provided to a respondent under paragraph (c) to prove the charges contained in the Statement of Alleged Violation (or any amendment thereof), such evidence shall be made immediately available to the respondent, and it may be used in any further proceeding under the Committee's rules.

(f) Evidence provided pursuant to paragraph (c) or (e) shall be made available to the respondent and respondent's counsel only after each agrees, in writing, that no document, information, or other materials obtained pursuant to that paragraph shall be made public until—

(1) such time as a Statement of Alleged Violation is made public by the Committee if the respondent has waived the adjudicatory hearing; or

(2) the commencement of an adjudicatory hearing if the respondent has not waived an adjudicatory hearing; but the failure of respondent and respondent's counsel to so agree in writing, and therefore not receive the evidence, shall not preclude the issuance of a Statement of Alleged Violation at the end of the period referenced to in (c).

(g) A respondent shall receive written notice whenever—

(1) the Chair and Ranking Minority Member determine that information the Committee has received constitutes a complaint;

(2) a complaint or allegation is transmitted to an investigative subcommittee;

(3) that subcommittee votes to authorize its first subpoena or to take testimony under oath, whichever occurs first; and

(4) the Committee votes to expand the scope of the inquiry of an investigative subcommittee.

(h) Whenever an investigative subcommittee adopts a Statement of Alleged Violation and a respondent enters into an agreement with that subcommittee to settle a complaint on which the Statement is based, that agreement, unless the respondent requests otherwise, shall be in writing and signed by the respondent and the respondent's counsel, the Chair and Ranking Minority Member of the subcommittee, and outside counsel, if any.

(i) Statements or information derived solely from a respondent or respondent's counsel during any settlement discussions between the Committee or a subcommittee thereof and the respondent shall not be included in any report of the subcommittee or the Committee or otherwise publicly disclosed without the consent of the respondent.

(j) Whenever a motion to establish an investigative subcommittee does not prevail, the Committee shall promptly send a letter to the respondent informing the respondent of such vote.

(k) Witnesses shall be afforded a reasonable period of time, as determined by the Committee or subcommittee, to prepare for an appearance before an investigative subcommittee or for an adjudicatory hearing and to obtain counsel.

(l) Prior to their testimony, witnesses shall be furnished a printed copy of the Committee's Rules of Procedure and the provisions of the Rules of the House of Representatives applicable to the rights of witnesses.

(m) Witnesses may be accompanied by their own counsel for the purpose of advising them concerning their constitutional rights. The Chair may punish breaches of order and decorum, and of professional responsibility on the part of counsel, by censure and exclusion from the hearings; and the Committee may cite the offender to the House of Representatives for contempt.

(n) Each witness subpoenaed to provide testimony or other evidence shall be provided the same per diem rate as established, authorized, and regulated by the Committee on House Administration for Members, officers and employees of the House, and, as the Chair considers appropriate, actual expenses of travel to or from the place of examination. No compensation shall be authorized for attorney's fees or for a witness' lost earnings. Such per diem may not be paid if a witness had been summoned at the place of examination.

(o) With the approval of the Committee, a witness, upon request, may be provided with a transcript of the witness' own deposition or other testimony taken in executive session, or, with the approval of the Chair and Ranking Minority Member, may be permitted to examine such transcript in the office of the Committee. Any such request shall be in writing and shall include a statement that the witness, and counsel, agree to maintain the confidentiality of all executive session proceedings covered by such transcript.

RULE 27. FRIVOLOUS FILINGS

If a complaint or information offered as a complaint is deemed frivolous by an affirmative vote of a majority of the members of the Committee, the Committee may take such action as it, by an affirmative vote of a majority deems appropriate in the circumstances.

RULE 28. REFERRALS TO FEDERAL OR STATE AUTHORITIES

Referrals made under clause 3(a)(3) of Rule XI of the Rules of the House of Representatives may be made by an affirmative vote of two-thirds of the members of the Committee.

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Indiana (Mr. BURTON) is recognized for 5 minutes.

(Mr. BURTON of Indiana addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Kansas (Mr. MORAN) is recognized for 5 minutes.

(Mr. MORAN of Kansas addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Minnesota (Mr. PAULSEN) is recognized for 5 minutes.

(Mr. PAULSEN addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from California (Mr. MCCLINTOCK) is recognized for 5 minutes.

(Mr. MCCLINTOCK addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Texas (Mr. OLSON) is recognized for 5 minutes.

(Mr. OLSON addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

THE 30-SOMETHING WORKING GROUP: HEALTH CARE

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 2009, the gentleman from Connecticut (Mr. MURPHY) is recognized for 60 minutes as the designee of the majority leader.

Mr. MURPHY of Connecticut. Madam Speaker, I thank you and Speaker of the House PELOSI for allowing the 30-Something Working Group, which has been empowered by the Speaker's office, to come down to the House floor every so often and share with our colleagues here in the House really some of the burning questions of our constituents out there, especially those that affect younger individuals and younger families, and to talk about how this House, under new leadership with a new face in the White House, is rising to answer those questions and meet those challenges.

We'll put this poster up at the end of the hour as well, but we are always eager to hear feedback from people who want to know more about the 30-Something Working Group. Madam Speaker, thanks to members of your class, we have a number of new members of the 30-Something Working Group and they've been coming down and joining us occasionally in these hours. We're glad to have Mr. ALTMIRE with us and hopefully some guests to join us this evening as we try to focus our discussion this evening on an issue of just incredible importance to our constituents. That is the issue of health care for all Americans.

