Mr. ALEXANDER. I thank the distinguished assistant Democratic leader for raising the point. It is a point I would be delighted to address.

I voted against that proposal. That proposal was a backdoor effort in what was a so-called jobs bill to spend $85 billion over 2 years for Medicaid. That is one reason why we have 10 percent unemployment today, because the money that was supposed to be for the stimulus was borrowed from the biggest deficits we have ever run up in history and spent on something other than jobs.

What it also did was it unrealistically lifted the level of Medicaid spending in Tennessee and every other State, forcing an expansion of that program, which I will go on to show in a minute is nearly cruel to the people who are dumped into the program because doctors and hospitals will not serve them.

So I was glad to vote against that program. I was sorry it passed because it borrowed money we don't have to spend on programs that didn't create jobs, and it artificially lifted and expanded Medicaid, which is already bankrupting the States.

Medicaid expansion is not real health care reform. One reason is because 40 percent—according to a 2002 Medicare Payment Advisory Committee survey—of the physicians restrict access for Medicaid patients; meaning they will not take new Medicaid patients because reimbursement rates are so low. Only about half of U.S. physicians accept new Medicaid patients compared with more than 70 percent who accept new Medicare—those are the seniors—patients.

According to a 2002 study in the Journal of American Academy of Pediatrics, the national rate for pediatricians who accept all Medicaid patients was 55 percent. In Tennessee, it was lower than that. Why is that? It is because reimbursement rates are so low. Today, doctors who see patients who are on Medicare get paid about 80 percent of what private insurers pay. Doctors who see patients who are on Medicaid get paid about 61 or 62 percent of what private insurers pay. For doctors who see children, it is sometimes lower than that. So doctors don't see those patients. What is going to happen if we dump 14 more million low-income Americans into a system such as that? Those patients—especially those children—are going to have a harder time finding doctors and hospitals to take care of them. It would be akin to giving somebody a ticket and a pat on the back to a bus line that only operated 50 percent of the time.

Further, the quality of care for Medicaid patients is significantly lower than those with private insurance and even those with no insurance. According to a survey by the National Hospital Ambulatory Medical Care, Medicaid patients visit the emergency room at nearly twice the rate of uninsured patients. A 2007 study by the Journal of the American Medical Association found that patients enrolled in Medicaid were less likely to achieve good blood pressure control, receive breast cancer screening, have timely prenatal care than similar parents in private plans, and they had lower survival rates.

I mentioned this a little earlier. According to the Government Accountability Office, Medicaid—the program we are seeking to expand, the government-run insurance program that sounds so good, the so-called largest public option plan we have to date, the plan where about half the doctors will not take new patients who are on the program—had $32.7 billion in improper payments in 2007 alone; 10 percent of the program's total spending is wasted.

So as we consider a so-called public option, I hope we will look at the public option we already have—called Medicaid—one which already has an opt-out provision for States, one which already has 60 million low-income Americans in it, one into which we plan to put 14 million more Americans, so that 50 percent of the doctors will say to new patients: I can't see you because the reimbursement rates are so low. Medicaid is the public option we have right now. States could opt out of it, but quality is low, fraud is high, costs are up, and Governors of States on both sides of the aisle are saying: We are headed toward bankruptcy at the present rate. If you are sending us more bills, if you want to expand it, pay for it. And doctors are turning away patients.

The American people deserve better than that. I am a cosponsor of a bipartisan bill that would actually reduce the number of patients on Medicaid. It is called the Wyden-Bennett bill. It adds no cost to the government. That bill is not being seriously considered.

The other approach that we Republicans believe we should take is focusing on reducing costs to the government, focus on reducing the cost of premiums; take four or five steps in the right direction and expand services to uninsured patients as we go. One way to do that, of course, would be the Small Business Health Insurance bill, which has broad support in both Houses, which would permit small businesses to come together and pool their resources. The estimates are that at least 1 million more Americans would be covered by employer insurance if that were to happen. Some estimates say many more millions.

But especially on a day when the press has it rumored that the majority leader may offer a new government-run insurance program with the States having the opportunity to opt out, I hope Americans will look carefully at the current government-run insurance program which States have the option to opt out of, but none do, and note that it has 60 million Americans—it is soon to have 74 million; half the doctors won't see new patients because of reimbursement rates; and $1 out of $10 is wasted. It is not a solution to health care and neither is a new public option.

I yield the floor and thank the Senator from Illinois for his question.

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

HEALTH CARE REFORM

Mr. DURBIN. Mr. President, I think we ought to step back and take a look at this health care debate. The Senator from Tennessee has raised some interesting questions that we should consider and discuss.

The reality in America today is that the cost of health care is out of control. We know it as individuals because the health care premiums keep going up. In fact, the health insurance industry not only announced but threatened 2 weeks ago that if we pass health care reform, premiums are going to go up again. Businesses are now reporting they anticipate the cost of health insurance premiums to cover their employees to go up at least 15 percent next year.

This is not new. Unfortunately it has become a pattern, a pattern that continues to raise the cost of health insurance across America. Fewer businesses offer protection, fewer individuals can afford to buy health insurance, and that is the reality, where we are today.

We have put forward now five different proposals, and the sixth is coming, to deal with health care reform. President Obama challenged this Congress to work together on a bipartisan basis to solve this problem, to bring costs under control. During the course of our debate on it, we identified some other serious problems in our health care system. We know what the health insurance companies do to people across America. They hire literally hundreds if not thousands of employees to sit in front of computer terminals with a sign above them that says just say no, so when the doctor calls and says I wish to admit Mrs. Smith for surgery or I wish to keep her in the hospital an extra 2 days, the answer is no and the battle is on. I know this because I have been in the hospitals of my hometown of Springfield, IL, standing with doctors at the nurses desk as they call the health insurance clerks in faraway States and beg them to allow a person to stay in the hospital so she will be there the night before her surgery. They were turned down and one doctor turned to me and said, ''I cannot in good conscience send this woman home. I am going to have her stay and we will fight them later on.'' I said, ''Does this happen often?'' And he said, ''All the time.''

Fighting health insurance for coverage when you need it the most, as they go through your application and find out that you did not put in some minor medical experience that you had—you know, it is not a fanciful story. In fact, it is a sad story. People have been turned down for coverage for health insurance when they need it the most for surgery because they failed to

disclose they had acne when they were teenagers. It sounds as though I am making that up, but I am not. That is a fact. When they want to turn you down, any excuse will do. We know this is happening. People, because of preexisting conditions, are being denied coverage. When they need their health insurance the most, after paying into it year after year, here comes that diagnosis that is going to require expensive treatment or a surgery or hospitalization or missing work, they find out the coverage is not going to be there or there is going to be a cap on the coverage.

We know these stories. We live with these stories. People are calling us, saying the health insurance company says no, they won't pay for it. And the battle is on. So part of health care reform is to deal with this health insurance reform too.

I have to say in all candor to my Republican colleagues, they have yet to come forward with any proposal for health care reform. They just say no. Whenever we come up with a proposal, it is not good enough, it doesn't reach the goals they want to reach. But when we ask them what would you do, they have nothing. When the HELP Committee, which is the Health, Education, Labor, and Pensions Committee of the Senate, now under the chairmanship of Senator HARKIN and then under the temporary chairmanship of Senator CHRIS DODD of Connecticut while Senator Kennedy was going through his cancer therapy—when they considered this bill they had literally hundreds of amendments, 500 amendments in open hearing as they went through this bill.

It is not a surprise. This is a big undertaking. Health care reform is the biggest domestic issue we have ever faced in this country—ever. It comprises one-sixth of our economy. There were 500-plus amendments, day after day, hour after hour, debating back and forth. At the end of the day, the bill was finished. The committee had adopted over 150 Republican amendments they had offered to the bill. Senator DODD believed it had a fair hearing—it is a bipartisan bill with input from both sides—and he called the roll in the committee to see if we could move the bill forward to the floor. Not one single Republican Senator would vote for it. Even after adding all those amendments they would not stand up and vote for the bill to move forward to the floor. Again, faced with the challenge of writing a bill, it is easier to stand back and say here is what is wrong with what you are doing. But in good faith they should step forward and be part of it.

Senator MAX BAUCUS in the Senate Finance Committee had one of the toughest assignments. He had to deal not only with policy but also with paying for it. That is what the Senate Finance Committee is all about. So what Senator BAUCUS did, for months, was to engage three Republican Senators on his committee: Senator GRASSLEY of Iowa, Senator ENZI of Wyoming, Senator SNOWE of Maine. Three Democratic Senators sat down with three Republican Senators and said let's come up with a bipartisan bill. Let's try to reach agreement among ourselves as to how to do this in a bipartisan fashion. Eventually, after literally months of trying, two of the Republican Senators left, leaving only Senator SNOWE of Maine, who ultimately supported the committee bill that came forward.

She is an unusual profile in courage in the Senate. She is the only Republican in the House or Senate who has ever voted in committee as a Republican to bring a bill forward on health care reform. It showed extraordinary courage on her part. But it also showed that despite the best efforts in both of these committees in open session and in closed meetings, we could not get Republican buy-in for health care reform. They are opposed to everything.

Unfortunately, to be opposed to everything is not a way to solve a problem. The current health care system in America is unsustainable. It costs too much. The costs are going up too fast—not just for individuals, families, and businesses, but for government as well. The health insurance companies are running roughshod over people who, when they need it the most, cannot count on the health insurance protection they thought they had purchased. It is a reality that in the bankruptcy courts across America today, two out of three people filing for bankruptcy in America are filing because of medical bills. It has grown over the last few years from one out of three to two out of three. Sadly, that percentage is going to continue to grow because you know what happens—a person goes in after an accident, a diagnosis, goes into the hospital for what appeared to be a brief stay and the next thing you know a bill comes rolling through for $80,000 or $100,000 or more. These bills pile up in an amazing fashion and you have no control over them. You are there at the instruction of your doctor, receiving the care the doctor said you should receive. You don't stop before the nurse leaves the room and say how much do those pills cost? It is the reality that we are helpless, defenseless, when we are in that position.

So people have these medical bills stack up in an attempt to find a cure or to save a life. At the end of the day, the health insurance doesn't cover them. They file for bankruptcy. But here is the statistic you should remember. In addition to 2 out of 3 people in bankruptcy because of medical bills, 74 percent of those people filing for bankruptcy because of medical bills have health insurance. They are not uninsured. They have health insurance that was not there when they needed it; health insurance that cut them off when they thought they had coverage; health insurance that had a limit on how much it would pay and they were left in a position where they were about to lose everything. They may be able to hang onto a truck or a toolkit or maybe even a small home, but their savings are gone, wiped out, because of a diagnosis or an accident.

That is the reality of where we are today and why we continue to engage this issue, despite the controversy that surrounds it.

Senator HARRY REID is the majority leader in the Senate and he has a tough job. He is in the process of taking the two bills prepared by the Senate committees, bringing them together into something that can pass the Senate. It is hard. There are a lot of policy questions and a lot of strong feelings. Within the Senate Democratic caucus are members who are very conservative, moderate, and liberal. We have it all, a wide range. We agree on some things but there is disagreement when it comes to other things. One of the questions that came up, one of the issues of controversy, was about the so-called public option. In shorthand, the public option is an attempt to create some form of health insurance protection that is a not-for-profit plan—it doesn't have to worry about paying profits to shareholders; isn't going to buy a fortune's worth of advertising; doesn't have to hire a lot of clerks to say no but tries to keep costs under control and compete with private health insurance companies.

We should be concerned about this because, without a public option—and it is only an option—without a public option, these health insurance companies have virtually no restrictions on what they can charge us. I say that because health insurance—insurance in general but health insurance companies—enjoy special treatment under American law. There are only two businesses in America that are exempt from antitrust law. One happens to be organized baseball; the other, the insurance industry. You say: What does that mean? It means that back 110 years ago when they took a look at the insurance industry, they argued that because it was subject to State regulation in every State, it was not interstate business. Students of the Constitution know there is an interstate commerce clause there that gives the Federal Government authority when we are dealing with interstate business. So health insurance companies and insurance companies in general were judged to be State businesses and exempt from antitrust law.

Then fast forward about 50 years. The Supreme Court took a look at insurance companies and said this has changed. These are no longer small insurance companies regulated State by State. They are now doing business nationwide, and so the Court decided in the 1940s that the exemption from antitrust law would no longer apply. A Senator from Nevada serving at that time, Senator McCarran, offered the McCarran-Ferguson bill, which became law and exempted insurance companies from antitrust laws.

That is a long lead-in to where we are today. What it means is that the insurance companies, unlike any other businesses in America, can literally meet in a closed room and decide to fix their prices. They will decide what premiums they will charge for insurance policies all across America. They can decide to allocate the market. One insurance company X, you take Chicago; insurance company Y, you take St. Louis; insurance company Z, you get New York. Any other business that tried to do that would be sued by the Federal Government for restraint of trade, for killing competition. But they are exempt and that is a fact.

So when the insurance companies, health insurance companies, tell us they are going to raise premiums, mark their words; they are going to do it and they have the power to do it and they can do it speaking as one and we cannot stop them under the current law as it exists. That is the reality.

The public option says there at least will be a choice out there for everybody who is in an insurance exchange, looking for a choice. There will at least be a choice out there that is not a private health insurance company: a not-for-profit company, not subsidized by the Federal Government, that is going to deal with providers across America to try to bring costs down.

The Senator from Tennessee said this public option is what Medicaid is but he is mistaken. Medicaid is different. Medicaid is a government insurance plan. What is the difference in this situation is there would be no government subsidy to this public option and the public option entity, the insurance company, the not-for-profit insurance company, would have to negotiate arm's-length transactions, negotiate with doctors and hospitals on the rates they would be paid. There is no government mandate on the rates paid. That is not the case in Medicaid at all. So the analogy falls apart. When the Senator from Tennessee says public option is basically Medicaid, it is not. Medicaid is a government plan, public option is not a government plan. Medicaid has government command and control when it comes to the amount they are paying. This plan has to negotiate arm's-length transactions. It is totally different.

