Black Caucus believes are important as we move forward with our comprehensive energy legislation.

And I must say you highlighted the involvement of minority- and women-owned businesses and entrepreneurs in this effort, also the role of the Historically Black Colleges and Universities.

The role of the Congressional Black Caucus, as many know, is to make sure that no one is left behind, that no community is left behind. And the Congressional Black Caucus historically has been and continues to be the conscience of the Congress.

So, Congresswoman FUDGE, I'm really pleased that you have laid out for us tonight what the Congressional Black Caucus sees as important in this energy legislation as we communicate it to our great chairman, who is doing a fantastic job, I must say, Chairman HENRY WAXMAN. And we have communicated this to him, and we are very confident that as this energy legislation moves forward that the Congressional Black Caucus's views and input and ideas to expand this legislation to make sure it's comprehensive and that it includes all communities in our country will be part of that.

Thank you for your leadership tonight. That was a very wonderful presentation, Congresswoman FUDGE. The Congressional Black Caucus is very proud of you.

Ms. FUDGE. Thank you so much, Madam Chair.

□ 2130

HEALTH CARE REFORM

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

Mr. SCALISE. Mr. Speaker, in the next 2 days we will be coming upon the 100 days, first 100 days of President Obama's Presidency, and the last few days we have already started to have some analysis, some discussion on those 100 days, what's happened, how does it compare to prior Presidents?

Of course, this is one of those traditions that seems to occur going back to the days of FDR. And I guess it's kind of ironic that a lot of these comparisons go back to FDR, because a lot of things that are happening today in our country have a lot of similarities to what happened back in the 1940s when FDR became President, when our country was in a depression, a depression that lasted for over 8 years. It didn't end until World War II got us out of it.

I think one of the things that seems to have symbolized the first 100 days more than anything has been the record levels of spending that's gone on here in Washington. All across our country we are facing tough economic times right now. Families are tightening their belts. Families are dealing with the problems that are existing in our economy, but they are doing it by trying to live within their own means.

I think one thing that's really symbolized this first 100 days has been the record levels of spending that's gone on with this new administration to run our country deeper into debt, adding more than 20 percent to the national debt in just the last 2½ months, and record levels of spending that I think have concerned many people across the country to the point where just a few weeks ago you saw thousands, hundreds of thousands of people taking the streets in these taxpayer TEA parties where people were literally showing up all throughout communities in this country to protest and send a signal. I think that they are frustrated with the record borrowing and spending and taxing, as well as these bailouts that are not working.

And so as we look at all of this, I think it hopefully is an indication that we need to pull back and refocus our country on those things that we truly need to take care of to address the problems that our country is facing and act in a fiscally responsible way to address those problems. So I think what we need to talk about now are the ways that the next 100 days can hopefully shape us in a different direction than first 100 days.

And as we look at some of these policies, we are debating right now in the Energy and Commerce Committee a major change in our Nation's energy policy. I think our Nation is severely lacking a national energy policy. There are good alternatives that are out there.

I am a cosponsor of a bill called the American Energy Act, which takes an all-of-the-above approach to fixing our national energy crisis, and a bill that would actually open up more areas of our own country's natural resources to drilling for oil, for natural gas, for developing clean coal technologies and then using that revenue not only to create good jobs and to reduce our dependence on Middle Eastern oil, but to fund our ability to transfer into those alternative sources of energy like wind and solar power. But we also need to keep nuclear power as one of the components of a strong national energy policy.

On the other side of that, what we are seeing is the presentation of a bill called cap-and-trade. And the cap-and-trade energy tax is nothing short of that, a massive change of energy policy that the President has brought us in the first 100 days that would literally turn over our energy economy in this country to a Wall Street speculative market where companies would be limited in how much carbon they can emit in this country, but then they would have to pay taxes, in essence, on any more production that they would do.

Early estimates are this would raise $646 billion in new taxes, but it would saddle every American family in this country. Early estimates by the President's own budget director show that there would be over $1,300 a year more that every American family would pay in their own home energy bills, not in addition to all of the jobs that would be lost.

Early estimates by groups like the National Association of Manufacturers show that a cap-and-trade energy tax would literally ship 3 to 4 million jobs out of our country overseas to countries like China, India, Brazil and other nations that would not have the same kind of environmental regulations that we have today. So for people who are concerned about carbon emissions, the cap-and-trade energy tax wouldn't do anything to lower carbon emissions in the world.

What it would do is run off a lot of companies in the United States, ship those jobs, millions of jobs out to other countries like China, India, Brazil and others who will emit even more carbon. So it's a very counterproductive strategy from that standpoint but one that has a lot of support by some in Congress. And then hopefully there will be enough of us on this side to not only defeat that bill but then bring our alternative plan, like the American Energy Act, a plan that would put a comprehensive national policy in place to get our economy back on sound footing, but also to reduce our dependence on Middle Eastern oil, something that has been a problem for a long time, something that hasn't been addressed by Congress adequately, but one that can be.

And so while we are talking about and evaluating these first 100 days, there are a lot of things that we can do to look at how to move us to a better place in our country. And if you will look at what has been happening with the budget, one of the interesting conversations that we hear about is how much debt was run up in prior administrations.

Frankly, I was not a supporter of the debt back then. I surely am not a supporter of the debt that's being added to our children and grandchildren right now.

And if that debt was bad, which I agree it was, then these proposals, in fact, the President's own budget that's going to be coming up on a vote here on this House floor probably later this week, would double the national debt, double the national debt in just 5½ years.

And so just about a week ago the President had met with some of his economic advisors and his Cabinet, he pulled in his Cabinet and he said, I want you to go out and find—in a $3.5 trillion budget, he called all of his Cabinet members in and gave them the task of cutting $100 million. Now, I think we can all find ways to cut $100 million in the budget.

But to bring all your Cabinet members as a task to figure out how to go and cut $100 million, just to equate that to an average American family, that's like a family of four who makes $35,000 saying, let's sit around the table. We have got tough economic times. We need to cut our budget. A

family of four making $35,000, if the best they could do is come up with a way to cut $1, that would be the same equivalent of the President's challenge to cut $100 million out of a $3.5 trillion budget.

So I don't think any family would be celebrating after they found that $1 amongst all of their expenses, $1 they could cut out of their entire $35,000 budget. That's, so far, the best that this administration has been able to come up with.

I think we can do better. I think the American people are challenging us to do better. Some people that are here will talk about ways that we can do better and have some good ideas of their own.

Dr. GINGREY from Georgia is one of them, and, Mr. Speaker, at this time I would like to yield to Dr. GINGREY of Georgia.

Mr. GINGREY of Georgia. I thank the gentleman from Louisiana for yielding.

We thought we would spend a few minutes this evening talking about another problem, a huge, huge problem, and, of course, that is with our health care system in this country and the fact that the administration has made one of their top priorities for this Congress health care reform.

Those of us on the Republican side, Mr. Speaker, the loyal minority, feel that our health care system does need some reforming, but not in the way that the President has proposed, not in the way that the majority party has suggested the road in which they want to travel in regard to health care reform.

I have got an opportunity this evening to be joined by a number of doctors on our side of the aisle; in fact, we are part of a new caucus in the House, the Republican or GOP Doctors Caucus. We have about 12 members in that group, Mr. Speaker. And I was trying to get my staff to real quickly this evening estimate the number of years of medical provider experience that, in the aggregate, we have got in this group. And that estimate, as just given to me by one of my colleagues, 331 total years of medical practice among the GOP Republican Doctors Caucus. Let me repeat that, Mr. Speaker, 331 years.

Now, I am not going to say that that necessarily makes us experts, but it certainly does give us, in the Republican Doctors Caucus, a perspective, an experience that we should definitely be heard on this issue of how to best reform this health care system of ours that we love to say and proudly say is the best in the world.

We know that it's not perfect, and we know that when statistics are thrown out by the United States Census Bureau that 47 million Americans every day throughout the year go without health insurance, that is a staggering statistic, and I would say, Mr. Speaker and my colleagues on both sides of the aisle, an unacceptable statistic.

Now, the truth of the matter is, when you peel back that onion, though, of 47 million people that have been determined by questions of survey that's done in the typical Census Bureau fashion, what you find is that this is just kind of a snapshot, Mr. Speaker, of any point in time there may be 47 million people who are without health insurance. But many of them, in fact, it's estimated that as much as a fourth of that number or maybe even as much as 40 percent, within 2 to 3 to 4 months, at the most, will have insurance. They may have lost it temporarily because of a job change or an illness, or they just happened to let their premiums lapse, and they regain that health insurance.

But one of the things that's without question, as we look at the statistics, the 47 million, is that there are 18 million of them who clearly can afford—I am not saying they live in luxury, but they could afford to provide health insurance for themselves and probably for their family as well, because 18 million of the 47 million make more than $50,000 a year.

□ 2145

Eighteen million of the 47 million have an income more than $50,000 a year, and 10 million of that 18 million make more than $100,000 a year.

So there are people in this country that are just simply, they are probably, I would guess, demographically between the ages of 22 and 35, who are healthy and young and in many cases single, have good jobs, professionals, just don't want to spend the money and just feel like, well, if I get sick, I will pay it out of my pocket.

I think it is a mistake. I think it is a huge mistake, and I certainly don't recommend that. I think people are playing Russian roulette almost by doing that because of some catastrophic illness, a broken neck in a motor vehicle accident that would leave a person disabled for life. That is a worst case scenario I guess you could think of. But that just shows you that the number is not as bad, that 47 million. Then it is estimated that one fourth of those are people who are not even citizens of this country.

So you get down and you start peeling the onion, and you peel the onion, the layers peel back and you may have 15 million in this country, 10 or 15 million people who, through no fault of their own, they are not poor enough to be eligible for our safety net programs like Medicaid and maybe the CHIP program, Children's Health Insurance Program, and they are not old enough to be eligible for Medicare. They are not disabled, thank goodness, but they don't make enough money to be able to afford it.

We definitely need to do something about that, and I can tell you that every member of the Doctors Caucus, the Republican Doctors Caucus, agree that number is too high, and we want to do something about it, and we will do something about it. There are a number of things that need reform in our system, and we will talk about that tonight.

I have been joined by a couple of my colleagues as I look across the Chamber and I see Dr. MURPHY from Pennsylvania, and I see Dr. FLEMING from Louisiana, and I think others will join us as we get deeper into the hour. But I am going to engage sort of in a colloquy, maybe an open mike with my colleagues, Mr. Speaker, talking about what we feel needs to be done, but, more importantly, what we feel absolutely should not be done as we bring to you these 331 total years of medical experience and working with patients, constituents now, that we have morphed into proud Members of the Congress, but to understand what they want, what the doctor-patient relationship is all about.

Some of our colleagues, Mr. Speaker, have not had that unique opportunity, and it is our obligation to share it with them as they share with us their experience in their professional lives. That is really why we are here. That is what we are all about.

