In the last few weeks, I have undertaken an aggressive campaign directed at the nation's financial leaders to dispel this myth. In letters to Treasury Secretary Henry Paulson and Federal Reserve Chairman, Benjamin Bernanke, I have asked that they both publicly refute claims by some conservative pundits and politicians that most of the defaulted subprime loans at the root of the crisis were made to African-Americans, Hispanics and other so-called ''unproductive borrowers.''

On the basis of hearsay, rumors and misinformation, seeds of division are being sown all across the United States in a volatile political environment where Americans are terrified by the economic situation. History provides too many lessons on the consequences of singling out only certain segments of the population as culprits for a country's woes for us not to do all within our power to stop this ugly and insidious smear campaign in its tracks.

I urge you, in the strongest possible terms, to join me in standing up to this big lie, this Financial Weapon of Mass Deception. It is your duty to stop the precious waste of time and energy being spent on blaming the victims and force a healthy debate on what must be done to curb too much Wall Street greed and too little Washington oversight. This hearing is an important step toward that end and I applaud you for holding it.

I call upon you to join with me to ensure that innocent people in our community who look to you for protection are not further scapegoated, victimized and exploited by unscrupulous and greedy players and those who do their bidding.

I call upon you to not allow yourselves to be distracted by the attempts to undercut the Community Reinvestment Act and undermine regulatory reform.

I call upon you to stay focused and to take strong and positive steps to strengthen our communities and the nation's financial foundation through regulatory reform.

I call upon you to do your part to disarm this false and dangerous Financial Weapon of Mass Deception.

In this time of global crisis, we must bring Americans together and not continue to divide ourselves with false racial arguments.

Please enter my testimony into the record.

BOARD OF GOVERNORS OF THE FEDERAL RESERVE SYSTEM

DIVISION OF RESEARCH AND STATISTICS

Date: November 21, 2008.

To: Sandra Braunstein, Director, Consumer & Community Affairs Division.

From: Glenn Canner and Neil Bhutta.

Subject: Staff Analysis of the Relationship between the CRA and the Subprime Crisis.

Summary: As the financial crisis has unfolded, an argument that the Community Reinvestment Act (CRA) is at its root has gained a foothold. This argument draws on the fact that the CRA encourages commercial banks and savings institutions (banking institutions) to help meet the credit needs of lower-income borrowers and borrowers in lower-income neighborhoods. Critics of the CRA contend that the law pushed banking institutions to undertake high risk mortgage lending.

In this memorandum, we discuss key features of the CRA and present results from our analysis of several data sources regarding the volume and performance of CRA-related mortgage lending. In the end, our analysis on balance runs counter to the contention that the CRA contributed in any substantive way to the current crisis.

BOARD OF GOVERNORS OF THE FEDERAL RESERVE SYSTEM,

Washington, DC, November 25, 2008.

Hon. ROBERT MENENDEZ,

U.S. Senate,

Washington, DC.

DEAR SENATOR: Thank you for your letter of October 24, 2008, requesting the Board's view on claims that the Community Reinvestment Act (CRA) is to blame for the subprime meltdown and current mortgage foreclosure situation. We are aware of such claims but have not seen any empirical evidence presented to support them. Our own experience with CRA over more than 30 years and recent analysis of available data, including data on subprime loan performance, runs counter to the charge that CRA was at the root of, or otherwise contributed in any substantive way to, the current mortgage difficulties.

The CRA was enacted in 1977 in response to widespread concerns that discriminatory and often arbitrary limitations on mortgage credit availability were contributing to the deteriorating condition of America's cities, particularly lower-income neighborhoods. The law directs the four federal banking agencies to use their supervisory authority to encourage insured depository institutions—commercial banks and thrift institutions that take deposits—to help meet the credit needs of their local communities including low- and moderate-income areas. The CRA statute and regulations have always emphasized that these lending activities be ''consistent with safe and sound operation'' of the banking institutions. The Federal Reserve's own research suggests that CRA covered depository institutions have been able to lend profitably to lower-income households and communities and that the performance of these loans is comparable to other loan activity.

Further, a recent Board staff analysis of the Home Mortgage Disclosure Act and other data sources does not find evidence that CRA caused high default levels in the subprime market. A staff memorandum discussing the results of this analysis is included as an enclosure.

As the financial crisis has unfolded, many factors have been suggested as contributing to the current mortgage market difficulties. Among these are declining home values, incentives for originators to place loan quantity over quality, and inadequate risk management of complex financial instruments. The available evidence to date, however, does not lend support to the argument that CRA is to blame for causing the subprime loan crisis.

Sincerely,

BEN BERNANKE.

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

MESSAGE FROM THE SENATE

A message from the Senate by Ms. Curtis, one of its clerks, announced that the Senate has passed a bill of the following title in which the concurrence of the House is requested:

S. 896. An act to prevent mortgage foreclosures and enhance mortgage credit availability.

The message also announced that pursuant to Public Law 110–229, the Chair, on behalf of the Republican Leader, announces the appointment of the following individual to be a nonvoting member of the Commission to Study the Potential Creation of a National Museum of the American Latino:

Sandy Colon Peltyn of Nevada.

The message also announced that pursuant to section 276d–276g of title 22, United States Code, as amended, the Chair, on behalf of the Vice President, appoints the following Senators as members of the Senate Delegation to the Canada-United States Interparliamentary Group conference during the One Hundred Eleventh Congress:

The Senator from Alabama (Mr. SESSIONS).