We sit at a moment of great economic peril for this country and the people that we represent. There is not an hour or minute, frankly, that goes by when we are back in our districts where we're not talking to a family or to a shop owner, to a factory worker, to a small business man about the difficulty that they face in this economy. It's getting harder and harder to keep businesses open. It's getting harder and harder to hold onto your job. And for the now 9½ percent of Americans that are out of work, it's getting hard to find a way back into the workforce.

For those of us who believe that now is the time to pass not incremental health care reform but major structural health care reform, we support that not just because we think that it's a moral imperative, as the richest Nation in the world, that we shouldn't be the outlier in the global health care system by which we still stand as the only country in the industrialized world that has such a high percentage of our citizens without access to our health care system; not just that, as the country which claims to be the leader of the free world, we still sit in a country where children go to bed at night sick because their parents can't afford a doctor; but because we believe that it's part and parcel of how we start to get this economy back on firm footing again.

For families out there that have seen their wages remain flat over the last 5 years and have seen the percentage of their income dedicated to health care costs grow exponentially, they didn't

figure out that this economy was in trouble last fall when the banks collapsed. They knew it long ago. For our auto companies that have been struggling for a very long time to compete competitively on a global stage when $1,500 of every car that they sell is attributable to health care costs, $1,500 more than their competitors in Japan or Germany, they knew that the health care system was dragging this economy down long before last fall. And for small- and medium-sized businesses across this country who have seen their premiums dedicated to keep their employees insured grow by 10 or 12 or 14 percent a year, far outpacing the similar increase in revenues coming into their coffers, they knew that health care was weighing this economy down long before the newspapers discovered that this economy was in crisis and in trouble last fall.

If we really want to emerge from this recession stronger than ever, if we really want to be competitive in the global stage, if we really want to recognize the strength of this economy lying in the hundreds of thousands of 2- and 5- and 10- and 20-person businesses out there in each and every one of our districts, then we have got to fix our health care this year. And we can't just do it with a Band-Aid here or there, pardon the pun. We've got to do it with real reform that at the same time lowers the cost of care and expands access to more people. I happen to think that it should be a right as a matter of being a citizen of the United States that you should get health care, but I recognize that the only way that you do that is by lowering the cost of care across the board.

We spend twice as much as all of the other industrialized nations on health care, essentially, maybe a little bit less than twice as much, for a system that still leaves 50 million people uninsured. We can get access for everybody out there as long as we start spending less or, at the very least, that we start controlling the rate of growth.

So I think we are going to talk about all these things tonight as the 30-Somethings come to the floor. We are going to talk about health care, health care reform as a moral imperative, as a matter of conscience for this Nation. We're going to talk about it as an economic imperative, and we're going to talk about it both from the context and the perspective of getting care to people that don't have it today and trying to lower the cost of care so that all of us, whether or not we have it or don't have it, don't continue to pay for a system that far too often provides very expensive care without having accompanying results.

So I'm glad to be here on the floor today with a good friend who has joined here for a number of Special Order hours, Mr. ALTMIRE. Ms. BALDWIN has joined us as well.

I'm glad to yield the floor to Mr. ALTMIRE.

Mr. ALTMIRE. I thank the gentleman for yielding.

I cannot think of a bigger issue to be dealing with right now. We have so many issues that this Congress is dealing with. Certainly energy, education, this enormous mountain of debt which we have accumulated over the years, all of these issues are critically important, and all of them are issues that this Congress is going to deal with. The issue of health care is an issue that impacts our national debt. We cannot dig our way out of this hole. We cannot achieve structural surplus like we had in the 1990s. We can't ever even approach that until we deal with the skyrocketing cost of health care.

This is an issue that affects every American in this country very directly. It affects every family and it affects every small business in the country in ways that other issues that we deal with don't on a daily basis.

So what we are talking about here tonight and what this Congress is doing over the course of this summer as we put together this health care reform bill is the three legs of the stool, as the gentleman pointed out, making sure that we find a way for every American in this country to gain access to our system and get affordable health care, making sure that we bring down the costs for everyone. Because we talk about the 47 million Americans who don't have any health insurance right now. They get treated. They show up at the emergency room, and they get their health care. It's certainly not the most cost-effective way. It's probably not the most efficient way, and it's probably not the best way for them to get health care, but they'll end up in the system somewhere. And as the gentleman knows, those of us who have insurance pay for them. They get covered. They get their treatment. But the cost shift that takes place is the reason why an aspirin costs $10 when you go to the hospital.

It's very easy to demagogue this issue if you're in it for political reasons, to say, well, here's what they want to do: They want to take your money and give it to those people who don't have health insurance because 87 percent of Americans in this country have health care. We spend a lot of time talking about those who don't, but 87 percent of Americans have health care. Now, they are in many cases one illness or injury away from losing everything, certainly one job loss away, and tens of millions of Americans that have coverage live in fear of losing it for those very reasons. Tens of millions more are underinsured. They have some coverage; they don't have what they need. And in many cases, the insurance companies have people, millions, approximately 2 million people, that are employed in this country specifically to find a way, if you are insured, to make sure that they can deny your claim, to redline you, to find a preexisting condition exclusion, to find a reason why they shouldn't have to pay your claim. Now, that's another of the issues. Lastly is quality. So you have cost, you have access, and you have quality.

We have in many ways the best health care system anywhere in the world, and the challenge that we have in putting this bill together is we want to preserve what works. We want to say to the 87 percent of Americans who have health care, if you like your plan, if you enjoy the health care plan that you have and you want to keep it, we're not going to touch it and you can keep it. But if you want another alternative, we're going to find you another alternative. And if you have too much out-of-pocket costs, you're not satisfied with the situation that you have, we're going to give you another alternative. But we want to preserve what works in the current system. We want those who have health care to be able to keep it. And we want to make sure that our medical innovation, our technology, our research, which far exceeds anything available anywhere else in the world, is preserved. We want to fix what doesn't work and we want to preserve what does work.

So we are going to increase quality. And we're going to talk about, tonight, ways we are going to do that, the approaches we are going to take. We are going to increase access, bringing everybody into the system, which helps us all. And we're going to do access, we're going to do cost, and we're going to do quality improvements in this bill, all the while preserving what works in the current system.

And the gentleman used an example of how we're already paying for health care, something I mentioned earlier. Those who are afraid to bring new people into the system because they fear that this is going to increase their own costs, well, what I talk about when I have town meetings about health care is, again, they're already paying for people who don't have health insurance in a variety of ways. When that individual shows up at the emergency room, the cost shift takes place because the person without insurance gets their treatment and somebody else pays for it. Those of us who have health insurance pay for it. That's why an aspirin costs $10.

I had knee surgery many years ago, and to make sure that they operated on the right knee, they put a black magic marker that said ''L'' on my left knee. When we got the bill, I saw that that black magic marker to put that ''L'' on cost $20. That's because of the cost shift that takes place. Now, that's one example. Every American who's had to deal with the health care system has a similar example. If everybody is covered and everybody is in the same risk pool, we're not going to have that type of cost shift that takes place. But that's only one example of how we are paying for it.

The gentleman talks about $1,500 of the price of every car made in this country is due to health care costs because American manufacturers have to pay for health care for their employees

and other countries don't have that burden in the manufacturing sector.

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So we're starting at a $1,500 disadvantage for that one product. Think about the supply chain. Think about the way goods and services end up in a consumer's hands. Think about the distribution from the person who manufactures it—from the company that manufactures it—to the people who distribute it, to the people who stock the shelves, to the people who operate the stores, to the people who run the cash registers. At every segment of that supply chain, there is a health care component to that. That company, that business is paying, in many cases, health care for their employees. That is what we're paying for.

So, when you hear about people who don't have insurance and when you hear about the skyrocketing costs of health care, think about that part of it as well, not just what your copayment or your premium or your deductible is. Think about how every sector and every segment of our lives is impacted by that.

Mr. MURPHY of Connecticut. Will the gentleman yield?

Mr. ALTMIRE. I will.

Mr. MURPHY of Connecticut. I want to just put an example to one of the points you made here, which is this cost shift that happens. You talk about the folks who don't have insurance or who are underinsured. They get it, right? We have universal health care in this country. You've just got to wait until you're so sick that you end up in the emergency room until you get it.

In fact, President Bush, while he stalled on health care for 8 years, famously remarked, you know, don't worry about the uninsured—I'm paraphrasing—because they'll get health care when they need it. They just have to show up to emergency rooms.

Well, I've told this story maybe even on this House floor before. I told it 100 times back in Connecticut. When we were debating health care reform in the State legislature, I'll never forget a woman who came and testified before us. She told this story:

She said, you know, I was working. I was employed, but my employer didn't provide health care, and I didn't make enough to go and get it on my own. I think she might have had some kids, and she had gotten them insured, but she hadn't had insurance herself. She started noticing over the course of a couple of weeks that she had a real pain in her foot. The pain would sort of get worse, and then it would get better. She knew that she should go see a doctor, but she knew that a couple of things were going to happen: one, she was going to be billed a pretty exorbitant amount for the visit; two, she was going to have to go into the pharmacy and have to probably pay for some antibiotic to treat it. She was savvy enough to understand that, when she did that, she was going to pay the highest cost in the whole system. If you were uninsured, you were going to pay top dollar for that visit, and you were going to pay top dollar for that drug. You don't get the benefit of the bulk purchasing that the Federal government gets through Medicaid or through Medicare or that the insurance companies get through similar programs.

So, one night, she finally decides the pain is just so unbelievable that she can't stand it anymore, and so she goes to the emergency room. She gets to the emergency room too late to save her foot. She has a foot infection that has gotten so bad that she has to have it amputated. For her, that is a life-changing event. Her life is never going to be the same. She is never going to be the same person or the same mother. She is going to have to deal with the disability for the rest of her life just because she didn't have the money or the coverage to get some simple antibiotics that would have treated that foot infection. That just doesn't make sense in the richest country in the world.

Think about it from just a cost perspective. I don't know how much that surgery cost, but it was in the thousands of dollars, I am sure. She didn't have the money to pay for it. Maybe she got billed for it, but probably, more than likely, it just sort of got sucked into the unreimbursable cost by that hospital and got picked up, essentially, by the taxpayers in subsidies for that hospital or by those people who had the insurance, through higher insurance rates, in order to help the hospital to compensate for the people like that woman who didn't have care.

So we paid for that surgery. You and I paid for a surgery that didn't have to happen. There is a woman walking around now with her life fundamentally altered simply because she didn't have access to insurance. Sometimes people need to hear these examples, Mr. ALTMIRE, of what it really means when somebody only has health care when they get so badly sick or ill that they show up in emergency rooms.

Mr. ALTMIRE. I thank the gentleman.

That is just one example, and we're going to deal with a lot of policy options over the next several months. To talk about just one related to what the gentleman is talking about, prevention and wellness is something that everyone can agree has to be an important component. We have to incentivize doctors and hospitals and our health care system more generally to keep people healthy and to keep people out of the system and not wait until the last minute when a situation develops like the one the gentleman talked about.

In western Pennsylvania, where I'm from, I'll just talk about one disease which is near epidemic proportion. That's diabetes. In some cases, it's preventable. In some cases, it's not. For every individual whom you can put on a program of wellness and can prevent diabetes from taking place or, at minimum, delay its onset, you're changing that person's life for the better. You're making a material difference in the life of that person and of his family. You're also, in a more global sense, saving money for the health care system. If you take that one person times the entire country and the entire group of people for whom you can delay the onset for not just diabetes but for any affliction which one may later get in life, you can prevent injuries if you keep people healthy. For the weekend warriors and so forth with joint injuries, with arthritis and its onset, these are very costly diseases to treat, and they can be debilitating in many cases, but they can be prevented or they can, at least, be made better in many cases.

So this is the type of thing that we want to incentivize in our health care system for which, right now, there is no incentive. Under our current reimbursement in health care, we reimburse based on the number of times one shows up to a doctor's office. Their incentive is also for you to be sick. They make more money the more often you go to see them. We want the reimbursement system to be based on keeping you healthy and on keeping you out of the system, reimbursing based on the quality of care provided, not on the volume of services provided. So this is one example of the policy option that we are considering.

I would be delighted to yield to the gentlewoman from Wisconsin at this time.

Ms. BALDWIN. Well, I thank the gentleman.

I also want to appreciate my friend and colleague, Congressman MURPHY, for bringing us together on this really critical issue.

You know, health care for all is the issue that brought me to politics in the first place, and it's certainly the issue that keeps me here. I join my colleagues tonight on the floor to affirm our fight that we must complete comprehensive health care, meaningful and affordable comprehensive health care reform, this year. We can no longer afford to wait for health care reform.

There was a recent report from the very respected Robert Wood Johnson Foundation that projects, if Federal reform efforts are not completed, that within 10 years the cost of health care for businesses could double, that the number of uninsured Americans could reach 65.7 million and that middle income families would really be the hardest hit. They would bear the brunt of our inaction.

I represent a district in south central Wisconsin. Last month, I had the opportunity to gather and to meet with a number of stakeholders in my community. I got a chance to hear from diverse perspectives—from public and private urban and rural health providers, from patient advocates, from insurers, from businesses, and from labor. I always find it extremely helpful to hear divergent viewpoints and to get new suggestions as we prepare to write this bold, new legislation.

No matter what their particular perspectives in this debate are, their main message was very clear, that the system is broken and that we have to fix it. Some would argue that we really don't even have a system intact anymore.

I want to share just three quick stories from constituents, from Wisconsinites, that really symbolize what is broken in our health care system, that being the unaffordability of individual markets, the insurance discrimination based on preexisting conditions, and the struggles of small businesses. I really think it's important that we, as Americans and as Members of Congress, hear these stories. Our constituents, using their own words and telling their powerful and compelling stories, make the best case for health care for all and for the actions that we must take. So I'm just going to share with you excerpts of three letters that I've received.

One is from Jean from Rio, Wisconsin. Jean writes, ''My husband, Steve, has worked hard his whole life, but as of last year, he has not been able to find work because of the downturn in the economy. Neither of the jobs that I have held have offered me health insurance. We have relied on insurance that we purchased in the individual market, which costs nearly $10,000 a year and has a $5,000 deductible, meaning that we pay out of pocket for basic doctor visits, screenings and prescriptions.

''Twenty years ago,'' Jean writes, ''Steve became very ill, and in the intervening years has developed multiple brain tumors that require extensive treatment and care. We eventually realized that he has recurring tumors due to a neurological disease and should be screened on an annual basis. Unfortunately, insurance does not cover these $13,000 procedures, and we cannot afford to pay that on an annual basis. We can only hope and pray that more tumors are not developing. It is just so infuriating that, in this wonderful country, we cannot get wonderful medical care.''

Lorraine from Port Washington, Wisconsin, writes, ''When my husband filled out an insurance application in July of 2002, he was asked if he had ever been diagnosed or treated for cancer in the past 5 years. He replied, 'No.' He had never been diagnosed with cancer nor operated on nor treated for cancer. What he did have was basal cells—small carcinomas—which are never malignant and have to be removed from most blue-eyed blonds in the course of getting older.

''When my husband was diagnosed with bone marrow failure disease, the insurance company denied any coverage for his medical care, citing a preexisting condition. We were left with over $125,000 in medical bills. My husband has now passed away, and I am just thankful that I am not in complete financial ruin.''

Sally, from Madison, Wisconsin, writes me to say, ''I've had my own law office for 29 years. I employ two full-time employees and one part-time employee. I provide health care benefits for our small firm, but I have faced an annual increase in premiums of 12 percent, forcing me to pass on higher cost-sharing to these three employees. One employee has diabetes and also extends coverage to her husband, who is a dairy farmer without health insurance coverage. Because of their high medical costs, it would have been very difficult for me to find new health insurance without facing even higher rates. Health insurance is becoming steadily less inclusive and more difficult to keep—and it's no wonder that, in today's economy, families count health care costs as one of their top pocketbook issues.''

