inaction dwarfs the cost of action. The downside risk is truly chilling. We are seeing that mount. We have seen study after study that shows that the American economy risks losing trillions of dollars of productivity. And the relatively small amount that we would be investing to forestall disaster seems like a bargain.

I appreciate your willingness to join with us this evening. I hope that we will be able to continue this discussion, not just in our committees, but here on the floor, to be able to put the bigger picture together. And I look forward to continuing that conservation with you.

Mr. Speaker, we thank you for the opportunity to share this with the American people tonight and yield back our time.

Mr. CONNOLLY of Virginia. Mr. Speaker, I rise to speak tonight, on the eve of Earth Day with respect to the most critical environmental crisis that this nation has ever faced: climate change. As daunting as this challenge is, I am proud that this Congress has done more in the past two months to combat climate change than the previous Administration accomplished in eight years.

With passage of the American Recovery and Reinvestment Act, we invested over $70 billion in clean, renewable energy. This important legislation will save or create over three million jobs. In the area of clean, renewable energy we will put people to work weatherizing homes of low income Americans. The previous Administration proposed eliminating all funding for the Weatherization Assistance Program. This stimulus legislation will invest $5 billion dollars over two years, which will weatherize at least two million homes. A wide range of studies suggests that weatherization is the most efficient way to save money while reducing greenhouse gas emissions. With the stimulus legislation, we are off to a great start.

The stimulus also invested $8.4 billion in transit and $8 billion in high speed rail. Communities around the nation, including my 11th District of Virginia, are suffering from congestion that threatens to constrain economic growth in some of the most productive communities in the Nation. These transit investments will give commuters choices, reduce congestion, and reduce greenhouse gas emissions. They will spur economic development while reducing greenhouse gas emissions.

The stimulus invests $2 billion in advanced battery research. This field is essential to develop the next generation of plug in hybrids and to store solar energy. With solar companies creating jobs throughout our region, we must make the investments in innovation that will continue to grow the green jobs sector. America invented the photovoltaic solar panel, yet Germany, China, and Japan now lead us in solar panel production. With these investments, in addition to loan guarantees, we will once again have the opportunity to lead the world in production of green energy. By investing in the development of a smart grid, we will ensure that we conserve energy at home while enabling the transmission of renewable energy.

Although we are already seeing benefits of the stimulus, whether it is repaving potholed roads or creating green jobs, we know that we cannot rest while carbon emissions continue to rise in America, China, and India. We must lead by passing comprehensive greenhouse gas reduction legislation that reaches 80 percent reductions in emissions by 2050, with aggressive but achievable shorter term targets. Without this legislation we will not be able to bring China and India to the table to develop binding goals for those large carbon emitters.

I look at greenhouse gas legislation as an opportunity. For a quarter of a century, we have accepted dependence on foreign oil. For a quarter of a century, we have accepted dramatic declines in mining jobs even as our communities are devastated by acid mine drainage and mountaintop removal. For a quarter of a century, we have lost market share in auto sales as we clung to production of gas guzzling dinosaurs.

No more will we accept the constraints that accompany an unwillingness to innovate. We may look forward to greenhouse gas legislation that sends a strong market signal to invest once again in America: in efficient automobiles, in wind turbines, in solar panels, in weatherization, in transit. These investments will not only protect our climate, and thus our coastal communities and agricultural heartland, but also lay the groundwork for a new age of industrial expansion founded on technological innovation.

The environment cannot sustain further increases in carbon emissions and neither can our economy. We must act now to pass greenhouse gas reduction legislation that protects our climate while unequivocally redirecting our economy toward a clean energy future.

HEALTH CARE IN AMERICA

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 2009, the gentleman from Texas (Mr. BURGESS) is recognized for half the time to midnight.

Mr. BURGESS. Mr. Speaker, I have come to the floor tonight to talk about health care, but some of the comments that we have just heard in the last hour, I just feel obligated to respond. I cannot let the fantasies that are put forward on this floor stand unchallenged.

We heard the statement made that no investment in renewable energy occurred in the last 8 years. That is absolutely preposterous. The State of Texas has one of the most aggressive renewable portfolio standards in the country. In fact, the State of Texas is the leader in the generation of wind.

And this did not spring from the Earth fully formed on January 21 of this year. This has been the product of well over a decade of hard work back in the State, our renewable portfolio standard that, I might add, was signed into law by Governor George W. Bush back in the 1990s in the State of the Texas.

□ 2240

Please, let's have the debate, but let's argue from the standpoint of facts. Let's not continue to engage in this fantasy that nothing has occurred over the last 8 years. Nothing makes the American people more angry than to hear this type of falsehood repeated over and over again.

Texas is the leader in the production of wind energy. We have an aggressive renewable portfolio standard, and all of that was initiated under the governorship of George W. Bush. It has been continued under the Republican governorship of Rick Perry and, yes, during the 8-year Presidency of George W. Bush.

Thank you for letting me get that off my chest. Now on to health care.

Mr. Speaker, the Health Caucus Web site went live this week, www.healthcaucus.org. I formed the Health Caucus earlier this year because I felt it was important to have a forum to talk about some of the changes, some of the things that we are seeing in this health care debate. The Health Caucus is not a legislative caucus. We're not going to write the law. That never was the intention of the Health Caucus. But the intention of the Health Caucus was to provide a forum where ideas can be exchanged, and, indeed, that's exactly what has happened. And I want to talk about a couple of those that we have had recently. It was to provide a vehicle for Member education so Members who perhaps weren't as familiar with issues surrounding health care would have an opportunity to avail themselves of recent information and prepare themselves for the debates, prepare themselves for the legislative process that's going to be ahead of us.

Certainly a great deal of effort in the Health Caucus is spent towards staff training, to prepare the communications staff for Member offices on how to communicate with constituents about health care, how to communicate effectively in the health care debate that is going to be ahead of us. And probably most important or one of the most important functions of the Health Caucus that was recently formed is outreach.

We spend a lot of time here in Washington, we spend a lot of time in windowless rooms in the basement of the Capitol of the new Capitol Visitor Center. And as beguiling as those accommodations are, it always seems that we have the same discussion with the same people rehashing the same ideas over and over and over again. And yet out across the country, there are men and women who are engaged and involved in this debate. They are engaged and involved in the actual delivery of health care, taking care of actual real patients on a day-in and day-out basis. They kind of know what works; they kind of know what doesn't. And it is so important for us to go out and solicit those stories, take the advice of the men and women who are working in the health care industry, and bring that information back to Washington, learn from what works, learn from what doesn't work. There is no reason that we should continue policies or try to develop policies that have been proven not to work, say, in a State jurisdiction or a State venue, but it is very important that we learn from

those things that do work because we are going to be called upon at some point this year to do something, and it remains to be seen what, but to do something with health care in this Congress.

Now, the Web site, www.healthcaucus.org, that Web site is available. There are links on that Web site to the various forums that have been held where ideas about health care are exchanged. And they're not all Republican ideas or Democratic ideas. We seek to have a balance of opinion. In fact, the very first forum that I held earlier this year had Karen Davis from the Commonwealth Foundation, Grace-Marie Turner from the Galen Institute, ostensibly one speaker from a little bit left of center, one speaker from a little bit right of center. We have had other speakers from the Commonwealth Foundation come and participate in some of our member organizations as well as other members from the Galen Institute. It's important to expose Members to ideas from both sides of the political stripe.

Today's forum was no exception. We had a lively discussion, in fact, in the Capitol Visitor Center. I will talk a little about the panelists and their presentations later. But, again, a Webcast of today's forum is available for anyone who wants to go to www.healthcaucus.org and view that. When we do these events, they are Webcast live. It's not always possible to compete for C–SPAN coverage, but we do generally Webcast these events live. And the audience that is seated at the forum is certainly free to ask questions. These events are open to the press, and questions can be submitted over the device called ''Twitter'' that many people use for instant message communications. So today's audience, for example, we had probably between 50 and 70 people in the audience, and we had a similar number who were watching live on the Webcast. And, indeed, we did pose a couple of questions from folks who sent in questions via e-mail and Twitter. We did pose some of those questions to the panelists in the course of that forum.

Also up on the Web site are brief, minute interviews primarily with the panelists who have come and talked, but we have had some other individuals that have just been part of the discussion and part of the debate as we go along. Dr. Mark McClellan, the former head of the Food and Drug Administration under the Bush administration, former head of the Centers for Medicare and Medicaid Services, graciously provided me a brief video which is up on that Web site and also available on Youtube. Today the policy forum was titled ''Making Health Care Affordable Without the Government.''

You know, it was interesting, yesterday one of the papers that is published up here in Washington called Politico had an article, and, in fact, it was a front-page article yesterday, talking about the health care reform debate as it's unfolding; in fact, talking about how it appeared that the Democrats are ahead of the Republicans in the health care debate. Some statements were made that were perhaps a little bit hyperbolic, a little bit overblown. It's not that there is no Republican health care plan right now. There are many Republican health care plans. The challenge is to get us all to agree on a set of facts, a set of principles, and a health care bill going forward. But I would point out that that is no different from the difficulties that are being encountered on the other side of the aisle.

In fact, last fall during the Presidential campaigns, the presidential debates, Senator BAUCUS, the chairman of the Senate Finance Committee, produced a white paper. He had a forum over in the Library of Congress and invited many of the stakeholders, many of the players who are involved in the issues around health care reform, and produced a white paper. Many of us thought that this white paper was, in fact, a prelude to legislation and, in fact, that this legislation would likely appear just shortly before the November elections. It's perhaps somewhat of a surprise that that legislation has not come forward yet. In fact, there was a recently released letter to President Obama from the Democratic leadership in the other body stating that indeed there would be a bill to mark up by early June. So you can see it is difficult not just for Republicans, but it is, indeed, difficult for Democrats. You've got lots of different and differing constituencies to be represented, and it is a challenge to bring everybody together, get everyone reading from the same page, and then going forward with a unified plan.

My suspicion last fall was that that would be very quick to materialize from the other body, from the Democratic leadership in the other body, and perhaps not too surprising that the Republicans are where they are, but very surprising that we had not yet seen more as far as a fully formed plan from the other side.

A question came up during the forum today: What do you think of President Obama's health care plan? And that's a tough one because I don't know if anyone can honestly tell you right now today what the President's health care plan is. In fact, during the Health Care Forum that he put on at the White House a few weeks ago, he was very careful to say that this is legislation that will be developed by the United States Congress. It will come through the appropriate committees on both the House and the Senate, that he would provide guideposts and guidelines and boundaries going along, but the legislation would be developed from the congressional committees. And that's a reasonable thing for the President to say because 15 years prior, another President who was new in town and was trying to also effect some major changes in the way health care is delivered in this country went entirely the other way.

□ 2250

He said, we are going to sit down within the confines of the White House—again, one of those small windowless rooms that we have so many of up here in Washington, D.C.—500 lawyers behind closed doors, and we are going to generate a health care plan, and, by golly, the Congress will like it. But it turns out they didn't. And, as a consequence, no health care reform was done in 1993 and 1994 and the argument languished for many years, 15 years after that.

It's not that nothing happened, I do want to stress. We keep hearing that the status quo is not acceptable. I will submit to my colleagues on both sides of the aisle here in the House, men and women, American medicine has not sat still during the last 15 years. In fact, there have been dramatic changes in health care in the last 15 years, dramatic changes in the science of health care, dramatic changes in the delivery of health care.

One of the changes that came about as a result of the Republicans having a plan back in 1993 and 1994 to offer, as a counter to the Clintons' plan, was the concept of the health savings account. At the time they were called medical savings accounts.

They came along after the Republicans took control of Congress in 1995. I think it was 1996 or 1997 that the first health savings accounts became available. They have matured over the last 10 or 15 years. In 2003 we expanded, and now they are called health savings accounts. But that program was expanded and some of the more onerous red tape was removed.

And now you do have a system that provides health insurance, on the individual market the high deductible health plans for probably anywhere between 7 and 14 million people. And these are individuals that at least almost half would not have insurance were it not for the availability of this product.

I know that because back in 1994, I attempted to buy an individual policy for a family member and could not find one at any price. I was prepared to write a large check in order to get that insurance coverage, and it just simply was not available.

Fast forward to the present time, you can go on to the Internet, to the search engine of choice and type in ''health savings account'' and find that there are a variety of programs, a variety of products that are out there and available and priced at a reasonable amount. A 25-year-old, such as I was trying to purchase insurance for back in 1994, a 25-year-old now for a high deductible policy, a good product, a PPO product from a well-recognized company that would be listed on the stock exchange, so you would know they were a reliable company, those policies are available for between $75 and $100 a month.

To be sure, there is a high deductible. But, of course, under the HSA laws there is the ability to put a medical IRA, a tax-deferred account away to help defer those high deductible expenditures. And, over time, this can be a very satisfactory type of insurance to have. In fact, it's the type of insurance that I carry. We have a health savings account option through the Federal Employee Health Benefits Program. It costs about half of what the high-option PPO costs. So I am saving the government money. I am putting money away in a medical IRA.

And, in fact, the HSA that is available is very conscious about making sure you have your routine studies done, your routine medical care done. I get e-mail alerts all the time reminding me I need to take care of this or that, and it's a good program. It's one that I think shows a lot of promise for into the future. But I do digress.

Right now, currently, President Obama does not have an official White House health care plan that's out there, so it was very difficult to provide a precise answer to the gentleman's question today in the forum.