The Senator from Maine (Ms. COLLINS).

The Senator from Ohio (Mr. VOINOVICH).

The message also announced that pursuant to Public Law 106–286, the Chair, on behalf of the President of the Senate, and after consultation with the Republican Leader, appoints the following Members to serve on the Congressional-Executive Commission on the People's Republic of China:

The Senator from Tennessee (Mr. CORKER).

The Senator from Wyoming (Mr. BARRASSO).

HEALTH CARE

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

Mr. BURGESS. I thank the Speaker for the recognition.

Mr. Speaker, I thought I would come to the House floor this evening and talk for just a little while about health care, because there is a lot of talk going on about health care in this Congress, a lot of talk about the bills that we will see, we haven't seen, and bills that we may not see.

I wanted to point out to the Members that yesterday I introduced a bill, H.R. 2249, which is a bill I had actually introduced in the previous Congress. It is the Health Care Price Transparency Promotion Act of 2009, updated from the last Congress and reintroduced this year. I urge Members on both sides to take a look at this because, after all, we hear a lot about the concept of transparency these days, and it is important for our constituents, for our consumers, for our patients in our districts to be able to access clear and timely information about physicians, hospitals, health care facilities in their areas, and understand and do some research on their own to find out which are the best facilities for them to use when they have occasion to need a doctor or a hospital.

□ 1845

So as we talk about health care—and it was, of course, all of the discussion during the Presidential campaign last year—I would just point out that there are good ideas that are coming from both sides of this House of Representatives. Certainly, Democrats are not the only ones with ideas on health care. There are Republican ideas. There are

Republican ideas that really should shape the debate of health care reform or the natural evolution of health care that we see going on in our country at the present time.

There are plenty of people working on health care reform. You know, when I take a step back and look at what should we be doing when we try to frame the debate, when we have our hearings in committee, when we mark up our bills in committee—really, when you look at the vast American medical machine, the widget that it produces, what we do on a daily basis in doctors' offices and hospitals across the country, it is that fundamental interaction that takes place between the doctor and the patient in the treatment room. That is the fundamental unit of production in American medicine. And when we look at it in that context, whether it be the treatment room, the emergency room, the operating room, that fundamental unit of interaction, are the things that we are doing here bringing value to that interaction or are they subtracting value from that interaction?

And to the extent that, whether it is a Republican or Democratic idea, if it brings value to that interaction, that is something that I am going to have to look at quite critically and quite favorably. If it is something that subtracts value from that interaction, that is something that is going to be very difficult for me to be for. So I try to always look at it through that lens of, ultimately, it is about doctors taking care of patients, it is about hospitals helping people get well. And to the extent that we can encourage and enhance that process, where there are places where we can help, certainly we should. If there are places where we don't belong—that is, between the doctor and the patient—maybe we ought not to do that.

Now, it comes to me frequently, not infrequently, when I'm sitting in committee—and I am fortunate enough to sit on a subcommittee that deals with health care, on the Committee on Energy and Commerce. In fact, in the last Congress I was the only physician to sit on that committee. And when we would deal with problems, when we would deal with issues that had to do with health care or the regulation of the Food and Drug Administration, I was always mindful, when I looked around the room, there is only one person in this room that has ever sat across from a patient, looked him in the eye, picked up a pen and written a prescription, counseled as to risks and benefits, torn off that prescription, and sent the patient on the way. There is only one person in the room that has ever done that, and that was me. And yet here we were with a hearing or a bill that might have profound impact on how that doctor/patient interaction was going to be carried out from that day forward for the next generation or two, and there is only one person in the room who has ever actually been there and done that. So I feel a tremendous amount of responsibility as we go through this health care debate.

Yes, I have been joined by some other physicians on the committee. There are physicians on the Subcommittee on Health on Ways and Means. We all bear that special burden to ensure that the decisions that we make today do not negatively impact the next generation and the generation after that.

Think back just 44 short years ago when Medicare was enacted in this body. The men and women who sat in this body at the time were the ones who crafted that legislation. And we are dealing with the good aspects and the bad aspects that have been dealt to us because of decisions that were made in our committees, in Congress, and in this body in the House of Representatives. So it is in that sort of context that we need to look at what we are doing.

It is not about, and let me emphasize, it is not about the next election. It is not about who wins or loses seats in the great economy that goes on here in the House of Representatives or over in the other body on the other side of the Capitol. It is not about the next election; it is about the next generation. And that is why it is so important for us to get it right.

That is why the American people get so frustrated with us as a group here when they see us fight about things and never work together. It is difficult, I know. It was difficult when we were in charge. When the Democrats were in the minority, it was difficult for them to understand how to work with us in the majority, and it is difficult for us to understand in the minority how to work with the Democrats, but it our obligation. That is why we were sent here. That is why we were elected, to do that hard work, and to work with each other where we can, to oppose each other where we must, but to always have focused not on November of 2010, but what is life going to be like when our children are the age we are now, when our children's children are the age we are now? What is it going to look like to them?

What is health care going to look like in this country? Are they going to continue to be blessed with the stunning rate of advances that we have seen since the Second World War in the practice of medicine? And it has been stunning. The last 50 to 60 years has seen untold events. Think of the physician in practice right at the dawn of the antibiotic age, when a patient comes into the hospital, significant infection, and there is just not much they can do but keep them comfortable, perhaps drain an abscess if one is available. But the medications that they had were—at best you hoped they didn't do any harm to the patient. Now we have a vast array, a huge armamentarium of medicines to fight infections, bacterial infections to be sure, but also fungal infections and some viral infections. It is an incredible armamentarium that today's physician has. When you think of the young physician sitting in a medical school or attending to a patient in a clinic at a residency program today, think of the things that they are going to have, the tools that they are going to have at their disposal if only we don't screw it up for them today.

So we always have to keep foremost in our minds and our imagination what that world is going to look like for the patients of tomorrow, for the young physicians and nurses, folks that work in the hospital that come after us. We have to keep them foremost in our minds.

And how great it would be if we didn't even need a health care system, if we had a way to keep people healthy throughout their lives. We're not there yet. But we always need to stay focused on that goal because, after all, I would much rather have my health than my health care. If I have my health, I don't have to worry about my health care. But we know it doesn't always work out. We know that people do have problems, we know that illnesses do strike, we know that problems and complications do occur. So when health care is necessary, to the extent we can make it more affordable and more accessible, sure, we need to do the things we can to make that happen.

Now, a lot of people are working on health care reform. A lot of people have been talking about it certainly throughout the last year or two on the floor of this House. I know I have come down several times a month to have this very discussion. Throughout the Presidential campaign last year I worked for the nominee of our party as a surrogate on the health care debates. I got to meet a great many of the surrogates on President Obama's team and heard their discussions for health care. And everyone talks about, well, where is the Republican plan? In fact, for that matter, where is the Democratic plan?

I have to say that as I watched the health care debates really from the inside last fall as a surrogate working for Senator MCCAIN, I thought that when this Congress convened with a referendum that was likely to be on health care in November, that they would be much further along as far as the development of a bill—maybe not from the Republican side, but certainly from the Democratic side.

The Democratic chairman of the Senate Finance Committee last October convened a big group over at the Library of Congress one day, developed a white paper that really had all the look to it of a roadmap for legislation. I was fully prepared, after the election, for the chairman of the Finance Committee in the Senate to have a bill that would be sort of the model bill, if you will, that everyone in the Senate would support and then, likewise, everyone in the House. In fact, I counseled my colleagues to think in terms of having something, if there are things that concern you about that white paper, be

certain you have your arguments all spiffed up and all toned up, because I thought we were going so see that perhaps even in the lame duck session last December.

So I was very surprised that we didn't see anything in November or December. Well, surely we are going to see a bill before the inauguration; but in fact we didn't. And then of course the story continued to unfold. The nominee for the Secretary of Health and Human Services ended up withdrawing his name and there was a several-month gap until Secretary Sebelius was confirmed last week.

So now we are near Mother's Day of 2009 and still no health care bill—from the Republicans, to be sure, but still no health care bill from the Democrats, either the Democrats in the House or the Democrats in the Senate.

Now, I know that there was a letter sent to the President from the Democratic leadership in the other body last week or the week before that said we will have a bill that will be marked up in the Senate the first week in June. But that is a pretty long timeline from a white paper in October to having a bill on the floor of the Senate perhaps in a month that is going to be debated. I think what that shows us, it underscores how difficult this process is.

There are many people in this body on both sides who have worked on this issue for years. There are many people in this body who have very set ideas of whatever this bill is when it comes forward—from whatever side that it comes from—they have very definite ideas of what it should look like. In fact, you stop and think; if you were to pick out six of us from either side of the aisle in this body, put us in a room by ourselves and say write the health care legislation that you would like to see, I have no question that there are six of us who could just sit down and do that really without any other help or any other input from anyone else. The problem is when you put all six of us in the room together and say now write a health care bill on which you all agree, that becomes much more difficult. And that is sort of the position that I know I see occur on my side of the aisle. I rather suspect that's the position we see on the other side of the aisle.

And then you add into the mix all of the other things that go on here in the course of a normal week or a normal month, notwithstanding the scare we had with the flu last week, the cap-and-trade bill that is out there that at some point is going to come through, it is going to come through my committee. So that is going to take resources and time that the majority, the leadership of the committee, the majority leadership of the committee has to devote their time and resources to that as well. So really working on two tracks in tandem, two parallel tracks, one on energy and one on health care. And it's a tall order. Either one of those bills by themselves is a tall order, but put both of them together.

And then you heard the discussion that just concluded from the last hour, what is going to happen as far as regulatory reform in the financial industry, in the banking industry? In fact, when President Obama gave his speech at Georgetown 2 or 3 weeks ago, he talked about how before the end of this year he will have a health care bill, he will have a climate change bill, and he will have a banking regulatory bill all signed before the end of December this year. That is an extremely tall order.

And of course many of these things, as their work is in process, one affects the other. Certainly, when you look at the way the budget was constructed, the health care part of the budget is likely to depend upon the energy part of the budget, as some of the costs for health care are going to be offset by some of the revenue that is raised on the energy side. One can't proceed without the other. And it becomes very, very difficult then to marshal these things through and keep everyone on track and everyone on task.

And then when you add to it the fact that, yes, by definition, the House of Representatives is a house that is divided between the two major political parties and we don't always work together, that just increases the amount of difficulty. It underscores to me why it is important for us to work together and why it is disappointing that sometimes we don't take those opportunities to work together. But a tall, tall order.

And then add to all of that, when you think of the timeline that stretches out ahead of us on health care, remember there was, in this body—I think it was September 23, 1993, when then-President Bill Clinton stood at this very podium and gave a beautiful, eloquent speech that had people weeping for joy about how the President was going to change the delivery of health care in this country. I was just a regular guy sitting in labor and delivery back in Louisville, Texas, monitoring a labor and watching the speech on television, but a beautiful speech delivered. And everyone left this House thinking, oh, now we are well on the way to getting this done. But the reality hit that by the end of September of a nonelection year, you are very close to everyone getting ready for the next election. Because in the House of Representatives, we have 2-year terms. We really don't have an off year. Many of us are already thinking about the next election. So that is another consideration and another thing that makes it more difficult to get big things done because the time frame for getting those big things done between elections is relatively small. The off year, if you will, is condensed down to perhaps 6 months.

Certainly by the end of July, when we leave for the August recess from this House, my impression is that the health care bill, whatever it is, likely will have to pass the House before then or it may become very problematic to get something done before the end of the year. And then of course you know what happens next year, it is all election all the time.

□ 1900

So even as late as the end of September of 1993, it turned out to be too late for then-President Clinton to get his vision of health care reform through the House of Representatives and the Senate because at the end of September, we were already into the electoral process, and by the time things were finally prepared and ready for a vote, it actually came too late.

Look at the difference between 2009 and 1993, 15 to 16 years' difference. But you didn't have all the cable news shows back in 1993. You didn't have the instant analysis, the 24 hours of instant analysis, that we have today. So if anything, the time frame for development of a complex legislative issue like health care or energy or banking regulation, the time frame likely is even more condensed now than it was back in 1993.

But I think back to 1993 and 1994. Again, I was just a regular guy working as a physician in a small town in north Texas. It wasn't like nothing got done during that interval. True enough, it wasn't the vision that was articulated by the President that night. But we do have now an entirely different type of insurance product called a health savings account that was actually a by-product of having an alternative solution to offer to what the then-Democratic majority was offering in health care reform. So there are things that happen during the course of the normal evolution of things, and sometimes they work out to be good things. I would argue that the institution of a health savings account, the ability to buy a high-deductible insurance policy on the Internet, at least provides an option for insurance particularly for younger individuals just getting out of college but also people more in the middle of life, like in their 50s, who may find themselves between jobs.

There are options out there for purchasing insurance. It actually didn't exist in 1994. And I know that because I tried to buy an insurance policy for a member of my family in 1994 and you couldn't do it at any price. Now you can go onto the Internet. You type ''health savings account'' into the search engine of choice, and you can get a variety of choices. The cost for a high-deductible health plan for someone in their mid-20s who's just getting out of college is very reasonable. It runs somewhere between $75 and $100 a month depending upon the policy that you select. These are reputable companies that are well recognized. Many of them are PPO plans with, again, a high deductible, but they are affordable and they are available. And it is not always necessary to go without insurance simply because we don't happen to be working for a company that provides insurance as one of its benefits.

You know, you want to see a plan. You want to see a plan come from the Democratic side. You want to see a plan come from the Republican side. You want to see the merits of each argued and debated here on the floor of the House. You want to see the strongest points articulated well and perhaps incorporated into whatever the final product is. And then, of course, the other body that has its opportunity to work on the legislation comes together in a conference. And in an ideal world, going through that regular order, in an ideal world, you would get the best possible legislative product. And I do worry that we will adhere to regular order throughout that process, but at the same time, as we sit here today, I'm going to profess to some optimism that we will adhere to regular order, mark the bills up in the appropriate subcommittees, have the full committee markup, as we are supposed to, bring the bill through the Rules Committee to the House floor, have ample opportunity for debate and amendment. Then it goes over to the other body. After passage of the bill, it goes to the other body, a similar process, and we have a real conference committee, not a made-up conference committee but a real conference committee of appointed conferees that get together and work out the differences between the House and Senate version and ultimately then get a product that will serve the American people well. We really do our best work when we go about it that way.

If we short-circuit the process, which we do—unfortunately, we do. We did it when we were in charge. And certainly the Democrats have done it in the last 2½ years since they have taken back the majority. When we short-circuit the process, that's when we get our less than perfect legislative products that are shoved out the door.

Now, if I were one of those people that sat in a room by myself, what would I envision as a plan? How would I make things better? And bear in mind that for 63, 65 percent of the country who has primarily employer-sponsored insurance, many people don't want to change from where they are now. So although people are concerned about where we are with what's happening in the health care system in America, those individuals who have employer-sponsored coverage or those individuals who have purchased their own coverage on their own may be quite satisfied with where they are today. So really it must be approached from building upon what is currently in place and working, building upon that platform, and making certain the problems that occur in the existing system today are mitigated or eliminated for the individuals who are feeling the effects of those problems.

Well, what are some of those problems? Well, I mentioned someone who perhaps owns their own insurance policy. And there are, depending upon what you read, for round numbers, 10 million people in this country who own their own insurance policy. They are discriminated against in the Tax Code, and that's unfortunate. That has the effect of actually raising their cost for insurance, and there are things we could do to correct that. I'm not sure I have all the answers there. I'm not sure that Republicans have all the answers there or Democrats, but we could fix that. We could fix that. That would be one of the relatively easy fixes we could do. And certainly that's something that I think has to be one of the pieces. That's one of the things that needs to be debated in subcommittee, full committee, here on the House floor, and in conference committee, but we could fix that problem. It is within our power to do that.