Madam Speaker and colleagues, these stories illustrate why affordable, quality health care for all is so important and is so necessary. Universal coverage is both a moral and an economic imperative if we are to succeed in the 21st century. For the first time, I firmly believe that health care for all is within our grasp. We must act now.

Again, I want to thank my colleagues, my friend Congressman MURPHY and my friend Congressman ALTMIRE, for taking this fight up and for bringing us together to address this important issue.

Mr. MURPHY of Connecticut. Thank you very much, Ms. BALDWIN. I'm always amazed at how articulate your constituents are. It really is amazing to hear the stories firsthand because, as Mr. ALTMIRE mentioned and as one of your constituents mentioned, there is an entire industry out there that is dedicated to trying to stop people from getting care. That's what you get when you build in the type of profit motivation that we have and the pressure on shareholder return. We treat health care and the economy around it just like we treat, basically, every other industry out there. I think there are a lot of us here who believe that there is something fundamentally different about health care than the auto industry or the cereal industry or the widget industry and that, when the consequences of somebody's not being able to get that product is life or death, maybe we should have some different rules that govern it. Maybe there is no problem with having some incentive built in for innovation, for success and for all the rest. Maybe there should be a limit to that, and there should be some constraints on the system.

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So I thank you for joining us, and please stick around for a little while.

Mr. ALTMIRE, you are talking about the three pedestals here of access, cost and quality. I think it's just important for us to talk for a second about how we sort of have an assumption in this country that the more money you spend, the better care you're going to get, right? And what we have found, as we sort of surveyed one particular segment of the country to the next, is that isn't necessarily the case, that spending more money and just having more health care doesn't necessarily deliver better health care. There are great surveys from Dartmouth University and other places that show that, actually, if you can better coordinate care, if you can get physicians talking to each other, if you can get primary care doctors doing more work up front, you can spend more money on preventive health care, as you talked about, that you can get better health care out there. So one of the things when we talk about controlling cost is trying to actually get people to have a decrease rather than an increase in utilization. I think it will be a big central part of our discussion here about how we do that.

There are very interesting ideas about how you try to encourage providers to work together, about how you invest more in primary care. But a subject that we have talked about on this House floor, which is going to be fundamental to this discussion, is giving those physicians and hospitals the tools to do that. The only way that you can try to get doctors talking to each other about complicated patients, the only way that you can try to really empower the consumers themselves to take more ownership over their own health care is to make sure that they have the ability, as physicians or providers, to track those patients through the system or, as a consumer of health care yourself, to track your care as you move through the system. Technology is really the key to that, and we have already taken a great step forward on that issue through the stimulus bill. There is $19 billion in the stimulus bill dedicated to building out the world's best, most connected, most highly technologically advanced health care information system so that as an individual walks into the emergency room, that that treating physician can immediately figure out what his medical history is, what tests he's already had, what's been ruled in, been ruled out relative to the illness that they present with. We can save billions of dollars just by having better information in the system. I am so glad that our President had the foresight to see those savings down the line by investing money in the stimulus bill to get that technology out as quickly as possible so that it can be a platform for those savings. There are going to be a thousand different ways that we talk about to save money in this system, and we know that that's how we get access. But I don't think any of it is going to be possible, Mr. ALTMIRE, without that investment in technology, something that you talk a lot about.

Mr. ALTMIRE. We have talked about that, and I do think that the money that was in the stimulus plan and then money in the succeeding budgets, which we're also going to make a priority, is going to make a big difference.

Health care is the only major industry in the country remaining that has not gone to an interconnected, interoperable computerized system. And I would ask my colleagues to think about the fact that—the gentleman's from Connecticut, and I'm from Pennsylvania—if we go to San Diego, and we put our bank card in the machine, we can pull up all of our financial records in a safe and secure way and never think about privacy or any type of intrusion. You just take for granted that that's going to work. But if you show up on that same trip at the emergency room in San Diego, well, they don't have any of your records. They don't have your history. They don't have your family medical history. They don't have your allergies. They don't have any of your imaging, your x rays and so forth. And they're going to ask you half a dozen times when you're there, what are you allergic to, and can you fill out these forms and, most importantly, how are you going to pay, what's your insurance? But if we were to go to a system, like every other industry in America has, where you have an electronic health record that goes with you everywhere you go and has your family history records, your personal medical history, your allergies, and yes, all your insurance information, then when you show up at the emergency room, they're not going to have to ask you half a dozen times. They're going to be able to get right down to the business of treating you for whatever the reason is you find yourself in that situation. We have to make sure that as we move forward as a country, we reward those who have already taken matters into their own hands. There are a lot of major health systems in this country from coast to coast that have spent hundreds of millions of dollars of their own money to make this a reality, to connect their own systems. The problem that we have in implementing this is, if you're a wealthy community and you have a system that's making a lot of money, a hospital system, you can afford to do that. But if you're a rural physician, a health care provider in central Pennsylvania or anywhere in this country 80 miles from the nearest hospital, you can't afford hundreds of thousands of dollars to upgrade your computerization to interconnect your records with the nearest hospital. It's just something you can't even consider, and that's where this money is going to go. We're going to move towards having an interconnected system in this country to resolve some of the issues that the gentleman has talked about. We're not going to allow it to get to the point—with the Department of Defense, for example, which has a wonderful health care information technology system, and the Department of Veterans Affairs, which also has a wonderful health care information technology system; but there's one problem. They literally cannot communicate with each other. What they do is, if you're one of the brave servicemen or -women who are serving our country as part of the Department of Defense, you're a part of their program, and they have all of your medical records; but when you leave the military and become a veteran and enter the VA system, under the current system, the Department of Defense sends a PDF file by e-mail to the VA, and somebody has to open up that file. They can't manipulate it in any way. They have to type by hand your entire career's medical history—if you've been there for 30 years, think about what we're talking about—into the new system for the VA.

