

that coveted final degree in 1994. The University of Southern California bestowed on her the title of doctor of education in educational planning, policy, and administration.

Dr. Inos immediately placed those three areas of expertise in the service of students and the educational system in her home. The newly minted doctor of education became commissioner of education responsible for all of the public schools in the Northern Marianas.

Her list of accomplishments in that position is considerable.

She established a data-driven assessment system of student achievement that anticipated the requirements of No Child Left Behind.

She implemented a standards-based curriculum and method of instruction, and set rigorous graduation requirements for students in the core curriculum areas.

She secured the funding to build new schools—Sinapalo Elementary, Dandan Elementary, Chacha Oceanview Junior High, Saipan Southern High and Kagman High—in response to a 30 percent growth in student population.

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She helped found two alternative education settings for Marianas students, the Advanced Development Institute at the three Saipan high schools and the Linala Malawasch Academy at Hopwood Junior High School. And she set the guidelines for the public school system that continue in use today: high student performance, safe and orderly schools, quality teachers, administrators and staff; and effective and efficient operation.

Dr. Rita Hocog Inos was an incredible source of good for the Northern Mariana Islands and for every student in our public schools, throughout her life and surely for many years to come. She left us too soon. But she left us so much, including one final gift, for in her final days, Dr. Inos had returned to her first love, preserving the indigenous language of the people of the Northern Mariana Islands. Even as her body failed her, her mind remained sharp, and her will unbending. I am told that she learned the revised Chamorro dictionary that was her final project was ready for publication the day before she died. And, I am told, then she was at peace.

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

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

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

(Ms. CHU 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 North Carolina (Mr. MCHENRY) is recognized for 5 minutes.

(Mr. MCHENRY 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 Wisconsin (Mr. KAGEN) is recognized for 5 minutes.

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

HEALTH CARE

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

Mr. AKIN. Madam Speaker, it's a treat to be able to join my colleagues today here on the floor of the U.S. Congress talking, once again, about a subject that has absorbed the attention and energies of Americans now for a number of months, the subject of American health care.

This is a big subject. It involves 18 percent of our entire gross domestic product. If you take a look at the hospitals, health care providers and doctors and all, you're looking at 18 percent of the U.S. economy. So from an economic point of view, it's a big deal. But we know it's a bigger deal than just that. We know it's a big deal because it's dealing with our personal bodies. It's a personal issue. And it's something that has to be done, and it has to be done the right way.

There are many different ways of looking at and talking about the subject of health care, and I'm going to be going through those. I anticipate being joined by some of my colleagues and friends here talking about this issue, but I thought I might start a little bit differently this week than I have in some past weeks on health care and read excerpts from a letter that I have received from a lady I have known for a good number of years. It turns out that she works in Europe, Eastern and Western Europe, has had a family over there for more than 10 years and has had access to the health care in a number of different Eastern and Western European countries.

So I thought I would share some of her comments as she hears about our debate here in the United States on the subject of health care and has shared some of her personal experiences from having lived there. She starts by saying, The first thing I note about the system of health care is that people who want really good health care travel to the U.S. if they can at all.

It's interesting, isn't it? People in Eastern Europe or Western Europe, if they want really good health care, they travel to the U.S. So regardless of what

we say may be broken about our system, certainly they prefer to do that if they can. In fact, some of the immigration to our Nation is based upon older people wanting better health care. And when you observe that with government-regulated health care, older people can get two free cancer treatments, and then they must consent to go home and prepare to die, you understand why the world envies our tradition of health care in America.

She continues: My family have had surgeries, transplants, various tests and medical maintenance checkups in facilities in a number of countries where medicine has long been regulated by the government. My first introduction to this was hearing a national friend express her joy, and others, by this statement: God has been so good to my mother. She got in a hospital where the staff mops the floors and changes the sheets. For an American used to even community health clinics that surpass some of the westernized, that is, these European specialized clinics, that I have seen in Europe, this was a shocking first revelation that government-run health care was not all that it had been cracked up to be.

Then she goes on and talks about some different people that might be getting health care. The first category she talks about is the elderly. She goes on: Later as I became a regular visitor in middle-class hospitals, I saw firsthand how very fortunate we are in America. I speak here of hospitals and clinics to speak of care for the elderly as almost too sad to describe, she says. But I can tell you that whereas once I was incensed by a low-budget nursing home my aunt was placed in—now she says in America she had an aunt that was placed in a low-budget nursing home. She was very upset about that kind of care in America. Now that I have ministered to elderly people lying in narrow beds in the back corner of dingy two-room apartments because nursing homes or assisted-living programs are beyond the hopes of the people who supposedly have free access to their nation's health care system, I think of my aunt and am grateful she had a comparatively luxurious environment. So much for the elderly.

Let's talk a little bit about children. As for the care of children in a government-regulated system, let me give one example. As a public school teacher in a capital city, I was not allowed to help the orphan girl who lived with me to get glasses, though she obviously needed them. According to the school nurse in charge of the health of the children in that school, she did not qualify. Unfortunately, I did not realize then that this was my cue as caregiver to offer the nurse financial incentive to write the recommendation to request an eye exam at the government clinic. In other words, here is a little girl in a school that can't see properly, and you have to bribe someone in order to get an eye exam. So much for government care for children.

Here's one for women. This is from her own personal example: No woman enjoys her gynecological annual check-up. I would ask American women to imagine a scene where in one of the best clinics you sit in a stark, icy cold room, naked from the waist up as folks walk in and out until you learn to bring your own cover-up when awaiting a mammogram. Imagine that one of the best clinics in your city cannot give you more sophisticated testing for a suspicious spot, and after seeking a clinic in a neighboring country, you end up in another stark clinic where attitudes and expectations are demeaning to any woman's dignity. Eventually, you are sent where for reliable testing? To America.

These are just some of the impressions of someone that in a number of countries has dealt with government-run health care systems. And they are not very pretty pictures.

That's what we're going to talk about once again, and that is, what happens when our government tries to do too much, when the government decides that we are going to take over 18 percent of the economy. Now, there are those who are going to tell you that what's being proposed by the Democrats is not a government takeover of health care. Well, it all depends on what version you're looking at. But in essence, most of the versions of the Democrat-proposed health care plans have the idea that the government is going to get into the business of bidding for government health insurance. And so if you have the government get into the business to start with, what happens is typically that the government tends, over time, to take the thing over.