Now, one of the great fears that people have is that, yes, I've got health insurance now through my job, but I worry that if I get sick, I might lose it, or if I lose my job, I might lose my insurance and then I get sick, and then it will be difficult when I have a claims history, when I have got a preexisting condition. It will be difficult for me to get insurance after that. Again, we can fix that. There are things that could be done to address that segment of the population. We may not even necessarily need to change the whole structure to help that segment of the population that has a condition of medical fragility or a preexisting condition. Many of the States, 32 or 33 out of the 50 States, already have some system in place for helping an individual with preexisting conditions. Certainly we as a body can look at the best practices from those States.

Look at the States that are doing things well. North Carolina, Idaho come to mind. Look at the States that are doing things well. Take from those best practices. Is it going to be necessary to ask there to be some contribution from the private sector? There may be. So there may be a level at which the premiums cannot increase above. There may need to be some help as far as a voucher or subsidization of the premium from the Federal Government, from the State government. But this can be fixed. This can be addressed. And it doesn't mean that we don't act upon it just because it's not everything we want. We can help those individuals who find themselves between jobs, between insurance companies, then with a significant diagnosis who then fear that they're not going to be able to get insurance past that point. That can be dealt with. That can be fixed.

Insurance reform, there's no question. Even the American Health Insurance Plan Organization admits that there is a need for insurance reform in this country.

One of the things that has concerned me is that if an individual works for a large corporation in this country, if that corporation does business in multiple States, that individual can move from location to location throughout the several States and their insurance never changes. It never varies. It's the same insurance policy in one State as it is in the other.

And think of the analogy of the National Football League. If there is a player that is traded from one city to another, their insurance goes with them. If they have a knee injury in one location, that knee injury is covered in their secondary location. But the fan, just the regular guy or woman who follows their favorite player from one city to the next, they've got to start all over again with their insurance policy. And that's one of the fundamental inequities. That inflexibility that we built into the system, that's one of the things people want to see us fix. So why not give the regular individual, why not give the little guy the same breaks we give the larger multi-State corporations? We can do that. That's within our power to do that.

One of the biggest issues that we hear about all the time is affordability. Well, there are things we can do as far as providing benefits packages that are affordable, and it is within our power to do that. And, quite frankly, I don't understand why we haven't done that. We have at different times agreed on what basic benefit packages are. We did that 35 years ago when we created the Federally Qualified Health Centers across the country. Anyone who goes into a Federally Qualified Health Center knows exactly the benefits that are going to be available to them in that facility. But why don't we get together and do the same thing for now, not necessarily a bricks-and-mortar facility, but do the same thing for a policy that could follow a person from place to place, job to job, State to State, a policy that would be affordable that perhaps could build some longitudinal stability because it would be a policy that someone could keep throughout various phases of their life?

We can do all of that. We don't need to endanger the current system that's in existence. We can build upon what is good in our system and add more choices and more options and more flexibility and ultimately more security for people within their health care.

After all, that's what people are concerned about. They're concerned about if I lose my job, am I going to lose my health care? If I lose my job and lose my health care, there is no way I could afford a product out there. We can help with that. There are things that we can do. There are regulations that we can look at, that we can suspend, that we can pull back. There is flexibility we can build into the system if we only have the courage to do it. And there's the problem. We won't have the courage or we won't have the opportunity if one side won't talk to the other on this, if we craft our bills out of the public view, behind closed doors, committee staff rooms, Speaker's Office, wherever they are done, and don't do it in the light of day.

Politics is a full-contact sport. I understand that. I didn't begin my life to live it in public service, but in the last 6½ years I have, and I understand the

nature of the beast. I understand that there are going to be people who take issue with what I say who want to attack me personally because of it. That's okay, as long as we do that debate here in the public arena, as long we do it in the light of day and that we don't do it behind closed doors and then roll out something at the last minute that the American people had just better like because that's what they are going to get.

It's wrong if we do it when we're in charge. It's wrong if they do it when they're in charge. That's not the type of legislative activity that the American people want to see. They want to see legislative activity that brings them peace of mind. They want to see legislative activity that saves them time and saves them money. And why wouldn't they? If we can deliver more care to more people at less cost with better quality, why wouldn't we do it? Why wouldn't we take that choice?

In short, as I look at this and I look at how to craft particular legislation, there's also room for common ground, I think, on both sides. On both sides. People talk about how we want to see an expanded role for information technology in health care. Some of the easy discussions that we can have. We may disagree on how it's to be apportioned or how it's to be structured. I don't think we should be writing the codes. I don't think we should be telling doctors and hospitals what type of platform they need to buy. But certainly we ought to be encouraging people to evolve into that next arena, which would include electronic medical records and electronic prescribing.

What about things like medical homes? I don't think you would find a lot of disagreement throughout the body on whether or not this is a good thing. Care coordination, we talked about it when we were talking about the Medicare bill back in 2003 and 2004. Disease management care coordination, accountable care organizations, these are things that bring value to that doctor-patient interaction that I referenced at the beginning of this talk. So it's easy to be for that stuff, and I think you would find a good deal of common ground on both sides on that.

Where the arguments occur is who is to be the owner and are we going to micro-manipulate these aspects of health care from here or from the committee room or are we, in fact, going to let the people know what they are doing, the doctors, the nurses, the hospitals, are we going to let them be in charge of the system?

In short, the American people want everything but a Washington takeover. And that, I think, is the one place where the American people really draw the line, and they are concerned that Washington will overreach, that we will put that congressional committee between the doctor and the patient. We have no place between the doctor and the patient, that interaction in the treatment room. The doctor and the patient activity should be completely free from any congressional interference, and too often, too often, it is otherwise the case.

□ 1915

We hear about expanding a public program. We hear about perhaps expanding Medicaid, maybe expanding Medicare. Some of the more serious problems that we deal with in this body are problems that are brought to us because those two programs, for all the good that they do, they do have some problems.

Medicare and Medicaid are programs where, unfortunately, the inefficiency, the duplication of services and sometimes just the actual theft of services occurs, and we don't do a good enough job to keep that under control. No one wants us to be spending money inappropriately in any of those programs.

The problem is, with both of those programs, they do consume a lot of time, they do consume a lot of activity, and they consume a big portion of the budget every year, the so-called entitlement budget. And when Congress looks to control costs on those programs, the only lever we can pull is to restrain payments to doctors. The other lever we can pull is to restrain payments to hospitals.

And the only problem there is you are going to be getting less, then, of the doctor's attention and less of the hospital's attention when you restrain those provider payments. And, unfortunately, we do that all the time.

Medicare is notorious for every year coming up and having to face a reduction in the reimbursement rate to physicians across the country. Medicaid reimbursements vary from State to State, but in many States the reimbursement for Medicaid is a fraction of what it is for Medicare.

And here is the hard truth of this. You can't run a medical practice off of what Medicare and Medicaid reimburse, at the levels where they reimburse. And you are sure not able to run a practice if we, in fact, restrain provider payments like we are scheduled to do later this year and like we are scheduled to do every year for the next several years.

We had a pediatrician come and testify in my committee last year in Energy and Commerce, and she testified and really got my attention because she started practice the same year I did, 1981. Her practice was 70 percent Medicaid in rural Alabama. She was having to borrow money from her retirement fund to keep her practice open.

That's a bad situation. If you are losing money on each patient, it's hard to make that up in volume, and that was the situation that she faced.

You know, a physician in that kind of crisis, they are not going to be able to keep their doors open. And if they can't keep their doors open, that entire patient population in rural Alabama, that pediatric population is going to be put at risk. Because she didn't talk about how many other providers are in the area, but you can only imagine, if it's that hard to make a practice go in that environment, there may not be many pediatrician practices.

If you don't have the private sector to cross-subsidize the public programs, the Medicare and Medicaid, a lot of practices just simply can't make it. Here was an individual who had cut expenses everywhere she could. She had let people go. She had reduced hours. She had reduced some of the services she provided, all in an effort to try to keep the doors open, but she was still unable do that.

Therein is a problem. If we expand the public sector, and we depend upon cross-subsidization from the private sector to keep the public going, what's going to happen if you reduce the private sector? How are you going to get that money to cross-subsidize the public part of that?

And the amount of subsidization varies from study to study on what you read, but it's about 9 or 10 percent that it costs the private sector to support the public sector to keep it going. So, on a 50/50 mix, Medicare, Medicaid, private pay, you will likely be able to make the cash flow, but when you get to 70/30, it just doesn't work any longer, and that's a physician who is at risk of not being in practice this time next year.

So those are some of the problems that we need to fix. We are obligated to fix those problems within our publicly administered health care plans before we expand them.

And that is my concern when I hear us talk in this body about how we want to have an expanded public option that competes with the private sector. Right now it doesn't really compete with the private sector. It depends on the private sector in order to keep those practices open. So I think we are obligated to look at the job we are doing now before we reward ourselves with an ever-increasing or an ever-larger segment of that.

You know, currently, we are close to about a 50/50 split in this country. About 50 cents out of every health care dollar that's spent comes from here, originates here in the House of Representatives. The other 50 cents of every dollar that's spent is self-pay private insurance or charitable gifting of a doctor who just doesn't expect to get reimbursed for what they do. Fifty percent comes from the Federal and State governments, 50 percent comes from the private. If we shift that balance, we are apt to find that we are no longer supporting the infrastructure we had hoped we would be able to continue to support.

So adding to the public sector may, in fact, be detrimental. For people who want to keep what they have now, we say you can, right up until the time we make it unprofitable for that to continue.

One of the things that concerns me greatly is, again, what we do with our provider payments. December 31 of this year, physicians across this country will face a reduction in reimbursement for Medicare patients of 20 percent, a little over 20 percent. That's a significant and stark reality that's facing every doctor that sees Medicare patients throughout the country. And doctors are concerned about it, patients are concerned about it.

Many patients will find they move locations, and finding a new doctor on Medicare becomes extremely difficult. There are stories in The Washington Post. I have seen stories in my hometown newspaper in Dallas and Fort Worth, extremely difficult to find a physician to take a new Medicare patient in many locations in the country.

And the reason for that is what Congress has done the last several years where we say we are spending so much money on Medicare, we would like to hold the costs back a little bit, we will just hold the cost down or we will hold the price down by cutting payments to doctors a little bit each year. And that, over time, has become a very pernicious effect on people going into medicine, quite frankly.

There are concerns that the physician workforce will continue to erode over time, such that just the sheer numbers of doctors available may not be enough to treat the patient load as us baby boomers get older, may not be enough to treat the patient load that emerges on the other side. So it's a problem that this Congress, this Congress, the one that's seated here, really has to face up to, because by the end of December, there will be a 20 percent pay cut across the board. We did a big Medicare bill July of 2008, big, big hoopla here on the day we did it. Yeah, we solved the problem for a little while.

Every time we do that temporary fix, every single time we do that temporary fix, we make it harder, we dig the hole deeper and we make it harder to get out of that problem on the other end.

Now, every Congress that I have been here, I have introduced legislation to deal with what's called the sustainable growth rate formula that creates that 5 percent, 10 percent or now 20 percent reduction in rates to physicians. I will be reintroducing a bill next week that will deal with this problem. I had a similar bill last year. There have been some changes made because of some of the changes in legislation that have happened over the past 24 months, but ultimately we are going to have to deal with this problem.

We need to move physicians into the same type of payment formulas that we do for hospitals, that we do for insurance companies, that we do for drug companies, that we do for HMOs, and that's essentially a cost-of-living adjustment that occurs every year.

There is no magic to it. I didn't invent it. It's called the Medicare Economic Index. It's about a 1 or 1.5 percent update that occurs every year to account for the increased cost of delivering that care.

We haven't kept up with the cost of delivering that care. There are some years we have provided a zero percent update. There are some years we have allowed the cuts to go into effect. There are some years we have provided a 1 percent update, but it hasn't been enough.

And as a consequence, it now costs doctors more to actually do the work of seeing the patient. It costs them more. It costs them money to see every patient on Medicare.

We are not carrying our load. We are not paying our freight from Congress, and that has an extremely detrimental effect on the physician workforce, the morale of the physician workforce, and certainly the continued—it will lead to continued problems with physician—spot physician workforce shortages, some patients not being able to get in to see a Medicare provider.

And it's up to us, up to us to address it. Doctors are seeing the patients we asked them to see, our Medicare patients. Congress in 1965 said we are going to take over the care of individuals over the age of 65 in this country, and we asked the doctors to see those patients.

They are arguably sometimes the most complex and complicated patients that will be in a physician's practice. They are complicated because they have multiple medical problems. They may be on multiple medications. They are not necessarily the easiest patients to take care of, but they are important, because they are our parents, they are our colleagues. In fact, many of us, in a few short years, will be in that Medicare age group.

It is critical that we provide the physicians the support they need to take care of those Medicare patients. And it's something I just frankly do not understand why this Congress is always so reluctant to deal with this problem and always pushes it off to the last minute.

We push physicians in this country up to the brink every year, every 6 months, every 12 months, every 18 months, whatever it is we decided to fix it for the last time. We don't even deal with it until we are right up against that problem again. Well, this time let's be different about it. We have 8 months till the end of the year, 7 months till the end of the year. Let's take that time to fix it and get it right and make certain that this time we don't leave our doctors waiting at the last minute to wonder if they are going to be able to keep their doors open January 1 or not.

One of the last things I want to touch on, a few weeks ago in March, I was invited down to the White House to participate in the White House forum. And, again, as alluded to earlier, I have been concerned that there is a bill that's already been done and the rest of this is just for show. At the appropriate time, the Speaker's door will fly open, the health care bill will come out. It will roll down here to the floor of the House. We will have a brief time to debate it, no time to read it, and off we will send it to the Senate.

I have been concerned about that. As I said, I am the eternal optimist, and I am going to be optimistic that we are going to go through regular order, but I also fear at some point there will be a bill that just comes crashing through with no time to read, evaluate or debate, and off it will go to the Senate and that will be that.

Now, the President, to his credit, said that that was not the case, that we would go through regular order. In fact, as we wrapped up after the breakout sessions that afternoon in the White House, the President stood in the East Room and said that it will up to the congressional committees and congressional leadership to get this bill done through the regular order, that he would be glad to offer guideposts and guidelines, perhaps some budgetary boundaries, but he wanted that work done in the Congress, where it was supposed to be done.

Again, I will take him at his word. In fact, I applaud his courage for saying so. He said at one point, I just want to find out what works. Well, I want to help the President find out what works, and to that end, I will continue to be involved in this debate.

Now, let me just spend a few minutes talking about a caucus that is currently working in Congress to try to help inform on the health care debate. It's not a legislative caucus. It's not a legislative committee. It won't write legislation, but we do have forums. We do have hearings. We do have Member educational events. We do have educational events for staff, congressional staff, particularly on the communication side.

On occasion, we go outside of the confines of Washington and talk to groups of doctors, nurses, hospital administrators, again, the people who are involved in taking care of our patients on a day-to-day basis. We like to solicit their input, to receive their advice and criticism on things they see happening from Congress.

And the caucus is the congressional health care caucus, and it does have a Web site, www.healthcaucus.org, healthcaucus being all one word with no space or bar in between. I encourage people, Mr. Speaker, to look into this. It is a way for people to have their voices heard on this debate.

We have had several good forums. I try not to make them one-sided. We try to have people who represent, perhaps, a left-of-center view and a right-of-center view. We had one forum on the options for reform that was attended by people from the Commonwealth Fund, by people from the Galen Institute and the Council for Affordable Health Insurance. It was a very instructive forum. The Webcast for that

is, in fact, archived on the Web site if anyone is interested in that.

We had another forum on improving affordability, listening to some of the people who have actually done the work of making health care affordable in their communities and for their groups of patients. We heard that time from Rick Scott, who runs a number of outpatient clinics in Florida. We heard from Greg Scandlen from the Consumers for Health Care Choices, and we heard from Dr. Nick Gettas, who is a chief medical officer at CIGNA. Again, on the Web site, the Webcast of that is archived and people are welcome to look at that and review that.

When we do these forums, we do Webcast them from the Web site, and they are available live and broadcast live on the Web site when they are done, and through the magic of Twitter, we are able to take questions from people who are not actually in the physical audience. We do take questions from the physical audience. We take questions from the virtual audience.

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This can, again, sometimes lead to some quite lively debate.

Upcoming within the balance of the month of May and into the month of June, we are going to be doing another forum, one dealing with the question of mandates and one dealing with the concept of health reform from the journalists' perspective. We have many good writers up here who write about this on a regular basis, and we want to bring them in, perhaps turn the tables and interview the interviewers for part of the morning on some of the aspects of the health care debate.

And then finally, in the month of June, we are going to have another forum on promoting quality. And we have got a number of good people lined up for that. Again, some left of center, some right of center, but designed to give a balance of opinion as we have these forums. And again, as I mentioned, Mr. Speaker, if anyone were interested, they are available live on the Web site when we hold those.

In short, Mr. Speaker, I did not leave a viable and active 25-year practice of medicine to come here and sit on the sidelines. I came here to be part of the debate as the debate was going on, and I intend to be fully engaged. I hope that both sides will stay lively and will stay engaged on this debate. I hope we can have this debate in the light of day and not in the dark of night. I hope we can have input from both sides when this bill ultimately comes forward from this and leaves the floor of this House and goes over to the Senate. Certainly I know the American people are depending upon Republicans and Democrats to work together. And it is my hope, my fervent hope and my prayer that that is indeed what happens.

Mr. Speaker, you have been very generous, and I'm going to yield back the balance of my time.

THE AMERICAN CLEAN ENERGY JOBS BILL

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

Mr. INSLEE. Mr. Speaker, I have come to the floor this evening to speak about a bill that we hope to have on the floor in the next couple of months that is going to be styled the ''American Clean Energy Jobs'' bill. It is the right name for the bill because it will jump-start, kick-start and initiate an economic recovery based on the growth of clean energy jobs in this country. And it is timely, it is vital, and we believe it is possible this year to really give a boost to the American economy by helping create the millions, and I say that with an M, the millions, not hundreds, not thousands, but the millions of new jobs that we can create if America fulfills its destiny to become the arsenal of clean energy for the world. America is a country with a very special destiny. We have fulfilled the destiny to bring democracy to the world. And later we served as the arsenal of democracy during World War II. We armed the rest of the world with the tools they needed to defeat the powers of darkness during World War II.

And now we will have a bill on the floor shortly that will call on the American economy to produce the clean energy jobs and tools to essentially provide a new clean energy future for the world. And when we do that, we believe we will dramatically expand our economy, dramatically expand Americans' employment opportunities, and as an additional side benefit, dramatically reduce the pollution that today is threatening, in a very serious way, the way we live. We will also, at the same time, dramatically reduce our dependence on foreign oil. And as a side benefit, we will dramatically increase our national security, because we know that our addiction to foreign oil is a security risk to the United States.

I want to start talking about this bill from its first job, which is to create jobs for this country. In the current economic malaise we are in, we have got a couple of choices. We can sort of roll over and play dead and not take bold action to jump-start the American economy by seizing this opportunity to start new businesses in this country that can create employment. Some people in this Chamber still think that is what we should do, which is nothing. They are unwilling to make the investments both in governmental action or in the dollars that it is going to take to really create these clean energy jobs.

We think they are wrong. We think inaction is not the American way. We think America should take bold action to create clean energy jobs and that Congress has the responsibility to create the policies that are going to help create those jobs in this country.

So if I can, let me just start this discussion tonight by talking about just some very simple samples of the kind of jobs that we believe need to be jump-started in this country. I will start in Michigan, a State that has been so hard-hit right now with some difficult times in the auto industry. I will mention a couple of companies that if we do the right thing can really expand employment.

One is General Motors, which is going to bring out a car called the Volt in a year or two. The Volt is a plug-in electric car. The Volt is a car where you can plug it in at night and the next day run it on all electricity for about 40 miles, which is really cheap. It is about 1 cent a mile, maybe a little more to run, compared to 7 or 8 cents a mile for gasoline. And 60 percent of all the trips we take a day are less than 40 miles. But if you want to go more than 40 miles, then it will run on the internal combustion engine that is in the car as well. And you can drive it for 250, 300 miles, bring it home at night, plug it in again and you are off to the races the next morning on very inexpensive electricity, very quiet electricity and very nonpolluting electricity.

Now at some point, they may use some batteries by another company. It is a Massachusetts company called A123 Battery Company. And A123 Battery Company now, because of some policies we just adopted in the stimulus bill, we hope to be able to open a manufacturing plant in Michigan to provide the advanced lithium ion batteries that we think can be the backbone of an American electric car industry.

Now those two companies, General Motors, we know they are in difficult times, and A123 Battery Company, have the potential to employ thousands of Americans in high-paying manufacturing work if—if—Congress takes a path of action to develop the clean energy policies we need to drive investment into those companies.

And that is what is at stake tonight. What we are talking about is making sure that those jobs of the future don't go just to China, where China has a very aggressive national policy to build electric cars. We need some national policies to make sure that they are done here.

I go to Washington State and I hail from Washington State. Take a look at the McKinstry Company, which is a little company that just started providing advice on how to do efficiency. And then they figured out that they could save corporations millions of dollars a year by teaching companies how not to waste energy, how to save energy. That company has now grown to hundreds of people who are working in Seattle, Washington, basically teaching companies around the world how to save energy. And that company is now probably the leading energy efficiency company in the world when it comes to teaching companies how to save energy. And hundreds of my neighbors