Anyone that says Republicans are the party of no, they have no opinion, they just show up and vote no, that is absolutely an unfair characterization, Mr. Speaker. We do have a plan. We have a second opinion, as I point to this first slide before yielding to my colleagues. We have a second opinion, heck, on everything, on every issue.

We heard from Mr. SCALISE a few minutes ago about spending and a second opinion that we Republicans have on the budget, a second opinion that we Republicans have on the Energy and Commerce Committee in regards to what kind of comprehensive energy bill this country needs that is not this cap-and-trade and the silent hidden tax of $3,000 per family that hits middle class Americans so hard, and that is what the second opinion that Mr. SCALISE was giving in regard to that issue.

Well, by way of introduction, Mr. Speaker, that is what we are going to be talking about here for the next 45 minutes. I see my colleague from Pennsylvania is here and ready to go, and I want to yield 5 to 7 minutes to the good doctor from Pennsylvania, Dr. TIM MURPHY, my classmate and colleague.

Mr. TIM MURPHY of Pennsylvania. I thank my friend Dr. GINGREY for yielding. Of course, Dr. GINGREY, you are well aware as a practitioner of how Medicare works. I want to lay out for a few moments here, as many people will start to say that we should use Medicare and Medicaid as examples of how to expand health care because they are run so well. I want to point out a few things about how I disagree with that premise and those that say that Medicare has a very low cost overhead.

In part, that is because some of the administrative fees are set, but there are several other things we need to know about that, and that is that they

pay very low fees to hospitals and physicians, and perhaps that is why so many physicians do not participate in Medicare-Medicaid payments. Another aspect too, is, understand that Medicare covers only about 58 percent of beneficiaries' health care expenses.

So when you leave that much in other fees on the table unpaid, what happens? Well, hospitals use some of their own coverage to cover that gap in Medicare coverage. Patients also carry their own supplemental insurance on their own to cover it, and many times it is left that the actual cost of Medicare that we are told does not anywhere near describe what the real cost is.

The Medicare Payment Advisory Commission, otherwise known as MEDPAC, said the way Medicare is going, its well-known design deficiencies and financial problems will certain inhibit the delivery of high quality care, in its June 2008 report to Congress. They said, ''Without change, the Medicare program is fiscally unsustainable over the long term and is not designed to produce high quality care.''

Let me give you a couple of examples of where I think Medicare is a particular problem, and Medicaid as well.

A constituent of mine has multiple sclerosis, and some of you may know that multiple sclerosis affects nerve cells and really affects the ability of those nerve cells to communicate with one another. There is a membrane over the arm of nerve cells called a myelin sheath, and what happens is the sclerosis or scarring of that sheath affects the ability of one nerve to communicate with another.

In multiple sclerosis, a person may have discrete attacks or long-term attacks that may affect their motor skills, their muscle skills or their thinking and cognition. At times it goes away completely for long periods of time and then comes back.

The annual cost per patient, however, for treating such patients may be $30,000 or $40,000 or $50,000 a year. And yet how does Medicare and Medicaid handle that? Well, they have this strange notion that says, for example with Medicaid, if you want to have some payment for that, you must be disabled. But to be disabled you have got to go 24 months of disability, which is not a characteristic of this illness. And, of course, to be disabled means you can't work. If you are not working, you can't pay for your medication. If you stop working and they find out you really are without symptoms, it is a problem. So, you see, it is one of those catch-22s we put people in with this.

There is also something here that Medicare and Medicaid does not pay for: Disease management. This is particularly important, because disease management for people on Medicare is extremely important because of the complexities of their illness. And these complexities are not small.

Nearly 80 percent of Medicare beneficiaries have at least one of the following chronic conditions: Stroke, diabetes, emphysema, heart disease, hypertension, arthritis, osteoporosis, Parkinson's disease, urinary incontinence. And because of this, 5 percent of Medicare beneficiaries account for about half of all Medicare spending each year. Among this top 5 percent, nearly half had congestive heart failure and 35 percent had diabetes.

You see, there is such complexity among people with chronic illness, it is a wonder they can manage it at all. That is why people with severe illness do better if the doctors and nurses can work with the patients to manage this complex care.

You don't have to be a member of our GOP caucus to notice how difficult it is, and hopefully some of the comments made by some of my colleagues tonight can illustrate that. But I know patients that I have worked with, sometimes it is absolutely overwhelming for them to have multiple visits and dealing with so much with their illness, and yet Medicare and Medicaid won't pay one penny to have anyone from that medical practice work with that patient.

So what happens? They forgo their treatments, they make mistakes in the medications, there are many difficulties that come up, and it could lead to unnecessary hospitalizations. And those, Mr. Speaker, those issues are ones that cost so much in the area of health care. I am sure my colleagues, no matter what branch of medicine or health care they are from, know this full well. When you have a patient with multiple complications, if they cannot deal with it, well, the complications increase.

Part of the reason that this is even more of a problem is that what happens, these complexities go on. If you have Medicaid and Medicaid plans that say we are going to pay for what they call quality of care, and it is only based on a narrow measure of outcome, then what happens is that patients stop to be compliant and hospitals may discharge some of them early because they are not paying for actually managing these difficult cases.

This is a serious, serious problem, and one of the reasons why out of this $2.4 trillion health care system we have no less than $700 billion or $800 billion worth of waste. It is because of that, Mr. Speaker, that what we ought to do is, before we say let's have the government expand Medicare and Medicaid and make it available for all, we ought to say let's use all of our abilities to fix these broken systems. It is wasteful, it is harmful, it is difficult for patients, and it is not effective health care. And because of that, I would certainly encourage what Congress should do with all full speed is instead of saying let's just replicate this broken system and expand it for everyone, we ought to fix this system.

