VACATING 5-MINUTE SPECIAL ORDER

The SPEAKER pro tempore. Without objection, the request for a 5-minute special order speech in favor of the gentleman from Texas (Mr. BURGESS) is hereby vacated.

There was no objection.

HEALTH CARE REFORM

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

Mr. BURGESS. The last hour just ended, and you heard the admonition at the end of the hour that it is extremely important for people to pay attention. And during this hour, I am going to echo that thought. It is important for people to pay attention, Mr. Speaker, and, yes, I will direct my remarks to the Chair. But, Mr. Speaker, if I could talk to the American people, what I would tell them is now is the time, it is late at night, but now is the time for you to be keeping this House under intense scrutiny and watch what happens here over the next 72 hours as we drag this carcass of a health care bill across the finish line.

Now, how did we get here? It's probably useful to think about things for just a moment. We had a big election in 2008. People said they voted for change. Right before that election in 2008, in the other body, the chairman of the Senate Finance Committee held a big meeting over in the Library of Congress and had all the big players and the stakeholders in health care in the room, and came up with what was called a white paper on health care reform. For all the world, it looked like a bill. For all the world, it looked like it would be the bill that was brought forth in the Senate should the Democrats take control of the White House, the House and the Senate. Indeed, the election was held, and they did.

I will tell you, Mr. Speaker, I was somewhat surprised that there was not a health care bill, no health care bill came forth in those early days after the election. I thought perhaps we would see one in December of 2008 during the holiday season, but no health care bill. No health care bill in the weeks that the Congress was getting organized. We had a big inauguration, no health care bill. We had a designee named to be Secretary of Health and Human Services. Still no health care bill was forthcoming. Well, surely it will come along right after that confirmation for Health and Human Services. But as it turns out, that individual had some tax problems and that nomination was withdrawn before it ever got to the confirmation vote in the full Senate. So we were left without a Secretary of Health and Human Services for several months, no health care bill.

Suddenly, it was early summer. There was a letter sent from the other body from the two committees of jurisdiction, the Health, Education, Labor and Pensions Committee over in the other body, and the Senate Finance Committee in the other body, they sent a letter to the President and said, We will be producing a health care bill within the next couple of weeks. In fact, the Health, Education, Labor and Pensions Committee did produce a bill. The coverage and cost numbers were quite startling when they were revealed: A cost of $1 trillion. It left a lot of people uncovered as the original plan was unveiled, and then several weeks were spent in what was called the markup of that bill over in that committee over in the Senate.

Then the three committees of jurisdiction in the House had a health care bill that was rapidly brought forward. We didn't really get a lot of time to look at it. There was certainly no subcommittee markup. It came straight to our Committee on Energy and Commerce for a markup. And to give credit to the chairman of the Energy and Commerce Committee, we did get a little more time than the other two committees, the Committee on Education and Labor and the Committee on Ways and Means. They each had a day, a 24-hour period, to mark up this bill. Think of that. This bill, this legislation that's going to affect the lives and livelihood of Americans for the next three generations was allowed 1 day in markup in Ways and Means, 1 day in markup in Education and Labor. We at least had 8 days in Energy and Commerce. Four of those days were spent recessed because we couldn't agree on some things, but we did have more time in the Committee on Energy and Commerce than in any other committee in the House.

Think back, Mr. Speaker, to the Clean Air Act in the early 1990s. I'm told it was an 8-month markup for the Clean Air Act, 8-month. Think how the people on those committees must have hated each other at the end of those 8 months. But what did they get? What did they get for that 8 month investment? They got a bill that had support from both Republicans and Democrats, eventually passed the House, eventually passed the Senate, eventually was signed into law by George Herbert Walker Bush, and the Clean Air Act became the law of the land and arguably has been successful since that time. So that's the way the process is supposed to work.

Let me take one step back. The House passed a bill, the Senate passed a bill, they went to a conference committee, had a continuation of that long and drawn-out process, but the conference committee produced a conference report that was endorsed by the Senate, endorsed by the House, again bipartisan majorities on either side, the bill then went to the President for his signature, and that's what we now know as the Clean Air Act.

But think of the difference between that major piece of legislation that had a great and far and reaching affect on the lives and livelihood of every American, contrasted with what we've done over the past year.

And quite honestly, Mr. Speaker, it's not that we didn't have time. It's not that we didn't have time. After all, we have been working on this thing nearly 15 months. We actually had time to do a real markup in each of the three House committees. We had time to do a real markup. We had time to do a real conference committee.

Look at the timeline of this bill. We got it in Energy and Commerce in the middle in July. We didn't have a lot of time to deal with it before, but when we got it, we worked on it, we worked hard. I offered a multitude of amendments. I had 50 amendments prepared in committee. Five of those were accepted by the time the bill passed out of committee, all of those on a voice vote, so presumably a unanimous vote, and every one of those amendments was stripped out when the bill went to the Speaker's Office before it came back to the House, to the House floor in late October, and then we had the vote in the House in early November.

The Senate had their bill. The Senate Finance Committee completed their work in the fall. They brought their bill to the Senate in the month of December. It was voted upon, famously, on Christmas Eve, and then the normal sequence of events would be for the bill to go to a conference committee. And there in the conference committee, yes, the Democrats have substantial majorities in the House and the Senate. The Democrats would have had a significant advantage in the conference committee. The idea of the conference committee is to meld the differences of those two bills to create a product that can be endorsed by both Houses in the Capitol.

But they didn't do that. They thought, well, that was hard to get that one through the Senate. Let's not go through regular order. Let's try something different. And that something different was, maybe we can just get the House to pass the Senate bill because the Senate bill was, in fact, a House bill. It has a House bill number. In fact, it was our appropriations bill, I think, for Treasury Department appropriations last year. It did pass the House as an appropriations bill, went over to the Senate for work on their appropriations bills. That never happened, but the bill was then used as a shell. The legislative language for appropriations was stripped out, the health care language was put in, so the Senate passed a House bill on Christmas Eve, and then that bill can come back through those doors, come into the House, and the Speaker of the House will say, the business of the House is now, will the House concur with the Senate amendment to H.R. whatever it is, the House agrees by a simple majority, at that time 218 votes, and the bill goes to the President's desk.

But House Members didn't want to do that. They didn't like the Senate bill. For some it didn't go far enough. For some it went way too far. But the Senate bill was not seen to be an acceptable product. So while all of that discussion was going on, there was a little-noticed, to that point, election that took place in the State of Massachusetts, and the election was to fill the vacancy that was created when Senator Kennedy died. And that election was won by SCOTT BROWN, who is a Republican who said he would be the 41st Republican vote against this health care bill.

Whoa. Now, a lot of doors are closed over in the other body. They can no longer go to a conference committee and expect that they will have their 60-vote majority to pass anything they want. In fact, to take any bill back to the Senate now, and under Senate rules where you need to have 60 votes to cut off debate, that is going to be a pretty tall order because they only have 59 votes, 41 votes on the Republican side.

So what to do? We do still have the bill that was passed by the Senate. That Senate bill passed with a 60-vote margin, so it is still quite viable. If there is just some way to convince the House to vote for that bill. Now the Republican side, we didn't vote for it in the first place, we are not likely to vote for it in the second place. But on the Democratic side, if they can put together enough coalitions and enough votes, now the number is only 216, with some unfortunate deaths we have had on this side and some people who have left the House of Representatives, so 216 is the simple majority in the House. That is all that is required. So, well, look, maybe if we could do some technical corrections, we can't really do them to the bill because the bill has already passed the Senate, and if we took those corrections back to the Senate, we would have to have 60 votes to cut off debate. But there is a Senate process called reconciliation to deal with budgetary and fiscal matters. And under reconciliation, only a simple majority is required in the Senate. Maybe we could do those technical considerations in the Senate under reconciliation and pass that through the Senate with 51 votes.

□ 2100

And if we, the Senate, do that, will the House then agree to pass our bill with the understanding that these technical corrections would quickly be instituted? That is the big question right now. And are there going to be any problems with any of those technical corrections to be done under reconciliation?

Well, there might be. There might be. Because, remember, reconciliation is to pass those very tough budget and fiscal bills that are really hard to get the number of votes because sometimes you are actually cutting spending, sometimes you are actually irritating a constituency back home because we are reducing Federal spending in some of those reconciliation bills.

If it deals with budgetary issues and spending issues, then it could pass under reconciliation with 51 votes. The Vice President gets to vote in the case of a tie over in the Senate. So 50 Senators plus the Vice President would actually pass any of those reconciliation provisions, unless, unless someone makes a point of order over in the Senate that they don't deal exclusively with budgetary issues, that they are in fact changes in policy that are outside the budgetary process. Then the Senate has rules that say if a point of order is made, that it would require 60 votes to put that provision into the reconciliation bill, the so-called Byrd rule initiated by ROBERT BYRD, the dean of the Senate many, many years ago, to keep just this type of problem from happening. Didn't want the Republicans if they got in charge to be able to do things like this.

So the Byrd rule has been in effect for a number of years; and the Byrd rule would say, well, say you have a contentious issue in the House bill. Say there is some issue with the language regulating the Federal funding of abortion. Say there is some question of what do we do as far as dealing with people whose legal status in this country may be in some question. Well, those issues are beyond budget and may in fact be subject to a point of order and may require 60 votes to then be included in the reconciliation bill.

So it is not a given that everything that is wanted by House Democrats in changes in the Senate bill for the House to agree to pass the Senate bill, they may not be there when those technical corrections are finally voted on in the Senate. And that will take some time, because every amendment in the Senate may not necessarily be debated, but every one will be voted on; and all of that is going to take some significant time.

So where we are in the House tonight is that my understanding is the Rules Committee is to meet soon, if they are not already meeting, and the Rules Committee will come up with the language for that reconciliation bill. None of us have seen that yet. It hasn't really been scored by the Congressional Budget Office, so no one really knows what this bill will cost yet. So all of that is still hanging out there.

Then there is one more wrinkle thrown in. The Speaker of the House said it very well the other day: no one wants to vote for the Senate bill.

Well, that is a problem if you are going to need to get 216 votes in the House for the Senate bill to allow the reconciliation bill to then go forward to fix the technical problems in the Senate bill. I know this gets a little confusing, but no one wants to vote for the Senate bill.

Is there a way around voting for the Senate bill? Probably not. But, wait. What if we voted on a rule that allowed us to go forward with reconciliation, and within that rule we kind of made it like the Senate bill had already passed without actually having to vote on it?

Mr. Speaker, I would just ask the question: Do you really think the American people are not paying attention? The last Democrat who spoke here in the well of the House said it is time for the American people to pay attention to this process. I would submit that is exactly right.

Now, many people will recognize this icon, the Capitol Rock figure from when my children were young. This was the individual who was just a bill, and one day he hoped to be a law but today he was just a bill. But you can see today he is mad. He is angry. And why is he angry? He is still a bill. He wants to be a law. But he doesn't want to be deemed, and he doesn't want to be ''slaughtered,'' referring to the Slaughter rule that the House may vote on. By this time on Sunday the House may vote on the Slaughter rule which would deem acceptance of the Senate product.

Well, you can see why Mr. Bill is upset. He wants to go through regular order. He wants to go through committee, he wants to be voted on by the House, he wants to be voted on by the Senate. He really would have liked to have gone to a conference committee and have those two products melded together and then come back for an up-or-down vote in the House or the Senate. But as it appears tonight, he may not get his wish.

And is there a consequence to doing this? Now, you are going to hear people say that, oh, things have been deemed for a long time. This is nothing new. I will tell you, this is different. This is new. This is not something that, certainly in my short tenure, I have seen.

In fact, I recall a reconciliation bill in 2005 when the Republicans were in charge, it was called the Deficit Reduction Act, a very contentious bill, because we were trying to bend the cost curve on Medicaid spending. Does that sound familiar? You have heard the term ''bending the cost curve.'' We were trying to bend the cost curve on Medicaid spending from an increase of 7.7 percent year over year to 7.3 percent growth year over year. Not a heavy lift in anyone's book, but it was a big lift here in the United States House of Representatives.

Now, we were coming to the end of the calendar year 2005. In fact, it was coming up on to the Christmas holidays. People were anxious to get home and be with their families. We voted on that bill, as I recall, early on a Monday morning. We had been here through the weekend, up all night, debates, debates, debates. A lot of changes, a lot of moving things around on the chessboard. And then, in the final analysis, the bill passed very early in the morning on a Monday morning. I think it was December 19, so it was getting very close to that cutoff for Christmas.

Later in the week, that bill was voted on in the Senate. And this was a

conference report. We had voted on the regular bills, it had gone to a conference, so these were the conference reports that we were voting up or down on.

The House passed its version. The Senate passed its version on Tuesday or Wednesday, quickly left town, and were gone. The House had already vacated the premises. And it was found that there was a little discrepancy. There were some differences in wording between the two bills.

Well, as they should have done, the Democrats that were then in the majority went nuts and they said, You cannot send that bill down to the White House for a signature because the House and the Senate did not pass the same bill, the same identical language. And it was a big deal.

The reason I remember this so well is, remember the doctor fix that we talked about a lot? In fact, we did a little doctor fix today. We extended the time before the doctors get their big pay cut; we moved that from April 1 to May 1. Well, there was a doc fix in the Deficit Reduction Act. At that point, I think the doctors were facing a 6 percent reduction in Medicare reimbursement, and that clock ran out at midnight on December 31.

We fixed it in the Deficit Reduction Act, but there was a problem. The House bill and the Senate bill were not word for word identical. I don't even remember the number of words that were different. It was not many. It seemed like an awfully picky process. But in order to comport with all of the laws in our Constitution, the House and the Senate had to pass identical bills for the bill to be regarded as passed and be available to go down to the President for his signature. So the clock ran out on Medicare and the doc fix.

Now, everything else that was in the bill was not perishable, and it would keep until the House came back in January of 2006 and could fix the damage. In the meantime, there was much wailing and gnashing of teeth here in the House on the then-minority Democratic side: this is unconstitutional. We will go to court. We will take this down. So the bill did not go to the President for his signature. It stayed and languished. And then, when the House came back, they passed identical language to the Senate. The bill was passed and went off to the President for his signature. The doc fix was taken care of a month late.

Dr. Mark McClellan, who was then the administrator for the Center for Medicare and Medicaid Services, told the country's doctors that he would make good and retroactively supply that difference in the bills that they had submitted; they would not have to resubmit. He tried to paper over the problem and make it as painless as possible.

But it was a big deal. It was a painful deal for the country's doctors. That is why I remember it so well, because so many were calling me in my district office and my staff here in Washington and voicing their displeasure that Congress really couldn't have gotten this right and passed the identical bill through the House and the Senate. But the fact is they didn't. And the fact is that that was a problem as far as passing a bill and getting it signed by the Senate.

Well, what are we doing today or this weekend? What are we doing? We are not even going to pass the bill. We just deem it as having passed. Because, you know, a lot of the things that are in the Senate bill are things that we have talked about a lot here in the past 14 or 15 months, and some of them we may have even voted on a time or two. So we can just deem it as having passed.

Well, no wonder, no wonder Mr. Bill is so mad. That is not what he signed up to do. He didn't want to be deemed or Slaughtered. Slaughtered refers to the chairwoman of the Rules Committee who has created the so-called Slaughter rule, which means that the rule that allows us to take up the reconciliation bill is a self-executing rule and will deem passage of the Senate product that passed on Christmas Eve.

Do you think the American people can't see through that, Mr. Speaker? Do you think there are many phone calls going into Members' offices over the past couple of days about this? I think so, because I have heard from a lot of people. They are not happy about a lot of things right now, but they are really upset about this, and I think rightly so.

We are supposed to do things by the book. That book is called the Constitution. And when we stray from that on something like this—and this is no small matter—this is going to affect one-seventh of the Nation's economy. This is going to affect the lives and livelihood of every American not just this month, not next month, not the month after that, but for the next three generations.

Think of Medicare, passed in 1965. How has that affected people's lives, for good or for ill? But this is sweeping legislation that has a long half-life and is going to affect the way of life in this country from this day forward, really long past my time on this Earth, and I suspect a long time past the life expectancy of almost everyone who is serving in this body.

So it is so important that we get this right. It is our obligation. It is the oath that we swore on this floor the early part of January of 2009 after those very famous elections, those historic elections that created the new Presidency, created a supermajority for Democrats in the House, created almost a filibuster-proof majority in the other body. A historic election.

We were signed in, we put our hands on our hearts, we put our hands on the Bible, we swore an oath to protect and defend and uphold the Constitution.

What happened to that, men and women who are here with me tonight? What happened to that oath? Did you not believe it then, or has something happened that you don't believe it now?

This is critical. I know it looks lighthearted. I know I have copied a figure from a children's musical. But this is critical. This is going to change the way of life for every American, not just now, but for far into the future.

Now, we don't even know yet the cost of this bill. There are multiple iterations of the reconciliation package that have been floated around the Congressional Budget Office. You call them up and try to get them to do anything at all and they will not because they are working on health care. Unfortunately, it has been that way now for well over a year. It is almost impossible to get any piece of legislation scored by the Congressional Budget Office, but we don't even know what this thing is going to cost.

We talk about bending the cost curve. The Commonwealth Foundation, the good folks at the Commonwealth Foundation, I attend a number of their seminars. I think they do a good job of trying to educate Members of Congress. They will talk in lofty terms about bending the cost curve. Well, we are just bending the cost curve, all right. We are just bending it in the wrong direction.

Now, this bill is supposed to cost on the order of $800 billion and change. I think it was $824 billion. But anyone will tell you that is not the real cost. In fact, when this reconciliation stuff gets scored, it is very likely that we are going to see a number in excess of $1 trillion.

You know, just a lot of this stuff people look at it and say, What is the plain truth here? You say that you are going to raise taxes by $500 million, you are going to cut expenses in Medicare by $500 billion, and you are going to cover 30 million more people. How is that not going to affect me? You say if I like what I have, I can keep it, but how in the world is it possible to do all of those things and it won't affect me?

And the President said this several times during the summer. He said: Many people look at this bill and say, What is in it for me? What do I see differently, either positively or negatively, after this bill has passed?

□ 2115

For one thing, we know what they will see is a lot of new Federal regulations. We're going to see new fees on insurance companies, new fees on medical devices, new fees on prescription drugs, new fees on insurance plans. All of those, of course, have to, by definition, drive up health care costs.

One of the things that we're not doing—and you've heard me reference the ''doc fix'' in the Deficit Reduction Act. We had a baby ''doc fix,'' if you will, for just the next month. But there is a looming 21 percent reduction in reimbursement for physicians who practice in the Medicare system, doctors

who take care of some of our sickest patients, our seniors who might have multiple medical comorbidities. We've asked them to do this, and yet we come at them every year with a formula that says we're going to pay you a little less this year than we paid you last year.

Now maybe that's okay if you're fortunate enough to practice medicine in a location where energy prices are falling by 5 percent every year, labor costs are falling by 5 percent each year, cost of capital is no concern because the banks are just giving away plenty of money at a zero percent interest rate. Maybe if you live in that area, this is not a problem.

But most of the doctors who live in the real world, the same world as you and I, know that their costs of labor are going up. Their cost of capital is going up. In a doctor's office, you don't make a great many large capital purchases, but you sometimes hire a new doctor; and in order to do that, you sometimes have to go down to your friendly banker and secure either a loan or a line of credit. So the cost of capital goes up for those physicians' offices year after year.

Energy costs go up the same as they do for every other American. Even the cost of the doctor buying the health insurance for their employees will go up. Believe it or not, the insurance companies don't come into the doctor's office and say, Doc, you know what? You've done such a good job at taking care of all the people enrolled in our insurance company that we're going to enroll your employees for free or at a very reduced rate. It doesn't happen.

In fact, what happens in doctors' offices across the country every year is the insurance underwriter comes in and says, Hey, you've had some claims activity. Your rates are likely to go up in your small business here. And the doctor says, Well, maybe that's okay because maybe my reimbursement rates are going to go up enough to match it. But then most private insurance companies actually peg their reimbursement rates in the private sector to Medicare. So if Medicare is reduced by 5 percent, 8 percent, 21 percent, as we're scheduled to do this year, guess what? Insurance reimbursement rates go down. So the poor doctor is left scratching his or her head, saying, How come it costs me more to insure my employees and my reimbursement rates are going down? How's that going to work out for me?

The cost of doing business in a medical office is no different than any other small business in America, and doctors' offices simply cannot continue to survive if we continue to impose this draconian pay formula upon them, and yet nothing in this bill fixes that problem. We had a temporary fix today. We talked in grand terms about this great and wonderful fix that the House passed last fall, but we all knew over here in the House, even those of us who voted for it, we knew that the Senate was never going to take it up and pass it. In fact, they had already rejected it. As a consequence, this provision has been left out of this big, gargantuan health care bill, this 2,700-page bill, and there is no fix for the problems that the doctors face in the Medicare reimbursement system. There is no fix in the bill.

It's a simple arithmetic problem. The simple arithmetic problem is that it costs somewhere between $280 billion and $350 billion to fix that problem. Well, clearly, if you're trying to keep the cost of your bill under a trillion dollars, and I'm not sure that they have done that, but if you're trying to do that, a $350 billion addition to the price tag is not likely to make your life any easier.

There is a cost for simply repealing the sustainable growth rate formula, as it's called. Medicare part B has an additional problem in that, by law, seniors are charged 25 percent of the actual cost of their premium. The Federal Government picks up the other 75 percent very generously. But if the cost of the Medicare part B program increases, then Medicare part B premiums, by law, have to increase, and they have to increase by a formula which, again, is 25 percent of the actual cost.

Now we hear a lot of talk about insurance companies raising the rates. They do. Can they justify it or not? There are supposed to be State insurance commissioners to oversee that process. I know we had a big hearing in my committee on Energy and Commerce a few weeks ago on the Anthem, WellPoint rate increases that occurred out in California, but I honestly don't know where the California insurance commissioner was when all of that was going on. And the people at Anthem did say they submitted their paperwork to the insurance commissioner. I don't know what happened there. I honestly don't know what the disconnect was, but there are rules in place where these types of increases are supposed to be justified.

But the fact is that part B recipients will likely get a big increase in their premiums this year because the cost of paying for the part B program goes up every year, and, just interestingly enough, that increase is likely to be somewhere in the order of 12 to 16 percent. The President is very critical of private insurance companies that will do that but, wow, he is the CEO of the biggest insurance company in the world. It's called Medicare. And he's raising his rates by 12 percent this year. In fact, over the last decade, over the last 10 years, those premiums have increased almost 150 percent. Again, it's by law. It's no one doing something that they shouldn't be doing. It is just the cost of delivering that medical care has, in fact, increased over time, more people making claims on the system. And as a consequence, those costs have gone up, and, by law, the seniors who are participants in the part B program are obligated to pay 25 percent of the cost of the program in their premium.

So when people tell you that the cost of insurance is going to increase, that's true whether you're talking about a Federal program, such as Medicare, or programs in the private sector.

One of the things that concerned a lot of us as the debate was going through the House this summer was the appearance of what was called a public option. At the time, a lot of concern by, actually, Members on both sides of the aisle—probably voiced more consistently by people on the Republican side—about what this public option was going to do to pay for insurance coverage in this country. Many people on the Democratic side said, Oh, it'll be competition for the insurance companies so it'll bring their prices down.

Well, here's part of the problem. One of the reasons that the insurance companies are raising their prices is because there is a cross-subsidization, that there is a shifting of cost from the government sector onto the private sector. Medicare reimburses at a rate that's far lower than most of the private insurers for both doctors and hospitals. In order for those doctors and hospitals to keep their doors open, that means they need to charge a little bit more to those patients who come in who have actual insurance coverage. So that cost shifting or cross-subsidization exists because the government isn't actually carrying its share of the load today. So if we expand that part, how are we going to help keep the costs low on the private side? Because, again, it's a cross-subsidization that we're already doing in the existing public plans—Medicare, Medicaid, SCHIP, and the variety of other programs that exist. Those public programs are not filling the holes that are being dug, the overhead holes that are being dug at hospitals and doctors' offices, and those holes have to be filled with dollars from private insurance.

So right now it's about a 50–50 mix. Well, that's not fair. Fifty cents out of every health care dollar that's spent in this country today is already spent on one of those public options—Medicare, Medicaid, SCHIP, add the VA, Federal prison system. It's about fifty cents out of every dollar that is spent on health care, and it is going up. The other 50 percent is not all private insurance. Some of it is paid out of cash flow for some families; some of it is paid out of savings for some families, and some doctors and hospitals just simply have to write off some debt because it will never be paid. They certainly do contribute more than their share of charity care.

So the government, which has about 50 percent of the health care dollar right now, is not carrying its load, which drives up the cost for people with private insurance. So we're going to expand that part and expect that the cost for private insurance is somehow going to go down. You're talking about magical thinking. That's just never going to work out. There's no way it can work out.

And sometimes you step back and you look at this and you think, Wow, the people who want a single-payer, government-run system have really set the wheels in motion to accomplish just that. Let's create another public option, bleed off more dollars from those greedy folks on the private side. Their prices go up. The President, whoever the President is at that point, says, Well, I tried. We tried to keep the private sector involved, but look what they've done to you. There's nothing we can do about it. We will just have to take over everything. At that point, you have a completely nationalized health care system in the United States of America.

A lot of people look at that and say, No, that's not what we want. You said, if you like what you have, you can keep it. That's what we want.

Sixty-five percent of Americans have insurance either through their employer or in the individual market, and they like what they've got. They're concerned about cost, to be sure. They want costs to be held down, but they like what they have and they want to keep it. So it does concern them when they look out over the horizon and say, What might have happened with this public option?

Now, the Senate bill, at least in theory, does not have the public option written into the bill. It does. It's kind of hidden. You kind of have to look for it a little bit. The Senate bill sets up insurance exchanges across the country in order to ensure that everyone has access to at least two products in an insurance exchange. The Senate has said that the Office of Personnel Management, OPM, will ensure that there is at least one for-profit and one not-for-profit insurance company in each of those exchanges. Well, what happens if no one shows up on the day they hold the auction to sell the insurance? Office of Personnel Management will find a for-profit company and a not-for-profit company, and if they can't find one, somehow they will make one.

Now, the Office of Personnel Management right now is a relatively small Federal agency. It administers Federal benefits. It administers things like the Federal Employees Health Benefits Plan. It does a good job with that, arguably, but this is a vast expansion of their mission, a vast expansion of scope to then put them in charge of these various exchanges that are in place all around the country. The Office of Personnel Management could become the de facto public option, and in fact, as it was looking like this bill was getting very close to being enacted in the early part of January before that famous election in Massachusetts, the Office of Personnel Management was indeed gearing up to take on that responsibility.

So whether you get the House bill or the Senate bill, there's still a possibility that you're going to see a public option. It may not be the so-called robust public option that you heard talked about here on the floor of the House ad infinitum last summer, but it will be a public option nevertheless, and it remains to be seen what happens to that over time. It may always stay a small part of what is available to the insurance market or it may grow significant.

What has been mystifying to me about that process, and you heard the President say earlier or last year in the fall, he cited there's a part of Alabama that you go to and you have only got one choice of an insurance company; and if you've only got one choice of an insurance company, there's not a lot of competition, so let us put a federally administered program on the ground to compete with that one insurance company.

□ 2130

But there's well over 1,000—in fact, over 1,300 insurance companies—in business right in the United States of America. What if we changed the regulations such that more companies could, in fact, sell in that market in Alabama? It looks to me like a market that companies might be interested in because, after all, there's not much competition there. That's the way to get robust competition in the market, and that is the way to get the types of cost controls that we would all like to see that could be delivered more efficiently by a competitive marketplace than it can be by government regulation and price-fixing.

We know what happens when you fix prices. Those of us my age who are old enough to remember gasoline purchases in the 1970s, when you put price controls on gasoline, you end up with gasoline shortages. You remove the price controls, and miraculously there's enough gasoline for everyone to buy. And as more gasoline becomes available, then the price comes down. It was a wonderful study in just how markets were supposed to work. You put the price controls on, it becomes very scarce and very expensive. And I can remember as a young resident at Parkland Hospital waiting for hours in line at a gas station because I did not want my gas tank to be empty and risk running out of gasoline on the way to the hospital in the middle of the night. It's something I couldn't afford to let happen to me. So I missed a lot of family time sitting in those gasoline lines. Fortunately, that didn't last long because the folly of that decision was recognized, the price controls were removed, and the price went up temporarily, and then it came back down as the supply of gasoline increased.

We don't know where we're going on the cost of this bill that's before us. The one charge that the American people gave us was, We want you to do something about the cost of health care. The one thing that we're not doing in this legislation is moving in a sane way towards doing anything that would get control of those costs. In fact, some of the things we're doing may, indeed, lead to a reduction of availability, and that means a reduction of access for patients to medical care.

An interesting little article that I found online on the way over here tonight was about what will happen to health insurance premiums under the bill that has been proposed. And what got this reporter's attention was a Presidential speech where he said that the cost of insurance if the bill was enacted would drop by 3,000 percent. Later on, the White House clarified and said the President meant to say the premiums would drop by $3,000, and that is money that could be returned to the worker.

The next quote in the story is, ''`There's no question premiums are still going to keep going up,' said Larry Levitt of the Kaiser Family Foundation, a research clearinghouse on the health care system. `There are pieces of reform that will hopefully keep them from going up as fast. But it would be miraculous if premiums actually went down relative to where they are today.' '' So next line in the story is, ''It could be a long wait.'' Indeed, it could.

I do urge people to pay attention. I do urge people to dig a little deeper in the story—don't necessarily accept what I am saying here tonight. But do look carefully into this story and understand what your Congress is doing because if it doesn't affect you the day after the bill passes, it will affect you at some time.

Now convincing reluctant Members to vote on this bill by doing the Slaughter rule and deeming the bill passed may be a way to trick some wavering Members into voting for the bill. But I promise you, it's not tricking anyone out there in America. You hear stories of people going to the supermarket at the checkout line, and the person who's checking their groceries will say, You are not really going to deem that bill as passed, are you? They get it. People understand it. They've been watching this. We've been working on this for 14 or 15 months. Goodness knows we're tired of it. The country is tired of it. People do understand and are watching.

Now tomorrow in The New England Journal of Medicine, it's been widely reported that they're going to have an article detailing the attitude of America's physicians towards this legislation that the House of Representatives is likely going to try to pass sometime this weekend. The numbers were somewhat startling, and I don't have the exact numbers in front of me. But if the bill were to pass, around 30 percent of practicing physicians would consider concluding their practice and finding something else to do with their time. And if a public option is included, that number gets significantly higher—45, 46 percent.

People who have been working in the trenches, who have been delivering the health care, understand how pernicious

it has been with the constant reduction in rates for Medicare, to be sure, Medicaid in some States. In most States, physician reimbursement is just an easy target. When those State budgets start getting stressed, that's one of the first places that the State legislatures will go to try to pull some of those dollars back in. They'll reduce reimbursement rates to physicians. And as a consequence, if it was difficult to keep your doors open and pay your overhead costs with the reductions that we were seeing in Medicare, it becomes an absolute certainty that those doors are not going to stay open if Medicaid rates are vastly curtailed.

One of the things we're going to do with this bill is significantly expand Medicaid. The cost to the States right now is somewhat in flux. Nebraska got a pretty good deal on the Senate floor right before Christmas that would kind of protect them against some of the dollars that the State would have to match into the Medicaid program. Now there's talk of extending that to every State and not just making Nebraska a special case but extending that to every State. I promise you, I promise you that is not going to make the cost of this legislation go down. It is going to make the cost of that legislation go up significantly.

If we don't do that, right now there is a Federal share and a State share of Medicaid expenses that are paid. It varies from State to State. In some, it's a 50–50 proposition. In some, it's much more generous from the standpoint of what the Federal Government contributes. On average, about 57 percent of the Medicaid cost is contributed by the Federal Government. The State pays 43 percent. In this bill, the language might be more generous than that, but there would still—unless the so-called Cornhusker kickback is applied to every State, then States are going to be hit with additional Medicaid expenditures.

I have received communications from senators and legislators back home in my State where that number could approach $20 billion for the 2-year budgetary cycle that we have in Texas. And although many people in Washington would consider that so small as to not even be worthy of consideration, in a State budget, it is significant, and that is why the legislators and senators have written to their Members of Congress to advise them of this that's occurring. That means money that's not going to be available to fund transportation projects in the State. That means money that's not going to be available to pay for educational activities in the State. These will be real dollars that are taken out of circulation in the State to pay for the expansion of Medicaid that the Federal Government is going to require.

The whole question of making everyone buy health insurance, the question of an individual mandate that is contained within the Senate policy, is something that this country has not done before. That is a new phenomenon. Now I know you hear people say, Well, look, look Massachusetts has a mandate, and it's working okay up there. Well, maybe. Maybe not. I think the costs went up a little bit because the insurance companies are now under no—there's no reason for them to try to hold costs down to attract customers because, hey, you've got to buy it. It's the law. But still, if a State wants to pass an individual mandate or an employer mandate, for that matter, within their State to cover health care costs, that's their business. They can do that under the 10th Amendment, that those powers not taken by the Federal Government are reserved to the States. That's one of those powers that are reserved to the States. So if a State wishes to do that, and the people who elect the Governor and State legislators and State senators in those States are saying, Well, that's okay with us, then good on 'em. That's what they should do.

But what's working in Massachusetts likely wouldn't work in Texas. It's a different demographic, different problems. So we can't apply a one-size-fits-all solution across the country, and the Founding Fathers recognized that. You will hear people say, Well, look, it's a mandate that you've got to have car insurance if you drive your car. But you are driving your car voluntarily on a public road, and that is a State mandate for the purchase of that insurance. Not every State has them. I think there are two States that don't have an insurance mandate. Texas didn't until a few years ago. I don't know if it's actually increased the number of people who carry insurance because you are forever hearing about some poor soul that was hit by someone else who carried no insurance. But that's a State issue. And the States make that requirement.

Again, those State governments have to be responsive to their citizens in the State. If the citizens get too upset by the liberties that are being taken from them by a State government, they are free to react against that. And that's what a democratic process is all about. That's what elections are all about. But never in the history of this country has there been required the purchase of a product just as a condition for living in the United States.

Now we do have to pay income tax, it's true. You don't have to earn any money. And if you don't, then you don't have to pay taxes. But in order to ensure that this program is administered effectively, we go to the meanest, biggest Federal agency of all, that very same Internal Revenue Service, and say that they're going to collect—they're going to enforce this individual mandate that you buy health insurance.

Just a thought on that in some of the moments that are remaining to us this evening. Does putting an individual mandate on people increase the number of people who carry, say, health insurance? Putting an individual mandate on for the requirement that everyone have health insurance, does that increase the number of people who have health insurance? Right now in the country with a robust employer-sponsored insurance program, people who are employed in the individual market, small businesses who provide insurance in the individual market for their employees, the compliance rate or the insured rate is about 85 percent. We hear the figure of the number of people uninsured in this country, and it works out to be about 15 percent.

In the Federal tax system, does everyone file and pay taxes who should? The answer is no, they don't. By the IRS' own estimates, by their own estimates, 15 percent of the population decides not to file or not to pay their income taxes. Now that's a pretty stiff mandate that the IRS puts on us. Most people don't know exactly what the penalty is, but they're pretty darn sure that they don't want to find out firsthand because they do know it to be severe. So with this very severe penalty hanging over people's heads, you still have 15 out of 100 who will say, No, thanks, I'll still take my chances. How many more people are going to buy health insurance who don't already have it if we put that on as a requirement?

And then one of the other considerations is, if the fine is not as much as the insurance policy itself, then someone who believes themselves truly to be at zero risk for any medical condition says, You know what, I'll just pay the fine if it's less money, and I'll worry about insurance if I get sick. Of course under the plan that's over in the Senate now, they can do that because there will be what's called guaranteed issue. If they get sick, they can literally purchase the insurance policy from the back of the ambulance on the way to the hospital.

You know, we heard a lot during the course of this debate on health care over these past 15 months. One of the things that I will never forget is the energy and enthusiasm that I encountered this summer in doing town halls during the month of August. As you will recall, we passed the bill out of the Energy and Commerce Committee sort of at midnight Friday night, July 31. We all went home to our districts. We started seeing the stories on the evening news of vast throngs of people showing up at Representatives' town halls, both Republicans and Democrats. Whether they had come out in favor or in opposition to the bill. We hadn't voted on the bill on the House floor at that point. Because I was sitting in the committee that voted on the bill, I could tell my constituents back home that I voted no in committee, and I would vote ''no'' when it came to the floor, unless there were substantial changes. And people supported that decision overwhelmingly in the town halls that I did this summer.

But it doesn't mean that they said, We don't want you to do anything.

They had some rather specific things that they would like to see Congress do to help them with the problems that they were having with either insurance companies or with their doctors or with their hospitals. There were some things they thought that Congress could do. Now bear in mind the approval rating for Congress is somewhere south of 20 percent. We do not enjoy a significant amount of political capital. In order to do something this big, you really have to have the American people behind you, but we don't. And therein is the trouble that the Democrats are having passing this bill. Right, they've got no Republicans, but then they really didn't try. They weren't interested in having any Republicans a year ago when this process was beginning.

□ 2145

So it's no surprise that at this point, a year later, they don't have any Republican support for their proposals. Their problem is within their own conference.

Now, they've got 40 seats on us. It really shouldn't be a problem. I'm sorry, they have 40 more seats than they need to pass this bill, because in the House it's a simple majority. It really should not be a problem. All you've got to do is keep 40 people from leaving you. That shouldn't be that hard. These are people who feel the same as you. They're members of your same party. They believe the same things you do. That shouldn't be a hard lift.

Why is it so hard?

It's hard because there's not the popular support for this bill that everyone assumed would be there shortly after the 2008 election. We had an election. President Obama won the election. Health care was a big deal during the election, so it was just naturally assumed that the American people would be with the Democrats no matter what they did, with, to or from health care. As a consequence, they didn't need any Republicans. They really couldn't be bothered. We were noisy and inarticulate in meetings, and they just wanted to write the bill they wanted to write, and they'd get it passed without any Republican votes.

Now they're up against an impasse with their own side. Very difficult to pass something this large that affects this many people without at least some input from both sides. That's never been done before, to my knowledge, in this country; and that's what we're trying to do tonight. You might be able to do that if you had the popular support of the American people behind you. You could say, well I've got the people with me. I don't need Republicans. And that would be true, but they don't have the people behind them.

So the fact that the Republicans are not supporting the Democratic bill is actually of no consequence. Their difficulty is the people don't believe what they're doing. And, quite frankly, I don't see how there is a way to change that equation between now and Sunday, the day we're supposedly going to vote on this monstrosity.

I did hear from people in town halls about things they do want done. I maintain a Web site that's devoted to health care policy. It's called healthcaucus.org, @healthcaucus.org. ''Healthcaucus'' is all one word. Healthcaucus.org. Under the issues tab, you see Dr. BURGESS' prescription for health care reform. And I've listed there the nine things that people told me most consistently during the summer and fall that they wanted to see us do.

Number one thing, people sure do want some help with preexisting conditions. There are things we can do to provide some help, and it doesn't mean an individual mandate. It doesn't mean guaranteed issue. It means helping those people who need help. It does cost some money. The Congressional Budget Office scored an amendment that Ranking Member JOE BARTON had on our committee. It scored at $20 billion. NATHAN DEAL, the ranking Republican on the Health Subcommittee and I have introduced legislation that captures the spirit of that amendment. We erred on the side of being more generous. That's a $25 billion authorization for that program. The Congressional Budget Office said $20 billion over 10 years. We plussed it up by $5 billion. Let's start it and see what happens.

After all, that Senate bill comes over here and becomes law, no one gets any help tomorrow. It's 4 years before they get help. Preexisting conditions are a problem today. We heard this over and over again in the summer time. This is something people actually wanted us to work on. We could work on this in a bipartisan fashion. We never even had a hearing on how to approach the problems of preexisting conditions without a mandate. We never even had one word of testimony about that in our committee leading up to this.

Does there need to be some fairness in the Tax Code? You bet. Why does someone in the individual market who's paying for their health insurance out of pocket have to pay with after-tax dollars when someone who works for a large multi-state corporation gets their insurance paid for with pre-tax dollars by their employer? That fundamental unfairness is something that has to be fixed. I'm not sure that I know the best way to fix that, but I know we haven't even tried. We haven't even had those discussions.

We do need some medical liability reform. It's working in Texas; it could work in other places around the country. It does help keep costs down, in spite of what congressional Democrats and the White House tell you.

Portability, the ability to carry insurance with you through life, is extremely important, especially to younger workers. Think of the relationship with your insurance company if you had a longitudinal relationship with that insurance company.

There are some things that we could be doing that are not that heavy a lift and don't cost that much money. Most importantly, we can show the American people we can deliver real value and work together while we're doing it. Then we could improve those approval rates, that low esteem that the country holds us in.

DR. BURGESS' PRESCRIPTIONS FOR HEALTH CARE REFORM

1. INSURANCE REFORM

We should eliminate the bias against patients with pre-existing conditions, outlaw rescissions except in cases of fraud, and ensure states have well-designed high-risk pools.

H.R. 4019—Limiting Pre-Existing Condition Exclusions in All Health Insurance Markets (Deal)

H.R. 4020—Guaranteed Access to Health Insurance Act (Burgess)

2. TAX FAIRNESS

Providing individuals the same tax benefits no matter where they want to get their health insurance, and tax credits to help individuals purchase insurance in the individual market.

H.R. 3218—Improving Health Care for All Americans Act (Shadegg)

3. MEDICAL LIABILITY REFORM

The success of Texas' 2003 reforms: Texas has licensed over 15,000 new physicians and Texas hospitals have delivered more than $594 million in charity care.

H.R. 1468—Medical Justice Act (Burgess)

4. PORTABILITY

Allowing patients to shop for health insurance plans across state lines = more choices at lower costs. Example: Average health insurance premium for a family of four: New Jersey: $10,000, Pennsylvania: $6,000, Texas: $5,000.

H.R. 3217—Health Care Choice Act (Shadegg)

5. MEDICARE PAYMENT REFORM

The current formula Medicare uses to pay doctors—the SGR—is unstable, and a permanent fix is needed to ensure seniors continue to have access to their doctors.

H.R. 3693—Ensuring the Future Physician Workforce Act (Burgess)

6. DOCTORS TO CARE FOR AMERICA'S PATIENTS

We must ensure that we have enough doctors to care for all of America's patients—now and in the future. H.R. 914—Physician Workforce Enhancement Act (Burgess)

7. PRICE TRANSPARENCY

Health care services are the only product that we don't know the actual cost of before utilization, so let's have the prices up-front, just like in a restaurant or clothing store.

H.R. 2249—Health Care Price Transparency Promotion Act (Burgess)

8. PREVENTATIVE CARE AND WELLNESS PROGRAMS

Health care reform must include participation from America's patients, so living healthy lifestyles and making healthy decisions is very important.

9. CREATE PRODUCTS PEOPLE WANT

Mandates have no place in a free society. Instead, we should challenge insurance companies to create innovative health plans that Americans want. Example: Health Savings Account—offers flexibility and control.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to: