzheimer's, and some key healthcare benefits might be excluded from insurance coverage altogether.

It is no surprise that the Minnesota Hospital Association has said that this proposal "creates a lot of chaos."

I was just at Northfield Hospital this weekend. It is a college town, but it is in the middle of a very rural part of our State, with a lot of farms surrounding it. In fact, they call the town "Cows, Colleges, and Contentment." In that town and in that hospital, there wasn't a lot of contentment during my visit.

The CEO of the hospital told me that he was worried that this bill could

drive more of his patients to bankruptcy. I met with a number of people who were on the board and work at the hospital, and they were all very concerned about what the bill would mean.

This did not mean that they didn't want to see changes to the Affordable Care Act. They do. They see the issues with premiums in our State. That is why our Republican legislature worked with our Democratic Governor to pass a bill for reinsurance, to try to use something to leverage the risk for the people in the exchange. We could do something similar on the Federal level, and we should, but that is not what this bill is about.

The head of another hospital in my State said: "They are shortening up the money, but they're not giving us the ability to manage the care."

A Minnesota seniors organization said that this bill "feels like we're pulling the rug out from underneath families and seniors." That is why AARP strongly opposes the bill as well.

According to the CBO report that we got today, this bill would cause 22 million people to lose their coverage over the next 10 years—22 million people. On Friday, my Republican colleague Senator HELLER said that he "cannot support a piece of legislation that takes insurance away from tens of millions of Americans." I agree.

I hope our Republican colleagues will come to the negotiating table in a bipartisan way. I hope this administration will not sabotage the bill that we have now and will work with States like mine that want a waiver to be able to do the kind of cost sharing and the reinsurance that I just described. During that time, we can work together to actually make healthcare in America better and more affordable.

We need to think about the real and devastating impacts on people's lives that this piece of legislation would have because that is what this debate is about. It is not about all of us going back and forth and citing facts and figures. In the end, it is about how this will affect people.

It is about the lives of people like the mom in Minnesota who has a child with Down syndrome. She told me how she has seen Medicaid help parents of kids with disabilities avoid bankruptcy and how it helps school districts pay for the therapy children like hers need. She said that this bill is "unconscionable"—that is her word—because of what it would do to adults and kids who have disabilities.

We have more than half a million children in Minnesota who rely on Medicaid and the Children's Health Insurance Program. This includes kids like the students of a retired teacher from Northwestern Minnesota, right across from the North Dakota border. The teacher wrote in, saying that the bill is "cruel and mean," especially for the families of special needs students.

A lot of us have talked about how the President called the House bill mean and how we hoped to avoid a bill like

this in the Senate. In fact, this last weekend, he did admit that he had called the House bill mean after he had celebrated its passage. That is behind us.

The President is the one who is known for speaking his mind and speaking directly. He didn't need a poll or a focus group or an accountant to look at the House bill. He just called it what it was—mean.

In Minnesota, people don't mince words either, and that is why that teacher told me exactly what the impact of this Senate bill would be. In fact, today the Congressional Budget Office—the nonpartisan Congressional Budget Office—confirmed it earlier today with its estimate that millions of people, 22 million people, would lose their Medicaid coverage because of the bill.

Our debate today is about the lives of people like the retiree with Parkinson's in Minneapolis, who told me she is "scared and worried." She is not just worried about the cuts to Medicaid but also about depleting the Medicare trust fund to pay for tax cuts for the very wealthy. As she told me, the future of these vital programs that so many Americans depend on is on the line.

This healthcare bill is also about the people who are worried about taking care of their baby boomer parents at the same time that they are caring for their children. One woman told me about her mom, who died 2 years ago at 95 after suffering from dementia for more than 20 years. She had worked her whole life, but as she got older, she couldn't afford the nursing care she needed so much. Luckily, she was able to rely on Medicaid to pay for it.

More than half—54 percent—of nursing facility residents in Minnesota rely on Medicaid. I think when this House bill first came out, people thought, well, Medicaid—what does that have to do with my life? Then they started talking to their parents, their grandparents or they started talking to their neighbors, and that is when they realized, whoa, over 50 percent of people who go into assisted living and nursing homes end up relying on Medicaid.

This woman's daughter told me she is worried that this bill's cuts would put those vital services for seniors at risk for so many other parents and their kids. And even for older people who don't use Medicare or Medicaid, this bill could put health coverage out of reach. That is because it has an age tax for seniors, allowing older people to be charged five times as much as younger people for insurance. As AARP has said, that is just not right.

These are the concerns I have heard from seniors and their families in Minnesota. They are shared by people across the country, especially by people in our rural areas, where they tend to have a little older population. One reason for that is because the Senate bill, actually more than the House bill when it comes to Medicaid, makes even deeper cuts over the long term that

will hurt seniors and rural hospitals along with children, people with disabilities, and people suffering from opioid addiction.

We actually have a strong bipartisan group working on the opioid addiction problem. Four of us—two Democrats, two Republicans—were the chief authors of the bill that passed last year, which set the framework for the Nation. We then put billions of dollars into treatment last year, and we shouldn't blow it up now by passing a bill that, because of the Medicaid cuts, would—in my State, one-third of the people who get opioid addiction treatment get it from Medicaid. Actually, it would be moving ourselves backward.

I know my colleagues Senator COLLINS and Senator MURKOWSKI have expressed real concerns about these kinds of Medicaid cuts in their States of Maine and Alaska, which also have big rural populations.

In my State, Medicaid covers one-fifth of our total rural population, about 20 percent of our rural population. These cuts could cause the rural hospitals that serve this population to close. This doesn't just threaten healthcare coverage; it threatens the entire local economy. That is a big deal for rural hospitals, which often have operating margins of less than 1 percent. These rural hospitals are on the frontlines of the opioid epidemic that is hitting communities across the country.

In my State, deaths from prescription drugs now claim more lives than homicides. They claim more lives than car crashes. While there is more work to do to combat the epidemic, I want to recognize our progress. Yes, we passed the blueprint bill, which I just mentioned, with the help of Senators PORTMAN, WHITEHOUSE, and Ayotte. Unfortunately, we are moving ourselves backward.

Medicaid expansion has helped 1.3 million people receive treatment for mental and substance abuse across the country. I know this bill's cuts to these important services for people struggling with addiction have real concerns in States like West Virginia and States like Ohio.

The problems with this bill, of course, go beyond Medicaid cuts, as a mom from Belgrade, MN, told me when she wrote about her daughter who died way too young from cancer. She asked me to oppose this bill in honor of her daughter and the thousands of other children diagnosed with cancer each year. She is worried that the waivers in this legislation would undercut protections for people with preexisting conditions, threatening to make health insurance unaffordable for families like hers who have children or children with cancer.

One man from Minneapolis told me that what this does is "downright scary." Those were his words. He is scared because he is self-employed. He has a preexisting condition, and he gets his insurance on the individual market.

He is worried that under this bill, his costs—which are already high—would skyrocket.

I am the first to say that we need to fix the individual market. In fact, I started out by talking about the fact that we have done some work in our State, and I would like to bring that out nationally. This bill is not the way to do it because—as the CBO said earlier today—it would actually cut assistance and increase deductibles for many people on the individual market. Based on CBO's projections, the Joint Economic Committee estimates that average premiums in Minnesota would go up substantially next year, even more than they have gone up already.

People across the country are making their voices heard about these types of problems. According to the Kaiser Family Foundation poll that came out just last week, only 30 percent of Americans had a favorable view of the House bill, and these concerns go across party lines. Only about half of Republicans—56 percent—supported the House bill.

I know this bill has some differences from the House version, but as Speaker RYAN said last week, the two are very similar. I hope that hearing from Americans on both sides of the aisle prompts my colleagues to start working together to make our system better in a bipartisan way.

Here are some ideas. I would love to include, if we worked on a bipartisan basis together, not only the work that needs to be done on the individual market, but on the exchanges, on the rates, and for small businesses. But I would also like to work on prescription drugs. I have a bill that would harness the negotiating power of 41 million seniors on Medicare to bring drug prices down. We have a number of Senators on the bill. Right now, Medicare is absolutely banned from negotiating with 41 million seniors. That is just wrong. Our seniors should be able to use their market power to negotiate.

I would also love to see more competition in this market. There are several ways we can do it. One is by bringing in less expensive drugs from other countries when we have drug shortages now in this country. Senator COLLINS and I worked on this, and the bill passed this Senate and got signed into law. Now the Secretary of Human Services can actually bring in drugs that are safe from other countries when we have a drug shortage. We refined some of the language where the rules already allowed the Secretary to do that. They could do the same thing right now, but we can make it even more clear if this Congress got behind it.

Senator MCCAIN and I have a bill to bring in less expensive drugs from Canada, which is very similar to the American market. We have a provision in the bill so they would be safe. Many people in my State are doing this now. We once had bus rides of seniors going up there to get less expensive drugs. We could do it with other countries, as

well, as long as they were certified as safe. For one of the ways you could do it, Senator LEE and I have a bill that looks at this. Again, this a bipartisan bill. If you have less competition in the market and you have less competitors, that would trigger the ability to bring in more drugs. You could do it based on the price. If it goes up high and the Secretary or someone else that we could put in that place finds that it is not because of input costs, you could allow this competition to come in from other countries. It would be a trigger. I would bet you right now that if you did that, it would create incentives on American drug companies not to jack up the prices like they have been doing.

The top 10 selling drugs in America have gone up over 100 percent. Things like insulin are up three times. Things like naloxone, which we rely on for overdoses from opiates, have gone up astronomically. It feels like when these drug companies get a monopoly in their lap, they go for it. That is what is happening.

A second way to bring in competition is by encouraging more generics. Senator GRASSLEY and I have a bill to stop something called “pay for delay.” This is unbelievable to me, when I describe this to people—that big pharmaceutical companies are actually paying generic companies to keep their products off the market. The nonpartisan Congressional Budget Office has found that this would save something like \$3 billion over a number of years if we passed our bill. That is for the government and taxpayers, but you could save an equal amount of money for consumers who are paying for this in premiums. How could you ever explain that pharmaceuticals are actually paying generics to keep their products off the market? That is a vote I would like this Senate to take. I would like to challenge anyone to explain why they would vote against that.

We also have another bill called the CREATES Act, with Senators GRASSLEY, LEAHY, LEE, and me, which makes it easier to get generics to market by sampling and other things.

These are just a few of the examples of bills that I think would be very good if we would consider them, but so far, we have done nothing. We banned seniors from negotiating. There is nothing in the House or the Senate repeal bills that does anything about these pharma issues. Again, that is one reason alone to be concerned about these bills.

I was at that baseball game a few weeks ago and saw firsthand that incredible bipartisan spirit, and at the women's softball game, as well. At the men's baseball game, the players played together, and, at the end of the game, when one team won—the Democratic team—they took their trophy and they gave it to the Republican team, and they asked them to put it in Representative SCALISE's office. That is what we need to see more of—not just two teams but one team. Cer-

tainly, on an issue as complex as healthcare, we just can't be playing in our separate ballparks. This is the time to come together. We have changes that we must make to the Affordable Care Act. I said that the day it passed—that it was a beginning and not an end.

I always thought it was unfortunate that it was more of a Democratic bill than it was a bipartisan bill. So we have an opportunity now to fix that, to make fixes to the bill, and to work together. But this bill is not the answer—this bill that we were not allowed to take part in, where the doors were closed, not only to Democratic Senators but to Americans themselves.

So I hope, as we go forward, that our colleagues on the other side will work with us on a truly bipartisan bill that would make some of the changes we need to bring down healthcare costs, instead of moving forward with this bill.

I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. MARKEY. Mr. President, I would like to thank my friend and colleague Senator HIRONO for her words and her willingness to share how this bill could impact the millions of Americans with preexisting conditions. I, along with everyone else in this Chamber, wish her the best and a speedy recovery so she can continue to fight for the people of Hawaii and the people of the United States.

After weeks of secret meetings, Senate Republicans released their healthcare legislation last week. In many ways, it is even worse than expected. It is no wonder that the Senate Republicans kept this legislative malpractice hidden behind closed doors. For working families and the elderly, for the disabled and for those suffering from opioid addiction, this legislation is a death sentence. This bill takes a machete to Medicaid. It abandons people with preexisting conditions. It punishes Grandma and Grandpa, who live in a nursing home, and 25,000 seniors in Massachusetts' nursing homes who are on Medicaid.

It causes the single greatest rollback of civil rights for people with disabilities in a generation, by taking away the funding for those with disabilities. It creates an age tax for those over the age of 50. It shreds a critical healthcare program for the disabled, working families, and children just to bestow billions in tax breaks for the wealthiest in our country.

This is an amazing number. The richest 400 billionaires in the United States will get a tax break of more than \$33 billion, which is roughly equivalent to the cuts from ending Medicaid expansion in four States. That is more than 700,000 people in just those four States who could be kicked off of their health insurance coverage to benefit just 400 billionaires in America who do not have to worry about their healthcare or their family's welfare. But for those

who are going to lose the coverage—people with cancer, people with Alzheimer's, people who need opioid addiction treatment, people with diabetes—they will have their healthcare coverage slashed so that 400 billionaires can get a tax break, which they don't need and they don't deserve. That is at the heart of this Republican healthcare bill. It is what it is all about. This legislation is of the rich, by the rich, and for the rich.

It is a “wealth care” bill for the upper 1 percent in our country, and it says to everyone else: Your healthcare is going to suffer in order to take care of that 1 percent with their tax breaks. It is a more than \$500 billion tax break to corporations and individuals making \$200,000 or more. It is no wonder that President Trump has kept his tax returns secret, because he knew he was about to get a massive tax break through this legislation from slashing healthcare for people with cancer, diabetes, Alzheimer's, heart disease, and substance use disorders. This selfish Senate Republican legislation will increase premiums and out-of-pocket costs, while decreasing the quality of health insurance coverage for most Americans.

This bill would result in many Americans—especially those over the age of 50—paying thousands more in premiums for skimpy health plans. It will put insurance companies back in charge of our healthcare by allowing them to waive coverage of the essential health benefits like emergency care, prescription drugs, maternity care, or mental health treatment.

That means that someone with a pre-existing condition, like a cancer survivor or a child with asthma, might have insurance but not actually be covered for the treatment they need, because under this bill, the anxiety of suffering from an illness or the constant fear of relapse will once again be exacerbated by financial insecurity.

Yet some of the most damaging provisions of this legislation are the brutal cuts to Medicaid, which already serves more than 70 million Americans, including, very importantly, two-thirds of all seniors in nursing homes in America, who are on Medicaid. Let me say that again: Two-thirds of all seniors in America are on Medicaid. Half of all seniors over the age of 85 have Alzheimer's, and 15 million baby boomers are going to have Alzheimer's. They are going to need some help. People have a hard time paying \$60,000, \$80,000, \$100,000 a year for a nursing home bed. What are the Republicans planning on doing over the next 15 years? Slashing that funding in Medicaid for seniors in our country who will need that help just to stay in a nursing home, or else they are going to have to go home to their families who will be responsible for providing the care for them.

The Senate Republicans doubled down and opted for even steeper cuts in their bill than in the House version. In

3 years, the Senate bill will start the process of kicking millions off of their Medicaid coverage by ending Medicaid expansion in States around the country. It will mean 22 million Americans are kicked off of coverage.

Then, as if that wasn't enough, starting in 2025, the plan will institute even more drastic Medicaid cuts that every year become a deeper cut than the year before, and it will literally mean death by a billion cuts for millions of Americans who will lose their healthcare coverage, especially those suffering from substance use disorders. Medicaid covers about one-third of Americans with an opioid use disorder and pays for nearly half of the medication-assisted treatments in Massachusetts. Taking away this treatment would be a death sentence for thousands of Americans.

A vision without funding is a hallucination. The Republicans are saying: We will find the will to take care of these people with opioid treatments. Well, you can't will your way to dealing with an opioid crisis. It is a disease. You need funding. You need treatment. And right now, there are millions of Americans who don't have the treatment they need. Medicaid is the way in which it will be provided, but the Republicans are just going to slash it, and the consequences are going to be catastrophic.

Now, here is what the Republicans are saying: To make up for the cuts to Medicaid, the Senate Republican healthcare legislation creates an opioid fund of \$2 billion for 2018. Compare that to the \$91 billion in funding for opioid use disorder treatment that would be provided by the Affordable Care Act over the next 10 years. A \$2 billion opioid fund is pocket change for a crisis that took 2,000 lives just last year in Massachusetts and 33,000 lives across the country. And if people were dying from opioid addiction at the rate they are dying in Massachusetts, that would be a 100,000 people a year—two Vietnam wars a year dying from opioid addiction. They are going to slash the funding for treatment for these families. It will be a death sentence for these individuals if they do not have access to the funding.

So the formula of this bill is simple: First, increase the cost of care, so working families pay more. Second, decrease the quality of care for seniors and the sick. Finally, hand over the hundreds of billions of dollars in tax breaks to the wealthiest people in our country—billions in tax breaks to people who don't need them, who don't deserve them, paid for by people who can't afford it. It is healthcare heartlessness.

To add insult to injury, it will devastate the budgets of already strapped States, which may be forced to raise taxes or cut other benefits, such as education or housing assistance, to make up for the billions of dollars States will lose because of this bill.

It is cruel. It is inhumane. It is immoral. It is just plain wrong to cut

healthcare benefits for those who need them to give tax breaks to those who do not need them. That is the Republican plan.

The Republican leadership is trying to catch a political unicorn with this bill—to make moderate Republicans happy while satisfying the most conservative elements of the Republican Party. But there is no treatment for TrumpCare. It is dangerous for healthcare, and there is no reviving Medicaid if this bill passes.

This Republican proposal has never been about policy. It isn't about covering more people or decreasing costs of healthcare or making it more patient-centered. The Republican proposal has always been about slashing healthcare for ordinary Americans to give a massive tax break to the wealthy in our country. That is the Republican policy agenda, not patient-centered care, because this will hand back over the power to insurance companies in our country, not to patients.

If Republicans were really concerned about reducing the deficit, then every single dollar in this bill would go to reducing the deficit—the crocodile tears which they shed about the deficit. No, ladies and gentlemen, they are shoving this money straight to the biggest number of billionaire beneficiaries than any tax bill in our country's history. They are, in fact, the party of the wealthy. They are the party trying to make sure that those who are in charge of funding the Republican Party now receive their pay back in the form of tax cuts at the expense of the healthcare of the ordinary people in our country. That is selfish, that is unconscionable, and that is why the Democrats are going to fight this every step of the way this week in order to protect healthcare for every American.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Vermont.

Mr. SANDERS. Mr. President, today's Congressional Budget Office analysis of the Trump-McConnell healthcare bill gives us 22 million reasons why this legislation should not see the light of day. What CBO tells us in truth is that this bill really has nothing to do with healthcare; rather, it is an enormous transfer of wealth from the sick, the elderly, the children, the disabled, and the poor into the pockets of the wealthiest people in this country.

According to CBO—and that report came out just a few hours ago—this bill would throw 22 million Americans off of health insurance, cut Medicaid by over \$770 billion, defund Planned Parenthood, and substantially increase premiums for older Americans. Under this bill, a 64-year-old with an income of \$56,000 could see his or her premiums increase from \$4,400 under current law to \$16,000—an increase of nearly 850 percent. How are older workers in this country going to deal with an 850-percent increase in their premiums? Meanwhile, the Trump-McConnell bill

would provide a \$231 billion tax break to the top 2 percent and hundreds of billions more in tax breaks to the big drug companies and insurance companies that are ripping off the American people every day.

At a time when the middle class of this country continues to shrink and when families all across America are struggling to make ends meet, to put food on the table, to pay their rent, to save a few bucks for retirement, we cannot take from working-class families and we cannot take from the sick and the elderly and the children in order to give even more to the very wealthiest people in this country—people who are at this moment doing phenomenally well.

Mr. President, this, in fact, is a barbaric and immoral piece of legislation. But let's be very clear. It is not just BERNIE SANDERS who opposes this bill. It is not just every Member in the Democratic caucus who opposes this bill. It is not just that the overwhelming majority of the American people oppose this legislation. According to a recent NBC/Wall Street Journal poll, only 16 percent of the American people thought this bill was a good idea. This bill is opposed by virtually every major healthcare organization in this country—the people on the frontlines, the people who today, yesterday, and tomorrow are dealing with healthcare issues, dealing with the sick, working in hospitals, working in community health centers. Almost without exception, every major healthcare organization in this country opposes this bill.

Maybe my Republican friends might want to get beyond the politics, get beyond Republicans and Democrats, and ask the people who really know about healthcare in America and ask yourself, how does it happen that virtually every major healthcare organization in this country opposes this legislation?

The AARP opposes this legislation—the largest senior group in America, which knows what high premiums for healthcare will do to their membership. The American Hospital Association knows a little bit about hospitals and what will happen to rural hospitals if this legislation is passed. The American Medical Association is a conservative organization. This is the doctors organization all over this country. This is not any progressive radical group; these are our doctors, the doctors we go to. They oppose this legislation because they know what will happen if there are massive cuts to Medicaid, if 22 million people are thrown off of health insurance. The American Academy of Family Physicians knows what this legislation will mean to the children of our country. The American Psychiatric Association, the Federation of American Hospitals, the Catholic Health Association, the American Lung Association, the Cystic Fibrosis Foundation, the March of Dimes, the National MS Society, the American Nurses Association—every one of these

organizations opposes the Republican legislation; not BERNIE SANDERS but every major healthcare organization says do not go forward with this disastrous bill.

This is what the AARP, the largest senior group in America, said recently:

This new Senate bill was crafted in secrecy behind closed doors without a single hearing or open debate—and it shows. The Senate bill would hit millions of Americans with higher costs and result in less coverage for them.

AARP is adamantly opposed to the Age Tax, which would allow insurance companies to charge older Americans five times more for coverage than every one else while reducing tax credits that help make insurance more affordable.

I ask all of my Republican friends to think for a moment about the implications of this bill and what it will mean to your constituents when they lose the healthcare they currently have. Put yourself in their place. Today you have health insurance, but tomorrow, next year, you might not. What does that mean? Think about it.

What does it mean if you are an individual today—and, sadly, there are too many of them. If you are a person today suffering with cancer and you are fighting for your life—maybe you are on radiation treatment. Maybe you are on chemotherapy. You are scared to death. You don't have a lot of money. You have cancer. You are struggling. And now you are reading in the papers that this Republican bill may take your health insurance away from you? How do you think they feel? I suspect scared to death. It is the same with people who have heart disease, who have asthma, who have diabetes or any other life-threatening illness. What happens to those millions of people when they cannot afford to go to the doctor when they are sick, cannot afford to buy the medicine they desperately need?

Mr. President, I know this is a sensitive issue, but I am going to raise it, and that is that the horrible and unspeakable truth is that if this legislation were to pass, and I am going to do everything I can to see that it doesn't, but if it were to pass, many thousands of our fellow Americans every single year will die, and many more will suffer and become much sicker than they should. That is not, again, BERNIE SANDERS talking; that is exactly what a number of studies have shown. Study after study, including one from the American Journal of Public Health to the New England Journal of Medicine, to the Harvard School of Public Health have told us. Again, this is not BERNIE SANDERS engaging in a rhetorical debate; this is what scientists and doctors who have studied the issue are telling us.

In fact, just this afternoon, a few hours ago, the *Annals of Internal Medicine*, a prestigious medical journal, published an article from researchers at the City University of New York School of Urban Public Health at Hunter College and Harvard Medical

School entitled: "The Relationship of Health Insurance and Mortality: Is Lack of Insurance Deadly?" That is the title of the article appearing today.

According to a summary of this article, "Insurance decreases the odds of dying among adults by at least 3 percent and as much as 29 percent and 'being uninsured substantially raises the risk of dying.'"

The coauthor of this article, Dr. David Himmelstein, commented:

According to the CBO, the Senate Republicans' plan would strip coverage from 22 million Americans. The best estimate based on scientific studies is that about 29,000 Americans would die each year as a result.

I know no Republican wants to see anybody die—none of us do—but that is the reality we are dealing with, and you cannot ignore it. If somebody has cancer, if somebody has heart disease and you take away their health insurance, I don't need studies from Harvard University to tell me and to tell you what you know to be the case. This is the United States of America, and we can do better than that.

Mr. President, I ask unanimous consent that the article that appeared today in the "Annals of Internal Medicine" be printed in the RECORD.

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

[From *Annals of Internal Medicine*, June 27, 2017]

THE RELATIONSHIP OF HEALTH INSURANCE AND MORTALITY: IS LACK OF INSURANCE DEADLY?

(By Steffie Woolhandler, MD, MPH, and David U. Himmelstein, MD)

(About 28 million Americans are currently uninsured, and millions more could lose coverage under policy reforms proposed in Congress. At the same time, a growing number of policy leaders have called for going beyond the Affordable Care Act to a single-payer national health insurance system that would cover every American. These policy debates lend particular salience to studies evaluating the health effects of insurance coverage. In 2002, an Institute of Medicine review concluded that lack of insurance increases mortality, but several relevant studies have appeared since that time. This article summarizes current evidence concerning the relationship of insurance and mortality. The evidence strengthens confidence in the Institute of Medicine's conclusion that health insurance saves lives: The odds of dying among the insured relative to the uninsured is 0.71 to 0.97.)

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At present, about 28 million Americans are uninsured. Repeal of the Affordable Care Act would probably increase this number, while enactment of proposed single-payer legislation would reduce it. The public spotlight on how policy changes affect the number of uninsured reflects a widespread assumption that insurance improves health.

A landmark 2002 Institute of Medicine (IOM) report on the effects of insurance coverage on the health status of nonelderly adults buttressed this assumption. The IOM committee responsible for the report found consistent evidence from 130 (mostly observational) studies that "the uninsured have poorer health and shortened lives" and that gaining coverage would decrease their all-cause mortality.

The IOM committee also reviewed evidence on the effects of health insurance in specific circumstances and medical conditions. It concluded that uninsured patients, even when acutely ill or seriously injured, cannot always obtain needed care and that coverage improves the uptake of essential preventive services and chronic disease management. The report found that uninsured patients with cancer presented with more advanced disease and experienced worse outcomes, including mortality; that uninsured patients with diabetes, cardiovascular disease, end-stage renal disease, HIV infection, and mental illness (the five other conditions reviewed in depth) had worse outcomes than did insured patients; and that uninsured inpatients received less and worse-quality care and had higher mortality both during their hospital stays and after discharge.

At the time of the IOM report, only one adequately controlled observational study had examined the effect of coverage on all-cause mortality. In this review, we summarize key evidence on this issue (Table 1), focusing on studies that have appeared since the IOM report and other previous reviews. Although not reviewed in detail here, more recent studies generally support the earlier reviews' conclusions that insurance coverage improves mortality in several specific conditions (such as trauma and breast cancer), augments the use of recommended care, and improves several measures of health status.

METHODS

We searched PubMed and Google Scholar on May 19, 2017, for English-language articles by using the following terms: "[uninsured] or (health insurance) or (un-insurance) or (insurance)] and [(mortality) or (life expectancy) or (death rates)]." After identifying relevant articles, we searched their bibliographies and used Google Scholar's "cited by" feature to identify additional relevant articles. We limited our scope to articles reporting data on the United States, quasi-experimental studies of insurance expansions in other wealthy nations, and recent cross-national studies. We contacted the authors of 4 studies to clarify their published reports on mortality outcomes.

We excluded most observational studies that compared uninsured persons with those insured by Medicaid, Medicare, or the Department of Veterans Affairs because pre-existing disability or illness can make an individual eligible for these programs. Hence, relative to those who are uninsured, publicly insured Americans have, on average, worse baseline health, thereby confounding comparisons. Conversely, comparisons of the uninsured to persons with private insurance (which is often obtained through employment) may be confounded by a "healthy worker" effect: that is, that persons may lose coverage because they are ill and cannot maintain employment. Nonetheless, most analysts of the relationship between uninsurance and mortality have viewed the privately insured as the best available comparator, with statistical controls for employment, income, health status, and other potential confounders.

Finally, we focus primarily on nonelderly adults because most studies have been limited to this group, and this group is likely to experience large gains or losses of coverage from health reforms. Since the advent of Medicare in 1966, almost all elderly Americans have been covered, precluding studies of uninsured seniors. Although Medicare's implementation may not have accelerated the secular decline in seniors' mortality, the relevance of this experience, which predates many modern-day therapies, is unclear.

Children have also been excluded from most recent analyses of the relationship of



insurance to mortality. Deaths in this population beyond the neonatal period are so rare that studies would need to evaluate a huge number of uninsured children to reach firm conclusions, and high coverage rates make assembling such a cohort difficult. The few studies addressing the effect of insurance on child survival have found that coverage lowers mortality and few policy leaders contest the importance of covering children.

#### RANDOMIZED, CONTROLLED TRIALS

Only one well-conducted randomized, controlled trial (RCT)—the Oregon Health Insurance Experiment (OHIE)—has assessed the effect of uninsurance on health outcomes. In 2008, the state of Oregon opened a limited number of Medicaid slots to poor, able-bodied, uninsured adults aged 19 to 64 years. The state held a lottery among persons on a Medicaid waiting list, with winners allowed to apply for a slot. The OHIE researchers took advantage of this natural experiment to assess the effect of winning the lottery on the 74,922 lottery participants.

Many lottery winners did not enroll in Medicaid, and 14.1% of lottery losers obtained Medicaid through other routes (some also got private coverage). Hence, the difference in the “dose” of Medicaid coverage was modest, an absolute difference of about

25%; to adjust for this, the OHIE researchers multiplied outcome differences by about 4.

At 1 year of follow-up, the death rate among lottery losers was 0.8%, and the winners’ death rate was 0.032% lower, a “dose-adjusted” difference of 0.13 percentage points annually. This difference was not statistically significant, an unsurprising finding given the OHIE’s low power to detect mortality effects because of the cohort’s low mortality rate, the low dose of insurance, and the short follow-up.

The findings on other health measures, obtained from in-person interviews and brief examinations on a subsample of 12,229 individuals in the Portland area, help inform the mortality results. Most physical health measures were similar among lottery winners and losers in the subsample. However, winners had better self-rated health, were more likely to have diabetes diagnosed and treated with medication, and were much less likely to screen positive for depression. Medicaid coverage was associated with a non-significant decrease of 0.52 (95% CI, 2.97 to –1.93) mm Hg in systolic blood pressure and 0.81 (95% CI, 2.65 to –1.04) mm Hg in diastolic blood pressure. In addition to the low dose of insurance, these wide CIs reflect the lack of baseline blood pressure data; this precludes analyses that take advantage of paired meas-

ures on each individual, which would reduce the variance of estimates.

In sum, the OHIE yields a (nonsignificant) point estimate that Medicaid coverage reduced mortality by 0.13 percentage points, equivalent to a (nonsignificant) odds ratio of 0.84.

Two older RCTs are also relevant to the effect of insurance and access to care on mortality, although neither directly compared insured and uninsured persons. In the RAND Health Insurance Experiment, random assignment to full (first-dollar) coverage reduced diastolic blood pressure by an average of 0.8 mm Hg ( $P < 0.05$ ) relative to persons randomly assigned to plans that required cost sharing, an effect size similar to the blood pressure findings in the OHIE. Unlike the OHIE, the RAND Health Insurance Experiment obtained baseline blood pressure readings, allowing researchers to determine that for participants with hypertension at baseline, full coverage reduced diastolic blood pressure by 1.9 mm Hg, mostly because of better hypertension detection; the effect was larger among low-income (3.5 mm Hg) than high-income (1.1 mm Hg) participants.

The Hypertension Detection and Follow-up Program also suggests that removing financial barriers to primary care in populations with high rates of uninsurance may reduce

TABLE 1.—SUMMARY OF STUDIES ON RELATIONSHIP BETWEEN INSURANCE COVERAGE AND ALL-CAUSE MORTALITY

Study, Year (Reference)	Participants	Information on Baseline Health	Estimated Mortality Effect of Coverage vs. Uninsured	Comments
<b>RCTs</b>				
Oregon Health Insurance Experiment, 2013, 2011, 2012 .....	74,922 nondisabled adults on waiting list for Medicaid.	Retrospective survey of a subsample; no baseline blood pressure or other measurements.	OR, 0.84 (NS) .....	Study was underpowered because of crossovers between insured and uninsured groups, low mortality rate, short follow-up. Coverage was associated with nonsignificantly lower (0.91 mm Hg) average diastolic blood pressure
<b>Quasi-experimental studies, population-based</b>				
Sommers et al., 2012, 2017 .....	Nonelderly adults in states expanding Medicaid (Arizona, New York, Maine) and comparison states.	None at individual level; compared trends in death rates in expansion with those in neighboring states.	RR of death expansion/nonexpansion states, 0.939 ( $P = 0.001$ ).	Study examined Medicaid expansions that preceded the ACA’s expansions
Sommers et al., 2014 .....	Nonelderly adults in Massachusetts and comparison counties.	None at individual level; compared trends in death rates in Massachusetts with those in matched control counties.	RR for death in Massachusetts counties/matched counties, 0.971 ( $P = 0.003$ ).	The 2006 reform expanded Medicaid and implemented subsidized coverage for low-income persons
Hanratty, 1996 .....	Newborns in Canadian provinces expanding coverage at different times.	None at individual level; compared infant mortality trends pre- vs. postreform.	RR for death, 0.95 or 0.96 ( $P < 0.05$ for both).	Estimates varied slightly depending on how time trends were modeled
<b>Quasi-experimental studies, clinic cohorts</b>				
Lurie et al., 1984, 1986 .....	186 clinic patients terminated from Medicaid vs. 109 who remained eligible.	Clinic-based data .....	OR at 1 y, 0.23 (NS) .....	Large effect probably reflects very high baseline risk. Among terminated patients with hypertension, average diastolic blood pressure increased 10 mm Hg at 6 mo vs. decrease of 5 mm Hg among controls ( $P = 0.003$ )
Fihn and Wicher, 1988 .....	157 patients terminated from outpatient VA care vs. 74 controls.	Clinic-based data .....	OR not calculable from published data; per authors, “at least 6% of terminated patients died”	Marked deterioration in blood pressure control among terminated patients
<b>Quasi-experimental studies using longitudinal data from the Health and Retirement Study.</b>				
Several cohorts followed for varying time periods from age $\geq 51$ y.		Repeated questionnaires linked to Medicare records and National Death Index; no examination or laboratory data.	Conflicting results; some found lower deaths among insured, and others were null.	Studies compared mortality before age 65 y and relative changes in death rates after acquisition of Medicare eligibility. Different analytic strategies yielded different conclusions
<b>Population-based cohort follow-up studies.</b>				
Sorlie et al., 1994 .....	CPS respondents 1982-1985 .....	None other than being employed .....	HR for employed white women, 0.83 (NS); HR for employed white men, 0.77 ( $P = 0.05$ ).	No data on smoking, health status or other non-demographic predictors of mortality at baseline
Franks et al., 1993 .....	NHANES respondents 1971-1975 .....	Surveys, physical examinations, and lab test results.	HR, 0.8 ( $P = 0.05$ ) .....	Controls for baseline health status included physician-assessed morbidity
Kronic, 2009 .....	NHIS respondents 1986-2000 .....	Questionnaires only .....	HR, 0.91 ( $P < 0.05$ ; without control for self-rated health) and 0.97 (NS; including self-rated health).	Control for self-rated health may bias findings because this variable is probably confounded by coverage
Wilper et al 2009 .....	NHANES respondents 1988-1994 .....	Surveys and physician-rated health after a physical examination.	HR, 0.71 ( $P < 0.05$ ) .....	Controls for baseline health status included physician-assessed health status

mortality. That population-based RCT carried out in the 1970s screened almost all residents of 14 communities, with oversampling of predominantly black and poor locations. Persons with hypertension were randomly assigned to free stepped care in special clinics or referral to usual care. Although the clinics’ staff treated only hypertension-related problems, they provided informal advice and “friendly referrals” for other medical issues. Strikingly, all-cause mortality was reduced by 17% in the intervention group, with similar reductions in deaths due to cardiovascular and noncardiovascular conditions.

Finally, a flawed RCT carried out by the Social Security Administration starting in 2006 bears brief mention. That study ran-

domly assigned people who were receiving Social Security disability income and were in the waiting period for Medicare coverage to receive immediate or delayed coverage. Unfortunately, randomization apparently failed, with many more patients with cancer assigned to the immediate coverage than to the control group, precluding reliable interpretation of the mortality results. Interestingly, persons receiving immediate coverage had rapid and significant improvements in most measures of self-reported health.

#### MORTALITY FOLLOW-UP OF POPULATION-BASED HEALTH SURVEYS

Several routinely collected federal surveys that include information about health insurance coverage have been linked to the Na-

tional Death Index, allowing researchers to compare the mortality rates over several years of respondents with and without coverage at the time of the initial survey. One weakness of these studies is their lack of information about the subsequent acquisition or loss of coverage, which many people cycle into and out of over time. This dilutes coverage differences and may lead to underestimation of the effects of insurance coverage.

Sorlie and colleagues analyzed mortality among respondents to the 1982-1985 Current Population Survey, with follow-up through 1987. In analyses limited to employed persons, the relative risk for death associated with being uninsured was 1.3 for white men and 1.2 for white women (neither overall figures nor those for minorities were reported).

The study's lack of data on important determinants of health, such as smoking, and its reliance on employment status as the only proxy for baseline health status weaken confidence in its conclusions.

Kronick used data from the 1986-2000 National Health Interview Surveys, with mortality follow-up through 2002. The mortality hazard ratio for uninsured versus insured individuals was 1.10 (95% CI, 1.03 to 1.19) after adjustment for demographic variables, smoking, and body mass index. The hazard ratio fell to 1.03 (95% CI, 0.95 to 1.12) after additional adjustment for baseline health, defined by using self-reported disability and self-rated health. Although the self-rated health scale is known to be a valid predictor of mortality, it may introduce inaccuracies in comparisons of uninsured versus insured persons. Recent data indicate that gaining coverage improves self-rated health, before improvements in objective measures of physical health are detectable (or plausible). This suggests that uninsurance may cause people to underrate their health, perhaps because of anxiety or the inability to gain reassurance about minor symptoms. Analyses, such as Kronick's, that rely on self-rated health for risk adjustment therefore may inadvertently compare relatively sick insured persons to relatively healthy uninsured persons, obscuring outcome differences caused by coverage. Studies that include more objective measures of baseline health should be less subject to any such bias.

#### MORTALITY FOLLOW-UP OF POPULATION-BASED HEALTH EXAMINATION SURVEYS

Two studies have analyzed the effect of uninsurance on mortality using data from the National Health and Nutrition Examination Survey (NHANES), which obtains data from physical examination and laboratory tests among participants.

Franks and colleagues analyzed the 1971-1975 NHANES, with mortality follow-up through 1987. They compared mortality of uninsured and privately insured adults older than age 25 years, adjusted for demographic characteristics, self-rated health, smoking, obesity, leisure time exercise, and alcohol consumption. In addition, their models controlled for evidence of morbidity determined by laboratory testing and medical examinations performed by NHANES staff. By 1987, 9.6% of the insured and 18.4% of the uninsured had died. After adjustment for baseline characteristics and health status, the hazard ratio for uninsurance was 1.25 (95% CI, 1.00 to 1.55).

Wilper and colleagues' study (which we co-authored) used data from the 1988-1994 NHANES, with mortality follow-up through 2000. The study assessed mortality among uninsured and privately insured persons age 17 to 64 years, controlling for demographic characteristics, smoking, alcohol consumption, body mass index, leisure time activity, self-rated health, and physician-rated health after the NHANES physician completed the medical examination. The study also included sensitivity analyses adjusting for the number of hospitalizations and physician visits within the past year, limitations in work or activities, job or housework changes due to health problems, and number of self-reported chronic diseases, which yielded results similar to those of the main model. In

the main model, being uninsured was associated with a mortality hazard ratio of 1.40 (95% CI, 1.06 to 1.84).

#### QUASI-EXPERIMENTAL STUDIES OF STATE AND PROVINCIAL COVERAGE EXPANSIONS

In two similar studies, Sommers and colleagues compared mortality trends in states that expanded coverage to low-income residents (before implementation of the Affordable Care Act) with trends in similar states without coverage expansions.

Their analysis of Medicaid expansions in Maine, New York, and Arizona during the early 2000s found that adult mortality rates fell faster in those states than in neighboring ones (a relative reduction of 6.1%, or 19.6 deaths per 100,000), coincident with a decline in the uninsurance rate of 3.2 percentage points. Mortality reductions were largest among nonwhites, adults age 35 to 64 years, and poorer counties. Sommers and colleagues' subsequent reanalysis using data that allowed better matching to control counties yielded a slightly lower estimate of the mortality effect. As the authors note, the large mortality effect from a relatively modest coverage expansion may reflect the fact that Medicaid enrollment often occurred "at the point of care for patients with acute illnesses," leading to the selective enrollment of those most likely to benefit from coverage.

A study of the effect of Massachusetts' 2006 coverage expansion compared mortality trends in Massachusetts counties with those in propensity score-matched counties in other states. Mortality decreased by 2.9% in Massachusetts relative to the comparison counties, a difference of 8.2 deaths per 100,000 adults, with larger declines in poorer counties and those with lower coverage rates before the expansion.

#### OTHER QUASI-EXPERIMENTAL STUDIES

Several researchers have used data from the Health and Retirement Study (HRS)—a longitudinal study that has followed cohorts enrolled at age 51 years or older—to assess the effect of insurance coverage on mortality. The HRS periodically surveys respondents and their families and has been linked to Medicare and National Death Index data.

McWilliams and colleagues found significantly higher mortality rates among uninsured compared with insured HRS respondents, even after propensity score adjustment for multiple predictors of insurance coverage. Baker and colleagues found that respondents who were uninsured (compared with those who had private insurance) had higher long-term but not short-term mortality. After adjustment for multiple baseline characteristics, including instrumental variables associated with coverage (such as a spouse's union membership), Hadley and Waidmann found a strong positive association between insurance coverage and survival before age 65 years. Black and colleagues suggested, on the basis of a "battery of causal inference methods," that others overestimated the survival benefits of insurance and that uninsured HRS respondents had only slightly higher (adjusted) mortality than those with private coverage. Finally, studies have reached conflicting conclusions as to whether the health of previously unin-

sured persons improves (relative to those who were previously insured) after they reach age 65 years and become eligible for Medicare. Overall, the preponderance of evidence from the HRS suggests that being uninsured is associated with some increase in mortality.

Some studies using other data sources suggest that death rates drop at age 65 years, coincident with the acquisition of Medicare eligibility, whereas others do not.

Finally, several studies have assessed the relationship between insurance coverage and hypertension control, a likely mediator of any relationship between coverage and all-cause mortality. Lurie and colleagues followed a cohort of 186 patients who lost Medicaid coverage because of a statewide policy change and a control group of 109 patients who remained eligible. Among those who lost coverage, 5 died within 6 months (compared with none in the control group;  $P = .16$ ), and the average diastolic blood pressure of those with hypertension increased by 10 mm Hg (compared with a 5-mm Hg decrease in controls;  $P = 0.003$ ). At 1 year, 7 patients who had lost Medicaid and 1 control had died; blood pressure differences were slightly less marked than seen at 6 months. A similar study of patients terminated from Veterans Affairs outpatient care because of a budget shortfall found marked deterioration in hypertension control among the terminated patients relative to controls who maintained access. These clinic-based findings accord with cross-sectional population-based analyses of data from NHANES, which have found worse blood pressure control among uninsured than insured patients with hypertension.

#### EVIDENCE FROM OTHER NATIONS AND FROM CROSS-NATIONAL STUDIES

The United States lags behind most other wealthy nations in life expectancy and is the only one with substantial numbers of uninsured residents. Although many factors confound cross-national comparisons, a recent study suggests that worse access to good-quality health care contributes to our nation's higher mortality from medically preventable causes (so-called amenable mortality). Similarly, a recent review of studies from many nations concluded that "broader health coverage generally leads to better access to necessary care and improved population health".

Quasi-experimental studies assessing newly implemented universal coverage in wealthy nations have reached similar conclusions. For instance, Taiwan's rollout of a single-payer system in 1995 was associated with an accelerated decline in amenable mortality, particularly in townships where coverage gains were larger. In Canada, a study exploiting the different dates on which provinces implemented universal coverage estimated that coverage expansion reduced infant mortality by about 5% ( $P < 0.03$ ).

Finally, a recent study of cystic fibrosis cohorts also suggests that coverage improves mortality. Such patients live, on average, 10 years longer in Canada than in the United States. Among U.S. patients, those without known coverage have the shortest survival; among the privately insured, life expectancy is similar to that among patients in Canada.

TABLE 2.—WHY THE CAUSAL RELATIONSHIP OF HEALTH INSURANCE TO MORTALITY IS HARD TO STUDY

Deaths, especially from causes amenable to medical treatment, are rare among nonelderly adults, who account for most of the uninsured.

Because insurance might prevent death by slowing the decline in health over several years, short-term studies may underestimate its effects.

Many people cycle in and out of insurance diluting differences between groups.

Randomly assigning participants to no coverage is unethical in most circumstances.

Observational studies must address reverse causality. Illness sometimes causes people to acquire public insurance by qualifying them for Medicaid, Medicare, or Department of Veterans Affairs disability coverage. Conversely, illness may cause job loss and resultant loss of private coverage.

In cohort studies, adequate control for baseline health status is difficult, particularly in uninsured patients, whose lack of access lowers self-rated health and also causes less awareness of important risk factors, such as hypertension or hyperlipidemia.

TABLE 2.—WHY THE CAUSAL RELATIONSHIP OF HEALTH INSURANCE TO MORTALITY IS HARD TO STUDY—Continued

Quasi-experimental studies, which exploit factors associated with coverage (such as policy changes), rest on unverifiable assumptions (e.g., that without a coverage expansion, mortality trends in states expanding coverage would parallel those in comparator state).

## DISCUSSION

The evidence accumulated since the publication of the IOM's report in 2002 supports and strengthens its conclusion that health insurance reduces mortality. Several newer observational and quasi-experimental studies have found that uninsurance shortens survival, and a few with null results used confounded or questionable adjustments for baseline health. The results of the only recent RCT, although far from definitive, are consistent with the positive findings from cohort and quasi-experimental analyses.

Several factors complicate efforts to determine whether uninsurance increases mortality (Table 2). Randomly assigning people to uninsurance is usually unethical, and quasi-experimental analyses rest on unverifiable assumptions. Deaths are rare and mortality effects may be delayed, mandating large studies with long follow-up. Many people cycle into and out of coverage, diluting the effects of insurance. And statistical adjustments for baseline health usually rely on participants' self-reports, which may be influenced by coverage. Hence, such adjustments may under- or overadjust for differences between insured and uninsured persons.

Inferences about mechanisms through which insurance affects mortality are subject to even greater uncertainty. In some circumstances, coverage might raise mortality by increasing access to dangerous drugs (such as oral opioids) or procedures (such as morcellation hysterectomy). On the other hand, coverage clearly reduces mortality in several serious conditions, although few are common enough to have a detectable effect on population-level mortality. The exception is hypertension, which is prevalent among the uninsured and seems a likely contributor to their higher death rates. Although uncontrolled hyperlipidemia is also more common among the uninsured, the OHIE—the only RCT performed in the statin era—found no effect of coverage on cholesterol levels.

Finally, our focus on mortality should not obscure other well-established benefits of health insurance: improved self-rated health, financial protection, and reduced likelihood of depression. Insurance is the gateway to medical care, whose aim is not just saving lives but also relieving human suffering.

Overall, the case for coverage is strong. Even skeptics who suggest that insurance doesn't improve outcomes seem to vote differently with their feet. As one prominent economist recently asked, "How many of the people who write such things . . . choose to just not bother getting their healthcare?"

## KEY SUMMARY POINTS

In several specific conditions, the uninsured have worse survival, and the lack of coverage is associated with lower use of recommended preventive services.

The Oregon Health Insurance Experiment, the only available randomized, controlled trial that has assessed the health effects of insurance, suggests that insurance may cause a clinically important decrease in mortality, but wide CIs preclude firm conclusions.

The 2 National Health and Nutrition Examination Study analyses that include physicians' assessments of baseline health show substantial mortality improvements associated with coverage. A cohort study that used only self-reported baseline health measures for risk adjustment found a nonsignificant coverage effect.

Most, but not all, analyses of data from the longitudinal Health and Retirement

Study have found that coverage in the near-elderly slowed health decline and decreased mortality.

Two difference-in-difference studies in the United States and 1 in Canada compared mortality trends in matched locations with and without coverage expansions. All 3 found large reductions in mortality associated with increased coverage.

A mounting body of evidence indicates that lack of health insurance decreases survival, and it seems unlikely that definitive randomized, controlled trials can be done. Hence, policy debate must rely on the best evidence from observational and quasi-experimental studies.

Mr. SANDERS. Mr. President, this issue is really not just about healthcare. This is a profound moral debate defining who we are as a people today and whom we want to be as a people in the future.

A great nation is not simply one judged by how many millionaires and billionaires we have and by how many tax breaks we can give to billionaires. A great nation is judged by how we treat the weakest and the most vulnerable amongst us—those people who don't have fundraising dinners, those people who don't contribute hundreds of thousands of dollars into the political process. A great nation is judged by how we treat the children, the elderly, the sick, the poor, the people who have disabilities. This is what a great nation is. This legislation is not worthy of a great nation. This legislation must be defeated.

I yield the floor.

The PRESIDING OFFICER. The Senator from Washington.

Ms. CANTWELL. Mr. President, I come to the floor to join my colleagues. We can see there are numerous colleagues on this side of the aisle who are speaking, just as my colleague from Vermont just did with great passion or my colleague from Massachusetts did with great passion and as I am sure my colleague from Minnesota will. We have all been home for the weekend talking to our constituents. We are all back here now with the CBO news, and we are here because we are very concerned about the next steps the Senate might take in this healthcare debate.

When I was at home, I heard some unbelievably positive stories about healthcare. I was at a hospital in our State, Virginia Mason, which has been one of the leaders in reducing healthcare costs by utilizing new efficiencies. They have improved the return time of getting lab results to patients by 85 percent; they have increased productivity in some areas by 90 percent; they have reduced liability insurance premiums by 76 percent. They have innovated. They have innovated. They have innovated. They talked about the direction healthcare should go, and not once did they mention cutting or capping Medicaid as a solution.

I also talked to a community health center which, under the Affordable Care Act, was actually able to expand in a community. They literally cut in half the uninsured, and they are delivering great adult dental access to thousands of people in a county that didn't have good access to dental care. They are making great progress.

I talked to a veteran who served our country, who literally got out and is now going to school but without the help of Medicaid would not have been able to cover her healthcare expenses.

I met a woman on the street who told me her husband had lost his job. She never thought they would be on Medicaid, but when he lost his job, they went on Medicaid, and they depended on that to provide healthcare for themselves and their children.

I met a gentleman who also said he, too, lost his job, and after that came down with a serious, life-threatening illness, and it was only Medicaid that saved him.

So what do we know today that is different than last Friday? We now have some CBO numbers. We know the numbers. We know the numbers: that 22 more million Americans, as a result of this bill, if it is passed, would be uninsured; 15 million of them on Medicaid; and \$772 billion in Medicaid cuts. We know we thought it was heartless. Now we see the numbers that say cutting that many people off of Medicaid is, in my opinion, as my colleagues have also said, not something we should be pursuing as a nation. It leaves us to ask about not just the impact of this on individuals, as I just mentioned—because I believe there is a much better way to go with innovation—but what it also does for the individual market. A lot of this debate started because people thought the individual market hadn't seen some of the benefits of the employer-sponsored system. Well, why not talk about the individual market?

If 7 percent of the way people access health insurance, the individual market, was having a problem, why not talk about ideas to improve the individual market? Instead, we have a bill from the House and the Senate that beats up on the Medicaid population as if they are the culprit. If you want to improve Medicaid and delivery services and help decrease costs, let's do that. There are so many innovative ideas, but just cutting people off Medicaid to solve the individual market problem doesn't even make sense to me.

We now have, as of last Friday, too, the Center on Budget Policy and Priorities' assessment, talking about how this would raise individual premiums in the individual market. They gave some examples. For example, in West Virginia and Nevada, a 60-year-old with an income of \$36,000 would pay respectively, \$5,000 and \$4,000 more than what

they are paying now. In Alaska, a 60-year-old making \$45,000 would pay \$5,777 more than what they are paying now for premiums. So the notion that this bill is driving down costs is just a fallacy.

We have heard from Republican and Democratic Governors talking about this. They sent us a letter saying the first thing we should do is focus on improving our Nation's private health insurance system. Where did the Governors ask that you come and beat up on Medicaid? They didn't say that. They didn't say: Please beat up on Medicaid, have a big party covering people on Medicaid as a partner with us for 65 years and then leave us stuck with the bill. They didn't say that. They say:

Medicaid provisions included in this bill are problematic. Instead, we recommend Congress address factors we can all agree need fixing.

That is a pretty clear message, I believe, from Republican Governors who are saying this is not the way to fix healthcare.

Also, last week, a nonpartisan study by the George Washington University found that the House-passed bill would have a huge economic impact on our country. States' economies would shrink by \$93 billion, compared to what they would be without the bill. Business output would be cut \$148 billion. The study notes that the bill, combined with normal economic cycles "could contribute to a period of economic and medical hardship in the U.S."

That report also talks about job loss throughout the country, saying that individual states would see more than \$1 billion in lost gross State product, just because of the number of people who wouldn't be covered, the number of healthcare providers who would no longer be there, the loss of healthcare infrastructure and then the impact on the healthcare system overall for uncompensated care. These are costs we can't afford.

As my colleague Senator SANDERS mentioned, there are all these healthcare organizations that have now come out saying they don't support this Senate-drafted bill. The Academy of Family Physicians knows about caring for the Medicaid population. They are seeing so many patients, and they know what this challenge is. The American Psychological Association doesn't support this bill. Other healthcare associations, such as the Catholic Health Association, do not support this bill. I have a long list.

Mr. President, I ask unanimous consent to have printed in the RECORD the list of healthcare-related organizations and others that don't support this legislation.

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

ORGANIZATIONS OPPOSED TO SENATE HEALTH CARE BILL

Alliance for Retired Persons, America's Essential Hospitals, American Academy of

Family Physicians (AAFP), American Academy of Pediatrics (AAP), American Association of People with Disabilities (AAPD), American Association of Retired Persons (AARP), American Cancer Society Cancer Action Network (ACS CAN), American Civil Liberties Union (ACLU), American College of Physicians (ACP), American Congress of Obstetricians and Gynecologists (ACOG), American Diabetes Association, American Federation of State, Country and Municipal Employees (AFSCME), American Federation of Teachers (AFT), American Health Care Association (AHCA), American Heart Association (AHA), American Hospital Association (AHA), American Lung Association, American Muslim Health Professionals, American Nurses Association (ANA), American Osteopathic Association, American Psychiatric Association (APA).

American Psychological Association, American Public Health Association (APHA), Association of American Medical Colleges (AAMC), Big Cities Health Coalition, Bread for the World, California Public Interest Research Group (CPIRG), Catholic Health Association (CHA), Cato Institute, Center for American Progress, Center on Budget and Policy Priorities (CBPP), Center for Law and Social Policy (CLASP), Center for Reproductive Rights, Children's Hospital Association (CHA), The Chronic Illness & Disability Partnership, Coalition on Human Needs (CHN), Commission on Social Action of Reform Judaism, Community Catalyst, Consumers Union, Cystic Fibrosis Foundation, Ecumenical Poverty Initiative.

Environmental Organizations, Families USA, Federation of American Hospitals (FAH), First Focus, Friends Committee on National Legislation, Hispanic Federation, Human Rights Campaign (HRC), Indivisible, Leadership Conference on Civil and Human Rights, Lutheran Services in America, Medicare Rights Center, MomsRising, MoveOn.org, NARAL Pro Choice America, National Advocacy Center of the Sisters of the Good Shepherd, National Alliance on Mental Illness (NAMI), National Breast Cancer Coalition, National Center for Lesbian Rights, National Center for Transgender Equality, National Committee to Preserve Social Security & Medicare (NCPSSM).

National Council on Aging (NCOA), National Council for Behavioral Health, National Council of Jewish Women (NCJW), Planned Parenthood, Presbyterian Church (U.S.A.), Service Employees International Union (SEIU), Trust for America's Health (TFAH), National Multiple Sclerosis Society, National Organization for Rare Disorders, National Partnership for Women and Families, National Physicians Alliance, NETWORK Lobby for Catholic Social Justice, Pacific Institute for Community Organization (PICO) National Network, Physicians for Reproductive Health, Society of St. Vincent DePaul, Tennessee Justice Center, The Arc, Third Way, United Church of Christ Justice & Witness Ministries, U.S. Conference of Catholic Bishops, U.S. Public Interest Research Group (US PIRG), Young Invincibles.

Ms. CANTWELL. Mr. President, I hope my colleagues understand that there are those here who are very willing to talk about how we can improve our healthcare system, but we are not going to make poor Americans the scapegoat of our healthcare challenges.

A gentleman named Joe Baker, president of the Medicare Rights Center, I think, said it best. He said:

You or someone you love is going to need Medicaid. You may not need the nursing home care . . . but you may rely on community-based services, like home care, that will

allow you to stay in your home and out of a nursing facility. Medicaid is the lifeline that covers many of the benefits that Medicare does not provide.

Now why did I read that? Why did I pick a guy who is the head of a Medicare organization? Because he knows what his individual organization participants need in a healthcare delivery system. Everybody knows—everybody knows the people of America are living longer and as they age they need more healthcare. To our colleagues who want to reduce those costs, we are ready to come and talk about how we are going to reduce those costs.

I have talked about how I authored a community-based "rebalancing" program—the kind of rebalancing that helped our State save more than \$2 billion. If we did that in every State, we would be saving billions of dollars, but the notion that we are going to proceed in the next 24 hours or so on a motion, after we have a CBO report that says this would have a devastating impact on millions of people with Medicaid, is not the right way to go.

Taking this out on the poor people of America who need Medicaid will make it worse for us as well. It will raise our rates, return the costs to where they were, and not help us solve this problem for the future. I hope our colleagues will understand that so many people are raising so many concerns about this. Yes, it is about economics, but there are also personal stories of people, such as our colleague from Hawaii who said: You never know. You never know when an individual situation is going to affect you, and you want to make sure there is healthcare to help you get through that crisis.

Thank you. I yield the floor.

The PRESIDING OFFICER. The Senator from Minnesota.

Mr. FRANKEN. Thank you, Mr. President.

I rise to talk about the effort to repeal and replace the Affordable Care Act. Before I begin, I thank Senator HIRONO for sharing her story and for leading us all here in the discussion tonight.

I thank the Presiding Officer who has been listening, and I appreciate that. I really do.

In recent days, we have finally gotten to see the plan that 13 Republican Senators have been working on in secret and behind closed doors. I really thought the Senate bill would be better. I thought it would be better than the House version that was passed. Even Senator BURR said of the House bill that it was "dead on arrival" in the Senate, but, unfortunately, the Senate plan is just as bad.

The nonpartisan Congressional Budget Office announced just today that, under the Senate plan, 22 million more Americans would be uninsured. That has consequences. Perhaps worst of all—and partly because this causes the reduction in the number of Americans who would be covered—the bill ends the Medicaid expansion and cuts the

funding for the Medicaid Program by nearly \$800 billion—a program that has been a vital part of our social fabric since 1965.

This bill—and I do not like to say this—is mean. The President said that of the House bill. I do not like to characterize something that way, but it is mean and would have far-reaching effects for millions of Americans across the country.

This past weekend, I hosted a healthcare forum in Burnsville, MN. It is a suburb that is south of Minneapolis, of the Twin Cities. It was on the importance of Medicaid and how the Republican plan's devastating cuts would affect Minnesotans. Over 230 people showed up to share their stories about how Medicaid changed their lives, and it was very moving.

I think it is really important to tell this in terms of people, not in terms of numbers, although the numbers are pretty stark. Brandon and his mom spoke, Brandon and Sheri. They are both from Burnsville.

Brandon was born 15 weeks premature. He weighed just 1 pound 13½ ounces. He was so small that his parents' wedding rings could slide on his arm. He was also born with cerebral palsy and hydrocephalus, which is a condition that causes fluid to collect in Brandon's brain, which results in brain damage.

Brandon, who is now 17, got up with a walker at the event. He told me that he was taken immediately to the Mayo Clinic in Rochester. He was born in the Twin Cities, but Mayo said that his case was too complicated to handle, so they sent him back to the Twin Cities, to Gillette, which is a children's hospital. It is a great children's hospital, a great hospital. Within 24 hours of his birth, the hospital told Brandon's parents that his costs were already over \$1 million—a terrifying addendum to what must have been a harrowing, harrowing experience.

Over the years, Brandon has needed 38 surgeries—surgery to reduce the fluid in his brain. He has a shunt. He has had surgeries to straighten out his legs. He has had eye surgeries and more. He has also needed extensive physical therapy, occupational therapy, speech therapy, and across his lifetime, he has needed other interventions to help him do basic tasks, like eat and now walk. He could not turn over. He could not do the things that babies do, that we parents and grandparents relish in every day.

But guess what. He is thriving. In fact, he just passed his first college course at Dakota County Technical College. He proudly told me and the rest of us that he received an A-minus, and he hopes someday to get a job at Gillette, the Gillette Children's Specialty Healthcare, which is the very place that provided him with the unique and high-quality care that he has needed over the years. All of this has been possible because Brandon and his family were able to get health insurance through Medicaid.

Sheri, Brandon's mom, said: "If we didn't have Medicaid, Brandon probably wouldn't be here"—meaning at our forum—"and he wouldn't be doing as well as he's doing."

Brandon similarly noted:

Kids with special needs are referred to as "special needs," and I like to think I'm pretty special. I also like to think our needs are also special depending on the kind of care we need and that's what Medicaid provides.

I really believe that all of us here tonight must do all we can to protect these kids and protect their families and everyone who relies on Medicaid, and I sincerely believe that means we have to defeat this bill.

My colleague Senator HIRONO stated last week: "We are all one diagnosis away from a serious illness." That is the case. Do you know what else? We are also just one accident away from a life-changing injury.

Another Minnesotan, Deborah, shared her story with my office. She described for me a car crash and the subsequent traumatic brain injury that she survived in 2012.

She explained:

It was just another day. I was on my way to work. I lost control of my SUV after sliding on a patch of ice and slammed into a concrete median.

Her whole life changed at that moment. She had to relearn basic tasks—reading, walking, talking, and eating—but all of it was possible because of the home- and community-based services she was able to receive through Medicaid.

She said:

Without the services funded by Medicaid, my goal of returning to paid employment would be impossible. I honestly worry that proposed changes to the Medicaid program could significantly diminish my overall health outcomes and even leave me facing long-term homelessness.

As my colleagues and people at home who are watching this debate well know, this week could prove to be an extremely consequential week in the history of this country. The decisions we make—the 100 of us—over the next few days could literally mean life or death for many Americans. Lives are on the line.

Tomorrow, I will give a speech that is more about the data, and we have heard about some of that, but there is a study in the *New England Journal of Medicine* that came out this week that reads that Medicaid—having the insurance—improves people's lives and that—this is not precise—for every 300 to 800 who will lose healthcare, who would lose Medicaid, there will be a premature death.

This is a study that is going to be summarized in the *New Yorker*, in an article by Atul Gawande, that the effect of having insurance is not about dramatic emergencies. This is especially about things like diabetes and heart illness and cancer—the day-to-day. It is about having access. Because you have insurance for care, it improves the health of people, and it ex-

tends mortality. This is real stuff. What we are doing is really serious.

I strongly urge my Republican colleagues to talk with their constituents about the bill that was drafted. Again, it was behind closed doors, and many of my Republican colleagues did not see it until last week. I urge them to talk to their constituents about the consequences this bill would have for seniors, for children, and parents who have Medicaid coverage.

Talk to the people who would see their healthcare costs rise. Talk to the families who may lose their health insurance. People are afraid.

I am a cochair of the World Health Caucus. I go all around my State. I talk to roundtables at rural hospitals and nursing homes. These are the parts of my State that voted for Donald Trump. During the campaign, Donald Trump said that he would not cut Medicaid. These are people who are scared, whose elderly parents stay home because Medicaid pays for their home healthcare, and they are afraid because that will go away. Both she and her husband work—this was a woman in Herman, MN—and they do not know what they will do.

Please, listen to your constituents. You need to do the right thing and vote no on this bill for their sake—for the sake of your constituents.

I yield the floor.

#### ARMS SALES NOTIFICATION

Mr. CORKER. Mr. President, section 36(b) of the Arms Export Control Act requires that Congress receive prior notification of certain proposed arms sales as defined by that statute. Upon such notification, the Congress has 30 calendar days during which the sale may be reviewed. The provision stipulates that, in the Senate, the notification of proposed sales shall be sent to the chairman of the Senate Foreign Relations Committee.

In keeping with the committee's intention to see that relevant information is available to the full Senate, I ask unanimous consent to have printed in the *RECORD* the notifications which have been received. If the cover letter references a classified annex, then such annex is available to all Senators in the office of the Foreign Relations Committee, room SD-423.

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

DEFENSE SECURITY  
COOPERATION AGENCY,  
Arlington, VA.

Hon. BOB CORKER,  
Chairman, Committee on Foreign Relations,  
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: Pursuant to the reporting requirements of Section 36(b)(1) of the Arms Export Control Act, as amended, we are forwarding herewith Transmittal No. 17-12, concerning the Air Force's proposed Letter(s) of Offer and Acceptance to the Government of Australia for defense articles and services estimated to cost \$1.3 billion. After this letter is delivered to your office, we plan

to issue a news release to notify the public of this proposed sale.

Sincerely,

J.W. RIXEY,  
Vice Admiral, USN, Director.

TRANSMITTAL NO. 17-12

Notice of Proposed Issuance of Letter of Offer Pursuant to Section 36(b)(1) of the Arms Export Control Act, as amended

(i) Prospective Purchaser: Government of Australia.

(ii) Total Estimated Value:  
Major Defense Equipment\* \$0.04 billion.  
Other \$1.26 billion.  
Total \$1.30 billion.

(iii) Description and Quantity or Quantities of Articles or Services under Consideration for Purchase:

The Government of Australia requested the sale of up to five (5) Gulfstream G-550 aircraft modified to integrate Airborne Intelligence, Surveillance, Reconnaissance, and Electronic Warfare (AISREW) mission systems, Global Positioning System (GPS) capability, secure communications, aircraft defensive systems, and whole life costs of airborne and ground segments.

This proposed sale includes up to five (5) AN/AAQ-24 (V)N Large Aircraft Infrared Countermeasures (LAIRCM) systems, and additional sub-component spares. Each prime LAIRCM system will consist of: one (1) Guardian Laser Terminal Assemblies (GLTA), five (5) Infrared Missile Warning Sensors, (IRMWS), one (1) LAIRCM System Processor Replacements (LSPR), one (1) Control Indicator Unit Replacement (CIUR), one (1) Smart Card Assembly (SCA), one (1) High Capacity Card (HCC), and one (1) User Data Memory (UDM) card. Also included are: MX-20 HD Electro-Optical and Infrared systems, Osprey 50 AESA Radars, AISREW equipment, secure communications equipment, and Identification Friend or Foe (IFF) Systems. These systems will be installed on up to five (5) G-550 aircraft.

Major Defense Equipment (MDR):

Eight (8) GLTA AN/AAQ-24 (V)N (5 installed and 3 spares).

Twenty-nine (29) IRMWS (25 installed and 4 spares).

Six (6) LSPR AN/AAQ-24 (V)N (5 installed and 1 spare).

Six (6) Embedded/GPS/INS (EGI) with GPS Security Devices, Airborne (5 installed and 1 spare).

Seven (7) Multifunctional Information Distribution Systems—Joint Tactical Radio System (MIDS JTRS) (5 installed and 2 spares).

Non-MDE includes: Also included in this sale are up to five (5) G-550 Aircraft, CIURs, SCAs, HCCs and UDM cards, AN/ALE-47 Countermeasure Dispenser Sets (CMDS), MX-20HD Electro-Optical and Infra-Red systems, Osprey 50 AESA Radars, AISREW ISR equipment, Secure Communications equipment, Identification Friend or Foe Systems, aircraft modification and integration, ground systems for data processing and crew training, ground support equipment, publications and technical data, U.S. Government and contractor engineering, technical and logistics support services, flight test and certification, and other related elements of logistical and program support.

(iv) Military Department: Air Force (QCS).

(v) Prior Related Cases if any: AT-D-SAA & AT-D-GCA.

(vi) Sales Commission, Fee, etc. Paid, Offered, or Agreed to be Paid: None.

(vii) Sensitivity of Technology Contained in the Defense Article or Defense Services Proposed to be Sold: See Annex Attached.

(viii) Date Report Delivered to Congress: June 23, 2017.

\*As defined in Section 47(6) of the Arms Export Control Act.

#### POLICY JUSTIFICATION

Australia—Gulfstream-G550 Aircraft with Airborne Intelligence, Surveillance, Reconnaissance, and Electronic Warfare (AISREW) Mission Systems

The Government of Australia requested the possible sale of up to five (5) Gulfstream G-550 aircraft modified to integrate Airborne Intelligence, Surveillance, Reconnaissance, and Electronic Warfare (AISREW) mission systems, Global Positioning System (GPS) capability, secure communications, aircraft defensive systems; spares, including whole life costs of airborne and ground segments; aircraft modification and integration; ground systems for data processing and crew training; ground support equipment; publications and technical data; U.S. Government and contractor engineering, technical and logistics support services; flight test and certification; and other related elements of logistical and program support. The total estimated program cost is \$1.3 billion.

This sale will contribute to the foreign policy and national security of the United States by helping to improve the security of a major contributor to political stability, security, and economic development in the Western Pacific. Australia is an important Major non-NATO Ally and partner that contributes significantly to peacekeeping and humanitarian operations around the world. It is vital to the U.S. national interest to assist our ally in developing and maintaining a strong and ready self-defense capability.

The proposed sale supports and complements the ongoing efforts of Australia to modernize its Electronic Warfare capability and increases interoperability between the U.S. Air Force and the Royal Australian Air Force (RAAF). Australia will have no difficulty absorbing this equipment into its armed forces.

The proposed sale of this equipment does not alter the basic military balance in the region.

The prime contractors will be L3 of Greenville, TX. There are no known offset agreements proposed in connection with this potential sale.

Implementation of this proposed sale may require the assignment of up to six (6) U.S. contractor representatives to Australia.

There will be no adverse impact on U.S. defense readiness as a result of this proposed sale.

TRANSMITTAL NO. 17-12

Notice of Proposed Issuance of Letter of Offer Pursuant to Section 36(b)(1) of the Arms Export Control Act

Annex Item No. vii

(vii) Sensitivity of Technology:

1. This sale will involve the release of sensitive technology to Australia. Sensitive and/or classified (up to SECRET) elements of the proposed sale include the AN/AAQ-24 (V)N Large Aircraft Infrared Countermeasures (LAIRCM) systems, Embedded/GPS/INS (EGI) with security devices, Airborne, Multifunctional Information Distribution Systems—Joint Tactical Radio System (MIDS JTRS), AN/ALE-47 Countermeasure Dispenser Set (CMDS), MX-20HD Electro-Optical and Infra-Red systems, Osprey 50 AESA Radars, and Airborne Intelligence, Surveillance, Reconnaissance and Electronic (AISREW) mission system.

2. The AN/AAQ-24 (V)N LAIRCM is a self-contained, directed energy countermeasures system designed to protect aircraft from infrared (IR)-guided surface-to-air missiles. The system features digital technology and micro-miniature solid state electronics. The system operates in all conditions, detecting

incoming missiles and jamming infrared-seeker equipped missiles with aimed bursts of laser energy. The LAIRCM system consists of multiple Infrared Missile Warning System (IRMWS) Sensors, Guardian Laser Turret Assembly (GLTA), LAIRCM System Processor Replacement (LSPR), Control Indicator Unit Replacement (CIUR), and a classified High Capacity Card (HCC), and User Data Memory (UDM) card. The HCC is loaded into the CIUR prior to flight. When the classified HCC is not in use, it is removed from the CIUR and placed in onboard secure storage. LAIRCM Line Replaceable Unit (LRU) hardware is classified SECRET when the HCC is inserted into the CIUR. LAIRCM system software, including Operational Flight Program is classified SECRET. Technical data and documentation to be provided are UNCLASSIFIED.

The set of IRMWS Sensor units are mounted on the aircraft exterior to provide omnidirectional protection. The IRMWS Sensor warns of threat missile approach by detecting radiation associated with the rocket motor. The IRMWS is a small, lightweight, passive, electro-optic, threat warning device used to detect surface-to-air missiles fired at helicopters and low-flying fixed-wing aircraft and automatically provides countermeasures, as well as audio and visual warning messages to the aircrew. The basic system consists of multiple IRMWS Sensor units, one (1) GLTA, LSPR and CIUR. The set of IRMWS units (each A-330 MRTT has five (5)) mounted on the aircraft exterior to provide omni-directional protection. Hardware is UNCLASSIFIED. Software is SECRET. Technical data and documentation to be provided are UNCLASSIFIED.

3. Multifunctional Information Distribution System—Joint Tactical Radio System (MIDS JTRS) is an advanced Link-16 command, control, communications, and intelligence (C3I) system incorporating high-capacity, jam-resistant, digital communication links for exchange of near real-time tactical information, including both data and voice, among air, ground, and sea elements. The MIDS JTRS terminal hardware, publications, performance specifications, operational capability, parameters, vulnerabilities to countermeasures, and software documentation are classified CONFIDENTIAL. The classified information to be provided consists of that which is necessary for the operation, maintenance, and repair (through intermediate level) of the data link terminal, installed systems, and related software.

4. The AN/ALE-47 Countermeasure Dispenser Set (CMDS) provides an integrated threat-adaptive, computer controlled capability for dispensing chaff, flares, and active radio frequency expendables. The AN/ALE-47 system enhances aircraft survivability in sophisticated threat environments.

The threats countered by the CMDS include radar-directed anti-aircraft artillery (AAA), radar command-guided missiles, radar homing guided missiles, and infrared (IR) guided missiles. The system is internally mounted and may be operated as a stand-alone system or may be integrated with other on-board Electronic Warfare (EW) and avionics systems. The AN/ALE-47 uses threat data received over the aircraft interfaces to assess the threat situation and determine a response. Expendable routines tailored to the immediate aircraft and threat environment may be dispensed using one of four operational modes. Hardware is UNCLASSIFIED. Software is SECRET. Technical data and documentation to be provided is UNCLASSIFIED.

5. The Embedded GPS-INS (EGI) LN-200 is a sensor that combines GPS and inertial sensor inputs to provide accurate location information for navigation and targeting. The



EGI LN-200 is UNCLASSIFIED. The GPS crypto-variable keys needed for the highest GPS accuracy are classified up to SECRET.

6. Wescam MX-20HD is a gyro-stabilized, multi-spectral, multi-field of view Electro-Optical/Infrared (EO/IR) system. The systems provide surveillance laser illumination and laser designation through use of an externally mounted turret sensor unit and internally mounted master control. Sensor video imagery is displayed in the aircraft real time and may be recorded for subsequent ground analysis. Hardware is UNCLASSIFIED. Technical data and documentation to be provided is UNCLASSIFIED.

