country is to make that distinction, and we are blurring it badly and it's going to cause a lot of trouble.

I am going to yield to my good friend Congressman KING from Iowa. Please join us.

Mr. KING of Iowa. I thank the gentleman from Missouri for yielding.

There are a couple of points that linger in my mind. One of them is to add to the points that the gentlemen from Georgia and Missouri were making about Spain, and I concur. For every green job created, it cost 2.2 jobs in the private sector because it starved capital, but also each of those green jobs created cost $770,000 to generate that job. So it was a massive cost in capital.

I want to throw another point into this in a brief way, a teaser in a way. The cap-and-trade component of this legislation that's impending to be driven through this House floor yet this month of June, we have experience with that here in the House of Representatives. When Speaker PELOSI was elected and received the gavel, she declared that this Capitol complex would be carbon neutral. So she ordered that the generating plant that provides the electricity that illuminates this room when she allows the lights to be on would be changed from coal generation over to natural gas under the auspices of this idea that natural gas isn't a hydrocarbon, which we know can't be upheld by an engineer or a doctor or a layperson. But in any case, she ordered the switch over to natural gas, doubled the cost of the electricity, and still found out we were not carbon neutral but we're still emitting a surplus of CO_2 into the atmosphere, so went on the Board of Trade and purchased $89,000 worth of carbon credits, the very central commodity that is at the middle of the cap-and-trade discussion that's going to be presented on the floor of this House, $89,000 for carbon credits to offset the CO_2 emissions that are going off into the atmosphere so we can light this Capitol complex. And I chased that back down and found out that some of that money went to no-till farmers in South Dakota. Presumably they had still been farming in South Dakota. It didn't change their behavior. And some of that money also went to a coal-fired generating plant at Chillicothe, Iowa, that had received a government grant to burn switchgrass. I went there and looked at that. They hadn't burned any switchgrass in 2 years and got a check anyway. That's how cap-and-trade will work in the United States of America. If we can't get it right in Congress, we are not going to get it right in America.

Mr. AKIN. I appreciate that vivid example of more wasted time. I am going to yield again to my good friend Congresswoman BACHMANN from Minnesota.

Mrs. BACHMANN. Last weekend my family sat down and we were watching the commercial movie ''Titanic.'' And as I was listening to Dr. BURGESS from Texas talk about the debt and the burgeoning debt load that the United States takes, once the ice gash came in the side of the Titanic, which we all remember was called the ''unsinkable Titanic,'' we think of the United States. Nothing can possibly sink the United States. We will always be a superpower. But one thing that has kept us a superpower has been freedom, free market economists. We are in the process of watching the deconstruction of free market economists before our very eyes, something we have never seen. But as the ice ripped that hole in the Titanic, water started being taken on, and the engineer came out and brought the blueprint of the Titanic. Water came into the first chamber, spilled over to the second, spilled over to the third, and by the time it filled up so many chambers, it was over. It was impossible to resurrect that ship.

That's, I think, Mr. AKIN, what you have been bringing before this body this evening. You've been showing to the American people that at a certain point when we have such excessive levels of spending that in turn leads to such excessive level of taxation that in turn leads us to excessive levels of borrowing that at a certain point we wonder what that tipping point will be if the United States will not be able to recover.

We do have an alternative, as Dr. BROUN said. We have a positive alternative that next quarter we could already see growth in our economy. But this plan that President Obama has put forward is the kind of plan that we could watch last night, or last weekend on TNT in the movie ''Titanic.'' If we follow that plan that President Obama has put before us, we know what that outcome will be and a lot of very innocent people may go down with that ship.

Mr. AKIN. I very much thank Congresswoman BACHMANN and the other great guests that we have had tonight. I thank you for this little symposium on freedom and the need to have the Federal Government restrained to its proper limits.

HEALTH CARE REFORM

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

Mr. GINGREY of Georgia. Madam Speaker, for the next hour, I am going to be joined by a number of my colleagues on the Republican side of the aisle, and most of them are members of the GOP Doctors Caucus, and we are going to spend time, Madam Speaker, talking about health care reform. Certainly that is the number one thing that's on our plate as we go through these next 6 weeks leading up to the August recess. And, of course, as the President has outlined his desire to have a health reform bill on his desk for signature sometime in mid October of this year, whether or not that can be done remains to be seen. There are a lot of thoughts out there as to how to approach this, but we feel that it's very important as physician Members. I think there is something like 339 years of clinical experience combined in this GOP Doctors Caucus. About 15 of us are health care professionals who have actually practiced in the field, if you will, most of us involved just in clinical medicine, what I like to refer to, Madam Speaker, as meat-and-potatoes medicine. Not research at some high academic institutions but actually seeing patients every day in the office, in the operating room, in the delivery room. And so I think we have a perspective that we would like to share with Members on both sides of the aisle.

Earlier in the evening, Madam Speaker, we heard from the 30-Something Group on the Democratic majority side. They were very articulate, very well spoken, but I think very wrong in some of the ideas that they have in regard to a government default plan, and we will talk about this during the hour.

□ 2200

I have been joined by a couple of my colleagues, Dr. John Freeman, the doctor from Louisiana; and Dr. PAUL BROUN from Georgia.

I would like to yield time to my colleague from Louisiana at this point.

Mr. FLEMING. I thank my friend and fellow physician and colleague, Dr. GINGREY.

You made reference to the 30-Something Democrats, and I watched that debate, that discussion with great interest because, to be honest with you, with 32 years of medical practice and also owning businesses for nearly as long, when I hear this discussion about how a public plan can work, I really try to view that and try to understand that; but I always come out totally mystified with how this sort of thing could ever work.

And to clarify the debate, basically Congress right now is looking at three different options. One is a total single payer nationalized health care system, Medicare for all. One would be a private system for all, which is what we, on the Republican side, back. And then the other is a public and private system that are competing with one another. So I really watch with great interest our colleagues on the other side—none of whom are physicians, I might add—talk about how this could be a great deal, a great success, where you have a public system that's competing with a private system, somehow that's going to drive cost and prices down, and we're going to get a dividend from that.

Well, what I would do is point out to my colleagues, let's look at Medicare today and Medicaid as well, both government-run systems. Both of them are running out of money rapidly, the budgets are exploding and expanding, and they are living off the fat of the

private system. Today we know—in fact, a recent survey, a study came out showing that the average subscriber to private insurance spends an extra $1,000 a year to support the Medicare and Medicaid system. We also know that a lot of that support comes by way of the uninsured who are routed through the emergency room, who don't have any coverage; and if you think that the Medicare recipients pay for that, forget it. That's not happening. Who is paying for that is the taxpayer and those who subscribe to private plans.

So right now the systems that exist, Medicare and Medicaid, are, for the most part, supported not by premiums and not even fully by the taxpayers, but are supported by those who pay premiums into private plans. So if you expand Medicare to where everyone is eligible for a Medicare-type plan, who in their right mind is going to stay on private insurance when they know that they're going to have to pay increasing size premiums in order to get the same level of care that those on Medicare, who are largely supported by taxes, are going to get?

What ends up happening is you lose that critical mass of those under private insurance, and so private insurance then becomes only an afterthought, a sliver of the economy. So what you're left with is a giant public system, a Medicare that's much bigger than what we have today. Incidentally, I will remind those that today, as it stands, Medicare will run out of money within 10 years, as it is. It's unsustainable as it is. Now if we grow it into a much bigger system, where are those cost savings going to come from?

I will yield back in a moment, but I just want to bring out the fact that no one has ever been able to show that a government-run system, particularly a health care system, but any government-run system in which the economy is being controlled in some way has ever controlled cost. And even today we know that health care costs are going up twice the rate of inflation.

Mr. GINGREY of Georgia. I want to apologize to the gentleman. I referred to him as Dr. John Freeman. Actually, it's Dr. JOHN FLEMING, a family practitioner from the great State of Louisiana. And it reminds me, the reason I did that, Madam Speaker, is because Dr. John Freeman was one of my classmates in medical school and also one of my co-residents in my OB/GYN training back in Georgia. I think Dr. John Freeman practiced his entire career in Boone, North Carolina; and I hope Dr. John, wherever he is, is doing well, if he happens to be tuning into C-SPAN tonight.

I wanted to say before yielding time to my colleague, Dr. PAUL BROUN, a fellow physician and family practitioner from the Athens and Augusta areas of Georgia, there was a letter sent from the National Coalition on Benefits within the last couple of days, addressed to the leadership of the House and Senate, House Speaker NANCY PELOSI, House Minority Leader JOHN BOEHNER, Senate Majority Leader HARRY REID, and Senate Minority Leader MITCH MCCONNELL, talking about the strong opposition to a public plan. I don't have time to stand here and read the names of all of these firms, but just to mention a few: Wal-Mart Stores, Xerox Corporation, Wellpoint Incorporated, Weyerhaeuser Company, National Restaurant Association, Bank of America, National Association of Health Underwriters, CIGNA Corporation, Chrysler LLC, Nike. I could go on and on. That's just maybe 5 percent of the number of companies that are a part of this National Coalition on Benefits that are so opposed to this idea of a public plan, which our colleagues, the 30-Something group, just an hour ago touted so strongly.

At this point, I would like to yield to my good friend and colleague from Georgia, Dr. PAUL BROUN.

Mr. BROUN of Georgia. Thank you, Dr. GINGREY, for yielding.

I think the American people need to look at what President Obama said as a candidate and go back to what Dr. FLEMING was talking about just a few moments ago about the options. Republicans are offering options because certainly we need to do something about health care financing. People are hurting. Health care expenses have gotten too high. Medicines are too high in the drugstore. Doctor bills are too high. Doctors are actually earning less money today. When I was practicing full time prior to coming to Congress, I was making in real dollars less money than I did 20 years ago and seeing as many or more patients. We see the whole health care system being strained tremendously. But candidate Obama talked about giving the American public options, a public versus private option. He said, if you like your current insurance, fine. Stay there. But as Dr. FLEMING was talking about just a few minutes ago, what President Obama is actually offering us is a reduced-price health care financing system that's going to take away people's choices. It's going to take away their ability to choose their doctors. It's going to take away their ability to choose the hospital, what medicines that they have. It's going to delay them being able to get needed procedures, surgeries, delayed in getting x rays that are needed, ordered by their doctor. It's going to take the choices away from the patient, and it's going to put those choices in the hands of a Washington bureaucrat. I don't think the American people want that. I'm not sure that they understand yet what we're talking about tonight in our second opinion, that government-run health care is not going to give them the choices that they're used to today. They're not going to be able to stay in their private plans because they're going to be priced out of the market. They're going to have to go to that government-sponsored plan that is going to markedly narrow their choices.

What it's going to do is it's going to kill people because, as we saw in the stimulus bill, there is a new program set up in the Federal Government to look at cost effectiveness and comparative effectiveness, comparing the effectiveness of health care decisions. Age is going to be one of the measures of how those decisions are going to be made.