I might say a word about Medicaid. I asked the Senator from Tennessee, earlier this year because of the recession, President Obama said: We think the States are in trouble. We think the governments are in trouble. With the recession, fewer people are working, fewer people are paying taxes, and the demand for government services is going up. So we need to help them. We came up with $80 billion, $85 billion to send back to the States in a rescue fund so they could get through this recession. Unfortunately, we didn't have the support from the other side of the aisle. So when the Senator from Tennessee comes in and says these governments are facing hard times, it is true they are, but the times would have been much harder for these governments without President Obama's stimulus package, which tried to help these States get through this rough period.

In the stimulus bill, the State of Tennessee received almost $760 million in FMAP, which is basically Medicaid payments. There are only three Republican Senators who voted for it, not including the Senator from Tennessee. So when we tried to help the States deal with the expenses they face, many of those who are coming to the floor today did not vote for it. I think that needs to be part of the record.

Let me also say the costs are going up for health care in general, and that affects the cost of Medicaid. Medicaid is for the poorest people in America. Medicaid, by and large, when it comes to those under the age of 65, covers children. These are the children of poor families. The only compensation to the doctors and hospitals when they show up, if there is any, comes from Medicaid.

Also, it covers those who are elderly and very poor. You find some of them living in nursing homes across America. They have lost everything. They have nothing left. They have their Medicare and the help of Medicaid.

The argument that Medicaid is a bad system and poor system—it is easy to criticize that system, and it should be improved. What would we do without it? What would happen to these elderly people who have nowhere to turn and no savings, who are living the last months and years of their lives because of Medicare and Medicaid?

The States, of course, say the Federal Government should give them more money for Medicaid. I wish we could. In my State, incidentally, it is about a 50–50 split in Medicaid. For every dollar in Medicaid, 50 cents comes from the Federal Government and 50 cents from the State government. Other States are more generous with more money coming in.

The fact is, I know it is tough on governments to keep up with the expenses. What is the alternative? Is the alternative to ignore any health care for poor people? They will still get sick. As sick as they turn out to be, they will still show up at the hospital, and in our compassion we will treat them and the cure will be paid for by everybody else who has health insurance.

I might also say I believe the opt-out provision, which is being discussed as part of our approach, says we are going to create these public options, these not-for-profit health insurance companies in States across the Nation. But if a State decides through its Governor and its legislature they don't want to be part of it, they can opt out of the system.

I cannot think of a fairer approach. It will be tough for some States to do that because the public sentiment is pretty strong, almost 2 to 1 in favor of a public option. People understand they want to have a low-cost alternative and not be stuck with the premiums the private health insurance companies decide to charge.

So I say in response to my colleague from Tennessee, whom I respect and call a friend, I don't believe characterizing the public option as the same as Medicaid is a fair characterization, and I don't think opt out is an unfair approach. I think there is fairness to it, allowing each State to make the decision what it will do based on the needs of the people who live in that State, and the people in the State will have the final say at the next election as to whether the legislature and the Governor made the best choice.

EXTENDING UNEMPLOYMENT INSURANCE

Mr. DURBIN. Mr. President, it has been 18 days since the Senate Democrats tried to pass a strong unemployment insurance extension only to see the bill blocked by the other side of the aisle. Since that time, over 125,000 Americans trying to find work have lost their unemployment benefits; 125,000 families across America now have the hardest possible question to answer: How are we going to keep food on the table? How are we going to keep a roof over the heads of myself and my family? Unfortunately, we have been unable to move an extension of unemployment benefits on the floor of the Senate.

This is unusual because in times gone by, this was never even controversial. Extending unemployment benefits was expected. If the economy was in recession and jobs were lost, we stepped up, both parties, and said: We can debate a lot of things, but let's understand there are a lot of Americans in very difficult circumstances who need a helping hand. That is not this time. Unfortunately, at this point in time, it has become a politically controversial issue about whether to extend unemployment benefits to people.

I have heard from a lot of people back in Illinois. A week ago in Chicago, I met with a room full of unemployed people and talked with them about their expenses first hand—people who have been out of work for long periods of time and are desperate to find a job. These people were all in training to improve their skills to get a better chance at employment. They told me about losing their health insurance. They worry about losing their homes. They are depleting their savings. They don't know which way to turn.

That is the reality. Any image anyone has of people on unemployment enjoying it and lazily waiting for the next check I think would be completely obviated by a visit with people who are unemployed.

I hope all my colleagues on both sides of the aisle will sit down with these families who are asking us for unemployment benefits.

A 50-year-old woman in Machesney Park wrote me recently: