

coming down the pike with baby boomers going into Medicare, going into Social Security and all of these issues. We have got to be a lean, mean, productive economic force in the world so that we can drive our economy and help pay for a lot of this debt that has been accumulated over the course of the last 8 to 10 years and move us forward.

But, again, we know the cost of doing nothing. We know exactly what will happen. Health care bills will go up another \$1,800 on average next year and as far as the eye can see. Again, this is not a plan. This is our friends on the other side; this is their Republican health care plan, a bunch of lines going to a bunch question marks and back again and maybe, you know, at some point, maybe off the chart somewhere there is a solution there. It hasn't worked.

They had an opportunity here when they controlled the House, the Senate, and the White House to implement whatever it is they come up with. Maybe they have a couple of these squares they can fill in. But whatever it is they came up with, they had a chance to implement it. And now it is Johnny-come-lately, and we are going to get this done. And I think the President is committed to this; we are committed to this.

Every time I go home, I meet thousands of Delphi employees who have been left behind in the GM bankruptcy, both salaried and union, and steel workers who have lost their jobs and had their pensions cut in half, those in the PBGC, lose their health care. This is what this is about. Those are the people that will benefit from this, Mr. MURPHY.

I want to thank you as we wind down here for the opportunity to do this. We will be here tomorrow and possibly Friday and next week, day in and day out, because it is that important for us to pass this. I really believe that the health and welfare of our country depend on it. And I think that the energy bill and with this, I think this is transformational for us and I think a great opportunity for places like northeast Ohio.

And I yield back to my friend.

Mr. MURPHY of Connecticut. I thank you for joining us here. We will be down here talking about this because it is so important to get health care for America. As you said, our friends on the other side of the aisle had 8 years to get this done. And people may say, well, Mr. President, you're taking on a lot really quickly. But we are paying for the costs of inaction. We are paying for the costs of a Republican Party which for whatever reason decided not to do much about the cost of our health care system.

And we are going to get this done. We are going to get this done so that nobody loses their livelihood, nobody loses their access to the apparatus of opportunity just because they get sick and can't afford to treat themselves.

We are going to lower the cost of doing business. We are going to lower the burden of the cost of living for families, and we are going to do it this year.

And with that I yield back.

HEALTH CARE REFORM

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

Mr. KING of Iowa. Thank you, Mr. Speaker. I appreciate the privilege of being recognized here on the floor of the House. And I would be happy if I could borrow the poster from Mr. RYAN with all of the question marks on it, because I have the one with the Democrats' answers on it. And I think what he has done is perhaps looked at these question marks and created, I'm not sure who actually comes up with these things, and decided that he would produce government solutions for all the question marks that could be produced on the poster that he has delivered here earlier in this hour.

And so I have here something that looks to me like the basis of it, which is HillaryCare, and I believe if I go back to my office in Iowa and I dig through my archives from my construction company that was seeking to thrive during the Clinton administration, I have in there the very poster that was laminated that showed the entire flow chart of HillaryCare which was presented to the American people and rejected by the American people. It has got to be, once I compared the two to the template, for what we have here that is produced off of this bill.

There really aren't question marks with what Republicans want to. We have more ideas than we can agree upon. I will concede that much. We have sought to improve health care, but we fought Democrats every step of the way. Now it is clear that when you look at the differences between the proposals that we have and what it is that they are poised to vote for, here is what will happen. You will hear all kinds of platitudes about how we can't stimulate the economy and grow our way out of this situation that we are in unless magically the solution that arrives is "let's go to socialized medicine and that is going to fix our economic woes." Somehow when I hear that said, I can't connect it, Mr. Speaker.

I'm listening to the dialogue that comes out, and with such great self-confidence it flows. Let me see. I wrote it down. I was listening to Mr. MURPHY from Connecticut, and he said, let me see, I see no way to get this economy back on track unless we fix health care. Fixing health care means nationalizing health care. It means turning into socialized medicine. And what goes on, if we look at the flow chart here, is the Health Choices Administration, HCA, just a moment, I will get this back where I can read it too, Mr.

Speaker, the Health Choices Administration, HCA sets up a commissioner. There is a health insurance exchange that would presumably broker health insurance through this exchange. It's kind of like where you might trade on the Board of Trade for a commodity like corn oil or beans or gold. And they want to trade traditional health insurance plans that would be in there and then a public health plan matched up against it. Now that is the center piece of this proposal.

And what it really says is that they want to establish a government health insurance program that would compete directly with the private health insurance programs that are out there. And we have hundreds and hundreds of those insurance programs that are out there, and if I remember correctly, the number that I have seen was 1,300 different companies competing in health insurance and the health insurance business. That is a lot of competition. It is not a little competition; it is a lot of competition.

If you believe competition brings out the best in us and the markets that are driven because of the competition and the demand that is there, then you have to know that there are a lot of different models that have been tried, and there may be some good models that weren't marketed very well, and there may be some bad models that were marketed well, and there may be some other alternatives out there.

But this I can guarantee you, Mr. Speaker, if there is a better idea in how to insure health care in the United States of America, it will not come from government. Government doesn't provide solutions. The creativity is not there. And this proposal that comes from the Democrats that was just unleashed on America yesterday has within it a series of presumptions on how they are going to save money on health care.

One, if we listen to the gentlemen that made their presentations here within the last hour, they would tell you they are going to squeeze the profit out, that there are people that are actually making money by providing us the very best health care in the world, and we surely couldn't have that. We couldn't have people that are making money doing this.

I don't know where people get incentive. We have good hearts. We are altruistic people. But it is nice to have a little profit so that you can justify going to work. Otherwise you might just stay home and raise the kids and work in the garden, go fishing, golfing, mow the grass, whatever you do. If you squeeze the profit out, people are going to quit going to work. And that is what they suggest is going to happen. Squeeze the profit out, take it out of whatever might be there for the insurance companies, take whatever might be in the profit for the health care providers, our doctors and our nurses and our administrators and all the people

that work so well in the health care industry—and by the way, let's acknowledge the volunteers, the EMTs that are out there on a daily and nightly basis. They deliver more regularly than the mail does, rain or snow or sleet or hail. Nothing stops them from going out to save people's lives and increase the quality of our life.

But into all of this mix, they propose that we upset the very, the largest and the best health care system in the world. To what purpose? Fix the economy? Mr. MURPHY would have you think that because he says that he can't imagine getting our economy back on track unless we fix health care.

Here it is: "I see no way to get this economy back on track unless we fix health care." This is something that was amazing to me, Mr. Speaker. I listened to, at the time, it was Senator Obama, Candidate Obama, arguing to the American people that they should elect him President because he is going to fix all of these things that aren't functioning with government and that the economy will work better if we just simply nationalize our health care plan.

Now, I will concede this point: this Nation spends too high of a percentage of its GDP on health care. It is too high if you compare it to other countries in the world. But it is not too high when you are someone who needs that care, when you have cancer in the family, when you need some emergency heart surgery. We are not a country that waits in line for health care. But the countries that are mentioned here do wait in line. Canadians wait in line for health care. The Europeans wait in line for health care. Those in the United Kingdom wait in line for health care.

One of the gentlemen, I believe it was Mr. RYAN from Ohio, said that people delay getting health care services until they qualify for Medicare, then the cancer spreads and presumably it is a bigger problem. "The cancer spreads because people wait until they qualify for Medicare" was what the statement was.

But it is a fact that if one is diagnosed with cancer in the United Kingdom, your life expectancy is, on average, 18 years less than if you are diagnosed with cancer in the United States.

Now I wonder how the gentleman that gave the presentation the last hour would reconcile that, and I will use that, that dirty little secret, about how much better our care is for cancer patients here in the United States and how much longer our life expectancy is than it is in a place like the United Kingdom. Presumably they have a similar health care plan to those in the European Union. And their answer will be, the life expectancy of Canadians and Europeans is 1 or 2 or 3 years longer than the life expectancy of those in the United States.

Well, that is typical liberal logic, Mr. Speaker. They would look at one statistic, and if that statistic could sup-

port the argument they want to make, they don't look underneath that to ask the question, why would the life expectancy of a Canadian be longer than the life expectancy of an American by 1 year, I think that data was. I didn't get to see the chart.

The first thing you need to do when you hear some data like that is ask some other questions like why? How could it be if one is diagnosed with cancer and lives to 18 years longer in the United States than if you are under the socialized medicine program of the United Kingdom, then how can you then equate that the life expectancy of someone in the United Kingdom is going to be longer than that of the United States because they have access to health care when that health care supposedly cures their cancer, but they are dying 18 years sooner?

□ 2030

Could it be, Mr. Speaker, that there are other factors involved that reduce the life expectancy here in the United States? How many of us die violently in accidents, for example, compared to those in Canada? How many of us die of addictions like abusing illegal drugs or from alcoholism? What are the ratios of that? How many die of suicide? I wouldn't think that is a situation that's going to be solved by a socialized medicine program, except I'm just willing to bet there's something in the flowchart here to expand the mental health that I might have overlooked in this nasty-looking, modern-day, technicolor, expanded and exploded version of the former Hillary Care.

It is here somewhere, I'm confident, how they would address the mental health situation. And that is an issue, and it is an issue we can certainly talk about how to address. But when you carve all of these things out of the statistics, I'd be willing to take the stand at the life expectancy of Americans who take care of themselves similar to the ways that Canadians take care of themselves is equal to or better than that of Canadians or Europeans.

And otherwise, what is the variable? If they're dying 18 years sooner from cancer in Europe than they do in the United States, then would there be some other illness that counterbalances that? Maybe it's diabetes here in the United States because we may tend to be a little heavier, and I believe we do tend to have diabetes more often. Put those factors into place, but don't just throw a blanket number out here and tell us that you have to upset the best health care system in the world because you've got one data point that you can point to without looking underneath that data point to draw a legitimate conclusion from that data.

This is a typical approach.

Let's see. If I go on, the dirty little secret from Mr. MURPHY. There is a secret limit to what insurance will spend on you. You know, I don't know that that exists, and it implies that exists in every health insurance policy in the

United States. I expect it exists in some of them. I'm confident it doesn't exist in all of them. But here is the real little dirty secret that is in this bill and this broad, exploded, technicolor floor chart that's built off of the foundation of the former Hillary Care plan that came out in about 1993.

Part of the secret is this. They intend to tax the middle class workers in America and some of the working poor in America—in fact, probably all of the working poor in America—to fund this outrageously high-priced socialized medicine plan. And how will that work, Mr. Speaker? And here's how it will work.

There will be a surcharge, according to this bill, that will be imposed upon the payroll of employees. Now, the employer is asked to pay the tax, 8 percent that would be put upon the payroll. It would be calculated off of the wages of the employer's workers in order to fund the health insurance plan for those employees if the employer doesn't provide the health insurance for them.

Now, to make it simple, they want to tax the employer who doesn't provide health insurance for the employees. Now, that may sound good to people who don't have health insurance. It may sound good to someone who a little begrudges their boss and maybe the lack of generosity on the part of their boss, but here's what happens. And I will just draw this comparison so we can think of it in relative terms.

The Social Security that we pay, the payroll tax that we pay, all of us on our payroll, up to whatever the cap is, is considered by economists to be—even though it's 50-50, and I've many times sat down and done the math formula making out payroll for my own employees. I would multiply .0765. That's half of the payroll tax, and that came out of the employee's side. And then that same .0765, which adds up to 15.3 percent, employer's half came out of my side. I would look at that and I would say, that 7.65 percent out of the employer is something I'm actually paying to the employee. It's the cost of hiring that employee. It's a fixed cost that comes with it.

So regardless of whether I take it out of his check or my check, it's all money that I would be paying that employee if it weren't going to the government. It is a tax on his earned wages, his or her earned wages. And so I've always viewed it that way, as the payroll tax being a tax on the earned wages of the employee and the limiting factor on how much I can afford to pay the employee.

Let's say you can afford to hire someone who will return for you \$30 an hour, and if you pay them in total cost of their wages, their overtime wages, the payroll tax, the benefits plan that you have, whether it be health insurance, retirement plan, whatever else it may be, all of those costs—including the lost time that's in transition, the lost time in production in coffee breaks

and all of those things that have to be added in, the inefficiencies are added in. Let's say all of that adds up and it costs you \$20 an hour to have this employee hired and you can make \$30 an hour off of having that employee. Now, there's a little margin there to work with. And of course you have other factors involved to take that profit to apply to, such as the overall overhead of the company, and the list goes on.

But let's say it costs you \$20 an hour to have this employee working for you and he's making \$30 an hour, and you can make that work and have a little margin for profit and apply some of that overall margin to your overhead, your own administrative costs, and along comes the government and says, Well, I'm going to tax you \$10 an hour for this employee.

Now they've taken entirely all of the cushion that was there and the necessary profit that you have to have to fund other parts of the company from that and the profit that you have to have to build enough capital so you can offer somebody else a job, and government takes it all away. Now, what's an employer to do? I will tell you exactly. He has to lay off the employees that cost him more money than they are making. You can't sustain yourself that way. You can bridge these gaps over time and things go up and down, but over time, this will all be reduced down to can you afford to have the employee or can't you.

And one of the ways that you adjust that affordability is if the Federal Government adds \$10 on to the cost of keeping the employee. You have to look at that in terms of, then, if that eats up all that you have to work with, then you have to look at lowering the employee's wages, or more often it happens, you simply don't offer the raises at the same time you might have otherwise. This comes off the backs of the worker.

Democrats want to tax the working poor and the working middle class and the middle and upper class Americans to pay for a health care plan that I believe is completely misguided, that doesn't fix what it's designed to fix and surely will not fix this economy.

We have to know that their approach to the economy is so far off that more of the same is not going to solve the problem. These are a bunch of Keynesian economists here that are in charge of the country today in the White House, in the House of Representatives, and in the Senate, and they believe, like FDR believed, that if you could just borrow enough money and pour it into this economy and replace jobs in the private sector with government jobs in the public sector, that somehow you could stimulate this economy and get the engine or this economic engine running again.

Mr. Speaker, I can find no empirical data out there that consistently supports the idea that we can borrow money from our children's and grandchildren's future, and actually borrow

it directly from the Chinese and the Saudis, while we're at it, and dump that money into this economy and stimulate the economy so that it grows.

Back to the 1930s, I thought—and I believe there's been a definitive experiment that's taken place with Keynesian economics, this borrow money and dump it in in government jobs and grow government to compensate for a shrinking that has taken place in the private sector.

And if we go back to Henry Morgenthau, who was the Treasurer for FDR back in the 1930s, he objected and he said, What have we to show for this? We borrowed money. We spent money like nobody has spent it before, and we haven't created any jobs. We have nothing to show for all of the money that we have spent. And he was the believer, he was the mouthpiece for FDR's Keynesian approach to the New Deal. The New Deal that I was taught was a good deal when I went to school—and, of course, I went back and actually studied the data and came to an informed conclusion rather than just simply a cursory statement that reinforced FDR's New Deal program.

The father of this, of course, was John Maynard Keynes, the father of Keynesian economics. And he—throughout those years, he was very influential in the 1920s and 1930s and less so in the 1940s, although America was distracted from economics during that period of time. But Keynes said that he could solve all of the unemployment in America. All we needed to do was go find an abandoned coal mine and go out there and drill a lot of holes down in that abandoned coal mine and fill those holes full of American cash, greenbacks, the dollar, drop cash down into those holes, fill them up again, and then fill the old coal mine up full of garbage—this is his story—and turn the entrepreneurs of America loose to go dig up of the money. It would create all these jobs in digging through the garbage, digging down through the holes, finding the money, keep everybody busy, and the entrepreneurs would find that money eventually—and probably all of it somehow—and it would keep everybody busy and they would all have a job and they would all have money.

And I know that it was a facetious model. I know that he drew that description as, let's just say, a facetious model that would illustrate how ridiculous it can be. I think he began to realize this later on in his career how ridiculous it can be to put government in to make work and to put government into the business of intervening between the private sector. That's what's going on here in America.

But the dirty little secret, to use the phrase used by Mr. MURPHY from Connecticut, is not that there is a limit on what an insurance company will provide and that they will shut off their health care. What the dirty secret is, Democrats have committed to taxing

the working people in America to fund their trillion-and-a-half or more health insurance plan that is designed to crowd out the private sector insurance companies in America, the hundreds and hundreds of them that are providing such a good job and such a highly professional service. And it comes down to the health insurance exchange and those qualified health benefits plans that exist today competing against a proposed and newly created public health plan that would crowd out our private health insurance here in America as we know it.

We have a model we can look at to learn from this. Otto von Bismarck established a national health care plan in Germany before the turn of—into the 20th century. My guess is 1898, but I suspect it was actually before that. I know that it's the oldest national health care plan in the world. And then it didn't cost very much because medicine hadn't developed very far. But they do have private health insurance in Germany, but what it is, it's 10 percent of the market. And the national plan, the required plan has crowded out all of the private health insurance in Germany except for about 10 percent. And the people that have that 10 percent are those who are self-employed, that run businesses, that have found a way within their business to go out into the marketplace and buy some health insurance that provides them perhaps a little better care than they get out of the government plan.

So that's what we can expect to happen with the insurance companies here in the United States should the Democrats in this Congress, in the House and in the Senate, and in the White House get their way, Mr. Speaker. We will see these proud, important, independent health insurance underwriters, their companies, these people that are doing this business, this service on Main Street in many small towns in America and across this country, we will see them shrink down, drop off one by one, companies dropping off one by one. Some will go in one fell swoop. But they're looking at almost the death knell of their industry if this socialized medicine plan gets passed by this Congress.

And yes, they will try to find a little niche in the market, but it isn't going to happen in the end. Some will find their way, but they will be narrowed down like they were narrowed down in Germany.

And we won't have the people that are answering the phone at 7 o'clock at night going over to someone's house to sit down and talk through their health insurance plan with them, helping to nurture them and helping inform them as to the situation. It will be a government bureaucrat that punches the clock, and there will be a lineup outside the door. We know how this works in government agencies. There will be a lineup outside the door.

And that bureaucrat will take the appointments at the appointed time, usually. And when it's time for the coffee

break in the middle of the conference, they will get up and go off into the break room. They will have their little coffee break and it will last all of 15 minutes, and when it's time for the lunch hour at noon, the "closed" sign goes on, the bureaucrat walks out the door and goes off down to the bistro or wherever to have lunch with his other bureaucrats. He or she shows back up again at 1 minute to 1 o'clock and opens up the door again and starts through this process.

□ 2045

And the American people will not be able to compete. They will not be able to go someplace where they're treated like a real human being customer. They will be treated by a government bureaucrat.

Don't we have 300 million Americans who have experience with bureaucrats? Don't we know what that does to the attitude? Bureaucrats have an attitude. It's the nature of it all. It's because they have a monopoly. People that have a monopoly have an attitude, and whether they're in the private sector or whether they're in the public sector, if it cashes out the same for being nice as opposed to being not so nice, to being the same for providing happy, friendly service, compared to providing that grumpy, reluctant service, we know the result. People like that often gravitate towards the government.

We'll create this great big massive technicolor flowchart of interrelated government agencies. And by the way, the ones in color are the new ones. The ones in white are existing. Medicaid, SCHIP, Medicare, they're existing. Go on down the line, through the private insurers, they're existing. Traditional health insurance plans, they're existing, but they get shoved into the qualified health benefits plan, but they have to write a plan that actually qualifies, too, which takes some of these people out.

These are existing government. Here are the departments: Treasury, Health and Human Services, Veterans Administration, Defense Department, Labor Department, here's Congress, the President. Institute of Medicine exists. There's the National Health Service Corp., they're there. States, all these programs.

And the ones in white are existing. The ones in color are created new. All of those that are in color, that's thousands and thousands and thousands, Mr. Speaker, of new bureaucrats, new bureaucrats who will be handed this monopoly, and they will be in the business of not only taking customers in and writing their insurance plans in the pace that they see fit, because they're government after all—what government office stays open after 5 o'clock on any working day? What government office would ever think of coming in on a national holiday? What government office would take a look at how they're going to retool their serv-

ice so they could compete with higher competition, so they could expand because they could compete better? They won't do that because they're handed a monopoly, and if they can't compete, then they will be subsidized more by the taxpayers in America.

And we will be trained as a people to line up outside the door, patiently wait our time, take what we can get, not be able to shop around because these qualified health benefits plans that come from our traditional health insurance providers will be squeezed out. And by the way, that squeeze-out that will come will not be an accident; that's the result of people who really didn't think through what they were doing to the American people. It will be the willful, premeditated result of the people who happen to have the gavels in this Congress now and the power in the White House now who believe in socialized medicine.

They want to adopt a policy that's a socialized medicine policy, and they want to kill the private sector because they don't believe in it. They believe that government provides better than individual competition, free markets and people provide, and that's the great divide in our two approaches here, not a chart with question marks on it. Those must be things that were confusing to Mr. RYAN, the chart with all of these new bureaucracies on them.

And I would say, Mr. Speaker, that it's a chilling thought to think that my children and my grandchildren and their children and every generation beyond them might be receiving their health care standing in line in front of a government agent who hangs the closed sign the minute the clock ticks past the appointed hour, regardless of how long the line is.

We're a people that will be conditioned to a lot of things, but standing in line is not one of the things that Americans do well. We have to do that when we get on an airplane now to go through the security at TSA. And I look at that and I watch that, the security line, and sometimes I wonder how do they ever get Americans to stand in line like that. We don't do that. We'll stand in line to get into a ball game. We will stand in line to get into a concert. We'll stand in line to vote. And now we will stand in line to get on an airplane. And if this broad exploded Technicolor Hillarycare expanded plan gets passed by this Congress, you know it will be signed by the President. He wants a bill to sign, and I don't think it matters what's in it. Americans will be standing in line for their health care, not just in the offices to get signed up to be part of the public health plan but lined up in emergency rooms, clinics, hospitals, all across this country or in a queue that doesn't show up so much, not one that you can see that's clearly tangible until you look at the long lists that will be there because it's an inevitable result that socialized medicine produces rationing of care. It's been a fact wherever it's

been tried. It's a fact today wherever it exists, and it will become a fact in the United States of America should this program that was unleashed on us yesterday be made law.

Here's another place where they think they're going to save. They're going to save money by rationing care, getting you in a long line. Places like Canada, United Kingdom and Europe, people die when they're in line. There are plenty of examples of that.

I listened to the gentlelady talk about some anomalies that justified to her socialized medicine. Well, they would describe those who die in line in Canada or the United Kingdom or Europe as being just simply anomalies, that somehow the system let them fall through the cracks. The families that lose their members don't think that it is just the system that fell through the cracks. It's a real life, a real loved one.

Someone whose health care is rationed by formulas that are created by bureaucrats, the bureaucrats that will close their door at the appointed time, could be the health choices administration commissioner; could be coming from the bureau of health information; it could be the "national priorities for performance improvements".

When I see national priorities, we know that some of the national priorities will be they want to spend less money on certain types of care. That will mean that people will die because they weren't a high enough national priority. They've already got it here in the bureaucracy. National priorities for performance improvements, it says. Well, here's how they want to improve their performance, and by the way, I endorse some of these things as being good ideas. I just don't think that government can run it and make it work.

They want to expand the information technology in their health care. I agree with that. I think we ought to have interconnected health—the health records so that if someone gets sick from my district who happens to be in Speaker PELOSI's district in San Francisco, they can put their health care card into an Internet-connected security database and find out what prescription drugs a person might be on, find out what they've been treated for and be able to save lives accordingly and provide efficiencies accordingly. And I think it could reduce the numbers of those people that are going around and shopping for prescriptions if we had a central database. And I believe that is being developed within the health care industry and not fast enough to suit any of us, I don't think, including the people that are developing it.

But info tech is a good thing, and it can be used in a lot of good ways, and you don't have to have socialized medicine to have information technology.

Second item that they would save money with would be comparative research. Good, we're doing a lot of comparative research. They're earmarking

comparative research. We're earmarking comparative research although you don't see it much because this place has been—this floor, there's not really legitimate debate on this floor because this House has been shut down by the Speaker and the Rules Committee. I have to inject that in. Special Order and 1 minutes is about the only place where you've got an opportunity to have these kind of discussions, Mr. Speaker.

Comparative research is good. The other countries can do a little more research and that would be great. But what happens is we do the research in this country. All of the progress—I put it this way—much of the progress that has been produced by the pharmaceutical companies and the innovations that have come on to the health care markets within the last generation have dramatically transformed the way we provide health care in this country. The research and the development is predominantly paid for by American users of pharmaceuticals, and the beneficiaries of that research are the people in the countries like Canada, United Kingdom and Europe where they do negotiate for a cheaper rate and where here in the United States we're paying too much of that. We can fix that without socialized medicine, and I'd like to see them pay a greater share of the costs of the research and development that goes into making these wonder drugs that we have today that do extend people's lives.

And I would add that those people in those countries that have a longer life expectancy are probably using American research and development pharmaceuticals. They might be made in a foreign country, but a lot of them are produced by the R&D here in the United States, and they're the beneficiaries of it as well.

Third thing they would do to save money on health care is more prevention and wellness. Mr. Speaker, you don't need to socialize the health care system in United States of America in order to have more prevention and wellness. That's something that is emerging. It's emerging in our culture. It's emerging with some of the health insurance providers we have in this country who are packaging up proposals in different ways to provide incentives for the insured to live a healthier lifestyle, to get regular checkups, to go across the scales and watch their weight and, let's say, avoid some of the vices that shorten our life expectancy, and letting that be reflected in the premiums that are being paid.

But I can guarantee you, Mr. Speaker, that this public health plan of the health insurance exchange is not going to have those incentive nuances in there. It's the private sector that's going to produce those things, and we need to encourage them to do that.

So they have borrowed some ideas from the private sector, but the idea

that they've borrowed that is the centerpiece of this is the idea of expanding Medicare to reaching across the generations and reflecting the model of socialized medicine that exists in Canada, the United Kingdom, Europe. We could keep going further east I think, Mr. Speaker, and might end up with something that's a little closer to what they're talking about.

So we're a country that has thrived on free enterprise. We need to continue to thrive on free enterprise, and the idea of socialized medicine is an idea that's abhorrent to Americans. The idea of standing in line waiting for a bureaucrat to approve your health insurance premium is also abhorrent to Americans.

I went over and visited Russia earlier this year, and as I traveled around Moscow, Mr. Speaker, I saw something there that was kind of a phenomenon that exists in Russia that I'm afraid might exist in the United States if they pass this socialized medicine. And that is, that if you watch the Russians walk around Moscow—I didn't go much beyond Moscow—so they walk around out there with their shoulders hunched, looking down at the sidewalk. And I see people on the streets of Washington, D.C., do that all the time, but they're looking out for all the cracks and bumps and holes that we have. It's a matter of survival here. Where I come from we look people in the eye when we walk down the sidewalk. We bid them good day, good morning, good afternoon, nice to see you. We're friends and neighbors working together.

And it doesn't happen in that country. They look down and their shoulders are hunched, and they wander around, and if you sit and watch them, they will wander around. You can follow one of those fur coats and a hat, and it will lead you to a line, and they go get in line. They stand there. And then the line moves slowly. And I stood in line for nearly 2 hours, even as a Member of Congress, to walk into their legislature, the Duma, and they knew we were coming. And I see the other Russians standing in line a lot longer than I was. It looks to me like they go find a line and stand in it, and then they get to the front of the line and find out why they're there, do whatever it is, buy their toothpaste or whatever, and then go find another line and stand in it.

It looks like the Russians, to me, are conditioned to go to from line to line, standing in line. It reminds me of that story of where you see someone will go out in the street—it's a comedy routine from back in I think the 1950s or 1960s—and stand on the street in New York City and look up into the sky and just stare into the sky. And someone else would come along and look, and someone else would come along and look. And after a while, there's a whole crowd of people looking up into the sky, and the original person that was looking at nothing, steps back, smiles. Well, he's drawn a crowd by doing that.

Just standing in line in Russia draws a line behind you. It doesn't really—I mean, without regard to what's in front of that—and I know they have to talk to each other and figure out if they're wasting their time. Human nature is human nature.

We're going to create line standers in America, people who capitulate to the system, submit themselves to the system. And I will argue that the health care system we have in the United States, some of the problems we have is because we have too much government and we submit too much to the system, and the individuals who are receiving the health care don't have enough vested interest in, not enough skin in the game, to be able to use their incentives that should be there to do a better job of evaluating the costs.

So what should we do? And I will provide some answers here, Mr. Speaker, on what we should do for health care.

First and foremost, take a look at our health savings accounts. We did that. We put that in place as Republicans, as a Republican majority in the House and in the Senate, and it was signed by President Bush. And who comes out against health savings accounts today? Well, they don't comport very well with socialized medicine, Mr. Speaker. So that's something that's probably going to go.

□ 2100

Probably not going to be in this flow chart here that—I don't see the health savings account. Now I've not read the whole bill, and I don't know that I'm going to put myself through that.

But we passed health savings accounts. And it stands today this way: if you are a young couple at age 20—I do this because round numbers, I can figure—at age 20, and you put in the \$5,150 for a couple into a health savings account, tax-free, first year. And then that groove being indexed to inflation grows each year since then. And we're in about year 6, I think we are. Maybe year 5.

You put that money, the maximum amount in the health savings account every year and spend \$2,000 out for reasonable health care costs and grow this account at around 4 percent, and when I did the math on this, that made sense. Today, it doesn't quite make sense. It will again.

Grow that at about 4 percent. If that couple would work and put the maximum into their health savings account every year from age 20 to age 65, they arrive at Medicare eligibility with about \$950,000 in their health savings account. Now that's a pretty good deal.

But I can tell you what the Democrats in this Congress want to do with that if they get their hands on that money. They want to tax the \$950,000 in the health savings account. They'll tax it then, before you can take it out, because you won't really need much of it, if any of it, anymore. Or, they will take it out of you in inheritance tax when you die.

You are not going to be able to avoid Democrats increasing taxes on you. And that's one of those dirty little secrets, is your health savings account will be taxed, by the ideas of Democrats, either when you die or when you try to take the money out when you retire.

Here's what I propose: let's increase that amount. Let's increase that amount to the point where that couple can arrive at age 65 with enough money to buy paid-up Medicare replacement insurance policies, policies that they own. Or maybe a transition policy that they have owned throughout their working lives that's theirs, that is transportable, that can go with them, a policy that they own, and let them transition into a lifetime health insurance plan and be able to use their health savings account to purchase that full up.

That's one thing we should be able to do to give people back some freedom. And I can tell you what it costs today if you wanted to buy a Medicare replacement policy at age 65. The liability—the present value of that liability of Medicare replacement at age 65 is around \$72,000 this year. That's about where we are.

So it gives you an idea if that \$950,000 were in a 65-year-old couple's health savings account today, they could write a check for \$144,000 and buy a paid-up Medicare policy and take the difference—let's just call that \$800,000—and I would want them to have that tax-free and go off and retire, travel the world, will it to their children, buy a new convertible, whatever they want to do, and give them their freedom because they've earned it by being responsible.

But the problem that we have is the Democrat plan takes away the responsibility of the insured, of the individuals in this country, and puts it on somebody else. It puts it on the employer that says regardless whether your employee wants to sit down and market his way through a health insurance plan—his or her—regardless of that, if they don't have health insurance provided by you, then we're going to tax you 8 percent on that payroll. And I said earlier that comes out of the worker. That's wages he is not going to get. The employer has to crank it out of the worker because he is paying all the market can stand on the wages that are there. So, we tax small business, we're going to tax workers.

There was the issue raised of pre-existing conditions. We can do some things with preexisting conditions without adopting socialized medicine.

But here's a point that was made by the gentleman from Arizona yesterday, JOHN SHADEGG, who is a leader on this health care policy that we have. He said, If you like your health insurance, and over 70 percent of Americans like the health insurance that they have, if you like it, then get ready to lose it, because you will lose it under this Democrat plan.

In this flow chart is the trap that you will be sucked in from here, over here to the public health care plan. And when President Obama says, If you like your health insurance, if you like the plan that you have, don't worry, you get to keep it.

Well, Mr. Speaker, you get to keep it for the first minute that President Obama signs such a bill, and probably the first hour, day, month, maybe even a year. But maybe not. Maybe not. Because most of the health insurance in this company is provided through people's jobs through their employer who brokers it. And there are long, deep reasons for that that I won't go into tonight.

But the President can't say you get to keep your health insurance plan because he doesn't make that call. If the government model, this public health plan here, if that model is financially advantageous for the employer, if the policies that the employer are paying for cost the company more than the policy that's offered by the public insurance plan, an employer will almost always then drop the private-payer health insurance plans, these that are in this circle, which would become the qualified health benefits plans, drop them and adopt the public health plan.

Now how is President Obama going to tell some company they can't do that? And if you don't quite follow this yet, Mr. Speaker, I will put it this way.

Walmart announced last weekend that they are supporting an employer-mandated health insurance plan. They announced that policy over the weekend and I thought, Why would Walmart do that?

I have the press release here. Let's see. I'm going to say this. They would do that because it looks like it would help their bottom line. Here's what they said. The company says it supports the employer mandate because all businesses should share the burden of fixing the health care system. Well, I don't know what the basis is for that statement except that there must be some advantage to this.

So are we to believe that a huge company, a company that I applaud for the business model that they've creatively put together, but are we to believe that a huge company like Walmart that is everywhere would propose and support—an employer-mandated health care system is the language that they used—would Walmart support that and then not adopt the public health plan, because they already have the traditional self-insurance plans provided to 52 percent of their employees? Would they then move into a qualified health benefit plan for all of their employees because of the mandate that they have endorsed, or would they opt into the public health plan option?

Would Walmart still support the President's proposal, which is basically what has been presented here in this Congress? Would they still support it if they had to guarantee they were going to keep the qualified benefits plan?

Would they still support it if there was in the bill that they couldn't drop the private provider and could not opt into the public plan, into the government plan, into the socialized medicine plan?

I think not. I think they want the best option of the two. They will fight to preserve that. So will a lot of companies. But I think this is about something that puts pressure on some of their competition that doesn't provide as much health insurance for their employees as Walmart does for theirs. Less responsible employers, some might call that.

But there still remain a lot of uninsured in that group. Some are on Medicaid. That's true for a lot of companies that are more entry-level wages.

I don't take so much issue with that. I just point out that the idea is this: the employees of Walmart won't get to decide that they get to keep the private plan that they have today, the traditional health insurance plan in this white box that will transition into a qualified health benefit plan, most likely, if it does qualify, unless a bureaucrat says it doesn't. They'll write some new rules for that. Those employees won't make that decision. Walmart will make that decision.

So when the President says, If you like the plan you have, don't worry, you get to keep it, in truth, you should worry. JOHN SHADEGG is right: if you like your plan, get ready to lose it, because you will lose it. The public plan will crowd out the private plan and everybody will fall under the same category, and we will have health care that is rationed in America. We will have lines, and we will have bureaucrats with their nose in the air making life and death decisions on the health care that will be provided to the American people. It is inevitable. It's resulted in that every time that it's been found.

Now, I draw another comparison. The Canadians are forbidden by law to jump ahead in the line. Now if they didn't have a line, you wouldn't have to have a law that forbids you from jumping ahead in the line and accessing health care.

So when you need a hip replacement—and I have seen the data on this. I actually have to guess, but I believe what I saw for a hip replacement number was 171 days of waiting. Something in that category is pretty close, anyway. I don't know how long you wait in the United States. Not at all, if you're in a hurry. Somebody will get you in. They'll find a way to schedule it. We have that kind of service here in this country.

I talked to an individual in my district a year and a half or so ago who had immigrated to the United States from Germany. And he had had hip surgery over there under their socialized medicine plan, a German; but he didn't get his surgery in Germany. He had to go to Italy to get his hip surgery.

The European Union has queues—longer lines in some places, shorter

lines in another place is—certain times that you get into a line and move closer to the front of the line. I suppose you try to get yourself in as many lines as you can.

But this individual happened to be—I ran into him when he was out picking up some things for home improvement, as I was, and he told me the story about how long he had to wait in line and what he had to do to go from Germany to Italy, get in that line and then get his hip replacement, hip surgery.

Here in the United States you're not going to have a measurable line. You might be able to get in one if you're not in a hurry and get it scheduled for convenience. But if you want that surgery, you're going to get that quickly.

Now, Canadians have an innovative thing. One is it's against the law to jump ahead in line. Those are not enforced equally across the provinces in Canada. So some people with more money, some people with more influence get ahead in the line.

Mr. Speaker, if you have ever had the experience of standing in line—and one of the easy ways to think of this is in the airport. If you're standing in line waiting to try to make a flight and you see one or two or three flight crews arrive late and they go get in line in front of you and they start going through the security—now they're actually pretty efficient at it and I know I want to get them on the planes and get these planes going. The lines would be longer if the crews don't show up.

But I stood in that line and had to back up. And the result is this: when someone gets in line in front of you, you have to back up. The line gets longer. Have you ever stepped in a line and watched the line get longer? You know that it isn't paying your time very well to stand in that line.

Well, the lines get longer in places in Canada and in Europe because you have people who have money and influence and power that get preferential treatment over those who don't have the money, influence and power.

So, in Canada it's resulted in this: some of the employers who offer a good employment package pay the wages and the benefits to their employees, the employees who have full access to the Canadian socialized medicine plan. But also as part of the package, let's just say, for example, if they need heart surgery and you're working in Toronto—just say you're wearing a suit and tie, working in a company in Toronto who puts together a good health care package, a good employment package. Here will be the wages, the vacation time, the retirement benefits. They don't get to say the health care plan for Canadian, but they do get to say, You can opt out and go to the United States.

And in their employment package will be an insurance plan that will put them on a plane in Toronto and fly them to Houston for heart surgery so that they can cut ahead of the line. They don't have to wait.

Now, what kind of a country has a health care plan that we would want to emulate that would have employment packages that fly people all the way across the continent to give them heart surgery quickly because the line is too long in Canada?

And it's worse than this, Mr. Speaker. There are companies that have sprouted up in Canada that turnkey these things. Sometimes within the health insurance plan that's part of the employment, that says, We will opt you out of the country to get you fast health care services to the United States. And sometimes it's someone in Canada who can't wait in line to get the service.

And so there are companies there like tour companies, travel agencies, travel/health care agencies that put together the package. So let's just say that you are in Quebec and you want to go to, let's say, the Mayo Clinic in Rochester, Minnesota, to get a hip replacement, and the hip replacement line you're in in Canada is long.

Well, the travel/health care agency in Canada that's sprouted up because of entrepreneurs, you can go contact them and they will set it up. They will say, Here, let me see. You arrive at the airport here in Quebec at this time and this is your flight number and here's your ticket. And you can fly down to the Mayo Clinic and here's the hotel that you can go check into. You'll arrive at this time. Transportation to the hotel is a shuttle bus from the airport to the hotel that you'll be staying at.

□ 2115

Here is your examination from the doctor and the surgeons, and they'll do that examination, and later on in the day, or overnight, they'll start the surgery, give you the hip replacement. Here's the package on the rehabilitation therapy. Here is your trip back and your plane ticket back to Quebec. Turnkey. I don't know how long it takes, I'm guessing three to four days turnaround, give you a little therapy, send you back home again. All of that, you write one check to the travel/health care agency that's sprouted up to meet a demand that exists because of the lines and the rationing that necessarily result in government-run plans and always have.

And, Mr. Speaker, I'll go back to 1948 and 1949. I had a World War II vet hand me a stack of Collier's magazines. And he fought in Europe, the Second World War. He'd saved these Collier's magazines all of those years, from 1948 and 1949. Now, 1948 was the year that the United Kingdom established their national health care plan, their socialized medicine.

And in the magazine, each issue of the magazine had a story about the health care that was unfolding in Canada. And you can just range through some of them. I can remember pictures of people lined up outside doctors' offices, nurses that were frazzled, doctors who were speaking into the record

quoted saying, I have to see so many more patients now in order to provide enough income because I'm being paid so much less per patient, I have to spend less time with the patient, and I have to run them through and see too many patients an hour. I'm missing diagnoses. I'm not able to treat these patients the way I should be. The relationship between us is so fast that there is no doctor/patient relationship.

People are leaving the health care industry because the stress was turned up and the margins were turned down. And we have a good lot of highly talented people in this country that stepped forward to go into the health care industry, good doctors and nurses and other providers. And they're highly educated. It takes a long time to train a doctor, roughly a decade to turn one out that can start to take charge and teach others. That takes time and money. They need to be paid what it's worth to attract them into the profession and to be able to be on call in the middle of the night and on weekends and all the things that they do. And that isn't going to happen in a country that rations health care and squeezes down the prices, Mr. Speaker.

So, I would just suggest that we should think long and hard before we leap into this abyss. As I listened to the gentleman from Connecticut (Mr. MURPHY), I would suggest that he should know this, if anyone does, and that is, when you turn government loose to do something that the private sector should be doing, Murphy's Law always applies. Murphy's Law, of course, is what can go wrong will go wrong.

The incentives will not be in place to provide the quality of care, the timely service. And we don't have rationing of health care in the United States today. We don't have lines that exist in a measurable way. We don't have long lists on paper of people that are waiting their turn to get their service.

We have the best health care system in the world, and it's getting better, and we can do more with competition. We can do more with addressing the medical malpractice litigation that we have in this country that they don't have to a measurable extent in the other countries. We can do better with health savings accounts. We can do better with bringing in competition. We can allow people to expand their health savings accounts, and we can allow them to have enough money in that they can bargain down a higher co-payment and a higher deductible in order to get a lower premium.

And you roll all of this together. If you give people freedom, if you give them responsibility, if you believe in the free market system and you let the markets do what they will without interference, without the intervention of some fraudulent medical malpractice suits that are driving up these premiums and causing doctors to do tests that are unnecessary, except to protect them from litigation, we can bring this

health care down, and we can see the quality of it go up, and we can also be an inspiration for the rest of the world.

And creating socialized medicine is not a solution for an economic problem. That will make the problem worse, not better. And we are, on one side of us, we are Adam Smith free-marketeers on the Republican side of the aisle. These are the Keynesian economists on the Democrat side of the aisle, those who want to grow government, nationalize eight huge entities in America; that all happened on the watch of President Obama, the nationalization of eight huge entities.

And with that in mind, nationalization, there is no exit strategy there. There will be no exit from socialized medicine, and cap-and-tax will crush this economy as well. We must draw a line. This is it. This is the Rubicon. I'm not going across into the irrevocable policy. And those that do, I believe, will regret it the rest of their life.

With that, Mr. Speaker, I thank you for your indulgence, and I would yield back the balance of my time.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. YOUNG of Florida (at the request of Mr. BOEHNER) for today on account of a family medical emergency.

SPECIAL ORDERS GRANTED

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

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

Ms. WOOLSEY, for 5 minutes, today.

Mr. MASSA, for 5 minutes, today.

Mr. KLEIN of Florida, for 5 minutes, today.

Ms. KAPTUR, for 5 minutes, today.

Mr. DEFAZIO, for 5 minutes, today.

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

Mr. JONES, for 5 minutes, July 22.

Mr. POE of Texas, for 5 minutes, July 22.

Mr. FORBES, for 5 minutes, July 16.

Mr. DREIER, for 5 minutes, July 16 and 17.

(The following Member (at his request) to revise and extend his remarks and include extraneous material:)

Mr. ENGEL, for 5 minutes, today.

ADJOURNMENT

Mr. KING of Iowa. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 9 o'clock and 20 minutes p.m.), the House adjourned until tomorrow, Thursday, July 16, 2009, at 10 a.m.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 2 of rule XXIV, executive communications were taken from the Speaker's table and referred as follows:

2655. A letter from the Director, Office of Legislative Affairs, Federal Deposit Insurance Corporation, transmitting the Corporation's final rule — Modification of Temporary Liquidity Guarantee Program (RIN: 3064-AD37) received July 8, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Financial Services.

2656. A letter from the Chief Executive Officer, Anti-Doping Agency, transmitting the Agency's 2008 Annual Report and Financial Audit, pursuant to 21 U.S.C. 2002 36 U.S.C. 10101; to the Committee on Energy and Commerce.

2657. A letter from the Chief of Staff, Media Bureau, Federal Communications Commission, transmitting the Commission's final rule — In the Matter of Amendment of Section 73.202(b), Table of Allotments, FM Broadcast Stations. (Mount Enterprise, Texas) [MB Docket No.: 08-226 RM-11494] received July 8, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2658. A letter from the Secretary, Department of the Treasury, transmitting as required by section 401(c) of the National Emergencies Act, 50 U.S.C. 1641(c), and section 204(c) of the International Emergency Economic Powers Act, 50 U.S.C. 1703(c), a six-month periodic report on the national emergency with respect to the former Liberian regime of Charles Taylor that was declared in Executive Order 13348 of July 22, 2004, pursuant to 50 U.S.C. 1703(c); to the Committee on Foreign Affairs.

2659. A letter from the Acting Assistant Secretary For Export Administration, Department of Commerce, transmitting the Department's final rule — Authorization Validated End-User (VEU): List of Approved End-Users and Respective Eligible Items for India [Docket No.: 0906151047-91048-01] (RIN: 0694-AE65) received July 8, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Foreign Affairs.

2660. A letter from the Acting Assistant Secretary For Export Administration, Department of Commerce, transmitting the Department's final rule — Implementation of the 2008 Australia Group (AG) Intersessional Decisions; Additions to the List of States Parties to the Chemical Weapons Convention (CWC) [Docket No.: 090113021-9025-01] (RIN: 0694-AE55) received July 8, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Foreign Affairs.

2661. A letter from the Chairman, Council of the District of Columbia, transmitting a copy of D.C. ACT 18-123, "Processing Sales Tax Clarification Act of 2009", pursuant to D.C. Code section 1-233(c)(1); to the Committee on Oversight and Government Reform.

2662. A letter from the Chairman, Council of the District of Columbia, transmitting a copy of D.C. Act 18-124, "National Law Enforcement Museum Sales and Use Tax Credit Act of 2009", pursuant to D.C. Code section 1-233(c)(1); to the Committee on Oversight and Government Reform.

2663. A letter from the Chairman, Council of the District of Columbia, transmitting a copy of D.C. ACT 18-125, "Records Access Amendment Act of 2009", pursuant to D.C. Code section 1-233(c)(1); to the Committee on Oversight and Government Reform.

2664. A letter from the Chairman, Council of the District of Columbia, transmitting a copy of D.C. ACT 18-126, "Raze Permit Com-

munity Notification Amendment Act of 2009", pursuant to D.C. Code section 1-233(c)(1); to the Committee on Oversight and Government Reform.

2665. A letter from the Chairman, Council of the District of Columbia, transmitting a copy of D.C. ACT 18-127, "Citizen-Service Programs Amendment Act of 2009", pursuant to D.C. Code section 1-233(c)(1); to the Committee on Oversight and Government Reform.

2666. A letter from the Chairman, Council of the District of Columbia, transmitting a copy of D.C. ACT 18-128, "Child Development Center Directors Relocation Fairness Clarification Temporary Amendment Act of 2009", pursuant to D.C. Code section 1-233(c)(1); to the Committee on Oversight and Government Reform.

2667. A letter from the Chairman, Council of the District of Columbia, transmitting a copy of D.C. ACT 18-133, "Transportation Infrastructure Improvements GARVEE Bond Financing Act of 2009", pursuant to D.C. Code section 1-233(c)(1); to the Committee on Oversight and Government Reform.

2668. A letter from the Chairman, Council of the District of Columbia, transmitting a copy of D.C. ACT 18-134, "Anacostia River Clean Up and Protection Act of 2009", pursuant to D.C. Code section 1-233(c)(1); to the Committee on Oversight and Government Reform.

2669. A letter from the Chairman, Council of the District of Columbia, transmitting a copy of D.C. ACT 18-135, "Clean and Affordable Energy Fund Balance Temporary Amendment Act of 2009", pursuant to D.C. Code section 1-233(c)(1); to the Committee on Oversight and Government Reform.

2670. A letter from the Chairman, Council of the District of Columbia, transmitting a copy of D.C. ACT 18-136, "Neighborhood Development Tax Deferral Temporary Act of 2009", pursuant to D.C. Code section 1-233(c)(1); to the Committee on Oversight and Government Reform.

2671. A letter from the Director, Office of Congressional Relations, Federal Trade Commission, transmitting notification that the Commission recently began the audit of financial statements for the fiscal year 2009; to the Committee on Oversight and Government Reform.

2672. A letter from the Deputy General Counsel, Small Business Administration, transmitting the Administration's final rule — Small Business Size Standards; Temporary Alternative Size Standards for 7(a) Business Loan Program (RIN: 3245-AF96) received July 8, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Small Business.

2673. A letter from the Director of Regulations Management, Department of Veterans Affairs, transmitting the Department's final rule — Vocational Rehabilitation and Employment Program-Duty to Assist (RIN: 2900-AM91) received July 8, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Veterans' Affairs.

PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XII, public bills and resolutions of the following titles were introduced and severally referred, as follows:

By Mr. FILNER (for himself, Mr. BUYER, Ms. CORRINE BROWN of Florida, Mr. STEARNS, Mr. SNYDER, Mr. MORAN of Kansas, Mr. MICHAUD, Mr. BROWN of South Carolina, Ms. HERSETH SANDLIN, Mr. MILLER of Florida, Mr. MITCHELL, Mr. BOOZMAN, Mr. HALL of New York, Mr. BILBRAY,