Now Secretary Shinseki and Secretary Gates have announced that moving forward, they're going to merge the systems for the new people who enter the military. So moving forward with the newer generation of our military men and women and our veterans, we're not going to have this problem. But for the millions who have served up to this point, it's not interoperable. They cannot communicate with one another.

Mr. MURPHY of Connecticut. Mr. ALTMIRE, scale it down. There are thousands of hospitals, some of which are in the State of Connecticut, that have competing systems, even within their own hospitals, that don't talk to each other. There are hospitals that have one electronic records system for their emergency room and then one electronic medical records system for their in-patient unit. So the same thing that happens as you move from active service out to be part of the veterans health care system works within a matter of days in a hospital setting. When you come in and present to the ED, you then aren't on the same record system when you move over to the in-patient unit. Now that is because we do not have a sort of nationally agreed-upon platform for how systems communicate with each other. And a lot of hospitals say to themselves, well, I have got one really good system for emergency rooms, and then I want to buy this other really good system for in-patient care. We have got to have some national standards that basically say to any hospital or physician's office that's buying into a records system that you can be guaranteed that you are going to get a system that presents you with all the data and tools that you need and will be able to communicate with everybody else. In fact, there's no way that we're going to spend that stimulus money without some national standards to guarantee that that happens. But as a sort of preview as to how politicized and how politically charged this debate can become, when we were debating that portion of the stimulus bill, which really is a commonsense investment in information technology, something that there should be no reason why Republicans and Democrats should disagree. I don't want to put words in Mr. BURGESS mouth. He is a Republican Member from Texas. He comes down to the floor very often to talk about the crisis in our health care system, and he talks in a very articulate way about the need to upgrade our information system. So there's a lot of potential agreement on this issue between Republicans and Democrats. But it didn't stop the sort of right wing in this country from going out and spreading lies that this investment in information technology was the Federal Government's attempt to have a Big Brother takeover of health care, and this was the Federal Government reaching in and controlling all of your health care information and knowing everything about every illness that you've had or prescription drug that you're on. It's the furthest thing from the truth. We're just simply trying to standardize private health care investments that have been made by hospitals and doctors across this country. But I think it speaks to how difficult this debate is going to become. There is a group of folks out there who are either just ideologically opposed to having the government have any role in health care, or folks who are part of the status quo who are making their fortunes off of health care today that don't want the rules of the game changed. Even when it comes to what should be fairly noncontroversial issues, like investments in information technology, I mean, my God, you know, it's boring to say, right, but it's so important. It's just not that controversial. We're still going to find a lot of people on the outside that are going to fight us on this issue, as they will on many others, Mr. ALTMIRE.

Mr. ALTMIRE. There are many issues that are just like that, as the gentleman knows; and this gets to the complexity of the bill that we are going to be bringing to this floor and to the other body over the course of the next several weeks. If you look at what we expect, at minimum, the outcome to be on the insurance side, I think everyone would agree that a very likely outcome is going to be the insurance industry will not be able to redline you. They're not going to be able to use pre-existing conditions to exclude you from care. They're not going to be able to do the lifetime limits for people with chronic diseases. Basically, they're going to have to take all comers, and they're not going to be able to set your rates based on your individual health status. I think we would all agree that is a likely outcome to this debate.

Now the insurance industry makes a compelling case, and I think an actuary would tell you that the only way that works is if we find a way to make sure everybody is included in our health care system. You can't just have the sick people or the people who are about to become sick part of the risk pool. You have to have everybody. That's why it's so important that we expand access to the entire Nation, include these 47 million Americans who don't have health coverage, the tens of millions of more that are underinsured

because the only way the risk pool works is if you have the young and the healthy, people who aren't going to use the services right now today to offset the risk for those who are. But as the gentleman indicates, there is still going to be opposition to this concept when we move forward and when we talk about ways to move people into the system that currently don't have access.

One of the ideas that we talk about, which the gentleman from Connecticut is very involved in, is the idea of having a choice for people to join a plan that would compete with the private insurance industry. We hear a lot of talk about how the private sector always does it better than government. They're more efficient. They're more cost effective. The government is too bloated. So I would say to those who make that case, well, then, what are you worried about? What are you worried about the competition from the government if the private sector always does it better than government? The difference in this case, if we do it right—and certainly there are ways you can structure it that wouldn't be the correct way—but if we establish a level playing field for the competition, you are going to have a situation where there's not going to be a profit motive, and there's not going to be any reason for someone to choose that plan who's involved in shareholding and so forth. You're not going to have that. You're not going to have people who are employed to try to deny claims. That might be a difference in the way these plans compete. But if we do it right, it would be a level playing field.

Mr. MURPHY of Connecticut. The gentleman knows that I think this is, for me, critical to reform going forward. I really do think that if you empower consumers to have real choice, that that is one of the ways in which we're going to control cost. Right now when you decide you want health care insurance, if you are a business or an individual, it's a real cloudy picture out there. You don't know exactly what you're buying. You don't know the combination of deductibles and premiums that are going to force costs on you. You can't ever be sure exactly what the benefit plan is, whether pre-existing conditions are covered here and not here. So one of the things that we're talking about that is fundamental to this reform is really trying to standardize the market, creating some national standards for health insurance; that you've got to have this basic benefit package that covers preventive services and real catastrophic care; that you can't discriminate against people that have pre-existing conditions; that you can't have lifetime limits; to basically give people some certainty that when they go out and purchase insurance, that they're going to get insurance, that they're going to get something they can actually use.

□ 2045

So, a lot of us say, well, you know, why not give people the option, if they don't like the private insurers who are inevitably going to take a piece of their premium and pay the CEO a big salary or pay back shareholders or turn it into profit, why not give them the option to purchase a nonprofit, government-issued plan?

Now, Mr. ALTMIRE, you are right, that that only works if that government option, that government health care option, has to finance itself; that it doesn't get a subsidy from the Federal Government to help it compete with the private plans. But if that public insurance option has to pay for itself, just like every private insurance company has to, they collect premiums, pay for care and it all has to be self-financing, then you are exactly right, what is the problem?

If the government is so inefficient, then they will end up having an insurance plan that costs more than the private insurers, and nobody is going to buy that. But if our theory is correct, that by not having the profit motivation that the private insurers have, that they can run a more cost-effective product, then why shouldn't consumers have that choice?

The people in this Chamber who are going to say there can be no public insurance option available to individuals are taking choice away from consumers. I would rather have my 700,000 constituents be able to have as many choices as possible. I want them to decide whether they think that private insurance or public insurance is better for them.

Everybody will answer that question differently. But I think that those of us that are going to be favoring a publicly sponsored health care plan as one of the options for individuals and businesses out there are going to be on the side of consumer choice, and I think if we give consumers that choice, it is going to create a really competitive structure that will end up with some people having public insurance, some people having private insurance, but a real competition by which we lower health care costs, Mr. ALTMIRE.

Listen, I get it. The devil is in the details of making sure that you don't give a little competitive advantage to that public option, but I think that it is really a linchpin of health care reform going forward, if we can get it right.

Mr. ALTMIRE. Think about the competitive advantage that businesses have in this country. Some are able to offer health insurance, some are not. Less than half of small businesses in this country are able to afford to offer health care to their employees.

What we want to create is a system where everyone in America will be covered and every business that chooses to do so will be able to afford to offer that benefit to their employees and to their potential employees to be able to recruit and retain the highest quality worker. That might be a benefit that small businesses would like to offer. We want to give them the opportunity to afford that benefit if they so choose.

But, again, we want to preserve what is working in our current system. We want those who have coverage and like it to not be touched in this. And that has to be a part of this. But for those that want to have another option, those who want to make a change, maybe the family status has changed over time, the plan that you are in doesn't work for you any more, we want to give them as many options as possible, and we want to give them the ability, as the gentleman indicates, to do some comparative shopping, to compare apples to apples, to look at what the costs are for the family situation across the different plans. Right now you are unable to do that.

If you are a Federal employee and you have the Federal Employees Health Benefits Program, it is a little bit easier. That is a plan where you are able to look at some of the paperwork and get on the computer and do comparison shopping. We want every American to have the same ability that Federal employees have today.

I would say to the gentleman, when we talk about this idea of the employers being required in some way to either offer health insurance to their employees or to pay into the system so that those employees will have the ability to make that choice, we don't want to do that in a way, and I want to be very clear about this, we don't want to do that in a way that is going to incentivize employers to say, well, you know what? I will just stop offering health care coverage and all of my employees can go into the plan. That is not what this is about.

We don't want to add one more financial burden to half of the small businesses in the country, the ones I am talking about that are already unable to afford health care. We don't want to add to their financial burden. We recognize that this is a very complicated issue and it is going to be very difficult to achieve these goals.

Mr. MURPHY of Connecticut. Mr. ALTMIRE, we spend so much time with our business community, our chambers of commerce, when we are back home and when they come visit us down here, that we know what the reality is out there.

These folks that right now can't afford to give health care to their employees desperately want to do that. They want to do it first because it is just the right thing. They are members of their community like anybody else is, and they want to be able to provide health care to their employees, whether they have two employees or 40 employees. That is just the kind of people that are out there running small businesses by the skin of their teeth across this country.

But they also need to do it from an economic standpoint. They know that to the extent that they can't offer

health care or can't offer the kind of generous plan that they would like to, they are at a disadvantage against their competitors who can offer that type of health care. They are at a disadvantage against the big employers who can steal their employees away.

So this is really an issue that our small businessmen are waiting to be a part of the solution, and if we can offer them, whether it is through a public option or through lower rates on private plans, a more affordable health insurance option, they are going to take it. They are going to grab it.

You are right, we don't want to set up any incentives where they are going to push people off to the public plan. But we know the majority of folks are going to want to be part of the solution out there, just for reasons of conscience, but also for reasons of their own salvation as a particular business.