Medicare's hospital payment system doesn't encourage or reward hospitals to reduce readmissions. It is a matter that we almost have like 18 percent of admissions results in readmissions within 30 days of discharge. What is wrong with a system that has those kinds of problems?

So, Mr. Speaker and my colleague, Dr. GINGREY, I know, doctor, how you and I have talked many times about these difficulties and how they go on.

I might add this other point, if I may, doctor. You are aware that with Medicare, that as people lay this out as being this great cost-effective plan, one of my concerns is if it is so cost-effective, why is it going belly up? It is out of money in less than 10 years. Yet it is touted all the time of having this effective health care system. It is not that way. I think it is that way simply because it is not paying for effective health care along those lines. That is one of the issues that the GOP Doctors Caucus is trying to bring before the American public, and certainly before our colleagues here in the House.

Mr. GINGREY of Georgia. Dr. MURPHY, if you would yield back to me just for a second on that point, this second slide, the cost of the current government-run health programs, well, on this first bullet, colleagues, look at this. CBO estimates that individual and corporate income tax rates would have to rise by about 90 percent through 2050 to finance projected increases in Medicare and Medicaid. That is what Dr. MURPHY is talking about. The cost of reductions in Medicare payments then are passed on to consumers who purchase their own care or get it from their employer, and that adds $1,500 annually or 10.6 percent to the annual cost of coverage for a family of four.

So, Dr. MURPHY, I agree with you completely that we are in a situation where if that is the model, then God help us, if that is the model that we are going to adapt for all Americans. ''Medicare for all'' I think is the way Senator KENNEDY put it.

I think there is a formality here, Mr. Speaker, in regard to who controls the time. Our colleague from Louisiana, he is not a physician, he is just a very smart Member of this body and my colleague on the Energy and Commerce Committee where we deal with health care, as is Dr. MURPHY, where we deal with health care every day, and Mr. SCALISE, the professor from Louisiana, is controlling the time, and I yield back to him as he yields to other colleagues.

Mr. SCALISE. Well, I thank the gentleman and the doctor from Georgia. As you said, I am not a doctor, and I don't play one on TV, but I do enjoy serving with you on the Energy and Commerce Committee, where we do deal with the policies that actually address the health care issues in our country, which are very important.

One of our newest Members, somebody who I am proud to serve with in my State delegation, a new Member from Shreveport, Louisiana, who happens to be a doctor and a very able student on these issues, is my friend Dr.

FLEMING, who I am going to yield time to now.

Mr. FLEMING. Well, first of all, I want to thank my friend from Louisiana, Mr. SCALISE, or should I say Dr. SCALISE. We have made him an honorary doctor tonight. Also I want to thank Doctors MURPHY and GINGREY for their comments. I do want to follow up on some of these comments. I think they all fit together nicely.

You know, first of all, I would like to say that the United States delivers the best health care in the world, or at least among the best, arguably the best, but the financing of it is a basket case.

You heard, Mr. Speaker, Dr. GINGREY talk about the 47 million uninsured, which is a very fluid number. But, you know, I have often said through my experience that these 47 million are not the people you think they are. They are not the poor, because we do have programs for the poor. They are not the elderly. We have Medicare for the elderly. And they are not those in stable employment in corporate America.

They are, for the most part, small business owners and their employees. There are really several reasons why insurance is difficult to obtain or to afford for these people, and I won't go into all of that in detail, but I do want to hit eight points that I recommend in terms of health care reform.

□ 2200

Mr. FLEMING. Before I get to that, I want to contrast with you what I understand the Democrat offering is on this subject, and that is a, more or less, expanding Medicare, which we have today for the elderly and for the disabled to everyone. I think there are a lot of satisfied recipients of Medicare out there. However, I would remind everyone that Medicare exists only because it's propped up by taxpayers and by private insurance. So, if we expand Medicare to everyone, who is going to prop that large system up, perhaps as much as 17 percent of our total economy?

I really think that we can have our cake and eat it, too. I think, Mr. Speaker, that we can have excellent insurance coverage and that we can actually cut costs in the process. So here is point 1:

Despite the need for Federal and State governments to pay many of the health care insurance bills, the government, itself, should get out of the administration programs. Why is that?

Any politician who tells you that when he is elected or that when she is elected that he is going to do away with all fraud and abuse in government is either lying to you or really has no idea what he's talking about. The reason for that, as we apply that to health care, is: If you take, for instance, two physicians who are treating the same pneumonia, physician 1 treats it with an office visit, with maybe a follow-up office visit and with, perhaps, a prescription for antibiotics. The other physician admits a patient to the hospital, costing upwards of $7,000 to $10,000. The question is: Who is right?

The answer is they're both right, but one costs many times more than the other. We really, currently, don't have a way of saying, Well, what is the best and most efficient cost in every case for every patient?

I would submit to you, Mr. Speaker, that the Federal Government does not have the ability to micromanage care to its most efficient point. However, we can—if we are allowed to provide health care through administrative means, that is—pay the money to certain organizations of providers and allow them to make those decisions as to where they can cut the waste out, and to do so through competition, I think we could actually save money and see improvement in care and certainly in customer service.

Second and as part of that is: physicians and other health care providers should be allowed to come together in both vertical and horizontal integration so that, instead of having a reimbursement rate that's dictated by the Federal Government—it's the only part of the economy, incidentally, in which the Federal Government determines the actual price that anyone is paid, the so-called ''price regulation.'' If we move from that into price competition where you have groups of providers who come together and who group together and who compete for covered lives and, in doing so, work efficiencies into the system of lowering the cost and improving the quality, I think we would see much more for our money, and certainly our patients would.

