(Ms. FOXX addressed the House. Her 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 Nebraska (Mr. FORTENBERRY) is recognized for 5 minutes.

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

HEALTH CARE REFORM

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

Mr. GINGREY of Georgia. Mr. Speaker, I thank you, and I thank my leadership on the Republican side for allowing me to control the time during this Special Order hour this evening. And surprise, surprise, we're going to be talking about health care reform.

Mr. Speaker and my colleagues, we all know that this is something that has been on the front burner for the entire 7, 8, 9 months of this 111th Congress. It has certainly been a priority of the President; the President has said so on many occasions. In fact, President Obama indicated that reforming our health care system is the number one priority of his administration. First and foremost, it is the thing that he is willing to spend political capital, whatever it takes, to have comprehensive health care reform and to have it before the end of this first year of his first term.

I certainly can see that the President, Mr. Speaker, has followed through on that pledge. I personally feel that he has made a mistake on that. I don't think that the American people believe that fixing our health care system to the extent that we literally would throw out everything that we've got and let the Federal Government essentially take over lock, stock and barrel our health care system—which accounts for something like 16 percent of our total economy—at a time when our economy is literally, figuratively in the tank. We're sitting here with a 10.5 percent unemployment rate across the country and 15 million people out of work. It has even affected my own family very, very personally, one of my four children. They say, Mr. Speaker, that when your neighbors lose their job it's a recession, but when you lose your job all of a sudden it's a depression. I know that feeling right now, and a lot of people across this country know that feeling.

When we adjourned for the August recess, the District Work Period that's traditional in this Congress, all Members go back home, they may squeeze in a little family vacation, but you've got about a month, August, it has been traditional probably for 100 years that Congress has done that. And we got an earful, did we not, Mr. Speaker, during those 4 to 5 weeks of these town hall meetings that Members had all across the country? And by a factor of 10, the attendance had increased that much.

On a typical town hall meeting in my 11th District of Georgia in the nine counties I represent—and we would always try to have our town hall meetings at a time that was most convenient to our constituents, that would be easy for them to get to, maybe at a senior center, and try not to schedule it during suppertime or during prime time TV evenings—you might get 50 people on a good night, maybe 75 people when they were really ginned up about something.

Well, in my case, in the 11th of Georgia, we were getting 750 people, 1,100, 1,500—in one instance 2,000 in some of the town hall meetings we had. And we were seeing the same thing all across the country, whether they were Republican districts or Democratic districts. Mr. Speaker, what these constituents were saying—many of them, of course, were seniors—they're most concerned about the economy, of course, because they're on a fixed income. My mom is one of those. God bless my mom, Helen Gannon Gingrey, originally from Manhattan, New York City, but lived in the South most of her life. She is 91 years old now on a fixed income, relies on Social Security and Medicare and Medicare part B and part D. She's a little disappointed she's not going to get a COLA this year. But these folks showed up at these town hall meetings telling us, We don't want to pay for some new government-run health care system from A to Z that's going to be paid for on our backs. And what they're referring to, of course, is mostly the cuts, the deep cuts that the bills in the House and the Senate propose to take out of the hide of the Medicare program.

I'm going to be joined, Mr. Speaker, by a number of my Republican colleagues. In fact, tonight the participants in our hour are going to be for the most part the doctors on the Republican side. We have a caucus, a group that we call the GOP Doctors Caucus; there are about 15 of us in that group. We have a number of M.D. physicians. We have a doctor of psychology, we have a doctor of optometry, we have a couple of dental doctors, and people that have spent before coming to Congress—and some of us now have been here 8, 10, 15 years even, but before coming here our day job, if you will, our profession was delivering health care. We were health care providers.

□ 1745

We keep our licenses active, I think most of us do, and we keep up with medical issues, realizing, of course, that Congress is not necessarily forever, particularly young ones who may want to go back and go back into the practice of medicine. Those doctors will be with me tonight.

When I totaled up, I asked my colleagues, well, how long did you practice? Some of them are OB/GYN doctors, some of them are orthopedic surgeons. There is a gastroenterologist. There is a family practice, a couple of doctors do family practice, just all across the spectrum. In the aggregate, we probably have about 400 years of clinical experience. That says something about our age, Mr. Speaker.

But as an example, I spent 31 years, from the day I graduated from medical school, practicing medicine either as a family doctor in a small town or while I was in training during my internship and my residency and then 26 years of being a part of an OB/GYN group and delivering over 5,000 babies in my hometown, which became my adopted hometown. My hometown is Augusta, Georgia, but Marietta, Georgia, in Cobb County is where I now live and practiced for 26 years.

Mr. Speaker, we feel we have a lot to bring to the table. It's so disappointing we get to do these things at night—as I say, my colleagues will join me and I will yield to them when they arrive—because this is our only opportunity. It's a shame we are in the minority. God forbid that it happens to the other side one of these days, and they will understand the feeling, but when you have got that knowledge of a particular profession, you would think, wouldn't you, that the Speaker of the House, the leadership, the minority side, both Chambers, they would open their arms and say, for goodness sakes, come on in here. Come on here behind this green door where we are trying to work out how we are going to do this health reform bill and tell us a little bit how it was when you were seeing patients and practicing and what were the things that would upset people about insurance, health insurance companies and denial of coverage or not being able to get insurance because of preexisting conditions. Also, Doctor, what do you think is causing the 10 percent, 12 percent rate of inflation in the cost of health insurance premiums year after year after year? Why is that?

Could it be this? I have heard some people say that maybe it's a medical malpractice issue and doctors ordering a lot of defensive unnecessary tests because they are afraid that if they are dragged into a court of law someone would say, well, you know, we have got, plaintiff's attorney, I have got this expert witness here from California. They will say, well, looking at the chart, I see where, Doc, you didn't order a fizzle phosphate level on this patient or some other esoteric test

that nobody has ever heard of and say, ah, you know, you are guilty of malpractice. Doctors order everything, almost to the point of the patient coming to the hospital, have blood drawn one day and becomes anemic the next morning for all the testing that's done.

Again, I bring up this point, Mr. Speaker, because we should be participating. We should be doing it on a bipartisan basis. If we would, if we had done it—and it's still not too late, my colleagues. It is still not too late. It's not soup yet. We have yet to vote on these bills that have come through committee on the House side or come through the committees on the Senate side. They haven't reached the floor of either Chamber. So there is plenty of time to amend, to start over. We don't need to rush it any more than we need to rush the decision to send the troops to Afghanistan.

The President, Mr. Speaker, made it very clear, as did his advisers and this administration, well, you know, you can't, you shouldn't knee-jerk now. I know what the General said. I know he said what his needs are, but we need to think about this. We need to get it right. It's better to get it right than to do it quickly.

Well, I sure wish they would take the same attitude toward reforming one-sixth of our economy, and I think that we could do that. There is no rush.

I will tell you where there is a rush though, Mr. Speaker. There is a rush in putting people back to work and stemming this tide of unemployment and all these jobs just disappearing and now 15 million people in this country out of work. That should be the President's number one priority.

But, anyway, we are going to talk about these issues tonight, and there are a lot of thoughts that my colleagues have, as I see them begin to join me. I am going to try to go in order of those that walked on the floor.

The first person that I am going to call on is our former majority whip, minority whip, someone who has been a part of the leadership with distinction on the Republican side of the aisle, and I am speaking of the gentleman from Missouri, ROY BLUNT.

I yield to Mr. BLUNT.

Mr. BLUNT. I thank my good friend from Georgia for yielding and appreciate the doctors letting me join them here for a few minutes.

Most of our doctors in the House, Republican doctors in the House have been on the Health Care Solutions Group that we worked hard on all year to have alternatives, alternatives to government-run health care, alternatives to create access to health insurance, health coverage for people, even people with preexisting conditions.

When I joined the doctors on the floor one day last week, there were 15 bills stacked up in notebooks behind, on the dais, Mr. Speaker, that talked about the 15 things that Republicans would like to do. We don't think they have to be in a 1,500-page bill. In fact, the things we have talked about, like access for everyone, allowing people to stay on their parents' plan until they were older, then they have to leave the plan today, medical liability reform, more competition in the system, associated health plans, all of those things could happen individually.

It would be great if all 11 bills that I personally cosponsored would pass and none of them conflict with the others. We think that's the way to move forward.

But our doctors are consistently our best leaders on this issue, because they know all the problems that come up in health care, all the challenges that come up in health care, the importance of the doctor-patient relationship and how important it is that you don't have someone come between the doctor and the patient.

I know, Mr. Speaker, that I and others have been criticized for saying that in the Canadian system, if you want to have a procedure done, you have to get permission from the government. Often that has been interpreted to mean that we are saying you couldn't possibly have that procedure done. What we are saying is not that. What we are saying is that somebody besides your doctor decides whether you get that procedure done or not.

A well-read Wall Street Journal article back in the spring talked about the 57-year-old Canadian that even wanted to pay for his own hip replacement procedure and wasn't allowed to do it. It doesn't mean that you couldn't get a hip replacement. It just means he couldn't get one. It just means some bureaucrat decided he couldn't get one.

We are going to be talking in the next few days, because of the apparent nature of the closed door, behind closed doors negotiation, we are going to be talking again about this government-run health care plan. The government option would be government-run health care as a competitor. My belief, sincerely, is that the government would not compete fairly. It would drive the other competitors eventually out of business. Now, this new wrinkle, Doctors, to the government-run option is, well, the States could opt out.

Now, I was never in the State legislature, but I worked in a capitol building that had lots of legislators in it. Many of my colleagues were in the legislature, and they know and I know, and the majority knows, that if the government-run option is cheaper—and it will be because they, like Medicare and Medicaid, don't have to pay the whole bill—if it's cheaper, no legislature is going to opt out and say people in this State are going to become the example of standing against government-run health care. We are not going to have in this State that cheaper competitor until the other competitors go away. That's just not going to happen. This idea that somehow this is any kind of a compromise doesn't stand any scrutiny.

And then the other big issue over the next few days will be this issue of why seniors and people who have been told their entire working career since 1965, and anybody who started work after 1965 has had Medicare, a Medicare deduction from their paycheck every single paycheck, now to be told we are going to cut Medicare benefits for half a trillion dollars to pay for this new government plan, if seniors figure this out in the next 10 days, this will not happen. If seniors understand how this bill would theoretically be paid, this would not happen.

Whether it's the elimination, as is proposed, of Medicare Advantage for a whole lot of seniors, one out of four, or whether it's finding $300 billion in cuts in Medicare to pay a majority of the costs, that $500 billion in Medicare Advantage and cuts in Medicare to pay a majority of the cost, now everybody who will walk on this floor is surely for finding any legitimate savings in Medicare, but, my friends, if we are going to find savings in Medicare, we should use them to save Medicare.

Everybody else that walks onto this floor knows that Medicare is supposedly in significant trouble beginning as early as 2017. Why do you take savings from a program already in big trouble and say we will use these savings to pay for some new program? It won't make sense to seniors or anybody who really, frankly, doesn't like the idea that they have paid into this program out of every single paycheck they have ever had, and the Congress and United States is not going to allow that program to be solvent in order to start down another road of more health care.

Mr. GINGREY of Georgia. I appreciate the gentleman's comments.

I am sure the gentleman would agree with me that it's really disingenuous to take $500 billion out of the Medicare program over the next 10 years and then, at the same time, tell seniors that, oh, by the way, next year you are going to get to pay $110 a month for your Medicare part B—I think it's $98 a month, $98.50 now—and we are going to raise it to $110 a month at the same time that we are going to cut $500 billion out of the program.

Mr. BLUNT. That's exactly right, you know, one out of every four seniors on Medicare Advantage, that would go away under any proposal out there right now. The administration apparently told the providers of those Medicare Advantage plans that they couldn't tell people that there was legislation that would eliminate the plan.

Now, after a lot of appropriate outrage about that administration decision, that gag order to these plans, apparently now they are going to say, okay, you can tell them the truth. What a step forward that is. You can tell people in Medicare the truth about this. If people in Medicare find out the truth about that, and they figure out the truth about the other way to pay for this new government program and

they start calling Members of the Congress of the United States, this will not go forward and we will be back to where my friend from Georgia said we should be, where we start over. We work together. We do the things that will fix what's broken in the system, but we also ensure that we keep what's working. More is working in health care than is broken.

If we are not careful about this, we will eliminate what's really working and will actually encourage the things that are broken. None of us here on the floor at this minute want to do that, and hopefully none of our colleagues will either, and we can all work together in new ways.

Again, I thank the doctors for the incredible credibility and knowledge base that they bring to this discussion. I know they are going to continue to be at the forefront of this debate between now and the end of the year, and, if possible, if it takes until next year. This is one-sixth of the economy. This is the most important thing to every family, people in your family being well. We ought to take the time that it needs to do this right.

Mr. GINGREY of Georgia. I want to thank the gentleman from Missouri and thank the gentleman for his work in leading Leader BOEHNER's task force on health care reform on the Republican side.

My doctor colleagues that are with me tonight were a part of that small group of about 15. We worked on coming up with meaningful reform issues in an incremental way over the last several months. I think we had a good plan that we submitted to the President, Mr. Speaker, and we are still waiting to hear back from him on that, unfortunately.

Before I yield to my good friend from Louisiana, in fact, my two good friends from Louisiana—I am going to start with Dr. CASSIDY, the gastroenterologist from Baton Rouge—I just want to say one thing. I have got this one poster. Dr. MURPHY may have some other posters when he arrives, but we have a second opinion.

□ 1800

The GOP Doctors Caucus is the second opinion. The Republican minority, 178 of us, Mr. Speaker, we have a second opinion, and that second opinion is, no government-run health care.

We listened to our constituents during the August recess, and that is what they told us loud and clear. Somebody might dig up some ABC-Washington Post poll that says people want government-run health care. I would suggest, Mr. Speaker, to all of the Members on both sides of the aisle, go back and check with your constituents, like I did last night during a tele-town hall meeting, when all of the seniors were on the phone and said, Goodness gracious, Congressman, we don't need that.

I will make this point, and then yield to Dr. CASSIDY. There has been so much gnashing of teeth and wringing of hands and pulling of hair over the last several months, Mr. Speaker, trying to say how are we going to pay for this thing? It is going to cost a minimum of $1 trillion. And then President Obama said, No, we are going to limit the expenditure to $900 billion, but we are going to pay for it all. I won't sign a bill that adds one dime to the deficit.

So, you figure out, well, we are going to tax here, we are going to tax there. We are going to take $500 billion out of Medicare, as the gentleman from Missouri just talked about, Medicare Advantage. We are going to gut that program. And, hey, we have come up with $900 billion and we are going to do this government-run health care. What in the world, Mr. Speaker, have we accomplished?

I want to use this analogy. It would be like a family 25 or 30 years ago scrimping and saving and cutting down on food and clothing and family vacation and college education for the children to save up enough money, and you finally save up enough money and you buy an Edsel.

My colleagues, I hope you all remember the Edsel. I am not knocking Ford Motor Company, but I think most of you are old enough to remember the Edsel. You saved up enough money, yes, you have sacrificed, and you bought an Edsel.

That is what it seems to me, Mr. Speaker, what the Speaker, Speaker PELOSI, and the leader, Leader REID and the President and his advisers, many of them holdovers from the Clinton administration, that is what they are wanting us to do. They want us to buy an Edsel. I don't care whether it is paid for or not, it is a bad deal.

With that, I yield to my friend from Louisiana, Dr. BILL CASSIDY.

Mr. CASSIDY. Thank you, Dr. GINGREY.

I think Congressman BLUNT made some great points. One of them is we want reform, but we want reform that works. Actually, I want to compliment President Obama, because of the three things we want in reform, one is to control costs so we can increase access to quality care. I think he has nailed it. My concern is the approach to achieving these will not work.

I am also concerned that the Democratic proposals before us attempt to achieve that through gimmickry. They are using gimmicks to try and convince the American people that they are achieving the appropriate goal that President Obama has laid out, that it will not add to our deficit.

I was struck today that on the Senate side they are saying that States can opt out of the public option. I am wondering, can you opt out of the taxes that will go into offsetting it? Can you opt out of the debt that the Congressional Budget Office says will accumulate? Can you opt out of losing the jobs that the increased taxes and the increased national debt will inevitably lead to? No. All you can opt out of is the benefit that is offered. You cannot opt out of the high cost that goes into providing this marginal benefit.

I am also struck that there is this tax that they are creating for the American people, and on some similar criticism, it is truly bipartisan. The bill before the Senate Finance Committee that Mr. REID says that we can opt out of is funded by about $350 billion in taxes. If I may quote Speaker PELOSI, she says that these savings, these taxes, if you will, come off the backs of the middle class.

So I think we have a bipartisan criticism of the bill that is before the Senate right now. I think we would agree on the Republican side with Speaker PELOSI that the ''savings'' in those bills, that $350 billion, comes off the backs of the middle class. Indeed according to the Joint Committee on Taxation, families earning less than $200,000 pay 87 percent of these taxes.

This is remarkable. During the presidential campaign it was stated that if you earn less than $250,000, your taxes will not go up. Yet, now, through these various accounting gimmicks, we are seeing indeed 87 percent of these new taxes will come off of those who earn less than $200,000.

There are other gimmicks in this as well. It is pushing the cost of an expansion of Medicaid. And for those watching who don't worry about—I used to work in a hospital for the uninsured. For 20 years I have spent my life trying to bring health care to the people who don't have insurance. Medicaid is the safety net insurance program that is partly funded by the Federal Government and partly by the State government.

Now, in this plan before both the House and the Senate, both plans, they are going to expand Medicaid. In the Senate plan, they are going to make the State taxpayers pay for this expansion. That is really great. It looks like we are saving money on the Federal level, but all we are doing is shoving that cost upon a taxpayer, it is just through the State income tax or property tax or sales tax, not through the Federal tax.

That is a gimmick. If you want to say it is the taxpayer paying for it, absolutely she is paying for it. And so this expansion, this increased cost is going to lead to increased taxes, but it will be through the State tax code, not the Federal. There is the sleight of hand that is being passed off as fiscal responsibility.

Now, on the other hand, we agree on the goals. We want to have quality health care, accessible to all at an affordable price. But we can see that this kind of bargain being offered by the Democratic proposals is really not controlling costs at all. It is merely shifting it onto State taxpayers or it is using taxes upon the middle class to fund.

I like to say they are using new tax dollars in the old wineskin of an old health care delivery system. Just as we

know that new wine in old wineskins will not work, so we know that these new taxes, these savings off the back of the middle class, as Speaker PELOSI says, will not work in the old wineskin of an old delivery system.

Republicans, on the other hand, I think we truly want a transformation of how health care is delivered. The Republican proposal I have signed on to, and I think several of my colleagues have, H.R. 3400, is wonderful in the sense that it empowers patients to make cost-conscious decisions.

If I might yield to my friend from Shreveport, he has got this great anecdote of how Health Savings Accounts in his business worked not only to hold down costs, but how by empowering his employees, also improved our health, if I may yield.

Mr. GINGREY of Georgia. Dr. CASSIDY, if you will yield back to me and I will yield to our good friend from Shreveport. That, of course, is our family practice doc who spent many years, and he will tell us about that, seeing lots of patients in south Louisiana, Dr. JOHN FLEMING.

I do yield to Dr. FLEMING at this time.

Mr. FLEMING. I thank the gentleman. And thank you, Dr. GINGREY, for having this hour. You have shown tremendous leadership over the last few months and even before that, of course, but particularly the last few months in being willing to control time for us to have these discussions. Of course, Dr. CASSIDY, my colleague from Louisiana, has been deeply involved in this issue, and we have all worked together, I think, as a great team, the GOP Doctors Caucus.

I will get to that anecdote in just a moment. I think it is an important one. But let me stay with the subject just for a moment about the gimmickry, because I think that is essential to our discussion. I will develop it very carefully, but quickly, and also point out that this is an important part of the macroeconomics of health care that everyone must understand, and that is this: Currently Medicare and Medicaid, which are the current government-run health care systems, do not pay for the service that they are providing.

Let me repeat that: These programs, Medicare and Medicaid, do not pay, at least completely, for all of the services that are provided, because the government requires and forces doctors, if you will, hospitals and other organizations, to provide care for less than the 100 percent reimbursement. Physicians, nurses, hospitals, home health agencies and so forth actually have to settle for less.

So, how is it that we can stay in business, we in the health care industry, and get by on less? The answer is that the private insurance market, a much bigger market, subsidizes to the tune of about $1,700 to $2,400 per year per family. If it were not for that subsidy, it would collapse. Yet and still, Medicare is scheduled to run out of money by 2017.

Now, how long is 2017? This is 2009. That is about 8 years that we are going to run completely out of money. Nobody in Washington is advancing any solutions to that.

All right, where did the gimmickry begin? Remember that in the time period from about 1997 to 2003, Congress decided in its infinite wisdom that Medicare will be subject to a limitation on the budgetary increases from year-to-year. We call that the sustained growth rate, SGR for a lot of people. But because it was recognized even in the first year that such cuts would block access to health care by patients, it has never been enforced. So it has been a bookkeeping gimmickry that now has created an incremental difference of about $250 billion, and growing. And even the other day the Senate attempted to resolve this.

Mr. GINGREY of Georgia. If the gentleman will yield for one second, Mr. Speaker, for clarification, that limitation based on that formula, Dr. FLEMING, applies to the doctors, doesn't it, all the health care providers? This is not applicable to the hospitals. They are reimbursed under a different system.

Mr. FLEMING. That is correct. It is just physicians only. It is actually part B, which is mainly physicians. It simply says if you guys can't keep your billing and your costs and everything down in totality, we will just cut across-the-board. Well, that is an impractical solution. It is gimmickry. It would never work. Now we have a $250 billion gap that is not being paid for. The Senate the other day tried to address that and failed to, because they knew it would be dumped on to the budget.

Let's advance, fast forward to this bill today. Right now this plan for approximately $500 billion that will be cut from Medicare, $160 billion or so of that would be a direct cut out of Medicare Advantage, which, as you know, is the more generous private system that is funded by Medicare dollars. If that happens, then those who are on Medicare Advantage, such as Humana Gold, will have to go back into the regular Medicare system and they will have to purchase Medigap insurance that they didn't have to purchase before. Again, seniors taking on the added burden.

On top of that is another $300 billion to $350 billion coming directly out of Medicare on the basis of some future savings, some future efficiencies that no one has been able to figure out.

So where are we today, Mr. Speaker? Basically $250 billion of doctor cuts, which have never been cut and will never be cut and are growing, that is going to end up in the budget at some point, another part of the deficit; another $350 billion which everybody in this room has known will never be paid for, but yet somehow it is being booked by the CBO as some savings. It is just continuous gimmickry. That is the only way this bill will ever be paid for, is gimmicks, which really means it is going to be taxpayers and premium holders.

Then to go back and kind of summarize, my point here is that, as Dr. CASSIDY points out, the only way that this is going to be an efficient health care system in terms of cost is the decisionmaking has to be in the exam room between the doctor and the patient, and one of the best methods to do that was a plan started in 2003 or so, Health Savings Accounts.

□ 1815

All this does is allow the employer—and government could do this, too, for Medicare and Medicaid—to put money in the bank that can be used at the discretion of the patient to buy medications or whatever, and it's his money or her money to use efficiently.

Just an example of how it works, we implemented this with my own private health plan with my companies a few years ago, and instead of our rates going up an average of 15 percent per year, they're going up an average of 3 percent per year. I was giving this discussion to my employees one day, and one of my employees piped up and said, Well, look, if we go to this health savings account idea, that's going to mean that I'm going to have to pay out of my health savings account $100, $150 a month for inhalers.

I said, Well, let me suggest to you this: Why don't you stop smoking? You will save money from the tobacco. You will be able to stop your inhalers, and then you'll just be banking all this extra money, which will end up removing any deductible you're going to have in the future. She came back to me 3 months later and said, I stopped smoking. I no longer have to use inhalers, and I've got extra money every week.

I wanted to pull together some of these salient points that have to go with the gimmickry and how we're going in the wrong direction. Expanding government control is going to expand cost. Instead, we should be looking inwardly and bringing it down to the doctor-patient level where the decisions can really be made efficiently.

With that, I will yield back.

Mr. GINGREY of Georgia. Dr. Fleming, thank you for those comments. Before I yield one more time to Dr. CASSIDY, just following through on this point that you are making, you may have mentioned one of the companies, Safeway and others who have testified up here—I don't know if they have been before the entire House or Senate, but certainly they have met with Members on our side of the aisle and explained some of the things that they're doing in regard to incentivize people to take care of themselves, to take better care of themselves, to realize there is a personal responsibility issue here. You pointed out in regard to smoking cessation, to not be using recreational drugs, to exercise on a regular basis. Certainly if you are overweight, particularly massively overweight, get on

a good program. In fact, some of these companies, Dr. Fleming, I think they have programs in-house where it's free, and these employees are incentivized by a reduction in their monthly premiums for health insurance, their copay, their deductible.

When we were marking up the bill, the health reform massive H.R. 3200, a 1,200-page bill in the Energy and Commerce Committee of the House of Representatives, we had an amendment on the Republican side of the aisle to actually expand this program that Safeway and others had initiated to allow even more incentives. You know, for the life of me, Mr. Speaker, I do not understand even to this day—and it's been 6 weeks ago July 30 that we passed the bill in the Energy and Commerce Committee—that amendment was voted down strictly on a party-line vote. Maybe one of these days they'll explain it to me. But to actually get healthier employees so there is less absenteeism, they have a longer work life, and to incentivize them with giving them monetary breaks in the cost of their health insurance, why in the world would we not want to do that?

Mr. FLEMING. Would the gentleman yield for a moment?

Mr. GINGREY of Georgia. Yes.

Mr. FLEMING. That is a great point you make. What I would like to say is that something we have all observed as physicians is that while we all recognize collectively that, yeah, we should lose weight, we should exercise, and we shouldn't smoke, we, as human beings, tend to not address those issues until something comes up, until it affects us immediately in day-to-day life. The beauty of systems such as Safeway's is that they implement a financial impact, both positive and negative, that encourages healthy behavior before you ever get to a point where you go, You know what, I'm going to have to have heart stents or bypass surgery. Now I am going to make changes. Why not make the changes 5 years in advance? Then you don't have to go through that. Look at all the money you save and the health that you have as a result of that.

I yield back.

Mr. GINGREY of Georgia. I thank the gentleman for yielding back. His final point was, give them the incentive when it really matters, not wait until it's too late.

With that, I will yield back to the gentleman from Baton Rouge, Dr. CASSIDY.

Mr. CASSIDY. I am actually going to disagree with my colleague from Shreveport—and by the way, he is from north Louisiana, not south. The point being is that these gimmicks only pay for on paper. So the Congressional Budget Office, which makes an assessment, Does this achieve the goal of controlling cost? Because as President Obama points out, controlling cost is important. These gimmicks only control it on paper. Ultimately, this would be paid for not by gimmicks, but it will be paid for by taxpayers or by debt. Ultimately, that debt will come from taxpayers again. That's why I think Speaker PELOSI says of the savings—this is a public statement—The savings in the bills before the Senate side, the Democratic bills before the Senate, will come off the backs of the middle class, and these taxes will continue to be paid for by the middle class.

I have learned in my practice—because, again, I have worked in a public hospital. I have worked in a government-run hospital where the nurses, doctors, med techs, therapists do their absolute best to bring health care to those who otherwise would not have it, a true safety net hospital. But when there is no money, the lines lengthen. When there is no money, something has to give. Now as it turns out, either we're going to raise taxes, we're going to borrow money, or their lines are going to grow; and our reform goals of controlling cost and, thereby, increasing access to quality care will not be achieved.

On the other hand, let me just kind of amplify on your health savings account. The Kaiser Family Foundation has a study—I believe the Web site is kff.org—and they looked at a family of four with a health savings account and a wraparound catastrophic policy versus a family of four with a traditional insurance policy. They found that the cost of the patient-empowering health savings account with a wraparound catastrophic policy was 30 percent cheaper than the traditional insurance policy, that 27 percent of folks who had the health savings account with the wraparound catastrophic policy were previously uninsured, and that these folks who now have insurance access preventive services as frequently as a family with a traditional policy. We achieve the goals. By empowering patients, we, the folks buying those policies, lower their cost. By lowering their cost, folks who were previously uninsured now have access to insurance and, once having access to the insurance, are accessing the primary and preventive services as frequently as those who are paying 30 percent more for their insurance. The goals of insurance have got to be that.

Now, again, I'll go back to the analogy I used earlier. We can either put the new financing, the new tax dollars in the old wineskin of a top-down, government-controlled, bureaucratic health care delivery system or we can use new wineskins, and I think the new wineskins that the Republican Party wants to use are patient-empowering. How do we empower patients to make a decision that's good not only for their health but also for their pocketbook? And by so doing, you lower cost. People previously uninsured can now afford it, and once they have their insurance, they're able to access those primary and preventive services. As practicing physicians, as a guy that's been working in a safety net hospital for some time, that seems the wineskin for us.

Mr. GINGREY of Georgia. I appreciate the gentleman for being with us. Mr. Speaker, I can't quote the chapter and verse, but obviously the gentleman's been reading the Good Book. It's somewhere in the Old Testament. I know about those wineskins as well, and I really appreciate his analogy and his great insight on health care reform.

We've been joined by another member of the GOP Doctors Caucus, and I will yield to him momentarily. But Mr. Speaker, as we heard from our colleagues from Louisiana—north Louisiana. I'll get that straight one of these days. Shreveport is not New Orleans. But they brought out some excellent points. There was some commentary about health savings accounts. I think most of our colleagues surely understand that program now, and maybe many of them—I bet many of them—I know that was the insurance plan that a lot of the doctors in Congress had when they were in practice, and Dr. BURGESS may want to talk about that in just a minute when I yield to him. But a high deductible—in other words, you don't get first-dollar coverage on your health insurance. You have more out-of-pocket expense, but your monthly premium is much lower than your standard first-dollar coverage-type policy. I mean, it might be less expensive by a factor of four, and you can fund it by putting in money. Your employer can do that. You can do it yourself. Family members can do it and get a tax break from doing that. But up to the limit of your deductible, every year you can fund these plans, and for the out-of-pocket expenses, whether it's an annual physical or Lord knows if somebody breaks their ankle playing soccer or something, you know, you pay for that out of this health savings account. If at the end of the year you haven't spent all that money, and you don't have to get into the catastrophic coverage, then that rolls over to the next year. And if you take good care of yourself and you exercise personal responsibility, which does include exercise, maybe at the end of 20 years, a young person has an account that has enjoyed the miracle of compounding, and they may have accumulated $125,000 in an account by the time they are 65 and they're eligible for Medicare.

Mr. Speaker, these are great programs, and I, personally, would like to see them expanded. In fact, I would suggest that we could make some changes in the law in regard to COBRA, where if a person loses their job through no fault of their own, that they are able to continue to stay on the company group health plan, except they have to pay all of the premium, plus 2 percent administrative costs. They can do that for 18 months while they're trying to get another job and get other coverage. Well, most people when they're out of a job, they can't afford that. They can't afford to pay those premiums. So why not let them, during that 18-month period, switch

over to one of these health savings accounts that has a high deductible and a low monthly premium? This is an incremental thing that could be done and that Members on our side of the aisle have suggested. Just as we have a number of other incremental things, like equalizing the tax treatment, setting up State-administered high-risk pools, absolutely giving government subsidies to those who are low income but not low enough to be eligible for Medicaid or some other safety net program, let people buy insurance across State lines.

I live in Georgia. Why can't I shop on the Internet for a policy that's offered in Florida, South Carolina or Alabama, my neighboring States, that fits my needs better and is more cost effective, less expensive, something that I can afford? We have done all of these things, made these suggestions. And yes, also on the Republican side, Mr. Speaker, we have a number of comprehensive bills. Some of my colleagues on the floor tonight have written and introduced comprehensive health care reform that would be cheaper than what the Democrats want to do with H.R. 3200, with the majority in the Senate, with what they want to do, the bill that Senator REID, the majority leader, is about to put on the Senate floor. But I would say that probably my colleagues on this side of the aisle would tell you in all honesty, yeah, we have better bills and they're less expensive, but you know what, we don't even recommend that we pass those right now when the unemployment rate is over 10 percent and the economy is in the tank, people are suffering, and 15 million have lost their jobs. We might want to do it next year or the year after that. Eventually we'll do it—probably better in an incremental way—but it is not the number one priority of the Republican Party to totally reform our health care system, throw out the baby with the bath water, spend $1.5 trillion and have the economy get worse and more and more people lose their job. This is not the number one priority.

With that, Mr. Speaker, I want to yield to my OB/GYN colleague and classmate, someone who I am proud to serve with on the Energy and Commerce Committee, MICHAEL BURGESS, an OB/GYN doctor from the Dallas-Fort Worth area, a great Member.

Mr. BURGESS. I thank the gentleman for yielding.

I actually didn't intend to come over here talking about HSAs. But having initiated the discussion, I do want to just mention that the HSA is a way to save significantly on the premium. I currently have an HSA. It costs me about half of what a PPO insurance cost last year. Most importantly, in addition to an insurance card, I also have a debit card, and that debit card is something I can use to pay for expenses that occur throughout the year, and as Dr. GINGREY pointed out, the money in that account does roll over at the end of the year. It does not go away if it is not used at the end of the year.

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You know, earlier today, we had many people come down to the floor of the House and speak on the issue of health care reform. One of the criticisms that was leveled at Republicans was that we were doing nothing but obstructing the process and that we had no ideas of our own. I did feel obligated to just touch on that point for a moment.

Let's be honest. We do not have the numbers. We do not have the organization. There is no way that the Republicans in this body can obstruct anything that the Democrats wish to do. They have a 40-seat majority in the House. They have all kinds of ways of getting to 218, and really, because they are the majority party, it is up to them to do it. True, they don't have much Republican support, but tell me: If you have an excess of 40 votes and if you can't pass your own bill, it tells you that something may be wrong with the bill, that it's not something wrong with Republicans. Something is wrong with the bill the Democrats have crafted.

More to the point, what makes a bill bipartisan? Is it because you can pick off a couple of Republicans at the final vote and can record a couple of Republican ''yeas'' in the final tally as the vote is passed? No. What makes a bill bipartisan is inviting the minority party in at the beginning and encouraging them to have their ideas as well as the ideas from the majority. That's exactly what didn't happen through this discussion.

In November, I reached out to the transition team. I told them I didn't leave a 25-year medical practice to sit on the sidelines while we discussed health care. I was thanked very much for my interest. Never heard back. I reached out to the chairman of my committee, the Committee on Energy and Commerce. Again, I reiterated that I did not give up a career to sit on the sidelines. Again, no response from the committee.

There was ample opportunity early in the year, as these bills were being crafted, to bring members of the minority party in and to get their ideas on paper, on record. Maybe there was room for some horse trading. Who knows? The problem is we never tried.

Then 5 weeks ago on the floor of this House, when the President came and spoke to us—and this is the same President who said he would meet with Hugo Chavez and with Ahmadinejad without preconditions but who won't meet with congressional Republicans without preconditions. This is the same individual who, as a candidate in 2004, said there are not just blue States and red States. There is the United States. This individual was elevated in the eyes of the Nation as someone who could rise beyond partisanship. Yet we see a city today that is absolutely immobile because of partisanship.

The fact of the matter is they've got the votes. They've got the votes on their side in the House of Representatives and in the Senate. They have a 60-vote majority in the Senate. There is nothing they can't pass if they want to. Please do not attribute the lack of passage of this bill to Republican obstruction. Again, I'd like to take credit for it, but the fact is we don't have the numbers.

The American people deserve a great deal of credit because, during the month of August, they spoke up and gave many Members pause, and caused them to reflect on where we were going with this bill. Unfortunately, today, it's almost as if August did not happen, because we're going full speed ahead with the direction they intended to go in the first place. Never mind what we heard or saw during the month of August.

I know the time is tight. I'll yield back to the gentleman the balance of my time.

Mr. GINGREY of Georgia. I thank the gentleman from Texas for yielding back, and I thank him for his comments.

Mr. Speaker, I'm going to yield the remaining time that we have. I wish we had more. When you're having fun, it goes fast. We've been joined by my co-chairman of the GOP Doctors Caucus, clinical psychologist Dr. TIM MURPHY from Pennsylvania. He is my classmate and is president of our class. He is going to take the rest of the time. Dr. MURPHY served with me—or I should say I served with him on the Energy and Commerce Committee, and I'm proud to yield time and the concluding remarks to Dr. TIM MURPHY.

Mr. TIM MURPHY of Pennsylvania. Thank you, Doctor. I appreciate that.

You know, the big question becomes: Are we going to reduce the cost of health care or are we going to increase it?

During the President's inaugural address, he said our health care is too costly. I could not agree more, and that has been our passion to reduce health care costs, and I still want to work with the President and with my friends on the other side of the aisle to make that work, but there are a couple of questions here.

If you're on Medicare, if you're sick or if you have health insurance under the plans being proposed, you may pay more. Let's review that really quickly.

First of all, with $500 billion cut from Medicare, there will be less to hospitals, less to skilled nursing facilities, $5 billion cut from inpatient rehab facilities, $56 billion cut from home health care, and fewer payments to doctors for drug programs, for part D and for Medicare Advantage, which has a lot of preventative services.

Those are a lot of cuts. When you're taking away preventative services and when you're taking away money from the programs that we know save money, such as disease management—and that's important—they're going to end up with higher costs.

The second thing is, in taxing the sick, the proposal that's being kicked around the Senate now is increased taxes on all of these medical devices: heart monitors, heart valve rotators, pacemakers, artificial hearts—I hope you don't have a heart attack, because it will cost you more—defibrillators, hearing aids, hospital beds, nebulizers, artificial hips. There are a number of things. There are wheelchairs and ventilators. All will be taxed, including the insurance plans because it comes down to this:

With the insurance taxes, you get taxed if you do have it and taxed if you don't. If the employers offer insurance, they may tax employers if they do offer it and tax them if they won't.

Finally, there are issues with States. If States have an opt-out provision where they do not have to have as a provision in their State where they will have this health insurance plan run by the Federal Government, they may still pay the taxes, and that becomes taxation without hospitalization.

Look, there's a lot we can do to fix this system. There's a lot we can do to reform Medicare. There are so many problems with the Medicare system, not just the fraud and abuse. I believe Congress will work on that, but it's just how things are run there, and we need a more effective and efficient system to make changes in how we operate with Medicare.

Why does it take months to get a power wheelchair for someone? Why do you need such expensive procedures to get a crutch? Why do we have so many things that cost so much money? It's because they're done ineffectively and inefficiently.

Let's change that. Let's make Medicare and Medicaid work better for people. If we're going to do anything so that the Federal Government can run it better, shouldn't we start off by making the government run it better? Let's cut the waste. Let's improve the quality. Let people cross State lines, as so many of my colleagues have said. In a survey in my district, 70 percent of people said that they wanted that.

Let people join groups and have the purchasing power of the group. Let's make insurance permanent because millions of Americans are begging Congress to work together with both sides of the aisle to fix the problems. That's what we should be doing. Millions of Americans can't all be wrong. Let's not dismiss Americans as being frivolous with all of that.

With that, Dr. GINGREY, I yield back to you for the remainder of our time here. Let's continue to work together as a Congress and as a Nation to fix this problem, not just to finance the problems.

Mr. GINGREY of Georgia. Dr. MURPHY, thank you so much.

I failed to mention to my colleagues, Mr. Speaker, that Dr. MURPHY is also an author, and has written a number of books on child psychology, and he knows of what he speaks.

I think the theme tonight, Mr. Speaker, is to try to present Members who are knowledgeable on the subject matter. If we were talking about the law, if we were talking about national defense, there would be the people like JOE SESTAK and Colonel JOHN KLINE on our side of the aisle. You'd listen to those folks. I hope that our colleagues will understand that we're trying to do this in a bipartisan way to help impart knowledge. Knowledge is power, and we hope and pray every day that God will give us all wisdom and that we'll make the right decisions and that we'll reform our health care in a way that doesn't destroy what really is the best health care system in the world.

With that, Mr. Speaker, I thank you for the time. I yield back.

HEALTH CARE REFORM

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

Mr. KAGEN. Thank you very much, Mr. Speaker. I feel very flattered that you have provided me with sufficient time to explain some of the problems and solutions that we're looking at in helping to solve our crisis in health care across America.

By way of background, my name is STEVE KAGEN. For the first time in my life, I ran for public office in 2006, and I was elected and reelected in 2008. I grew up in Appleton, Wisconsin; went to public schools; went to the University of Wisconsin; studied molecular biology; went to medical school. I went back home to Appleton with my wife, Gayle, to raise a family in 1981, practicing allergy, asthma and immunology.

Over the years, what has been happening to my patients is they've been having more and more difficulty paying for their prescription drugs. What has been happening to my friends I went to high school with is they've had more and more difficulty running their businesses and having access to affordable health care.

The health care costs in this country have simply gone through the roof. It's becoming more and more impossible for people to pay for, not only their medically necessary and life-saving prescription drugs, but also their health care coverage that they so dearly need. It's not just difficult for families. It's difficult for small businesses. It's difficult for large businesses.

Recently, I received an e-mail from a large employer in Green Bay, Wisconsin—home of the world champion a long time ago, the Green Bay Packers. This very large employer-CEO said: KAGEN, keep the public option on the table. I just got my quote from Blue Cross, and they're jacking it up by 29 percent in 2010.

People have to understand that, if we don't address this crisis and begin to solve it immediately in 2010, they'll either have a job with no health care coverage or no job at all, and good luck with the coverage you can get.

Now I'd like to share with you some of the personal stories and comments from people in Northeast Wisconsin, and I trust that they're very much the same as they might be all across this great land.

Ned writes from Dunbar, Wisconsin: The part D doughnut hole needs to be eliminated.

Well, Ned, you're right, and we're working very hard on the Democratic side, and I'm sure the Republicans will go along with the idea of closing the doughnut hole in Medicare part D. Medicare part D, after all, was a prescription drug plan which was written by and for the insurance industry, which was nothing more than a windfall profit of billions and billions of dollars for Big Pharma. It wasn't intended to help my patients. It wasn't intended to help the senior citizens who live in Northeast Wisconsin. It was written by and for Big Pharma, and they're the ones that had the windfall profit. Ned needs help now because he needs to be able to go to the pharmacy and pay for his prescription drugs without having to go to the bank before doing so.

Jack from Kaukauna writes: I need help. Prescription drugs are most important to very many seniors on limited incomes.

In these economic times, those people who are most at risk are people who are living on fixed incomes, not only because they may not receive a cost-of-living adjustment but also because they have fixed incomes. They're not getting the interest payments they were before on their investments.

So it is for Ned, for Jack and for everybody who is living on fixed incomes that we must write a bill here in the House that will guarantee access to affordable prescription drugs, and we have to do it soon.

Eleanor from Green Bay, Wisconsin writes: Drug prices rise since part D. One of my husband's drugs in December 2005 was $144; in January of 2007, $189. A $45 rise in 14 months is too much.

They need help now with prescription drugs, and we intend to provide it in the legislation that we're writing.

Deb from Florence, Wisconsin writes: I have no health insurance. We cannot afford it.

Well, we've got to make sure that the prices are driven down. Ordinary people, both seniors and hardworking families, students alike—everybody understands there is a crisis in affordable health care.

Here is a note from Carl from Greenleaf, Wisconsin: I have a pacemaker, and feel better than I had a year ago. I don't know why I had to pay $1,725 every 3 months for insurance with a $3,500 deductible.

You know, one of the games that's being played by the health insurance