7. The Osprey family of surveillance radars provides second generation Active Electronically Scanned Array (AFSA) surveillance capability as the primary sensor on airborne assets. The Osprey radars are at a high technology readiness level and are in production for fixed and rotary wing applications. This Osprey configuration employs a side-looking radar. Osprey radars provide a genuine multi-domain capability, with high performance sea surveillance, notably against "difficult" targets, land surveillance with wide swath, very high resolution ground mapping small and low speed ground target indication, high performance air to air surveillance, tracking and intercept.

8. The AISREW mission system provides near-real-time information to tactical forces, combatant commanders and national-level authorities across the spectrum of conflict. The mission system can forward gathered information in a variety of formats via secured communications systems. Most hardware used in this AISREW system is generic and commercially available. However, if any of the specialized hardware or publications are lost, the information could provide insight into many critical U.S. capabilities. Information gained could be used to develop countermeasures as well as offensive and defensive counter-tactics.

9. If a technologically advanced adversary were to obtain knowledge of the specific hardware and software elements, the information could be used to develop countermeasures or equivalent system which might reduce system effectiveness or be used in the development of a system with similar or advanced capabilities.

10. A determination has been made that Australia can provide substantially the same degree of protection for the sensitive technology being released as the U.S. Government. This sale is necessary in furtherance of the U.S. foreign policy and national security objectives outlined in the Policy Justification.

11. All defense articles and services listed in this transmittal have been authorized for release and export to Australia.

DEFENSE SECURITY  
COOPERATION AGENCY,  
Arlington, VA.

Hon. BOB CORKER,  
Chairman, Committee on Foreign Relations,  
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: Pursuant to the reporting requirements of Section 36(b)(1) of the Arms Export Control Act, as amended, we are forwarding herewith Transmittal No. 17-33, concerning the Air Force's proposed Letter(s) of Offer and Acceptance to the Government of India for defense articles and services estimated to cost \$366.2 million. After this letter is delivered to your office, we plan to issue a news release to notify the public of this proposed sale.

Sincerely,

J. W. RIXEY,  
Vice Admiral, USN, Director.

#### TRANSMITTAL NO. 17-33

Notice of Proposed Issuance of Letter of Offer Pursuant to Section 36(b)(1) of the Arms Export Control Act, as amended

(i) Prospective Purchaser: The Government of India.

(ii) Total Estimated Value:  
Major Defense Equipment\* \$285.0 million.  
Other \$ 81.2 million.  
Total \$366.2 million.

(iii) Description and Quantity or Quantities of Articles or Services under Consideration for Purchase:

Major Defense Equipment (MDE):

One (1) C-17 Transport Aircraft.

Four (4) Engines, Turbofan F-117-PW-100.

Non-MDE includes: Also included in the proposed sale are one (1) AN/AAR-47 Missile Warning System, one (1) AN/ALE-47 Countermeasures Dispensing System (CMDS), one (1) AN/APX-119 Identification Friend or Foe (IFF) Transponder, precision navigation equipment, spare and repair parts, maintenance, support and test equipment, publications and technical documentation, warranty, quality assurance, ferry support, U.S. Government and contractor engineering, logistics and technical support services, and other related elements of logistics and program support.

(iv) Military Department: Air Force (X7-D-SAE).

(v) Prior Related Cases, if any: IN-D-SAC—\$4.12B, 29 Jun 2011.

(vi) Sales Commission, Fee, etc., Paid, Offered, or Agreed to be Paid: None.

(vii) Sensitivity of Technology Contained in the Defense Article or Defense Services Proposed to be Sold: See Attached Annex.

(viii) Date Report Delivered to Congress: June 26, 2017.

\*As defined in Section 47(6) of the Arms Export Control Act.

#### POLICY JUSTIFICATION

Government of India—C-17 Transport Aircraft

The Government of India has requested the possible sale of one (1) C-17 transport aircraft with four (4) Turbofan F-117-PW-100 engines. The sale would also include one (1) AN/AAR-47 Missile Warning System, one (1) AN/ALE-47 Countermeasures Dispensing System (CMDS), one (1) AN/APX-119 Identification Friend or Foe (IFF) Transponder, precision navigation equipment, spare and repair parts, maintenance, support and test equipment, publications and technical documentation, warranty, Quality Assurance, ferry support, U.S. Government and contractor engineering, logistics and technical support services, and other related elements of logistics and program support. The estimated cost is \$366.2 million.

This proposed sale will contribute to the foreign policy and national security of the United States by helping to strengthen the U.S.-India relationship and to improve the security of an important partner which has been, and continues to be, an important force for economic progress and stability in South Asia.

The proposed sale will improve India's capability to meet current and future strategic airlift requirements. India lies in a region prone to natural disasters and will use the additional capability for Humanitarian Assistance and Disaster Relief (HA/DR). In addition, through this purchase India will be able to provide more rapid strategic combat airlift capabilities for its armed forces. India currently operates C-17 aircraft and will have no difficulty absorbing this aircraft into its armed forces.

The proposed sale will not alter the basic military balance in the region.

The principal contractor will be the Boeing Company, Chicago, IL. The purchaser typi-

cally requests offsets. Any offset agreement will be defined in negotiations between the purchaser and the contractor.

Implementation of this proposed sale will not require the assignment of any additional U.S. Government personnel or contractor representatives to India.

There will be no adverse impact on U.S. defense readiness as a result of this proposed sale.

#### TRANSMITTAL NO. 17-33

Notice of Proposed Issuance of Letter of Offer Pursuant to Section 36(b)(1) of the Arms Export Control Act

Annex Item No. vii

(vii) Sensitivity of Technology

1. The Boeing C-17A Globemaster III military airlift aircraft is the most flexible cargo aircraft to enter the U.S. Air Force fleet. The C-17 is capable of strategic delivery of up to 170,900 pounds of personnel and/or equipment to main operating bases or forward operating locations. The aircraft is also capable short field landings with a full cargo load. The aircraft can perform tactical airlift and airdrop missions as well as transport litters and ambulatory patients during aeromedical evacuation when required. A fully integrated electronic cockpit and advanced cargo delivery system allow a crew of three: pilot, co-pilot, and loadmaster, to operate the aircraft on any type of mission.

2. The AN/AAR-47 is a small, lightweight, passive, electro-optic, threat warning device used to detect surface-to-air missiles fired at helicopters and low-flying fixed-wing aircraft and automatically provide countermeasures, as well as audio and visual-sector warning messages to the aircrew. The basic system consists of multiple Optical Sensor Converter (OSC) units, a Computer Processor (CP) and a Control Indicator (CI). The set of OSC units, which normally consists of four, is mounted on the aircraft exterior to provide omni-directional protection. The OSC detects the rocket plume of missiles and sends appropriate signals to the CP for processing. The CP analyzes the data from each OSC and automatically deploys the appropriate countermeasures. The CP also contains comprehensive Built-in-Test (BIT) circuitry. The CI displays the incoming direction of the threat, so that the pilot can take appropriate action. Hardware is UNCLASSIFIED. Software is SECRET. Technical data and documentation to be provided are UNCLASSIFIED.

3. The AN/ALE-47 Countermeasures Dispensing System (CMDS) is an integrated, threat-adaptive, software-programmable dispensing system capable of dispensing chaff, flares, and active radio frequency expendables. The threats countered by the CMDS include radar-directed anti-aircraft artillery (AAA), radar command-guided missiles, radar homing guided missiles, and infrared (IR) guided missiles. The system is internally mounted and may be operated as a standalone system or may be integrated with other on-board electronic warfare and avionics systems. The AN/ALE-47 uses threat data received over the aircraft interfaces to assess the threat situation and to determine a response. Expendable decoys tailored to the immediate aircraft and threat environment may be dispensed using one of four operational modes. The hardware, technical data, and documentation to be provided are UNCLASSIFIED.

4. The AN/APX-119 Identification Friend or Foe (IFF) Digital Transponder is an identification system designed for command and control. It enables military and civilian air traffic control interrogation systems to identify aircraft. The hardware, technical data, and documentation to be provided are UNCLASSIFIED.

5. If a technologically advanced adversary were to obtain knowledge of the specific hardware and software elements, the information could be used to develop countermeasures or equivalent systems which might reduce weapon system effectiveness or be used in the development of a system with similar or advanced capabilities.

6. A determination has been made that the Government of India can provide substantially the same degree of protection for the sensitive technology being released as the U.S. Government. This proposed sale is necessary to the furtherance of the U.S. foreign policy and national security objectives outlined in the Policy Justification.

7. All defense articles and services listed in this transmittal are authorized for release and export to the Government of India.

#### ADDITIONAL STATEMENTS

##### TRIBUTE TO DR. DEBORAH ZYCH

• Mr. COONS. Mr. President, I wish to honor the remarkable service of the Polytech School District superintendent, Dr. Deborah Zych, and to recognize her commitment and service to the district. Throughout her career, Debbie has been an outstanding leader and innovative thinker, serving in many positions throughout Delaware's school districts. Her hard work, perseverance, and dedication will truly be missed by students, parents, and Delawareans up and down our State.

Since 2011, Debbie has played an active and integral role within the Delaware Department of Education, the New Castle County School District, and the Polytech School District, serving as a teacher, administrator, director of curriculum, assistant superintendent, and superintendent. Throughout her time in Polytech School District, Debbie has been a major leader, instrumental in guiding POLYTECH through facility enhancements, the expansion of educational opportunities for students, as well as a marked growth in student certifications. She also played a significant role in establishing a more visible link between Polytech's highly recognized high school and adult education programs. I join the many Delawareans who have had the opportunity to work alongside Debbie, and we are truly grateful for all she has done to improve the lives of Delaware's youth and adults.

In addition to ensuring that Kent County students got quality educations, I got to know Debbie through a lot of the work she and her staff did with manufacturers in Delaware and with their impressive apprenticeship programs they ran. She came down to a Democratic Steering and Outreach Committee meeting we hosted on workforce training, and last year, she hosted an event I helped organize on National Manufacturing Day. Debbie and her staff recognized that what manufacturers in Delaware needed was for the training to be done on the shop floor rather than in the school, and they have made dozens of companies

stronger as a result. Under Debbie's leadership, Polytech School District also expanded the number of English language learners in Delaware.

Beginning her career in Maryland, Debbie has always been an advocate for students, teachers, and the local community. She was committed to ensuring that each student—no matter their age—was equipped with the tools and skills necessary to go out into the world and take advantage of each opportunity that came their way.

We cannot simply attribute Debbie's long service in Delaware's school systems to her hard work and advocacy, but also to her genuine passion for seeing each student and program participant excel. Her forward-thinking ability and insight into the value of incorporating all district resources has undoubtedly laid the foundation for helping all students succeed.

Debbie's work has been nothing short of incredible, and I am sincerely grateful for all that she has done on behalf of the students and families across our State. It is my privilege to offer my sincerest congratulations on a job well done and wish her much success in her future endeavors at the University of Delaware where she will continue to serve Delaware in the UD Professional Development Center for Educators.●

##### REMEMBERING DAVID COLEMAN, JR.

• Mr. YOUNG. Mr. President, the great State of Indiana is proud of and ever thankful to those who defended our Nation's freedom, especially through military service. Today I wish to recognize the service and life of a member of the Greatest Generation, David Coleman, Jr., a veteran of World War II.

Mr. Coleman, born June 12, 1924, served in both the U.S. Army and the U.S. Air Force from 1943 to 1946 and then again from 1953 to 1960. During his military career, he earned the National Defense Service Medal, the Good Conduct Medal, the World War II Victory Medal, and the EAME Theater Ribbon. As a veteran myself, I am proud to know of fellow Hoosier veterans such as Mr. Coleman. Mr. Coleman called Indiana home for 60 years, 56 of them with his beloved wife, the late Dorothy Coleman, by his side. Like many Hoosiers, Mr. Coleman enjoyed America's favorite pastime, baseball, and was an avid fan of the Indianapolis Indians. Mr. Coleman also had a strong Hoosier work ethic, working at both Bryant Heating & Cooling and Goodyear Tire Company until retirement.

Mr. Coleman loved his family, his God, and his country, and for these things, he will be remembered. Mr. Coleman passed away on June 18, 2017, just a few days after his 93rd birthday. My thoughts and prayers go out to the family he left behind, including his children, grandchildren, and great-grandchildren. They should know that Mr. Coleman was an exemplary patriot, and I am proud to call him a fellow Hoosier.●

#### MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Ms. Ridgway, one of his secretaries.

#### EXECUTIVE MESSAGES REFERRED

In executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

(The messages received today are printed at the end of the Senate proceedings.)

#### MESSAGE FROM THE HOUSE

At 4:03 p.m., a message from the House of Representatives, delivered by Mr. Novotny, one of its reading clerks, announced that the House has passed the following bills, in which it requests the concurrence of the Senate:

H.R. 1654. An act to authorize the Secretary of the Interior to coordinate Federal and State permitting processes related to the construction of new surface water storage projects on lands under the jurisdiction of the Secretary of the Interior and the Secretary of Agriculture and to designate the Bureau of Reclamation as the lead agency for permit processing, and for other purposes.

H.R. 2353. An act to reauthorize the Carl D. Perkins Career and Technical Education Act of 2006.

H.R. 2842. An act to provide for the conduct of demonstration projects to test the effectiveness of subsidized employment for TANF recipients.

##### ENROLLED BILL SIGNED

The President pro tempore (Mr. HATCH) announced that on today, June 26, 2017, he has signed the following enrolled bill, which was previously signed by the Speaker of the House:

H.R. 1238. An act to amend the Homeland Security Act of 2002 to make the Assistant Secretary of Homeland Security for Health Affairs responsible for coordinating the efforts of the Department of Homeland Security related to food, agriculture, and veterinary defense against terrorism, and for other purposes.

#### MESSAGE FROM THE HOUSE RECEIVED DURING ADJOURNMENT

##### ENROLLED BILL SIGNED

Under the order of the Senate of January 3, 2017, the Secretary of the Senate, on June 23, 2017, during the adjournment of the Senate, received a message from the House of Representatives announcing that the Speaker had signed the following enrolled bill:

H.R. 1238. An act to amend the Homeland Security Act of 2002 to make the Assistant Secretary of Homeland Security for Health Affairs responsible for coordinating the efforts of the Department of Homeland Security related to food, agriculture, and veterinary defense against terrorism, and for other purposes.

## MEASURES REFERRED

The following bills were read the first and the second times by unanimous consent, and referred as indicated:

H.R. 1654. An act to authorize the Secretary of the Interior to coordinate Federal and State permitting processes related to the construction of new surface water storage projects on lands under the jurisdiction of the Secretary of the Interior and the Secretary of Agriculture and to designate the Bureau of Reclamation as the lead agency for permit processing, and for other purposes; to the Committee on Energy and Natural Resources.

H.R. 2353. An act to reauthorize the Carl D. Perkins Career and Technical Education Act of 2006; to the Committee on Health, Education, Labor, and Pensions.

H.R. 2842. An act to provide for the conduct of demonstration projects to test the effectiveness of subsidized employment for TANF recipients; to the Committee on Finance.

## REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Ms. MURKOWSKI, from the Committee on Energy and Natural Resources, with an amendment in the nature of a substitute and an amendment to the title:

S. 713. A bill to establish the Mountains to Sound Greenway National Heritage Area in the State of Washington (Rept. No. 115-118).

By Mr. JOHNSON, from the Committee on Homeland Security and Governmental Affairs, without amendment:

S. 459. A bill to designate the area between the intersections of Wisconsin Avenue, Northwest and Davis Street, Northwest and Wisconsin Avenue, Northwest and Edmunds Street, Northwest in Washington, District of Columbia, as "Boris Nemtsov Plaza", and for other purposes (Rept. No. 115-119).

## INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mrs. ERNST (for herself, Mr. RUBIO, and Mr. PERDUE):

S. 1427. A bill to provide States with the option of applying for and receiving temporary waivers for the States to experiment with new approaches that integrate Federal programs in order to provide more coordinated and holistic solutions to families in need, and for other purposes; to the Committee on Homeland Security and Governmental Affairs.

By Mr. RISCH (for himself, Mr. PETERS, Mr. KENNEDY, Ms. DUCKWORTH, and Mrs. SHAHEEN):

S. 1428. A bill to amend section 21 of the Small Business Act to require cyber certification for small business development center counselors, and for other purposes; to the Committee on Small Business and Entrepreneurship.

By Mr. CARDIN (for himself and Mrs. CAPITO):

S. 1429. A bill to amend the Federal Water Pollution Control Act to reauthorize the Chesapeake Bay Program; to the Committee on Environment and Public Works.

By Mr. CARDIN (for himself, Mr. CARPER, Mr. WARNER, Mr. COONS, Mr. Kaine, and Mr. VAN HOLLEN):

S. 1430. A bill to amend the Chesapeake Bay Initiative Act of 1998 to reauthorize the

Chesapeake Bay Gateways and Watertrails Network; to the Committee on Environment and Public Works.

By Mr. INHOFE (for himself, Mr. KING, and Mr. ROUNDS):

S. 1431. A bill to provide liability protection for volunteer pilots who fly for the public benefit, and for other purposes; to the Committee on the Judiciary.

By Mr. INHOFE (for himself and Mr. MORAN):

S. 1432. A bill to prevent the Federal Aviation Administration's Aircraft Registry Office from closing during a Government shutdown; to the Committee on Commerce, Science, and Transportation.

By Ms. HIRONO (for herself, Ms. MURKOWSKI, and Ms. CANTWELL):

S. 1433. A bill to approve the 2010 Compact Review Agreement with Palau, and for other purposes; to the Committee on Energy and Natural Resources.

By Mrs. GILLIBRAND (for herself and Mr. COTTON):

S. 1434. A bill to enhance the military childcare programs and activities of the Department of Defense, and for other purposes; to the Committee on Armed Services.

By Mr. COTTON:

S. 1435. A bill to provide an amnesty period during which veterans and their family members can register certain firearms in the National Firearm Registration and Transfer Record, and for other purposes; to the Committee on the Judiciary.

By Mr. CRAPO (for himself and Mr. CARDIN):

S. 1436. A bill to conserve fish and aquatic communities in the United States through partnerships that foster fish habitat conservation, improve the quality of life for the people of the United States, enhance fish and wildlife-dependent recreation, and for other purposes; to the Committee on Environment and Public Works.

By Mrs. GILLIBRAND (for herself, Mr. BLUMENTHAL, Mr. CARDIN, Ms. KLOBUCHAR, Mr. MARKEY, Mr. COONS, Mr. VAN HOLLEN, Mr. WYDEN, Mr. BROWN, Ms. DUCKWORTH, Mr. WHITEHOUSE, and Mr. SANDERS):

S. 1437. A bill to modernize voter registration, promote access to voting for individuals with disabilities, protect the ability of individuals to exercise the right to vote in elections for Federal office, and for other purposes; to the Committee on Rules and Administration.

By Mr. BLUNT (for himself and Mrs. MCCASKILL):

S. 1438. A bill to redesignate the Jefferson National Expansion Memorial in the State of Missouri as the "Gateway Arch National Park"; to the Committee on Energy and Natural Resources.

By Ms. WARREN:

S. 1439. A bill to require the Secretary of Defense to include gambling disorder in health assessments for members of the Armed Forces and related research efforts of the Department of Defense; to the Committee on Armed Services.

By Ms. WARREN:

S. 1440. A bill to ensure the safety of workers of contractors that serve and supply the Armed Forces and the accountable use of taxpayer dollars; to the Committee on Armed Services.

By Mr. SANDERS (for himself, Ms. WARREN, and Ms. HARRIS):

S. 1441. A bill to provide funding for Federally Qualified Health Centers, the National Health Service Corps, Teaching Health Centers, and the Nurse Practitioner Residency Training program; to the Committee on Health, Education, Labor, and Pensions.

By Mr. SULLIVAN:

S. 1442. A bill to establish United States policy for the Arctic region for the next 10

years, and for other purposes; to the Committee on Commerce, Science, and Transportation.

## SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Ms. BALDWIN (for herself, Mr. BENNET, Mr. BLUMENTHAL, Mr. BOOKER, Mr. BROWN, Ms. CANTWELL, Mr. CARDIN, Mr. CARPER, Mr. CASEY, Mr. COONS, Ms. CORTEZ MASTO, Mr. DURBIN, Mr. FRANKEN, Ms. HARRIS, Ms. HASSAN, Mr. HEINRICH, Ms. HEITKAMP, Ms. HIRONO, Mr. Kaine, Ms. KLOBUCHAR, Mr. LEAHY, Mr. MARKEY, Mr. MENENDEZ, Mr. MERKLEY, Mr. MURPHY, Mrs. MURRAY, Mr. NELSON, Mr. PETERS, Mrs. SHAHEEN, Mr. VAN HOLLEN, Ms. WARREN, Mr. WHITEHOUSE, Mr. WYDEN, Mr. SCHUMER, Mrs. FEINSTEIN, Mr. SANDERS, and Mr. WARNER):

S. Res. 202. A resolution expressing support for the designation of June 26, 2017, as "LGBT Equality Day"; to the Committee on the Judiciary.

By Ms. HEITKAMP (for herself, Mr. HELLER, Mr. TESTER, Mr. TILLIS, Ms. BALDWIN, Mr. GRASSLEY, Mr. BROWN, Mr. SULLIVAN, Mr. MURPHY, Mr. KENNEDY, Ms. HIRONO, Mr. HOEVEN, Mr. LEAHY, Mr. ROBERTS, Mr. BLUMENTHAL, Mr. DAINES, Ms. STABENOW, Mr. CRAPO, Mr. HEINRICH, Ms. COLLINS, Mr. DONNELLY, Mr. DURBIN, Mr. NELSON, Mr. MARKEY, Mr. CASEY, Mr. PETERS, Mr. WARNER, Ms. HASSAN, Mr. COONS, Ms. CORTEZ MASTO, Mr. BENNET, Mr. CARDIN, Mr. FRANKEN, and Mrs. FEINSTEIN):

S. Res. 203. A resolution designating the month of June 2017, as "National Post-Traumatic Stress Awareness Month" and June 27, 2017, as "National Post-Traumatic Stress Awareness Day"; to the Committee on the Judiciary.

## ADDITIONAL COSPONSORS

S. 16

At the request of Mr. PAUL, the name of the Senator from Florida (Mr. RUBIO) was added as a cosponsor of S. 16, a bill to require a full audit of the Board of Governors of the Federal Reserve System and the Federal reserve banks by the Comptroller General of the United States, and for other purposes.

S. 445

At the request of Ms. COLLINS, the names of the Senator from Arkansas (Mr. BOOZMAN) and the Senator from New Mexico (Mr. HEINRICH) were added as cosponsors of S. 445, a bill to amend title XVIII of the Social Security Act to ensure more timely access to home health services for Medicare beneficiaries under the Medicare program.

S. 480

At the request of Mr. PORTMAN, the name of the Senator from Massachusetts (Mr. MARKEY) was added as a cosponsor of S. 480, a bill to reauthorize the Multinational Species Conservation Funds Semipostal Stamp.

S. 540

At the request of Mr. THUNE, the name of the Senator from Vermont

(Mr. LEAHY) was added as a cosponsor of S. 540, a bill to limit the authority of States to tax certain income of employees for employment duties performed in other States.

S. 654

At the request of Mr. TOOMEY, the name of the Senator from Ohio (Mr. PORTMAN) was added as a cosponsor of S. 654, a bill to revise section 48 of title 18, United States Code, and for other purposes.

S. 720

At the request of Mr. CARDIN, the name of the Senator from Delaware (Mr. COONS) was added as a cosponsor of S. 720, a bill to amend the Export Administration Act of 1979 to include in the prohibitions on boycotts against allies of the United States boycotts fostered by international governmental organizations against Israel and to direct the Export-Import Bank of the United States to oppose boycotts against Israel, and for other purposes.

S. 765

At the request of Mr. PERDUE, the name of the Senator from Vermont (Mr. LEAHY) was added as a cosponsor of S. 765, a bill to amend title 18, United States Code, to provide for penalties for the sale of any Purple Heart awarded to a member of the Armed Forces.

S. 816

At the request of Mr. CASEY, the name of the Senator from Oregon (Mr. MERKLEY) was added as a cosponsor of S. 816, a bill to amend the Internal Revenue Code of 1986 to allow rollovers from 529 programs to ABLE accounts.

S. 822

At the request of Mr. INHOFE, the name of the Senator from Rhode Island (Mr. WHITEHOUSE) was added as a cosponsor of S. 822, a bill to amend the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 to modify provisions relating to grants, and for other purposes.

S. 1109

At the request of Mr. MERKLEY, the name of the Senator from Minnesota (Ms. KLOBUCHAR) was added as a cosponsor of S. 1109, a bill to amend title VIII of the Public Health Service Act to extend advanced education nursing grants to support clinical nurse specialist programs, and for other purposes.

S. 1146

At the request of Mrs. SHAHEEN, the name of the Senator from Virginia (Mr. KAINE) was added as a cosponsor of S. 1146, a bill to enhance the ability of the Office of the National Ombudsman to assist small businesses in meeting regulatory requirements and develop outreach initiatives to promote awareness of the services the Office of the National Ombudsman provides, and for other purposes.

S. 1238

At the request of Ms. COLLINS, the name of the Senator from Delaware (Mr. COONS) was added as a cosponsor

of S. 1238, a bill to amend the Internal Revenue Code of 1986 to increase and make permanent the exclusion for benefits provided to volunteer firefighters and emergency medical responders.

S. 1286

At the request of Ms. KLOBUCHAR, the name of the Senator from Minnesota (Mr. FRANKEN) was added as a cosponsor of S. 1286, a bill to lift the trade embargo on Cuba.

