With that, Mr. Speaker, I yield back the balance of my time.

GOP DOCTORS CAUCUS

The SPEAKER pro tempore. Under the Speaker's announced policy of January 5, 2011, the gentleman from Louisiana (Mr. CASSIDY) is recognized for 55 minutes as the designee of the majority leader.

Mr. CASSIDY. Mr. Speaker, an issue tonight that is much more important to the American people than many realize is Medicaid. Now, for folks who don't understand this, and you really had no need to until this health care debate began, but, if you will, there are three types of coverage for folks who have insurance. One is Medicare. Medicare is the program for folks who are typically 65 and above. It is the program that all of us pay into, having a certain amount deducted from our paycheck, and it goes into this account. The second is private insurance. Ninety percent of Americans have their private insurance policy through their employer. And then the last group is Medicaid.

Now Medicaid is a program designed to support those of lower income as well as those who are elderly and, again, of lower income and long-term care—think nursing homes. And lastly, it supports the blind and disabled. The financing in Medicaid comes from your tax dollars, but it can be your tax dollars either funneled through the Federal Government paying a portion to the State, which is matched by what is called the State match, which is from the State itself.

So Medicaid is a program for lower income which receives about, on average, 57 percent of the money that goes towards it from the Federal Government and 43 percent on average from the State government. The State administers the program to take care of, again, low income for acute medical services, long-term care, think nursing homes for the elderly, and then the blind and disabled. Tonight's discussion will be about Medicaid.

Now, the importance of Medicaid is that 16 percent of the health care dollar in the United States goes towards Medicaid. So almost a little bit over one-eighth of the money our country spends is on this combined Federal-State program that provides health insurance, if you will, for the poor.

Additionally, Medicaid is important because right now Medicaid is consuming an ever larger portion of both the Federal Government's budget as well as the State government's budget. One example of this: the Simpson-Bowles bipartisan debt commission, which President Obama appointed to help give guidance as to how our country could get out of our indebtedness, pinpointed Medicaid as one of the drivers of our national debt. So first, we know that on a national level, Medicaid has been pinpointed as a driver of our national debt. On a State level, Medicaid is consuming an ever larger portion of State budgets.

Now, there are many examples of the importance of this, but as Medicaid is costing more and more, State dollars for other programs are less and less. Senator Lamar Alexandria from Tennessee said that the reason that tuition is increasing at universities in Tennessee is because there is less public support. More tax dollars are going to Medicaid, and so therefore, to make up the budget for the universities in Tennessee, they have to increase tuition.

One example of this, as well, for K–12 is that for the first time beginning around 2009, States spent more of their income upon Medicaid than on education. And so this is a chart from the National Association of State Budget Officers, and it shows how total State spending on Medicaid now surpasses K–12 education, and K–12 is kindergarten to 12th grade. So this is primary and secondary education. In this blue line you see funding for education, and you can see the percent of total State expenditures devoted to, in this case, education.

So in 2008 it peaked at around 22 percent, and now in 2011, it has decreased down to roughly 20 percent. Here you can see that in 2008, Medicaid expenditures were about 20.7 percent of the State budget, and they are rapidly rising. They are now up to almost 24 percent.

We are now spending more money providing Medicaid services for those who are eligible than we are educating our children. Now, it isn't as if this is something that is temporary, related to the recession; this is actually expected to continue to worsen. So Medicaid, again the program that both the Federal and State Governments—which means both taxpayers paying to the State and taxpayers paying to the Federal Government—finance, is growing so rapidly that it is cannibalizing the rest of the State budget.

An example of this is that expenditures for primary and secondary education now for the first time in history are lower than those expenditures for Medicaid. And this is expected to worsen.

So if you will, we have this program which is important. It's a safety net program. But under its current construction, it's costing more and more.

Now I'm joined by a couple of my colleagues, and I will first go to Dr. NAN HAYWORTH, who is an ophthalmologist—she held up a note earlier that my eyes are not good enough to read—an ophthalmologist from New York, and she can discuss how President Obama's health care plan expands Medicaid, a program which is rapidly expanding in cost but nonetheless will be further expanded in terms of those who benefit.

Ms. HAYWORTH. I thank our colleague, Dr. CASSIDY, and I understand that your time may be slightly limited this evening, Doctor, so Dr. HARRIS and I will be more than happy to lead this discussion as we go along, and I thank you for all the work you do on this very important subject.

The American public has much to be concerned about with regard to the massive 2010 health law, and this was, of course, passed on a party line basis, unfortunately. I and Dr. HARRIS are two of the representatives who were elected in part in response to the public's grave concerns about this act. And if I can direct everyone's attention to the chart that Dr. CASSIDY has revealed next to him, you can see what is projected to happen in terms of Medicaid spending alone as the years go by and, of course, under the terms of the Affordable Care Act, it is like putting gasoline on a fire, unfortunately.

□ 1910

Mr. CASSIDY. Will the gentlelady yield?

Ms. HAYWORTH. Yes, absolutely.

Mr. CASSIDY. Federal and State Medicaid spending in billions of 2010 dollars by 2009. It's down here, the year. So 1993, 2009, going out to 2081. And so here is about $400 billion. This is combined Federal and State spending. By 2017, this rises to $750 billion. By 2025—obviously within our lifetime—that will rise close to $1 trillion. And projections are by 2081, it will be over $4.5 trillion.

Ms. HAYWORTH. I'm going to imagine, Dr. CASSIDY, that this chart does not take into account—because it could be, indeed, very difficult to do so, but it has to enter the public mind when we think about these things. The enormous cost on the American public of the well-intentioned, but poorly designed, 2010 health law will make our economy weaker. So it's fair to anticipate that there will be a further impetus to acceleration of Medicaid spending merely because of the imposition of that $2 trillion or more of Washington-generated cost due to the terms of the Affordable Care Act.

So this is an issue that concerns every one of us, not only people who are truly in need and unable to sustain a job or their health care—and we've all met these fellow citizens. I have in my own district, the Hudson Valley of New York. These are people like the folks I met at Park, which is a center that provides for people who are severely disabled by developmental disabilities, such as autism, but not only autism. These are good people who, no matter how robust the economy is, will not be able to afford the kind of care that they need. And those are the people in particular who Medicaid was initially intended to help.

Mr. CASSIDY. Will the gentlelady yield?

Ms. HAYWORTH. Yes, sir, absolutely.

Mr. CASSIDY. So just to emphasize, Medicaid is an important safety net program for those folks without means. It was traditionally designed to take care of the blind and the disabled, the elderly and long-term care, and then

oftentimes focused upon pregnant women and upon children. So the importance of making sure the program is sound is that we continue to care for these people.

Ms. HAYWORTH. Precisely. So we need to be able to provide for the people who are most in need. That is a reasonable role for government in a great Nation. But what we don't want to do, what we want to avoid is creating economic hardship that will push more Americans into this category. We see that phenomenon happening across our economy as we speak, and it's one of the reasons why so many States have said, we cannot possibly afford to expand our Medicaid programs.

Indeed, Dr. CASSIDY, you, being the good teacher that you are, provided me with an example from the State of Connecticut, with their recent experience in opening up their Medicaid program and opening up the enrollment because they had such a dramatic increase—I think it was something like 70 percent increase in the number of enrollees—that the State actually couldn't handle that increase in any way readily. So their services to all of their Medicaid recipients, unfortunately, of necessity, were compromised.

Mr. CASSIDY. If the gentlelady will yield, I'd like to bring in Dr. HARRIS, who is an anesthesiologist from Maryland, the Eastern Shore.

You just mentioned how Medicaid, as it attempts to expand and be all things to all people, becomes stressed and in that stress becomes less capable of being anything to anybody.

Ms. HAYWORTH. Exactly.

Mr. CASSIDY. So the concern regarding a program which becomes, again, too stretched, too unfocused is that it becomes ineffective at its original mission.

Dr. HARRIS, I can leave this one or go to the next one.

Mr. HARRIS. If the gentleman from Louisiana will just leave that one up so the American public that is watching just understands because a picture says a thousand words.

That picture is the growth of Medicaid for the next generation. My son is 12 now. When he reaches age 65, he'll be at the right-hand side of that graph. And although none of us like to think of it, we all remember when we were 12, we never thought we would retire, but here we are nearing retirement age. So it's not that far off in the future.

If I read that graph correctly, our current entire budget, in 2010 dollars, is $3.5 trillion—our entire Federal budget, paying for everything. That graph indicates that by the time my child reaches retirement age, every penny of that budget would be taken up by Medicaid, every penny—not a single penny for Medicare; not a single penny left over for Social Security; not a single penny left over for interest on a debt that is now $16 trillion and growing; not a single penny left for defense; not a single penny left for Pell Grants; not a single penny left for anything.

Mr. CASSIDY. I think the point being made is that not only will the safety net become tattered in and of itself, but, rather, even though tattered, it will destroy our ability to finance these other governmental functions.

Mr. HARRIS. The gentleman is correct. Every single program that we have, whether it's the elderly with health care, the elderly with Social Security, whether it's food stamps, whether it's unemployment insurance, whether it's to do the things this government has to do, like pay the interest on an ever-growing debt, whether it's Pell Grants, whether it's K–12 education, which your last slide showed, every single program that we have is threatened by this one single program, a program that the President's Affordable Care Act ballooned out of control.

Mr. CASSIDY. Reclaiming my time, if you could elaborate. We know that under the President's health care proposal, Medicaid—a program which right now is driving Federal indebtedness and which is threatening to bankrupt States, despite that was greatly expanded under the President's health care proposal to include people up to 133 percent of Federal poverty level. So I'll yield back to the gentleman if he will just comment if this is what he is referring to regarding expansion, and if so, any further thoughts he has.

Mr. HARRIS. The gentleman is absolutely right. What we have done is we have once again made promises to people we know we can't keep. We know because that graph—and I'll yield to the gentleman to answer the question—that's from the Congressional Budget Office. That's a non-partisan group that objectively looks at the effect of Federal laws and policies and projects the anticipated costs. Is that correct?

Mr. CASSIDY. That is correct.

Mr. HARRIS. So what we have here is we have a third party looking at what's going on and saying the emperor has no clothes; that, in fact, if we continue the current policy with Medicaid—which, as the gentleman well knows, roughly doubles the number of people eligible for the safety net program under the Affordable Care Act—we will not only bankrupt the Medicaid program, future generations will no longer have the ability to be confident that Social Security will be there when they retire, that Medicare will be there when they retire.

The ratings agencies, whether it's Moody's, Standard and Poor's, all the various rating agencies will look at us and say: you don't have the ability to pay the interest back on your debt.

We know when that bill was passed, we know what happened. We know the cornhusker kickback. We know what went on—the buying and selling of votes at the expense of future generations and the ability of the Federal Government to keep their promises to future generations—the promises of Medicare, Medicaid, again, Pell Grants, K–12 education.

The gentleman showed a slide that showed a 3 percent increase in the cost—an average of 3 percent in the States' budgets—the cost of Medicaid over the past only 3 years before the President's health care bill kicks in. Well, as the President may know, 3 percent doesn't sound like much, but in Maryland that's a $1 billion increase. That's an increase we can't afford. That's an increase that means that property or income taxes would have to go up, further strangling our economy.

As the gentleman fully recognizes, this is why the President's policy with regard to Medicare and the Affordable Care Act is poorly thought out, is going to bankrupt the Nation, and really ought to be repealed and rethought.

□ 1920

Mr. CASSIDY. Now, if the gentleman will yield, I'll go to Dr. DESJARLAIS who joined us, who although he has a French last name and you would think he is from Louisiana is actually from Tennessee.

Now, Dr. DESJARLAIS, obviously, to you and me, but perhaps not to those who are listening, Tennessee experimented with using Medicaid as a safety net program back in the nineties and, if you will, extended it to many others. If I can yield to you, please, could you please comment as to the results of that.

Mr. DESJARLAIS. I thank the gentleman for yielding.

And you're absolutely right. I moved to start my practice in Tennessee in the fall of '93, and our program, TennCare, was implemented somewhat as an experiment in '94, January '94. So I witnessed it from its inception through what I would call its continuous failure.

The program continued to grow and expand, continued, as I think you referenced earlier, as substantiated by Senator LAMAR ALEXANDER, has drained our State's educational resources. And it got so bad that, in 2007, Governor Bredesen actually had to remove about 270,000 people from the program just to keep the State from going bankrupt.

So clearly, it was an example of how the program and the system does not work and did not work. And that's maybe a glimpse of what we can expect to see moving forward with the President's health care law. So it failed to accomplish its objectives, and just as we would have suspected, the costs grew exponentially. And so we have a great example in Tennessee of how the system does not work. So clearly, we need alternative reforms.

I would be happy to yield to the gentleman from Georgia, Dr. BROUN.

Mr. BROUN of Georgia. Thank you, Dr. DESJARLAIS. I appreciate your yielding.

In fact, Medicaid is going to destroy the Federal budget and create a total economic collapse of America if we don't change it from the present system. That's before ObamaCare even

takes place and markedly expands the States having to cover many more people, as my good friend from Maryland, Dr. HARRIS, was just explaining.

But there are alternatives. Hopefully, we can repeal ObamaCare and replace it with something that makes sense. But there is a solution today. And, in fact, the Republican Study Committee, several us in the Republican Study Committee—JIM JORDAN, our chairman, TODD ROKITA, TIM HUELSKAMP, and I—introduced the State Health Flexibility Act, which would freeze Medicaid spending at the current level and will block grant those funds to the States with no strings attached. Not only for Medicaid, but also for the State Child Health Insurance Program. And what the States would do is utilize those funds in any manner that they want to. If they want to do drug testing on Medicaid or SCHIP recipients, they can. They can organize the program any way they want to, which is going to be the solution because it freezes spending at current levels.

Mr. CASSIDY. If the gentleman will yield.

Mr. BROUN of Georgia. Absolutely.

Mr. CASSIDY. I'll say, just out of pride of authorship, there's another alternative, a Republican Medicaid proposal, one that I and others are sponsoring, and it does, if you will, similar to the block grant, it readjusts as your population changes.

I'm from Louisiana. When Hurricane Katrina hit, we had lots of folks who moved to Atlanta and moved to Houston. If you will, the dollar would follow the patient. It wouldn't just stay in Louisiana. I love my State, and it would be nice to have the extra money. But it is more important that, where the patient is, have the money. It's a variation on the theme. But also part of it is that the State has flexibility, freeing them from the money-consuming regulations that the Federal Government puts on how those monies are applied.

Mr. BROUN of Georgia. Absolutely. In fact, the State Health Flexibility Act does that same thing, and the only growth is due to population in any State, so it does account for that change in the population of any given State.

But we have solutions. We have economically viable solutions that Republicans are submitting and, hopefully, we can get passed into law. But of course we've got to have a Senate that will even take up those kinds of bills, because the House has passed bill after bill after bill to create a stronger economy, to create jobs here in America, to lower the cost of gasoline, to develop all our energy resources.

We've got these bills that will solve the problems for Medicaid. Even my Patient Option Act is across-the-board health care reform. It repeals ObamaCare and replaces it with policy that makes health care cheaper for everyone, provides coverage for all Americans, and will save Medicare from going broke. And you add that, with the State Health Flexibility Act, it covers everybody.

We have solutions, but HARRY REID is an obstructionist. He's acting as a puppet for this President, and they throw in the trash can every bill we send over there.

We've got to create jobs. We've got to create a stronger economy. We have solutions to the health care problem.

All of us are physicians. All of us are physicians out here that are talking tonight. We've just been joined by one nonphysician, but she's been a strong supporter of the Doctors Caucus, and we've seen her here many times, Mrs. LUMMIS from Wyoming.

But we have solutions. The American people need to understand, Republicans have solutions, and we need to have the ability to pass those solutions into law so that we can have policy that's not going to break the bank. We're going into an economic collapse of America if we don't stop this inanity.

Mr. CASSIDY. I thank the gentleman.

One thing I am struck by—and I'd like to bring Mrs. LUMMIS in—oftentimes it is, when folks say, Wait a second, it's Medicaid and the government will pay for it, or the State should enroll because the Federal Government is going to pay so much more, and there's a sense that it is the government that is paying for it but not the taxpayer. Now, what we know is the government is nothing but an aggregator of our pocketbooks, and it will take that money and bequeath it.

I asked Mrs. LUMMIS to come tonight because she is a former State treasurer in Wyoming and will discuss the impact this program is having upon State budgets and, therefore, other State services.

Mr. BROUN of Georgia. Before you go to Mrs. LUMMIS, I'd like to reclaim my time and just say this: Our State of Georgia is struggling. We have a balanced budget amendment to our State constitution. We're having a difficult time dealing with the extra cost, not only of Medicaid, but all these government mandates that are foisted upon our State from the Federal Government.

It has to stop. And the only way we're going to stop it is for we, the people, across this country to demand a different kind of governance from their Senators and Congressmen, and particularly from the President of the United States.

Mr. CASSIDY. Thank you, Dr. BROUN.

Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. Under the Speaker's announced policy of January 5, 2011, the gentleman from Maryland (Mr. HARRIS) is recognized for 28 minutes as the designee of the majority leader.

Mr. HARRIS. Thank you very much, Mr. Speaker, and I will yield to the gentlelady from Wyoming.

Mrs. LUMMIS. I thank the gentleman for inviting me to participate, although a non-physician, the only non-physician here.

I thank Dr. HARRIS, and I want to thank Dr. CASSIDY. I have seen Dr. CASSIDY in the cloakroom talking on the phone, pro bono, to patients that he used to serve in Louisiana, and I have seen other members of our Doctors Caucus do the same thing.

These are people who care about their patients. And even though they're here, working for the people of the United States and their district, and not compensated financially, they are still here caring about their patients, working without compensation, pro bono, to help people that they used to serve, to make sure their lives are better and their health care is better.

□ 1930

So I want to compliment the physicians in this conference who have made such a difference to my life and to other people's health care lives, and I want to thank them for serving in Congress. They make a huge difference in the dialogue, the debate, the nurturing, the care, the tenderness, and in what we all experience because of their training and because of their love of the people of this country and the manner in which they serve their patients.

Mr. Speaker, I was the State treasurer of my State. I have seen Medicaid and other programs soak up the compensation that taxpayers in every State provide through taxes to their States, preventing States from being able to allocate more money to education and other State-based functions, and Medicaid is definitely one of them. In addition, States care for their working poor. States want to see their low-income, Medicaid-eligible people have access to high-quality health care and support the Medicaid program but to not support it in a way that requires these rigid handcuffs on States in a one-size-fits-all program that prevents States from innovating and from providing quality care to their people.

Case in point: My State of Wyoming has the smallest population in the Nation. As a consequence, we have the opportunity to study things that other States cannot study because their populations are so large. My State of Wyoming, through its own health care commission, studied every single Medicaid-eligible child under the age of 18. It determined that it would be over 2½ times cheaper to buy each one of those children a standard Blue Cross-Blue Shield policy than it would be to provide health care through Medicaid.

These are the kinds of things that States are studying, that they are learning, that they are innovating. Furthermore, there are places in the country that are dealing with different health care problems than other places in the country.

Case in point: The Rocky Mountain West has a much higher incidence of multiple sclerosis than has other parts

of the United States. No one knows why, but it's a fact. So Wyoming and other Rocky Mountain States should be able to concentrate on MS. Other States, perhaps Southern States, may have more problems with diabetes.

I recently was in Saudi Arabia. There is a tremendous diabetes problem there. They are spending tremendous amounts of money at their brand new higher education university, at which they partner with businesses, in order to study diabetes in a way that will help the great number and growing number of people who are affected by diabetes.

These should be things that regions of our country are allowed to work together on and to create programs for in order to innovate and to be the great incubators of innovation that States are. So that's why I do want to compliment the U.S. Supreme Court in the portion of the decision on ObamaCare that provided that States do not have to be held hostage under the ObamaCare law, that they do not have to expand beyond the original intent of the Medicaid-eligible population to accommodate its expansion under the ObamaCare law. They can still concentrate, if they choose, on the Medicaid-eligible population as it exists today and can continue to provide quality Medicaid to low-income, eligible constituents within their States.

That doesn't mean they should be under the same constraints they are under now to provide Medicaid to their populations—because of the variance and the kinds of diseases that are cropping up in different parts of the country and because of the different innovations that States are able to use if they are not constrained by the shackles of the Federal one size fits all.

I want to thank the physicians in our conference for continuing to raise these issues, to discuss these issues. You discuss them to the benefit of those of us who are not physicians who serve with you in Congress. You discuss these issues to the benefit of the people to whom you provide health care in this Nation, and you do it as a service to the people of this country. I thank all of the physicians who are here tonight to discuss this issue.

Mr. HARRIS. Thank you very much to the gentlelady from Wyoming for bringing up that point about what Medicaid does to State governments and about what the potential is to State governments and all the other programs that they have to fund.

I will tell you that, with regard to what happens, what we know is that access under the Medicaid program is already suffering, the access of patients. Again, passing the Affordable Care Act puts an insurance card—a Medicaid card—in the hands of probably 10 to 12 million Americans, but that doesn't guarantee access to health care.

As a physician, I've taken care of Medicaid patients for almost 30 years, but increasingly what I'm finding is my colleagues who are facing decreased payment reimbursements by the governments that are under financial hardship now. Even under current conditions, as this chart will show, there are very few States in the Union that actually have extra money around to fund that Medicaid increase. This chart shows various specialties and how Medicaid patients have access to them.

Under the current reimbursement, which of course will get nothing but worse for specialists under the new Affordable Care Act, among all specialists, 89 percent of patients with private insurance have access to all specialists and only 34 percent of medical assistance patients, or Medicaid patients. That's true whether it's orthopedics, psychiatry, asthma, neurology, endocrinology, ear, nose and throat, or dermatology. In all cases, access to a physician is restricted because, when a government controls the health care budget, the way it contains costs is by decreasing reimbursements to providers.

Those are the facts. That's what happens. That's what's going to happen under Medicaid. We know, with the Independent Payment Advisory Board, that that's what's going to happen under Medicare.

I yield to the physician from Tennessee.

Mr. DESJARLAIS. Thank you for yielding.

I just want to expound on your comments and on, actually, what the gentlelady from Wyoming talked about in terms of the efficiency in her study, where they could actually buy a policy for those cheaper than what the Federal Government has implemented.

We were promised better access to care at a lower cost with the Affordable Care Act, and the TennCare program in Tennessee really was an experiment of nationalized health care confined to one State. What we found was that more and more physicians, as you stated, were dropping out of the TennCare program because of reimbursement issues and also because of the bureaucracy and the frustration with trying to find specialists.

I had a primary care practice, and I actually had to hire an extra staff member, which drove up my costs, to sit after hours to try to find specialists to take care of these patients. It was very frustrating for us. It was very frustrating for them. Yet the reimbursement, compared to a privately paid patient versus a Medicare patient versus a TennCare patient, continually was less money.

Mr. HARRIS. So what you're saying is that you had patients under TennCare who had insurance cards. You just couldn't find anyone to take care of them.

Mr. DESJARLAIS. Right, which is exactly what we're going to see under the President's plan. You're going to see people who allegedly now have access to care, but they really don't because the reimbursement rates are so low that physicians really aren't even able to keep their doors open. The reimbursement rate for a TennCare patient in Tennessee was almost half of that from a private patient. It's not that physicians don't want to help and take care of these people. They do. It's just financially unfeasible, especially in solo practices, which are common in rural areas.

Mr. HARRIS. You may or may not be aware of the study done early last year that showed that, actually, whether patients have private insurance or no insurance or Medicare or Medicaid, when you compare the outcomes, Medicaid patients have the worst outcomes. In fact, they are 93 percent more likely to die of their illnesses than patients with private insurance. They were more likely to die than even patients who had no insurance. I don't know. Is the gentleman aware of that finding?

Mr. DESJARLAIS. I have heard of that study as well. Again, I think it is an access to care issue, and that's certainly a problem that has not been addressed.

The ObamaCare law does nothing to address access to care, and it does nothing to address the cost of health care. Frankly, we all know that the cost of health care is driving our national debt, so we need to look at solutions that have been offered by the Republican caucus and the Doctors Caucus that will make real reforms to health care: that will make it more affordable and involve a greater attempt to get government out of the way. Just like in small businesses, the number one complaint is that government bureaucracy is driving down the profitability. It remains the same in health care as well, and we need to look at more free market options in health care if we're going to actually reduce costs.

□ 1940

Mr. HARRIS. I thank the gentleman.

I would love to bring the gentleman from Texas into the discussion, because women actually are specifically affected by the shortfalls in Medicaid because the reimbursement rates for women's health care is frequently so low that it's actually hard to find an obstetrician to take care of those patients. I know in Maryland this is a problem we had.

In the First Congressional District on the eastern shore of Maryland for a while, before we did Medicaid payment reform, women who were pregnant in that part of the State had to drive 3 hours to find an obstetrician to take care of them because the reimbursements were so low. And we know the Affordable Care Act does nothing for medical liability.

We also know, for instance, that we have a cesarean section rate that is 35 percent now, the result of medical liability. We have obstetricians who have left the practice later in their careers of obstetrics and gravitate toward just doing gynecology where they

join frequently large group practices. So we've left the practice of obstetrics to be an impersonal practice with people who generally don't have as much experience as those who have left the practice. And because of the lack of liability reform, we have a cesarean section rate that has roughly doubled over my career in dealing with obstetrics and obstetric anesthesiology.

I would like to hear the gentleman's comments on medical assistance and what it's doing for this country and for the women's health care in this Nation.

Mr. BURGESS. I thank the gentleman for yielding.

Of course the doctor from Maryland makes an excellent point about having an insurance card—in this case, a Medicare card—that it does not necessarily guarantee access to care. I would see it literally every month in my practice. Being an obstetrician, if I'm called by the emergency room doctor to attend to a patient who is pregnant, under EMTALA laws I have got 30 minutes to show up or I get fined $50,000, so I would always show up.

The difficulty is that, although she was pregnant, sometimes the problem that brought her to the emergency room was something unrelated to pregnancy, such as a heart murmur, tonsillitis, you name it. I may not be the best person to take care of that particular condition, but, just as the doctor from Tennessee pointed out, it was almost impossible to find someone in a specialty practice who would agree to see that patient. Oftentimes, you would find yourself admitting a patient who might otherwise not require admission but simply so that you could get them the specialist care that they needed. It's a very inefficient and very expensive way to go about getting that care.

Mr. HARRIS. If the gentleman would just yield for a very brief question.

Do you think that's the kind of health care that the women of America deserve?

Mr. BURGESS. Look, it doesn't have to be this way. That's what's so disappointing about every aspect of the Affordable Care Act.

I don't want to get too far into it, but we know now that this law was written by special interest groups, secret deals down closeted in the White House, Senate-constructed deals on Christmas Eve before a snowstorm to get out of town. This was constructed under the worst of possible circumstances. Should it be any surprise to us that the darn thing, regardless of how you feel about everything else, it's just not going to work? And yes, as the gentleman pointed out, the difficulties in obstetric care is just one aspect of that.

If I could, I would like to bring up the point that I was in the Supreme Court the day the oral argument was heard on the individual mandate. I heard the Solicitor General make his argument that the cost of health care is going up because we have people showing up in the emergency room without insurance and everybody needs to be compelled to buy insurance and, by golly, that will fix our problem.

Wait a minute. That ain't going to fix your problem because we know, in the State of Texas, only 31 percent of doctors will see a Medicaid patient. As a consequence, if you expand your numbers of Medicaid patients and you don't have the doctors there to see them, what are they to do? They've got this card in their hand, and they go to the emergency room to get the most expensive care.

I wanted to bring this up because in the Austin American-Statesman this weekend, Dr. Tom Suehs, the executive director of the State Department of Health—or the Executive Commissioner of the Texas Health and Human Services had an op-ed in the Austin American-Statesman. I just want to read the first two paragraphs of his piece:

> Do you know how much a Medicaid client pays for an emergency room visit? How about if the visit isn't an emergency? The answer to both questions is the same: nothing. Not one dime.
>
> The Texas Medicaid program paid $467 million for almost 2.5 million emergency visits in 2009, and half of those visits weren't even for emergencies. Yet Federal law makes it virtually impossible for States to charge even small copays to discourage unnecessary emergency room utilization by Medicaid clients.

I think Dr. Suehs has hit the nail on the head here. We have to provide the flexibility back to our States.

But it also belies the question: Who thought of taking a safety net program for blind and disabled nursing home residents, pregnant women, and children and then expanding that to cover 15 million more Americans? That wasn't the way to go about this. There were better ideas out there. For whatever reason, the Obama administration chose not to listen, not to solicit those ideas, and now we have the situation as it exists today.

With that, I thank the gentleman for yielding. I thank him for allowing me to participate in this hour. This is an important subject, one that is not going to go away, and we're going to be talking about it a lot for the next several months and the next several years.

Mr. HARRIS. I thank the gentleman from Texas.

Again, we have on the floor with us now two obstetricians and an obstetric anesthesiologist. If women are ready for childbirth, we're ready on the floor of the House tonight.

The gentleman makes a great point that in the end, having an insurance card doesn't guarantee access and having an insurance card doesn't guarantee affordable care. As we know, what the Affordable Care Act did is to again pretend that, really, economics don't exist, to pretend that the laws of mathematics don't count; that we can expand this program, as the gentleman pointed out, a program that was meant to be a safety net for the poor elderly, for women, for children, and we expanded it well beyond that to the point where, as we brought up earlier in the hour, if gone unchecked, it will bankrupt everything else in government.

The time has come, as the gentleman has pointed out, for us to reconsider whether that Affordable Care Act was the right approach.

We know that just today the Congressional Budget Office has rescored the President's Affordable Care Act and has said that, as a result of the Supreme Court decision—because one of the goals was to insure as many Americans as possible—that an additional 3 to 4 million individuals will not be insured as a result of the Supreme Court, because the States will make a rational decision that they can't afford to let their budgets go bankrupt through this Federal Government-mandated expansion that does nothing to control costs. It does nothing, really, to increase access, other than putting a card in someone's hand.

And as the graph shows, that card doesn't help all the people who are in these pink bars. They're the ones with the Medicaid card currently, and their chance of seeing a specialist is somewhere between 17 percent and 57 percent because the government payment is so low and because these programs are so expensive and never adequately budgeted for, just as in the case of the Affordable Care Act.

Now, we're joined this evening by my colleague from Georgia (Mr. GINGREY), who is also an obstetrician, who has spent years taking care of patients and understands what it will take to fix the health care system in the United States. I'm very interested to hear your perspective, Dr. GINGREY, on the topic we're discussing tonight, Medicaid and its expansion under the Affordable Care Act.

Mr. GINGREY of Georgia. Mr. Speaker, I thank the gentleman from Maryland, my physician colleague, for yielding.

I missed some of the hour. I regret that, and hopefully I'm not repeating some remarks that have already been made. Even if I am, I think it's important for people to understand that Medicaid expansion is threatening each and every one of our 50 States and the territories.

The provision in the Affordable Care Act, ObamaCare, that's titled, ''Maintenance of Effort''—actually, this maintenance of effort provision, Mr. Speaker, began even before the passage of ObamaCare. ObamaCare passed March 23, 2010, a little more than 2 years ago. It just extended this.

But what happened with the stimulus package back in 2008 is that States were told that they would not be allowed to purge their rolls of people that were, at that point in time, under Medicaid to see if, per chance, they were in this country illegally and not eligible or their income level had risen to the point that they were doing just fine, thank you, maybe making $50,000 a year and could afford their own

health insurance premiums not to be paid for by we, the taxpayer and the citizens of the State of Georgia, my great State. And then it was extended with the passage of ObamaCare to say that, through the year 2013, these States could not do that.

□ 1950

Well, what's happened is, I've got some statistics. And just to quote from the National Governors' Association report, ''States are facing a collective $175 billion budget shortfall through 2013'' in large part because of this maintenance of effort requirement under Medicaid, that they're not allowed to make sure that the people on the Medicaid program are the ones that need to be there, the most needy that can't afford—their children can't afford health care. And now these rolls are sort of set in stone until the year 2013. And in many cases, Mr. Speaker, they include childless adults, childless adults who maybe were eligible to get on the program at a point where their income was very low or maybe they were out of work. But now, shouldn't the Governors be allowed—at least on an annual basis, if not every 6 months—to look at those rolls and make sure that the dollars for health care are going to the folks that really need it and their children? That's what the Medicaid program was all about when it was started as an amendment to the Social Security Act back in 1965.

So I wanted to mention that. It may have already been talked about earlier. My colleagues in the Doctors Caucus of the House know of what they speak with regard to health care. There are a lot of other issues in Medicaid. But I thought, in particular, I would want to discuss that.

But in conclusion, on this point, if allowing a State to improve its enrollment and its verification system saves enough money to keep our children's education program intact and the safety of its citizens, with regard to police and fire protection, intact, then why wouldn't we support this change? Why wouldn't we repeal this maintenance of effort?

If giving Governors the ability to manage their own Medicaid programs prevents drastic cuts to education or job creation programs, why in the world would we not support that? The only reason I can think of would be to force, under ObamaCare, more and more people into the Medicaid program, where the States have to eventually do that FMAP and that sharing of the cost because, otherwise, they would be in the exchanges, and the subsidies, as we know, go up to 400 percent of the Federal poverty level. It's all part of this grand scheme to eventually have national health insurance, Medicare for all, if you will, and it's got to stop.

Mr. HARRIS. I thank my colleague, the obstetrician from Georgia, who points out that on the graph, as the gentleman from Louisiana showed before, Medicaid expenditures now exceed K–12 education. And as the other chart we've seen shows, we're over at the left-hand side. It will only get worse over time.

I yield to the obstetrician from Texas.

Mr. BURGESS. I thank the gentleman for yielding.

I wanted to make one point on this new Congressional Budget Office score that was provided today. And I know some people are looking at that and saying the cost for the program, for the Affordable Care Act over the next 10 years, was only scored I think at $1.16 trillion—if I can use the words ''only'' and ''trillion'' together in a sentence.

But what many people overlook is that the Congressional Budget Office must score under existing law. And one of the things that existing law does is it cuts physician reimbursement in Medicare by 35 percent on December 31 of this year. So add another $300 billion to $400 billion to that cost just for the so-called sustainable growth rate formula, which has not yet been repealed.

Now we will fix that before the end of the year for at least 1 more year. But the Congressional Budget Office has no way of scoring that. They must go with existing law.

And, of course, with the Independent Payment Advisory Board, the same thing applies. They have to think that those cuts that the Independent Payment Advisory Board is programmed to produce, that they are going to continue occur.

The other thing the Congressional Budget Office cannot easily estimate is the number of people who will be moved off employer-sponsored insurance onto the State exchanges or the Federal exchange. And that is a difficult number to know. The MacKenzie Corporation said it was going to be 30 percent. The Deloitte corporation has said 10 percent. We don't know what that number is. CBO is scoring that at a very low 1 to 2 percent because historically, that is the average of the erosion of employer-sponsored insurance.

Those points are important to remember in looking at these figures.

Mr. HARRIS. I thank my colleagues for their participation, and I yield back the balance of my time.

AMERICAN JOBS AND HEALTH CARE

The SPEAKER pro tempore. Under the Speaker's announced policy of January 5, 2011, the gentleman from California (Mr. GARAMENDI) is recognized for 60 minutes as the designee of the minority leader.

Mr. GARAMENDI. Mr. Speaker, thank you for the privilege. And thank you, to my colleagues in the Republican Doctors Caucus, for a most interesting but factually incorrect 45 minutes of debate here.

We really were going to spend this evening talking about jobs and about the American Jobs Act and one of the great ''woulda, coulda, shoulda's'' of our time. But we're going to hold that for just a few moments, though, because there are a few things that really need to be discussed from the last half-hour.

First of all, most of the discussion was about Medicaid. That's a national program in which the Federal Government pays about 50 percent—it varies State to State, but roughly 50 percent of the cost of providing medical services to the poor, women, and children in the States.

Now the debate was most interesting in that the argument was that there would be a lack of access and simultaneously an argument that there were no cost controls. Yet if you were listening to our esteemed colleagues, you would have heard them say, The doctors are not paid enough.

I think if they're not paid enough, and the doctors want to get paid more in order to provide services, then the costs are going to go up. So the cost control argument here doesn't make a whole lot of sense. If you want to keep the costs down, you need to improve the effectiveness and efficiency of the system.

Certainly certain services within the Medicaid and Medi-Cal, as we call it in California, are not paid sufficiently. Some other services are paid more than enough. So you need to balance that up over time. And all of these programs are run by the States. It's really the State that decides what the reimbursement rate is going to be. The Federal Government then matches the State's contribution.

So the argument really didn't make a whole lot of sense. And even more so, in the Ryan Republican budget, which has passed this House twice now, there is a significant reduction in the educational services for doctors so that the money that we, all Americans, spend to educate doctors—particularly in that part of the program, both the basic education and then in the residency programs—the Ryan Republican budget significantly reduces the amount of money available for residency programs for family care practices, for the very basic programs that we all want to access.

□ 2000

For family care, for basic care, that money is reduced. You go, wait a minute, that doesn't make any sense. If you are down here on the floor arguing that there is an insufficient number of doctors and they are not paid enough, then don't argue at the same time that it is too expensive and there are not enough cost controls; and please don't argue that there are not enough doctors because, in fact, the Affordable Care Act expanded the number of residencies for very basic care, for the family practice programs. I'm not quite sure I understand what they are arguing.

In addition to that, access across this Nation for millions and millions of people is provided in clinics. These are the