Third, we need to provide basic health care insurance for every American, at least make it affordable. In doing that, remember that today, through the EMTALA laws passed in the 1980s, someone with or without insurance can appear to the emergency room, simply request care and will be provided care despite that person's ability to pay. Well, that's all well and good, but what often happens is it's a person arriving to the emergency room who's receiving the highest cost of care and oftentimes the lowest quality of care because it's provided at the wrong time during the illness. Ultimately, someone else, such as other subscribers and taxpayers, end up paying the cost.

If we had private insurance for those individuals who were uninsured, oftentimes they wouldn't need to come to the emergency room. They could simply receive early treatment, diagnostic treatment or even prevention therapy, before ever having the need to come to the emergency room.

Fourth, we should allow the public to be informed consumers with simple and transparent systems so that they can make wise choices.

Fifth, we should reform antiquated insurance laws and give incentives to the young and healthy to opt into private insurance so that we have large risk pools and so that we do away with the term ''preexisting illness.''

Sixth, we need to move forward on incentives for providers to move into the digital age with electronic health records. That will greatly enhance communication. At least in my own experience, I've had electronic health records in my clinic now for over 10 years. It has actually lowered our cost and has improved our efficiency.

Seventh, we should make family physicians the linchpin of our health care system. Supported by midlevels, they can have a tremendous effect on lowering the cost while improving care.

Finally, we need to provide strong incentives for patients to function as consumers and to behave in every way possible to prevent disease rather than enter the system at the worst possible time when cost is the highest and outcomes are the poorest.

So, you see, Mr. Speaker, while we are not hearing about these solutions from the other side of the aisle even though there's a placeholder for over $600 billion as a down payment towards health care reform, on our side, we're being very specific about what can be done and about what should be done. Many private and connected governmental agencies agree with these major points that I've discussed today.

So, with that, I thank the gentleman, Mr. SCALISE, for allowing me this time, and certainly, I yield back my time.

Mr. SCALISE. I thank the gentleman from Louisiana. I yield back to my friend from Georgia.

Mr. GINGREY of Georgia. Well, I thank the honorary Dr. SCALISE for yielding time back to me because the point, before we go back to Mr. SCALISE and then hear from Dr. ROE, is this a point about a new government-run health plan that, I think, we want to emphasize to our colleagues because this is the one thing that we fear the most.

Well, I guess the one thing that we fear the most is, in one fell swoop, going to a single-payer system of socialized medicine like they have in Canada or in the United Kingdom or in other countries where there are major, major problems that some of my colleagues might want to address. That's the worst thing.

What we fear from the strategy of the Democratic majority, Mr. Speaker, is to get there in two steps. The first step, of course, would be to have a government plan, a government health insurance plan, to compete with the private market, but the question is: Will that government plan compete fairly? We think not, and we have a great fear that it would drive the private market out of a competitive position and that it would cause employers who right now cover 119 million lives through employment-provided health insurance to just simply drop that and say, Well, shoot. You all go get it from the government.

I will yield back to my colleague from Louisiana, Mr. SCALISE, so he can yield time to other colleagues in the doctors' caucus.

Mr. SCALISE. I thank the gentleman from Georgia, and I think your concerns about a government-run system are very heartfelt. Obviously, we've got many other countries that have gone down that road and then have had the very bad experiences to show for it. I know what you all are doing here is a great service to be talking about alternative solutions, a better way to fix and to reform our health care system.

Mr. TIM MURPHY of Pennsylvania. Will the gentleman yield?

Mr. SCALISE. I will yield to the gentleman from Pennsylvania, Dr. MURPHY.

Mr. TIM MURPHY of Pennsylvania. I thank the gentleman.

I wanted to just take a moment to illustrate what Dr. GINGREY was saying as to the effect of the inefficiency of government-run health care.

The New York Times, just a couple of weeks ago in an article written by Julie Connelly, talked about a growing number of physicians—it's an article entitled ''Doctors Are Opting Out of Medicare''—particularly internists, who are dropping out of Medicare all together because of low reimbursement rates and the burden of paperwork and, I might add, because of some of the ridiculous policies sometimes.

It's noted in a Texas Medical Association survey that 58 percent of Texas doctors accepted new Medicare patients, but only 38 percent of primary doctors did so. Think of some of these absurd principles in some of these government-run plans.

For some patients, they might need home infusion therapy, that is, they may need antibiotics; but the strange thing about this is that the person has to come to the hospital to get them. They're sick. Instead of being at home and having a nurse or someone in the family trained to give some home infusion, they've got to get up, leave the house and go somewhere else. I know my colleague, Representative ELIOT ENGEL, and I are working on a bill to allow a part D drug benefit to cover some of these home infusion drugs because, right now, when you are denied access to home infusion therapy and are being forced into receiving infusion therapy in hospitals and in skilled nursing facilities, it's significantly higher in cost.

There is one other example I wanted to talk about, too. I've talked to some oncologists who have pointed out, when patients come in for chemotherapy, they need to be evaluated at that time to see if they're healthy enough or in the right condition—that they're not sick at that moment or have the flu or something else which would cause serious problems if they received chemotherapy. Yet what happens is, when they get to have those results and to have those tests and to have that treatment done, you have to do certain lab work, and they don't get reimbursed for that. So the medical practice eats that cost, once again, to supplement the Medicare and Medicaid plans.