S. 1311

At the request of Mr. CORNYN, the names of the Senator from Nevada (Ms. CORTEZ MASTO) and the Senator from North Carolina (Mr. TILLIS) were added as cosponsors of S. 1311, a bill to provide assistance in abolishing human trafficking in the United States.

S. 1312

At the request of Mr. GRASSLEY, the names of the Senator from Vermont (Mr. LEAHY) and the Senator from Delaware (Mr. COONS) were added as cosponsors of S. 1312, a bill to prioritize the fight against human trafficking in the United States.

S. 1330

At the request of Mr. ROUNDS, the name of the Senator from Massachusetts (Ms. WARREN) was added as a cosponsor of S. 1330, a bill to amend title 38, United States Code, to authorize a dependent to transfer entitlement to Post-9/11 Education Assistance in cases in which the dependent received the transfer of such entitlement to assistance from an individual who subsequently died, and for other purposes.

S. 1350

At the request of Mr. ALEXANDER, the name of the Senator from South Carolina (Mr. GRAHAM) was added as a cosponsor of S. 1350, a bill to amend the National Labor Relations Act with respect to the timing of elections and pre-election hearings and the identification of pre-election issues, and to require that lists of employees eligible to vote in organizing elections be provided to the National Labor Relations Board.

S. 1354

At the request of Mr. CARPER, the names of the Senator from Delaware (Mr. COONS) and the Senator from North Dakota (Ms. HEITKAMP) were added as cosponsors of S. 1354, a bill to establish an Individual Market Reinsurance fund to provide funding for State individual market stabilization reinsurance programs.

S. 1361

At the request of Mr. CRAPO, the name of the Senator from Iowa (Mr. GRASSLEY) was added as a cosponsor of S. 1361, a bill to amend title XVIII of the Social Security Act to allow physician assistants, nurse practitioners, and clinical nurse specialists to supervise cardiac, intensive cardiac, and pulmonary rehabilitation programs.

S. 1393

At the request of Mr. CORNYN, the name of the Senator from South Dakota (Mr. THUNE) was added as a co-

sponsor of S. 1393, a bill to streamline the process by which active duty military, reservists, and veterans receive commercial driver's licenses.

S. 1414

At the request of Mr. WICKER, the name of the Senator from Wisconsin (Ms. BALDWIN) was added as a cosponsor of S. 1414, a bill to state the policy of the United States on the minimum number of available battle force ships.

S.J. RES. 5

At the request of Mr. CARDIN, the names of the Senator from Michigan (Mr. PETERS) and the Senator from Hawaii (Mr. SCHATZ) were added as cosponsors of S.J. Res. 5, a joint resolution removing the deadline for the ratification of the equal rights amendment.

S.J. RES. 6

At the request of Mr. MENENDEZ, the name of the Senator from Hawaii (Mr. SCHATZ) was added as a cosponsor of S.J. Res. 6, a joint resolution proposing an amendment to the Constitution of the United States relative to equal rights for men and women.

S.J. RES. 16

At the request of Mr. WYDEN, the name of the Senator from Indiana (Mr. DONNELLY) was added as a cosponsor of S.J. Res. 16, a joint resolution approving the discontinuation of the process for consideration and automatic implementation of the annual proposal of the Independent Medicare Advisory Board under section 1899A of the Social Security Act.

S. CON. RES. 12

At the request of Mr. GRASSLEY, the name of the Senator from Vermont (Mr. LEAHY) was added as a cosponsor of S. Con. Res. 12, a concurrent resolution expressing the sense of Congress that those who served in the bays, harbors, and territorial seas of the Republic of Vietnam during the period beginning on January 9, 1962, and ending on May 7, 1975, should be presumed to have served in the Republic of Vietnam for all purposes under the Agent Orange Act of 1991.

## SUBMITTED RESOLUTIONS

SENATE RESOLUTION 202—EXPRESSING SUPPORT FOR THE DESIGNATION OF JUNE 26, 2017, AS "LGBT EQUALITY DAY"

Ms. BALDWIN (for herself, Mr. BENNET, Mr. BLUMENTHAL, Mr. BOOKER, Mr. BROWN, Ms. CANTWELL, Mr. CARDIN, Mr. CARPER, Mr. CASEY, Mr. COONS, Ms. CORTEZ MASTO, Mr. DURBIN, Mr. FRANKEN, Ms. HARRIS, Ms. HASSAN, Mr. HEINRICH, Ms. HEITKAMP, Ms. HIRONO, Mr. KAINE, Ms. KLOBUCHAR, Mr. LEAHY, Mr. MARKEY, Mr. MENENDEZ, Mr. MERKLEY, Mr. MURPHY, Mrs. MURRAY, Mr. NELSON, Mr. PETERS, Mrs. SHAHEEN, Mr. VAN HOLLEN, Ms. WARREN, Mr. WHITEHOUSE, Mr. WYDEN, Mr. SCHUMER, Mrs. FEINSTEIN, Mr. SANDERS, and Mr. WARNER) submitted the following

resolution; which was referred to the Committee on the Judiciary:

S. RES. 202

Whereas the United States recognizes that all people should be treated equally;

Whereas Members of the 115th Congress support the rights and freedoms of individuals who are lesbian, gay, bisexual, and transgender (in this preamble referred to as “LGBT”);

Whereas, on June 26, 2003, the Supreme Court of the United States ruled in *Lawrence v. Texas*, 539 U.S. 558, that States could no longer criminalize the private conduct in which same-sex couples engage;

Whereas, on June 26, 2013, the Supreme Court of the United States ruled in *United States v. Windsor*, 133 S. Ct. 2675, that section 3 of the Defense of Marriage Act (Public Law 104-199; 110 Stat. 2419) was unconstitutional and the Federal Government could no longer restrict married same-sex couples from receiving Federal benefits and protections;

Whereas, on June 26, 2015, the Supreme Court of the United States ruled in *Obergefell v. Hodges*, 135 S. Ct. 2584, that same-sex couples have a constitutional right to marry and States could no longer discriminate against same-sex couples when recognizing or licensing a marriage;

Whereas decisions handed down by the Supreme Court of the United States on June 26 in 2003, 2013, and 2015 ended marriage discrimination and the criminalization of same-sex private intimate conduct under the law;

Whereas LGBT people and their allies have worked together for more than 60 years to make progress toward achieving full equality for all people in the United States, regardless of sexual orientation or gender identity;

Whereas LGBT people in the United States continue to face many barriers that cannot be solved through courtroom litigation alone;

Whereas transgender people and LGBT people of color are disproportionately and uniquely burdened by such barriers, including violence, discrimination, poverty, and societal isolation;

Whereas, although victories at the Supreme Court of the United States have affirmed the dignity and equality of millions of same-sex couples, statutory reforms are needed to ensure that LGBT people in the United States are free from discrimination and have equal access to the American dream; and

Whereas June 26, 2017, would be an appropriate date to designate as “LGBT Equality Day”: Now, therefore, be it

*Resolved*, That the Senate—

(1) supports equal rights and protections for all people, regardless of actual or perceived sexual orientation or gender identity;

(2) supports the designation of June 26, 2017, as “LGBT Equality Day”;

(3) encourages the celebration of “LGBT Equality Day” to—

(A) commemorate the significance of decisions handed down by the Supreme Court of the United States on June 26 in 2003, 2013, and 2015; and

(B) continue educating all people about the forms of discrimination, harassment, and intolerance that lesbian, gay, bisexual, and transgender people continue to face; and

(4) acknowledges the need for further legislation to ensure that people in the United States are free from all forms of discrimination on the basis of actual or perceived sexual orientation or gender identity, including in employment, housing, public accommodations, education, Federal funding, credit, and jury service.

SENATE RESOLUTION 203—DESIGNATING THE MONTH OF JUNE 2017, AS “NATIONAL POST-TRAUMATIC STRESS AWARENESS MONTH” AND JUNE 27, 2017, AS “NATIONAL POST-TRAUMATIC STRESS AWARENESS DAY”

Ms. HEITKAMP (for herself, Mr. HELLER, Mr. TESTER, Mr. TILLIS, Mr. BALDWIN, Mr. GRASSLEY, Mr. BROWN, Mr. SULLIVAN, Mr. MURPHY, Mr. KENNEDY, Ms. HIRONO, Mr. HOEVEN, Mr. LEAHY, Mr. ROBERTS, Mr. BLUMENTHAL, Mr. DAINES, Ms. STABENOW, Mr. CRAPO, Mr. HEINRICH, Ms. COLLINS, Mr. DONNELLY, Mr. DURBIN, Mr. NELSON, Mr. MARKEY, Mr. CASEY, Mr. PETERS, Mr. WARNER, Ms. HASSAN, Mr. COONS, Ms. CORTEZ MASTO, Mr. BENNET, Mr. CARDIN, Mr. FRANKEN, and Mrs. FEINSTEIN) submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 203

Whereas the brave men and women of the Armed Forces, who proudly serve the United States, risk their lives to protect the freedom of the people of the United States and deserve the investment of every possible resource to ensure their lasting physical, mental, and emotional well-being;

Whereas more than 2,000,000 members of the Armed Forces have deployed overseas since the events of September 11, 2001, and have served in places such as Afghanistan and Iraq;

Whereas the Armed Forces have sustained a historically high operational tempo since September 11, 2001, with many members of the Armed Forces deploying overseas multiple times, placing those members at high risk of experiencing combat stress;

Whereas, when left untreated, exposure to traumatic combat stress can lead to post-traumatic stress, sometimes referred to as post-traumatic stress disorder (in this preamble referred to as “PTSD”) or post-traumatic stress injury;

Whereas men and women of the Armed Forces and veterans who served before September 11, 2001, remain at risk for post-traumatic stress;

Whereas the Secretary of Veterans Affairs reports that about 11-20 percent of veterans who served in Operation Iraqi Freedom or Operation Enduring Freedom have PTSD in a given year, about 12 percent of Gulf War veterans have PTSD in a given year, and about 30 percent of Vietnam veterans have had PTSD in their lifetime;

Whereas many combat stress injuries remain unreported, undiagnosed, and untreated due to a lack of awareness about post-traumatic stress and the persistent stigma associated with mental health conditions;

Whereas exposure to military trauma can lead to post-traumatic stress;

Whereas post-traumatic stress significantly increases the risk of anxiety, depression, suicide, homelessness, and drug- and alcohol-related disorders and deaths, especially if left untreated;

Whereas public perceptions of post-traumatic stress or other mental health conditions create unique challenges for veterans seeking employment;

Whereas the Department of Defense and the Department of Veterans Affairs, as well as the larger medical community, both private and public, have made significant advances in the identification, prevention, diagnosis, and treatment of post-traumatic

stress and the symptoms of post-traumatic stress, but many challenges remain;

Whereas increased understanding of post-traumatic stress can help eliminate the stigma attached to the issue;

Whereas additional efforts are needed to find further ways to eliminate the stigma associated with post-traumatic stress, including—

(1) an examination of how post-traumatic stress is discussed in the United States; and

(2) a recognition that post-traumatic stress is a common injury that is treatable and repairable;

Whereas post-traumatic stress can result from any number of stressors other than combat, including rape, sexual assault, battery, torture, confinement, child abuse, car accidents, train wrecks, plane crashes, bombings, or natural disasters, and affects approximately 8,000,000 adults in the United States annually;

Whereas the diagnosis now known as PTSD was first defined by the American Psychiatric Association in 1980 to commonly and more accurately understand and treat veterans who had endured severe traumatic combat stress;

Whereas combat stress had previously been viewed as a mental illness and the word “disorder” carries a stigma that perpetuates this misconception; and

Whereas the designation of a National Post-Traumatic Stress Awareness Month and a National Post-Traumatic Stress Awareness Day will raise public awareness about issues related to post-traumatic stress, reduce the associated stigma, and help ensure that those individuals suffering from the invisible wounds of war receive proper treatment: Now, therefore, be it

*Resolved*, That the Senate—

(1) designates June 2017, as “National Post-Traumatic Stress Awareness Month” and June 27, 2017, as “National Post-Traumatic Stress Awareness Day”;

(2) supports the efforts of the Secretary of Veterans Affairs and the Secretary of Defense, as well as the entire medical community, to educate members of the Armed Forces, veterans, the families of members of the Armed Forces and veterans, and the public about the causes, symptoms, and treatment of post-traumatic stress;

(3) welcomes the efforts of the National Center for PTSD of the Department of Veterans Affairs and local Vet Centers (as defined in section 1712A(h) of title 38, United States Code) to provide assistance to veterans who are suffering from the effects of post-traumatic stress;

(4) encourages commanders of the Armed Forces to support appropriate treatment of men and women of the Armed Forces who suffer from post-traumatic stress; and

(5) respectfully requests that the Secretary of the Senate transmit a copy of this resolution to the Secretary of Veterans Affairs and the Secretary of Defense.

## PRIVILEGES OF THE FLOOR

Mr. CASEY. Mr. President, I ask unanimous consent that Christopher Friesse, a congressional fellow on my staff, be granted floor privileges for the duration of the debate on the Better Care Reconciliation Act.

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

The PRESIDING OFFICER. The Senator from North Carolina.

ORDERS FOR TUESDAY, JUNE 27,  
2017

Mr. TILLIS. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 2 p.m., Tuesday, June 27; further, that following the prayer and pledge, the morning hour be deemed expired, the Journal of proceedings be approved to date, and the time for the two leaders be reserved for their use later in the day; finally, that following leader remarks, the Senate be in a period of morning business for debate only, with Senators permitted to speak therein.

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

#### ORDER FOR ADJOURNMENT

Mr. TILLIS. Mr. President, if there is no further business to come before the Senate, I ask unanimous consent that it stand adjourned under the previous order, following the remarks of our Democratic colleagues.

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

The Senator from Connecticut.

#### HEALTHCARE LEGISLATION

Mr. BLUMENTHAL. Mr. President, I am proud to be on the floor today, proud to stand with my colleagues, and I hope that at the end of this week, I will be proud of all of my colleagues when we vote to defeat this measure, or at least to delay it, because we owe the American people the right to be heard.

Our responsibility as elected representatives is at the very least to listen. I have been listening over the last week but really over the last year to constituents of mine in the State of Connecticut and over the last week at two emergency field hearings that I conducted because no hearings were held by the Senate and no markups and no votes in committee. What we saw here in Washington was complete secrecy, a bill produced behind closed doors, only seeing the light of day for the first time last Thursday.

Our Republican colleagues have gone from total secrecy to total chaos. The reason for the chaos is the facts that were most dramatically revealed today—just hours ago—when the Congressional Budget Office told us, not surprisingly, that 22 million Americans would be thrown to the wolves as a result of this measure—thrown to the wolves of no healthcare coverage—and eventually 49 million Americans would be without healthcare insurance by 2026.

Next year alone, 15 million more people will be uninsured under the Republican plan, TrumpCare 2.0. Low-income Americans would be unable to afford any plan at all, and anybody who does would be paying higher costs for fewer services of lesser quality. Americans will pay a higher share of their income

and receive less as a result. A 64-year-old making almost \$57,000 will go from paying \$6,800 under the Affordable Care Act to \$20,500 under the proposal before this body. This jump in cost is absolutely staggering.

It will destroy the financial well-being of middle-class Americans who also, when they need nursing home care, after they have exhausted their savings, will be thrown to the wolves. I visited one such facility just last Friday, where two-thirds of its 60 beds will be unaffordable when those middle-class families find their savings will no longer cover it.

These facts are the reason for the Republican chaos. One of our former colleagues, my mentor, Senator Daniel Patrick Moynihan, famously said: "Everybody is entitled to his own opinion, but not to his own facts." The administration's statement that the CBO is not to be blindly trusted—nobody has to trust the CBO blindly. Those facts are driven by reality. Their report speaks truth to power and to the American people, and the American people get it.

None of us can look our constituents in the eye, look ourselves in the mirror, look inside ourselves, in our hearts, and justify a vote for this bill. The American people are angry, many of them because we are even considering it. It is not an anger that is kind of a shrug of the shoulders; it is a deep, vocal, vehement, vitriolic anger. I have seen it and heard it at those hearings, where I listened to people coming forward and talking about this bill, recognizing it for what it is. It is not a healthcare bill; it is a massive tax cut for the wealthy.

Just Friday afternoon, one of the folks who attended the hearing came to the microphone and said: Don't call it a healthcare bill; it is a wealth care bill. In fact, she is absolutely right. This bill cuts hundreds of millions of dollars in taxes for the richest so that they will do better, but it also cuts \$800 billion in Medicaid spending and investment to provide for that kind of tax cut. It is not a healthcare bill; it is a wealth care bill. And for most Americans, it is a catastrophic, cruel, and costly insult to their intelligence, their health, and our American values. It is a sham and a charade, making possible those cuts for the rich—tax cuts for them—at the expense of our most vulnerable citizens. And it has been the result of a profoundly undemocratic process—secrecy and speed.

Despite the best efforts of our Republican colleagues to keep Americans in the dark about what this proposal would do, I have seen growing awareness, again, not only at these hearings but as I walk through the airport, as I march in parades—twice over this weekend—as I attend public gatherings. Whether it is Boys State, sponsored by the American Legion for 16- and 17-year-olds, or nursing facilities for elderly citizens, there is a growing awareness that this bill is bad—profoundly bad—for the American people.

The people I have heard from have prescriptions to fill, appointments to make, lives to live, but they have come to these hearings on very short notice in Hartford and in New Haven, literally filling rooms so that there was standing room only.

I challenge my colleagues to hold the same kinds of hearings, to delay this vote so that they can go home at the end of this week and hold hearings in their State and listen to their constituents about what they have to say and what the consequences will be.

Nearly 1 in 10 veterans has Medicaid coverage, meaning that a staggering 1.75 million veterans, including 18,000 veterans in Connecticut, would be impacted by these reckless cuts. Let me repeat that number for all of us who rejoiced in the recent Accountability and Whistleblowers Act. Some 1.75 million veterans—18,000 of them in Connecticut—will be harmed by this reckless and needless insult and injury.

Put simply, this bill would make it hard for veterans with mental health disorders like post-traumatic stress disorder to get care. Nearly a quarter of all veterans receive care for mental health disorders outside the VA system, meaning they rely on protections that guarantee their access to affordable care. Under this proposal, those protections would be severely threatened, and the veterans who need that care would see that care at risk.

Here we are talking about a choice program that enables veterans to seek care outside the VA system, privately, and we are endangering care for millions of Americans—veterans—who need and seek it by using Medicaid.

If my colleagues listen to their constituents, they will hear from many of the people who have come to my townhalls, like Christine Girassi. Christine has two beautiful 4-year-old twins named McKenzie and Cameron. McKenzie was born with Prader-Willi syndrome, a rare genetic disorder that her mom described as "including low muscle tone, seizures, temperature instability, sleep apnea, infertility, OCD, intellectual disabilities, and developmental delay."

In the first few weeks of her life, McKenzie was in the hospital for 57 days, accounting for \$2 million in costs. Their family was spending \$30,000 a year to help their daughter thrive. So when Christine learned that her daughter had received a waiver to become a Medicaid beneficiary, she was overjoyed.

Christine told me:

When we received McKenzie's diagnosis, we were told that she wouldn't do a lot of things, and at only 4 years old she's already defying the odds. I have no doubt in my mind that if we are able to continue down our current path of the proper therapies and doctors, McKenzie will be able to have her fruitful life. I am terrified if the rug comes out beneath her that she will become just another statistic.

Another statistic? There are enough statistics in that CBO report. We will hear a plethora of statistics on the



floor, but a picture is worth a thousand words and many more than a thousand statistics, and no one—no one should be consigned to being a statistic.

This family is one of the many faces and pictures and stories of Medicaid. They deserve to be heard. If we gut this program, if we strip away the important services it provides, we know all too well what will happen to McKenzie and her family as statistics. Like her mother said, Medicaid has been the path to success for them, and that rug will be pulled from that family, from beneath McKenzie.

At the hearing on Friday in New Haven, I heard from Kent O'Brien, who told me about the eight prescription medications he takes—four for psychiatric reasons and four for medical reasons.

Of course, mental health parity has been one of the crusades of my life. When I was State attorney general, I worked with Senator Ted Kennedy and Congressman Patrick Kennedy to help advocate for that bill. As a Senator, I advocated for the regulations that were necessary for its enforcement, and we finally got it done.

I want to quote what Kent said directly. He told me:

Hi, everybody, how are you today? I'm going to keep this brief, because I know the senators are on a very strict time constraint and I respect that. So I'm just going to talk very quickly about my prescription medications; there are eight of them. Four of them are for psychiatric reasons and four are medical. And if I lose my Medicare and Medicaid, I will be unable to pay for them obviously, which in turn I will end up in the hospital.

Kent went on:

Now, for the Republicans who are seeing this in Washington, can you please listen to me carefully?

I am speaking to an empty Chamber. Let nobody make any mistake that Republicans are hanging on Kent's words as I speak now, but every one of them should go to the RECORD. Every one of them should be listening in their offices. Every one of them should go to the RECORD.

Kent goes on:

If I lose that medication, I will end up in the hospital, and it's going to cost the state and the federal government much more money than it would be to simply let me go to the pharmacy and pick up my medication.

If there were ever a message that Washington should hear, it is from Kent O'Brien, who closed by simply saying:

So I'm just going to close up with that, and don't hurt the American people. Help them!

If you met Kent, you would wonder how he was capable of that eloquence. He is an ordinary American, someone who looks like all the rest of us. He has said to this body what it means to hear: "Don't hurt the American people." He couldn't be more right. This proposal would cost our Nation so much, not just financially—Kent had it right—but morally. It will lead to a weakening of what makes our country strong and great in the first place: our

ability to care about our neighbor, to fight for what is right, and to listen to the people who represent here in the Senate.

First, do no harm. That is what the ethos of the medical profession is. It ought to be our mantra as well. It ought to be what my colleagues, if nothing else, heed as we reach this decision to listen to people who sent us here and hear their stories. Listen to the anxieties and fears and value of America. They will tell you all you need to know about this bill. Kent told me. As he said, the cost will be staggering—not just in financial terms but in human terms.

This bill—written behind closed doors, away from the light of day, away from the realities of medical care in the United States of America, away from the voices and faces I have brought to the floor today, and which I will continue to bring to the floor—ignores the most important thing we can do this week. As Kent said, don't hurt the American people. As the doctors tell us: First, do no harm.

I yield the floor.

The PRESIDING OFFICER (Mr. TILLIS). The Senator from Maryland.

Mr. VAN HOLLEN. Mr. President, I wish to start by thanking my colleague from the State of Connecticut for bringing those powerful testimonies to the floor of the Senate. It is really important that all of us—all 100 of us—spend time back home in our States listening to people who are telling us those kinds of stories.

I have received over 2,500 calls in my office just since Thursday, all of them strongly opposed to this so-called healthcare proposal.

Some things improve with time. Some things improve with age, like red wine. Some things get stinkier and smellier the longer they sit out there, like rotten things. That is the case with the series of Republican so-called healthcare bills, TrumpCare 1, TrumpCare 2.0, and now, TrumpCare 3.0. They are all rotten to the core, and the more they sit out there, the stinkier they get, and the American people know it.

If you had any doubts, take a look at the most recent Congressional Budget Office report we got today. There is a pretty clear pattern between all of these Congressional Budget Office reports and the first bill we saw and the second bill and now on this latest version.

Here is the pattern. Tens of millions of Americans will lose access to affordable healthcare in the United States of America in order to provide tax breaks for powerful special interests and richer Americans. That is the pattern. In this most recent report, we are told by the nonpartisan professionals at the Congressional Budget Office that 22 million of our fellow Americans are going to lose access to affordable healthcare. For what? To give powerful special interests and wealthy Americans a tax break.

Insurance companies currently are not allowed to deduct the bonuses they pay to their CEOs. Now you are going to allow insurance companies to deduct the bonuses they pay to CEOs, and while tens of millions of Americans will lose access to affordable care, millionaires in America will get an average annual tax break of \$50,000 a year, every year.

So make no mistake. You can call this a healthcare bill, but it has nothing to do with healthcare and everything to do with wealth care and transferring wealth from more struggling vulnerable Americans to the very wealthy.

If this were about healthcare, why is it that we have all received in our offices long lists from patient advocacy organizations that are dead-set against this legislation? These are organizations that have been dedicated to trying to improve healthcare for people and patients in our country: the American Cancer Society, the American Diabetes Association, the American Heart Association, the American Lung Association, National Alliance on Mental Illness, National Breast Cancer Coalition, and National Multiple Sclerosis Society. The list goes on and on from organizations that have dedicated themselves to advancing patient health.

On the other side, I haven't seen a single—not one—patient advocacy group that has come out to support this so-called healthcare bill. How can that be? If this is good for the health of our fellow citizens, why is it we have a long list of organizations dedicated to that cause against it and not one for it?

How about healthcare providers, the folks who help provide the care to our constituents? They are all dead-set against it: the nurses, the doctors, the hospitals, the people who have that network of care.

I was just out on the Eastern Shore of Maryland, a rural part of our State. The National Rural Health Association is opposed to this bill. They know the people they serve are going to be badly hurt, and, by the way, it is also going to hurt the economies in those parts of our State, especially the rural parts of the States, because those hospitals depend heavily on many of the people who get help through the Affordable Care Act, whether through the exchanges or through expanded Medicaid. As those patients come in the door and no longer can pay for their care, those hospitals said they may have to close down operations and lay people off. It is a double whammy—bad for patients and bad for those who provide the care to our patients.

That is why AARP has been all out against this, because they know that for Americans between the ages of 50 and 64, before you get on Medicare, this is a total disaster. As they have said, there is an age tax. If you are older, you are going to pay a whole lot more under this Republican bill than you pay today.

Many people are just realizing now as they follow this debate that two out of three Americans who are in nursing homes today are supported by Medicaid payments. So millions of our fellow Americans who now get their care in nursing homes, where Medicaid is providing support for two out of three, are going to be put at risk and made vulnerable because of this legislation.

Remember, Donald Trump said he wasn't going to cut Medicaid. This cuts it by over \$750 billion. Make no mistake, on this issue, this Senate bill is a lot meaner than the House bill. We all know that President Trump out in the Rose Garden celebrated the passage of the House bill. But behind closed doors, what did he call it? Mean. This Senate bill, as time goes on, will cut Medicaid far more deeply than the House bill. As we look at this Congressional Budget Office report, it talks about how you get to the end of year 8 and 9 and 10, and you go beyond that. You are going to have very deep cuts, much more painful, much meaner than in the Senate bill.

We have heard a lot about pre-existing conditions. The reality is that the Senate bill is very devious in this regard. It is a great sleight of hand. On the one hand, it creates the impression that if you have preexisting conditions, you are going to be all right. But what it pretends to give with one hand, it takes away with the other. It makes those Americans as vulnerable as they were before the passage of the Affordable Care Act.

I am not talking about those who are directly benefitting, like those on expanded Medicaid or those in the exchanges. I am talking about those who are benefiting from the patient protections in the Affordable Care Act.

I just got a note the other day from Mark in my State of Maryland saying:

My son was diagnosed with Crohn's disease in 2008, at age 18. He was repeatedly denied insurance and was only able to cover part of the cost of care through the Maryland high-risk pool. Obamacare made it possible for him to be insured and care for this lifelong disease.

It was ObamaCare that "will literally save his life." We have many stories like this one from others who were denied access to care because of pre-existing conditions before the Affordable Care Act.

There is another major sleight of hand in this Senate Republican proposal, and that relates to premiums. I have been listening. We have been hearing a lot from our Republican Senate colleagues about how this is going to bring down the price of premiums. We all know that what Americans care about is what they are having to put out in total for their healthcare. There are premiums. How much is the deductible? Great, I got a lower premium, but my deductible is now \$10,000. There are copays.

Here is the dirty little secret if you dig into the Congressional Budget Office report, after listening to many of

our Republican colleagues talk about premiums. Now, you have to translate a little bit here because this is in the budgetese of the Congressional Budget Office. What they say on page 9 is this: Some people enrolled in nongroup insurance—in other words, in the individual market, the people who are currently in the Affordable Care Act exchanges—would experience substantial increases in what they would spend on healthcare even though benchmark premiums would decline on average in 2020 and years later.

So the translation is that in some cases the premium—that sticker price—may go down, but you are going to end up paying a whole lot more when it comes to your deductible and your copays.

It goes on to say that because nongroup insurance—in other words, the individual market—would pay for a smaller average share of benefits under this legislation, most people purchasing it would have higher out-of-pocket spending on healthcare than under current law. It goes on and on.

In other words, keep your eye on the ball, America, because when someone tells you your premiums are going to go down, watch what happens to all your other healthcare costs. The Congressional Budget Office, the non-partisan analysts, are telling you they are going up.

This brings me to my final point. I said at the beginning that some things get better with time and some things get stinkier and smellier. We know that the more the American people get a look at this latest Senate Republican proposal—TrumpCare 3.0—the less they are going to like it. The more they see it, the more they will hate it. Just like something that is rotten gets stinkier with time, this will get worse and worse with time. That is why it is so important that we not try to jam this through the Senate.

I understand the Republican leader. He knows this is rotten to its core, and he knows the more it sits out there, the more people are going to see what it is all about and the more they are going to hate it.

Let's have a full debate, and let's make sure all of us go back to our States over the Fourth of July—to the parades, the barbecues, and the picnics—and look our constituents in the eye and tell them that we are going to take healthcare away from tens of millions of Americans, that we are going to open up the discrimination once again to preexisting conditions. We are going to increase their overall healthcare costs, even though we tell them we are going to be reducing them. Let's look them in the eye and tell them what this bill is all about rather than trying to push it through in 24 or 48 hours or later this week.

Our constituents deserve to know the facts, and we need to make sure we vote to protect the interests of the United States of America, not just provide another round of tax breaks to

powerful special interests and millionaires.

The PRESIDING OFFICER. The Senator from Hawaii.

Mr. SCHATZ. Mr. President, you might think that for the last 7 years, the major complaint people had about the Affordable Care Act was that it hurt rich people, because they seem to be the only people who stand to gain with this Republican Senate healthcare plan. They get a giant tax break. The rest of America, on the other hand, is in trouble.

With TrumpCare, healthcare will cost more, and 22 million people are going to lose their healthcare altogether. Some healthcare bill. To put this in perspective, imagine if everyone lost their healthcare in Hawaii, Maine, Nevada, Alaska, West Virginia, Ohio, Idaho, and Wyoming. That is what TrumpCare does. That is 22 million Americans. It also devastates one of the best healthcare programs this country has.

With this bill, Medicaid is going to lose nearly \$800 billion. If your only worry is that your investment income gets taxed at 3.8 percent every year, you can breathe a sigh of relief. Let me drill down on that because one of the most egregious tax breaks in this bill—and this is mostly a tax cut bill and not a healthcare bill—is the following: If you are making \$200,000 as an individual or \$250,000 as a couple, capital gains income is currently taxed at 3.8 percent. If you are making \$200,000 as an individual or \$250,000 as a couple and you have capital gains, not regular income, it is taxed at 3.8 percent. This bill zeros that tax out. This bill zeros that tax out. On top of that, it is retroactive. Think about the absurdity.

Here we are. I am looking at the Senator from Pennsylvania and how much he has advocated for children and especially for children with disabilities. I am looking at the Senator from Connecticut and the work he has done for people with chronic diseases and mental health challenges and the resources we need for that. And in the middle of a supposedly oriented toward healthcare piece of legislation, we are giving a retroactive capital gains tax cut to people who make over \$250,000 a year in combined income. It is absurd. It is not a healthcare bill.

If you have a loved one in a nursing home, if you are pregnant or thinking of having a baby, if your kid has a disability that requires costly care, if you work two jobs but your employer doesn't provide health insurance, then this bill does not take care of you. Instead of less taxes, you get less care, and you are going to pay more for it.

This is what happens when legislators don't have committee hearings or they refuse to meet with patients, doctors, nurses, advocates, their own constituents. There have been so few town-halls about healthcare. There have been so few real Senate debates about healthcare.

I have seen every single Democratic Member of the Senate come here and

talk about this piece of legislation. I have seen every single Republican Member of the Senate talk about legislation that they are proud of. I have seen very few people on the Republican side of the aisle come down and talk about this bill because they know it is not a good piece of legislation.

At this point, we are not even debating healthcare policy. It is not a question of what is the best way to get people to sign up for insurance or how we can lower premiums and deductibles or how we can improve the delivery system; it is a question of how many people are going to lose their healthcare so that insurance company CEOs can continue to make millions of dollars a year. That is literally what is in this bill. Those are the conversations we are having—nothing related to reforming the healthcare system or getting people more coverage for less but, rather, tax cuts for people who are involved in the healthcare industry.

How many grandparents are going to get kicked out of nursing homes? It is not a rhetorical question. My wife's grandmother was in a nursing home 2 months ago. It was a beautiful facility. They took great care of her. They had three beds, three nursing home beds. I think the normal reimbursement is about \$9,000 a month. They took wonderful care of my wife's grandmother. They won't exist. That nursing home and all the nursing homes like it won't exist if there is an \$800 billion cut to Medicaid. This is not a theoretical conversation. This isn't even a partisan conversation. Everybody has nursing home beds in all of their home States. Everybody at least ought to know some middle-class people who rely on Medicaid for nursing homes.

CBO gave us the answer today. Too many people are going to be locked out of the healthcare system if this bill goes forward, and all for giant tax cuts.

Look, our healthcare system is not perfect. Changes need to be made, but this bill is just not it. It has no clear guiding principle other than slashing Medicaid to pay for tax cuts. We have to start over.

I am looking at the Presiding Officer, who was a speaker of the house in North Carolina and understands how to do a bill on a bipartisan basis. I am thinking of the numerous Republicans who are capable of working on a bipartisan bill that can get 60 votes.

By the way, the politics would change because if we worked on a bill that could get 60 votes, we would be in a wonderful position—the Senate is set up to encourage us to work together—because if we abide by that 60-vote threshold and we come up with a bill together, we would own the American healthcare system together. We don't get to play this blame game about what is happening with premiums or what is happening with coverage numbers. We actually, on the level, collaborate.

When you think about a bill or an issue that used to be as partisan as

public education, we had LAMAR ALEXANDER and PATTY MURRAY come together. Heck, in the last Congress, we had JIM INHOFE and Barbara Boxer do a bill together. It is possible for us to do a bipartisan piece of legislation.

The decision was made to go with reconciliation, and that is backfiring because the problem with not involving Democrats is that there are Democrats across the country. The problem with not involving experts is that you end up with a product you can't defend.

What we really need to do is take a breath, take the Fourth of July weekend, and reconvene as a Congress—not as Democrats and Republicans but as Americans who understand that our healthcare system is not perfect, that it is in need of improvement, but this bill doesn't get it done.

I yield the floor.

The PRESIDING OFFICER. The Senator from Connecticut.

Mr. MURPHY. Mr. President, I want to pick up where my colleague from Hawaii left off. There is a wonderful analogy that President Obama used after the 2016 election. As you could imagine, Democrats were pretty dejected the day after, and President Obama put it pretty simply. He said: Listen, just remember, these elections are intramural scrimmages. We put on temporary pinnies, Republicans and Democrats, but in the end, we all belong to the same team. We are all Americans.

Elections and legislative fights are temporary skirmishes before we recognize and realize our greater identity, which is that we have this commonality. Clearly, that is not what the American people see here. They think our primary identity is our partisan identity, and there is a lot of days in which we give them fodder for that belief.

It really is amazing, when it comes down to it, that when you think about the healthcare system, we do have the same goals in mind. There are actually lots of other issues on which we don't have the same goal. Republicans want to go left, and we want to go right. Republicans want to go right, and we want to go left. On healthcare, we actually all want to get to the same place: More people have access to health insurance, the cost of that insurance is less than it is today, and the quality of the care people get is better. It is funny because underneath that, it is just mechanics. It is not actually ideology. It is a decision as to which lever you press and which you don't.

I get that a lot of my Republican colleagues don't think we are sincere when we say: If you put this monstrosity of a bill aside, we will work with you to do something better. But it is sincere. We don't want to blow up Medicaid. We are not with you on that. We don't want to pass along big tax breaks, only going to the very wealthy. But we get that you want some more flexibility for States. We get that you want maybe an additional plan offered

on the exchanges that doesn't have all the bells and whistles the existing plans do. But you get that we want stability in the exchanges. We want some certainty in the markets going forward.

There is an important conversation to be had here. Our hope is that, with this CBO score, maybe it will be the straw that breaks the camel's back, that will cause our Republican colleagues to give up this nonsensical approach to healthcare reform and work with us.

I am going to repeat some of the ground that has already been covered here in the next few minutes, but I want to go over some of the highlights of this CBO report.

Senator SCHATZ previewed this, but it is hard to get your head wrapped around what it means for 22 million people to lose insurance.

This is an old chart from the CBO score on the House bill that held that under their approach, 23 million people would lose insurance. I X'd that out. We now have 22 million people who would lose insurance under the Senate approach. That is the entire combined population of Alaska, Delaware, Hawaii, Idaho, Kansas, Maine, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Dakota, West Virginia, and South Dakota. All that happened between the House Bill and the Senate bill is that the people of Rhode Island got saved. I X'd out Rhode Island because Rhode Island has about 1 million people. About 1 million more people will have insurance under the Senate bill, but that is humanitarian catastrophe. That is a big deal, to have that many people lose insurance.

I know that is not what you set out to do. I know the Republicans didn't set out to do this, in part because I listened to Senator CORNYN come down and complain on the Senate floor relentlessly that the Affordable Care Act still left a whole bunch of people without insurance. In fact, he sent out a tweet today highlighting that the CBO does confirm that if current law continues, there will still be a lot of people without insurance. He left out the fact that the CBO says that under the Republican bill, 22 million more people will lose insurance, but that is a whole lot of people.

By the way, in the first year, CBO says 15 million people will lose insurance. Fifteen million people is the entire population of 13 States. That happens next year. Emergency rooms in this country cannot in 12 months absorb 15 million people losing insurance.

For all the folks who say that the ACA is in a death spiral, CBO says you are wrong. Very flatly, CBO says that if existing law remains, even without any improvements, the number of people without insurance effectively remains static. Yes, at the end, if you make no improvements, you will go from 26 million people not having insurance to 28 million people not having insurance.

CBO says—I had to change this because it used to be 51 million under the House bill. CBO now says 49 million people will lose insurance if you actually pass the bill the Senate is going to consider this week. The death spiral happens if we pass the Republican healthcare proposal. That is not a death spiral; that is stability. It is not an optimal result, 28 million people not having insurance, but it is far preferable to 49 million people not having insurance. I understand that Republicans will quibble with CBO and say that maybe they didn't get it exactly right. Even if they were 50 percent wrong, that is still over 10 million people losing insurance. By the way, just for good measure, CBO was right in their estimates of the percentage of Americans who would have insurance under the Affordable Care Act. Inside of their estimate—the details worked out differently—but they said that by 2016, 89 percent of Americans would have health insurance, up from 83 percent prior to the passage of the Affordable Care Act. Guess how many people have health insurance today: 89 percent of Americans, 89 to 90 percent of Americans.

We all agree that premiums should go down. If we are going to pass something, the result should be that premiums go down. Here is what CBO says: Premiums go up and not by a little bit. They go up by 20 percent in the first year. Admittedly, I am painting a partial picture here. That is 2018. After that, CBO says for certain populations in this country, premiums will go down, but it is largely for the young, the healthy, and the wealthy.

CBO says that you will have massive premium increases for older Americans. For lower income Americans who are in that age bracket of 50 to 64, premium increases will go up by at least two times, up to four times.

CBO also says that if you are lower income, you are not going to buy insurance because you can't afford it. It doesn't even matter what your premiums are because they will be so high, you can't afford them. Premiums go up for everybody off the bat—and for lots of vulnerable people after that.

So who gets hurt? Everybody, except for the folks who are getting tax cuts. If you are an insurance company, a drug company, or you are super rich—maybe that is an unfair term—people making \$200,000 or more a year get tax cuts, but most of the tax cuts go to the super rich. People making over \$1 million a year will do fine. If you are an insurance company, a drug company, or you are very wealthy, you get a great deal out of this piece of legislation, but pretty much everybody else gets very badly hurt.

Today, one of our Republican colleagues said this to a reporter—I won't give you a name. One of our Republican Senate colleagues, when he was asked about the Republican healthcare proposal, said: "I am not sure what it does. I just know it's better than

ObamaCare." That is about as perfect an encapsulation of the Republican positioning on this bill as I can imagine, because if you did know what it did—if my Republican colleagues did get deep into the CBO report, it doesn't solve a single problem in the American healthcare system. There are big problems, such as 26 million people still don't have insurance. This bill makes it worse.

People are paying too much for insurance, especially those folks who are making middle incomes who are just outside of qualifying for the Medicaid subsidies. This bill makes it worse. Almost every problem is made worse by this piece of legislation. I guess that is sort of what a lot of Americans wonder—if our Republican colleagues do know what is in this bill. "I am not sure what it does. I just know that it's better than ObamaCare."

This solves one problem for Republicans. It is a political problem. Republicans have said for the last 8 years that they are going to repeal the Affordable Care Act. My Republican friends promised it in every corner of this country, at every opportunity they had, and this does solve that political problem. If you pass this bill, you can successfully claim that you have repealed the Affordable Care Act, but that is the only problem it solves. It makes almost every other problem in this system worse.

The number of people without insurance goes up. Premiums, especially for the poor, the vulnerable, go up. There is nothing in this bill that addresses the cost of healthcare, of drugs, of devices, of procedures. There is nothing in this bill that talks about the quality of healthcare. Every problem—virtually every problem in the healthcare system gets worse.

I will just end by reiterating the offer that Senator SCHATZ made. I think you have a lot of people of very good will who want to work with Republicans and are sincere about it. I will be part of whatever group gets put together if this bill falls apart this week.

I held an emergency hearing in New Haven, CT, on Monday, just to try to explain to people what was in the Republican Senate proposal and to get people's feedback. It was hard to sit through. It was 2½ hours of some really scared folks.

I will be honest with the Presiding Officer. Most of the people who came had disabled kids. Most of the people who came had disabled kids who were on or relied on Medicaid, and they were just scared to death about what was going to happen to their children. But they also talked about the problems that still exist in the healthcare system—the fact that drugs are too expensive. Many of them pay too much for healthcare. They wanted those problems solved, and they wanted us to work with Republicans on it.

Senator SCHATZ was right. If we did it together, we would own it together. It would stop being a political football.

While that would be a secondary benefit to the actual good that would come from a bipartisan piece of legislation that actually addresses the issues in the underlying healthcare system, it would be a pretty remarkable good that is possible because we have the same goals in mind. We both want the same things. It is just, in the end, putting aside this bill that makes all of those problems worse and, instead, sitting down together and deciding which levers we want to push to make things better.

I yield the floor.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. CASEY. Mr. President, I rise, as well, to talk tonight about the issue of healthcare. I thank my colleague from Connecticut for looking down the road to when, maybe, we can actually work together on this issue. We are in conflict this week, and that is not a place any of us want to be.

We are in conflict because of the elements of this bill. I will make two basic points in my remarks tonight, one about Medicaid and then one point about another provision in the bill that I think is particularly insulting.

A lot of our discussions start with policy and data, and that is important. That is obviously part of the debate about the bill and what is in it and what impact it will have on programs and people over a long period of time, but part of this debate, of course, is about the people we represent. I know the Presiding Officer understands this, and I am heartened that he is paying attention to our arguments because sometimes—I have done it myself—when you preside, sometimes you are doing something else. So we are grateful for his attention.

I have talked on this floor a couple of times over the last couple of weeks—even months—and I will not repeat the stories because they have been told a number of times, but Rowan Simpson is a young man whom I recently just met. His mom had sent me a letter. Rowan is on the autism spectrum, and his mom is very worried about his future because of the potential impact on Medicaid and the benefits he is getting today from Medicaid.

I just referred the other day—I guess it was Thursday on the floor—to a letter from a dad about his son Anthony, who has a number of challenges, one of them being that he is on the autism spectrum. I have another letter, as well, which I will not go through tonight, but it is from a mom in Northeastern Pennsylvania, who wrote to me about two of her children—principally, her son who has Type 1 diabetes and what the loss of Medicaid coverage will mean for that child, who, in this case, is just 4 years old.

Everyone in this Chamber in both parties has stories like this to tell—stories about people who are, because of a disability, totally dependent upon Medicaid. That is not unique to one State, and, of course, it is not unique to one party.

One of the more egregious and objectionable parts of this 140-plus page bill is the impact it will have on Medicaid—the Medicaid expansion, which many people now know represents probably on the order of 11 million people who got healthcare coverage since 2010 and got that coverage because Medicaid was expanded. But the bill also speaks to the Medicaid Program itself by the so-called per capita cap, capping the dollars the Federal Government would provide in the future with regard to the Federal-State partnership on Medicaid. These are big stakes when it comes to a program that has been with us for 50 years.

As everyone knows, Medicaid is principally about individuals with disabilities, and that is obviously those children I mentioned. It is about folks who need some help getting into a nursing home, senior citizens. Of course, it is about kids from low-income families who have no other healthcare, absent Medicaid. In our State, there happen to be 1.1 million kids on Medicaid who are from low-income families. The disability number in both children and adults is, by one estimate, more than 722,000 people. These are big stakes, even if it is just involving one of those individuals or hundreds or thousands. But as I will refer to later, some of the numbers are, of course, a lot higher than that. So those stories and those pleas for help from those families obviously do not just inform us, but they inspire us to keep working, to keep fighting. I will be fighting against this bill as long as it takes.

It is likely that we will have a vote this week. I am assuming we will, so we have only hours and a few days to fight and point out what we believe to be the defects. One of the things that is significant about this debate is that we have had people not just writing those stories and telling us their story but also telling us and giving us ideas about how to conduct the debate and how to fight and how to oppose it.

I have in my hand—I will describe it first before I offer a consent request. I have in my hand several pages that list almost 600 names from people in Pennsylvania who have written to me over the last number of weeks and months, actually. What they are urging me to do is to pursue a legislative strategy to protect their healthcare. Why are they doing that? It is not because they have nothing else to do. They are worried. These people are really worried. They are worried about those kids like Rowan and Anthony, whom I just mentioned, and a 4-year-old with Type 1 diabetes or a whole long list of other disabilities a lot of kids have. They are worried about their parents, who may not be able to get the long-term care they need if Medicaid is capped and cut and decimated. They are worried about their friends and their families. They are, in a word, as worried as anyone has ever been about the healthcare of those they love and the healthcare of those they care about. That is why

they have been writing and going to meetings and making phone calls and engaging in such a robust way, all these weeks and months.

Mr. President, I ask unanimous consent that this list of almost 600 names from Pennsylvanians be printed in the RECORD.

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

Ashley De Padua, Carol Ribner, Lisa Brown, Adam Huard, Julie Strauss, Amy Reynolds, Dianne Spatafore, Pamela Nolan, Karin Fox, Claire Witzleben, Wendy Albertson, Laura Rose, John Mack Jr., Elizabeth Failor, Lisa Bargielski, Peg Welch, Jason Carnahan, Robert Perry, Morgan Vinokurovi, Melissa Byrne.

Patricia DeWald, Kristin Kondrlik, Michael Crane, Diane Smith-Hoban, Diane Sayre, Benjamin Andrew, Janice Diehl, Robert Bahn, John Bair, Angela McClain, David Cassidy, Dara Bortman, Judi Reiss, Nicholas Marritz, Amber Blaylock, Tina Nightlinger, Lisa Bradshaw, Kimber Schladweiler, Michael Dwyer, Vashiti Bandy.

Christine Russell, Mary Farrington, Ralph Mcdermott, Anna Cunningham, Linette Schreiber, Barbara Powell, Shelley Francies, Joyce Fentross, Shannon Bearman, Jocie Dye, Ina Martin, Mary-jo Tucker, Bracken Babula, David Mosenkis, Martha Franklin, Nathaniel Missildine, Kristin Nielsen, Maria Duca, Erica Bartlett, Irina Pogrebivsky.

Stephanie Romano, David Hinchey, Diane Holland, Tracy Krider, Michelle Nutini, Anne Martin, Tracey Miles, Alexis Lieberman, Dorothy Posh, Thomas Hennessey, Cynthia Mould, Jennifer Kunkle, Ann Calamia, Jennifer Zoga, Barbara Turk, Raymond Hopkins, Carol Proud, Alex Hesten, Kimberly Jones, Richard Pavonarius.

Robert Huff, Klvdya Vasylenko, Mike Kass, Bernadette Flinchbaugh, Jo Johnson, Carolyn L. Johnson, Abby Godfrey, Mark Herr, Jeri Sebastian, Lisa Hartjen, Anne Smith, Melissa Nurczynski, Christine Crooke, Ellen Garbuny, Harry Richards, Ruth Hetrick, Carolyn Rahe, Stephanie Moats, Sally McAfee, Abigail Gertner.

Stacey Smith, Davinica Nemtzw, TC DeAngelis, Shelley Schwartz, Lisa Keppeler, Katie B, Joseph Willard, Maryam Deloffre, Kathie Brown, Ellen Catanese, Cynthia Donahue, Porter Hedge, Gretchen Bond, Mary Dallas, Fae Ehsan, Kathy Goldberg, Jennifer Jarret, Dan Potter, David Dutkowski, Rich DeAngelis.

Patricia Kay, Sharon Doros, Stephanie Doyle, Lynn Loomis, Elizabeth Adams, Kathryn Petz, Agatha Andrews, Alex Lombardi, Erin Gautsche, Marie Turnbull, Carol Sinclair, Robert Turnbull, Elisa Bermudez, Marie Vincent, Florian Schwarz, Daniel Pencoske, Ina Shea, Beth Collins, Meenakshi Bewtra, Jillian Bosmann.

Mari Greipp, Michael DiEva, Andrea Epstein, Fredrica Friedman, Starla Crandall, Stanley G., Cindy Fogarty, Ron Ashworth, Trudy Watt, Kristen King, Kathleen Sheehan, Ryan Brown, Kevin Collins, Kelly Collier, Ambry Ward, Joseph Melchiorre, Catherine Abrams, Michael Bourg, Ed Gragert, Hien Lu.

Jo Johnson, Cody McFarland, Maggie Deptola, Sandra Blair, Zoe Soslow, Yoko Takahashi, Anna Drallios, William Dingfelder, Shawna Knipper, Cheryl Brandt, Larissa Mogano, Linda Bishop, Lital Levy, Laurie Pollack, Judith Navratil, Natalie Duvall, Richard Owens, Elaine Giarusso, David Thomas, Leslie Collier.