We've seen the same thing in student loans. There were government-assisted student loans a number of years ago, but there were a lot of private people offering student loans. Now after a bill that was just passed, essentially the Federal Government, while it just had its toe in the door before, now it has 80 percent of all the student loans in America.

And so what happens if the government does too much? It goes beyond what it's effective at doing. Well, we have seen some of these kind of things—inefficient allocation of resources, bureaucratic rationing, degraded quality and excessive expense. This has led people to quip in the case of health care, "If you think health care is expensive now, just wait till it's free."

And so let's take a look at some of these areas and see this if there is real cause for concern. The first chart that I have here is an attempt to try to put on a flowchart the proposal that NANCY PELOSI has set forth in the House plan. And it's about a 1,000-page bill, so this chart, to try to reproduce 1,000 pages, what they're doing is all of these colored boxes are new agencies or some new structure which is going to start taking over this 18 percent of our econ-

omy. This is the House Democratic health plan. There are several others in the Senate. But this is the House picture. And what you see here, in a sense is, if you're a consumer, if you're ill, you're over here, you've got doctors on the other side and you've got to somehow get through this maze. I was thinking about creating a cartoon with all these little paths and you would find that, unfortunately for many people, there is no path through this morass of government bureaucracy.

Now there are some people who have a tremendous faith in Federal Government, have a lot of faith in government in general, and feel the government could run this process better. But when you think about it, it's your body. And if you're sick, do you really think the government is going to provide you with a level of care?

So the first thing here is there is a complexity. It's very hard for the government to reproduce our free enterprise system of health care. And so this gives you a picture as to what the Democratic bill would look like. Now what I would suggest to you is that if you take a look at American health care, there is a lot of talk about it being so bad. And yet foreigners, if you're sick, if you're a multimillionaire sheikh from Bahrain and you're sick, guess where you're going to go with your money to get your health taken care of? You're going to come to the good old U.S.A.

So in America, we realize that there are some problems in health care, but we also realize that we still have the best health care in the world. So the idea that we just have to have change, let's change it to make it like all these other countries, doesn't make a whole lot of sense.

What is broken about American health care? If you stand way, way back and look at it from a distance, what you see is that it's not so much the care that is being provided for people, although there is always ways you can improve that, what is more broken is the way we pay for it. That is the more complicated question. And the reason that's complicated is because about one-third of Americans don't pay anything for health care, and the other two-thirds have to pay for the one-third that aren't paying. So that's part of the nature of the problem.

But the question is, is the solution to that problem to have the government take it all over, either directly or de facto by getting into the business of selling health care until nobody else sells it except for the government? That's what this proposal would suggest.

Now there are other problems as we have seen. Excessive expense is one of the things you have to worry about when the government takes over something. Do we have any reason or basis for being concerned about an aggressive government takeover of the medical area? Well, take a look here at three of the large, large entitlement

programs created some many years ago. One you know is Social Security, which is not so much medical. But Medicare and Medicaid are. If you take a look at the projected growth, particularly in Medicare here over a period of time, you realize that the government is not doing a good job of controlling cost. It's almost impossible, in fact, for the government to try to control the cost. They've written the program, written all of this law, and the law just ticks away and people collect their benefits. It's called an entitlement program. These entitlement programs—these graphs are agreed-to numbers by liberals and conservatives alike—are showing that these programs are financially out of control. In fact, if you really want to take a look at understanding the real challenges to the American economy and the biggest challenges to the solvency of our government, certainly the major component parts are the tremendously ballooning increases of Medicare, Medicaid and Social Security.

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Now, this red line here is about what the historical average of tax revenues are. You think, well, shoot, if these things go up, we just raise taxes more and everything will be okay. But that doesn't necessarily work, because what happens when you raise taxes too high, you kill the economy. You may have a very high rate of taxes, but the amount of money that the government takes in is not very good.

That may seem strange to you, but if you really think about it, let's say you are king for a day and your job is to raise taxes by taxing a loaf of bread. And you think to yourself, well, I could charge a penny a loaf and make some tax revenue on that. Then you think, ha, maybe I could charge \$100 a loaf on bread. But maybe people wouldn't buy so much bread then. Somewhere between a penny and \$100 there is some optimum level of taxing where you are going to get the most tax revenues.

What we found historically, when the Federal Government runs its taxes too high, it just kills the economy and we end up not making too much money. So you can't fix this problem by constantly taxing people more and more.

So, with this experience, this would give us a lot of confidence to say we want the government running our health care. I would suggest now that that is an optimistic way of looking at things, if you want the government to do that.

This is a statement made by our President. "Most of this plan can be paid for by finding savings within the existing health care system, a system that is currently full of waste and abuse."

It is as though we had some government document in our ledger books that said "waste and abuse," and we can just subtract some money out of waste and abuse and we have all this extra money in here.

Well, where was it he was going to go to get all of this “waste and abuse”? Well, he was going to go to Medicare. And how much money was he going to take out of Medicare? Oh, at one time the estimate was \$500 billion being taken out of Medicare, particularly the Medicare Advantage program which is enjoyed by many seniors all over this country.

So here he says, “Most of this plan can be paid for by finding savings within the existing health care system.” What sort of savings? Taking it out of Medicare. That is one of the reasons why these health care proposals have been not too popular. The senior population enjoys Medicare Advantage and other parts of Medicare, and they are not so sure that this is the way to pay for socialized medicine.

Another statement by our President: “Here is what you need to know. First, I will not sign a plan that adds one dime to our deficits, either now or in the future. Period.”

Very emphatically. I am not going to add one dime to our deficit, says the President; yet, if we take a look at the last 6 months, we kind of wonder whether he is really very serious, or maybe whether he was joking. Because if you take a look the Wall Street bailout, \$250 billion we spent; economic stimulus, which was really an expansion of welfare and a lot of other programs, \$787 billion; SCHIP, another \$66 billion; another \$410 billion for appropriations in the IMF bailout here. When you get all done, we are looking at a spending of \$3.6 trillion, which we don't have.

In fact, by the time we got to about March or April of this year, we had spent all the money that was coming in in taxes. In other words, it would be like you and your family budget, and you are sitting there, you have one year you are supposed to make your budget over, and you get through the first 4 months and you have spent all the money for the year. That is what happened here federally with the trillions of dollars of debt and deficit that is being piled up under the Pelosi and Obama leadership.

We were told that George Bush spent too much money, and he did. That is why I voted against a bunch of his proposals even though I am a Republican. But he is a mere piker when it comes to spending. So when we say we are not going to add one dime for a health care plan that isn't paid for, this record that has been established over the last 9 months certainly is one that leads us to be just a little bit skeptical about that promise.

We have had some other promises from the President. Here is one: “If you are among the hundreds of millions of Americans who already have health insurance through your job, Medicare, Medicaid or the VA, nothing in this bill will require you or your employer to change the coverage or the doctor you have.”

Boy, I am sure glad to hear that. One thing, if I knew the Congress were

going to be having the government take over health care, if they told me I could kind of keep the program I have and the doctors that I am comfortable with, I would think that is a good promise. I really like that. But is it true? Is it true? Let's take a look at what other evidence there is to see if this is true or not.

This is an MIT health economist. “If you like it, you can keep it?” with a question mark. Is that really true? If you like your health insurance today, can you keep it?

Here is what Jonathan Gruber said. “With or without reform, that won't be true,” said Gruber. So he is basically saying the President is wrong, it is not true. His point is that the government is not going to force you to give up what you have, but that is not to say other circumstances won't make that happen.

So, what you have going on here is that by having the government involved in health care, what is going to happen is the government will continuously exert an influence. It will change the way that the private insurance companies write their health care, and you will not be able to continue with the care that you currently have. So this is another promise which is a bit misleading.

One of the things that is particularly important I think for most Americans in health care overall, and that is they want that doctor-patient relationship protected. When you go to see your doctor, most of the people who practice medicine do so because they like to heal people, they like to help people, and they will take time with you. They will try and diagnose what is wrong with you, and they are going to say, you know what I think you should do, you ought to do this, this and this.

They are going to make a recommendation. You may or may not choose to take their advice. You may get a second or third opinion if it is something that is very serious, but you are going to check it out. Then, when you and the doctor eventually come up with a plan as to what you are going to do if you have a problem, you don't really want somebody in an insurance company telling you, No, you can't do that. You want to be able to have the doctor-patient relationship to be intact and that you can proceed on that track. You certainly don't want somebody that works for an insurance company getting in the way.

But there is one thing worse than some big insurance company getting their nose in the relationship between you and your doctor, and it is much worse, and that is when a bureaucrat gets his nose in and says, Sorry, you are not qualified to get that care.

You see, there is nothing about the way the bureaucrat is going to figure out who is going to get care, because this is basically a law of supply and demand. It is a basic law like the law of physics, and that is, if you have an unlimited demand and a limited supply,

things aren't going to work. So you have everybody in the country wanting absolutely free health care and you have got a limited number of hospitals and doctors, something has got to give.

So what is the solution? Well, the government bureaucrats are going to get these big old calculators and they are going to figure out whether you are the right age to get this particular health care or not, or maybe use other parameters to determine do you get service or do you not. It is called bureaucratic rationing.

You know, the trouble with their calculators, those big old calculators, they don't know anything about health care. They are just counting dollars. So, if you are the wrong age, too bad. You get a bottle of aspirin and get to go home and just wait to die.

Anyway, one of the things that is very important to Americans is the idea that you and your doctor's decisions about health care should be protected and final. So this is something that never can happen here on the floor of the House, because people wouldn't want an embarrassing vote to happen here on the floor. But they do allow amendments in committees.

Here was an amendment that was offered by a good friend of mine, Dr. GINGREY from Georgia, an amendment in a committee. Here is what the amendment says: “Nothing in this section shall be construed to allow any Federal employee,” you can translate that bureaucrat, “or political appointee,” an appointed bureaucrat, “to dictate how a medical provider practices medicine.”

That is, we want to leave the doctor-patient relationship intact. That is what this is about. This is kind of a simple little amendment. You may think we pass thousand-page bills on the floor here that we haven't had read or printed. That is true. We don't like it. We have a bill to try to fix it. That does happen. This isn't any 1,000 pages.

This is a simple little sentence. You can read it off this chart. This amendment was offered in committee, and guess what? This amendment failed. People voted on it. Do you like this? Do you want to keep the doctor-patient relationship sacrosanct?

Here is the votes. The Republicans, 23 of them, voted for this amendment that Dr. GINGREY proposed. The Democrats, 32 of them, voted against it, and one voted for it. So it was almost a straight party-line vote, and this amendment failed. This amendment failed.

So if we start talking about some bureaucrat dictating whether you are going to get care or rationing of health care, don't be surprised. A lot of politicians say a lot of things. This here is a written sentence in English, and this here is an historic vote total. People can have opinions, but they don't have the right to their own set of facts. This is a fact. This is what happened in committee, and this should give you some concern if you don't want the government rationing your health care.

Here is another statement by our President: "There are also those who claim that our reform effort will insure illegal immigrants. This, too, is false. The reforms I am proposing would not apply to those who are here illegally."

Well, I am glad to know that the people who are paying for health care in America wouldn't be having to pay for people that aren't even American citizens. And that is what the President is assuring us of. We are not going to be paying for people who are here illegally.

Well, again, like a lot of these other statements, instead of just taking it at face value, you probably better take a look at the fine print to see if he is telling the truth, because the last couple of statements he made, I don't believe him at all. Do we have any reason to believe this statement? Let's take a look and see.

This is an amendment that was offered by Congressman HELLER, and it is going to clarify this question. This is an amendment that is going to go on to the Democrat health care bill. It was tried in committee. What he wanted to do was, Congressman HELLER, who is a Republican, he wanted to take Obama up right on this promise right here that he made that no illegal immigrants are going to be getting any of this government-paid-for health care; translated, that means you and I pay for it.

So, he says, well, fine. If that is what you mean, we are not going to have illegal immigrants getting health care, what I am going to do is write up a sentence here just to make that absolutely clear. Here is the sentence: In order to utilize the public health insurance option, an individual must have had his or her eligibility determined and approved under the Income and Eligibility Verification System, IEVS, and the Systemic Alien Verification for Entitlements, SAVE, program.

In other words, using other parts of our government law, you have to prove that you are here legally if you are going to get any of this health care provided courtesy of the U.S. Government, provided courtesy of the U.S. taxpayer.

So here is an amendment that just makes clear that what the President was saying is true. And how did this amendment go in terms of voting in committee? Well, here we have it again. The Republicans voted 100 percent; that is, 15 of them voted for this amendment. They said, yeah, we don't want illegal immigrants getting this socialized health care. And the Democrats voted 100 percent, that is 26 noes, and they don't want this in the bill.

Now, does that give you a sense of confidence that what the President said is really true? If we didn't want illegal immigrants to be getting this health insurance from the government, wouldn't the President say, hey, Democrats, vote for this amendment so we can make it clear to the public that we don't have any illegal immigrants getting this? No. Of course, this is voted.

So we hear one thing from the President, and yet, in fact, when we actually put an amendment up in committee, we find a straight party-line vote.

Some people say there is no difference between Republicans and Democrats. If you worked down here, my friends, you would know there is a very big difference. A very big difference indeed.

I am joined by a good friend of mine, Congressman HOEKSTRA, and you have joined us before as we have talked about health care, just kind of running through a whole series of different aspects of what is involved in this huge debate that is taking place. Apparently, at some period of time there is going to be a big vote on this subject. I don't know if we will get a copy of the bill or not, but there is going to be a big vote.

I would yield time to my good friend from Michigan to let us know what your thoughts are.

Mr. HOEKSTRA. I thank my colleague for yielding and talking about health care.

You know, we can go through all of the different issues that are out there on health care, what is going to be covered, what is not going to be covered, but I will tell you, the more that I look at this and the more that I study, the more that I am coming to the conclusion this is not about the quality. It is not about the quantity of health care in America today. This is becoming more and more about who is going to control your health care, my health care, my family's health care. It is about control. Because health care is 18 percent of the economy, and it is going to be about whether you and I are going to be in power to make those decisions, whether our families and others.

Someone called me after I did the Special Order last night and they said, you know, it is not you and I empowering people in the private sector. They already have the authority. They take a look at the Constitution. The Constitution gives them that authority to make these kinds of decisions for themselves.

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It empowers the States. It is the States that have the power to do it. The only thing that may happen here in Washington is we may take that authority and that opportunity away from them and say, I'm sorry, the choice of health plans that you may have, we're going to restrict that. We're going to restrict that. You're not going to be able to choose a health savings account. You're not going to be able to choose a high deductible account. Everyone's going to have to purchase from a narrow range of options of more Cadillac-type of plans that have all kinds of benefits into them, many that people don't want. So it's about control rather than quality and quantity of health care.

Mr. AKIN. So basically what you're really saying is one of the things that's

going to be lost, one of the big things that's going to be lost is the person who's sick having some say over the direction of which way they're going. I think this big blue button here, this is the nerve center. And if you want to be in the right place in health care, you want to be this health care—I don't know if this is a czar or not.

Mr. HOEKSTRA. If the gentleman will yield.

Mr. AKIN. I do yield.

Mr. HOEKSTRA. Yeah. We're not only taking the authority and the opportunity to control your health care when you're sick, but it's more important. It's like for our young kids, for our kids. What we're doing is for the young person who is saying, you know, I might want a high deductible plan because I want low premiums because I've got a dream of starting a new business and I need all the cash that I can to funnel into that start-up business because, you know what? I've got the belief and the dream that my business is going to be the next Apple computer, and I want to use all of my available resources after I've got, you know, after I've bought this health insurance plan because I do recognize that I want to be covered if I get a catastrophic illness or whatever. But I want to put that money into my business. They're not going to have that opportunity anymore.

Mr. AKIN. Just reclaiming my time. Gentleman, you're talking about a situation, you're 30 years old, bullet proof, but you say, yeah, it's possible. If I got the really bad part of the statistic, I could get something I couldn't afford to pay for so I'm going to get that catastrophic plan that fits me in my situation. I don't need OB-GYN coverage because I'm a guy, and so I don't need that part of the plan. I'm just going to get this catastrophic thing and take the rest of my money and I'm going to put it into my small business because I've got a dream.

Mr. HOEKSTRA. If the gentleman will yield.

Mr. AKIN. Go ahead.

Mr. HOEKSTRA. I think what we're taking a look at here—because what happens is we're shifting the authority from individuals to make those kinds of decisions, and we're moving it right into that chart that's next to you and saying, your health care decisions are now going to be made by the people in those charts, the people who fill those boxes. You don't know their names. You don't know their background. You don't know their values. All you know is that the health czar, I guess that blue box there—

Mr. AKIN. If you push this button, it'll make the whole thing go, I think.

Mr. HOEKSTRA. But you push that button 181 times I think in one of the bills here in the House, we've instructed the czar to, you shall, you will, you must and every time that health czar has the opportunity to make that kind of a call, that's a little bit more of an erosion of the power from you and me and our constituents.

The other thing is it's an erosion of power from our States. There's lot of States that are experimenting with how to fix health care, how to issue, address some of the concerns that are out there. And so they're experimenting and they're working, and now we're saying, Sorry, it'll be one size fits all. It'll be the size that comes out of Washington. Where in the Constitution, this right now, our colleague, you know him well, JOHN SHADEGG, and I wrote a series of op eds, one of which says we have a vision for health care which is about markets and it's about personal authority. That was the first thing.

The second op ed we wrote was one that said, here's what's wrong with the Baucus plan. Actually, the Investor Business Daily that ran that op ed, they put their own title on it. They called it, "Lies, earmarks and corruption all in one bill." If you read the op ed that Congressman SHADEGG and I wrote, I think the title aptly fits the content that we have in it.

Then the third op ed says, we've got a vision as to empowering individuals or not empowering. We have a vision of leaving the power and authority with individuals. We have identified what's wrong with the Baucus plan and H.R. 3200. The third op ed says and here are the specific things that we would do. Seven specific things.

Mr. AKIN. You're talking about freedom.