I point that out as some of the many examples of how, anytime someone says Medicare and Medicaid are much cheaper, of course they're cheaper. They don't pay for treatments; they discourage comprehensive medical care, and they place the burden back on the patient and back on the States. That's not how we want to run a health care system; and I believe, in many cases, it leads to more difficult care.

□ 2210

God bless the doctors and hospitals who do the right thing and give of their time anyway.

With that, I yield back.

Mr. SCALISE. Before our committee just a few weeks ago, Louisiana's Department of Health and Hospital's Secretary, Secretary Levine, was testifying about exactly that problem about a Medicaid-type model being followed and used by Congress to replicate that throughout the country and the devastating impact it would have because, clearly, as you pointed out, there are serious drawbacks from having a Medicaid system. The lack of access to health care physicians is a big disincentive that many consumers would have if they found out that they were being shifted over to a system like Medicaid that's very broken right now, to have that system replicated for the entire country.

Again, I appreciate you pointing out these dangers, because before we go down that road, these are important things to lay out.

Somebody else that's going to help lay that out is our colleague, a doctor from Tennessee, Dr. ROE.

Mr. ROE of Tennessee. Thank you, Mr. SCALISE or Dr. SCALISE, whatever it is tonight.

I am going to share with you some of the experiences that—we've already done this experiment in the State of Tennessee. And as a physician from Tennessee and who has delivered babies in that State for over 30 years, we've seen our health care system change dramatically.

Remember back in the 1980s, early 1990s when managed care was going to be the be-all, save-all for us and obviously didn't slow the health care costs at all. And none of us here tonight, not a single person—there is well over 100 years' experience in this room tonight discussing this—defend the status quo. Not any of us do. Many of us have a tremendous program, I think, and we're here tonight to share these experiences, what is positive and negative about the system.

Let me turn the clock back about 15 or 16 years to a very noble cause in the State of Tennessee—not a wealthy State—to cover all of our citizens, and we went into a managed care plan. We got a Medicaid waiver called TennCare, and what happened was this was a very rich plan that was offered by the State to compete with other plans. And businesses made a perfectly logical decision: 45 percent of the people who ended up on TennCare had private health insurance but dropped their private health insurance to go on the State plan.

And I went to several of the hospital administrators, the providers there locally, and I said what percent of your cost did TennCare pay in your hospital system? It was about 60 percent. And Medicare, at least in our area—it varies in different areas—pays about 90 percent of the costs. And then you have the costs of the uninsured which pays somewhere in between, leaving a cost shifting to the private payers.

Well, what is going to happen—and this is so predictable because we've already done this experiment—we're going to have a plan that's going to be set forward—again, a noble plan—to cover everyone. If we have time tonight, I will go over some principles that I feel are important in the health care debate. What will happen is there will be a plan brought forth to compete with the private sector that will be subsidized by the taxpayers, that when you go to provide the care, it will pay less than the cost of care. And once again, businesses will make a perfectly logical decision to drop that, and over time, you'll end up with a single-payer system. That's how exactly it's going to work.

And what happened in Tennessee was this: In the State of Tennessee, you had a choice. In Tennessee, we can't borrow money. It's against the State Constitution, so we have to balance the budget. When the TennCare rolls got so big, the legislature and our Governor—who is a Democrat, different party—made a decision. We had to pare the rolls. So they rationed care by basically cutting the number of people on the system.

What happens in a system like in Canada and in England, what happens when you've spent all the health care dollars? The only other option you have is to create waits, and that's exactly what happened.

Let me share with you another statistic that hits me right in my heart, because when I started my medical practice, as did Dr. GINGREY, the 5-year survival rate of breast cancer was approximately 50 percent for women in America. Today, it's 98 percent. One of the great stories.

So when a patient comes to me or the physicians in this room, they can tell that patient, You're going to have a 98 percent survival rate. In 2003, the 5-year survival rate of breast cancer in England was 78 percent.

Now, in England, which is a single-payer system—and in that system, they quit doing routine mammography, and the reason for that was cost. The mammogram comes along and says the woman has a problem in her breast. You do a biopsy, and it shows up that it's negative. She doesn't have cancer, and that is a wonderful thing to be able to tell a patient. But these wire-guided needle biopsies are more expensive than the routine mammogram is, so

they quit doing those, and they wait now until a patient develops a mass in her breast which is approximately 2 centimeters, about three-quarters of an inch, of which a certain percentage of those women will have spread to a lymph node. We're not going to do that in this country. I cannot believe we're going to do that.

The survival rates of colon cancer are less in England than in this country, and the reason is because the screening takes place at a much later time. I, myself, had a screening colonoscopy at age 50. I had a lesion discovered, clipped out. I've had absolutely no problem whatsoever. If I had waited later in my life, I most likely would have had colon cancer.

So just from a personal testimonial here, those health care decisions, Mr. Speaker, should be made between a patient and the doctor, mutual decision made between both of them. That's where the health care decisionmaking should be made.

And I will yield back my time. I have some other things to talk about, Mr. SCALISE, and I appreciate the honorable gentleman for giving me this time to express my opinion.

Mr. SCALISE. I appreciate your comments, and hopefully we can hear more from you about the TennCare experiment as well as the other ideas that you've got that make a lot of sense.

I yield back for a few moments to Dr. GINGREY, until we go to the other side of Georgia.

Mr. GINGREY of Georgia. Thank you very much.

Just momentarily, before we go to east Georgia and Dr. BROUN, I did want to show in graphic form on this next slide, this poster that I have—my colleagues, when I talked about the employment-based health insurance, the 119 million, here they are in this pretty green box here, chart, showing that 119 million in these private plans under this so-called public default plan will end up over here in this nice orange bar graph showing something like 132 million people on the government plan.

And as our colleague from Pennsylvania, Dr. MURPHY, was talking about earlier, if that's the model that we want, that's the model that right now, 33 percent of physicians have closed their practices to Medicaid, 12 percent have closed their practices to Medicare. Why? Because these artificially low reimbursement rates do not even cover the doctor's expenses.

Physicians want to give their time out of compassion and to treat the poor who cannot afford health care through no fault of their own, but they can't keep the doors open. They're small business men and women as well, and they have salaries to pay. They have insurance to provide. So it's just a matter of going down a road that's not sustainable.

Representative SCALISE, thank you for yielding me time, and I yield back to you so you can yield to Dr. BROUN.

Mr. SCALISE. The chart you showed gives us a good indication why we have the physician shortage in this country. It is a crisis in health care, and in part because of not only the high cost of medical education, but then when so many get out, they realize that these types of payment methodologies actually inhibit their ability to make that back and ultimately be able to pay back those student loans. And so these types of programs have very dangerous consequences that we're seeing today.

Somebody else that can talk about that is our good friend from Georgia on the east side, as you said, Dr. BROUN.

Mr. BROUN of Georgia. I thank the gentleman for yielding.

He just brought up a good point about—Dr. GINGREY did also—about the reimbursement rates. I'm a general practitioner, and I've done a full-time house call medical practice prior to being elected to Congress 2 years ago. I would go see my patients at their home, at their work, and I did that full time.

□ 2220

Prior to that, though, I was in an office. And the reimbursement rate for all primary care physicians in this country is dismal. And that is the reason that, what Dr. GINGREY was saying, that even the physicians who have quit taking Medicare, a lot of those are primary care docs, family practitioners and internists, pediatricians—and there are some pediatricians that do see Medicare patients that are disabled. And so the physicians have had to quit practicing on patients that are on Medicare or Medicaid.

I want to make a point tonight—and I think you all are making great points—but we have two very different opinions of how to tackle this issue. On one hand, we have the Democratic Party's philosophy, which I have been describing as a ''steamroller of socialism'' that is being shoved down the throats of the American public. And it is going to strangle the American economy; it is going to actually slay the American people economically. And one of those issues that the steamroller of socialism is rolling over is health care.

What NANCY PELOSI and company here in the House and HARRY REID over in the Senate are proposing are policies that are going to destroy the quality of health care. On one hand, they want Federal bureaucrats making health care decisions. On the other hand, Republicans have plans—several, actually—that will allow the doctor/patient relationship to be how health care decisions are made.

On the Democratic Party's plan, government bureaucrats are going to be setting the fees. On the other hand, the Republicans' plans will allow the marketplace to set those fees. The Democratic Party's plan, on their hand, we see basically a monopoly controlled by the Federal Government. On the other hand, the Republican plan allows market decisions, marketplace factors to control the quality, quantity, and cost of all health care decisions, as it should be.

I believe very firmly in the marketplace, and I think the marketplace can make the quality of care be high. The cost of care—whether it is insurance, or doctors offices, or pharmaceuticals, or durable medical equipment, or infusion services, all these things—the marketplace is the best way to control the quality, cost, as well as the quantity of all the goods and services even in health care.

And so the American public have really two alternatives; one is the steamroller of socialism that is being fostered by the majority here in this House, the majority in the U.S. Senate, and the administration. They want to totally socialize health care. When they talk about health care reform and comprehensive health care reform, those are code words for them for socialized medicine.

When we talk about comprehensive health care, we are talking about changing the whole system to allow the doctor/patient relationship to be how health care decisions are made, to allow patients to own their insurance instead of the government owning their insurance. And we have plan after plan; but unfortunately, the Democratic majority are obstructing us being able to even present those plans here on the floor of the House.

The American people are going to have to demand of the Democrats, demand of their Members of Congress, Republican and Democratic alike, that we want an alternative, a private system alternative, an alternative that will allow me, as a patient, to make health care decisions so that I don't have some government bureaucrat rationing the care that me or my mom or my daddy or grandma gets, or my children. And those are the opportunities that the American public have; do we want a socialized health care system that is being mandated by the Federal Government, by the Democratic majority, or do we want to have comprehensive health care that makes sense, that is delivered in the private system where the doctor/patient relationship is how health care decisions are made, where patients own their own insurance, where patients make their decisions, not some government bureaucrat?

We have got to demand better than this plan that the Democratic majority is trying to force down the throat of the American people. And it is up to the American people to demand from the Democrats, say no, we don't want this socialized medicine. We want the Republican plan to be voted on in the U.S. House. We demand it. And that is the way we are going to see responsible, market-based health care decisions brought about.

Mr. SCALISE, I yield back.

Mr. SCALISE. And Dr. BROUN, I think the strength of the American system is the fact that the patient and the doctor, the two of them get to decide what their health care decision is

going to be, not some outside party, some government bureaucrat like we saw in the stimulus plan where they set up this health care czar, literally a Federal bureaucrat that would be able to interfere with the relationship between the doctor and the patient. Definitely the wrong road to go. That is why I think it is so important that you are bringing up this point.

And I will yield for one moment.

Mr. BROUN of Georgia. If the gentleman will yield a moment, government regulation, government control—Medicare policy is driving the health care system. It is so expensive today because of government intervention in the health care decisionmaking process. Let me give you an example of how government regulation markedly increases the cost.

