

process took about 2 weeks, 2½ weeks, and he's doing fine. That's the miracle of American medicine.

Let me explain one thing, which is, if you're some sheikh in Bahrain with unlimited money, where do you want to go to get your health care? To the good, old USA.

I say to you doctors, Hats off for the great health care that you provide. Yes, there are some things that we can do to improve it, but it doesn't mean we have to burn the entire barn down.

Mr. FLEMING. Will the gentleman yield?

Mr. AKIN. I yield my last minute or so.

Mr. FLEMING. Some might say that that's anecdotal, but let me point this out: for all cancers, 66.3 percent of American men and 63.9 percent of American women survive. In Europe, it's 47.3 and 55.8. So we're not talking about just a single story like you gave, which, I think, is representative. What we're talking about across the board are statistically significant differences in cancer survival rates in the U.S. versus Canada versus Europe.

Mr. AKIN. Let's do that statistic one more time, and we'll probably have to close up with that.

In the U.S., your survival rate is 60-something percent overall.

Mr. FLEMING. For all cancers it's 66.3 for men and 63.9 for women.

Mr. AKIN. Okay. This is over 5 years? Mr. FLEMING. Yes, versus Europe, which is 47.3 percent.

Mr. AKIN. So, if you've got cancer, you'll want to be in the good, old USA then.

Mr. FLEMING. Absolutely.

Mr. AKIN. Yes.

I very much appreciate your all joining us tonight. I thank my colleagues and the American public for continuing this discussion on health care.

God bless you all. Thank you.

DEAR ____: With the media reporting daily on Congress' and President Obama's efforts to enact meaningful health reforms this year, many Humana Medicare Advantage (MA) members are contacting us with questions. Members just like you want to know what these reforms might mean for their Medicare health plan and how they can get involved to help protect Medicare Advantage.

We are working diligently to ensure that our nation's leaders understand how proposed reforms might affect you. At the same time, we have created the Partner program to keep you informed about proposed Medicare changes and help you get involved so your voice is heard in Washington. Your opinions matter to us, to others on Medicare, and to your elected officials. There are two things you can do now to help show Congress the importance of Medicare Advantage:

Opt into the Partner program. Becoming a Partner is easy. Just complete the accompanying, postage-paid form and follow the instructions to fold and mail it back. As a Humana Partner, you will join more than 50,000 Humana Medicare Advantage members who are receiving information about this issue and learning how to get involved to protect your Medicare health plan coverage.

Let your Members of Congress know why Medicare Advantage is important to you.

Congress is considering significant cuts to Medicare Advantage now, and your Members of Congress will want to know why this program is valuable to you because these cuts could mean higher costs and benefit reductions to many on Medicare Advantage.

We've made it easy for you to have your voice heard. Just call (877) 698-9228 (toll-free) or visit www.humanapartners.com for additional information about this issue and how you can offer helpful input to your elected officials.

Leading health reform proposals being considered in Washington, D.C., this summer include billions in Medicare Advantage funding cuts, as well as spending reductions to original Medicare and Medicaid. While these programs need to be made more efficient, if the proposed funding cut levels become law, millions of seniors and disabled individuals could lose many of the important benefits and services that make Medicare Advantage health plans so valuable.

On behalf of Humana's 28,000 employees, I would like to thank you for being a Humana member. We look forward to partnering with you to ensure the Medicare Advantage program remains strong, so you can have peace of mind about your health coverage—now and in the future!

Regards,

PHILIP PAINTER, M.D.,
Chief Medical Officer,
Humana Medicare.

DEPARTMENT OF HEALTH & HUMAN SERVICES, CENTERS FOR MEDICARE & MEDICAID SERVICES, CENTER FOR DRUG AND HEALTH PLAN CHOICE, BALTIMORE, MD.

MEMORANDUM

Date: September 21, 2009.

To: All Medicare Advantage Organizations, Medicare Advantage-Prescription Drug Organizations, Cost Based Organizations and Demonstration Plans.

From: Teresa DeCaro, RN, M.S./s/, Acting Director, Medicare Drug and Health Plan Contract Administration Group.

Subject: Misleading and Confusing Plan Communications to Enrollees.

CMS has recently learned that some Medicare Advantage (MA) organizations have contacted enrollees alleging that current health care reform legislation affecting Medicare could hurt seniors and disabled individuals who could lose important benefits and services as a result of the legislation. The communications make several other claims about the legislation and how it will be detrimental to enrollees, ultimately urging enrollees to contact their congressional representatives to protest the proposals referenced in the letter.

Our priority is ensuring that accurate and clear information about the MA program is available to our beneficiaries. Thus, we are concerned about the recent mailings as they claim to convey legitimate Medicare program information about an individual's specific benefits or other plan information but instead offer misleading and/or confusing opinion and conjecture by the plan about the effect of health care reform legislation on the MA program and other information unrelated to a beneficiary's specific benefits. Further, we believe that such communications are potentially contrary to federal regulations and guidance for the MA and Part D programs and other federal law, including HIPAA. As we continue our research into this issue, we are instructing you to immediately discontinue all such mailings to beneficiaries and to remove any related materials directed to Medicare enrollees from your websites. If you have any questions about whether plan communications comply

with the MA program requirements and guidance and federal law, we urge you to contact your Regional Office account manager.

Please be advised that we take this matter very seriously and, based upon the findings of our investigation, will pursue compliance and enforcement actions.

DEPARTMENT OF HEALTH & HUMAN SERVICES, CENTERS FOR MEDICARE & MEDICAID SERVICES, OFFICE OF MEDIA AFFAIRS, WASHINGTON, DC.

MEDICARE ISSUES NEW GUIDANCE TO INSURANCE COMPANIES ON MEDICARE MAILINGS

Medicare today called on Medicare-contracted health insurance and prescription drug plans to suspend potentially misleading mailings to beneficiaries about health care and insurance reform. The Centers for Medicare & Medicaid Services (CMS) recently asked Humana, Inc. to end similar mailings. Humana has agreed to do so.

"We are concerned that the materials Humana sent to our beneficiaries may violate Medicare rules by appearing to contain Medicare Advantage and prescription drug benefit information, which must be submitted to CMS for review" said Jonathan Blum, acting director of CMS' Center for Drug and Health Plan Choices. "We also are asking that no other plan sponsors are mailing similar materials while we investigate whether a potential violation has occurred."

Humana is one of a number of private health plans that contracts with CMS to offer health care services and drug coverage to Medicare beneficiaries as part of the Medicare Advantage and Part D programs. CMS learned that Humana had been contacting enrollees in one or more of its plans and, in mailings that CMS obtained, made claims that current health care reform legislation affecting Medicare could hurt Medicare beneficiaries. The message from Humana urges enrollees to contact their congressional representatives to protest the actions referenced in the letter.

"We are concerned that, among other things, the information in the letter is misleading and confusing to beneficiaries, who may believe that it represents official communication about the Medicare Advantage program," said Blum.

Specifically, CMS is investigating whether Humana inappropriately used the lists of Medicare enrollees for unauthorized purposes.

Based on the findings of the investigation, CMS will pursue appropriate compliance and enforcement actions.

THE 30-SOMETHING HOUR

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 2009, the gentleman from Connecticut (Mr. MURPHY) is recognized for 60 minutes as the designee of the majority leader.

Mr. MURPHY of Connecticut. I thank the Speaker for granting us this time on the House floor this evening.

I hope to be joined very shortly by a few other of my colleagues who are also from the 30-something Working Group. As our colleagues know, this group comes down to this floor on a regular basis to talk about the issues that matter, not just to our constituents or to the American people but, in particular, to young families out there.

We are also to be joined this evening by a few other Members who care deeply about this Congress' commitment to

health care reform. This is the defining subject of this moment in Congress. It is the defining moment for our constituents when we're back home, and rightly so.

Mr. Speaker and my colleagues, when I was home for August, I went out there and talked to the people I represent in every forum possible. I spent early mornings in the dew of village greens. I did town halls in the evenings. I set up a card table outside supermarkets, and talked to health care professionals, nurses, doctors, and patients.

Listen, we certainly saw in Connecticut the disagreement over the solution just as we saw it all over this country, but we had an agreement that something had to be done. The current system is unsustainable. Now, there is not that kind of agreement here in Washington. I hear too many of my colleagues on the other side of the aisle and groups that are affiliated with that party talking about the system being okay as is and talking about the lack of need for any real reform.

Well, in Connecticut, at the very least, we understand the need for reform. We saw it plainly earlier this year when the State's major insurer, which covers over 50 percent of the individuals in Connecticut, proposed a 30 percent increase on individuals and small businesses. Now, thanks to government, thanks to the State of Connecticut's regulatory system, it looks like we're going to be able to push that increase down to 20 percent. Think of that. Think of the impact of a 20 percent 1-year increase in health insurance premiums for individuals in Connecticut who are struggling to get by.

The fact is that most people in my State and across the Nation who don't have health care insurance today and who are purchasing on the individual market, frankly, are struggling to get by. These are folks who are either running their own businesses, who are self-employed or who work for an employer who doesn't provide health care benefits. Those folks cannot take a 20 percent increase. Neither can the small businesses that are being charged those premiums as well.

Study after study shows us that small businesses bear the brunt of the costs in our health care system. On average, a small business is paying 18 percent more in health care premiums than are large businesses. It's simple economics. I didn't get past econ 101 in college, but I learned enough to know if you're a small business that's purchasing anything, staples, paper or health care, on behalf of only 5 or 10 or 20 employees, you're just not going to get the same deal as a company that's purchasing it on behalf of 100 or 1,000 or 10,000 employees. So it's the small businesses in today's marketplace which are getting hurt the most just as individuals are getting hurt the most.

So, in Connecticut, I think we're representative of most folks and of most businesses across the Nation. They

know that this current system just doesn't work for people. We're not talking about tinkering around the edges. We're talking about comprehensive, bottom-up reform to make this market work again for families, for individuals and for businesses.

In Connecticut, we have seen over the last 10 years an increase of 120 percent in the premiums that small businesses have been paying. During that same time, wages for their employees have only gone up about 30 percent. Now, that's not a coincidence. The fact is that the costs of our health care system are sometimes invisible to employees and to workers because they result in a lack of wage increases. They result in a contraction of pay for those Employees.

□ 2045

When a business is making a little bit extra money in 1 year, too much of that additional income is going simply to pay those 10 or 20 percent increases in health care premiums. The result is that the workers of those businesses get a zero percent pay increase or get a 1 percent or a 2 percent pay increase. All the extra money the companies are making is going to health care. That's not sustainable either.

On the other end, we have got to ask what we are getting for all of this money. It would be one thing if we were paying in for the most expensive health care system in the world—and it's the most expensive health care system in the world, not by 5, 10, 20 percent, by 100 percent. We are paying twice as much for health care in this country as any other industrialized nation in this world.

For one thing, if we were getting the added quality, maybe, maybe my friends on the Republican side of the aisle who are so defensive of our current health care system, who are so complimentary of the current health care arrangement in this country, maybe they would have a little bit better defense if all of this money that they are so proud that we are spending on health care today got us better results. But the fact is it doesn't.

Yes, if you have access to the best health care centers in this country, to the best hospitals and the best doctors, you can absolutely, absolutely get better care. You can absolutely get the best health care in the world. I don't deny for a second that there are people from all over this world that are coming to those top centers of care in this country. But the fact is not enough people have access to those centers of excellence. There are too many people who can't get into the best of our health care system.

It means, when a group like the World Health Organization surveys the quality of health care in the United States and all of our economic competitors across the globe, we turn out to be in the middle of the pack. Any health care indicator you look at, life expectancy, hospitalization rates, in-

fant mortality, infection rates, we rank 10, 15, 20. For all of the money that we are spending in this country, we should be at the top of the list regarding outcomes. Our health care system should be the best in the world.

This debate around health care reform has to encompass all of those problems. This debate has to start with cost, about how we get at making sure that never again the people in my district see a 20 percent or 30 percent increase in health care costs in one given year.

This debate has to get to a point where businesses can make extra money in one particular year and pass that extra income along to their employees rather than to insurance companies. This debate has to address the quality gap between those who have access to the best of our system and those that can't get there. We should be at the top of those lists that the World Health Organization puts out, not the middle or the bottom.

That's why Band-Aids aren't going to work. In the Energy and Commerce Committee, my Republican friends today unveiled maybe what is one of their first detailed proposals for an alternate to the effort that the President and this Congress are putting forth. It was nothing but a series of Band-Aid fixes on our current system, slight tweaks to the system of private insurance that has gotten us into the problem that we are in today.

Republicans had control of this House for 12 years. During those 12 years, that's the strategy that they employed. Empower the private market, tweak and change the current private health care system here and there.

The jury is in on that approach. The evidence is set. During that time that our Republican friends controlled this House, insurance premiums skyrocketed. The number of people without insurance increased. Our health care system got more broken.

It is time to reset the competitive playing field. It is time to dramatically alter the rules by which insurance companies play. That's what we are talking about here today. No more incremental changes to our health care system that have proven to be ineffective, but serious reform that protects what we like about our health care system but fixes what is broken.

I hope that that's the debate that we will have here in this Chamber and in committees throughout this Congress. That's what we need. That's what the businesses in my district need. That's what the constituents in my district need.

Let's have a real debate. Let's have a debate on the facts, not based on innuendo, not based on distortions, not based on outright fabrications in this bill.

I listened to our Republican colleagues who had the previous hour talk about this issue regarding the access that illegal immigrants will have to the new health care system that we hope to build here. They talked about

an amendment in the Energy and Commerce Committee, which I sit on, that would, in their mind, restrict the access to the health insurance exchange or to the subsidies in the bill for the lower-income people so that it wouldn't accrue to illegal aliens.

They failed to mention that we passed that amendment. The Space amendment passed. Check it out, thomas.gov online, passed by the House Energy and Commerce Committee, which states in as plain English as you can make it—and I get it, a lot of the amendments in the bills that we passed here are pretty hard to understand, whether you are watching Congress or in Congress. But this thing was about as clean as you could make it, that nothing in this bill shall allow people who are in this country illegally to access subsidies, to access government programs like Medicare or Medicaid.

The existing law which requires verification of citizenship remains the same. Not a lot of talk.

Mr. KING of Iowa. Would the gentleman yield?

Mr. MURPHY of Connecticut. I yield for a moment, certainly.

Mr. KING of Iowa. I thank the gentleman.

I think we are talking about a different amendment. The amendment with the general language that says nothing in this bill, I believe was written into the bill, may have been an amendment that was adopted. But the amendment that Mr. GINGREY referred to was the Deal amendment, which would have required proof of citizenship. It failed by a vote of 29-28, not exactly a party-line vote.

Mr. MURPHY of Connecticut. Reclaiming my time, I thank the gentleman.

My point being that you don't hear a lot of discussion about the amendment that did pass, the amendment that is attached to that bill today, which states very clearly what the law is and which, I think, is one of the things that leads the President, when he appears before groups out in the public or before this Chamber, to state that the law is very clear on that issue.

I wish that we had a more honest discussion about the entirety of the debate in the Energy and Commerce Committee, which included the passage of a very clear and very restrictive amendment on that case.

This is, I think, one example of many in which we have got to start matching the facts of this proposal and this debate to the rhetoric that's out there today. I think if we can do that, I think if we can get by the political jibs and jabs of this debate, there is real substance here.

I will just close on this, Representative BOUSTANY, in response to the President's speech several weeks ago, talked about the fact that there is and can be agreement on a lot more than there is disagreement over. I think that many of us who went home for the break found out amongst our constitu-

ents that folks out there were arguing around the margins of this bill.

But on the guts of it, whether or not we have an obligation in some form or fashion to try to help people who don't have insurance today get insurance, whether or not we have an obligation to start holding insurance companies accountable for their actions, whether or not we have a responsibility to try to stimulate a competitive health care market that is in the majority of States today not competitive, I think there is agreement on a lot of that.

If we can start talking about what's really in the bill, talking about the amendments that passed, not just the amendments that didn't pass, start talking about what the words in the bill say rather than what the words of political pundits on the evening cable news shows say, I think that we can find some agreement here.

I am glad that our leadership, Mr. ALTMIRE here, in the House, has re-engaged the minority side. I am hopeful that the President is absolutely sincere in his intention to bring Republicans to the table. You see in the Senate Democrats and Republicans talking to each other about how they can forge a compromise here between the two sides.

There are absolutely going to be disagreements. Maybe in the end we can all come together on something. But if we listen to our constituents, if we listen to how very broken the health care system is in their eyes, small businesses, individuals and family, I think our mandate is not to put a Band-Aid on the current system, but to make major reforms that correct years of health care neglect from this body and this government.

I would be glad to yield to my friend.

Mr. ALTMIRE. I thank the gentleman from Connecticut, and I greatly appreciate the opportunity to participate tonight. We could certainly stand here and discuss the merits of the bill, and we will, the bill that has come before Congress already and the bills that we are trying to mold together and what we expect the end result to be. We can have a discussion on the need for health care reform in this country and the merits of the system that we have, what we can do better. We are going to have that discussion. But I did want to come down to agree with the gentleman.

I watched some of the previous hour and Members who I consider to be friends and I work with. I certainly don't question intent, but we did hear a lot of rhetoric that does not in any way match up with the facts of the issues that we are discussing.

I did not vote for the bill. I am not here to defend the bill. But when I hear Members come to the floor and talk about things that are not in the bill as though they are, and then hear them reference portions of the bill and greatly take out of context what they are talking about in that bill, I don't think that's a legitimate discussion on health care reform in this country.

I am someone who wants to pass a health care reform bill. I want to find a way to make it work. I thought the House bill that was before us could have been better. I am hopeful that we are going to make it better. But I don't want to engage in a discussion and talk about how somehow we are in the process of putting together a bill that's going to lead to illegal immigrants getting health care or death panels or some of the other things that we heard over the course of the recess. That's rhetoric that is misplaced.

I think, as the gentleman said, we do have the best health care system anywhere in the world if you have access to it. Our medical innovation, our technology, our research capability far exceeds anything available anywhere else in the world. That's true. And we want to preserve what works in our current system. There is no question about that. But there are things we can do better.

I don't know how many people there are on the other side that think we shouldn't do any reform. I would expect not many, but we should be able to agree on the fact that in large segments of society, people who have insurance, they have access to the best health care system in the world. That's not to say that we can't do better.

I want to engage in a dialogue of how we can improve upon the bill that was put forward. What can we do to achieve consensus, because in America that's where we end up. We start with an idea and we build to a consensus and we get something done. That's how legislation is passed.

It offends me when I hear rhetoric put forth that is just not consistent with the facts of what's in the legislation. And, again, I am not here to defend that bill, but I understand that some of the things that we heard are just not legitimate concerns.

We talk about what's the need for reform. I had an August where I went around and I talked to Rotary clubs and physician groups and hospital boards and went to all the fairs and had town hall meetings, everything that other Members of this House did. And one of the things that stuck out in my mind, I had, in a Rotary Club I was speaking at, a small business owner come up to me and handed me his statements from his previous 4 years, his rate increases, annual statement from the insurance company. The lowest increase he had over an annual period for 4 years was a 28 percent increase. That was the lowest in the 4 years.

He said to me, and he clearly was upset about it, that he was going to be unable to offer health care to his employees because he couldn't sustain this increase, 4 straight years of at least a 28 percent increase. He had to drop coverage. These are the things that we can't allow to happen in this country.

When you have the best health care system in the world, you want everyone to have access to it. We want our

small businesses to be able to offer coverage.

If you are a small business owner who can't offer health care to your employees, it's not because you are a bad person. It's not because you don't want to. It's because you can't.

□ 2100

You can't afford to do it. So we need to bring the costs down for small businesses. Every family in America has had a similar discussion around the dinner table to talk about the increased cost of health care, the impact that's having on their family. Some of them have to make very difficult decisions on what they can afford and what they can't to keep health care. But everyone understands that costs are going up at an unsustainable rate.

We all know the impact it has on government budgets, whether that be the Federal budget—but every State in America has experienced the State budget crisis that Pennsylvania has certainly experienced. And municipal budgets, with their health care costs. So it has an impact on governments at all levels. This is what we need to address when we talk about health care reform.

Mr. MURPHY of Connecticut. I thank the gentleman. I spoke a little bit about the costs that we don't see. As my friend from Pennsylvania knows as a former hospital administrator, the folks who don't have insurance today cost us money. We have a universal health care system in this country. You just don't get it until you're so sick that you show up to the emergency room.

Often, the care that you get in that emergency room when you become so sick or so ill that that's your only resort is the most expensive care that you could get. It's crisis care.

And so for folks out there that have insurance—and that's the vast majority of the people in my district and throughout this country—you're paying for the health care of those that don't have it today, and you're likely paying a lot more through taxes to your government that go to hospitals to pay for the uninsured, towards increased rates that you're paying in private insurance, that the private insurers pay hospitals to pay for the uninsured. You're paying more to pay for that crisis care than you would if we just got some preventative care for those folks.

Mr. ALTMIRE. If I could make a point before you leave that issue. This reminds me of a couple of things that I heard when I've been back in the district. One of them was a gentleman who clearly was uncomfortable with the health care reform bill as he understood it and told me all the reasons why we shouldn't do it.

The point he made was, Look, people who don't have health care, they get insurance and they get high-quality care. And he talked about his 15-year old nephew who had gone to the Chil-

dren's Hospital of Pittsburgh with a hip injury of some sort, and he didn't have any insurance. His family didn't have insurance. And he got the treatment. And it was great quality, the best he could get. He's fine now. Everything is great.

I said, Well, you said he didn't have any insurance. How did he pay for it? The gentleman said, Well, Children's Hospital paid for it. I said, No, that's not the way it works. You and I paid for it. That's how it works. And he said, What do you mean? And I'll explain what I mean.

But there was a similar story of a woman who came up to me at a meeting, and she was very upset—was not a fan of the President, or me—and told me all the reasons that she thinks we as a Congress are doing a bad job. And she was really getting herself worked up. And she said, And don't you dare take my money to give it to those people who don't have health care, because I've worked hard to get where I am. And I've earned everything that my family has. And we have insurance. And we deserve it. And if those people don't have it, well, that's too bad for them. That's not my problem.

The point of both those stories and what I said to both these people was, It is your problem. Because we can have a discussion about whether it's a moral imperative to offer coverage to people who don't have it. Is it our obligation as a country to make sure that whatever number of uninsured we can agree on, if it's 47 million or 31 million or 1, should we, as a country, have an obligation to cover those people?

That's an interesting philosophical argument, but I'll tell you what the moral imperative is. The moral imperative is that we, who are insured, the people that I was talking to, we're already paying for them. The moral imperative is we're subsidizing them right now. And the people who don't have insurance get their treatment and their health services in the most inefficient, most costly setting—the emergency room—which leads to increased rates for us.

The woman who I told you about who said that she didn't want to pay for other people's health care had an interesting story when I started to explain to her that she was already paying. She said, Oh, it's interesting that you mention that because, she said, she just had surgery done at a hospital in February and the insurance company denied part of her claim, and she had to pay \$18,000 out-of-pocket, and because she was paying for it, she read that bill very closely and she noticed everything cost a lot more than it should have.

So she called the hospital, she told me, and she said, Why does an aspirin cost \$10? Why does everything on this bill cost five times more than it should? And the hospital said to her, Well that's because we have so many people who come through here who can't pay at all, we have to shift those costs to make up for the difference

with the people who can pay. And she got it. And so did the gentleman who talked about the Children's Hospital.

The point of those stories is that's why we're going to pass a reasonable, rational bill that's going to improve the health care system in this country when all is said and done, because everyone in America, even those who have great concerns about this administration and this bill and those who are never going to support the administration or this Congress for political reasons, they have had a situation in their lives that has demonstrated for them why we can do better or how we can do better.

The woman I'm talking about with her \$18,000 bill—but everyone has had something happen. They had to wait 9 months for an appointment with the dermatologist. They had a bad quality experience with a nursing home for their grandparents. They're that small business owner who just had his fourth straight year of 28 percent increase in his rates. Everyone has had something happen.

We've all had to spend time on the phone, maybe upwards of an hour, haggling with an insurance claims adjuster who has just denied our claim or is arguing with us about that.

So when you hear these stories, and you hear about how we shouldn't pay for people who don't have insurance and that that's not our problem, it is our problem. We're already paying for them. What we're trying to do by reforming the system is making sure everyone has coverage that wants it in a rational way so that we're not going to subsidize them in the least efficient, most costly setting, as we do today.

Mr. MURPHY of Connecticut. Mr. ALTMIRE, this is a remarkable debate in the sense that many players even within the health care system that potentially have something to lose off of health care reform, that 15 years ago, during the Clinton health care reform debate, were fighting from the outside with torches and pitchforks to make sure that health care reform didn't happen, are part of the debate this time around. That you have the drug companies and the insurance companies and the doctors coming to the table—not everybody being holly-jolly about what's in this bill or what's in other proposals—but everyone at this point, after 15 years since the last major debate over health care, of almost complete neglect of the ills within our system, everybody realizes that there's need for reform.

Certainly our constituents do. But even those institutional players, some of which have gotten pretty fat off the existing system, know that this thing is broken and know that we have to fix it.

I think that they also see some real wisdom in the approach that we are building here. I've listened to Republicans and critics of health care give me story after story of how bad the Canadian system is, and the anecdotes

they've heard about people waiting in lines in England and France. I listened to all those stories. And I heard them at my town halls from people.

My response is: No one here is talking about importing some system from Canada or England or Europe or any other country. We're talking about developing a uniquely American solution to what is, unfortunately, a very uniquely American problem. That means basing our solution on the marketplace, basing our solution in the world of private employer-based insurance that we have today.

Now there are absolutely people out there in this Chamber and in this country who want to see a Medicare-for-all system. There are others that say we should completely divorce health care from the place of employment. But for many of us those are changes that are a little bit too radical for our constituents.

So what I think we have to work on—and, again, a point in which I think we can get more agreement than you might otherwise think there could be on this issue of health care—is in making this market actually work.

In half of the States in this Nation, Mr. ALTMIRE, as you know, there's one insurer that controls more than half of the market. In 70 percent of the States there are two insurers that control almost three-quarters of the market. There's not a lot of choice out there for most people today.

Maybe the greatest contribution that we can make is to take this ingenious thing that we created in this country, the most vibrant capital marketplace in the world, and make it work for health care.

Now it's never going to work perfectly for health care because it's a strange system in which the people paying for health care are often not the people that are choosing the health care. So the health care marketplace is never going to work like buying a car or a gallon of gasoline. We can make it work a lot better than it does now.

And so the reforms that the President has proposed to establish health care exchanges, these regional health care marketplaces where insurance companies would really have to compete against each other for the business of individuals and small businesses, the reforms in this bill to make sure that insurance companies can't try to push out of their portfolios people that are sick or people that have certain expensive diseases, those are all engaged in the process of trying to make our health care marketplace work better.

And so we talked about the distortions surrounding the benefits in this bill to illegal immigrants. I say the same thing about those who come down to this floor or go out in public and talk about this proposal or any of the like proposals that we're debating as a government takeover. The CBO has been pretty clear on what the 10-year results of the bill that passed the En-

ergy and Commerce Committee would mean.

Mr. ALTMIRE, as we've talked about, there are a lot of people, including yourself, who want to see some changes to the proposal that's out there from Energy and Commerce. So I don't want to present that as the bill that's going to come to this floor for a vote. But let's take it as a foundational point of argument.

The Congressional Budget Office—again, the nonpartisan sort of analyst arm of this Congress—says that if you pass the bill out of Energy and Commerce, in 10 years more people would be on private insurance than are on it today. That private insurers in this country would have more business—not the same, not less—because we would reinvigorate that private marketplace and get more people into private insurance by helping them with tax credits both through business tax credits and individual tax credits to buy insurance.

That's a concept that I want to support, using the marketplace that is broken right now as the way that we fix health care going forward. I think that that's one of the points that we can get some agreement on going forward, Mr. ALTMIRE.

Mr. ALTMIRE. The gentleman said a couple of things that I wanted to comment on. I will get to the public option momentarily. But I agree with the way the gentleman characterized the discussion about Canada and Great Britain, the two countries that we most often hear the horror stories from.

Look, I don't live in Canada. I don't live in Great Britain. I don't know what it's like to live under those systems. But I do know this. I have a master's degree in health care administration. I've spent a career in health care policy.

I can tell you it is interesting to study what other countries do—not just Canada and Great Britain, but other countries around the world—and everyone has a different system. That's a nice political science or health policy discussion to have. But, as the gentleman talked about, that has nothing to do with what we're doing in this bill.

This bill doesn't in any way bring to America what Canada does, certainly. It's not even close. There's no comparison to be made. It doesn't do anything close to what Great Britain does, which is even more to the left of Canada.

And so we can watch the TV and hear the horror stories. And they're interesting to listen to, but it has no place in this discussion because it has nothing to do with the proposals that we're voting on.

With regard to the public option—and I'm going to use another example from when I was back in the district. I continued to hear people say, You know what? The government is inefficient, it's bloated, it can't do anything right. They would say, You can't name one program that the government has ever run that's worth anything. Everything it touches is bad. And if you have

them touch a public option, it's going to cost too much, it's going to be inferior care.

And I would say, Look, the public option is going to be self-sustaining. We do need to work out the details of what exactly it's going to look like, but it's going to be self-sustaining, with no taxpayer subsidies. It's going to compete on a level playing field with the insurance companies. It'll have to meet all the same regulatory requirements that they meet.

And there is some disagreement on this. I would like to see it have negotiated rates like the insurers. There are other opinions on that. But the point is it's going to be a fair fight. And it'll have to meet all the same requirements as the private insurers.

If you believe that the government can't do anything right, that they're going to mess up everything that they touch, and it's going to be inferior quality at a higher cost—and, under the terms of the bill no one is forced into the public option; it's voluntary—then what are you afraid of if you believe the private market can do everything better?

I'm not afraid of that competition. I think the private market can't compete and win. I think there are some families and businesses that would choose the option and feel that's a better deal for them—not because it has an unfair advantage, but if it's a level playing field and you don't think government can do anything right for those that have that belief, then why are you afraid of the competition?

□ 2115

Mr. MURPHY of Connecticut. Reclaiming my time, we have example after example of where the private sector and the public sector compete pretty well side by side, and most of the examples involve public sector entities that are heavily subsidized, and they still compete side by side with private entities.

Public colleges haven't run private colleges out of business despite the fact that they are heavily subsidized by the government. Public hospitals haven't run private hospitals out of business despite the fact that they are often subsidized. The same thing for even smaller, more mundane examples. Public golf courses and private golf courses, public pools and private pools. There is example after example of where public entities can coexist side by side with private entities, and they actually compete with each other.

I think this is such an important point, and I go back to the CBO estimate here, Mr. ALTMIRE. Assuming that you create that level playing field, which you and I both want, with an insurance exchange that includes a public option, the CBO tells us that not only will you have more people in private insurance when all is said and done but the number of people in the public option will be about 10, 12 million people, 2, 3, maybe 4 percent of the

overall health care consumers out there. A significant number but by no means a government takeover, as some people would have us believe. This is an option for people that can compete.

For me, I look at government health care and I think, well, you know, if it's good enough for our soldiers, if it's good enough for our veterans, if it's good enough for our Federal employees, if it's good enough for Members of Congress, if it's good enough for State employees, if it's good enough for every individual in this country over 65, then I think that my constituents should have the choice of whether it's good enough for them. I don't want to make that choice for them. I don't want to be like a European country that says your only choice is public insurance.

But I also don't like the arrangement we've got today where our law as set by the Federal Government tells my constituents that your only choice is private insurance. I give my constituents credit. I mean, I think that they'll be able to make the best choice for them. And I think if we do that, then we will get to where I think a lot of us want to get to, which is to really stimulate and reinvigorate that market, Mr. ALTMIRE.

Mr. ALTMIRE. I agree with the gentleman on those points.

I would say also let's look at the totality of what we're talking about with reform. When we talk about making reforms in the private insurance market that I think everybody agrees with, this is what you're going to get from health care reform: no more pre-existing condition exclusions. No more caps for people with chronic diseases, annual caps or lifetime caps, out-of-pocket costs. Insurance companies won't be able to deny you coverage or drop your coverage because you get sick or injured. These are all practices that we know exist. They won't be available after this bill passes.

The help for small businesses who can't afford health care to be able to help them, hopefully through tax credits or some other way, to afford coverage for their employees; to do the reforms in the system to incentivize quality of care, not quantity of care. We've talked about this many times on the floor where the current system is a fee-for-service system. The number of times you show up in the doctor's office, the number of tests they run and procedures they order, that's the amount of money that they make. So they have a financial incentive for you to be sick. The more often you're there, the more things you have wrong with you, the more money they're going to make. Well, that's a perverse incentive.

We want to change the reimbursement system to incentivize quality to keep you healthy and keep you out of the system before you get sick. And that's why we're going to incentivize prevention and wellness, to make those services that senior citizens especially can access the Medicare system at no

cost so that you can have the diabetes screenings and the mammograms and the flu shots and things that are prevention at no cost. They're going to prevent people from getting sick in the first place.

So these are things that I think we all agree on when we talk about reform.

Mr. MURPHY of Connecticut. Reclaiming my time, on this point of reforming the way that Medicare works to start paying for outcomes, start paying for systems and doctors and providers and hospitals that get results rather than just paying for volume, it is incredibly discouraging to me to watch Members of this body that proclaim to be fiscal conservatives come down here and eviscerate the efforts of the President and of the Democratic side of the aisle to try to rein in the cost of Medicare.

I hear sort of arguments out of two different sides. Opponents of reform talk about the fact that the government can't run anything, that they can't run Medicare; but then they also at the same time attack the fact that this bill for the first time in a long time tries to rein in the cost of Medicare, actually tries to fix the abuses out there.

Yes, in this bill there are reductions in the cost of Medicare. Nobody should apologize for the fact that we are going to rein in the abuse and waste and sometimes fraud in the Medicare system. It just doesn't make any sense, Mr. ALTMIRE, that there are health systems with the same medical populations and one is spending \$16,000 per year on every Medicare beneficiary and the other community is spending \$8,000 per Medicare beneficiary. And when you actually look at it, there's no difference in the outcomes that they get. Why are we rewarding systems of health care that just add volume upon volume of care and get no added benefit out of it?

Now, I'm not saying that the way that you fix that is easy. I'm not saying that there is some silver bullet that comes in here and all of a sudden finds a way to reward value over volume. But I'm saying that for those out there that have come down to this floor and have gone out in public and railed against the cuts in Medicare in this bill, they've got to pay attention to the reality.

The reality is the benefits stay the same for beneficiaries. In fact, they get better. As you said, we're not going to require seniors to pay for the costs of checkups and preventative health care anymore. We're going to eliminate the doughnut hole over time. We're going to start paying their physicians more to take care of Medicare patients rather than what the Republican majority insisted on, which was an annual 4 percent cut.

Are we going to say to health care systems and hospitals and providers who are just ordering tests and procedures for the sake of reimbursement

and volume and not for quality that they shouldn't get paid as much as they do now? Absolutely. But that's our obligation as stewards of the taxpayer dollars, as people that care, like our constituents do, about preserving the life of Medicare.

So I hope that we can join together in this conversation. I hope that my friends out there that claim to be fiscal conservatives don't spend the next 2 to 3 months out there railing against every single 10-year reduction in Medicare spending in this bill because, again, if we want to come together, there is nothing more appropriate to come together on than spending our taxpayer dollars wisely on existing government programs like Medicare. I want Medicare to be around when I turn 65, and if we don't tackle the excessive costs in some parts of our Medicare system right now, it's not going to be, Mr. ALTMIRE.

Mr. ALTMIRE. And on that point, Medicare, as we all know, is scheduled to go bankrupt within 7 years. It's already, as a trust fund, paying out more than it's taking in. It has for the last few years. It's going to be completely insolvent in the year 2016. That's because of rising health care costs which are, unlike Social Security, which is going to be solvent through the year 2040, and because of demographics, it takes a downturn thereafter, but health care costs are unpredictable.

Retirement costs are very predictable. You can generally figure out how long a population is going to live in the aggregate, what kind of money they're going to make, what their salary progression is, and what their retirement benefits look like. That's easily predictable.

Health care benefits aren't. You don't know how much technology is going to change, how much prescription drugs are going to cost, how much high-technology treatments are going to cost, and what the future holds with regard to new innovations and technologies down the road. So for that reason, it's impossible to predict Medicare costs in the same way. The first baby boomer becomes eligible for Medicare in the year 2011. That's a big part of it too demographically.

So what we're trying to say is what can we do to preserve and protect Medicare for the long term? That's the whole point of health care reform, to bring down those costs, to make Medicare solvent, to make the reforms necessary so that it can last into the future and be there certainly for all the current beneficiaries, the baby boomers, for the gentleman and myself, and for our grandchildren. That's why we have to reform the Medicare system, the payment system, and that's why we need to reform our health care system.

But we spend as a Nation \$2½ trillion a year. This year, 2009, we're going to spend \$2½ trillion as a Nation for 1 year on health care. So what are we talking about?

Now, we used to in this House score things over a 3-year period; and then people, I think rightly, said that doesn't give you an estimate of sort of the long-term impact of the legislation; let's do it over 5 years. So for a while, several years, we scored all the bills over a 5-year period. Now in the interest of transparency and to give the public an idea of the full long-term costs, we actually score legislation that comes to this floor over a 10-year period.

And what's the cost of this bill going to be? The President of the United States stood right behind where the gentleman stands about a month ago and told us that it's going to cost somewhere in the neighborhood of \$900 billion over 10 years, which is going to be fully paid for. It's not going to add to the deficit. We'll talk about that. But \$900 billion over 10 years. So on average, that's \$90 billion per year in a system where we're spending \$2½ trillion this year, and it's going to go up exponentially every year for the next 10 years.

Is there anyone out there who doesn't think we can find inefficiencies in the system and waste that we can squeeze out to the tune of \$90 billion a year in a \$2½ trillion system, that we can't make it more efficient and save enough money to make the reforms that we're talking about?

I just think that the American people, when they think about these numbers, need to remember that we're talking about reforms that are going to increase quality, that are going to increase benefits for people, but that we are talking about in the aggregate a relatively small portion of the health care system as a whole when you talk about this stuff.

Mr. MURPHY of Connecticut. Mr. ALTMIRE, you've been a great leader on this question, which is to say, listen, to fix the problems with our health care system, we're going to need to spend a little bit of money up front, with tax credits to individuals or to small businesses to help them afford insurance, money to plug the doughnut hole to pay for preventative care for our seniors, expansion of Medicaid programs to cover some more people. We have got to look to savings first. And that is a point you've made to dozens of Members on this floor. To say, listen, exactly as you put it, and you're much more eloquent on this subject than I am, we can squeeze savings out of this system.

And as you enunciate, it's important to remember that that 10-year cost of this bill, whether in the end it's \$900 billion or \$700 billion or \$600 billion, that's the gross cost, not the net cost. That can be paid for in whole or in large part by the savings that we're talking about here to the current government health care expenditures.

Now, listen, for those people that say I don't want the government involved in health care, guess what? It's too late. Fifty-five percent, somewhere in

that neighborhood, of health care dollars in this country are spent by the government. Medicare, Medicaid, the veterans system, et cetera. We have not just the obligation but the opportunity to modernize those programs, glean real savings out of them, and turn it back around to people who are left out right now.

And for those opponents of reform who go around demagoguing the Medicare reductions in this bill and say we cannot touch Medicare, those Democrats had better not make any changes to Medicare, well, Mr. ALTMIRE, as you pointed out, Medicare's going to go bankrupt. So if you don't control Medicare costs, if you're one of the people on this House floor or out there on the stump saying that Congress, whatever they pass on health care reform, can't touch Medicare, then you have only one other option in order to preserve Medicare for your kids and your grandkids, and that's to increase taxes. That's to increase the amount of money that comes out of everybody's paycheck to pay for Medicare.

□ 2130

So I can certainly understand a disagreement about where we need to rein in costs on Medicare and where we shouldn't, but I hear a lot of commotion out there by people who say we should not touch it. I agree we should keep benefits where they are and improve them, but we do need to find efficiencies in the system.

Turning to another subject, Mr. ALTMIRE, you and I both have young children. I know in the 12 months that I have had the joy of being a parent, there is not a day, not a week that goes by that I don't think about the cost of what we are doing to my son.

As someone who, frankly, voted for the stimulus bill, what I thought was a necessary means to get this economy back up and running and to stabilize what had been up to that point a free fall, I approach this health care bill with the same bottom line that the President does: We need to pass a bill that finds a way to get coverage to more people and reins in the cost of care. And to the extent that requires spending some money at the outset in order to get a better system in the long run, it has to be done in a deficit-neutral way. "Deficit-neutral" is kind of an inside Washington term, but the bottom line is this, we can't borrow any money to pass health care reform.

I think that is a growing commitment on behalf of both sides of the aisle here. It is certainly a bottom line for the President. And again, I think a central tenet of health care reform has to be do what you push for, squeeze the savings out of the system as much as we can in order to pay for what we need to do, and then make a rock-solid commitment that we won't borrow a cent in order to pay for it.

Mr. ALTMIRE. I agree with the gentleman. I have said that I will not support a bill that adds one penny to the

deficit. Even more important than that, the President of the United States said that from the podium behind you. He will not sign a bill that adds one penny to the deficit.

I heard time and again over the course of being back in the district concerns about the spending that is taking place in Washington and the increase in the debt and the annual deficits over the past 9 years. I have young children, as the gentleman said. I completely agree, we have to do this in a way that is not going to add one penny to the deficit or the national debt.

One of the Senate bills which has been finalized and is being marked up this week, in fact, saves money over 10 years. I don't know if that is going to be the finished product. Certainly it is not word for word, but it is possible to do health care where we might actually bring a bill to the floor that, at minimum, is not going to add to the debt but might even reduce the debt over a 10-year period, or reduce the deficit on an annual basis.

That is something that I think the American people should consider when they talk about the need for health care reform, but also the need to bring down our long-term deficit. We can't ever address our long-term deficit without doing health care reform. It is too big a part of our economy to ignore.

Mr. MURPHY of Connecticut. Estimates are, within the next 30 years, health care costs will consume 50 percent of gross domestic product in this country. Think of that. One out of every two dollars spent in this country by the government or private sector will be spent on health care. Today, it is creeping up on 20 percent, but in 30 years things will be out of control.

You are exactly right, there is no way to talk about deficit and debt reduction without talking about health care reform. We have examples of how we have been able to do that just in the last week.

Last week we passed an education reform bill that modernized our student loan program, got \$87 billion worth of savings, and applied a significant portion of those savings not to new student loan programs but to deficit reduction. Frankly, that should probably be a model for everything that we do here. If we can glean savings out of government programs, we need to apply all or part of that to paying down the debt.

We are at the close of our hour, so if you have any closing comments, Mr. ALTMIRE. I appreciate you joining us down here for this hour.

I am optimistic by nature. We both focused on the points of agreement we think we can get here. I do make a point to call out my Republican friends when I think they have tried to lead folks out there astray on a particular point on the bill, but it is because I want to have an honest debate in the end. I think if we are all talking about the facts, we can get to a point of

agreement, because our constituents out there want us to get there because the problems in our health care system dictate that we create a real solution that isn't incremental and isn't small and around the edges, but attacks the foundation and the gut and the root of our problems.

So I look forward to coming back down to the House floor and continuing to push forward this case for reform.

HEALTH CARE REFORM

The SPEAKER pro tempore. 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, and I thank the gentleman for yielding to me earlier in the hour. I think an open dialogue is a good thing, and I hope the gentlemen will be here to hear the rebuttals that I am about to provide to the statements that they made in the previous hour, starting with the bill that passed out of the Energy and Commerce Committee and other committees, H.R. 3200, which is the foundational bill to the health care act, the national health care act that Democrats are seeking to pass.

And regardless of the statement that there is general language in the bill that says nothing in this bill funds illegals, the fact remains that the amendment that was offered by the gentleman from Georgia (Mr. DEAL), which was language that is tried and true, that existed in the Medicaid legislation that we have used for at least a decade that requires proof of citizenship, that amendment was voted down in Energy and Commerce 29-28, resulting in an open-door policy where there are no restrictions to keep the bill from providing access to benefits to illegals or to people who are here legally but are barred under the 5-year bar.

In fact, the standard that exists was a standard that required proof of citizenship. Democrats first took that apart when they passed an expansion of SCHIP, the State Children's Health Insurance Program. They took that from a 200 percent of poverty, and the first time it passed the House it went to 400 percent of poverty. Mr. DEAL offered the same amendment in that bill to put in language that existed in law before it was struck out by the expansion of SCHIP, and it was voted down on almost a party-line effort.

We know if there are not provisions which require proof of citizenship, then there aren't provisions that are going to prohibit illegals from getting benefits under the bill. The Congressional Budget Office knows that. They scored that language in SCHIP as costing \$8.9 billion to fund health insurance for illegals and to provide Medicaid to illegals because it removed the citizenship standard. Removing the citizenship standard, according to the Congressional Budget Office, on H.R. 3200, the health care bill, would provide for

access to those benefits under the bill for as many 5.6 million illegals. And that's the score that came out from the Congressional Budget Office.

Another nonpartisan organization is the Congressional Research Services, and they also concluded there weren't restrictions in H.R. 3200, the health care bill, so that would result in those benefits going to illegals who would apply. And we know how fast the grapevine works and how effectively people can game the system, and no one should be in a position of responsibility in this Congress if they can't understand that equation, especially if they are on the committee.

And it is not just STEVE KING making this statement. It is the Congressional Budget Office on at least two different occasions, rendering a judgment on that specific language of the Deal amendment, and it is Congressional Research Services. And by the way, it goes on down the line and a number of other entities, including the President, who finally had to address it and say we are going to have to write something in the bill to protect us so it doesn't fund illegals. And it also includes the Senate, which took the position that they would address the language.

So why do you have to fix it if it doesn't fund illegals the way it is? And I believe that the President stood here and called a group of Members of Congress who were exactly right on their facts, I believe he accused them of not being honest. And directly, he said, We will call you out.

Well, I'm saying this: The President got it wrong. Maybe he has it right now, but these gentlemen have it wrong, and they need to go back and check their facts. The amendment was voted down 29-28. The Deal amendment required proof of citizenship. When you remove the proof of citizenship requirement, the Congressional Budget Office and the Congressional Research Services and every nonpartisan, objective evaluation comes to the same conclusion: We will be funding illegals if we don't have the language in there. That is the only language that is going to be satisfactory. And by the way, I don't think Senator BAUCUS has it in his bill yet, although he has pledged to do so, and we will watch that language very carefully as it unfolds over in the Senate.

So yes, illegals would get health care under this system unless we write the language in that sets the standard so that they don't.

The statement that was made by the gentleman, Mr. ALTMIRE, with the public option there would be no subsidies. The facts of the health care bill don't support that. First of all, it is going to take capital to set up the public option as a national health insurance company. If you set up a national health insurance company, it is impossible to do so without putting capital in, without injecting some billions of dollars to jump-start a national health insurance

program that would compete directly with the 1,300 private health insurance companies that we have.

That is not what you call a no-subsidy situation. That is called a subsidy situation. Putting capital in to compete against the private sector is subsidy.

What do we suppose will happen if we put \$10 billion into the front end of this national health insurance program and we find out that it becomes insolvent? Do we then let it collapse or does this Congress at a later date decide we are going to have to put some billions of dollars in there to keep the national health care plan up?

Under these majorities, under this Pelosi Congress, I guarantee you they will borrow money from the Chinese, if necessary, in order to subsidize a national health care plan. It isn't going to go any other way. They have worked for 30 or 40 years to try to establish a national health care, and they are not going to allow it to go under because it falls a little short on some kind of promise that there won't be subsidies. Yes, there will be subsidies, and any rational person who understands history will know that.

The argument that a national health care plan will compete on a level playing field, a level playing field with referees that will be chosen by the government, not by the private sector, and I will make a point.

This, Mr. Speaker, is the formerly embargoed flowchart that actually depicts the language that exists in H.R. 3200, the national health care plan. We call it the Organizational Chart of the House Democrats' Health Plan. This is the government plan. This is the government option configuration. This creates at least 31 new agencies.

Now, down here at the bottom, I just direct your attention to these two purple circles at the bottom. This is where the crux of the matter is. The gentleman, Mr. ALTMIRE, made the statement that the public option, there wouldn't be any subsidies and they would compete on a level playing field. Well, here is how this field is regulated, and it will not be a level playing field.

Oh, by the way, anything that is a white box is existing programs or agencies. There is Medicare, SCHIP, Medicaid. But the existing private insurers in this little box here, Mr. Speaker, once the bill is passed, these private insurers, this is 1,300 health insurance companies in this little box. That is how many private insurers we have. Those traditional health insurance plans, the policies, there are approximately 100,000 different varieties of policy combinations available across the United States. These policies would have to qualify to become qualified health benefits plans. Now, if there is going to be a qualification set up, I think it is not possible to presume that all 1,300 companies and all 100,000 policies will be qualified under this bill.