□ 2210

We already see this happening in Canada. We already see it happening in all the socialized health care systems around the world. When people have celebrated a few birthdays and are getting what growing up down in Georgia folks talked about being ''long in the tooth,'' a little white haired, as I am turning to be, then what happens in those government-run health care systems is they just deny the procedures, deny the tests, deny the care that the people need to stay alive, and people just die.

Now, in Canada, a system that many tout, many on the other side in the Democratic Party tout the Canadian system and others, if you are a certain age and need a kidney transplant, you just don't get it. If you need bypass surgery, if you are a certain age, they will put you on the list, but you never get off the list. You just die. If you need medications, you are denied those. If you have cancer treatment that is needed, you just don't get those.

We in this country, with the health care that we as physicians can give, we have made marked strides since I graduated from the Medical College of Georgia in how people survive various forms of cancers.

I think Dr. ROE is probably going to talk about breast cancer, because he very eloquently talks about that frequently, but our breast cancer survival rates in this country are extremely good. In other countries, where they have socialized medicine, people die, and there is very poor long-term survivability of that disease. Heart disease, diabetes, you can go down the list of all these chronic diseases.

In socialized health care systems, as this administration and the leadership in this House and the Senate across the way want to take us, it is going to take away people's choices. They are not going to be able to get the care that they desperately need to stay alive, and it is just the wrong thing to do.

Dr. GINGREY, I just congratulate your efforts in trying to bring these things out to the American public, and I appreciate your being one of the cochairman of the Doctors Caucus and helping the American people to understand the direction that we are being led by this leadership, the liberal leadership in this House and the Senate, because it is not going to be in the best interests of the American public, and it is actually going to create a financial collapse, as Dr. FLEMING was talking

about, that is going to be exacerbated, and people are going to be exasperated because of this rationing of care, taking away their choices, and some Federal Government bureaucrat in Washington, DC is going to make those health decisions for them. It is not going to be their doctor, it is not going to be their family and it is not going to be the patient, and it is the wrong thing to do.

I thank you for yielding.

Mr. GINGREY of Georgia. Reclaiming my time, I thank the gentleman.

Before yielding to our colleague from Tennessee, Dr. ROE, a fellow OB–GYN physician, I just want to say to my colleagues on both sides of the aisle, Madam Speaker, that what we are about is trying to work in a cooperative way on both sides of the aisle and offer our expertise, to say to our colleagues, and there are some health care practitioners on the majority side as well, and we have reached out to them and made ourselves available, we want to be at the table.

Unfortunately, Madam Speaker, we are not at the table. We haven't been enjoined, if you will. But we still hope, we still have hope that that can occur, because we do have some ideas, I think some very good ideas, in regard to bringing down the cost of health care, making it more accessible, making it more portable, making it available to everybody, and that would include people who are currently considered high risk, maybe even considered uninsurable, or if they can get insurance it is because they can afford to pay three or four times the normal standard rate, which many, many cannot.

So we want to talk about some of those things tonight, and we will get back to that.

At this point I yield to my colleague from Tennessee, Representative ROE.

Mr. ROE of Tennessee. Thank you, Dr. GINGREY and also Madam Speaker. It is good to be here tonight to discuss a very important, and I believe, Dr. GINGREY and Madam Speaker, probably from a social standpoint, the most important issue that we will discuss, and probably this health care debate is the most important one since the mid-sixties when Medicare was voted on.

Just to give you a little background, I am a native Tennessean, practiced medicine in Johnson City, Tennessee, in that region for 31 years, and really saw a tremendous change in the health care delivery system from 1970 when I graduated from medical school until the current. I really marvel myself at the miracles that occurred.

I recall when I was in medical school when St. Jude's Children's Hospital had just opened, it hadn't been there long, and the death rate among childhood cancers was 80-plus percent. Today, over 80 percent of those children survive and live and thrive.

We are having a debate on what kind of system best fits America and its personality, and I will share with you some things we have learned in Tennessee about a public and a private system.

What I hear when I am out talking to people is that, number one, they are worried about the cost of care. They are worried about the availability of it. And there is another whole discussion that we haven't had, which is accessibility.

As we age, as the medical population and caregivers age, there is going to be a huge problem of accessibility in this country. We are already seeing it in our own communities, where in the next 7 years we will need 1 million more registered nurses in America. In the next 8 to 10 years there will be more physicians retiring and dying than we are producing in this country.

Well, you know, that is not sustainable. You cannot maintain the quality of care that we have grown to expect and the medical advances we have grown to expect without practitioners. That is an entirely different issue, not part of this debate, but indeed very much a part of this debate.

In Tennessee, about 14 or 15 years ago we had Medicaid. We got a waiver to try a managed care system. Back in the eighties and nineties, managed care was going to be how we were going to control the ever-escalating health care costs. So it was a wonderful idea to try to provide care to as many Tennesseans as we could at as low a cost as we could.

What we did was we hastily put a plan together, as we are doing right here in this Congress right now. The most astounding thing I have ever heard in my life is in 60 days, or less than that, we are going to vote on a health care plan that affects every American citizen, 300 million of us. And your health care choices, as you know, are very personal choices. They are between you and your physician and your family.

So the plan was a managed care plan, and it was a very rich plan. It provided a lot of care for not much money, and for some people no money. What happened was that people made very logical choices. About 45 percent of the people who ended up on TennCare actually had private health insurance, but dropped it. Why did they drop their care? Well, you had a plan, this TennCare plan, which was cheaper, but provided more coverage, so therefore people made again a very conscious decision.

