We passed H.R. 2200, the bill I authored, helping to secure transportation—airports, trains, busses—to emphasize more training for flight attendants, to provide more resources for the Transportation Security Administration, to ensure that America is safe.

And so this House has been busy. And as we go home to our districts, we will not run away from the idea of good health plans. Because, my friends, I don't know what my friends on the other side of the aisle have, a bunch of question marks about the health plan that my friends on the other side of the aisle have offered.

I want them to join us. I can articulate what we have done. I realize that we've made great strides. I know that the people want, if you will, good health care.

And so as I close, I want to thank the Speaker. And I just want to leave you with this forceful message: We're going to get the job done. We're going to get health care for all Americans, and the stimulus is going to work for you. And celebrate Gospel Music Heritage Month in September as we help our automobile dealers return to their jobs and to retain their jobs. You know we've been working.

## HEALTH CARE IN AMERICA

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 2009, the gentleman from Iowa (Mr. KING) is recognized for 60 minutes.

Mr. KING of Iowa. Mr. Speaker, I appreciate the privilege to be recognized here on the floor of the United States House of Representatives. And having had an opportunity to listen to some of the dialogue that went on previously, I'm glad that I have a chance to raise these issues.

On the front of everybody's mind in this country is the situation of our health care and our health insurance for 306 million people in the United States. And I would point out that if we look at the size of this economy and the size of this population, it is a huge endeavor to think that we would take 17.5 percent of the American economy, 17.5 percent of our gross domestic product and switch it over to a government-run plan, and do so in almost the blink of a legislative eye, and do so without the full deliberation of the floor of the House of Representatives or without the American people having an opportunity to weigh in.

I am glad that this process has been slowed down—however great the price has been—so that there is an opportunity now for some of the legislation that has been more closely refined, shall we say, in its 1,100 or so-page form to be available to the public, a public that has more access to this information that is going on in the House than ever before because of being able to access this information now by the Internet. And all of us in this Congress have Web sites, and I would think there is at least one link on every Member of Congress' Web site that will help you access this information on where we are with bills that are being deliberated here in this Congress.

And as I look at where we are today and what's out there, I'm very interested in the entire month of August and I'm very interested in the first week of September. Those are the times when the American people will have had a chance to read the bill, talk to the people within their profession or whatever their interest group is that have read the bill, weigh their ideas, do this across the backyard fence and do this at the coffee table at work, and be able to give us the benefit of the wisdom of the American people to weigh in on all the components that have been created here that are promised to come at us and perhaps have a vote on a final passage; not here, not any longer this week or next week or in the month of August, but perhaps in the first or second week in September, and something that—this will decide the fate, if it's passed, of the health care system of the United States, I believe, at least as far as we can look into the future. And it is a national health care plan. It is a government-run health care plan. It is a model that transforms the entire health care system in the United States.

Today we have more than 1,300 private health insurance companies competing for premium dollars, And they do so by providing the best value for the dollar and marketing that best value for the dollar and trying to adjust those policies to meet the demands of the American people. Over 1,300 private health insurance companies, and among them they offer, in the aggregate, perhaps as many as 100,000 different health insurance options. And the President of the United States has said he just wants to offer one more option, 100,001 policies now for everybody in America to choose from if this bill should pass.

And this extra government option that he would offer, as if there wasn't enough competition out there among the 1,300 health insurance companies and the roughly 100,000 policies that are there, how can anyone presume that one more policy that would just compete with the other policies out there would result in anything other than one one-hundredth more options for the people of the United States?

I would submit that there is a lot more afoot here, Mr. Speaker, there is a lot more afoot here. The people that are advocating for this public option, the people that are advocating that the Federal Government should run their own health insurance policy in order to compete against the private sector are the people who sometimes they will leak it into the media, sometimes they will shout it out in a private meeting, but in their soul they want a single-payer, government-run, socialized medicine, one-option government plan for everybody. And they want to run every private health insurance company out of business and take the 100,000 options that the American people have with them. That is their agenda.

And I can put together a string of quotes from the very liberal Members of this Congress that find themselves in powerful positions in this Congress, gavels in hand, that are determined to take away the private health insurance options and turn it into one government plan.

Even the President of the United States believes in that, however much lip service he has paid to the idea of telling the American people, well, if you like your health insurance that you have today, then you get to keep it. That's one thing that I cannot accept that the President believes when he says it. He is a very smart man. He's got to understand that if it says in the bill—and it does, section 102 of the bill—that every private health insurance policy has to be rewritten in the first 5 years of the passage of the legislation that's proposed, that means the American people's individual policies will all change within 5 years and they will have to accommodate themselves to the new qualifications that will be written by a health insurance czar to be appointed by the President later, and regulations that are not in the bill, but regulations that would grant that health insurance czar the power and the authority to set the standard.

So he might rule that every health insurance policy in America has to pay for abortion. He might rule that everyone has to pay for mental health. He might rule that everyone has to pay for all pharmaceuticals, or maybe only generic pharmaceuticals.

□ 1700

Whatever he may decide, he'll be looking at the costs of the premium, the percentages of copayments, and the regulations will be written so that the public option, which is so carefully defined and that language that's determined to be defended by the Democrats in this Congress—so that the public option can compete with all of these 1,300 private health insurance companies that have competed in the marketplace for years and found their niche in the market and done it the American way.

Now, if somebody thinks that there's too much money in the health insurance business, why don't they get in that business and provide that health insurance and lower the premiums and cut down on the administrative overhead and take some money and take some profit out of it?

That's how this works in the free market system. If there's something out there in the marketplace that has too much profit in it, you don't need government to come in and do it for you. You need to take a look and determine is it a monopoly? If it's a monopoly, then Teddy Roosevelt rides again. Let's bring him in and let's bust the trust. But if you have 1,3000 health insurance companies and 100,000 health

insurance policies, you don't have anything that looks at all like a monopoly. You see something that looks like the maximum amount, or nearly the maximum amount, anyway, of competition in the marketplace.

So that argument is specious, the idea that we need to create one more company, unless it is the intent of the proponents to create socialized medicine—one size fits all, take away the American people's individual policies and give them a government policy or a facsimile of a government policy that would be their former private health insurance company that has had to adapt to the new rules written by government and offer a qualified plan.

Now, why am I suspicious of this? I am more than suspicious. I'm convinced that this is the initiative: to wipe out all private health insurance and force everybody into a public policy and a public plan. One of the reasons is because there has been such an indignation about those of us who have said that this is a government-run health care plan that they're proposing.

They have tried to censor us here in the United States. They have actually effectively to a degree censored Members of Congress who wanted to simply mail out the flow chart, the schematic, if you will, of what this proposed health insurance plan or this health care policy looks like.

And I would take the people in this country back, Mr. Speaker, to this little chart right here. This is a chart that hung on my office for probably a decade starting in 1993, when Hillary Clinton came to town and became the secret master of the reform of the health care and the government takeover of health care in the United States. A lot of people remember, as I do, those were intense times. I was watching my freedom being marketed away day by day in secret meetings. I don't know if they actually kept minutes, but I know they weren't available to the public. I know the press wasn't allowed in the room. The public wasn't allowed in the room. There weren't Members of Congress representing their constituents. There were people like Ira Magaziner and others who were handpicked by Bill and Hillary Clinton to devise a plan.

And the idea of this was, put these smart people in a room, have them devise a plan, don't let anybody weigh in on that, no kibitzers on this plan, because if that happens, then the American people would start to grumble, and if they start to grumble, they might start to talk out loud, and if they talk out loud, they might start to yell, and if they start to yell, they might come to town and tell us that they don't want to have a government-run health plan in the United States, that they don't want to have their private plans taken over.

Well, that's what they finally did. They finally said they are not going to tolerate it, and the American people scared enough Members of Congress and enough United States Senators that they were going to lose their seat if they supported this monstrosity that this monstrosity finally was pulled down. This was a time when United States Senator Phil Gramm said that this health care policy will be over his cold, dead political body if they pass something like this. He stood there. He meant it. They held their ground. People in this House held their ground. And people like Dick Armey held their ground. In fact, Dick Armey was instrumental in helping to form this chart, this black and white chart that is the schematic that shows all the government agencies that are created by the old plan back in 1993, which I will at least give Bill Clinton credit for. He wrote a bill. He presented a bill to Congress, and he asked Congress to pass the Hillary plan. And, of course, Congress liked their job. They didn't pass the Hillary plan.

And when I call it a ''schematic,'' I don't know that one might think today that that's pejorative, but in here they actually do call their own plan a ''scheme.'' Someplace in this chart it addresses at least some of the components in it as a ''scheme.'' Well, I call it a ''schematic'' or maybe more appropriately a ''scheme-attic,'' Mr. Speaker.

But it has here an ombudsman who is supposed to broker the deals between government because people can't get through government bureaucracy; so you create an ombudsman. Well, we have to change the name of that because now people know what an ombudsman is. We have the HMO provider plan that doesn't show up in the other chart that I can see. HMOs have slid down in their popularity.

Here we have the global budget. In 1993 a global budget for a health care plan. All of these squares and boxes are created as new affiliations with the exception of the executive office of the President. A few others, but generally speaking, this scheme, and they call it a ''scheme,'' does scare the American people.

Now, Mr. Speaker, I would point out that as scary as this chart looks, we have another chart here that is far more scary. This is the color-coded, modern-day, software-driven, packaged-up plan that is a very accurate facsimile of what actually is taking place in the Democrat bill here in the House of Representatives. This is 31 new agencies, and there are subagencies and other responsibilities that are behind it.

But just to look at the chart, Mr. Speaker, one can look at all these white boxes here. If they're not colored, if they're white and they have black letters in them, they're existing government agencies. These are already hoops that people have to jump through. And then when you look at the colored boxes, the orange and yellow and the green and the blue and the purple, those are all new agencies. These are all new hoops for the American people to jump through. These are untried. They are untested.

When you create new government agencies, you run a little beta test because you don't know how it's going to act, how it's going to function, and you don't know how people are going to react. All you can do is guess how people will react. And you don't know if you can actually manage this.

But I will suggest this: We don't do that good a job of managing the health care that we pay for out of this Federal Government today. Right now the Federal Government is paying 80 percent of what the cost is to deliver Medicare services. And if I look at my State, where we have a high percentage of Medicare patients because we have a very high percentage of senior citizens, then the percentage of that Medicare that they're providing is less than 80 percent, and one of the reasons is because we have some of the highest-quality care. In the State of Iowa, if people go there, Mr. Speaker, they can expect that they will receive quality care in the top five of all of the States in the country year after year after year. And with that high-quality care, Iowa sits at the lowest Medicare reimbursement rate.