Nicole Seefeldt, Jonathan Lipman, Ellen Gallagher, MaryAnn Black, David Hughes, Michael Niemeyer, Pegene Watts, Kelly

Sack, Glynnis Arnold, Ruth Lawson, Michelle LeMenager, Iris Valanti, Danielle Callahan, Frederick Ward, Martha Haines, Audrey Marsh, Lynn Campbell, Kristen Cochran, Judith Brennan, Michael McCabe, Joshua Miner, Jaime Bassman, Rachel Murphy, Elena Knickman, Nelson Vecchione, Daniel Laurison, Karen Osilka, Roger Knisely, Theresa Baraldi, Holly Best, Thomas Baraldi, Patricia Walsh, Michelle Herr, Karen Heenan, James Paul Johnson, Alexander Kimball, Sigal Ben, Leah Durand, Ingrid Gustafsson, Mary Jo Maggio.

Ken Hardis, Lisa DeAngelis, Mary Jo Harris, Alice Ung, Lance Flowers, Deborah Hoelper, Joel Cardis, Georgine Dongillig, Renee Donahey, Anna Payne, Hallie Kushner, Linda Cortese, Mark Vecchione, Natalie Garner, Rachel Marx, Janet Cavallo, Adrienne Gunter, Heather Turnage, Kenneth Reisman, Flora McGettigan.

Tricia Connell, Nicole Conley, GiGi Malinchak, Ellen Toplin, Eileen Brumbaugh, Theodore Fallon, Elizabeth Dooley, Stacy Klein, Deena Thornton, Barbara Stephan, Cheryl Dungee, Louisa Alexander, Brett Krasnov, Mary Gallant, Kathy Gardian, Irene Lin, Colleen Dunn, Liane Norman, Susan Yerk, Ann Telford.

Leslie Elder, Sheri Utain, Christine Hooper, Teri Vanore, Paula Baxter, Mordecai-Marl Mac Low, Nicolette Byer, Donna Vito, Michele Forbes, Rebecca Kane, Katherine Fein, Sue Meyers, Deb Yohman, Sherri Suppa, Jim Greipp, Jeffrey Bussmann, Rachel Smith, Eileen Reed, Louise Beer, Mary Reichart.

Tesia Barone, Nicole Gilchrist, Richard Greenstein, Amy Levengood, Judith Max, James Walton, Mary Widing, En B, Mary Jo Harris, E. E. Zachai, Tammy Harkness, Timothy McCormick, J Pensiero, Betty Fisher, Cindy Shannon, Elisabeth Whyte, Carmela Daniels, Amy Felton, Judith Gold, Jack Guida.

Sarah Gaffen, Linda Bullock, Pamela Woldow, Katherine Kurtz, Lisa Harrison, Esther Wyss-Flamm, Catherine Roundy, Jim Barlow, James Schreiber, Dave Carlton, Andrew Famiglietti, Maria Catrambone Rosen, Breanna Jay, Bethany Altieri, Alicia Oliviant Fisher, Chris Braak, Jessica Atchison, Elizabeth Dennis, Elizabeth Cates, Elizabeth Reilly.

James Berry, Marita Scheibe, Sheila Thomas, Randy Sarnier, Alyson D'Alessandro, Suann Snavelt, Chantal McKelton, Theresa Glennon, Josie Byzek, Marlene Katz, Deborah Grill, John Moffa, Anne Coles, Liane Norman, Chanda Lawrence, Norma Kline, Colleen Kessler, Maria Catrambone Rosen, Laurence Coles, Kate Wallis.

Carol Harris-Shapiro, Briana Latta, Melanie B, Charlotte Ridge, Nathan Krisanda, Meredith Sonnen, Margaret Walter, Hallam Carrie, Leslie Richards, Jenny Anne Horst-Martz, Karen Roberson, Richard Vanore, Susan Devenny, Rhana Cassidy, Maria Golden, Kathy O'Brien, Vanessa Baker, Robert Bruciman, Sarah Smith, Yuliya Benina.

John Ascenzi, Melanie Cichy, Paul Gottlieb, Shannon Browne, Jen Britton, Erin Dunke, Debi Seltzer, Anna Edling, Brianna Wronko, Francis Palombaro, Katie Morrison, Jennifer Hombach, Jessica Lennick, Ellen Toplin, Charlene Kurland, Joanne Mahoney, Sherry Greenawalt, Abigail Hyde, Sara Sierschula, Amy Leddy.

Emmy S, Renee Broxk, Kimberly Winnick, Melissa Reed, Lisa Jaremka, Karen Shelly-Genther, Melissa Welshko-Williams, Naomi Pliskow, Joan Susski, Rachael Pinsley, Lindsay Friedman, Shari Johnson, Melanie B, Keith Adams, Lynn Martin, Anastasia Frandsen, Brooke Petry, Tamara Davis, Martha Posnet, Phoebe Wood.

Lindee Fitting, Isabelle Mahoney, Tamar Granor, Nancy Berman, Karen Jensen, Katie Haurer, Beth Collins, Catherine Budd, Miriam Phillips, Christine Bradley, Michelle Gorski, Chris Gorski, Sophie Taylor, Catherine Borges, Mary Alice Clevenger, Nick Ingram, Brenda Scholtz, Melissa Miller, Jeanne Burd, Nad Rosenberg.

Joanna Kempner, Maria Boyd, David Shen, Sara Sobel, Jessica White, Jennifer Pennington, Margot Keith, Catherine Sunnen, Naida Reed, Ashley Morgan, Beth Brindle, Amy Friedlander, Millicent Wilson, Richard Baron, Max Ray-Riek, Ruth Cary, Sandy Heisey, Sharon Furlong, Laura Tilger, Donkey Dover.

Lynn Jones, Kaytee Ray-Riek, Janice Test, Mary Terp, Faith Cotter, Sarah Campbell-Szymanski, Frank Wallace, Judie Howrylak, Minna Ltumey, Erin Hetrick, Melinda Kohn, Jenny Stephens, Susan Gambler, Olivia Landis, Terry Hirst-Hermans, Jill Hall, Roseanne Multherin, Susan Miller, Julie Platt, Lori Spangler.

Hiro McNulty, Greg Carey, Amanda Fogarty, Sissy Gault, Mona Callahan, Meryl Mintzer Puller, John Hoetzel, Stacey Kallem, Thomas Paquette, Karen Clark, Paige Wolf, Patricia Scanlon, Ellen Reese, Rosalind Bloom, Gary Stein, Eric Berue, Jenn Hrehocik, Tamara Myers, Mara Kaplan, Amanda Cranney.

Deborah Miller, Debra Nathans, Paul Stockhausen, Johanna Hollway, Leah Holstein, Susan Robbins, Roger Latham, Alison Yazer, Melissa Marshall, Mary Lynn Colabrese, Harry McLaughlin, Samantha Payne, Elizabeth Hawkins, Julie Krug, Lisa Heinz, Shoshana Kaplan, Corrine Richter, Lee Baer, Eve Glazier, JoEllen Bitzer.

Judith Cardamone, Hilary Schenker, Faye Clawson, Caren Leonard, Carol Feldhaus, Judith Moyer, Sharyn Feldman, Jessica Martucci, Mike Kutik, Marylou Streznewski, Ann Baker, Abby Martucci, Dennis Cusin, Marie Norman, Debra Brokenshire, Martha Cornell, Maria Swarts, Sherell Chambers, Suzan Hirsch, Alison Wojtkowiak.

Patricia Carbone, Marcella Glass, Benjamin Mills, Peg Welch, Rita Shah, Marcia Gever, Karen Phoenix, Tabitha Felton, Carolyn Stillwell, Katherine Parys, Roxanne O'Toole, Harold Love, Nicole Jaffe, Steven Weitzman, Meredith Brown, Lauren Lewis, Sarah Wheeler, Maria Lauro, Jason Magidson Lorette Lefebvre.

Denise Marcolina, Eric Krewson, Joseph Bosh, Joan Stein, Kami Schaal, Melissa Nerino, Dorothy McFadden, Heather muntean, Donna Devonish, Gloria Rohlf, Terry McIntyre, Kaitlin Marks-Dubbs, Frederick Page, Douglas Graham, Sarah McKay, Zack Greenstein, Janice Nathan, Michel Wilcox, L Roulston, Laura Wukovitz.

Andrew Wilson, Amy Moulton, Christina VanSant, Donna Bullard, Nancy Entwisle, Tessa Lamont-Siegel, Ben Cocchiaro, Yasmeen Ali Khan, Rachel Amdur, Amalia Shaltiel, Sara Stetler, Bruce McDowell, Pat Hanahoe-Dosch, Mara Rockliff, Tristan English, Ryan Bross, Lynn Rubenson, Elizabeth Cheney, Regina Vicoli, Vicki Hewitt.

Kelli Servello, Charles Ang, Kierstyn Piotrowski Zolfo, Leah Bailis, Tom Petersen, Pamela Magidson, Kathleen Morrison, Genevieve Coutroubis, Susan Rubinstein, Ruth Ann Davidson, Frances Winsor, Janis Rainer, Margaret Grubbs, Anna Kuhnreich, Melissa Melan, Wendy Forman, Kristina Witter, Joan Kwortnik.

Mr. CASEY. Mr. President, I will make two final points about Medicaid and then juxtapose Medicaid with another part of the bill. If you look at the bill—it is about 140, I guess, 142 pages—more than 60 pages deal with Medicaid. So this is principally a bill about Med-

icaid. There are some other issues, obviously, addressed on the exchanges and the fundamentals of healthcare. But it is mostly about Medicaid and tax cuts, unfortunately; and that is particularly objectionable to me that you have a small group of very wealthy people who are going to make out in ways we can't even imagine, like a big bonanza for the superrich.

Now, let me just talk about the Medicaid part of it first, and then I will refer to a chart. I am holding in my hand the Congressional Budget Office report from today, which came out. It, of course, is a document produced by the Congressional Budget Office as well as the Joint Committee on Taxation so it is a joint effort.

On the CBO—so-called CBO Congressional Budget Office report, recently—a couple weeks ago now—on page 17 of that document, there was an assessment made of the number of people who would lose Medicaid as a result of the House bill, and that number was 14 million Americans would lose Medicaid over the decade up until 2026.

Well, unfortunately, as of 4 p.m. or something this afternoon—I guess about 4 p.m., 4:30—we got the Congressional Budget Office assessment of the Senate bill, the Senate bill that was unveiled last week. Not on page 17 of this report but actually on page 16, here is what the Congressional Budget Office and the Joint Committee on Taxation says about enrollment in Medicaid. I am quoting from the bottom of page 16:

Enrollment in Medicaid would be lower throughout the coming decade, with 15 million fewer Medicaid enrollees by 2026 than projected under current law in CBO's March 2016 baseline.

Then, they refer to a figure in the report.

So the House bill CBO assessment says 14 million will lose Medicaid coverage. The Senate bill, analyzed by CBO, which is supposed to be a more moderate bill, a better bill in the eyes of some Republican Members of the House and the Senate, that was supposed to be better, but here is what we know now: 15 million people will lose Medicaid. That alone should cause any Senator to be very concerned about the impact of this legislation. That alone should, I hope, require some people to use an old expression: Examine your conscience about what will happen if you vote for this legislation.

Let's say someone says: Do you know what? I can put that into context, and I think actually that will not happen or I have another explanation or whatever justification or rationale you use for voting for a bill that will result in 15 million people losing Medicaid coverage. People are very vulnerable. Let's just say you can analyze that a different way and come to a different conclusion. We will see how people deal with that number this week when they go home and when they have to talk about this legislation over time.

Here is where it gets a lot worse. This is a chart that is rather simple. Even

though it has a lot of data on it, it is rather simple. Here is what it says at the top. First of all, this isn't my chart; it is the Center on Budget and Policy Priorities' chart. You can go to cbpp.org to see it.

This is based upon the House bill, but I just told you that the Medicaid enrollment number is 1 million higher—or that the number losing Medicaid is 1 million higher under the Senate bill, and the tax cuts that are in the Senate bill are almost identical. You can just go down and count them. The House and Senate bill are virtually identical on tax cuts.

Here is what the headline is: Tax cuts for the top 400 roughly equal to Federal spending cuts from ending Medicaid expansion.

Now, remember, I said before that Medicaid expansion is one problem I see. The per capita cap is another. This chart just deals with one of the Medicaid problems—Medicaid expansion—so ending Medicaid expansion in Nevada, West Virginia, Arkansas, and Alaska, just four States, right? Alaska, they project, will lose \$2 billion worth of Medicaid over the decade, Arkansas would lose \$7 billion, West Virginia would lose \$12 billion, and Nevada would lose \$12 billion. That adds up to \$33 billion Federal Medicaid cuts from ending Medicaid expansion. So \$33 billion dollars just for States. By the way, these are not really high-population States. There is no California, New York, Texas or big States like that. So \$33 billion lost in Medicaid in just those four States.

What does this orange bar graph show? The same number, \$33 billion tax cut for the 400 highest income households in the country. It is the same number. So 400 households get a tax cut of \$33 billion, not in some other bill down the road, not in some other year, not in a budget bill or a tax bill. They get this massive tax cut in what is called a healthcare bill. At the same time, it is equivalent to the total Medicaid lost in just four States.

It gets worse if you add more States. Guess what. If you add up about 30 States in a different chart, it is about the same as all the tax cuts together, but here we are just talking about four States and 400 families.

I hope I am not offending anyone if they are in those top 400 households who are making either billions or, by one estimate, the average might be \$300 million. I know it has been difficult to make ends meet. You have been struggling and trying to pay the mortgage and the light bill when you are one of the top 400 richest households in the country.

But this chart, when you juxtapose this chart—and especially the orange part, the tax cut for 400 families, the giveaway to families who don't need it. Frankly, they don't even want this tax cut. I haven't found one person who came up to me in the last couple of years and said: You know what, I wish my taxes didn't go up. I wish those



taxes didn't go up while you were trying to help people on Medicaid. Not a single person said that.

Most people who will get this tax cut would rather that we make sure we take care of those children I mentioned with the disability or those families who need the protection of Medicaid.

When you put this chart next to the policy and those 60-plus pages of the decimation of Medicaid, there are a lot of words we could use that we are not allowed to use on this floor, but one of the words we should use is "obscene." That is an obscenity. When you match these cuts for 400 families next to the cuts to Medicaid, that is obscene, obnoxious, and bad policy.

If there was ever a reason to take this 142-page bill and throw it in the trash, throw it in a garbage pail as fast as we can, it would be this chart because that is not what the American people are asking for. They actually think some people in the Senate are actually working on a healthcare bill. That is what they believe. A lot of people don't know about this yet, but they are going to know. They are going to know by the end of the week, at least, if not sooner, that the 400 richest households in the country are getting that much money—\$33 billion. Maybe in the Senate bill it is only \$32 billion or \$31 billion, so we will stand corrected if it goes down, but that is really an abomination. That is an insult to the American people. People should be ashamed this is part of that bill.

I get it. We can have a debate about Medicaid. I get that, but when you are taking Medicaid dollars and transferring to wealthy people, no one should support that kind of a policy, but that is what we have. That is what we are up against.

If there was ever a reason to fight to the ends of the Earth against a piece of legislation, it is this. We are going to continue to fight this. We are going to continue to point out this basic inequity, this insult for the rest of this week.

We hope folks on both sides of the aisle will not only be listening, but we hope our Republican friends will take another look at this bill and understand how objectionable this is to so many American families. All of that worry I talked about before is made worse, is aggravated by this kind of result when it comes to tax cuts.

We can do all that as a great nation. We can make sure wealthy folks who need a break once in a while—they have gotten a lot of them in the last 25 years—that they can get a fair tax code. We could also make sure kids with disabilities, seniors, and kids in rural areas and big cities and small towns can get the healthcare they need from Medicaid. We are a great country. We can do that. We can have a growing economy and still support a critically important program like Medicaid.

I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

Ms. WARREN. Mr. President, we have just gotten the latest numbers on the Senate Republicans' reckless plan to take away health insurance from millions of American families, take it away from sick, little kids, take it away from seniors in nursing homes. These numbers are worse than anyone expected.

After weeks of secret work behind closed doors, the Republicans came up with a plan that will take away health insurance from 22 million people and slash the Medicaid Program by nearly \$800 billion, all in exchange for shoveling hundreds of billions of dollars of tax cuts to the richest families in this country.

You know, with results like these, Senate Republicans should not still be trying to figure out the best way to ram this bill through the Senate. They should just throw it in the trash.

We don't have a lot of time left, and I know it is easy to tune out these debates and to assume these are all just a bunch of partisan games. So if you aren't inclined to take my word for it, don't, and don't take the Republicans' word for it either. Take a look at what the experts are saying about the Republican bill because since this brutal bill was finally revealed on Thursday, it has been denounced by nonpartisan doctors groups, health policy experts, and patient organizations. The American Medical Association says the bill violates the fundamental principle of medicine: "First, do no harm." The Children's Hospital Association says it is "a major step backward for children and their health." The National Council for Behavioral Health says, "Instead of 'repeal and replace,' it is 'wreck and wreak havoc.'"

Lynn Nicholas, the head of the Massachusetts Health and Hospital Association, has actually come up with a pretty simple test for the Republican plan: "I challenge any Republican Senator to name one thing in this bill that will make healthcare in the U.S. better for patients or healthcare professionals who care for them."

Think about that. She says use that as the test, one thing. That is a pretty low bar—one thing. Yet the Republicans can't pass that test. They can't name one thing in this bill that will improve healthcare in America. That is because this bill is not supposed to improve healthcare in America. It is not a healthcare bill. It is a tax cut for the rich, paid for by gutting healthcare for millions of working Americans.

Doctors, patients, parents, families, experts, they are terrified by this bill because they have read it, and they have concluded that nearly every line in this bill would make life worse for young people and for old people and for families across this country.

I want to focus on just one major part tonight, the part that rips away the Medicaid Program. Let's do some basic Medicaid facts. Who uses Medicaid? Thirty million kids. That is about 4 out of every 10 kids in this

country count on Medicaid to help pay the medical bills. About 6 out of 10 children with complex medical needs—children who need breathing tubes, special therapies, and multiple surgeries, 6 out of 10 of those children count on Medicaid to help pay their medical bills. Nearly two out of three seniors in nursing homes count on Medicaid to help pay their bills, and one out of every three people dealing with addiction counts on Medicaid to help pay for treatment.

Who uses Medicaid? America uses Medicaid—children, the elderly, hard-working families, people with disabilities, and people struggling with addiction. At any given moment in this country, one in every five Americans is counting on Medicaid to help pay the bills. What are these people supposed to do when the Medicaid expansion goes away, when this bill's additional massive Medicaid cuts go into effect? What are they supposed to do? What are their families supposed to do?

Dig in on one issue around this. Dig in on opioid abuse. This is a problem that is growing around the country. Last year we lost 2,000 people in Massachusetts alone. I hear from parents who have lost children, from brothers and sisters who have watched a loved one disappear. I hear from people who are desperate because their child or sister or brother can't get into a treatment facility. I hear from dedicated doctors, nurses, and counselors who need more resources so they can expand treatment programs. Now the Republicans propose a bill that is like throwing gasoline on a bonfire. One in three people struggling with an addiction are counting on Medicaid, and the Republicans plan to cut nearly \$1 trillion from the program. I do not understand. I cannot understand how the Republicans could turn their backs on literally millions of people who need help.

The cuts to Medicaid are terrible, but there is more. The Republican bill also slashes the tax credits that people use to help pay for insurance. The budget nerds at the Congressional Budget Office say that "most people" would "have higher out of pocket spending on healthcare than under current law."

Think about that. Under the Republican plan, healthcare costs will go up for most people, and even if someone can manage, somehow, to afford coverage under the Republican bill, the Republicans are willing to let insurance companies drop expensive benefits that the companies just don't want to cover, including—are you ready?—opioid treatment. If this bill passes, it will devastate our ability to fight opioid overdoses. This isn't a hypothetical. This isn't speculation. Before the Affordable Care Act became law, one-third of individual market health plans didn't cover substance use disorder services, and about one in five plans didn't cover mental health services. The insurance companies don't want to cover these services, but the ACA made coverage mandatory. That

meant that no one in this country had to wonder when they showed up at a clinic whether or not their insurance would help them out, but the Republican bill opens the door to dropping those requirements. Millions more people could be left out in the cold at a time when they most need help. This is cruel. Our country is already struggling with a treatment gap, and far too many patients facing addiction can't get the care they need. The last thing we should be doing is kicking millions of these patients off of the coverage they already have.

Now, let's face it. The Republicans realized this, and they have a plan on this issue. They know that what they are doing is indefensible. So they have a plan. They propose to throw \$2 billion into a special fund for opioid treatment and say: Problem solved. This is political spin at its worst.

For every dollar the Republicans propose to put into opioid treatment, they are taking out more than \$100 from Medicaid, the rock on which our ability to provide opioid addiction treatment is built. Why? Why treat our brothers and sisters, our children, our elderly parents so shamefully? Why? So that Republicans can produce a giant tax cut for a handful of millionaires and billionaires. That is it. Our friends, our families, and our kids can struggle on their own. They can die on their own so that Republicans can cut taxes for the richest people in this country.

What the Republicans propose is morally wrong. It is not too late to do the right thing. It is not too late to reverse course. It is not too late to junk this bill and start over. I hope the Senate Republicans have the courage to do exactly that.

I yield the floor.

The PRESIDING OFFICER (Mr. ROUNDS). The Senator from Colorado.

Mr. BENNET. Thank you, Mr. President.

I appreciate very much the comments from my colleague from Massachusetts and my colleague from Pennsylvania.

I notice my colleagues from the other side of the aisle are not here tonight to defend this piece of legislation. It doesn't surprise me, given what is in this legislation and given what we have heard over the last week.

The Senator from Massachusetts was explaining what it was we were trying to do when we passed the Affordable Care Act, now years ago. Part of what we were trying to do was to extend coverage to a lot of Americans that didn't have it. In my State of Colorado that meant over 600,000 Coloradans who didn't have it before the Affordable Care Act was passed. Another thing we were trying to do was to say to insurance companies that it is not OK to have as your business practice that you take month after month after month of premiums from people and then when they call on the phone and say: My kid was sick; my kid got struck by lightning; my kid had an accident, to then

hold them on the phone as long as possible just as a way of denying their claim. Most people in America are too busy trying to move their family ahead, trying to get by, to stay on the phone all day with an insurance company. While we were at that, we said: It is not fair to deny people insurance in the richest country in the world because they have preexisting conditions. It is not fair that it is a business plan in America to have lifetime caps on people in the richest country in the world who might hit those lifetime caps because they get cancer. It is not fair that in America, the richest country in the world, some seniors have to cut their medicines in half every month just to get through the month and to pay their bills. These were some of the issues that we were trying to address when we passed the Affordable Care Act.

Mr. President, I am from a Western State, like you. I was out all those months in Colorado, having town hall after town hall, not just in Democratic parts of the State but in Republican parts of the State, trying to explain what it was we were trying to do—both to give people better coverage, more predictable coverage, and less costly coverage and also to try to do something to bring down healthcare costs in this country. We succeeded at some of those things. We didn't succeed at others of those things. It was a legitimate attempt at trying to deliver something for the American people that people all over the industrialized world don't have to live with.

Only in this country do people have to make choices about feeding their family and taking care of their kids at the doctor. Only in this country do seniors have to make choices about cutting those pills in half. Only in this country do people have to make choices about paying their rent and taking care of their kids. It doesn't happen in the rest of the industrialized world. Before I hear it from the other side tonight, let me say: Our results are getting worse, not better. For populations across this country, longevity is actually getting shorter, not longer. This is a difficult, complex, but urgent question for our country.

That is what we were trying to do with the Affordable Care Act. Some of it succeeded and some of it didn't. I will talk more about that in a minute.

For 8 years Republicans ran for election after election after election on ObamaCare: ObamaCare is socialism; ObamaCare is a Bolshevik plot to take over the United States; ObamaCare is destroying jobs—just at a time when we were coming out of the worst recession since the Great Depression. We saw uneven job growth in this country but undeniable job growth over the entire period of time they were saying ObamaCare was destroying the country and destroying our economy.

The recession was at the end of the last administration. The Obama administration saw the largest job increases

we have seen in this country since World War II. I know it is inconvenient to believe that or to say that. I know that in corners of the internet where false news really does dominate, people don't believe it, but it is true. I am the first to say there are not enough good jobs, and I am the first to say there are not enough high-paying jobs, but compared to the record we inherited, it was a success, all while we had the Affordable Care Act being implemented, all while we were extending coverage to millions of people in America—many of them children who didn't have adequate coverage before we passed the Affordable Care Act.

It has been called every name in the book, just like President Obama was called every name in the book, and they linked those two things—healthcare reform, the Affordable Care Act, and ObamaCare. That became its name.

Every single attack under the sun was levied on that. Why? Because people really believed it was destroying the healthcare system? Maybe some people did. Because they believed that it was destroying businesses? Maybe some people did. I suspect there was a much more simple reason, and that was to try to win elections.

By the way, while we are on the subject, no matter whether you support the Affordable Care Act—and I support some things about it; there are other parts of it that have been disappointing to me—I think it is fundamentally important for people to understand that the Affordable Care Act is not our healthcare system. It is part of our healthcare system. The regulations that it has placed on insurance providers so that people with preexisting conditions couldn't be denied insurance is part of our system. The fact that it tried to create accountable care organizations so people got better primary care so we would reduce the amount of hospital readmissions from something like 18 percent or 19 percent, which wasted billions of dollars in this country, down to 2 percent or 3 percent, that is healthcare.

But there is a lot of healthcare that has nothing to do with ObamaCare or that has something to do with it but it was not the creation of ObamaCare. There is Medicare and Medicaid. There are doctors. There are nurses. There are patients. There are drug companies. That is our healthcare system, and our healthcare system is a mess. It is a mess. It is a mess. We tried to take this thing and improve it when we passed the Affordable Care Act. Some of it worked; some of it didn't work. Some people would argue we went too far. Some people would say we didn't go enough.

But I can state this. I have been doing those town halls again in Colorado, and what I know is that people feel defeated not by ObamaCare but by the American healthcare system—by our healthcare system, which is less predictable and less affordable than in many countries around the world.

Now President Trump knew this. He is a smart politician. I never thought he was going to win. I never thought he was going to win on a campaign that on so many dimensions was out of step with conventional American political thought, and I was wrong. He won. I don't think he represents a traditional Republican view, and that may be one reason he won. In no sense do I think of Donald Trump as a conservative. I think of him as quite radical in his proposals. I think of him as a reactionary force on a political system that the American people, for whatever reason—some of them are probably good reasons—were losing their patience with.

You cannot deny that the guy, somehow, in the far reaches of Trump Tower, had his finger on the pulse of what was going on in some parts of this country. I don't know if it was because he was a reality TV star or what it was, but one of those things was healthcare. He understood the American people's dissatisfaction with our healthcare system, just as these 7 years and 8 years of Republican campaigns have understood it. Majority Leader MCCONNELL made it clear when we were passing the bill: You own it. You own it. He said in a book later that it was very important to him that the American people were able to demarcate between the Democrats' responsibility for the healthcare system as it was and the Republicans' willingness to take no responsibility for it.

Even though we had hundreds of hours of hearings that lasted more than a year and even though we had—they are not countless—well over 100 Republican amendments that were made in committee and on the floor that were incorporated in the legislation, in the end, not a single Republican voted for the bill.

Maybe that was a principled reason, not just a political reason, because maybe there are some people who have the view in the Republican Party that the Federal Government should not have any increased involvement in their healthcare system. In fact, I have heard some people say the Federal Government should play no role in the healthcare system. Yet whatever the reason, not a single Republican voted for ObamaCare.

The rest of the history writes itself, which is that every premium increase in America, whether it was related to ObamaCare or not, becomes part of ObamaCare. Every drug that gets increased in price becomes ObamaCare, and for everybody who loses his insurance, that is ObamaCare when what is happening is really far more complex than that.

There are very legitimate critiques of ObamaCare, but it is not the same thing as our entire healthcare system. I think it is important to make that point because, whether we are considering the Republicans' proposed bill tonight or someone else's proposed bill tonight, we would have to understand it was not going to fix the whole problem all at once.

People in my State are deeply dissatisfied with our healthcare system. I say that as somebody who voted for the Affordable Care Act. I have said it before. People have tried to make a political issue out of it. They write ads about it: Look, Bennet said the healthcare system is not perfect.

I will go further than that. It is a crying shame that people in this country have to spend their lives wrestling with insurance companies, lying awake, wondering whether their kids are going to be able to get primary care or dental care or cancer care if they get sick. That keeps families up every night in my State, not so much the people who are on Medicare but a lot of other people.

So Candidate Trump saw this unease in the American people, this concern that the American people had with our healthcare system, which I share, and in his campaign—in his very populist campaign for President—he promised to provide “such great healthcare at a tiny fraction of the cost.” Those knuckleheads in Washington do not know what they are doing. I am going to deliver you “such great healthcare at a tiny fraction of the cost.” That was his promise to the American people. That is what he said he was going to deliver.

He differentiated himself from other Republicans by saying: “I will never cut Medicare.” “I will never cut Medicaid.” He said: Those other Republicans say they will. I am not going to do that, but I am going to supply better healthcare than you are getting now at a tiny fraction of the cost. He said: “Everybody is going to be taken care of much better than they're taken care of now” with no cuts to Medicare and no cuts to Medicaid.

We had our election, and people voted for this nominee who made not just these promises but many other promises about what he was going to do for our economy based on, I think, largely, a complete fiction about what is actually going on in our country—for that matter, in the world—with respect to our economy. So he won. He did not just win—the Senate is Republican, and the House of Representatives is Republican.

Now, after running elections for 8 years to get rid of that scourge on America, that stain on America, that legislation that has destroyed our economy and destroyed our healthcare system, they wrote a bill. It took them a long time, really, to get it through the House of Representatives, which was shocking, because they had 8 years to figure out what was wrong with the current system and how to address the current system. They tried it once, and they could not even bring it to a vote in the House. They could not even bring it to a vote.

Then, understandably, the people who sent those Republicans to office in the House said: What are you talking about? You said you were going to repeal ObamaCare. You told us all of

these terrible things that ObamaCare had done. Your first order of business was to repeal ObamaCare. How dare you not have a vote?

I am glad they said that because people should keep their promises.

I have believed for a long time that people want consistency out of their politicians, that they will put up with inconsistency if you say to them that the facts are different than I thought they were and that is why I changed my view. Yet, in these times of fake news, of the media having the challenges it has, and the rest of the things that ail our system, consistency is not something that a lot of politicians pay attention to. I think they think that is because voters do not pay attention to it, but, in this case, they did. They said: You said you would repeal ObamaCare. You did not just say it once. You said it year, after year, after year, after year. Finally, they then passed a bill in the House. Not a single Democrat voted for it.

We learned from that process, which took place before the Congressional Budget Office had even scored the bill—imagine that. There were all of these people who criticized the Affordable Care Act, and proponents were rushing the bill through. As I said, I think there were 200 Republican amendments adopted. It was a bill that held almost countless committee hearings in the Senate Finance Committee and the Senate HELP Committee. It was a bill that consumed 25 days of legislative process on this floor, a modern record in terms of time. In fact, we had all of that process, and I will come back to this.

Here is what Senator MCCONNELL said about that. After all of that process, he said on this floor, I think, that Americans were “tired of giant bills negotiated in secret and then rammed through on a party-line vote in the middle of the night.” Oh, that bill was negotiated completely in public, painfully in public. I used to go home, and people in my townhalls literally had copies of the bill. Do you remember the chant: “Read the bill. Read the bill”? That is because everybody had the bill.

On the House side, it is important for people to understand that they passed the bill without even getting a score from what is called the Congressional Budget Office. The head of the Congressional Budget Office is appointed by Republicans when the Republicans are in the majority, not by the Democrats. It did not even get a score. We had a score on the Affordable Care Act before we passed the bill. We had a score that every single American could see about what it would cost and what money it would spend, what money it would save, how many people would be added to the insurance rolls. We had that. They did not have the decency to do that in the House.

They should have because—guess what happened—when the score came out, it said that 24 million people would lose their health insurance after

a candidate for President said that you are going to have “such great healthcare at a tiny fraction of the cost.” “Everybody is going to be taken care of much better than they’re taken care of now,” unless you are one of those 24 million and, I would argue, many of the rest as well. I will come to that.

So they passed that bill, a terrible bill. I think that bill has the lowest approval rating among the American people of any piece of legislation that has existed in the time I have been in the Senate. It is still not as low as the approval rating of this place, which used to be 9 percent, but it is low because people know it does not really address their healthcare problems. It is not a healthcare bill.

Then the President found out what was in the Congressional Budget Office’s score, and he had some Republican Senators over to the White House and said: I hope you will not pass a bill like that. That is a mean bill.

That is not my description. That is President Trump’s description of the House bill. That is a mean bill.

He said: I want a bill with a little more love in it than that bill out of the Senate.

He has to be disappointed tonight because the Congressional Budget Office’s score came back and said that under the Senate’s version of the bill—the less mean bill—only 22 million people will lose their health insurance and that far from having better insurance at a lower price, half of the country—literally half the country—is going to pay thousands more in out-of-pocket expenses because of what has become known as TrumpCare.

There are three principal parts to the bill in the Senate and in the bill that has passed the House. There are some differences, but I would say they are differences without a distinction. They are immaterial distinctions. There are three major components to these so-called healthcare bills.

The first is a massive tax cut for the wealthiest people in America. If you are making \$200,000 or less in Colorado or in any State in the country, you will not get a penny from this tax cut—not a penny. As my colleague from Pennsylvania said, if you are one of the top 400 taxpayers in America, together, you are going to get \$33 billion in tax cuts. That is an average tax cut for each of those 400 Americans of \$82.5 million. There is not a person in Colorado at any one of my townhalls who has said to me: MICHAEL, the key to doing a better job with our healthcare and the key to fixing ObamaCare—and I am talking about the critics of ObamaCare. There is not a one who has said to repeal those taxes on the top 1 percent of taxpayers in America at a time when our income inequality has not been greater than in 1928 and at a time when we are collecting in revenue only 18 percent of our gross domestic product and spending 21 percent. Not a single person has stood up in a town-

hall meeting and said the key to success here is in cutting those taxes. Just to be clear, I should mention that \$82.5 million is over a 10-year period. It is about \$8.25 million a year.

As Senator CASEY, from Pennsylvania, noted, that \$33 billion adds up to be the equivalent of what it would cost to pay for the Medicaid of 772,000 people who live in just four States—the entire Medicaid population of four States.

But what they would consume in healthcare to try to support themselves and their family is not \$8.5 million a year; it is not \$85 million over 10 years; it is, on average, \$4,500 a year on healthcare. That is the first part of this bill—a massive tax cut that is not going to benefit anybody in my State who earns below \$200,000.

The second element of this bill is a massive cut to Medicaid, which is one of the fundamental safety net programs in this country. The cut, whether you look at the House cut or the Senate cut, is massive. It is about a quarter of the program. It is about \$840 billion. And in the Senate bill, the cuts are even deeper than they were in the House bill. I wonder what the President would say about that. The House bill was mean. I bet he would say the Senate bill is cruel because it perpetuates those cuts.

I have heard the rhetoric from politicians in Washington about why it is so important to cut Medicaid. They need to cut Medicaid so they can pay for the tax cuts for people who are so wealthy, most of them probably don’t even need to mess around with insurance to pay for their healthcare or their doctors. Now they are going to have another \$8.5 billion a year. Now they are going to have another \$85 million over 10 years if they want to spend it not on insurance but on whatever else they want to spend it.

So on the one hand, they had to find the money to pay for this tax cut. They found it from some of the poorest Americans there are. How do they justify that? They justify it by painting a picture that says that there are Medicaid recipients all over America who are receiving Medicaid but not working, and therefore we should cut the program because if we cut the program, they will know they have to get a job in order to buy health insurance, and they won’t be on the Federal Medicaid Program. They say to go to work, and that is why we can cut this program. Keep people out of that hammock they are lying in instead of working for their healthcare.

What an insult to the almost 50 percent of Medicaid beneficiaries in Colorado who are poor children. Are they supposed to go to work, or can they go to school? And while we are at it, maybe we should think about giving them better schools so they can actually compete in this economy. But are we really going to take away their healthcare?

Then there are a whole bunch of people who have spent down their life sav-

ings for the privilege of being in a nursing home paid for by Medicaid. There is not a townhall I have where there aren’t sons and daughters or grandsons and granddaughters of people who are in nursing homes paid for by Medicaid after they had to spend their whole life savings down to be there. What a terrible system it is that a family has to be near bankruptcy before we say: We will give you a helping hand. It is a terrible system, but it is what they have. And they can’t work. They are in a nursing home. They are in long-term care.

Then there are a whole bunch of people in my State and in other States—and this may be the greatest insult of all—who are working at one job or sometimes at two jobs, and in the richest country in the world, they are working and are getting paid and are not getting paid enough to be off the Medicaid rolls. They are working, and they are still on public assistance. And we are cutting a quarter of the Medicaid Program because people need to go to work.

I am not making this stuff up. I asked Secretary Price, who is the Secretary of HHS, Health and Human Services—he is in charge of the healthcare for this administration—I said: Mr. Secretary, let me take you through the faces of the people in my State who are on Medicaid. And not only did they confirm that that is who is on Medicaid in my State, he said that is the way it looks all over the country.

What an insult to justify a massive tax cut for the richest Americans by taking away poor people’s healthcare; by saying they are not working for it, when they are children, when they are in nursing homes, when they are working one and sometimes two jobs in the richest country on the world.

So that is the second part of this healthcare plan—tax cuts for wealthy people and cutting Medicaid for poor people. And in the middle of that is the only thing that could fairly be described as a healthcare plan; it is just a terrible plan.

Senator PAUL from Kentucky—one of the more principled people in this Chamber—said it very well when he called it, not politely, “ObamaCare lite.” He is absolutely right. If you hate ObamaCare, you are really going to hate ObamaCare lite. It is the same structure, which amazes me because all of the people who said we should repeal ObamaCare are now preserving the very basic structure of how the program worked, but the problem with it is that they have cut the subsidies. They have turned them into tax credits and cut the value of the subsidies. If you think insurance is expensive now in the individual market, wait until you meet ObamaCare lite, in the words of RAND PAUL.

So those are the three components of the bill. And it is not surprising to me that for those reasons, Senator McCONNELL has written this bill in secret. It

is not surprising to me that he hasn't wanted to have a committee hearing. It is not surprising to me that he brought the bill here on the floor last Thursday, then accused people on the other side of not having read the bill and still wants us to act on the bill this Thursday so he can go home before July 4th and say to the American people: We did it. We kept our promise. We repealed ObamaCare. We may have written a terrible piece of legislation that has nothing to do with improving your healthcare, but we repealed ObamaCare. And he is hoping the American people won't notice.

Let me tell you something. The American people are noticing. There is a reason why the House bill has the worst approval rating of any piece of legislation in modern American history. The American people are not stupid.

I was in Frisco, CO, not that long ago, which is a place that everybody should visit from all over the country. There is tremendous skiing, and there is tremendous hiking, wonderful people. And before I had the townhall meeting, I went and visited a healthcare center there that they are justifiably proud of. It turns no one away. It gives phenomenal primary care. It gives phenomenal dental care. They have to figure out every week how to get through, but they always figure out how to get through so that people in Frisco and in the surrounding area have healthcare.

This is not a poor community by American standards. It is a resort community, but there are people who live there year-round. I asked the people who run the clinic: Who are the payers for healthcare in your clinic? Who are they? What pays for healthcare here? And she said: Well, MICHAEL, the Medicaid is 33 percent. That shocked me because if you are in rural Colorado, the Medicaid number is usually a lot higher than that because people don't have access to a lot of resources, and we all know they don't have access to a robust insurance market. Thirty-three percent was Medicaid, 53 percent was uncompensated care, and the rest was private insurance companies that pay for the insurance. That shocked me.

I said: Fifty-three percent is uncompensated care, people with no insurance? How can that be?

She said: These are people in our community who make too much money to be eligible for Medicaid, but they can't afford private insurance.

They are working full time; that is not the problem. They are not even—as I described before in a case where somebody is paying them too little, so they are eligible for Medicaid; their problem is that they are being paid too much, and they are not eligible for Medicaid as a result, but they can't afford private insurance. I think that is an indictment of the Affordable Care Act that I accept as somebody who voted for it. The idea that we would re-

quire people in America to buy health insurance and then not have a market that gave them quality health insurance at an affordable price is ridiculous.

I have had people in rural Colorado say to me: MICHAEL, look, why are you requiring me to buy something where there is not enough competition, so the premium is high and the deductible is ridiculous. So it is of no use to my family, and you are requiring me to buy something that is useless to me. We should have more competition to drive down price.

I say: You are 100 percent correct.

And if we had a functioning Congress that wanted to take a bipartisan approach to fixing that problem, we could fix it, and there are probably 15 or 20 other things along those lines. But the Republican healthcare bill—so-called healthcare bill—does none of that. It does none of that.

So to the extent that you don't like ObamaCare because you feel as though your premiums are going up and you are not getting enough for it, as opposed to the millions of people who have gotten insurance as a result of it, some for the first time—to the extent you are worried about that, the House bill makes it worse and the Senate bill makes it worse.

There is a projection in the CBO report that says that at a certain point in time, your premiums might come down under the Republican bill, but the reason for that is because you will be buying lousy insurance. It is not because Donald Trump, as he said to the country, has provided such great healthcare at a tiny fraction of the cost. That is not the reason. It is because they provided terrible healthcare at a fraction of the cost. That is not a benefit to anybody. If an insurance company can put you on lifetime caps, of course they are going to charge you less.

I am all for working together in a bipartisan way to address the issues in our healthcare system that, frankly, go far beyond the Affordable Care Act to make sure people in America don't have to continue to make the choices people all over the world don't have to make about having to stay in a job they hate because they have to keep the insurance or being able to quit a job and do something else because they know the insurance will be there. Nobody else has to make those decisions. And nobody else in the world goes bankrupt because of healthcare, but that is still a problem in America.

I think fundamentally the problem we have here tonight is proponents of this legislation didn't set out to fix our healthcare system; they set out to repeal ObamaCare or the cartoon of ObamaCare they have been running on for the last 8 years. That is what they set out to do. Along the way, they obscured it all so they could have the opportunity to cut taxes on the wealthiest Americans—which, for some reason, is an obsession with some people

around here—and dramatically cut access to healthcare by poor children.

I know there are people who are hearing this will not believe what I am saying is true. It is true. I hope you will familiarize yourself with the facts. I hope, in particular, people who feel the last bill we considered on this floor didn't get the process it deserved—people who quite rightly wanted to make sure Members of the Senate and the House had actually read the bill, people who wanted to know what it was like to live in a country where your health insurance is uncertain from month to month, where you have to decide between paying the rent, buying the food or being on health insurance; people who are dealing with and whose families are dealing with the effects of this terrible opioid crisis that wasn't even really a gleam in our eye when we passed the Affordable Care Act.

I especially say to people living in rural America how sorry I am that people aren't paying attention to your needs; that your hospitals may be cut because of an ill-considered piece of legislation which has nothing to do with delivering healthcare in rural Colorado or rural America.

We can do so much better than this, but to get to a place, unfortunately, where Democrats and Republicans have the opportunity to work together, the first order of business has to be to defeat the bill on the floor. I hope people know this is the week when it is critical to call and let your voices be heard, let people know you expect something better than what we are getting, and that Americans ought to have a healthcare system that is affordable, that is predictable, and that actually creates stability instead of instability for their families.

Mr. President, I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. BENNET. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

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

#### ADJOURNMENT UNTIL 2 P.M. TOMORROW

The PRESIDING OFFICER. Under the previous order, the Senate stands adjourned until 2 p.m. tomorrow.

Thereupon, the Senate, at 9:55 p.m., adjourned until Tuesday, June 27, 2017, at 2 p.m.

#### NOMINATIONS

Executive nominations received by the Senate:

##### DEPARTMENT OF TRANSPORTATION

MARK H. BUZZY, OF VIRGINIA, TO BE ADMINISTRATOR OF THE MARITIME ADMINISTRATION, VICE PAUL NATHAN JAENICHEN, SR.

##### DEPARTMENT OF STATE

MARIA E. BREWER, OF INDIANA, A CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF MINISTER-

COUNSELOR, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE REPUBLIC OF SIERRA LEONE.

JOHN P. DESROCHER, OF NEW YORK, A CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF MINISTER-COUNSELOR, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE PEOPLE'S DEMOCRATIC REPUBLIC OF ALGERIA.

KELLEY ECKELS CURRIE, OF GEORGIA, TO BE REPRESENTATIVE OF THE UNITED STATES OF AMERICA ON THE ECONOMIC AND SOCIAL COUNCIL OF THE UNITED NATIONS, WITH THE RANK OF AMBASSADOR.

#### UNITED NATIONS

KELLEY ECKELS CURRIE, OF GEORGIA, TO BE AN ALTERNATE REPRESENTATIVE OF THE UNITED STATES OF AMERICA TO THE SESSIONS OF THE GENERAL ASSEMBLY OF THE UNITED NATIONS, DURING HER TENURE OF SERVICE AS REPRESENTATIVE OF THE UNITED STATES OF AMERICA ON THE ECONOMIC AND SOCIAL COUNCIL OF THE UNITED NATIONS.

#### DEPARTMENT OF STATE

ROBERT WOOD JOHNSON IV, OF NEW YORK, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND.

JAMIE MCCOURT, OF CALIFORNIA, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE KINGDOM OF BELGIUM.

CARL C. RISCH, OF PENNSYLVANIA, TO BE AN ASSISTANT SECRETARY OF STATE (CONSULAR AFFAIRS), VICE MICHELE THOREN BOND.

#### NATIONAL MEDIATION BOARD

KYLE FORTSON, OF THE DISTRICT OF COLUMBIA, TO BE A MEMBER OF THE NATIONAL MEDIATION BOARD FOR A TERM EXPIRING JULY 1, 2019, VICE NICHOLAS CHRISTOPHER GEALE, TERM EXPIRED.

#### EXECUTIVE OFFICE OF THE PRESIDENT

MICHAEL RIGAS, OF MASSACHUSETTS, TO BE DEPUTY DIRECTOR OF THE OFFICE OF PERSONNEL MANAGEMENT, VICE CHRISTINE M. GRIFFIN.

#### DEPARTMENT OF JUSTICE

CHRISTOPHER A. WRAY, OF GEORGIA, TO BE DIRECTOR OF THE FEDERAL BUREAU OF INVESTIGATION FOR A TERM OF TEN YEARS, VICE JAMES B. COMEY, JR.

#### DEPARTMENT OF VETERANS AFFAIRS

THOMAS G. BOWMAN, OF FLORIDA, TO BE DEPUTY SECRETARY OF VETERANS AFFAIRS, VICE SLOAN D. GIBSON. JAMES BYRNE, OF VIRGINIA, TO BE GENERAL COUNSEL, DEPARTMENT OF VETERANS AFFAIRS, VICE LEIGH A. BRADLEY, RESIGNED.

#### IN THE NAVY

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES NAVY TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

#### *To be vice admiral*

REAR ADM. FREDERICK J. ROEGGE

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES NAVY TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

#### *To be vice admiral*

REAR ADM. DEWOLFE H. MILLER III

#### IN THE MARINE CORPS

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES MARINE CORPS TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

#### *To be lieutenant general*

MAJ. GEN. DANIEL J. O'DONOHUE

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT TO THE GRADE OF LIEUTENANT GENERAL IN THE UNITED STATES MARINE CORPS WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

#### *To be lieutenant general*

MAJ. GEN. MICHAEL A. ROCCO

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT TO THE GRADE OF LIEUTENANT GENERAL IN THE UNITED STATES MARINE CORPS WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

#### *To be lieutenant general*

LT. GEN. MARK A. BRILAKIS

#### IN THE AIR FORCE

THE FOLLOWING NAMED AIR NATIONAL GUARD OFFICER FOR APPOINTMENT TO THE GRADE INDICATED IN THE REGULAR AIR FORCE UNDER TITLE 10, U.S.C., SECTION 531:

#### *To be major*

MICHAEL J. SILVERMAN

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES AIR FORCE AND AS PERMANENT PROFESSOR AT THE UNITED STATES AIR FORCE ACADEMY UNDER TITLE 10, U.S.C., SECTIONS 9333(B) AND 9336(A):

#### *To be colonel*

MAIYA D. ANDERSON

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE REGULAR AIR FORCE UNDER TITLE 10, U.S.C., SECTION 531:

#### *To be major*

KIMBERLY M. KITTLESON  
KEVIN C. PETERSON

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT IN THE GRADES INDICATED IN THE REGULAR AIR FORCE UNDER TITLE 10, U.S.C., SECTION 531:

#### *To be lieutenant colonel*

CECILIA A. FLORIO

#### *To be major*

DEEPTHI V. BYREDDY  
DIANE L. EVANS  
JOHN M. FEJES

#### IN THE ARMY

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES ARMY UNDER TITLE 10, U.S.C., SECTION 624:

#### *To be colonel*

JOSEPH M. O'CALLAGHAN, JR.

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT AS PERMANENT PROFESSOR AT THE UNITED STATES MILITARY ACADEMY IN THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTIONS 4333(B) AND 4336(A):

#### *To be colonel*

BRET P. VAN POPPEL

THE FOLLOWING NAMED OFFICER FOR REGULAR APPOINTMENT IN THE GRADE INDICATED IN THE UNITED STATES ARMY MEDICAL CORPS UNDER TITLE 10, U.S.C., SECTIONS 531 AND 3064:

#### *To be major*

ALIYA I. WILSON

#### IN THE NAVY

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES NAVY UNDER TITLE 10, U.S.C., SECTION 624:

#### *To be captain*

LINDA C. SEYMOUR

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES NAVY UNDER TITLE 10, U.S.C., SECTION 624:

#### *To be commander*

CHAD J. TRUBILLA

## CONFIRMATION

Executive nomination confirmed by the Senate, Monday, June 26, 2017:

#### NUCLEAR REGULATORY COMMISSION

KRISTINE L. SVINICKI, OF VIRGINIA, TO BE A MEMBER OF THE NUCLEAR REGULATORY COMMISSION FOR THE TERM OF FIVE YEARS EXPIRING JUNE 30, 2022.