Mr. HOEKSTRA. Freedom. This is why we need the TEA Party movement, why we need the 10th Amendment groups that are out there that are fighting for State sovereignty and fighting for us to go back to the Constitution. That's why we need them to reenergize to bring the momentum back that we saw in August, to have them fight for freedom and to stop this massacre.

You know, people are now saying it's going to happen. The question is, how bad will it be? And whatever form it will be, it will be very, very bad because it's going to be an erosion of power and a shifting of power here.

Mr. AKIN. Gentleman, I don't accept that and I know you don't accept that, that we just roll over and say we're going to have this government takeover of everything. I don't accept that.

Mr. HOEKSTRA. We know government takeover doesn't work. It doesn't work in transportation. Michigan, in the 50 years that we've had a highway transportation bill, we've gotten 83 cents back on the dollar for 50 years. I call that legalized Washington corruption because other States have stolen that money from us. And as one of my constituents said the other day—my friend from California must be smiling, he must be getting some of that money in California. But you know—

Mr. AKIN. He's looking too happy over there.

Mr. HOEKSTRA. They're stealing from us. And one of my constituents said that they had just been—they

went through West Virginia. And they said, West Virginia has gorgeous roads and all we've got is potholes.

Mr. AKIN. Well, I think somebody's getting their fist in some of that Federal money. You know, you talk about free enterprise. One aspect is in free enterprise you can fail, and we even allow some of our States to fail. You talked about their examples, Massachusetts and Tennessee have been pioneers in this system. And what have we learned from them? It's like Thomas Edison making light bulbs. He made 100 light bulbs. The first hundred, none of them worked. Well, these light bulbs don't work either. They not only have mercury in them, you turn them on, they just cost you money and don't work.

Mr. HOEKSTRA. And this will be the first light bulb that we try, and we will impose it on all of America. As a matter of fact, we'll impose the taxes to pay for it really, really soon; and we won't be able to implement this for about 4 years. It's interesting. Of course, it won't be implemented until after the next election. Interesting point.

Mr. AKIN. We are joined by your good friend from California. I see he has a little something he wants to say. But, Congressman LUNGREN, I would just be delighted if you'd join our conversation here.

Mr. DANIEL E. LUNGREN of California. Well, I thank the gentleman. I was noticing as I looked at the chart that outlines the 53 different departments, agencies and new programs that are in this bill that there's at least one box missing. Can you tell me where the box for litigation reform is?

Mr. AKIN. Oh, litigation reform box. It's got to be here somewhere. Could it possibly be forgotten?

Mr. HOEKSTRA. It's not there.

Mr. DANIEL E. LUNGREN of California. Well, see this is the problem. I have had these town hall meetings, not just in August, I started back in June on the subject of health reform, and saw all the people coming out in my district not to organize, but coming out as individuals. And one of the first things they said to me, and actually, I did a little test later on when I held some of my town hall meetings, I didn't mention litigation reform and immediately people jumped on me and said why didn't you talk about litigation reform? Well, I happen to think, having experienced medical malpractice litigation while I was practicing law, mostly defending doctors and hospitals—

Mr. AKIN. You're admitting to being a lawyer here on the floor. I appreciate that.

Mr. DANIEL E. LUNGREN of California. But I was on the right side for most of those cases. And I listened to what the people at home said. And they were saying they thought that we were wasting a good deal of money adding to the total cost of health care because of frivolous lawsuits. And now that it's been borne out by study after study

after study talking about the billions, tens of billions, of dollars which we are wasting because we have frivolous lawsuits.

And there are ways of dealing with that, but I have noted that it is not in the bill that came out of Energy and Commerce. It is not in the bill that came out of Ways and Means. It is not in the bill that came out of the other committee here in the House. It is not in the bill that came out of the Senate Finance Committee. It is not in the bill that came out of the Health Committee on the Senate side. In other words, it's not in any of the bills that we're going to dealing with.

And that prompts this question: What happened to August? Did August actually occur? Did those town halls come together? Was that imaginary, or, like the President did in his speech to us, are we to forget about it or pretend it didn't occur? And if we can do that, can we forget about the possibility that litigation reform may be an essential part of bringing the overall cost down and produce better medicine because defensive medicine, that is, unnecessary tests will not be done.

And so, I again, ask the gentleman, are you aware of litigation reform being a part of any of the bills that have come through the committees in the House or the Senate or part of that display that you have before you?

Mr. AKIN. Well, gentleman, as a way of trying to answer that question, I do recall the President saying earlier, and repeatedly, that the Republicans don't have any ideas on this. And so this must be one of those ideas that's not an idea because that's why they didn't put it any of their plans. Of course most people that know anything about medical care know that some of the excessive costs are created by things that are done just for the purpose of attorneys.

Actually, I would like to defer your question to the good doctor from Georgia who's here, who has had 20 years or so in practice. Well, we've got two doctors actually. Just a second, now. Congresswoman FOXX, are you trying to escape on us here? We've got two doctors. I'm going to go to my most beautiful doctor who's here joining us this afternoon. Would you please share for a minute, and then I am going to go to you, Dr. BROWN.

Ms. FOXX. Well, I want to thank the gentleman from Missouri for the yeoman work that he has done on leading these Special Orders to explain to the American people what's wrong with these plans that are being presented by our colleagues across the aisle, and pointing out that Republicans do have alternatives to what is being presented here.

This morning, during 1-minutes, at least two of our colleagues got up and said, Republicans have no alternatives. And I think it's very important that we continue to point out that we are not just here to be critical of what has been proposed by the Democrats, but to

say, yes, we have alternatives. Our alternatives don't cost any money. We can do whatever needs to be done.

Mr. AKIN. Congresswoman FOXX, let's just hold right there for a second. What you just said is so very, very important. We've already mentioned one Republican alternative that is not in any single Democrat plan, which is tort reform, isn't it?

Ms. FOXX. That is correct.

Mr. AKIN. And so our good friend from California, who is an attorney who came in here and warned us about this, there's one. Okay, now why don't you name another one or two.

Ms. FOXX. Well, we have bills that talk about accessibility and portability. Portability, meaning we would all own our own health care insurance. If we lost our jobs, we take it with us. We want to give tax deductions to individuals.

Mr. AKIN. So that's usually called by the word "portability," isn't it? And that's something that Republicans largely support; is that your understanding?

Ms. FOXX. That's right. And the American people support that. We also support accessibility for people who have preexisting conditions. We support groups being able to band together and form larger groups to bring down the cost. So we support all those things the American people say they want.

Mr. AKIN. So, in other words, another proposal would be that if you got a bunch of small businesses, if they want to pool their employees and get a better deal on health care, they can create these health care pools. Now that's an idea. Do you know any Republicans that are opposed to that?

Ms. FOXX. I don't know any Republicans that are opposed to it; and, frankly, I don't know any Democrats who've signed on. But what we need to point out again is that what the Democrat plans do is to cut existing Medicare programs to come up with sham funds to put in their new program.

And with that I'm going to yield back, because the Rules Committee is currently meeting, and I'm going to have to go back there.

Mr. HOEKSTRA. If the gentleman would yield for a minute.

Mr. AKIN. Well, we appreciate very much your good work on the Rules Committee, and Congresswoman FOXX it's just a treat to have you. And I yield to my good friend, Congressman HOEKSTRA.

Mr. HOEKSTRA. I just want to build on what my colleague was talking about. You know, there's a very fundamental difference between how Republicans are approaching this problem and how Democrats are. Democrats have taken the approach that says we're going to create this massive new bureaucracy, 53 different organizations and panels and these types of things, and we are going to change health care for every single American. It is going to change.

Now, when I was in the private sector, I was a marketing guy, but I spent

a lot of time working with engineers. And at one of my first town hall meetings an engineer said, you know, Congressman, why don't you take the approach that we take in the engineering world and that you would have taken at your career at Herman Miller? Let's identify what's broken in the system and let's fix those pieces. And that's exactly what the Congresswoman was just talking about.

□ 1545

On my Web site, we've put up seven solutions for health care that address the issue of accessibility, they address the issue of cost, and tort reform. Seven specific bills that go after those three areas that almost everybody agrees are the things that need to be fixed in health care and can be implemented today—not in 4 years, not at a massive cost—and the effect upon those who have issues with the current system and the rest of the 85 percent of Americans, most of whom are pretty satisfied with the health care they've got, is, we leave them alone.

Mr. AKIN. In the State of Missouri we have the same sort of principle. It may be not quite as much defined by engineers, and we say, "If it ain't broke, don't fix it." And you've got a hundred million people with health care that they like pretty well, everything is chugging fine, and you want to destroy and throw the whole thing overboard because you may have at the most 10 or 12 or 15 million that aren't getting the care that you think they ought to get. That's one of those, "if it ain't broke, don't fix it."

And that really does raise a question. It almost seems that we're starting with the premise that we want the government to run all of health care and just looking for an excuse to try to do that.

We got a little bit off track.

The question was, are there really legitimate savings and costs through some reform in terms of tort reform?

We have a doctor here. He's practiced medicine 20-some years.

Dr. BROUN, what do you think about tort reform? Does it make sense? Do we have some savings there? And can we improve the quality of medicine in America by making some adjustments in that area?

Mr. BROUN of Georgia. Mr. AKIN, as you know, I've practiced medicine. I am a family doctor. I've done general practice for almost four decades.

The problem with defensive medicine, overutilization of testing and services in the health care industry is a huge part of the expenditure. Patients are actually demanding these things, and doctors are complying with that because of the possibility of a medical malpractice suit being filed against the doctors.

So something needs to change because we are overutilizing tests, we're overutilizing services.

In fact, I was talking to the administrator of one of my local hospitals in

my district recently. And the day I was talking to him, just that day the lady who runs the CAT scan unit at their hospital was asking for some more help at night, and he couldn't understand why she would need more help. And the lady said, Well, we've run 10 CAT scans through the night through the emergency room. He said, Well, how many of those were positive? Zero. How many were really indicative? If you look at the medical indication for those, it's zero.

So the overutilization of very expensive testing is rampant within the system. So you're exactly right. If we do something to stop the doctors from having to practice this medicine—

Mr. AKIN. Let me ask you a specific question, Doctor.

You picture yourself—and maybe you're the emergency room doctor that night or you're practicing medicine—and somebody comes to you and they say, I think I need this such test, and it's vaguely related to something that might have happened to them. You look at them and in your medical opinion, there isn't one chance in a thousand that they need that test. So if you deny them getting that test, then do you have some risk?

Mr. BROUN of Georgia. Absolutely. It is a tremendous risk.

Mr. AKIN. Even though it doesn't make any sense at all to do it?

Mr. BROUN of Georgia. Absolutely.

Mr. AKIN. You have a big liability because if you don't do the test, then what could happen?

Mr. BROUN of Georgia. Let me give you a good example of that exactly.

I've worked in emergency rooms many times throughout my career and sometimes was even a full-time emergency room director.

But if a patient comes in with a headache that they've never had before, comes in with a severe headache and—well, maybe, it's not even a severe headache. Maybe it's in the front part of their face and it's typical of a sinus infection. A doctor has a tremendous pressure on them to get a CAT scan or a CT of the head, or both, because if they don't and several years later that patient is found to have something such as a brain tumor, they could come back and sue the doctor for failing to diagnose, even though frequently in these cases the patient's history and the physical examination will not indicate any medical need, any medical indication of a brain tumor. But the doctor has to do that to prevent the suit.

Mr. AKIN. If you do order the test, what does that cost you?

Mr. BROUN of Georgia. It doesn't cost the doctor anything. It doesn't cost the patient anything either. It costs the whole system.

Mr. AKIN. So it runs the cost up on the system so the incentive for the doctors is, take the fallback, it's safe. I don't care. Let the cost go up. I'm not going to stick my neck out, right?

Mr. BROUN of Georgia. The patients will come and say, I'd like to have an

MRI on my head or a CAT scan on my head or belly or something, and their attitude is it doesn't cost them anything. It doesn't cost them anything. It costs the insurance company.

Just like a lot of people think the government can provide all of this free health care and the government just pays for it. Well, where does the money come from?

Mr. AKIN. It violates the law of supply and demand, doesn't it, Doctor?

Mr. BROUN of Georgia. Absolutely.

Mr. AKIN. My good friend from California would like to jump in here.

Mr. DANIEL E. LUNGREN of California. I was recently at a meeting with a number of doctors in my district at one of the local hospitals. And this one doctor said, Look, Congressman, I want to tell you about something that just happened. This fellow happens to be a plastic surgeon. They had sent somebody over for him to sew up this fellow's head. He had fallen down and split his head open. He had gone to an urgent care facility. And there they looked at him. They had him have either a CAT scan or MRI, I'm not sure which.

I said, What was the problem with that? He said, There was no medical indication of that.

He said what should have happened is—worried about a subdural hematoma, I believe—he said what should have happened is that you tell the patient the chance is one in a thousand you might have that. Here's the situation: If over the next 6 hours these sorts of things are evident, then you come back and at that point in time we do it.

He said they took it. Of course it showed nothing positive whatsoever before it came to him. Then he sewed the person up.

He said that expense to the system is one of those kinds of things that was exactly the defensive medicine that we ought to stop. He gets nothing out of that. That's paid into the system. I don't know if it's \$900 or something like that for one of these.

He said, I would have been doing my job as a doctor to sit down with the patient and tell him the chances are about one in a thousand that this might be the case, but here's what you can do to make sure that the indications are such that we would have to do it. That's just simple, commonsense medicine and a relationship between the doctor and patient, which is interfered with now because of the specter of the possibility of a lawsuit. It is that kind of real stuff, real occasions that adds tremendously to the cost of medicine.

Now, there's no medical malpractice lawsuit. There probably is never going to be one filed in that case. So some people say well, the cost you're talking about in terms of defensive medicine are not that large. Yes, they are if you talk with the doctors who actually do this.

Mr. BROUN of Georgia. Will the gentleman yield?

Mr. AKIN. Yes, I yield.

Mr. BROUN of Georgia. Let me add to your discussion about this one particular case.

The doctor is going to give them that counsel anyway with or without the CAT scan or MRI or whatever it was. The doctor—it's incumbent upon them to do so because the doctor, if they do ever develop trouble—and they may very well—a good physician is going to give that sort of counsel anyway. And if their level of consciousness starts going down, if the pupils become different sizes, if the headache lasts for longer than 24 hours, the vomiting lasts for 24 hours, these are the types of things that we tell patients anyway.

So doing this expensive radiological study is not medically indicated. The doctor is going to give that counsel anyway.

Mr. AKIN. We've got just about maybe 5 or 6 minutes to go.

We've been accused, as Republicans, as not having any ideas. You started by saying, Yeah, we sure do. You want to take a look at one thing, you can avoid getting into this kind of mess. If you're worried about the cost of medicine, you can deal with tort reform. That's one piece.

The lady who was here from the district before, Ms. Foxx, talked about the idea of treating pools of people, small businesses coming together and getting a better buy on their insurance. She talked about portability, so that when you leave one job, you can take your insurance along with you. All of these things are things that we talked about that we agreed to. And there are a couple of other things.

Mr. DANIEL E. LUNGREN of California. One very important one that we talked about is to allow people the opportunity for employers or individuals to purchase their policies across State lines. The reason for that is you will multiply tremendously the number of opportunities people have to make choices about what kind of policy would serve them or their employees better than any other.

Mr. AKIN. More choices equals freedom, doesn't it, gentlemen?

Mr. DANIEL E. LUNGREN of California. That's what I grew up hearing in this great country of ours.

Mr. AKIN. So if you have some insurance companies that may have a little bit of a monopoly in one part of a market and you allow people to buy insurance across State lines, you're breaking up monopolies, allowing prices to come down and giving people more choice, which is more freedom. Is that right?

Mr. DANIEL E. LUNGREN of California. That is correct, and those contracts—which that's what insurance policies are—would be enforced in the State in which the person lived. So we're not talking about the insurance companies getting a free ride; we're talking about giving much more choice—the essence of freedom—to the average citizen. That is another major

proposal that is contained in a number of different bills that have been introduced by Members on this side of the aisle.

Mr. AKIN. Do you know if that is included in any of the Democrat bills at all?

Mr. DANIEL E. LUNGREN of California. Not the major bills that have been introduced that we have been talking about.

Mr. AKIN. None.

So we don't have any malpractice reform. We don't allow the competition of—of course, they don't need to worry about that in their bill because their plan is, they're not going to have any private insurance companies in a period of time because the government is going to run it all.

Mr. BROUN of Georgia. Mr. AKIN, if you'd yield?

Mr. AKIN. I do yield.

Mr. BROUN of Georgia. The American people should look at what the real purpose behind H.R. 3200 is, and we can see what their real purpose is by going to people like the President, Barack Obama, and the leadership in this House. They have said that the public option is the way to go to a single-payer health care system administered by government bureaucrats. Socialized medicine. That's their stated purpose.

Mr. AKIN. That's the end goal.

Mr. BROUN of Georgia. That's their stated purpose. That's their end goal, and the public option is the way to get there. And it's going to cost jobs. It's going to cost millions of people their jobs because it's going to put a high tax on small business.

Mr. AKIN. Not to mention \$500 billion out of Medicare, taxing small business when we already have close to 10 percent unemployment.

Mr. BROUN of Georgia. Plus the seniors are not going to be able to get the care that they need because they put in there a cost-effectiveness research that was in the stimulus bill, and there's a cost-effectiveness decision panel that is created with this atrocity there that's going to make medical decisions according to patient's age.

And when they make the decision according to the patient's age, they're going to compare spending \$100 here or \$100 there, and they're going to spend \$100 on a 40-year-old and not an 80-year-old.

Mr. AKIN. Now you're getting off to preaching and getting on to meddling a little bit.

Mr. BROUN of Georgia. Well, it's factual.

Mr. AKIN. I just hit 62, and I was just reading that in Canada—I've got a bad hip—I wouldn't be able to get that hip replacement that Dan got because I am too old, I'm an old geezer now, and it's not worth it for a government bureaucrat to pay me to get my hip fixed.

Mr. BROUN of Georgia. Mr. AKIN, you're a young pup. I'm 63, but I've practiced medicine for almost four decades, and I already see the rationing

that Medicare and Medicaid puts into place today. And what the Democratic bills will do is going to ration care much, much, more. Seniors are not going to get the care that they need and deserve, and thus it's going to be detrimental to their health.