So we're looking at this and wondering if it is the majority's, and that means the Democrats' and that means the President's idea, that we are going to fund the cost of this $1 trillion to $2 trillion health care ''scheme-attic'' that we have here, and we're going to fund it, in part, by reducing the funding that is going to Medicare by roughly $500 billion when Medicare funding that is already inadequate at best pays 80 percent of the costs, and they're going to cut these costs and fees going into the States to come up with enough money to pay for this?

So what it means is, Mr. Speaker, is this: If you take $500 billion out of Medicare in order to fund a national health care plan, that means you're taking it right out of the health care for the senior citizens in the United States of America across the board. The health care access for senior citizens will be diminished. The services will be diminished. Presumably the quality will be diminished because the doctors and nurses and providers will have to spend less time per patient, accelerate their time with them, and that means less quality care. And it means fewer services to our seniors.

So this $500 billion, a half-trillion dollars, taken out of Medicare, right out of the Medicare services, the health care services for our senior citizens, in order to find a way to do a pay-for for a $1 trillion to $2 trillion National Health Care Act. And President Obama has said we're going to pay for all of this. We're going to find a way to pay for it. Well, that's the problem that CHARLIE RANGEL has run into in the Ways and Means Committee. But it looks like some of it comes out of not the pockets of our senior citizens that

are accessing their health care; it comes out of services to them.

And the arguments I've heard were behind closed doors, the derogatory comments that have been made about doctors and nurses and providers and the allegations made, for example, by the President of the United States that we have doctors that are removing tonsils because it pays rather than because they need to be removed. I think that needs to be documented and it needs to be quantified. And, yes, there are people in every industry that don't meet the highest standards. But to paint the whole industry with anecdotes like that without any data to back it up just further clouds this debate and makes it harder for us to make progress.

This chart, by the way, this chart that we have called government-run health care, we have called this—well, it is. It's the organizational chart of the House Democrats' health plan, and this ''scheme-attic'' that has 31 new agencies, I would just direct, Mr. Speaker, your attention and the public's attention down to these boxes right here on the bottom:

This white box here that says ''traditional health insurance plans,'' that's where the 1,300 companies are. That's where the 100,000 policies are, in this square box right here; 1,300 companies, 100,000 policies in traditional health insurance plans. According to the bill, section 105, all of these plans, every single health insurance plan in America, would have to run through—they would be here in this white box. They couldn't function after 5 years unless they met the qualified health benefits plans here in this purple circle right here. In order to be qualified, they would have to meet the new government standards that are not yet written. These new government standards would be written by the Health Choices Administration right here.

Health Choices Administration would be run by the HCA, Health Choices Administration, Commissioner. Now, he's a commissioner, or she, because America is up to here with czars. We have 32 czars. We do have more czars than the Romanovs, and they're less accountable than the Romanovs. They're not held up to any kind of confirmation. They're not answerable to Congress. I don't know that we have subpoena power to even bring them before Congress to ask them what they did when they were managing the car industry, for example. We know we had a Car Czar that had never made a car nor sold one. I presume he'd driven one, probably never fixed one.

But he was running the car business in America and on the phone sometimes multiple times a day with President Obama's appointed CEO of General Motors. The Car Czar wasn't doing too well. He got replaced. Now we have a new Car Czar, and that new Car Czar says, well, the Federal Government would like divest themselves eventually of General Motors and perhaps the Chrysler stock, but there's no definitive plan, just kind of a general goal. Well, it looks to me like the general goal has been to nationalize huge industries in America rather than divest the Federal Government from those and let the free market prevail.

So if this bill passes, we will end up with a health insurance czar. He will be running the Health Choices Administration, and he will be called the Commissioner of the Health Choices Administration, but he'll be the czar. Commissioner. I don't call him commissar. Maybe I'll call him ''commi-czar-issioner,'' but he will be calling the shots for all of these 1,300 health insurance companies that exist today and writing the regulations so that they could become qualified health benefits plans coming out of there. So 100,000 qualified health benefits plans from 1,300 companies would have to qualify under new standards written by the new ''commi-czar-issioner'' of the Health Choices Administration.

Now, if you had a few million dollars invested in a health insurance company, Mr. Speaker, would you really be interested in investing more money in that company on the odds that that new ''commi-czar-issioner'' would write some regulation that lets you stay in business, when the people that are writing this regulation want to take you out of business and they say so, people like the chairman of the Financial Services Committee, BARNEY FRANK, who on tape says that he believes there has to be a public option? The public option is this purple circle right here, the public health plan. Chairman FRANK believes there has to be a public option.

□ 1715

This is because that public option is the path to a single-payer plan. A single-payer plan is code word for socialized medicine, one-size-fits-all, the government runs it all, and every one of these plans here that were in the private sector will all be swallowed up, they will all be squeezed out, and eventually this purple circle becomes the whole and everything else is swallowed up and diminished.

I think this happens if this bill happens, because it is the goal of the liberals in this Congress to end private health insurance and eventually end private health care and eventually have every doctor working for the government or else for a government prefixed price, and the nurses and the clinics doing the same thing. They might be billing fee-for-service or fee-for-patient, but they won't be running their own clinic; they won't be working competitively anymore.

When I look around the world, I will give you examples of why I believe this. The oldest example is Germany. Now, Germany has had its ups and downs over the last century, but the last century and a decade, about that far back, they passed their first national health care plan. That was back before we had modern medicine and certainly didn't have anything that looks like modern medicine today.