During the fall, we heard some campaign rhetoric on what some of the—perhaps the proposals that President Obama would put forward. We heard discussion of a mandate for covering children. I don't hear much talk of that currently.

You hear some talk currently of there being some sort of government-run public plan, either a Medicare, Medicaid or some other type of plan to compete with the private sector.

There is some unease on both sides of the aisle about this type of program, but, nevertheless, these are the relatively broad areas that are being talked about under the Obama plan. There is no specific Obama plan.

So it's a little bit, again, a little bit overly critical for the newspaper article yesterday to say there is no Republican plan. Well, there is no Republican House plan, but there is no Democratic House plan. In fact, there is no White House plan that is being talked about.

The other thing the article said, there is no Republicans leading the charge. I would submit to you that I have been on the floor of this House an hour, at least 1 hour out of every month for the last 2½ years. As many people who suffer from insomnia who from time to time turn on C–SPAN, Mr. Speaker, will recall that I have talked on this subject, sometimes at painstaking length.

And I would just say that there are a number of leaders on the Republican side in the arena of health care. It perhaps does not get the billing that the energy debate does, perhaps does not get the billing as the security debate, but, nevertheless, suffice it to say that there are good and engaged and energetic people on the Republican side who are working this area.

One of the things that did concern me about the article is it points to findings from a Kaiser health tracking poll that said 58 percent of Americans lack confidence in the Republican Party to do the quote, unquote, right thing for health care.

And that does concern me and that is why, when I put together the Health Caucus, I wanted to be sure that we included the communications arm of Members' offices because people do want to hear Republicans talk about health care. In fact, that's one of the things that comes out consistently in the polling. They do want us to talk more about health care. They want to hear our ideas.

In fact, during the months of the Presidential campaign, from time to time I would be tasked to participate in a debate. Well, after the debate was over and both candidates' points were discussed, as things were winding down and the podiums were being taken away, invariably, invariably I would have a throng of people around me wanting to hear more. Is there really a way to do this without the government taking everything over?

And I would submit to you that there is, and I would submit to you that we are closer now to achieving that state than we really ever have been at any time, certainly in my professional time, having practiced medicine for 25 years before I came to Congress some 6 or 7 years ago.

Isn't it ironic that we are perched on the threshold of being able to provide more care at lower cost and better quality to more people under the existing system, and we are talking about doing things that might fundamentally disrupt the system. And I will tell you that's one of the very difficult things both sides have to wrestle with.

You heard it repeatedly during the Presidential campaign. Both sides said if you like what you have got you can keep it. Of course they said that. Polling shows 65 to 68 percent of Americans are satisfied or very satisfied with their health care and do not want it to change.

Yes, they are concerned about the number of people who are uninsured or underinsured. They want to see that segment of the population get some help, but they are also terribly concerned that, in the process of doing so, will undo what they have.

And that is a great concern. Again, it's something that has to be borne in mind by both sides when they talk about doing anything to the health insurance market.

When Republicans talk about we would like to see more people own their own insurance policies, some people are concerned because that might undo the employer-sponsored insurance that so many people like. When the Democrats talk about we want a robust option to compete with the private sector, people are legitimately concerned that there will be a crowd-out and drive-out of the private sector, and they, indeed, will lose what they have.

The old adage is, if you like what you have got you can keep it right up until the time we take it away from you. Both sides have to be mindful of that concern.

You know, in any case, we have got to continue to move forward in this debate, and it's important that we Republicans, my side of the aisle, continuously challenge and continuously try to penetrate the echo chamber that surrounds Capitol Hill and hear from Americans that are on the front lines of delivery of health care all over the country.

At some point, both sides are going to unite behind a plan. Both sides maintain they want to unite behind a plan that actually will work, and both sides will be required to take their ideas to the American public.

Now, certainly Democrats have an advantage. They have a huge size advantage here in the House of Representatives. My committee, the Committee on Energy and Commerce is no contest. The Democrats can pass anything they want with no Republican input. It is not necessary for us to even show up and vote most days because they are going to overwhelm us with their numbers in committee and subcommittee.

The Rules Committee upstairs, a 9–4 ratio, Democrats to Republicans. We are not going to win any of the arguments in the Rules Committee.

It is very possible that we will win no arguments here on the floor of the House. It's possible the Democrats can pass whatever they want.

Where it is possible for Republicans to make a difference, and this is why it's so important that we be able to communicate these issues, is we can win this in a court of public opinion.

□ 2300

And that is really where this battle is going to be fought, probably late this summer, but certainly into the fall.

Now, a lot of people have asked me about the time line, what I see ahead as far as the time line for health care reform. We've heard 2 hours tonight on energy tax, cap-and-trade. We're going to do that in our committee before we do health care. Sometime before the end of next month, before the end of May, we will have that work done in our committee, or at least that is what the chairman has told us, and we'll clear the decks for health care in committee starting in June or July.

I would submit to you, having watched then-President Clinton 15 years ago deliver his speech here on the floor of the House to a joint session of the House and Senate, and I think it was about the third week in September of 1993, and he gave a wonderful speech, had everyone in the room mesmerized. Go back and get the video of it and watch it. It was a wonderful speech. But it was about 3 months too late because they were already into an election time and, as a consequence, the ability to get a big concept like that through the Congress was severely compromised.

By the end of September, first of October, a lot of Members here are thinking about their re-election. The House of Representatives has 2-year terms, remember. And we are about to finish our so-called off year. Our off-year lasts about 6 months, and it will be done by the middle of the summer. So the time window is real very, very narrow for getting a big concept like this through.

Add to that the fact that we are going to do some major piece of legislation on climate change, energy, energy tax, whatever you want to call it. That will be a big push to get that done.

And the President said in his speech last week that he is going to sign a major banking regulatory bill before the end of the year. Those are three very big things to get done. And that's a lot on the to-do list, and we're already halfway through April of this year. And we really haven't gotten the guts of any one of those bills to get to the House floor. So the window of opportunity may be closing faster than some people realize.

Just briefly, today's forum, we had three great folks come and talk to us. We heard from Rick Scott, we heard from Greg Scandlen, we heard from Dr. Nicholas Gettas who is the chief medical officer at CIGNA, a family physician who gave a wonderful talk about how important it is to have things like care coordination; how important it is to have things like disease management to be able to manage the exponential increase in the rising cost of care. Rick Scott talked about a number of outpatient clinics that he runs in Florida and how he manages these clinics by absolute transparency. Everyone who comes in knows exactly what it's going to cost for any procedure that's done, and there is a cap. There is a limit on the amount that can be charged on any patient visit.

And how about this: if you come in to see a doctor in the clinic, say, you've got a viral syndrome, a little cough, a little runny nose, scratchy throat; 3 days later you've taken the medicines they're giving you; not only are you not better, you're worse, you can come back in for a reevaluation, and according to Rick Scott, the patient would not be charged for that revisit within 3 days' time, if, indeed the patient felt that the treatment was—or they were not responding to the treatment that was recommended on the previous visit. So a very forward way of looking at things, both in the outpatient clinic sitting, by being very transparent about price, and with Dr. Gettas within CIGNA Health Care, found that by anticipating problems, covering problems early, taking care of problems early, they could significantly hold costs down. And both of these are different sides of the same coin. They both are what are called consumer-directed health care, where you engage and involve the consumer. You engage and involve the individual in the control of, as an active participant in their health care, and you tend to get the ability to lower cost without resulting in denying care and without pulling that ratchet that we love to pull, that reduces reimbursement to the physician and creates so much anxiety in our physician community across the country. So these were two very forward looking statements that we, three very forward looking bits of testimony that we heard today. And I would just encourage people who are interested in learning more about this, it's www.healthcaucus.org.

Now, tomorrow morning, for the Member briefing, we're going to have Ramesh Ponnuru, who is the senior editor of the National Review, came to my attention because he wrote an article that appeared in the Dallas Morning News over the break, and he was also talking about ways we can increase affordability; very, very important concepts. He talked about, you know, some people are concerned about universal coverage. Other people are concerned with the desire to reduce costs. Turns out when you poll this, the people who have the desire to reduce costs are much more than those that desire universal coverage. People are concerned about flexibility and policy design and benefit design, and there ought to be ways that we can get around some of the State regulatory problems, the State regulatory burdens that cause insurance in some locations in the country to be priced so high that literally prices some people out of the market.

Another concept that Mr. Ponnuru brought up was the ability to bring more people into, if you hold down costs, the ability to bring more people into a state of insurance coverage. In fact, Steve Parenti out of the University of Minneapolis did an economic study, which indicated that in excess of 20 million people could be brought into coverage simply by doing things that will hold the price of care down.

What about individuals with pre-existing conditions? And this can be a terribly difficult, difficult problem to deal with. But, you know, we've got 34 States right now that are doing what are called assigned-risk or high-risk pools. Some are working better than others. We ought to look at those States, take the best practices from States that are working well and create at least a floor below which no State would go on learning from these best practices.

To be sure, it is going to take some shared support from the insurance company that is providing the insurance, probably will have to be a cap on insurance premiums so that they will stay affordable. The State and the Federal Government are likely going to have to participate, depending upon income levels, but likely have to participate in that shared support.

But it just goes to underscore that doing these three things, where we no longer discriminate against someone in the Tax Code, where we provide someone the ability to buy an affordable insurance policy in a reasonable fashion, and we take care of, or provide for contingencies for people that have pre-existing conditions, we've gone a long way towards solving a lot of these problems.

And then, just like Dr. Gettas relayed this morning, add to that the care coordination, disease management, the electronic medical records, infection control, the kinds of things that you want to do because they're the right things to do and they provide better care at a lower price. Accountable care organizations are one of the things that I talked to Dr. Mark McClellan about. These are all ways of holding costs down. And you've actually got the nidus of an almost pretty workable health care plan just right there in the last 30 or 40 words that I spoke. So it's not terribly difficult to construct something. What's difficult is to construct something that more of us can agree on than disagree on, and that's certainly the challenge that is ahead of us.

Certainly, the work done through the Health Caucus is going to continue. I did have an opportunity to go to Omaha last Friday and speak with doctors at Alegent Medical Center in Omaha, heard from them about a number of their concerns.

You know, I'm from Texas and we passed a bill in 2003 dealing with medical liability, a bill that put caps on noneconomic damages. Other parts of the country, issues of medical liability are still front and center as far as doctors are concerned, and I did hear a little bit about that in Omaha, a lot of concern that if we really push things in the government-plan realm, that public option, if that's really what catches on, and that's what's going to be the model for reform, that the concern there is that in those settings there's very little incentive to hold down costs, and what we end up doing in these government plans, and we certainly do it in Medicaid and we certainly do it in Medicare. In fact, if we don't do something by the end of this year, doctors across the country are facing a 20 percent cut in Medicare reimbursements.

□ 2310

We go through this type of machination all the time because one of the only leverages we have to pull to hold down costs is to decrease reimbursements to providers.

I did hear from one gentleman in Omaha who felt that the way forward was going to be an individual mandate that required everyone to purchase health insurance. We need to be careful. Certainly, there are some States that have done that on an individual basis, and certainly we need to look at and learn from those States that have explored with mandates. We do get some information back that, yes, more people are covered but that, yes, costs have gone up. Insurance companies are only human. You tell them that, yes,

now everybody is going to have to buy your product and, doggone it, wouldn't you know that the price just crept up a little bit.

You do have to be careful about pricing products out of the range where people can afford them because, if you put an individual mandate out there and say you have to buy insurance or you're going to get a fine, some people will look at the cost differential and will say, ''You know what? The fine is cheaper than the insurance,'' and it never crosses their minds that actually the insurance is something of value that they need. They will just simply pay the fine, will pocket the extra cash and then will hope that they'll be able to get care if they do, indeed, ultimately get sick and need that care. So mandates, in my opinion, are something that we need to be extremely judicious of in our approach there.

We just finished tax time. The IRS. There is no bigger and harsher mandate out there than what the Internal Revenue Service places on each and every American. We know that, if we earn above a certain level every year, we've got to file a tax return. We know, if we don't and if we don't pay our taxes, the retribution will be swift and it will be certain. Well, almost. I mean there are a few exceptions. Members of Congress and some members of the administration, perhaps, don't have to pay taxes, but for most Americans, we know that this mandate out there from the Internal Revenue Service exists and that the consequences are extremely unpleasant if we do not comply.

What is the compliance rate with the IRS? What is the voluntary compliance rate with people who pay their income taxes? Well, it's about 85 percent. Right now, we have a voluntary system of insurance in this country. We don't have a mandate. What is our compliance rate? It's about 85 percent. So, before we go down the road of mandates and of putting yet more governmental control into people's lives, I think we ought to look at what the other options are. Well, the other options are keeping the product at an affordable price and to actually create programs that people want.

When part D in Medicare was constructed a few years ago, it was done very, very carefully so that there were six protected classes of drugs that had to be covered, that had to be provided for anyone who wanted to provide a prescription drug benefit. Okay. There are six classes of drugs where you have to at least offer two choices in each of those six classes of drugs. Now, the original cost for the prescription drug benefit—I forget the number—is reported to be at $35 or $37 a month under the plan that was constructed by the Centers for Medicare and Medicaid Services; but with the competition by allowing many people to participate, in fact, we were criticized because there are too many plans out there, and it's hard to choose. There are some plans out there, but the price for that prescription drug coverage was down at about $24 or $25, easily $10 per month under what it would have been under the program designed by the Centers for Medicare and Medicaid Services, and those prices have held now over the past 3 years. It's not that there weren't some problems with the initial rollout, but by and large, 9 out of 10 seniors are satisfied with their prescription drug coverage, and over 9 out of 10 seniors have some type of credible drug coverage. So we have exceeded what we would have expected with voluntary coverage. We have exceeded those numbers, and the satisfaction rates are high.

Well, maybe that's a model that we ought to look at. How was that so successful?

It was so successful because we offered a lot of choice. It was so successful because there was competition between the companies that were involved. Yes, there were some significant parameters laid down. Dr. McClellan would not budge on the concept of the six protected classes of drugs. Now I don't remember all of them, but they dealt with anti-inflammatories and anticancer drugs. There were six classes that he said you had to offer, and each of those classes had to have at least two different offerings. You didn't need to offer everything within that class, but you had to have at least two choices for patients in that. Again, the result is a program that has gained wide acceptance and that has enjoyed significant popularity.

So I would submit that that would be a better model to follow than the IRS model where we put a big, bad penalty out there if you don't comply, and we still see that 15 percent of the people are still willing to take their chances and stay away from the mandate.

The city of Dallas, Texas, close to my home, has an individual mandate for car insurance, and they were having difficulty with compliance. People would just not purchase the car insurance. So now my understanding is, if you get a traffic ticket in the city of Dallas and you cannot provide proof of insurance, they'll tow your automobile. Well, you can't really do that in health care. It just leads to all kinds of bad news stories when you go and repossess people and lock them up for not having health care insurance.

How are you going to enforce that individual mandate? We're going to have to ask ourselves: To what limits are we going to go? Is it going to be purely a monetary penalty? What are going to be the consequences of not providing that mandate?

Remember back during the campaign, then candidate Obama talked about, if he became President, he would have a mandate to cover children—a noble concept to be sure, but nobody could really ever define what was a child as far as: Is that age 18, 19, 25, 30? I heard every one of those numbers during the course of the Presidential debate depending upon the audience that was hearing the information.

Who is going to be responsible for a 23-year-old who had moved out of the home? Obviously, the parents are going to be looked to for the responsibility of a mandate for children if we're going to mandate children's insurance, but what about a 23-year-old who is on his own, perhaps off and not living with his parents any longer? Who is responsible for paying that insurance premium? Is it still the parents? Is it the parent's employer? Is it the child, himself, or the child's employer? No one could define it. It becomes very, very difficult, and there are lots of areas where corners can be cut. Unfortunately, it's in just the areas where those corners are cut where you typically get into the bad problems where someone finds himself without the coverage that he so desperately needs.

When we look going forward at the very programs and plans that might be available, one of the things that concerns me greatly about the so-called ''public option plan''—and during the campaign this was always talked about—is that we will have insurance coverage for everyone who is uninsured today. Insurance coverage will be available that's just as good as a Member of Congress'. That's the Federal Employees Health Benefits Plan.

Now, remember. There are a variety of products available under the Federal Employees Health Benefits Plan. I chose a Health Savings Account, which again saves the government money, but who's going to get to pick and choose which of those plans it is? Even with more on the low options side, we're still talking about a tremendous amount of money. How much money were we talking about putting into this?

Well, in the President's own budget that he submitted to Congress, he said $650 billion is the down payment on health care. That's over a 10-year budgetary window, so that's about $65 billion a year. Is $65 billion a year going to pay for insurance in the Federal Employees Health Benefits Plan for 40 or 45 million uninsured individuals? I don't think so. It's not even going to be close.

Steve Parente, the economist from the University of Minneapolis, estimated that cost to be somewhere north of $700 billion a year. The $60 billion a year actually buys you a slimmed-down Medicaid product.

□ 2320

Now, many people have difficulty—different States do things differently, but Medicaid has—without the cross-subsidization from the private sector, Medicaid would have a very difficult time providing the coverage that we're required to provide.

So I feel I'm at the end of my time. Obviously, it's not the end of this discussion. We'll be back to do this again many more times before the time is through.

I yield back my time.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. JACKSON of Illinois (at the request of Mr. HOYER) for today on account of illness.

Ms. KOSMAS (at the request of Mr. HOYER) for March 23 on account of travel delays.

Mr. REYES (at the request of Mr. HOYER) for today on account of illness in family.

Mr. CRENSHAW (at the request of Mr. BOEHNER) for today on account of the birth of his second granddaughter.

Mr. CULBERSON (at the request of Mr. BOEHNER) for today on account of an illness.

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 Mr. LEWIS of Georgia) to revise and extend their remarks and include extraneous material:)

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

Mr. SKELTON, for 5 minutes, today.

Ms. WOOLSEY, for 5 minutes, today.

Mr. DEFAZIO, for 5 minutes, today.

Mr. SESTAK, for 5 minutes, today.

Mr. BOCCIERI, 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, today, April 22, 23, 27 and 28.

Mr. JONES, for 5 minutes, today, April 22, 23, 27 and 28.

Mr. BURTON of Indiana, for 5 minutes, today, April 22, 23, 27 and 28.

Mr. COFFMAN of Colorado, for 5 minutes, today.

Mr. LINCOLN DIAZ-BALART of Florida, for 5 minutes, today.

Mr. MORAN of Kansas, for 5 minutes, April 22 and 23.

Mr. INGLIS, for 5 minutes, today.

Mr. FLAKE, for 5 minutes, April 22 and 23.

Mrs. BACHMANN, for 5 minutes, today.

SENATE BILL REFERRED

A bill of the Senate of the following title was taken from the Speaker's table and, under the rule, referred as follows:

S. 735. An act to ensure States receive adoption incentive payments for fiscal year 2008 in accordance with the Fostering Connections to Success and Increasing Adoptions Act of 2008; to the Committee on Ways and Means.

SENATE ENROLLED BILLS SIGNED

The Speaker announced her signature on Friday, April 3, to enrolled bills of the Senate of the following titles:

S. 383. An act to amend the Emergency Economic Stabilization Act of 2008 (division A of Public Law 110–343) to provide the Special Inspector General with additional authorities and responsibilities, and for other purposes.

S. 520. An act to designate the United States courthouse under construction at 327 South Church Street, Rockford, Illinois, as the ''Stanley J. Roszkowski United States Courthouse''.

BILL PRESENTED TO THE PRESIDENT

Lorraine C. Miller, Clerk of the House reports that on April 20, 2009 she presented to the President of the United States, for his approval, the following bill.

H.R. 1388. To reauthorize and reform the national service laws

ADJOURNMENT

Mr. BURGESS. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 11 o'clock and 20 minutes p.m.), the House adjourned until tomorrow, Wednesday, April 22, 2009, at 10 a.m.

OATH OF OFFICE MEMBERS, RESIDENT COMMISSIONER, AND DELEGATES

The oath of office required by the sixth article of the Constitution of the United States, and as provided by section 2 of the act of May 13, 1884 (23 Stat. 22), to be administered to Members, Resident Commissioner, and Delegates of the House of Representatives, the text of which is carried in 5 U.S.C. 3331:

> ''I, AB, do solemnly swear (or affirm) that I will support and defend the Constitution of the United States against all enemies, foreign and domestic; that I will bear true faith and allegiance to the same; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties of the office on which I am about to enter. So help me God.''

has been subscribed to in person and filed in duplicate with the Clerk of the House of Representatives by the following Member of the 111th Congress, pursuant to the provisions of 2 U.S.C. 25:

MIKE QUIGLEY, Illinois, Fifth.

EXPENDITURE REPORTS CONCERNING OFFICIAL FOREIGN TRAVEL

Reports concerning the foreign currencies and U.S. dollars utilized for speaker-authorized official travel during the fourth quarter of 2008 and the first quarter of 2009, pursuant to Public Law 95–384 are as follows:

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, COMMITTEE ON BUDGET, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN JAN. 1 AND MAR. 31, 2009

Name of Member or employee	Date		Country	Per diem [1]		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]
HOUSE COMMITTEES											
Please Note: If there were no expenditures during the calendar quarter noted above, please check the box at right to so indicate and return. ☒											

HON. JOHN M. SPRATT, JR. Chairman, Apr. 7, 2009.

[1] Per diem constitutes lodging and meals.
[2] If foreign currency is used, enter U.S. dollar equivalent; if U.S. currency is used, enter amount expended.

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, COMMITTEE ON HOUSE ADMINISTRATION, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN OCT. 1 AND DEC. 31, 2008

Name of Member or employee	Date		Country	Per diem [1]		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]
HOUSE COMMITTEES											
Please Note: If there were no expenditures during the calendar quarter noted above, please check the box at right to so indicate and return. ☒											

[1] Per diem constitutes lodging and meals.
[2] If foreign currency is used, enter U.S. dollar equivalent; if U.S. currency is used, enter amount expended.

HON. ROBERT A. BRADY, Chairman, Apr. 9, 2009.