Mr. ALTMIRE. And the gentleman hits the nail right on the head, talking about bringing down the costs. That is where we started this discussion. We are going to pass a health care reform bill this year. I am confident in saying that. The public support is there, the support in this Congress is there. We need to certainly finalize the details, and that is going to take some work. But this issue is too important, it is too important to this country, it is too important to families, it is too important to businesses, and it is too important to every individual in this country for this not to become law this year. I am confident that will happen.

We have to bring down the costs of health care. That is why this is so important. We have to bring down the costs for our families, we have to bring down costs for our businesses, and we certainly have to bring down the costs for our government.

As I started our remarks tonight by saying what this is about is the structural deficit over the long term that we have in our budget, and addressing the issues like energy and like education that have led to the skyrocketing deficit and debt that we have over the long term, and the only way you can begin to bring that under control is by bringing down the cost of health care for everyone in this country at every level, both in the private and the public sector. That is what this bill is going to do, that is what this discussion is about.

So, to close it out, I would yield back to the gentleman.

Mr. MURPHY of Connecticut. I thank Mr. ALTMIRE and Ms. BALDWIN for joining us tonight.

Let's make no mistake about this. This is going to be a fight. This is going to be a fight, because to do this right, you are going to have to take on some folks who have gotten real fat over this health care system. You are going to have to take on some ideologues that just don't believe that the government has any role in trying to get health care to people.

There is a polling memo going around Washington written by Newt Gingrich's pollster essentially outlining in 28 pages how you stop health care reform from happening. That is the agenda of a lot of people in this town, a lot of folks on the other side of the aisle, that they do not want health care reform to happen.

Now, some of it is for good, honest policy reasons. I believe it is an incredibly mistaken belief that the private sector can just fix this on their own. They haven't done it for the last 50 years. How can we expect they are going to do it overnight?

Some of it though is very cynical politics. Some of it is due to people that look back to 1994 and the failure of the Clinton health care plan in the 2 years prior, and believe that if folks can stand in the way of President Obama or this Democratic House passing health care reform, that they will gain some electoral advantage out of that.

Now, I hope that is the minority of people that are standing in the way of this bill. But make no mistake, there are people out there who simply see political advantage against Democrats in general or against the President of the United States in stopping health care reform from happening.

Now, they may have succeeded back in 1993. I wasn't here, Mr. ALTMIRE wasn't here, so we can't speak to all the reasons that happened. But that is not going to happen this time. Not because you have got smarter people in the House of Representatives or you got necessarily a better strategy moving forward, but because the American people are not going to stand for the status quo.

They know this economy is tough and they feel more conscious than ever of the fact that they are just one paycheck away from losing their health care and becoming one of the tens of thousands of individuals out there who have been forced into bankruptcy because of health care costs.

The status quo is not good enough for people out there, and despite 28 pages of polling telling the folks on the other side of the aisle how to stop this from happening, I believe that the will of the majority of Americans is going to bring us together to get a good bill passed.

We are here as 30-somethings in the Democratic Caucus talking about that tonight, but I believe that there is going to be a groundswell of public support that is going to force us, both parties, to come to the table and do something, not small, not minor, not temporary, but something big and permanent to fix all of the underlying problems in this health care system, to make sure that more people have it and less businesses are burdened by it.

So, again I would like to thank Speaker PELOSI for once again giving us the opportunity as the 30-something Working Group to come down here tonight, and remind folks that they can e-mail us at 30somethingdems@mail.house.gov. If you have any questions for us, any feedback on what you have heard this evening, www.speaker.gov/30something is where you find us on the Web.

NOT LEARNING FROM HISTORY

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 2009, the gentleman from Missouri (Mr. AKIN) is recognized for 60 minutes as the designee of the minority leader.

Mr. AKIN. Madam Speaker, there was a cynical comment that was made by people who take a look at history. They say that one of the things we learn from history is that we learn nothing from history. I don't know that that is universally true, but certainly for our subject for this evening, that will certainly be the theme, that we are not learning very much from history.

We are going to be taking a look at the fruit of fiscal mismanagement, and particularly what is going on in our country in terms of a very, very important number, and that is unemployment. The unemployment numbers have continued to rise, in spite all kinds of assurances that by spending tons and tons of money, that we can turn those numbers around.

The historic connector here that is I think quite interesting is a fellow by the name of Henry Morgenthau. Probably you have not heard of Henry Morgenthau, but he was an important figure in his own day. And here in this Chamber, in this House, Henry Morgenthau met with the Ways and Means Committee in 1939.

Henry Morgenthau was FDR's Secretary of the Treasury and he had 8 years working on a theory that is known as Keynesian economics. He was one of the main architects of Keynesian economics, whose idea was that what the government needs to do is to stimulate the economy. You have heard that phrase over and over, stimulate the economy, and the purpose of stimulating the economy is, of course, to create more jobs.

That is a little bit like grabbing the straps on your boots and lifting up and trying to fly around the room. It doesn't work. And after 8 years of failed experience, these were the words, the very quote of Henry Morgenthau here in this building before the Ways and Means Committee.

He said, ''We have tried spending money. We are spending more than we have ever spent before, and it does not work.'' His words are echoing down through history. ''It does not work, I say. After 8 years of the administration, we have just as much unemployment as when we started, and an enormous debt to boot.''

These are the words coming to us, floating down through history by Henry Morgenthau, the main architect of Keynesian economics. Franklin Delano Roosevelt, the master of the policy of stimulating the economy with big spending.