But the German plan was passed under Otto von Bismarck. And as I read history, he did so in order to consolidate a political base in order to expand his political power. But it got established then.

Of course, there will be Germans that will defend their policy. And it probably has helped and it has no doubt helped millions of them, and other millions have stood in line and they probably at this point don't have a concept of what it is like to have the freedom we have to go out and purchase a policy or be an employer to negotiate and select from the policies we want and do the best we can working with our employees and being an agent for our employees to put the best packages together, or for individuals to purchase individual policies.

In Germany it works this way: you can buy a private plan there. They are pretty proud of being able to have private plans in Germany, even after more than a century of socialized medicine. But today it is this, Mr. Speaker: ninety percent of the plans in Germany are the public option. Ninety percent. And the 10 percent are the private options.

Now, the private options, they only exist as the company is functioning and selling health insurance in Germany in order to cater to those people who are reasonably well off, those that believe they can get a little bit better quality of care, even though they have to pay a premium for that better quality care, because they don't want to be in the government line. They want to try to find a way to take care of their care and health means too much to them to let the government run it.

That is the bottom line in Germany. Ninety percent on the pubic option, 10 percent on the private option, mostly self-employed and independently wealthy people. Not regular common people, very rare, not people that are generally working for someone else for a wage, not punching the time clock, not paid a salary so much. It is self-employed people and often independently wealthy people that carry their private health insurance in Germany. That is about 10 percent. Ninety percent the public plan, 90 percent socialized medicine. That is Germany.

The United Kingdom passed their National Health Care Act in 1948. There they were recovering from the Second World War. They were a nation that was nearly broke. Nobody had any money, their industrial base had been destroyed by the bombing from Germany, and they had used all of their resources to save their country.

God bless them, they were a great ally and it is a great thing for the world that the Allied Powers were successful in World War II and we turned back the level of tyranny that was threatening to swamp the world.

But Great Britain was broke post-World War II, and they were looking

for anything that provided them security, and they believed that they could manage health care in Great Britain if they just took it over and they could do better in government.

If we remember, this nation was in peril in World War II, and we grew government in a great big way. There was a threat to take over the steel industry in that era as well. We managed to provide private sector industry that turned out bombers and battleships and the things that we needed to be successful in that war.

But if our industry had been destroyed, if the spirit of the people had been hammered as hard as it was on a percentage of its population as it was in Great Britain, we might have been looking for security. We might have decided that we needed to do something with government to supplant what was being so efficiently provided in the private sector.

For whatever the reason, Great Britain passed their National Health Care Act in 1948. And I read, Mr. Speaker, through a whole stack of Collier's magazines from that era, and each of them featured the socialized medicine that was being implemented in the United Kingdom at that time. And they showed pictures of long lines at the doctors' offices, lines that went outside the clinic, and they interviewed doctors and showed doctors that were haggard and frazzled and tired, and they lamented that they could not do that doctor-patient relationship in the fashion that they had before, that they had to limit the time per patient and they had to move from room to room and they had set up more rooms so they could get the patients in the room and get them ready for exams so they could walk in, do the exam, order what was to happen and go on to the next one.

And doctors that are hurried like that make mistakes. So does any human being. But a human being should not be treated like they are on an assembly line. That was already what was taking place in the United Kingdom in 1948.

The stories that are in those Collier's magazines from that era are the same stories that we hear in the modern version of socialized medicine that exists in the United Kingdom today. They are not a lot different than the stories you read and hear about in other countries in the European Union, including Germany.

For example, I ran into an immigrant from Germany, actually it was in a Menards Store some months ago, and he told me that he had a hip replacement done. It had gotten very bad and he could hardly walk, and he had to wait, and he waited a long, long time in line. Finally he decided that he would try to get himself in more than one line so that he had the best chance of getting it over with so he could get on with his life. And so he got in a line, and the shortest line that he could get into was the line in Italy.

So he queued himself into the line for a hip replacement in Italy, and some months later he was able to go to Italy to have the surgery to replace the hip. And now, good surgery, good job, he is healthy, moving around and enjoying life.

But to have to go to another country to have the surgery done, it begs the question. It must be a lot of what it is like to be a Canadian, to go to another country to get your surgery done. And thinking of the Canadians and those kinds of surgery, I could give an example on that.

We had a presentation done that was a little over a week ago by a doctor from Michigan, and this was at the Policy Committee on a Thursday night, a week ago last Thursday, if I recall.

He has practiced medicine in Canada and in the United States. In one of his earlier forays into providing medicine and services in Canada, he was working in the emergency room and a patient came in, a younger man, who had torn up his knee playing sports. He had a torn meniscus, a torn ACL, an anterior cruciate ligament, and his knee was a mess. This doctor in this emergency room in Canada examined the knee and said, You need surgery and you need it right away. I will schedule you for surgery in the morning.

Apparently the doctor wasn't familiar with the standards of qualifying for reconstructive surgery care, and he found out after he made that promise to the patient that he had to first get him scheduled for the specialist who approved the surgery. So he did his best to get that patient covered, because the patient was in a lot of pain. They had to put him in a knee brace. He was on crutches. And they scheduled him finally to be examined by the specialist who approves for the surgery, and he was examined 6 months later.

He was not operated on the next day, not operated on 6 months later, but on crutches and with a knee brace on, unable to work, 6 months later examined by the surgeon, the specialist, who approved the surgery. The surgery was approved. Well, that was an obvious thing to the doctor who looked at him the first night, and 6 months later they did the surgery.

Now, Mr. Speaker, I have to go back and reiterate, because it sounds implausible. A young man with the knee torn up, a torn meniscus, a torn ACL. He needed surgery the next day. In the United States of America he would have had surgery the next day. Instead, the exam to approve his surgery, which is required in Canada, took place 6 months after the injury, and the surgery itself took place 6 months after the exam.

Almost a year to the day the surgery took place to reconstruct the knee. And we know what happens. He lost more than a year's work because the rehab was another couple of months, and that leg will atrophy because you are not using it, and all of that loss of quality of life, the things he could have been doing, his entire lost productivity gone, because bureaucracy is calling the shots, not the doctors, in Canada.

Now, that sounds like anecdote. Well, it is a real live human being case, and I am confident that I could trace that back and name the individual, and I am confident I am likely to get that individual to come here and try to talk to the thicker skulls that exist on this side of the aisle.

But suffice it to say that here is the data that supports this individual that some might allege is an anecdote. And it is this: the average waiting time for hip surgery to replace a hip in Canada, the average waiting time is 196 days. Once you are approved for surgery, you wait in the line, in the queue, 196 days. A lot of people with bad hips are on crutches—196 days.

If you are waiting for a knee replacement, Mr. Speaker, you wait for 340 days on average in Canada. Outrageous delays, loss of human productivity. And there isn't anybody's chart that calculates the loss to the GDP, the gross domestic product of Canada, lost work time, the loss to their economy, because people who would otherwise be productive are hobbling around on crutches or sitting in a wheelchair because they can't get the services until that delay is over.

Mr. Speaker, that is what goes on in Canada.

Furthermore, there are companies in Canada that when they offer their employment, they set it up as part of the employment package that the worker has an opportunity to come to the United States if he needs reconstructive surgery.

If, let's say, for example, it is heart surgery that would be necessary, it is written into the policies. In some of the policies in Canada, if you have a good job and you have a good benefits package, they will have it set up so they will package it up. Say you need bypass surgery, they can put you on a plane, fly you to Houston for heart surgery, and give you the heart surgery, get you back on the wellness side of this thing, get a little rehab, and then send you back home again and set that all up, and it is turnkey. It is turnkey provided there because they know that people can't wait in line in Canada. Everybody is not going to be alive at the end of their waiting period.

But in the United States, it is a different story. We get people in immediately. We bring them in immediately because it is lifesaving. In Canada they make provisions to get out of the country and come to the United States.

There are companies that are set up in Canada for the very purpose of packaging up health care access into the United States. And so let's presume this, and this is not a documented story, but let's just presume it this way.

Let's say you live in Toronto and you need hip surgery and you don't want to wait the 196 days. You want it done. You want to get on with your life. So

let's just say travel agency companies are a natural to tie up together with health care providing companies, people that know things about health care.

You might be able to go into a company in Canada and contract to come down to, let's say, the Mayo Clinic at Rochester, Minnesota, and they will turnkey that. They will say, we have got you an airplane ticket. Here is the hotel you go to. Here is the shuttle bus, the transportation from the airport to the hotel. You will up show up at the clinic tomorrow morning or on the morning following your flight. You will be examined that morning. If it is what I think it is, you will go right into surgery the same day or the next day.

They will give you the rehab that you need, take care of you to get you back out to the airport, fly you back home to Toronto. All of that for, write one check, hand over your debit card or your credit card, and have access to the best health, reconstructive surgery in the world, right down here in the United States of America.

Why is that? Do the people on the other side that propose this scary schematic, this color-coded, it will be quotas. There will be 31 new agencies, do they think that the best health care in the world that brings people from not just Canada, but all over the world to access this best health care, do they think that it just kind of randomly spawned itself out of American society? Or do they think that there is real reasons that we have the best health care system in the world? I think there are reasons for that.

One is health care is important to us and the American people are willing to pay for high-quality health care because our health is the most important thing that we can protect with the capital that we have in this country.

□ 1730

We're a country that's comparatively very, very wealthy. We've demonstrated our commitment to health care by committing a lot of our wealth to health care. We should not begrudge the people that are making our lives longer and more enjoyable for making a profit at it. We should not begrudge them for that. If we think they're making too much money, we should get in the business, compete against them, gather in some of that profit, and then lower our prices. Competition lowers prices. That, we know. Adam Smith wrote about that in 1776 in Wealth of Nations; and it's been true well before he recognized it; and it's been true every day since; and it always will be true.

This schematic, by the way, that is here is not something that the Democrats in this Congress want to see out in the public eye. It's something that they want to censor, in fact. Here's the model of what they have done. This chart shows 31 agencies. It shows how every American who has a health insurance policy will have to watch as that policy submits to the new regulations that are written by the health insurance czar and qualify under new rules that will be written by that Health Choices Administration commissioner. They will watch every policy change in America or else watch the qualifications be adapted to a few policies in America that the Federal Government wants to allow to compete. People understand this chart.

But here's what's going on over the head of the Franking Commission, I believe. It's been prohibited for Members of Congress to send this chart out in our mail to the American people, Mr. Speaker. I don't think there's ever any comparable job of censoring Members of Congress than what's going on here. They have decided this chart can't go out in the mail, paid for under the franking privilege that any other chart can go out. We saw mail go out under President Obama's stimulus plan that advocated in a partisan way for how the stimulus plan was going to solve our economic problem. Democrats in this Congress used the franking privilege to try to convince the American people that the stimulus plan was the only way to go, and it's clear to everybody in America today that the stimulus plan has failed, with the exception of the gentlelady from Texas who I heard a little bit ago say that it had succeeded, and it had created jobs. She hasn't shown me where they are yet. So I will reserve my judgment on the accuracy of that statement until I actually see some jobs created by the stimulus plan.

Mr. Speaker, my point is, in a partisan fashion, Democrats in this Congress used the franking privilege to put the virtual stamps on their mail to tell the American people that the stimulus plan was necessary or the economy was going to collapse. That went on. This chart is not pie-in-the-sky threats that scare people. This chart is just stomp-down accurate, and it has withstood the test of the criticism of even the Democratic staff in the Ways and Means Committee, the Energy and Commerce Committee and the Joint Committee on Taxation. They've tried to blow holes in it, and yes, there's a little tweak there, but it's not substantive. It's simply specious to make that single little point, and it doesn't change the score of this bill.

Bottom line—31 new agencies, other obligations that are behind these squares, added to all of these white boxes that are existing programs or agencies, it creates all these hoops that the American people would have to jump through, and Democrats don't want this chart shown to the American people. So I thought, Okay, if they don't want us to show this chart, there must be a lot of truth here that they surely don't want to have to face, and they surely don't want to see the American people come to their town hall meetings and fill up that room and ask them how they're going to defend swallowing up 17.5 percent of America's gross domestic product, our health care, and turning it into government run.

Have we done that good a job with Fannie Mae and Freddie Mac? Have we done that good a job running General Motors and Chrysler? Have we done that good a job with anything the government is doing other than, let's just say, our military, for example, who's done a great and fantastic and noble job and has achieved victory in Iraq? Does anybody have confidence that the Federal Government can run health care better than the American people, working with their private health insurance companies, negotiating for their own policies? I say not, Mr. Speaker. I think the American people understand what this is. I think they understand that when something is censored, it's not profane. Democrats want to fund the National Endowment for the Arts, which is funding millions of dollars to produce profanity in America. They're not offended by all of the profanity that goes out from the National Endowment for the Arts. They're offended by the truth about their bill about health care; and so they censor it because they have the majority here in this Congress, and they decide which staff people get a paycheck and which ones don't, in some cases. They also have the benefit of the President, I believe; and there are people in this Capitol building and in this complex of offices around who are more interested in pleasing the President, I think, than they are in preserving the fundamental integrity of the franking privilege or objective debate. This is objective debate.

Here are some of the subject matters that the Democrats don't want us to use when we describe this national health care plan. Mr. Speaker, these are all objectionable phrases, the seven dirty words or phrases you're not supposed to use to describe the leading Democratic health care proposal. It says, ''you can't use,'' but I'm going to use them. These are the words that, in part, brought about the censorship of this color flow chart of the 31 new agencies that swallow up people's private health care in America. We can't call it a government-run plan. They want to amend that. They have another word for that. I think it is the public option, rather than the government-run plan. It is a government-run plan. I will submit, Mr. Speaker, that you could walk down the streets of America, and you could ask those good, well-educated, commonsense people that I have the privilege to represent in western Iowa and in many places across this country, and go to them a month ago and say, Explain to me with regard to health insurance what is a public option. I can only imagine what kind of answers we would get if we asked people what that meant. But I will suggest that most of those answers would not have been accurate. They would not have said, Oh, a public option. Let me see. That's what President

Obama wants to make sure everybody has. That would be government-run health care. If they were going to describe what a public option is, a regular man or a woman on the street with common sense couldn't describe what a public option was, if they understood what it was, without describing it as, Oh, government-run health insurance. They would have to describe it as government-run or they couldn't even describe it at all. This phrase is far more descriptive and honest than public option. Public option is Orwellian gobbledygook for the eventual Federal Government monopoly on health insurance. We just say government-run. The President wants us to say public option. They want to censor government-run. I say, I'm going to say it over and over again. It's government-run. Don't say single payer. A single-payer system means socialized medicine. So we can't say single payer. How do you describe that? Ask a commonsense person on the street, What is a single payer for a health insurance public option? Well, let's see. They would have to say, A single payer is when only one entity pays for all of the health care that an individual might receive. So let me describe how that works. Mr. Speaker, let's use that hip replacement because that's an easy thing to describe. Somebody went into the clinic and said, I'm in terrible pain here. I don't think I can hobble along any longer. What can you do, Doc? A doctor would do that examination. He would likely do an x-ray. He would evaluate the x-ray. If he was satisfied that he knew what was there, he might prescribe that there be reconstructive surgery done that would put a new hip joint in that individual, put him through some rehabilitation and hand him a cane that could be handed away later on and get him back out to the square dance. All of those things are going to take place. There would be billing that would come from the clinic, billing that would come for the service of the surgery, billing for the anesthesiologist, the operating room, the hospital bed, the gauze, the Tylenol, and whatever else there might be. Who would pay for all of that? Well, it might be the patient today, and it might be Medicare, and it might be a private health insurance company. But when they say single payer, that's code for—the only entity that ever pays for it all—I shouldn't actually say that because there are private individuals that will pay for it all out of their pocket. So the entity they're talking about is the Federal Government paying for all of the health care services. That is socialized medicine. That's taxpayer-funded government doing it all single payer. But if you're not versed in the vernacular of the Orwellian gobbledygook, when they use the term single payer, you might think something entirely different. I don't think a normal person on the street can describe what a single payer means. We say single payer. Democrats think it's pejorative, that it is biased against the single-payer plan, for example. So using the terms that describe what they want to do is pejorative, and they are, presumably, forbidden, and it shouldn't show up on a color chart. We shouldn't send it out and can't send it out on our frank mail, otherwise they will bill us back for the costs out of our own pockets. We can't say socialized medicine. I already slipped into that in describing single payer. Socialized medicine does describe what they're talking about, maybe not in the first phase because they won't do like Canada eventually did and outlaw the health insurance policies of everyone in America. If you apply the Canadian plan today, the Canadians outlawed private health insurance. They did so incrementally in the provinces over the years, and then they did so in a Federal fashion. I would have to guess, but I think the year was 1964 when that happened. It may have been after that. So Canadians have socialized medicine. They have single payer. They have government-run.

We know what's going on up there, don't we? There is a 196-day wait for a hip, 340-day wait for a knee. They have government-run, single-payer socialized medicine. They just don't have ObamaCare. You can't say ObamaCare because that aligns the President with a policy that is becoming ever more unpopular. We use shorthand around here to describe things, and this is why the American version of the English language has been such an effective language to communicate because it's fluid, and it picks up new meanings, and it conveys those meanings. I think that we can paint the picture of this society and this culture very effectively because our language adapts, it flows, and it moves. This is one of those words in our language that—back in 1993, everybody knew what HillaryCare was. HillaryCare was the black-and-white schematic that we had then. No one wondered. It wasn't pejorative then. This chart got mailed out by franking mail, by Members of Congress in '93. It was devastating to those that wanted socialized medicine. We just simply called it HillaryCare, and this chart was in the minds of millions of Americans as they went in and filled the offices of their Members of Congress and said, I don't want that. And I don't want this thing to be run over the top of Senator Phil Gramm's cold, dead, political body either. I don't know who has put a stake out there in the United States Senate that's taken that kind of stand, that's gotten that much press out of it. But I hope they're there, and I hope they're strong, and I encourage them to speak up.

This was HillaryCare in 1993. We are not supposed to declare this to be ObamaCare in 2009 because this has been censored by the Democrats in this Congress who think that these terms that are on this chart are pejorative. Pejorative terms, government-run. What about a government-run United States Marine Corps? That makes me feel good. I like government-run Air Force. I like government-run Navy. I like government-run Army. We cover those four branches. Government does some things good. Government-run is not pejorative. But it tells you what is going on if they are going to run health care. Single payer—hmm. Single payer does tell you that government will be calling all the shots because of the golden rule. Whoever has the gold makes the rules. The government will have all the gold, and they will write all the rules for everybody's health insurance policy in the United States of America. That's in the flow chart that's behind here that's been censored. And if it's single payer, it is socialized medicine. To declare it to be ObamaCare, it is pretty accurate. I haven't heard whether the President disagrees with the liberals in this Congress or the liberals in the United States Senate. I have heard the President talk about all kinds of socialized medicine programs. All he has said that defends the private market is if you like your policy, you get to keep it. That is simply not true, Mr. Speaker. When you look at the chart, when you look at the language, and you understand that every single policy would have to qualify under rules yet to be written by President Obama's appointee, the health insurance, czar-issioner.

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Would we get rationed care? Indeed. We're only paying 80 percent of the Medicare today of what it costs to deliver it.

They propose to take $500 billion out of the Medicare funds that are streaming there now. How are they going to do that? They're going to have to cut down on services, cut down on surgeries for seniors, cut down on access to health care in order to come up with the $500 billion. All of that spells rationed care.

Care has been rationed in every Nation that has a single-payer, socialized medicine, government-run plan. We can't believe it's anything else. It will be rationed care. ObamaCare will be rationed care. We're on a path, if we pass this, to single-payer, socialized medicine, because there will be government-mandated care for everybody, whether you can hang on to your private plan or whether you can't.

Government-mandated care is another term that we're not supposed to use because they think it's pejorative, but this chart, the color-coded chart of the 31 new agencies schematic is full of all kinds of government mandates. That's what they are. They're mandates, Mr. Speaker, almost all of them. You're not even supposed to say keep your change care. Well, I don't know that you get to keep your change. I don't use that phrase very much, but it's one of the things that they've raised as objectionable.

So in the end, in real summation of this issue of the national health care

plan that is almost completely crafted here in the House of Representatives and probably poised to go before this House on a vote sometime after Labor Day, presuming that there are enough Members of Congress still standing after the public shows up at their town hall meetings, at their offices, at their house, wherever they might be able to encounter their Member of Congress or their staff, presuming that there are enough Members of Congress still willing to walk this path, we're likely to see a vote here on the floor, and the result will be all of these things that we're not supposed to say now.

If it passes, it will be a government-run, single-payer, socialized medicine, ObamaCare, rationed care, government-mandate care. If not the first day, it will be over time when everybody's health insurance has to requalify and be run through the qualifications that will be drafted by the new health insurance czar, the commissioner, the comiczarissioner of health insurance in America. That's where we are, Mr. Speaker.

And so I will quote Congressman JOHN SHADEGG who articulated this as well as anyone in this Congress when he said, if you like your health insurance that you have today, get ready to lose it. That's what will happen. The American people understand that it is their freedom, that their discretion is at risk, and there are people who want to create a complete nanny state, who have privatized—excuse me—who have nationalized eight huge entities here and moved us on a leftward lurch off the abyss into socialism in the private sector; three huge investment banks, AIG, Fannie Mae, Freddie Mac, General Motors, Chrysler, all now under the control of the White House. And this White House now wants to take over all the health care in America, eventually. And we understand that was President Obama's original policy. He has just moved to try to set up health insurance in such a way that he can promise you you get to keep it.

And I promise you that it will not look like anything you have today if the government's going to write new regulations that it has to qualify for. And I will submit that Republicans have good solutions to this. I'll submit also that what we're trying to fix here is this. Here's where I agree, Mr. Speaker.

I believe that we have a very, very difficult economic situation to work our way out of. I believe that it may be as serious as anything that we have seen since the Great Depression, but I'm not certain of that because I lived through the eighties during the farm crisis and the other, the housing crisis that we had and the banking crisis that we had during that period of time. We lost 3,000 banks in the eighties. Those were tough times. I want to measure this after it's over and look back before I would commit that this is the worst time since the Great Depression. But it's not a very good time. It's a bad time.

And we have our challenges ahead of us, and we have to fix this economy. With that, I agree with the President. But the President says that health care in America is broken. I don't agree. I don't believe it is broken. I believe that we can improve it, and we should. But the President declares that we can't fix the economy without first fixing health care.

Now, if health care—and that encompasses health insurance and the health care that's provided through our clinics and our hospitals and the whole breadth of the health care that we have. If health care is broken, there must be a service out there that's not adequate compared to some other country in the world.

I'll submit health care is not broken. We have the best health care in the world. It costs too much money. I'll agree with the President on that. About 14½ percent of our GDP, and some of the costs that you see in the rest of the industrialized world are around 9½ percent of GDP. They ration health care. They have socialized medicine. They don't have the research and development that we have. We have the best in the world.

We lead the world in development of pharmaceutical and surgery techniques, and we lead the world in survival after cancer diagnosis. And we also lead the world, I believe, in the diagnosis of cancer itself. All of those things are at risk today. But if we have to, according to the President, change 100 percent of the health care system that we have in order to declare we have fixed it so we can declare we're fixing the economy, I will submit that that statement cannot be valid. It cannot be defended or sustained in open public debate or any kind of analysis because they want to spend $1 trillion to $2 trillion.

Now, if we're spending too much money on health care in America, and we are, why do we need to dump another $1 trillion to $2 trillion into it to fix it? If we're going to fix it, we should be able to fix it and save money, not fix it and dump trillions of dollars into it and raise taxes and cut funding that goes into Medicare and deny health care services to our seniors, all of that wrapped up in the name of fixing something that's not broken, just changing and transforming America.

We socialized three large investment banks, AIG, Fannie Mae, Freddie Mac, General Motors and Chrysler. They're nationalized today. This is about the nationalization of the best health care system in the world, and 17½ percent of it, and taking away the freedom of the American people to go out and purchase a health insurance policy that they choose.

I want to expand the health savings accounts and I want to provide 100 percent deductibility for everybody's health insurance premium. And I want to reduce the medical malpractice liability that's out there by capping the liability claims so people get whole again but trial lawyers don't get rich. We can do all of those things and more, besides.

And by the way, there's only 4 percent of America that are chronically uninsured, 4 percent, 10 to 12 million people, depending on whose study you look at. That's 4 percent. And we would upset 100 percent of the health care system in order to fix an expensive health insurance program only if you compare to other countries that don't have the quality that we have. I think that would be a colossal mistake, and we could never get back from that colossal mistake because it creates 306 million people that would be dependent upon the government-run, single-payer, socialized medicine, ObamaCare, rationed care, government-mandate care. And I reject it. I hope the American people do.

## SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Members (at the request of Ms. KAPTUR) to revise and extend their remarks and include extraneous material:)

Ms. WOOLSEY, for 5 minutes, today.

Ms. LINDA T. SÁNCHEZ of California, for 5 minutes, today.

Ms. KAPTUR, for 5 minutes, today.

Ms. JACKSON-LEE of Texas, for 5 minutes, today.

(The following Members (at the request of Mr. POE of Texas) to revise and extend their remarks and include extraneous material:)

Mr. WOLF, for 5 minutes, today.

Ms. FOXX, for 5 minutes, today.

Mr. PRICE of Georgia, for 5 minutes, today.

(The following Member (at his request) to revise and extend his remarks and include extraneous material:)

Mr. KUCINICH, for 5 minutes, today.

## HOUSE BILLS AND JOINT RESOLUTIONS APPROVED BY THE PRESIDENT

The President notified the Clerk of the House that on the following dates he had approved and signed bills and joint resolutions of the following titles:

April 21, 2009:

H.R. 1388. An Act entitled The Edward M. Kennedy Serve America Act, an Act to reauthorize and reform the national service laws.

May 7, 2009:

H.R. 1626. An Act to make technical amendments to laws containing time periods affecting judicial proceedings.

May 12, 2009:

H.R. 586. An Act to direct the Librarian of Congress and the Secretary of the Smithsonian Institution to carry out a joint project at the Library of Congress and the National Museum of African American History and Culture to collect video and audio recordings of personal histories and testimonials of individuals who participated in the Civil Rights movement, and for other purposes.

May 22, 2009:

H.R. 627. An Act to amend the Truth in Lending Act to establish fair and transparent practices relating to the extension of