Mr. AKIN. So we've been talking a little bit bad about these Democrat proposals. This is something that Congressman LUNGREN's been hitting, and that is it reduces health choices. Freedom is about increasing health choices, not reducing them. It raises premiums as long as there's even going to be premiums, it delays and denies care, \$500 billion in Medicare cuts.

Mr. DANIEL E. LUNGREN of California. Would the gentleman yield?

Mr. AKIN. I do yield, yes.

Mr. DANIEL E. LUNGREN of California. On the \$500 billion. As part of that \$500 billion is at least \$133 billion taken out of Medicare advantage. I have 42,000 seniors in my district who are enrolled in Medicare Advantage. What is Medicare Advantage? It is the private option put into the Medicare system when the Republicans were in charge. There's a new idea that actually was implemented. It is tremendously successful across the country. Yes, they've got some imperfections that we need to work on, but their bill would destroy it.

There is no better evidence that they want to destroy private options than the fact that this bill destroys the only private option that currently exists in the Medicare system, Medicare Advantage.

Mr. AKIN. In our last minute or two, what I might do is share something personal because I came to this Congress 9 years ago, and they have a little medical clinic that's downstairs, and the medical clinic gives you—if you want to spend about \$400, you can get a test, you can get a physical.

□ 1600

I hadn't had a physical in years because I had some sort of State HMO policy. I never could see my primary care doctor. I don't even think he existed. I could never get an appointment.

So I go down there and find out I was bulletproof, as I thought, except for one detail. I had cancer. So when you use the "cancer" word around me, my ears pick up a little bit. I take a look at how does it work when these governments run and deal with cancer. Here's your survival rate for men in the United Kingdom, 44.8 percent. It jumps up here quite a number percent to 62.9 among men in the United States. And we want to go over and make ours like that? I don't think so.

I yield to my friend from Georgia, last minute.

Mr. BROUN of Georgia. Well, you are exactly right. The reason that the survival rates—these are 5-year survival rates for people with cancer. Women with breast cancer, you look at your chart, which is accurate. This comes

from independent data. Five-year survival rate for cancer. Actually, for breast cancer, it's over 90 percent, where in Great Britain it's much less than that. But all cancers for women on your chart is 66.3 percent for women, 5-year survival rate, and in the United Kingdom, 52.7 percent. Why is that? The reason it's that way is because they have delayed diagnosis because of the ration of care because of the constraints.

Mr. AKIN. So you have rationed care. Rationed care means you've got to wait longer in line. Waiting with cancer is not a good deal.

Mr. BROUN of Georgia. You don't get that evaluation, so you have delayed diagnosis. So people have late diagnosis, and then their treatment outcomes are not as good.

So, as a physician, I can tell you that ObamaCare is going to cause people to have to wait for all treatments, wait for the diagnosis, and they're going to have poor outcomes. So it's going to hurt everybody.

Mr. AKIN. And "poor outcomes," that's doctor's talk for you're going to die, isn't it?

Mr. BROUN of Georgia. Well, that's correct. There is going to be a greater percentage of people that are going to die because of it.

Mr. AKIN. Thank you, Madam Speaker.

HEALTH CARE

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

Mr. STUPAK. Madam Speaker, thank you for allowing me time to speak on the floor on health care.

I couldn't help but listen to the last group, my colleagues on the other side of the aisle, talking about health care and calling it all kinds of names, about everything but what it is.

The health care in America, the bill that we're marking up, H.R. 3200, is America's Healthy Choice Act. There is no such thing as "ObamaCare." I guess we use that just to try to scare people, like much of the rhetoric I heard in the few minutes I was here.

I can't help but notice that the folks who were speaking on the floor were not in the committee of jurisdiction where H.R. 3200, the House health care bill, actually went through; those of us who spent months working on this legislation and over 2 weeks in committee considering amendments and making sure that this is a bill that actually helps America and all Americans.

As we Democrats look at health care, we take a little different perspective. My colleagues in the last hour said, Well, if it ain't broke, don't fix it. Well, for the American people, health care is broken and it does need fixing. That is why we are bringing forth this legislation, H.R. 3200.

In fact, I have a picture here of a family from Colorado who actually came and testified—and I will talk more about them during this next 60 minutes—on their concerns. But these are the folks that we are trying to help: Average Americans who work hard, play by the rules, pay their bills, think they have good health insurance until someone gets sick, and then they are left financially ruined.

I sit as chairman of the Energy and Commerce Subcommittee on Oversight and Investigations. For the last 2 years, we've been taking a look at the private insurance industry. We have held hearings on the insurance industry's practices on nursing homes, long-term care insurance, Medicare Advantage that the group spoke of, and most recently, we've been looking at hearings on the private health insurance market.

The findings of these hearings really highlight the need to address the abusive practices, terms such as "rescission." That's when the insurance company takes a look at your insurance policy when you get sick and finds any excuse to rescind your policy. Or "purging." That's when the insurance companies for small businesses in particular, they jack up the price, because under Federal law, if you're a small business, they can't cancel you, so they jack up the price so bad that you can no longer afford it. It's called purging. Or the problem of uninsured, which millions of Americans are facing.

So in June, July, and August, we spent a lot of time looking at the most egregious practices found in the insurance industry: abuse of consumers, the practice of rescission in the individual insurance market, and, as I said, underinsurance.

Take a look at rescissions. Every night when Americans go to sleep—more than 45 million Americans do not have any health insurance—they do so with the nightmare scenario that if they develop a catastrophic illness or are unable to pay for their treatment, what happens to them? This fear causes many hardworking Americans who are not covered by an employer or government-sponsored health care to purchase an individual insurance policy. But those Americans fortunate enough to be able to even afford an individual policy—an individual family policy now is about \$13,000 a year. But if you're fortunate enough to be able to buy individual health care coverage, you're not immune from this nightmare scenario of health care, not having it there for you and facing financial ruin, and that's because of a little thing called rescission.

Let me tell you quickly about what happened to Otto Raddatz. Otto Raddatz was a 59-year-old gentleman from Illinois. He owned a restaurant. He had insurance all his life. He was diagnosed with an aggressive form of non-Hodgkin's lymphoma. That's a cancer of the immune system. He underwent intensive chemotherapy and