When I was in an office down in southwest Georgia, I had a small, automated lab. If a patient comes in to see me with a red sore throat with white patches, running a fever, coughing, runny nose, I would do a CBC to see if they had a bacterial infection and thus needed antibiotics, or had a viral infection because it looks the same. Don't need the expensive antibiotics, don't need the exposure of the antibiotics. I charge $12 for the test. It took 5 minutes to do it in my office. A totally automated lab with quality control because I wanted to make sure that the quality of the test was correct. Congress passed a bill, signed into law, called the Clinical Laboratory Improvement Act, CLIA; shut down my lab—every doctor's lab across the country. The same test, I had to send the patient over to the hospital. It took 2 to 3 hours—which I could do in 5 minutes—cost $75. Now, you think about how that increased the cost across the whole health care system. It markedly exploded the cost of all insurance to everybody, government as well as the private sector.

We have got to get the regulatory burden off the health care system. We have got to put market-based solutions in the system. And we can solve these problems, but that is exactly what we need to do.

Mr. SCALISE. And reclaiming my time, that is why these policy changes can be so dangerous because they have serious ramifications if they are not done properly.

I want to go back for a moment to Dr. ROE before we wrap up with Dr. GINGREY.

Mr. ROE of Tennessee. Thank you very much for yielding.

I think, just to kind of emphasize what Dr. BROUN said, if you like the way the government managed AIG, you are going to fall in love with a government-run health care system.

I think there are a few principles that we all ought to abide by, and I think we have, and we have discussed this tonight. One is, above all, do no harm. Eighty-five percent of people have health insurance now. We have to help control the cost.

Again, as Dr. BROUN was talking, physicians and patients should be making decisions. And every American needs access to quality, affordable health care. I think we all agree on that, and we have brought up some ideas tonight about how to do this.

An illness should not bankrupt you; you shouldn't go bankrupt because you get cancer or another serious illness, and today it does. It should be portable. We have got several ways—and we can talk about this in the future. It shouldn't just be tied to your job. And the COBRA payments now, you have to be Bill Gates to pay for it. You would have to have an affordable way to do that.

And lastly, every single person ought to make an investment, ought to have some investment. Let me give you a very quick example. Let's say a patient on the Medicaid/TennCare system in Tennessee would come to my office to be treated for a cold, as he was talking about; a perfectly rational decision because it costs nothing to do that. If you go down to the local pharmacy to get some medicine, it might cost you $15 or $20 to be treated for the same cold.

With this system right here we are talking about, exactly what happened in that graph, Dr. GINGREY, is what is going to happen to the national system; you are going to push people out of a higher quality private system into the public system that we have seen.

I had patients who had to go to Knoxville—which is 100 miles from where I live—to see an orthopedist because no one would take the Medicaid-type insurance. And I can go on and on. And we will discuss this further, obviously, as this debate goes on.

I yield back my time, Mr. SCALISE.

Mr. SCALISE. Thank you, Dr. ROE.

I would like to have Dr. GINGREY wrap up this hour that we have had a great discussion on health care.

Mr. GINGREY of Georgia. Representative SCALISE, I thank you for controlling the time, and I know we are getting very close to the end here.

But just to say we are not picking on our great neighbors to the north, Canada, or our great friends in the United Kingdom—they do wonderful things, they are wonderful people, but we don't necessarily feel that we want to adopt their health care system. And of course part of the reason is because so many Canadians come down to our country every year, they spend $1 billion annually on getting health care in the United States, so there must be a problem.

□ 2230

I think the main problem is a long cue because of rationing, and it's going to cost trillions of dollars to try to cover everybody under a single payer system, Mr. Speaker.

We Republicans, the Doctors Caucus on the Republican side, are here tonight to talk about better ways to do it and share that with all of our colleagues, Republicans and Democrats, and especially with the administration. And we hope that President Obama is listening because I know that he wants to do something to improve health care in this country. But, hopefully, we can talk him out of having a default plan that everybody morphs into a single-payer system.

RECESS

The SPEAKER pro tempore. Pursuant to clause 12(a) of rule I, the Chair declares the House in recess subject to the call of the Chair.

Accordingly (at 10 o'clock and 30 minutes p.m.), the House stood in recess subject to the call of the Chair.

□ 2335

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Mr. GRAYSON) at 11 o'clock and 35 minutes p.m.

CONFERENCE REPORT ON S. CON. RES. 13, CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 2010

Mr. SPRATT submitted the following conference report and statement on the Senate concurrent resolution (S. Con. Res. 13) setting forth the congressional budget for the United States Government for fiscal year 2010, revising the appropriate budgetary levels for fiscal year 2009, and setting forth the appropriate budgetary levels for fiscal years 2011 through 2014:

CONFERENCE REPORT (S. CON. RES. 13)

The committee of conference on the disagreeing votes of the two Houses on the amendment of the House to the concurrent resolution (S. Con. Res. 13), setting forth the congressional budget for the United States Government for fiscal year 2010, revising the appropriate budgetary levels for fiscal year 2009, and setting forth the appropriate budgetary levels for fiscal years 2011 through 2014, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the Senate recede from its disagreement to the amendment of the House and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the House amendment, insert the following:

SECTION 1. CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 2010.

(a) DECLARATION.—Congress declares that this resolution is the concurrent resolution on the budget for fiscal year 2010 and that this resolution sets forth the appropriate budgetary levels for fiscal years 2009 and 2011 through 2014.

(b) TABLE OF CONTENTS.—The table of contents for this concurrent resolution is as follows: