The Levin Group showed that by looking at the health care that we have in front of us, in all likelihood about 114 million Americans will be thrown off the current health insurance plan they have and onto the government system, which means about 114 million Americans won't have the health care that the President said we would all be entitled to keep. And we remember what the President said, he said, If you like your current health care plan, no problem, you can keep it.

The only problem is, that's just not so. If you take 114 million Americans, throw them off the health care they already like, well, then they're stuck being in the government's plan. That means fewer choices. And that means the women of America don't get to make the choices anymore, it's government.

I think the thing that all American women really get out of this is that there is going to be an enormous hassle factor. There is a big hassle cost that's in all of this. That's what we women deal with, we deal with hassles—hassles with our jobs, hassles with the kids, hassles with trying to make the books balance, and now the biggest hassle of all, life and death decisions because if government literally controls the health care decisions from cradle to grave—because it would be every single American—that means the hassle cost goes way up. That's kind of the last thing we women need right now.

Women are tired, we're burdened, we have so many things on our plate. And I think especially women who are senior citizens, because they're watching this debate, and they get that $500 billion is going to be cut out of Medicare. That's what we know—cut out, gone. So what that means is scarcity, and that means less. So we are all going to be paying a lot more, but we are all going to be getting a lot less. The simple fact is we can do so much better.

The Republican women here know that there are many positive solutions that we can do. We can really do a lot better. I will be real brief, and I will end with one positive solution we could take.

I am a former tax lawyer. Rather than government owning your health care and making all the decisions, or rather than your employer making the health care decisions for you, we change the tax code so that you, every American, gets to make your own health care decision. You own it, you make the decision, it's a wonderful thing. So you own it, you make the health care decision, and you get to take your own money, tax free, purchase the health care plan of your choice—you're not limited to what government says you buy, you buy any plan anywhere. Anything that we don't cover out of your own tax-free money you get to fully deduct on your income tax return. Have true lawsuit reform that costs billions of dollars. In fact, that covers 95 percent of Americans. For the 5 percent who truly, through no fault of their own, can't afford health insurance, we can take care of them and we will take care of them, but we won't break the bank to do it.

We have great solutions. Let's try that rather than burdening the American people, and especially women who don't need those burdens. And I yield back to the very kind gentlelady who's doing an outstanding job tonight, Mrs. BLACKBURN of Tennessee.

Mrs. BLACKBURN. I thank the gentlelady from Minnesota for her good work on this issue and for being here with us tonight as we have brought forward the alternatives that are there, the good, solid, positive, free-market-oriented alternatives that are there from our conference and from the women in our conference. I thank everyone for joining us, and I yield back the balance of my time.

HEALTH CARE REFORM

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

Mr. ROE of Tennessee. Madam Speaker, we are here tonight to continue the discussion of health care.

Before I get started, I am a freshman here in Congress, and I am going to tell you a little about myself and why I'm here to discuss this.

I grew up in the rural south in a small, rural community. My father was a factory worker. I went to college, I went to medical school in Memphis, Tennessee, at the University of Tennessee—the real UT, I might add, for my Texas friends—and I spent 2 years in the military. I trained in an inner-city hospital, an urban hospital. I spent time in an infantry division in a medical battalion in Korea near the DMZ. I served in a military hospital, in a VA hospital. I practiced in Johnson City, Tennessee, an area in Appalachia in northeast Tennessee, and taught medical school with residents and interns. I really have had a varied experience, 31 years in private practice. My specialty was obstetrics and gynecology, where I delivered almost 5,000 babies. So I bring a rather unique experience to the House floor, and I am very privileged to be part of this debate.

I think before, as a physician, what I would try to do in any case that I saw was try to identify the problem. In America, we are trying to identify a problem with health care. And certainly, I think we have heard it on both sides of the aisle that we do need health care reform. I think the main reasons for that are two: One is costs—health care costs are escalating beyond the average person's ability to pay for the care—and access to adequate care for all of our citizens.

In this country, about 170 million of our citizens are covered by their job. Their health insurance is provided by their job. And this started where your employer provided health insurance after World War II as an incentive to get workers to come work for a particular company. And it has, of course, grown since that time, and I think it has been a good thing for most people. We have been able to provide a level of care in this country that has been unequaled anywhere in the world.

What I have been able to see since 1970, when I graduated from medical school, were advances that I didn't even dream of. The one advance that we haven't seen come to fruition that I thought would is the cure for cancer. We haven't done that, but we have made tremendous strides in cancer and heart disease, diabetes, and so on.

So we have a cost issue, and we have an access issue. We have approximately 47 million of our citizens in this country that are not covered currently by health insurance. Who are they? Well, the Census Bureau believes that approximately 10 million of these folks are illegally in the country. We also believe that probably 9 million or so have incomes above $75,000 a year and choose not to buy health insurance—their own choice. About 8 million people make between $50,000 and $75,000, and they may be families where this does stretch them, where they're a small business, and health insurance premiums—again, the cost factor has gotten so expensive that these folks can't afford it. So we really are looking at about 20 million people in this country who are working poor who don't have access to care.

How are we providing the care in this country now? Well, we're using private health insurance. Many people use their own employer, a small business, their health savings account. There are variations that people use to buy their health insurance.

We have the government now which provides about 46 cents of every dollar spent on health care with Medicare and Medicaid and the VA. So we have government taxpayers approaching 50 percent of the care, and then we have the rest, the 15 percent, who don't have coverage at this time.

So how do we go about keeping the cost down, quality high, and the access? We are joined here this evening—and I am going to stop, having framed the debate—with my good friend from Louisiana, Dr. JOHN FLEMING. And JOHN, I am going to turn this over to you to sort of continue this thought that I put forward.

Mr. FLEMING. I thank the gentleman, my colleague and good friend, Dr. ROE from the great State of Tennessee. I have visited there many times, the Smoky Mountains. Also, speaking of smoky, everything there is smoked, and it smells so delicious you want to eat bark off trees when you go through Tennessee. So it's a lovely State, and I always enjoy visiting it.

Like you, I grew up in a very middle class, working middle class environment. I had to work my way through

college. My mother became disabled when I was five, and then my father died just as I graduated from high school. I suddenly had the burden of helping out with the family, but also working my way through college and then ultimately medical school, which, with the help of the U.S. Navy, I was able to do that. I served 6 honorable years—some of the best years of my life, and my wife—in the Navy practicing medicine in such duty stations as Guam; Charleston, South Carolina; Oceanside, California; Camp Pendleton Marine Base.

It was, indeed, an honor to serve my country in that capacity as a physician. And then of course I've been in private practice since 1982, family medicine. I still see patients, I still provide care. I'm still dealing even day-to-day with some of the issues that all of us as physicians deal with.

Like you, in your many years of practice, I have carried a burden about what a wonderful contrast we have here. We have tremendous quality of care and delivery of care and the best of care and the best of technology, but yet some people do have access problems. There is no question about it; that needs to be solved.

I ran on a reform campaign, health care reform. I wanted reform, I came here to reform, but you know what I found when I got here is really anything but reform. What I'm seeing is a Congress that has taken a sudden left turn towards socialism to dismantle what is the best health care system in the world and remake it into the same image as Cuba, North Korea, Soviet Union, the U.K., Canada. Even some of the States like your own, Tennessee, who have experimented with socialized medicine and government takeover of medicine, have failed. I have actually asked, I have been to venues and asked, please, show me one example where government-run health care has ever been successful, and I have yet to find one single example of that.

So, like you, I am very interested in health care reform that is true reform, that is common sense, that makes the cost go down—bend the cost curve down, that's the common theme today. And there are so many ways that I'm sure we will get into as we go forward that we can do that. And I thank the gentleman for recognizing me.

Mr. ROE of Tennessee. We have also been joined this evening by our colleague from Wyoming, CYNTHIA LUMMIS. We appreciate you being here, and I would like to now yield time to you.

Mrs. LUMMIS. Well, I thank the gentleman from Tennessee, who has tremendous experience with government-run health care in the State of Tennessee. And after he saw the 1,990-page bill that we received last week and saw how much government intervention is involved through that bill, how many unfunded mandates are being passed onto the States, how many government bureaucracies are created, how many times the word ''shall'' appears in that bill, this is truly transformational.

Some of the Members of our caucus have said that this is the most significant debate that they have ever been involved in. So for those of us who are freshmen and did come here to reduce the size of State government, or to reduce spending, or to, as the gentleman from Louisiana said, reform health care, we are seeing things that we hoped would not be a consequence, and that being more government intervention, more spending, more involvement in our lives.

And so we are here to protect people from more government intervention and to protect the relationships that you have with your doctor, with your local community hospital, with your health care provider so you all can make decisions regarding your own lives and your own quality of treatment and the efforts that you will make to enjoy the type of health care and quality of life that you hope to have in your communities. And that is reflected in this recent survey of women. Sixty-four percent of American women would rather have private health insurance than a government-run health insurance plan. Sixty-six percent describe their health insurance as excellent or good. Seventy-four percent describe their health care as excellent or good. Seventy-five percent want few to no changes made in their own health care.

We all know that there needs to be some reform. The cost is too high, and in some areas access is limited. And certainly with regard to Medicare, in rural areas hospitals and doctors are not reimbursed for the full cost of providing the services they provide. In my home State of Wyoming, in fact, the hospital in Casper, Wyoming, has said they are only reimbursed for about one-third of the actual cost of providing care to a Medicare patient.

□ 2100

Now, some doctors who are reimbursed at these very low levels have decided not to take Medicare patients anymore. So, when things like that happen, we really are denying access to care by having a government-run program.

Not only that—and this is one of my greatest concerns—it's what we are giving up by taking on a government-run program. Let's compare ourselves to countries that have government-run programs. Let's look specifically at cancer.

For men in the U.S., survival rates exceed 60 percent and also for women. In fact, two-thirds of women will survive. Spain, Italy, and the United Kingdom are all significantly below the United States in terms of survival rates. One of the reasons for that is, when diagnosis occurs in the United States, treatment follows much more quickly than in some of these countries. So, if you are rationing care, that is a consequence. You don't have the same survival rates that we do in the United States.

Take, for example, my own sister-in-law. She was diagnosed with a very aggressive form of breast cancer on her annual mammogram. She had no symptoms. She had none of the usual markers or factors which would indicate she had a risk of an aggressive breast cancer. Yet she was diagnosed based on her annual mammogram. She was in surgery in the same month that she was diagnosed, and she then began a regimen of both radiation and chemotherapy. Shortly thereafter, it saved her life.

So she falls into that category of two-thirds of American women who are surviving cancer. In fact, with breast cancer, it's a very significant number—the difference between survivability in the United States versus survivability in European countries—and that's because health care is rationed. This is a quote by the chief justice on the Canadian Supreme Court: access to a waiting list is not access to health care.

In this bill, we have to have assurance that we're not going to be on a waiting list. Quite frankly, we don't have that at all. In fact, based on what I've read in this 1,990-page bill and based on what I've been told by my colleague, the gentleman from Tennessee who is leading this discussion tonight, in fact, we will have rationing. The cost will be tremendous, and the taxes that will be imposed on so many of us as a result will be exorbitant.

So it sounds to me like health care reform, in the style of the bill that was introduced last week, includes higher taxes, penalties, less choice, more government, more costs to States, more costs to individuals, more costs to small business, and no guarantee of an improvement in access, in quality or in the ability to craft a plan of treatment between you and your physician or to seek a second or third opinion in the event you feel it's necessary for you, for your family, for your parents or for your children.

This is not health care reform as was envisioned by my colleagues who are here tonight, the gentleman from Louisiana and the gentleman from Tennessee.

Thank you kindly for allowing me to join you.

I yield back.

Mr. ROE of Tennessee. Thank you, the gentlewoman from Wyoming. Excellent comments.

Health care decisions should always be made between patients, their families and their physicians, not the insurance companies and not the Federal Government. I believe that, and I have used that in my practice for many years. It's one of the reasons I was a very successful practitioner. I knew who I worked for—my patients—and I looked after their benefit.

Now, one of the things I want you to think about in this bill—and this is the bill here. It's H.R. 3962. They've changed the number because H.R. 3200

has become so tainted now. It's two parts. As the gentlewoman pointed out, it's 1,990-pages long. I've only been through the first 1,000 or so pages, and it's going to take me a few more wakeful nights to go through it, but I will. In the Senate's Baucus plan, for instance, it's an alleged 1,500-page bill. It gets you to 91 percent coverage.

You can do two things on one page and get to 91 percent coverage, which is to allow young people who have graduated from high school or from college and who are not yet covered by insurance plans at their work or who can't afford it to stay on their parents' plans until they're 26 years old. You can cover 7 million young people by doing that.

Number two, you can sign up the people who are currently eligible for government programs, which would be SCHIP and Medicaid, and you would then be at 91 percent without all the other bureaucratic morass that this bill goes through.

I want to make this point tonight: this bill right here is almost incomprehensible when you read it, because, when you do read it, you have to refer to the IRS code, to HHS, to Medicare, and so on. It's just almost incomprehensible. So I'm going to go over about four or five things which, I think, could be done very simply—and I want the gentleman from Louisiana to step in—which will allow those health care decisions to be made by families.

Number one, one of the big arguments we hear today, or issues which we deal with, is preexisting conditions, and they're real. I've dealt with patients who've had breast cancer who then, as individuals, could not be insured. Well, in the group market, in large groups, that's not a problem because you just accept those increased risks and spread those risks among large groups of people.

When I was mayor of the city of Johnson City, we had 1,500 people, plus their families, with plans—teachers and employees of the city—and we were able to spread risk and to buy reinsurance for high-risk patients, but an individual has a real problem. I, as an individual, going in with a problem am not insurable.

Well, how do you do that, how do you make that same group market available for an individual that you have for large businesses?

Well, you eliminate State lines. You take the State lines out, and you allow association health plans to be formed, and then the individual market becomes a very large group market. Costs go down, and the preexisting condition problem goes away.

Number two, I think that a person shouldn't be bankrupted if a person gets ill. I think, if you become ill through no fault of your own, you shouldn't go into bankruptcy. I think that's a fairly simple thing.

What are you going to do for low-income people who can't afford these things? Well, you can have subsidies or tax credits so that people in this income bracket can also join health plans and can share their risks.

I've never understood why the government treats our patients on Medicaid differently than they do from Medicare patients. They're not treated as well, I don't think, because of the payment differences, but they shouldn't be. They should be allowed to take those dollars as a credit that are spent on Medicaid, and they should be allowed to go into an association health plan and also spread those risks. So those are a few little things.

Lastly—and I think it's barely mentioned in this 2,000-page bill—we talked at the beginning of this hour about costs and about how we control costs. You will never ever control the costs of health care unless you begin to do something with tort reform, or with malpractice reform, because, as a physician, if I don't order a test—if I have a patient come to the emergency room and if I don't get a CT scan and if something by chance happens to that patient, then I'm going to be liable for that problem. If I order the test and if there is nothing wrong, there is no penalty to me. So we have to change that. Let me just explain a couple of things that helped me understand this.

We have a terrible tort system in this country. The reason it's terrible is we have no way to compensate injured people. When someone does have an injury due to malpractice, we have no way to compensate him.

In 1975 in the State of Tennessee, we started a malpractice company called the State Volunteer Mutual Insurance Company. Since the inception of that company, over half the premium dollars have gone to attorneys. Now, these are defense attorneys and plaintiff attorneys, but less than 40 cents on the dollar have actually gone to injured people. All the thousands and hundreds of thousands of dollars I have paid in over these years have not gone to compensate injured people. So that's something which, I think, is not in this bill. Until you address that, you're never going to address the ever-escalating costs.

What do you think about it, JOHN?

Mr. FLEMING. Well, I quite agree, with you, Dr. ROE.

I would like at this moment—and I think it would be a fitting time for this—to quote an excerpt from The Wall Street Journal, today's edition, where there's an editorial, probably the best editorial I've ever read.

For those of you who are watching tonight, I would strongly recommend that you read a copy of, again, today's Wall Street Journal editorial. I'm going to read just an excerpt. Here is what it says. Again, these are financial experts who are writing this. This is probably the widest read newspaper in the country, period, even more than USA Today, and they're certainly the most intelligent and best-trained financial people.

It says: Speaker PELOSI has reportedly told fellow Democrats that she is prepared to lose seats in 2010 if that's what it takes to pass it.

This is obviously suggesting that there are a lot of people out there who don't like this, and she's bound and determined to have this as her legacy.

ObamaCare, as it says—I call it PelosiCare—and little wonder. The health bill she unwrapped last Thursday, which President Obama hailed as a critical milestone, may well be the worst piece of post-New Deal legislation ever introduced. In a rational political world, this 1,990-page runaway train would have been derailed months ago.

That's quite true. Not one single Republican at any point has supported this bill, and many Democrats have not supported it.

With spending and debt already at record peacetime levels, the bill creates a new and probably unrepealable middle class entitlement that is designed to expand over time.

Again, I emphasize ''unrepealable.'' Once this thing gets into law, like so many things, there is no way we can get rid of it. It will be with us forever.

Taxes will need to rise precipitously. Even as ObamaCare so dramatically expands the government control of health care, eventually all medicine will be rationed via politics.

So I think that's very critical. First of all, it's one party—and one party only—that wants to force this. Really, it's even less than that. Just the leadership of one party wants to force this takeover of one-sixth of the American economy forever and wants to put it under government control forever, controlling your life from day to day. For what gain? Dr. ROE just pointed out that we could easily cover the same number of additional people with much less cost and with much less effort.

What it does is it leads to rationing. It leads to long lines. I think, certainly, what has been said about justice is true about health care: health care delayed is health care denied.

Mr. ROE of Tennessee. Will the gentleman yield for a moment?

Mr. FLEMING. Yes, I would be happy to.

Mr. ROE of Tennessee. I just want to give a brief example.

I was home this past week, and I spoke to one of my partners, Dr. Lewis. Dr. Lewis had a patient who had a fertility problem, which he helped her with. She was able to become pregnant, but miscarried. She lost her baby. Her husband worked for the State Department and was sent to England. Apparently, when the American employees are sent to England, they get private insurance. Well, she wanted to move on with her fertility evaluation, so she first had to go through the public system before she could access the private system in England. She went there and she didn't see the doctor. She saw a nurse.

The nurse said, Well, you need to see the doctor for your fertility problem. That will be a year.

She was going to have to wait a year to see the fertility doctor. Well, she had a visit planned back home in a few weeks; and while she was home, she called her doctor, Dr. Lewis, who got her into the office in 1 week. He got her back on her treatment, and she is now back in England. Hopefully, it will be successful.

Those are the kinds of delays that you're going to see. This is just one example. I could spend the rest of the night giving these examples.

Dr. Fleming, I want to get into the cost because that's something that isn't talked about in this CBO report. Now, the CBO report we got said this is going to be deficit-neutral. Well, I want to go back through history a little bit. Let's look at the history of Medicare, of Medicaid, of the TennCare, and of the Massachusetts plan. I'll just briefly and quickly go through them.

In 1965, when Medicare was passed, it was passed as a plan that was going to be about a $3 billion to $4 billion plan. The CBO estimate was that, in 25 years, by 1990, this would be a $15 billion plan. Fast forward to 1990. This was a $90 billion plan. They missed it just a tad there. Today, it's over a $400 billion plan. It's about $428 billion.

The Medicaid program has gone up 37 times since its inception.

The Massachusetts plan had a noble goal, which was to try to cover as many of its citizens as possible. That's absolutely what we should try to do in an affordable way. In Massachusetts now, they're at around 97 percent coverage.

□ 2115

Government spending on health care is up 70 percent since 2006. Between then and 2009, that's just 36 short months. In TennCare—and we will go into that a little bit more. The reason it's important to go into TennCare and what's happening in Massachusetts is because that's basically what the basis of a lot of this plan is that we are debating tonight.

TennCare, which started in 1993 with a $2.6 billion Medicaid plan, by 2004, just 10 years later, 11 years later, it was at 7.5 billion and would go to 8.5 billion in 11 years, which almost bankrupted our State. Today our State is in such dire financial—and this is with the stimulus money that came in—that we can no longer add any further children to the State Children's Health Insurance Plan.

I got a letter from Governor Phil Bredesen, who is a Democrat, who is a health care expert, I might add, and has done a very fine job in Tennessee managing this along with the Republican legislature. They have worked together to try to control these costs. What the Governor said is that in the next 5 years this will add $735 million, which we do not have. If certain other stipulations are placed on this plan, it could be in the billions of dollars. We have seen every single government plan that's out there that didn't meet these cost expectations, and this one won't either.

For our seniors, I know they get it, but I want you to listen, and you can do the math. This plan, according to CBO, is going to be financed by taking $400 to $500 billion out of an underfunded Medicare plan that's going broke by 2017. That's the last number that I saw. That it would be upside down, more money going out than coming in.

We are going to take $400 to $500 billion out of that plan. We are then going to add between 3 and 3.5 million seniors, our baby boomers that are hitting Medicare age, beginning in 2011. That will be between 30 and 35 million new recipients in the next 10 years.

Then in 2 years, in 2011, we are going to cut provider pay by as much as 25 percent. We are going to now add 30 to 35 million more people. We are going to cut $400 to $500 billion and cut our providers. Let me tell what you that adds up to. They get it. I was home this weekend and spoke to many. Our seniors are genuinely worried.

They know, number one, when you do that, you are going to cut access, because when you cut that much money out, you are going to have a very difficult time getting to your doctor. If you can't get to your provider, you are going to cut quality. Number three, to get there, you are finally going to increase your own costs because you are going to have to pay more for the care you are getting; without a doubt, you are.

We have seen it in our State, as I said. We will go into it in more detail, but, Dr. FLEMING, I would like to hear your comments about financing this.

Mr. FLEMING. One thing that I think can be said about this bill that's pretty obvious, and that is by virtue of a lot that you have said tonight, Dr. ROE, is that everyone will see costs go up. There is individual mandates, so even individuals who don't sign up for insurance will pay 2.5 percent taxes, which they don't have to pay. That's middle class, even lower socioeconomic class taxation.

There will be taxation on health savings accounts that does not exist today. Taxpayers will see their taxes increase. An employer will see their net tax go from 35 percent marginal rate today to 39 when the Bush tax cuts expire. Then another 5 percent above that, they will get to marginal rates of 45 percent, which most of those higher-income individuals in that range are small business owners, which means that they will have to reduce other benefits or reduce pay or reduce number of employees. That's all there flat is to it. There are only so many places you can cut.

Mr. ROE of Tennessee. Have you had any of your constituent businesspeople come to you and say, if this plan passes as they understand it, they are out? Their business is closed? I have.

Mr. FLEMING. I have. I have had a number of them say that. They have done the math. They cannot figure out where they are going to get the extra 5, 10, 15 percent. I mean, most businesses today operate on a margin of around 5 percent of gross income. Well, when you add overhead of another 15 percent, that means you are upside down by 10 percent. The bottom line is that everybody, not just the high-income people, everybody is going to be paying more in either taxes or premiums or both. Everybody is going to be getting less access to care. Yes, less access to care.

Again, just quickly going back to Canada, remember in Canada, care is free for everybody. It's universal, 100 percent. Well, only one out of six people have a family doctor in Canada. They actually have a lottery system. Yes, it's 100 percent universal. Unfortunately, you can't get in the system. They close hospitals down.

Even Cuba claims to have universal health care and medicine is free. The only problem is they've got no medicine. So what good is free when it isn't available? That is the direction that we are taking here if we go off this way.

Just to kind of summarize my comments on this, that is that every health care model in the world looks at two possibilities, two options to save money. One is to bring it down to the unit between the doctor and the patient and give them both a stake in what the total cost is, not necessarily pay completely out of pocket but at least pay a portion of it, and that's where health savings accounts make savvy consumers out of patients. Either that, in which they have a stake in controlling costs, or you have a giant bureaucracy such as in Canada and the UK, in which case you have to have long lines and rationing. It's one way or the other.

America, you are going to have to decide what you want. Today, we don't have the ideal thing. We need to improve the system we have. But if we go with the public option, which will lead to single payer, then we are going to go down the road of rationing and long lines. There is no doubt about that. And even Members of the other side of the aisle said that's where they want to be.

Mr. ROE of Tennessee. I think one of the things I want to talk about now—and we have been joined here by Dr. BURGESS, our good friend from Texas—I think, where is the money coming from to pay for this? I think at the end of the day, when a patient comes to me in my office and sees me, am I going to be able to deliver better care when we pass this in the House, if the House does pass this 2,000-page bill? The answer is no. Will access go down? I believe it will. Will costs go up? I believe they will.

You mentioned about the individual mandate. So people understand what that is, you are a person working out there as a painter or you work in a small business or whatever and you don't have health insurance. You choose not to buy it if it's offered at

your group, or you just choose not to. You will pay 2.5 percent of your total income into this exchange as a penalty.

Well, what's happened in Massachusetts? Let me sort of go over that for just a moment. They have a mandate. That experiment is being tried right now in the State of Massachusetts.

The Harvard Pilgrim Health Care plan found from April of 2008 until March of 2009, 1 year, they found that 40 percent of their new enrollees kept their insurance for only 5 months. During that 5-month period of time, the average payment was $2,400 a month; whereas, the average person who just had part of their plan was $350 a month. People were waiting because you don't have any—in Massachusetts, you cannot be denied coverage, and you get a community rating, meaning that everyone pays the same rate. What people are doing is they are waiting until they get sick, at least in this Harvard Pilgrim plan. Then when they get well, they drop their insurance and pay the 2.5 percent penalty.

The other is an 8 percent penalty on business, which is a payroll tax. Basically, a business will pay 8 percent of its payroll into this exchange or into the government. Well, if you are paying 10 or 12 percent now, then what you are going to do is you are going to drop that if you can and get into the public option.

Well, I started thinking about this the other night. It's the first time before, in my business, in my medical practice, I negotiated the health insurance policy every year as a separate cost than payroll. Now what's going to happen is your health care costs are tied directly to the payroll, meaning that if you give your employees a raise, you have also just raised your health care premiums. You put those linked together for the first time, and I think that's not good for the person out there working.

I am going to yield now to my good friend, Dr. BURGESS from Texas. Thank you for joining us, and we have been joined also this evening by Dr. CASSIDY from Louisiana.

Dr. BURGESS.

Mr. BURGESS. I thank the gentleman from Tennessee for yielding.

I was watching the events of this Special Order hour as you all were discussing it earlier. I felt like I needed to come over and talk for just a minute about words we heard on the floor of this House the middle of September that this bill could be passed, and it would be entirely paid for, not one dime would be added to the deficit.

The American people look at this, whatever the figure is, 890 billion, 1.055 trillion, 1.4 trillion, whatever the number is, and they know a statement that it will not add one dime to the deficit is, on its face, preposterous. No one believes that. Yet if we are asking people to believe that statement, what else is hidden in this bill that we are not telling you, because again, clearly, the American people do not believe us on that.

The gentleman talked about how we pay for it. Some significant cuts to the Medicare program in order to fund a new entitlement; a lot of people have difficulty with that.

But what about the taxes? What about the promise that there will be no taxes on individuals in the middle class, no taxes on individuals who earn less than $250,000 a year? And yet, we are going put a tax on so-called Cadillac insurance premiums. We are going to put a tax on medical devices.

I did a press event this morning at a library where I distributed copies of the bill for people who wanted to read the bill. A woman said, Well, then on my $1,000 insulin pump, am I going to have to pay a 15 percent tax? I said, Well, at some point someone will. She said, Well, how will that be assessed? I said, My understanding is it will be like a sales tax or value added tax. She did some quick math and said, That's a lot of money to add to my already stressed budget trying to cover my medical expenses, because I do have diabetes.

Ten percent of people earning under $50,000 a year, 10 percent of the taxes will be paid by people who earn under $50,000 a year. Ninety percent of the taxes are going to be paid by people who earn under $240,000 a year. Clearly, this is a tax on the middle class. That is how it's going to be paid for.

I did have some people ask me, Well, if the benefits don't kick in for 4 years, is there perhaps not a way to, if this passes, if no one can stop this and the Speaker gets her way and this bill passes on Thursday or Friday or Saturday, what about, then, since the benefits don't kick in for a while, maybe we can dial it back over the next several years. My concern there is if we already start collecting the taxes for a benefit that is to occur in the future, it may be very, very difficult to indeed dial back the portion of this bill if we are going to—the sensible thing to do would be to hit the pause button, the reset button. Let's sit down and figure out really what the American people want us to do.

We heard participatory democracy all the way through the month of August. I know. I was on a listening tour of sorts through my town halls in my district. Some people were quite vociferous about what they felt about this bill, both pro and con. But I felt that, after listening to her this summer, that we would come back here to Congress and perhaps sit down and try to rethink where we were. It was almost as if the Democratic leadership said that didn't happen, it didn't matter. It was some sort of national fugue state. This was all an illusion this August. People really weren't upset with the bill. They just wanted it so badly that you misinterpreted their passion because they want the government to control. They want the government to take over the health care system in this country.

One of the other things, and I don't think we can underestimate this, is the effect that this bill will have on jobs and job creation. More people are concerned about jobs in this country than they are about health care right now by a factor of 4 to 1. We are going to go over 10 percent, in all likelihood, on Friday when the jobs report comes up from the Department of Labor, will be the first double-digit unemployment in this country in decades.

People are concerned about jobs; yet, at the same time, our small business people, the people that we, as politicians, say they are the backbone of the economy of America, they are the engine that drives economic growth, they are scared to death of what we are going to do to them in the coming months. They are scared of this health care bill. They are scared of an 8 percent payroll tax that may be levied upon them. They are scared of what we are going to do in cap-and-trade, and they are scared of what we are going to do in financial regulation, not to mention the fact that there are significant tax increases just around the corner when the tax laws of 2001 and 2003 expire.

This is a debate that we must keep at a fever pitch all week. This is the opportunity. Now is the time to aggressively document and talk about what is in this bill. Doesn't really matter so much about what I think, what I would do if I was in charge. Right now, the task before us is to lay out to the American people what is in this bill, let them see for themselves whether they like it or not. Then, Madam Speaker, the American people need to tell us.

Quite honestly they will have a chance on Thursday at noon, the west front of the Capitol, the people will have an opportunity to speak up about this bill.

□ 2130

Mr. ROE of Tennessee. Dr. BURGESS, thank you for your comments. Also, just so people understand, it is not just an insulin pop. It is any medical device that we are talking about. It could be a wheelchair; it could be a prosthetic device, if you have a leg that is a prosthetic device; if you have stents in your heart or hip replacements. And who is going to pay that? The consumer is going to pay that, we know that, the person that is getting that device. What we don't want to see is this unbelievable amount of innovation that has occurred.

Dr. BURGESS, what comes to mind for me is the equipment we use for a laparoscopically assisted hysterectomy. When we first started, those took us 5 to 6 hours because we didn't have the equipment to do it with. Now it is a 1-hour procedure because of the new equipment that is there. Patients have benefited tremendously from this. Did it cost money to do this? Yes, it did. But I look at the advantages for the patient. I don't want to see that innovation brought to a halt, and I fear it will be.

Mr. BURGESS. Well, if the gentleman will yield for a moment on that point, minimally invasive surgery has changed the face of operations like hysterectomy operations, like a cholecystectomy, removal of the gall bladder. I am sure you remember, I remember when I was in medical school and a resident, this large incision that would go underneath the person's rib cage. They would be in the hospital 7 days; not because their gall bladder surgery was that traumatic, it was the incision that was traumatic.

Now it can be done laparoscopically through two or three 1-centimeter incisions. That patient is out of the hospital the next day, or sometimes even the same day if it is done in a surgery center, and that has vastly decreased the cost of hospitalization for that procedure and that has vastly decreased the cost of the time lost from work for people in recovery for operations like gall bladder removal and hysterectomy.

I yield back.

Mr. ROE of Tennessee. I thank the gentleman.

We have been joined by Dr. CASSIDY from Louisiana. I yield to Dr. CASSIDY. We thank you for being here this evening.

Mr. CASSIDY. You know, I agree with almost everything Congressman BURGESS said, except for one thing, in that I do think it is important to discuss our Republican alternatives, because, frankly, part of the rationale, the steamroll we are on, is there is no other option. We have, as the President has said, the cost of doing nothing, the costs will double over the next 10 years, and that is an inflation rate of about 7 percent if it compounds.

Well, as it turns out, since the cost according to the Congressional Budget Office of the reforms before us—the inflation rate is 8 percent per year—under the reform proposals before us, costs more than double in 10 years. At a minimum, reform should not be more costly than the status quo.

That said, I think it is important for us to discuss alternatives. I think we can all agree on the goals. We need to control costs. I am with the President on this. If we cannot control costs, we cannot expand access to quality care.

Now, as it turns out, we three are physicians. We know that if the patient is in the middle of the process, then costs are controlled. There is a report by McKinsey & Company and it talks about the three imperatives for health care reform, and they are to decrease the administrative costs—so much money goes to administration; to have transparency, so that when a patient goes in for her knee surgery, she knows before the surgery how much it will cost her, not find out a month later; and, lastly, incentivize healthy lifestyles. So in a patient-centered plan we should lower administrative costs, increase transparency, and incentivize healthy lifestyles.

So I would like to compare it to the 2,000-page, $1 trillion, 20-pound bill.

Now, does it lower administrative costs? You almost have to laugh, because it creates 111 new bureaucracies, boards, commissions. You name it, it clearly expands administrative costs.

Does it incentivize healthy lifestyles? I actually read that provision today, and it gives grants to small businesses that come up with innovative ways in which you can make employees healthier. But it is very vague and very gauzy. And I kept thinking of that small businesswoman who is really struggling to make ends meet, trying not to lay people off. What is the likelihood that she is going to take 2 hours a day to write a grant application to submit to the Federal Government on the hope they will give her $150 per employee, which is the maximum allowed, in order for her to come up with a wellness program? That is something written by a Washington bureaucrat, not by someone who knows the travails of a small business person.

Lastly, transparency. Frankly, I just find it unbelievable that a bill that creates 111 boards and commissions will be transparent.

That said, what are the alternatives? I think we would all agree from our own experience, patient-centered care can work. For example, you have got great anecdotes about health savings accounts. Congressman FLEMING, who just left, I love his story about a health savings account.

For those who don't know what they are, with traditional insurance policies, a family of four, you put up $12,000 a year. If you use the insurance, you may get some of your money back, but at the end of the year it is gone, and you put up another $12,000 for the next year.

With a health savings account, you sluice off some of that money and you put it into a banking account, and that banking account is yours and you can spend it on the things which you choose. But at the end of the year, if you haven't spent it, you keep it.

With the traditional policy, you start over. With the health savings account, you conserve that money and it is there for you the next year. It rolls over, and it is that much less you have to put forward. It changes the psychology. We know that.

But just to explain it, in a patient-centered account, a patient was telling me, he goes to a doctor. The doctor writes him a prescription, $159. He says, doctor, you have given this to me before. It is $159. Listen, I have got a health savings account. Can you write me something cheaper? He goes, oh, I am sorry. He writes him a $20 generic, so the system just saved $139.

I actually think the power of millions of individuals making decisions at $139 a decision has more ability to control costs than 111 boards and commissions in Washington, D.C., that are attempting to control health care in all the small towns across the United States.

Mr. ROE of Tennessee. If the gentleman will yield for a moment, you are absolutely dead right on this. In my district, I visited four businesses, one is the City of Johnson City, Tennessee, where I was mayor. Another is Holston Munitions, or BAE Corporation.

They have instituted a wellness program that in the last 5 years they have not had a premium increase. What they have done is they have basically incentivized behavior, for instance, smoking.

If you smoke, and one of my good friends had a patient come to him the other day, and he said last spring, and this was in June, she said I have to quit smoking by the first of July. He thought, that is pretty good. I am glad to hear that. They've been trying to get you to quit for several years. But why are you going to quit? She says well, my insurance changes and they are going to penalize me if I smoke. It is going to cost me money.

So, if you don't smoke, or you get your hemoglobin A1C, which is the way we monitor your sugar and diabetes, to get your hemoglobin A1C down, you lose weight, they will pay you for that. So you can earn the money back. And they have done that with their wellness program and been wildly successful.

To tag-team into your health savings account, just me personally in 2 years, and people will say that, well, you can't use that in Medicaid or you can't use that, I absolutely disagree with that. In our own medical practice, of the 294 people that get insurance through our practice, 84 percent use a health savings account. These are the folks that check you in at the front and draw the blood and the nurses that assist us and so forth. So it works very well for everybody. We all respond.

Mr. CASSIDY. If the gentleman will yield for just a second, this bill specifically excludes small businesses from doing what you described as a wellness program. That effective program is specifically excluded. So the patient-centered program which was so successful in Johnson City is not allowed in that 2,000-page bill.

Mr. BURGESS. If the gentleman would yield, you bring up a great point about tobacco. One of the problems with this bill is you are not allowed to rate on tobacco use. In fact, there will be only 2 ratings bands, based on age.

Health savings accounts—I am a big believer. I have had a medical savings account since 1996. I skipped for a few years when I came up here, and we didn't have them available. Now I have it established again, and it is working very, very well. But the problem is, that will not be a qualified plan. It will not meet the minimum benefit standards under the new health care commissar that is going to be developed by this bill that we have before us. So the very thing that may lead to a reduction in costs, we are not going to be allowed to have.

Now, since the gentleman disagreed with me, I do feel obligated to point

out that it is not that Republicans don't have alternatives or shouldn't have alternatives. I individually have 20 bills dealing with health care under my name and have cosponsored at least 30 additional bills. There are a plethora of bills out there with Republican names that do everything from fix the problems that doctors have with the sustainable growth rate formula in Medicare to liability reform. They are not part of this bill. They are not part of the discussion this week. What is the discussion this week is that monstrosity behind the gentleman.

It is our obligation, it is our obligation to our patients and to our profession to kill this bill so we can then begin to talk about some of the alternatives that are rational, because it makes no sense to preclude a wellness program simply because it doesn't fit into some chairman's idea of what a health care bill should look like, some chairman who might have been here since 1974, by the way.

That is the problem we have before us this week, is this bill. After we get rid of this bill, after we get past this bill, yes, we can begin to talk about those things to provide benefit to the American people, help to the American people who actually need it.

You said it earlier in this hour. It is that 8 to 10 million people that have a preexisting condition. If we could make their problem go away, and we can, the Congressional Budget Office estimates between $8 billion and $20 billion over 10 years. That is a far cry from $1 trillion. We could make that problem go away with State reinsurance programs and State high-risk pools. We have that power within our hands. Some people may argue that constitutionally we don't have that power, but it would be a darn sight better than what we are talking about doing tonight.

Mandates have no place in a free society. There was no mandate that required me to buy an iPod, yet everyone in the country has an iPod or iPhone today because it is a great product, and everyone wants one. That is what we should be looking at in our insurance policies, how to create products that people actually want, not making someone take a policy that the insurance company says I can make money selling. That is where we will go with mandates.

Mr. ROE of Tennessee. Reclaiming my time, I would also say it takes away personal freedom to decide what is best for your family. For instance, in my family now we don't need fertility evaluations that maybe other families do need. They should be able to purchase those if they need to.

I want the viewing public tonight to take a peak at H.R. 3962, which is a new name for H.R. 3200. I would encourage you to begin to read this. It will take some time. But the American people did read H.R. 3200. They actually did. I had hundreds that came to me at town halls that printed it off the Internet and read it. It is probably just out on the Net.

It is amazingly complex, and the devil is in the details. When you start reading the details, and I did begin the details today, that is where you begin to see what you lose in this.

Mr. CASSIDY. If the gentleman would yield, I was a little late coming over here because we were having a telephone town hall. For the folks who are watching, that is where we from Washington have a phone call that goes out to thousands of people in our district, and we have a telephone town hall.

There was a woman that got on and she just nailed it. You pointed out, we have a 2,000-page, $1 trillion bill that was introduced last Thursday that we are going to vote on this coming Friday that is going to remake 17 percent of our gross domestic product, drastically affecting the health care for us all.

If it seems kinds of crazy that we would do that, this woman calls in, Rebecca, and I happen to know the family, I didn't realize it was from her family, and they are very bright people, very hardworking, good people.

So here is kind of her quote. She went to the Kaiser Family Foundation site to determine what her costs would be under the bills before Congress, and she figured out that her family's costs would double.

She says a small business is going to do a cost-benefit analysis, and they are just going to dump patients upon the public option because, why shouldn't they? Now, she says, I am quoting her, it seems like the people writing this are obtuse. They are not writing this for the middle class of the Nation. It is not centered on the patient. It feels rushed. It doesn't make sense; 2,000 pages, one week to digest it. It feels rushed.

She finishes up by saying, for all the possible plans, our premiums will double. It is very expensive. You can't get ahead. The more productive a citizen you try to become, it is like you take one step forward and go two steps back.

This is a bill which is two steps back.

Mr. BURGESS. If the gentleman would yield on one point, it is hard to see if we make health care more expensive that we are going to make it more affordable.

I yield back my time.

Mr. ROE of Tennessee. I think, in summary, in closing up this evening, what we have got this week is a discussion, I think the single biggest social discussion we have had in this Nation in 50 years, since Medicare. The challenge is how do we make health care affordable, and how do we provide it for the citizens now who don't have it?

I think, as Dr. BURGESS stated just a moment ago, that right now, the bill before us, they are not our solutions. We keep hearing there are no Republican solutions. There absolutely are. They are not on the table. They are not being discussed. This bill right here, H.R. 3962, all 1,990 pages, that is what we are discussing this week, and, as Dr. FLEMING said, we are probably going to vote on this week.

So I think that this needs to be looked at as quickly as we can by the American people to try to peel this onion back, so to say, and look at what's there. I appreciate my colleagues being here tonight, and we'll be here throughout this week to further discuss this bill and what is in this bill.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. ABERCROMBIE (at the request of Mr. HOYER) for today and November 3.

Mr. DAVIS of Tennessee (at the request of Mr. HOYER) for today and November 3.

Mr. DEFAZIO (at the request of Mr. HOYER) for today on account of travel difficulties.

Mr. LUCAS (at the request of Mr. BOEHNER) for today on account of family illness.

Mr. PATRICK J. MURPHY of Pennsylvania (at the request of Mr. HOYER) for today, November 3 and 4 on account of the birth of a child.

SPECIAL ORDERS GRANTED

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

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

Ms. WOOLSEY, for 5 minutes, today.

Mr. MCNERNEY, for 5 minutes, today.

Mr. DEFAZIO, for 5 minutes, today.

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

Mr. POE of Texas, for 5 minutes, November 6 and 9.

Mr. JONES, for 5 minutes, November 6 and 9.

Ms. FOXX, for 5 minutes, today, November 3, 4, 5, 6 and 9.

Mr. MCHENRY, for 5 minutes, today, November 3, 4, 5 and 6.

Mr. WILSON of South Carolina, for 5 minutes, November 3.

Mr. HASTINGS of Washington, for 5 minutes, November 3, 4 and 5.

Mr. BURTON of Indiana, for 5 minutes, November 6.

ENROLLED BILLS SIGNED

Lorraine C. Miller, Clerk of the House, reported and found truly enrolled bills of the House of the following titles, which were thereupon signed by the Speaker:

H.R. 2996. An act making appropriations for the Department of the Interior, environment, and related agencies for the fiscal year ending September 30, 2010, and for other purposes.

H.R. 3606. An act to amend the Truth in Lending Act to make a technical correction