The problem with the plan is, as with every public plan so far, is it does not pay the cost of the care. That cost has been shifted over to the private sector. So when you look at your health insurance costs going up each year, you are paying or supplementing, a tax really, on your private health insurance premiums caused by the increased usage of the public plan.

In Tennessee, for instance, the TennCare plan covered about 60 percent of the cost of actually providing the care. If everyone in Tennessee had the TennCare plan, most providers would lock the door, throw the key away and walk away because they couldn't pay their bills. Medicare, another plan that we have, pays about 90 percent of the cost, and our uninsured pay somewhere in between.

Now, what I think will happen with this public plan is that once again, because politicians are involved in designing the plan, what will happen is more and more and more things will be promised about what will be covered in the plan, but when it comes to paying for it, and if we have time we can get in and discuss the Massachusetts plan a little bit, what will happen is you will have a Medicaid plan that doesn't pay the cost, you will have a Medicare plan that doesn't pay the cost, and you will have a public funded ''competitive'' plan that is subsidized by government but doesn't pay the full cost of the care, meaning more and more costs will be shifted on to the private payers.

□ 2220

Well, what will happen over time, I think, is that, again, individuals first, small businesses, 20, 30, 40, 50 in the business will say, We just can't afford this private continually escalating cost of private health insurance. And what will happen then is more will be shifted to the public plan, and over time you'll end up with a single-payer system. And a lot would say, and I've heard it argued here on the House floor, Well, so what? What's wrong with that? We have a government-run, one-payer health care system. What's the problem with that? Everybody has coverage. Well, everybody has a health insurance card, but that doesn't necessarily mean you can get health care. Don't confuse a plastic card that says you have coverage with actually getting care.

Well, what do I mean by that? Well, let me give you an example.

When President Clinton had his heart attack, he went to the hospital, had a heart attack. He was operated on several days later, I think 3 or 4 days, and probably the reason, in my opinion, he probably got a blood thinner that took a few days to get out of his system. And he was operated on and went home.

Had he had that heart attack in Canada, they would have said, Mr. Clinton, you can go home and in 117 days, that's the average amount of time it takes to get a bypass operation in Canada, you can come back and get your bypass operation.

Two weeks ago, I was in Morristown, Tennessee, talking to a physician there who is Canadian. His father began to have chest pain. I won't go through all the details about how long it took him to get a treadmill, how long it took him to see a cardiologist. Anyway, 11 months later, the man got—his left anterior descending coronary artery was 90 percent blocked, and he finally survived and got a bypass operation. I do not believe the American people are going to put up with that type of health care system. We are not.

The other thing that I think that's been so astonishing to me, and I know Dr. GINGREY and Dr. FLEMING, you have seen this, and Dr. BROUN also, are the medical advances. When I graduated from medical school, we had one cephalosporin antibiotic, one. That's a type of antibiotic we use in infection. There probably are 50 today.

There were about five antihypertensives, high blood pressure medicines, three of which caused severe side effects. I mean, it was almost better to have the high blood pressure than take this medicine. Today there are over 50, and the side effects have been reduced dramatically. People do so much better.

So there are a lot of reasons, and we can go to it, and I'm going to yield back some time now, Dr. GINGREY and Dr. FLEMING, for comments. And I have some other comments about a single-payer system. It's a good idea, as you pointed out a moment ago, to try to cover as many people as we can in this Nation as inexpensively as we can, and I agree with that.

I yield back.

Mr. GINGREY of Georgia. Well, I thank the gentleman. And before yielding back to Dr. FLEMING, I wanted to say to my colleagues, Madam Speaker, that we are the party of a second opinion. And, of course, tonight we are talking about health care reform, but it could be an energy bill, a comprehensive, all-of-the-above approach to solving our energy problems and any other issue. But none really at this point in time is more important than solving this health care problem.

And the bottom line is to, again, to lower the cost of health care, to make it accessible to everyone within their financial reach. And there are so many things that we can do short of, Madam Speaker, turning this over to the Federal Government to run what may be like they run Amtrak or the post office or, indeed, the Medicare program. And I don't think that that's what people really want and expect. We can do better than that. And there are a number of issues in particular that we could talk about in detail if we had more than just an hour, Madam Speaker.

But clearly, this idea of electronic medical records, I think, is a way eventually to save money. I think the money that we put in the stimulus package, $19 billion to provide grants, I've got a piece of legislation that would help physicians purchase hardware and software and a maintenance program that's specialty specific, whether it was my specialty of OB/GYN or Dr. FLEMING's specialty of family practice or a general surgery specialty program produced by a company in my district called Greenway where you have, as part of that electronic medical record program, you have algorithms set up of best practices that are developed not by a government bureaucrat, Madam Speaker, but by that very specialty group, those men and women, those leaders of that specialty society that want to do what is best and they want the best outcome at the lowest possible cost. They want to get paid a fair amount for their services, of course.

And, in fact, with an electronic medical records system, they're more likely, Madam Speaker, especially under the Medicare program where you have something called evaluation and management code and intensity of care that you bring, doctors, I think, tend to undercode because, Madam Speaker, they're petrified that some inspector general is going to come along and demand to see 10 charts out of their 10,000 and nitpick and find some few, two out of 10,000 where they overcoded, and first thing you know they're not participating in the Medicare program and maybe even they're facing a jail sentence.

So electronic medical records would—I don't know how much money, my colleagues, it would save, but I know that it would lead to a better practice of medicine based on best principles. We wouldn't need to have some comparative effectiveness institute, kind of like the Federal Reserve Board, telling doctors what they should do and not do, when it's time to operate, what medication to prescribe. We would have those best practices as part of an electronic medical records system. We could cut down on duplication of testing.

People could be in Timbuktu, and with that little card smaller than our voting card, they, Madam Speaker, they could take that card, even in a country where they don't speak the language, or maybe they come to the emergency department comatose and can't speak any language, you reach in their pocket, pull out that card, swipe it, just like we would our voting card, and there's the entire record. We know what they're allergic to. We know what medications they're on. We know their past medical history, and we give them the best and most effective, cost effective, safest medical care.

Mr. ROE of Tennessee. Would the gentleman yield?

Mr. GINGREY of Georgia. I'll be glad to yield to the gentleman.

Mr. ROE of Tennessee. Just a point right here. You were making an excellent point, Dr. GINGREY, about why you don't want the Federal Government to come between a patient and a doctor.

A veteran can go to an emergency room, have an electronic medical record at the VA, can show up somewhere in an emergency room, let's say, in our area we have a VA Hospital in Johnson City, and let's say he lives in Mountain City, Tennessee. He shows up there and the doctor in the emergency room at Mountain City does not have access to his VA record, to his electronic record that they have at the VA. Now, I think we can do better than that, and that's going on right now.

So that veteran who's up there with, maybe he's an elderly veteran, a World War II veteran with a very complicated medical history, that emergency room doctor is flying by the seat of his or her pants, and I think we can do better.

And again, the health care decisions should be made between a patient and a doctor. And I don't want to let the private insurers off the hook here. You and I know this, and Dr. FLEMING, also.

I remember one of the last cases I did in practice before I retired to run for Congress, I spent almost as much time on the phone with a private insurer trying to get the case approved as I did actually doing a major surgical procedure. Now, that's the ridiculous item of the day when you do that, when you're not providing care to someone, you're arguing with a bureaucrat at the private health insurer.

I yield back.

Mr. GINGREY of Georgia. Reclaiming my time, those stories are just all too familiar, and it's a shame that that time is wasted when it can be better spent with the patient.

I wanted to mention too, Madam Speaker, the issue of medical liability reform. Now, for a number of years—I've been here 7, this is my fourth term, and every year I have introduced medical liability or tort reform modeled after the system that was adopted back in the late seventies in California. The acronym for that bill is MICRA, but it has worked. It has stabilized the malpractice insurance premiums in that State. Yes, they've gone up somewhat because of inflation, but compared to other States that don't have that reform where there is a limitation on a claim, a judgment for pain and suffering, noneconomic, and where there is the elimination of this joint and several liability and there is collateral source disclosure—and I could go into some of the weeds of it.

□ 2230

But, obviously, we have not been able to pass that. When we Republicans had the majority in this House, we would pass it every year, Madam Speaker, in the House; but so many attorneys who are Members of the United States Senate would block that.

Well, why can't we come together again in a bipartisan way and say, look, we can agree that part of the cost of medicine, cost of health insurance is the fact that medical practitioners order so many unnecessary—and in some cases, Madam Speaker, harmful—tests, draw too much blood, get an MRI one day and a CAT scan the next day and a standard x ray the next day because they're trying to cover the possibility that someone would say, Why didn't you order this, or why didn't you order that?

Lord knows we've gotten to the point now where everybody who shows up in the emergency department anywhere across these great 50 States with a headache is going to get a $1,200 CAT scan instead of a blood pressure check and an aspirin and a ''come back to my office in the morning.''

So this is an area in which we could clearly come together in a bipartisan

way and hash out. Well, if the California version of tort reform is not acceptable, how about a medical tribunal, a group of independent people looking at the claim and saying whether or not it has merit?

There are so many things that we could do. And I've got a few more ideas, Madam Speaker, that I want to talk on, but I do want to refer back to Dr. FLEMING and hear from him because I know he's got a lot of things he wants to share with us.

I yield to Dr. FLEMING.

Mr. FLEMING. I wanted to tone down on the debate a little bit more.

Again, we heard the 30-something Group Democrats talking about the debate earlier, and one said something very interesting. It really caught my ear. He said that the debate is basically Democrats want health care reform, Republicans do not want health care reform.

Now, I have spoken on this floor, as you know, Dr. GINGREY and Dr. ROE as well, and I've heard you speak many times; many Members of our conference have spoken; I've spoken a number of times throughout the district. I've listened to everyone from Speaker Gingrich to many others. I have yet to hear one Republican say that he is against health care reform.

So I want to remind my colleagues on the other side of the aisle that the only way we're ever going to solve our health care problems—which make up about 20 percent of our economy—we must have an honest debate. And framing the other side into a position that really doesn't exist is not going to get us there. In fact, I would say that we really agree, from what I can understand, on 90 percent of the discussion.

We all agree that we should do away with pre-existing illness; we all agree that we should have portability; we all agree there should be a hundred percent access to care; we all agree that we should lower the cost of care. I can draw you a great list. There is really, when you get down to it, only one thing we disagree with, and that is we feel that a private system, private industry—even if it's paid for by the Federal Government—in many cases does a much better job in terms of quality of care and customer service and a much better job of controlling costs.

This is proven time after time.

Compare our economy with a socialistic economy and you see every time that we provide much better products and services and at a much better price than those countries do.

So, really, the only disagreement is who is actually controlling the care. And, of course, I submit to you that a government-run system is a real problem. And I will tell you where I learned this.

When I was in the Navy as a physician, I noticed in the first year that the commanding officer of the hospital sent out a call and said if there is—this is budget time of the year—and if there is anything that you think we could ever want in this hospital, wink wink—meaning, think of something; dream of things—put it on a list, because if we don't preserve that budget the way it is, then our budget will be cut next year. And that, my friend, is the way government works. If you don't force it into the budget, if you don't make sure and protect your territory, it won't be there next year. Somebody will cut into it. And that's really the way government works.

And I will give you an example, a real-life example of how we will never be able to get rid of waste, fraud, and abuse from our health care system if it's run by the government.

Think about this: we have to throw out a wide net, which is very expensive. We may capture a few offenders out there. Because it would have to be a criminal act, we would have to prove that they really did it on purpose; and then at the end of the day we would have to prosecute them with a lot of dollars; and then we may get one person, and we may get a few dollars. That's the way you get rid of fraud and abuse in a government system.

In a private system, much different. You have a physician or some other provider in a health care organization that's privately run, and if his practices are not the best practice and he's not practicing in a cost-effective way, that shows up on a graph; and often, of course, you go to that provider and you reeducate, and you have him work with colleagues, and you get him back to the protocols. And if that doesn't work, then you fire him. Easy problem to solve. It doesn't require all of that—there is no crime involved. So you can work in the most effective way possible.

Mr. GINGREY of Georgia. Reclaiming my time, I think that the gentleman has certainly hit the nail right on the head in regard to this, and we could go back to what we talked about earlier in regard to electronic medical records, which would be specialty specific—the information, of course, would be available for any provider who is seeing the patient.

But in regards to best practices, as the gentleman was talking about, and these algorithms, I mean, doctors, let's face it, they're busy. They're operating; they're delivering babies. They don't have time, nor can they afford every 4 months going to a continuing medical education course. A lot of times they have to do that online. And it is hard to keep up.

But with electronic medical records, this would help them keep up. It would absolutely help them order the right tests, give the best outcomes. And as Dr. FLEMING pointed out, if they're in a single specialty group of eight surgeons and one in the group is not getting the information the others are getting, that information is available internally and externally. And you kind of police your own.

I want to give—I think he just asked for 1 minute—my good friend, DANA ROHRABACHER, is going to be on the floor in the next hour. He asked for a minute, and I yield to him.

Mr. ROHRABACHER. As we are making fundamental decisions about things such as health care, which is so important to our country and important to each and every citizen, we should keep in mind the fundamental differences that you are bringing up tonight between a government-controlled health care system and an individual-controlled health care system, where the individual basically controls a great deal of the resources that he or she depends upon for his or her health or the health of their family as compared to having those resources totally at the command of the government. And the one word that comes to mind is politicalization of what's happening and what could that possibly mean in health care.

Let me give a little suggestion that if we have government-controlled health care, we're going to have illegal immigrants involved in the system. Our Democratic colleagues, as good-hearted as they are, cannot get themselves to say ''no'' to providing health care benefits to illegal immigrants. If we provide the type of operations that we want for our own people—heart operations and various things that are very expensive operations for health care—to be granted to illegal aliens, you can expect that it will, number one, bankrupt the system; but, number two, we will have illegal aliens coming here from every part of the world. And, in fact, one of the problems right now is that we already provide too much health care for illegal immigrants.

□ 2240

That issue alone should be a red bell for everyone out there saying, Do I really want the government to control health care and make the decision and give part of the money to an illegal immigrant?

Mr. GINGREY of Georgia. Well, reclaiming my time, and I thank the gentleman for his contribution in regard to that.

When you look at that number of 47 million who do not have health insurance, according to the Census Bureau, Madam Speaker, probably as many as 10 million of them are illegal immigrants. Now, they're not entitled, so to speak, to health insurance. That's not to say that you might not have a situation of extreme compassion if an illegal immigrant is admitted through one of our emergency departments and they are absolutely in the throws of a fatal illness, maybe it's a young, otherwise healthy person with congestive heart failure or congenital malformation that is resulting in an inability to sustain their blood pressure and they are on the verge of death, they would get the care in that hospital—in any hospital I think across the United States.

Mr. ROHRABACHER. And no one argues with that.

Mr. GINGREY of Georgia. Yes. Of course not. They would get that care to save a life, of course we would. But the gentleman brings up a good point. And I did want to point out the segue into that number of 47 million.

It is estimated that maybe 18 million of those 47 million are making more than $50,000 a year, and many of them just choose, of their own volition—maybe they're 10 feet tall and bullet proof, 20-somethings, 30-somethings, have the Methuselah gene, they think, and don't spend much money on health care, and they just elect not to put the $200 a month payroll deduction or whatever it is. And maybe they have their own escrow account or their own health savings account. I think it's a bad decision, I think it's a bad bet, but a lot of people do that.

And you can't really force them, I don't think, unfortunately, in this Democratic plan, Madam Speaker. What the President is talking about is to have a mandate on the employer. If they are above a certain number of employees and if they don't provide health insurance for their employees, then they have to pay a tax or pay a percentage of their payroll into this connector; and individuals are absolutely required to sign up for health insurance, or if not, they have to pay a tax. I mean, that is not the American system. We want to encourage young healthy people to get health insurance.

And I want to make one point before I yield back to either one of my two colleagues. The insurance industry can help in a great way by looking at this. Let's say, take an example, a 22-year-old young man, newly married, newly employed, is not really convinced that paying for health insurance on a monthly basis is to his advantage, but he does it anyway. And he puts in whatever the cost is for a family premium and his portion of that payment month after month, year after year, with the same company maybe 15 or 20 years. During the course of that time, Madam Speaker, envision this, that individual develops high blood pressure, or maybe in addition to that high blood pressure develops type 2 diabetes—maybe the diabetes comes first, and then the high blood pressure—and then after that develops coronary artery disease. And then all of a sudden the company goes out of business and that individual is out of work, out of insurance, and desperately needs it. But because of these preexisting conditions, once COBRA runs out, how are they going to get health insurance? How are they going to afford—struggling maybe to find a new job, but how are they going to be able to go out with no tax deductibility and purchase a health insurance plan that is three and four times the amount of a standard plan for everybody else?

What I would say, Madam Speaker, to the Association of Health Insurance Plans, why don't you grant those individuals credible coverage, just like we did in Medicare part D, the prescription drug benefit? If you have a credible insurance plan that covers prescription drugs, say, on a supplemental plan, and then you lose that after 4 or 5 years, then you shouldn't be penalized when you get into part D—and, indeed, the law says you won't be penalized. But why should the insurance company penalize these people who, in good faith, all those years have put that money, that premium—the insurance industry had it invested and had a good return on their investment—when these people all of a sudden are in a high-risk situation, I think they should get a community rating.

I would be very curious to know how my colleagues feel about that, and I will yield to Dr. FLEMING.

Mr. FLEMING. I appreciate your yielding. I just wanted to take a moment to follow up on what you said and Mr. ROHRABACHER.

We have 47 million uninsured, 10 million of course are illegal aliens. And of course that is a solvable problem by only allowing legal aliens and requiring them to pay taxes and insurance like anyone else, and those who are here illegally should not be here. So that's not really a health care problem, at least primarily, that is an immigration problem.

We also have, as you point out, at least half that 47 million who are insurable people, and very cost effectively, but they choose not to. That really hurts the risk pool, and we should do things to incentivize them.

The real problem is the 10 or 15 million people who are either business owners or they work for small businesses and they can't get cost-effective insurance. And they're the ones that delay care, they're the ones that don't go to their primary doctor, they're the ones that end up going to the emergency room, getting care at a time when the outcomes are the worst and the cost is the highest.

So when you think about it—and polls show that 75 percent of people are happy with what they have, whether it's Medicare or Medicaid, private insurance—it's that 25 percent that can't get affordable care. That's where the problem is, and that's where the focus needs to be. And if we do that, we get cost-effective coverage for them—and there are many ways of doing this, and we would have to get into ways to determine that—we would really have this problem under much better control. But if we, on the other hand, blow this thing out with a single-payer system, we are going to have exploding budgets as far as the eye can see, and I don't see any end to that. I thank you, and I yield back.

Mr. GINGREY of Georgia. I thank the gentleman, and I yield to the gentleman from Tennessee.

Mr. ROE of Tennessee. Just a couple of comments.

Our colleague from California made great points. And I am going to ask the two of you who have been here for a while to discuss this Medicare part D discussion in just a moment. But he is correct. What happened was, when we created the TennCare plan in Tennessee, we are surrounded by eight States in the State of Tennessee, and we had a plan much richer than the surrounding States. So guess what happened? People came into the State. First of all, when we first put the plan out, all you had to have was a post office box. Well, there were a lot of post offices boxes that occurred, and a lot of people came into the State of Tennessee to get care.

The way the Governor handled that—and remember that government-run plans—and I want people to understand, this is a very important point—in Tennessee, when it was about to break the State, our Governor, along with the legislature, made some very tough decisions. They cut the rolls. They limited the number of people that were on the TennCare plan. In a plan in England or in Canada or other single-payer systems, what happens is you ration care, you create waits. For example, in Canada—and this is the head of the Canadian Medical Association, not PHIL ROE saying this—but he said you could get your dog's hip replaced in a week in Canada, but it takes 2 to 3 years for a person to get their hip replaced in Canada. And I think you made that point this morning during 1 minutes.

Mr. GINGREY of Georgia. Reclaiming my time, we did talk about it this morning, and it was a Canadian testimony, was it not? And I yield back to you.

Mr. ROE of Tennessee. It was. And I think the discussion, as I recall—and Dr. FLEMING is absolutely right, there are not that many disagreements, it's who is controlling these health care decisions; is it a bureaucrat or is it the patient and a doctor? And I think that is where the big discussion is.

Now, as I recall, when the Medicare part D discussion came up, the problem was going to be—the argument I heard the other side make was that without this public option there wouldn't be enough competition, and therefore prices would go up. But was what happened in part D—and I'm not saying part D certainly is perfect, it's not—but what happened was, with a competitive market out there, that actually came in lower without the public option when you had the private option competing in the open market. And I believe the discussion among the Democrats was that without this public option, that wouldn't happen. Well, just the opposite happened.

And again, we have seen what happened in Tennessee, I don't want to go over it again. But I can assure you that it will be a plan that promises more than it can deliver for the funds that are available, and there will be two options. And you know what those options are, and that's long waits—and I just don't think the American people are interested, I know I'm not interested in that.

Mr. GINGREY of Georgia. Well, reclaiming my time, and I think you're absolutely right, that the only way to solve the cost overruns, which would no doubt occur—and I do believe, as our friend from California suggested, that if the government was running the whole show, and eventually if we approve this government default plan, that's just a giant step, and it's just a baby step toward a single-payer system. And when you get into that situation, I can almost assure you, Madam Speaker, that under current leadership, you would have any and all, come one come all, just like they did in Tennessee. And Dr. ROE was describing the TennCare program and the problems they ran into.

□ 2250

And then the only way you could pay for it, as he points out, would be to start cutting reimbursement to the providers, to the health care providers, to the physicians, to those primary care docs that we so desperately need to be focusing and to be running our medical homes and to make sure that people are taking their medication, that there's an emphasis on wellness and keeping people healthy, keeping them out of the doctor's office, keeping them out of the emergency room, out of the hospital, and toward the end of life hopefully out of the nursing homes and in their own homes. That's why I think it's a mistake to even go in that direction of government-run health care.

I clearly feel, and I know my colleagues on the floor tonight agree with me, Madam Speaker, that the private marketplace works. And my two colleagues that are with me tonight weren't in the House back in 2003, but I know they were following the debate very carefully and very closely and maybe even felt that Medicare part D was something that we couldn't afford. Certainly it added cost, if you crunch the numbers statically, to the Medicare annual payments, Medicare part D did. But in the long run, in the long run, because of that program, if they can afford to take their medications for some of these diseases that I mentioned earlier, high blood pressure, high cholesterol, diabetes, and keep these things under control, then clearly what happens is you shift costs from part A, the hospital part of Medicare, and from part B, the doctor part, the surgeon part, the amputation part, the renal transplant part, and then also in part D keeping folks from having a massive stroke hopefully by controlling their blood pressure and you spend less on the skilled nursing home part. So I think that's a pretty good bargain and a pretty compassionate way of approaching things.

But our Democrat colleagues, Madam Speaker, who were in the minority at the time, stood up here and they symbolically, some of them, tore up their AARP cards because that senior organization had the audacity to support a Republican bill. And then, of course, they said, well, why can't we have a government default plan and why can't the government come in and set the price and say, okay, this is the price, this is the monthly premium for part D, the prescription drug part, and these free market thieves will not be able to run up the price? And they even suggested, Madam Speaker, that we set that monthly premium at $42 a month. Fortunately, my colleagues, that amendment was defeated. And when the premiums first came in from the prescription drug plans, the private plans competing with one another for this business, they came in at an average of $24 a month. Now, 3 years later, that has gone up a little bit because of inflation, but it's nowhere near $42 a month.

So if we don't learn from our history, we are going to repeat those same old mistakes. And it looks like the Democrats, with this idea of letting the government come in and run everything and saying that we can't trust the free market, I guess that's what they want to do with General Motors as well, and I'm very anxious to see how that one turns out.

Mr. ROE of Tennessee. Will the gentleman yield?

Mr. GINGREY of Georgia. I yield to the gentleman from Tennessee.

Mr. ROE of Tennessee. Good points about the private versus the public sector. The private sector will always be more efficient and more responsive. And you have heard this story before, but when I began practice and when you did, Dr. GINGREY and Dr. FLEMING also, when a patient came to me, and I took care of nothing but women, and when they came to me with breast cancer—which I unfortunately saw way too much of and our practice diagnosed about a case a week. It was that common or is that common.

And we just had a relay this weekend. In 1977 or so, the 5-year survival rate was about 50 percent, maybe a little bit better, but about 50 percent. And the big argument came: Do you do a disfiguring operation of a radical mastectomy or a lumpectomy? Because the survival rates were the same. So what has happened over that time is that now a patient can come to you or me or any of our colleagues and we can tell them that because of early detection, because of education, because of mammography, you're going to have a 98 percent survival rate in new medications. That is a wonderful story to tell. And I know no matter how tough the times are for that patient, you can look at them and say, You're going to be okay.

In the English system, they quit doing routine mammography. And why did they quit doing that? Screening mammograms aren't done anymore. Why? Well, because it costs more than the biopsies. Sometimes a test will tell us we have something when we don't have it. That's called a false positive. And the phone call that I love to make is to my patients to say, You do not have cancer. So this is one where they quit doing that because the cost of the biopsies was more than the screening. The best rates they had were 78 percent survivals, and those are going to go down if you use that technique.

Mr. GINGREY of Georgia. If the gentleman will allow me, as we get very close to that bewitching hour of 11 o'clock, my southern drawl had better get a little faster than a drawl. But my mom, Helen Gingrey, who lives in Aiken, South Carolina, in a retirement community, a great community, Kalmia Landing, my mom had her 91st birthday on February 8 of this year. Well, when she was 90, about 5 or 6 months ago, 6 or 8 months ago, she had a knee replacement. And Mom had gotten to the point, Madam Speaker, where she could barely walk, in constant pain, on the verge of falling and breaking her hip at any moment. And now she is enjoying life and enjoying being with her friends, and maybe she's going to live another 10 or 15 years. I don't know. She seems to have the Methuselah gene. But do you think in Canada or the U.K. or one of these countries where they ration care that she would have had an opportunity to have that knee replacement? The answer we all know, Madam Speaker, is absolutely not.

I would say in closing, the one thing I would like to see is the equal tax treatment of the health care benefit for individuals who have to go out and buy them in the market on their own. They don't get it from their employer. Why should they not get a tax advantage health care plan just like everybody else? And you know what, Madam Speaker? I have not heard the Democrats in the House, the Democrats in the Senate, or President Obama talk about that. And talk about fairness and wanting to be equitable, let's hear some more about that. We will talk about it in future Special Orders.

I want to thank my colleagues Dr. ROE, Dr. FLEMING, and my good friend from California, Representative DANA ROHRABACHER, for being with me during this hour.

□ 2300

THE BIGGEST POWER GRAB IN HISTORY

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

Mr. ROHRABACHER. Thank you very much.

Madam Speaker, a thought came across me about 2 days ago. I was out on the water, surfing off of San Clemente, California. I was sitting there on my surfboard. The pelicans and the birds were jumping into the water and carrying fish out of the water, and the dolphins were swimming by. It was just a beautiful day. I