those services, I am able to take the floor and pay tribute to Mr. James Hadley, a businessman, a banker, community advocate, a civic and church leader, and a friend to all of those who knew him.

For most of his adult life, James Hadley spent it building financial and business enterprises in low, moderate income, and disadvantaged communities. And Jim worked with many, many programs and projects, business ventures, and financial institutions.

And while he worked with many throughout the City of Chicago, I believe that that which gave him the greatest sense of pride and accomplishment was the work that he did with the Community Bank of Lawndale, where he, Cecil Butler, Diane Glenn, Reverend Shelvin Hall, and others pioneered the development of a community-owned bank, which has changed its name and is now named the Covenant Bank, and is under the leadership of Pastor Bill Winston of the Living Word Christian Center.

James Hadley and I both grew up in Arkansas not very far from each other, I in a little town Parkdale, and he in another town, Warren. And I really didn't know him at that time. But as fate would have it, we both migrated to Chicago. And as I got to know Jim, he became a role model for me. He was seriously committed to every endeavor to which he was a part of. He was loyal to whatever he was engaged in. He was a great family man, dedicated to his family, had a comprehensive approach to life, and was just a pleasure to know, to be around, and to work with.

As a matter of fact, I commend James Hadley for a life well lived, take note of his many contributions, and thank him for helping to make the world a better place in which to live.

As a matter of fact, he served on the board of many not-for-profits, the hospital board, Mount Sinai Hospital, was an active member of the Carter Temple CME church, worked with the Boy Scouts, worked with the male initiative in his church, and was simply known as a good man to all of those who knew him.

And so, Mr. Speaker, I extend condolences to his wife Gloria, his daughter, and all of the James Hadley family, and trust that there will be others who will come along like him, who was willing to give of himself continuously for the benefit of others.

James Hadley, he lived a good life. Well done.

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from South Carolina (Mr. INGLIS) is recognized for 5 minutes.

(Mr. INGLIS addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Texas (Mr. PAUL) is recognized for 5 minutes.

(Mr. PAUL addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Oregon (Mr. DEFAZIO) is recognized for 5 minutes.

(Mr. DEFAZIO addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Florida (Ms. ROS-LEHTINEN) is recognized for 5 minutes.

(Ms. ROS-LEHTINEN addressed the House. Her remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Ohio (Ms. KAPTUR) is recognized for 5 minutes.

(Ms. KAPTUR addressed the House. Her remarks will appear hereafter in the Extensions of Remarks.)

HEALTH CARE SUMMIT

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

Mr. BURGESS. Thank you, Mr. Speaker.

Well, we have had quite a day here in Washington, D.C., in your Nation's capital. The 6½ hour health care summit that was held down at the Blair House right adjacent to the White House has mercifully concluded. And as the saying goes up in Washington, everything's been said, everyone has said it, so it was time to go home. But for those who haven't had quite enough discussion about health care today, maybe we can spend just a little while longer talking about some of the things that we heard today and some of the things that we maybe perhaps didn't hear today.

One of the things that I do want to stress, we heard several times in the past several weeks that the Republicans don't have ideas. In fact, that was one of the admonitions of the President on starting this summit was that the Republicans didn't have ideas, and he wanted to in fact show the country that the Republicans were devoid of ideas. But nothing could be further from the truth. If anything, we saw today abundant Republican ideas. Some may say there are too many Republican ideas, too many to fit in one room.

I wanted to spend a few minutes tonight talking about some of those ideas on our side. I have a Web site, Mr. Speaker, that is devoted entirely to health care policy. It is from the Congressional Health Care Caucus. The Web address is *www.healthcaucus.org*. And under the Health Caucus Web site, under the Issues tab, I think it is the second heading, is a Prescription for Health Care Reform. Anyone is free to go to that site and click on the Prescription for Health Care Reform, follow the links, and they will be taken to a one-page description of nine different bullet points on health care reform.

In fact, there is even a little segment to record comments if someone would like to leave their ideas or their thoughts on the paper. Or if someone thinks of other things that might in fact be included, we welcome those comments on the Web site.

I am just going to briefly go through this list, and then I have got some other observations that I want to make on the summit that occurred today. And we will be joined from time to time by other Members of Congress, and I want to give them an opportunity to speak. But under the Prescription for Health Care Reform, certainly everything I heard this summer was, we don't want a 1,000-page bill. People really didn't want a 2,000-page bill after we came back and revamped it after the summertime. But what did people want Congress to do on health care?

There are people who have legitimate concerns that the system is not functioning in an optimum fashion. We do have great health care here in America, but there are distributional issues. The employer-sponsored insurance system does work well for the 60 to 70 percent of the population that is therein covered, but in fact there are problems for people who are outside the employer-sponsored insurance system, and there are certainly problems that all of us face with the advancing cost and complexity of health care.

So just running down the list, insurance reform that would include limitations on insurance companies excluding people for preexisting conditions, and guaranteeing access to insurance. Now, one of the fundamental differences on the Republican and Democratic approach to this is that the Democrats want to have, and the President wants to have, a mandate. That is, you are required to buy a product, an insurance product.

It is interesting because during the campaign in 2008, President Obama, when he was a presidential candidate, actually moved away from mandates. Candidate Hillary Clinton during her candidacy was in favor of mandates. Barack Obama was less enthusiastic about mandates. He did feel that there should be a mandate for children. We don't hear much discussion about that anymore. In fact, I don't think I heard that during the 6½ hours of debate today.

□ 2030

But mandates really have no place in a free society. There's some argument as to whether or not it would even be constitutional for the Federal Government to require someone to purchase an insurance product that they might

not want. So there are legislative products out there. And this is the point I want to make. When people say, oh, we can't start all over, this would be too taxing. There are a couple of bills out there that I would encourage, Mr. Speaker, people to look at. H.R. 4019, a bill introduced by NATHAN DEAL of Georgia; H.R. 4020, a bill introduced by myself. Those two bills, taken in conjunction, would go a long way towards eliminating the problems with preexisting conditions.

Another bill to address the tax fairness or the tax inequity that exist in the health insurance market today introduced by JOHN SHADEGG, H.R. 3218, the Improving Health Care for All Americans Act, that would allow the same benefits, no matter where you get your insurance, whether it's through employer-sponsored insurance or in the individual market, the same benefits should accrue to an individual as accrue to a business.

Medical liability reform. Texas and California have taken big strides in medical liability reform. So why do I care? If Texas has fixed their problem with medical liability, why would I care about that? Well, I care because the cost of defensive medicine is significant. And since the Federal Government is the purchaser of about 50 percent of all the health care in this country, the costs of defensive medicine that drive up the price of Medicare and Medicaid, those costs need to be brought back under control, and medical liability reform is a way to do that.

Portability. Allowing patients to shop for health insurance across State lines, again, a bill introduced by Mr. SHADEGG is H.R. 3217, the Health Choice Act.

To back up for just a moment to medical liability reform, H.R. 1468, the Medical Justice Act.

We're about to bump up against an important deadline on Sunday night, and that is the expiration of the prevention of a reduction in payment to doctors who take care of Medicare patients. We go through this time and time again. It is time for Congress to fix the physician payment reform, and H.R. 3693 would do just that.

Do we need to be worried about if there are going to be doctors there to see us when we get sick in the future? I think that is a concern, and I think that is something where Congress might play a role. Doctors to care for America's patients, the Physician Work Force Enhancement Act, H.R. 914. People ought to be able to know what the cost is when they go to the doctor or the hospital.

How about a bill for ensuring price transparency? H.R. 2249, the Health Care Price Transparency Promotion Act. Prevention and wellness programs, we all agree, during the hearings this summer, the individuals that come in who worked at Safeway and talked about how health promotion and wellness was saving them money, firms like Allegiant in Omaha, Nebraska, brought in great stories about how they had involved their employees in living healthier lifestyles and reaped the benefits from lowered insurance costs.

An odd thing about the way we do things at the Federal Government, we're actually going to have to change the HIPAA laws, the privacy laws, a little bit in order to have this type of legislation be passed. But that's certainly within the purview of Congress and within the ability of Congress to do that.

But prevention and wellness programs, although I do not have the bill number attached to this, we had several amendments in committee and in the Rules Committee leading up to the passage of the Democrats' bill this fall that dealt with prevention and wellness. The legislative language is written. It is not in bill form right now because it would require a simultaneous modification of the HIPAA laws in order to allow that to happen.

And finally, I mentioned before, mandates. No place in a free society. And this is one of the fundamental differences between the President and myself. He wants to force everyone to buy an insurance policy. He said that's the only way to bring costs down. I would submit that if the insurance companies know you have to buy their product, their prices are not likely to go down. In fact, if you're required to buy their product under the penalty of law, with the IRS as the enforcer, it is very likely that the cost will go up because no one wants to run afoul of the Internal Revenue Service.

And then we make insurance companies lazy. Why bother to compete with a better product? Why try to create a program that people actually want? You've got to buy it anyway. The government's going to force you, you're going to buy my product, I don't even have to make it something that you want, and I can charge you more for it. Mandates make insurance companies lazy.

We actually have a model for what works in this endeavor, and that is when the Medicare part D program rolled out, then Administrator of the Center for Medicare and Medicaid Services, Dr. Mark McClellan, required, out of six classes of pharmaceuticals, there were six protected classes of drugs. Within each class, an insurance company had to offer two choices, and using that as the parameter, the companies did produce the plans that people wanted. The product, part D, has been very popular. Ninety-two percent of seniors now have credible drug coverage under Medicare because of the flexibility and the desirability of these programs. The cost came in way under budget, and 92 to 94 percent of seniors are satisfied or very satisfied with their prescription drug coverage, so a program that indeed worked. And the whole emphasis was to make this look more like insurance and less like an entitlement.

Creating products people want is a better way to go about getting meaningful change in the insurance market than giving the insurance companies a license to steal, which is what a mandate would be, in my opinion.

I have some other observations on the day's activities, but I wanted to yield such time as he may consume to my good friend from Pennsylvania, Mr. G.T. THOMPSON, who in a former life was a health care administrator. I know it's odd that a doctor and a health care administrator would get along, but the two of us do get along very well.

G.T., I will yield to you such time as you may consume.

Mr. THOMPSON of Pennsylvania. Thank you, Dr. BURGESS. I really appreciate what my good friend from Texas is doing in terms of his leadership with the Congressional Health Care Caucus. It's refreshing in this Chamber to deal with folks who have the facts and have the experience to make informed decisions when it comes to such important topics like health care. I think of all the issues that come before this Chamber, there are probably few things as intimate to our individual lives as health care. And to observe this process over this past 14 months, where bills are written as I look at these bills, 1,000, 2,000, 3,000 pages, which has been special agendas for, you know, just misled government-run health care, it's apparent to me that those who are writing those bills have very little experience, if any experience in health care. And so it's been a real privilege to be able to work with you and under your leadership to really look at the solutions that we need to have.

Now, as I travel around, and I did, my background was 28 years nonprofit community health care where I, in the hospitals, the health systems I come out of, we work very hard to be partners with our physicians.

And so what am I hearing? As I travel in my congressional district and I listen to folks throughout the country, I haven't met anyone that says, just don't do anything. The commitment is that, as I talk with folks, that they feel that they like the health system we have. Can we improve it? I think there's an acknowledgment that we can do that. And I've certainly spent my professional career serving my patients first as a therapist and a rehabilitation services manager and ultimately as a nursing home administrator. And looking at four dimensions of health care that we should always continue to strive to improve. Number one is cutting cost. And that's just not cost for a certain segment or a certain group, but cutting cost of health care for all Americans, which we're committed to that with the solutions you've talked about. It's about improving access, increasing access and improving quality and strengthening that decisionmaking relationship between

the patient and the physician, not allowing government or a bureaucrat to be that wedge in between.

As I talk with people about health care, and I've been doing that since I came to Congress, that's what they're asking for. The people I talk to, they like the solutions. They like the bills that we've introduced as far back as last July that dealt with medical malpractice reform, tort reform that drives the cost of the health care up for all Americans through both the premiums for medical liability insurance that has to get absorbed into the cost of doing business, those premium costs get passed along as a part of the fees, and not just the premium fees, but then there's the cost of defensive medicine that occurs, with extra tests that are ordered, not so much maybe to serve our needs and whatever particular illness or disability we come to the doctor for, but to provide a record that shows that the physician has exhausted every possibility.

It's things like many of the solutions you talked about, allowing to purchase across State lines. It fascinates me that you can go to the Internet and you can go on a Web site, some of them got little critters like lizards on them, and you can purchase car insurance and get the best value, the best product for the best cost. You make that decision as an individual. And yet we are barred from purchasing health insurance across State lines.

In States like Pennsylvania, especially rural Pennsylvania where I'm from, if you have choices, you have just a couple of choices. Maybe if you're lucky, you have three choices to pick from. And a lot of people say, well, I want the insurance that you have as a Member of Congress. Well, I'm quick to tell people, I worked nonprofit community health care for hospitals for 30 years. I'm paying more today as a Member of Congress than what I ever paid for health care. But what I would like every American to have, certainly every constituent in my district that I have today are just lots of choices. And we do that by allowing purchasing across State lines, more competition. That's a good thing. Competition brings the cost down and raises quality. I don't care what you're purchasing, that's a principle that lasts.

Certainly, a formation of association health plans, and preexisting conditions, as you've talked about. I mean, those are all just a few of the different parts of the proposals that Republican Members have introduced and are pending bills that are right here that the Speaker could elevate to the floor at any moment so that we could actually take an up-or-down vote on these. I think the American people would vote yes. I see a thumbs-up from the American people as we talk about these different proposals.

Preexisting conditions, that's a tough issue, but we're addressing that within the proposals we have. Just because you're born with a preexisting condition or you happen to have the misfortune to develop a disease such as breast cancer or prostate cancer in the course of your life doesn't mean that you shouldn't be able to afford to be able to purchase affordable health insurance. We address that in the solutions that we put forward. I'm so very proud of all of the representatives from the Republican Caucus who were at the Blair House today. I thought they did an outstanding job of representing the American people and ideas that the American people are looking for.

You mentioned about workforce issues, and to me that was something that I came to Congress just looking as a crisis. Starting with rural America and underserved urban areas first, the baby boomer generation, my generation, we're beginning to retire in tremendous numbers. And in those areas where our physicians, our nurses, therapists, technicians are retiring, this payment system will get changed if we don't proactively address those workforce issues. If you don't have a physician in your community to provide services, you do not have access to quality care. And so because we've been misled with these 1,000, 2,000, 3,000 pages, all the attention's been drained in the wrong direction, we're missing the bigger issues that, frankly, we've been talking about. We've got bills that address some of the workforce issues, and so it's time to get beyond the misinformation and the misdirection that my Democratic colleagues have been putting together in these 1,000, 2,000-page bills, and get to the business of really addressing the real health care issues.

Mr. BURGESS. I thank the gentleman for his work on these issues. I thank him for always being willing to be involved in these. These are tough problems. These are complex problems.

You know, the activity today, I referred to it earlier today on a radio show as the Blair House project, not to be confused with the Blair Witch project. There were times when it did seem to be that there probably were some spells being cast.

The other thing that really had to strike you in watching the discussion today is that there are fundamental differences as to the role in government, fundamental differences as to the involvement in government.

□ 2045

You know you can't help but be struck. Here we've worked on this concept now for 13 months. The President was sworn in the 20th of January of last year. Here we are at the end of February, and still no bill is across the finish line. Boy, I thought it would have happened much, much more quickly. In fact, had the energy that was put into the stimulus bill been put into a health care bill, in all likelihood they could have passed whatever they wanted in February of last year. Instead, they chose to work on the stimulus first and then cap-and-trade and then gradually, gradually, gradually, their capital bled away to where they did not have the votes necessary on their side to pass one of these bills.

And this is the fundamental problem that is happening with the President's plans and the Democrats' bills in the House and the Senate right now is they do not enjoy popular support. Pick your number: 56, 58, 75 percent of the American people who do not support this 2,000-page monstrosity that literally required bribes to bring Senators down to the well to pass this bill Christmas Eve. The American people saw that and they rejected it.

They might trust us—I am not sure that they will—but they might trust us to work on some of these individual concepts one at a time. But at the very end of the summit today, the President decried incrementalism and said we have to be bold and we have to move forward with a large bill.

Why? Why do we have to do that? The programs to deal with preexisting conditions would involve risk pools to be sure. Reinsurance options for States, yes, it's going to require some Federal subsidy. The Congressional Budget Office has estimated $25 billion over 10 years. They may be a little bit light on that, but still we're nowhere near a number like a trillion dollars, which is scaring Americans to death.

We could provide some help in that market. The States could provide some help in that market. We could ask our partners in the insurance industry to voluntarily or by law cap their premiums at some level so that the person who was in this market did not find the costs so daunting that they simply gave up and did not get insurance.

Now, all of these great programs that the President and the Speaker talk about that they're going to give to the American people at no charge, none of these programs start for at least 4 years.

Now look, here we are 13 months into a new administration and the administrator at the Center for Medicare and Medicaid Services is not there. He hasn't even been appointed, much less confirmed by the Senate. That is the individual who is going to be responsible for taking this 2,700 pages of legislation that we give them and turning the legislation into rules and the Federal rulemaking process. That is going to be an enormously difficult task. It is going to take 4 years to work through all of that and impugn all of the legislative intent and make those Federal rules and leave the rulemaking period open long enough so that people can comment on it. That is an enormous task. It's not going to happen overnight.

So the people that come to us and say, My premium's going up too much, I want you to take it over, they're not getting anything for at least 4 years.

Now, in the meantime, what if we took an approach—and, in fact, it was an approach that was talked about by

Senator MCCAIN in the fall campaign of 2008. What if we took the approach of we're going to take existing risk pools of the States—34 States have already created. We're going to emulate the best practices of the best States. We're going to allow for some reinsurance options if companies are willing to take on higher-risk individuals so that no individual insurance company is tasked with too much in the way of financial loss, and we're going to cover this group of individuals.

I heard it over and over and over and over again this summer at town halls, Stop what you're doing. We don't want you to destroy the system that is working well for 65 or 75 percent of the country. We want you to concentrate on those individuals who, through no fault of their own, have suffered a tough medical diagnosis, have lost their job and employer-sponsored insurance, couldn't keep up with the COBRA payments and now find themselves having fallen into that dreaded category of uninsured with a preexisting condition.

While we're at it, we might look at the COBRA system. COBRA was placed as a protection to help people who had employer-sponsored insurance but they lose their job. So employer-sponsored insurance means the employer generally pays about two-thirds of the premium; the employee pays about one-third of the premium. When you lose your job, you can't continue that insurance. But in all likelihood, your employer is not going to pay their two-thirds any longer because you're no longer their employee. But for 18 months, you can pick up the whole premium and pay that with a small administrative charge—I think it's 102 percent of the premium—and you can continue your insurance for 18 months and not fall into the category of uninsured. And if you have a preexisting condition, you continue to be covered at that cost.

But that's a tall order for someone who just lost their job to continue to carry that degree of premium. What if we allowed people—instead of you had to keep that same insurance your employer provided you, what if we allowed them into a lower-cost, high-deductible plan for those 18 months and still preserved their insurability during that time, so that when they found employment, they would not fall into that same category again. Or they might even decide to continue that high-deductible policy with a lower premium and continue to have the protection of health insurance without falling into a preexisting category.

But we never really worked on those issues. We just decided we were going to do this big bill, and it was going to have mandates, and it was going to have a public option, and this is the way it was going to be. But to tell you the truth, for 4 years there is no help. There is taxes. For 4 years there is the immediate Medicare cuts, but the benefits don't start until year 4 or 5 or possibly even 6. We don't even know how long it's going to take to set up those programs. And again, we don't even have the administrator at the Center for Medicare and Medicaid Services. The President needs to nominate one. The Senate will then have to confirm them. We may still be months away from filling that very important bureaucratic job over at the Department of Health and Human Services.

I'll yield back to my friend from Pennsylvania

Mr. THOMPSON of Pennsylvania. Some of the observations of just watching the summit, as I guess it was called—I have a question for you. I will come back to you for that.

Some observations of the proceedings that I watched today when I had an opportunity to tune in in my office—I wasn't on the invitation list to be there. It was pretty limited invitations. But I heard—and I don't know which leader it was, whether it was the President or the Speaker or whom, made comments there were absolutely no Medicare cuts that are involved in this. And yet the fact is the Congressional Budget Office Director, Doug Elmendorf, back on December 19, just a month ago or 2 months ago, noted that there were Medicare cuts, and those Medicare cuts built into this impact all areas of health care from hospitals to skilled nursing to home health to hospice. Hospice, which is a wonderful service for people who are in the final stage of dying, where they have the support of compassionate health care professionals surrounded by family to be able to die with dignity, and yet that is an area, one of many areas of Medicare cuts that are slated for under these proposals.

In my responsibilities across many different settings of health care, I have to say that there is a lot of reasons why commercial health insurance is expensive. Tort reform I would put right on top of the list.

But maybe even higher on the list, I would say, is the Federal Government. The Federal Government pays—underfunds and has systematically underfunded the costs of health care—the physician, the hospital for Medicare payment. For every dollar of cost of providing care, the Federal Government pays 80 to 90 cents. For medical assistance, it's maybe, if you're lucky, 40 to 60 cents. It depends on the State. The commercial health insurance pays, on the average across the Nation, 135 percent of costs. And the primary reason for that is the hospitals' physicians have to negotiate at that rate. If they don't, they can't make up for what the government does not pay.

So what are some of the other costs that I heard today that really intrigued me?

I heard the Democratic leadership claim that it was going to bend the cost curve, meaning it's going to bring the cost down for everyone. Yet, what we saw was the administration's actuarial—the professionals that work for the White House, that look at those numbers and do those cost projections—have found the Senate bill, in fact, will not decrease health care costs. The Center for Medicare and Medicaid Services, who you just talked about, the Medicare professionals, their finding was that those were going to increase expenditures by $222 billion, with a ''b,'' billion; not hold costs, not cut costs, but will expand the costs of health care.

And the President today was very up front in his comments where he said that, yes, this proposal will increase premiums for the average American and American family by 10 to 13 percent. Well, I thought the number one thing we were looking at here is decreasing the cost of health care, making it more affordable. How do you truly get access to greater health care? Well, you bring the costs down so people can afford it.

So I was curious to get my good friend's opinion. This morning when I woke up and I knew this was going to occur, it struck me as I was walking to the Capitol, was this going to be a health care summit today or a health care plummet? And to me, the indicator was whether the President showed up with either a white board, a large white board that was blank that we could start over and do what the American people want, and that would be what today's events would be—it really would be problem solving, because that is what Americans are looking for, problem solvers—or would he show up with a rather large hammer and really try to hammer through, push through Big Government, bad ideas that the American people, in a large majority, have rejected.

So I yield back to my good friend just to get your impressions of do you think it was a health care summit today or a health care plummet.

Mr. BURGESS. I was criticized on a news show earlier today referring to this exercise as a 6-hour photo op. Probably I would fall into the category as a ''plummet.''

Isn't it interesting that, yes, premiums for the average family may increase for 10 to 12 percent, but that's okay. Instead of an apple, you get an orange, so you're coming out better in the deal.

Now, yesterday, in our Committee on Oversight and Investigations, we hauled in Anthem Insurance Company in California. And Anthem, to their great discredit, chose right now as a time to increase their premiums, and they have become the whipping boy and the poster child. And I will concede, I think they raised their premiums too fast. They were tone deaf. Their highest premium increase was 39 percent. Their average was 25 percent. Twenty-five percent. Okay, that seems high, but the President's already said 12 percent. Yeah, that's okay because you get an orange instead of an apple, so after all, you're good in that transaction.

So I guess if Anthem wanted to raise their rates, they probably should have stayed at that 12 percent rate. They would have been right in line with the President of the United States. They could have raised their rates and all been happy about the transaction. Instead, they overshot. They hit an average rate of 25 percent and, as a consequence, found themselves sworn in under oath in our committee having to absorb the ordeal that we put people through when they come before our committee.

Mr. THOMPSON of Pennsylvania. I have to wonder with that because I see premiums like announcements, and they are going up. And this is why we're committed to doing the right type of smart government solutions to bring the costs of health care down, the premiums down. Giving a license to 12 to 13 percent additional increases, that's unacceptable to me for the American people.

I have to wonder how much of what's going on in Washington and these health insurance companies as America is watching the debate here, that—you know, giving this approach that the Democratic leadership, my good friends and colleagues on the other side of the aisle are taking, how much is that driving up premiums right now because they don't know what's coming. They don't know the premiums. There is a lot of uncertainty.

I mean we, not too long ago, passed a credit card bill under similar circumstances. It was going to provide all kinds of limitations and impose new conditions on really what has been kind of a free market type of process, and what I have seen, actually, as a result one of the unintended consequences, is some of those interest rates—before the new regulations kicked in, some of those interest rates went way up as an unintended consequence of government overreaching, government-run approach.

□ 2100

I have to wonder if what we are seeing with some of these more recent—like the situation you just talked about, may be an unintended consequence of just the wrong-minded direction that our Democratic colleagues are taking this health care debate in, as a reaction by the health insurance industry.

Mr. BURGESS. It's interesting, perhaps the one thing that would provide the right impetus in the competition to hold down those costs we are not going to do, and that's the ability to buy across State lines.

In the individual market, buying a policy for a family of four in New Jersey is $10,000 a year. Your State of Pennsylvania, $6,000 a year, my State of Texas, $5,000 a year. As long as people know what they are purchasing, I don't see why it is reasonable to restrict someone from having a policy that may be more affordable.

My insurance premiums have decreased by about 50 percent over the last 2 years. Not because I am a Member of Congress and I get a special deal, but I said, you know what, I can no longer afford this high option PPO insurance that is available to us in Congress, so I have elected to go into what's called a high deductible health plan with a health savings account. I actually had one several years ago when I was in private practice. I liked it.

I liked the fact that I was the one who got to choose which doctors and facilities I got to use. I didn't have to call 1–800–California to get an X-ray preapproved. I wrote the check and I controlled the money, and I made the decision about who I saw and when. So I have gone back to that type of policy, and I will tell you I am very satisfied.

We have improved from the old medical savings account in 1986 to the Health Savings Account improvements that started in 2003 and continue to this day. Preventive care is now included as part of the benefit in a high deductible health plan because the insurance company has an interest in making sure if you have a problem that it is diagnosed early, while it is less expensive to treat, and I think ultimately that's a good thing.

I have chosen a plan that does not have prescription drug coverage because after we passed the prescription drug benefit in Medicare in 2003, one of the unintended consequences was we changed the market so that now many generic medicines are available at Wal-Mart for $4 a month. I try to find those bargains for those medicines if I should need one. I try to find those bargains at Wal-Mart or go to an over-the-counter variety, which is much cheaper than the name brand that is bought at the pharmacy, and you can actually achieve significant savings.

I am motivated to do that because it's my money that I am spending for those compounds. Yes, I could have paid more for PPO insurance and then, yes, I could have had a nice mail order, even gone down to my pharmacy and gotten brand names, but I have found that, hey Prevacid is over the counter now. It costs a fraction of what it used to cost a few years ago. Even before that, Prilosec was a similar medicine, not quite the same thing, but that was available in a generic form over the counter at that time at a fraction of the cost of the 30-pill bottle of Prevacid that I was taking before.

So it makes the consumer more informed and motivated. Here is how you hold down health care costs: Let me be the decisionmaker about that. Don't tell me from a comparative effectiveness board that, hey, this medicine is just as good as this medicine, and so this is all you get because this is what we are buying for you this month.

Let me have some of that money back to spend myself, the premium that I pay every month, a portion of that goes into the medical savings account. Every year that it accrues and grows larger it's tax deferred until—if I don't spend it on health expenses I would obviously have to pay taxes on it when I took it out. As long as I spend it for legitimate medical purposes, hey, that's pretax dollars. That's probably the best deal you could do in the individual market. So these are changes that we actually ought to encourage.

I was stunned today to hear the Democrats admit, you know, we agree on a lot of this stuff that we have got here on these sheets, but, well, we don't do the health savings account thing. My goodness, that is the one way to really start to bring—you talk about bending the cost curve, that's one way. Get a motivated patient, educate them about some of the options that they have, and, oftentimes, not oftentimes, almost always they will make the right decision. I cannot tell you how many times in my medical practice if I recommend a test, a CT or MRI scan, a CAT scan or an MRI scan, and the next question from the patient back to me was not, Doctor, is it really necessary, or, Doctor, is this safe to do this, the next question was, well, does insurance cover it? If it did, there were no more questions. Go ahead and have the test.

I, on the other hand, with the type of policy that I have, yes, I may have hurt my knee or shoulder bad enough to go get a CAT scan, or I may make the decision that, Doctor, with a little ice and tincture of time would this not perhaps resolve on its own? Yes, it could, and if it doesn't get better in a week we could still do the CAT scan and we won't have delayed beyond the therapeutic interval, so it is okay to do that.

I am happy to take that advice and not have the test. If I don't feel better in a week or 10 days or whatever the prescribed time limit is, fine. Go get the test, and I will still be able to write the check and have that done. Here is how you bend the cost curve down. You get the patient involved, put the power back in the hands of the patient. Let the patient and the doctor make those decisions.

Don't make them buy the insurance at 1–800–California, but don't make them buy across the street at Health and Human Services. Let the patient and the doctor make those decisions. Every doctor has had the unpleasant experience of having called a preapproval number and have their patient denied a test or a procedure or a surgery, and then you have got to go to bat for them and prove all of these things. It is an enormous nuisance, and I hated it every time it happened.

On the other hand, in the Medicare and Medicaid system, they go ahead and cover that, but maybe 3 or months from now, maybe a year from now, they call you back and say, you know, we don't think that hospitalization was actually necessary, and we are going to deduct what we pay to you from the next round of payments that we give you for your next round of Medicare and Medicaid patients.

That is beyond frustrating because at that point you may not have at your immediate disposal the documentation that you at least would have had with a preapproval process. Neither is a good occurrence in a doctor's office. We need to come to some sort of consensus. But, as much as I hated the preapproval process, I see now, dealing with these large, large Medicare and Medicaid outlays, why it is necessary sometimes to assess medical necessity and why it is necessary sometimes to seek that preapproval, perhaps in our Medicare system.

If we really were serious about bending the cost curve, instead of just cutting doctors' payments—and that's what we do, we say, well, we will pay 20 percent less this year than we did last year—what's the practical effect of that? Well, the doctors' costs are fixed. He is not paying less for electricity to light his office this year than he was last year. His office help certainly didn't come in this year and say, hey, you know what, we can all take a pay cut because we love working for you.

That doesn't happen. His costs go up every year. The reimbursement rate goes down because Congress says, hey, we are spending too much money. What is the practical effect of that? The practical effect of that is, you know, I was able to pay my bills and take something home last year seeing 18 patients a day. But you know what, this year I have got to see 25 patients a day. And maybe if I can squeeze an extra procedure or two out, maybe I should do that because I have got to make up that difference somewhere.

So we have gone about this the wrong way. We are ratcheting down costs at the provider, and yet the doctor, he or she is the one who picks up the pen and writes the prescription, orders the hospitalization. The most expensive item in the doctor's office is their ballpoint pen most of the times because the doctor is the one making the decisions about that medical care.

Wouldn't a different way to look at this might be to say, Doctor, we are not going to cut your pay this year. We are, in fact, going to pay you a little bit more. We hope you will see fewer patients and maybe take a little bit more care and a little bit more preventive medicine and education with those patients along the way. It would be a phenomenal thing to look at but we never tried. We just cut the doctor's pay and said, whew, we got through it this year, the doctors are all mad but maybe they won't remember come November, and we will cut them again at the end of the year.

We are probably going to bump up against the clock. I do want to make this point from what we talked about the cost of insurance at the hearing we had yesterday.

It is important to understand, I think, that Speaker PELOSI, HARRY REID, President Obama, their health proposals would not make health insurance significantly cheaper for America's families. Under the bill passed by the House in November, H.R. 3962, a family of three making just under $55,000 a year and buying now a plan in this new exchange that's going to be set up and created by the bill, they would have to personally contribute after a tax credit about $5,500 a year in premiums. Additionally, this family would also pay $4,000 of out-of-pocket costs exclusive of the premium—copays and drugs that weren't covered—so this family would pay about $9,500 for a family of three that earns $55,000 a year in the Health Insurance Exchange.

I think it's important for people to understand that when we pass these bills and it's all settled and done, it doesn't mean free insurance. It doesn't mean free health care. It means, yes, you have got a government option here for buying insurance, but it's still going to cost something. It is still going to be an expensive item in that family's budget every year, and we are misleading people by telling them that, hey, we need to pass this bill because too many people don't have health care.

True enough, the person who has no income and no job will now have access to Medicaid, which they may not have had before, but the average person earning a reasonable salary is still going to find that the cost, the expense they paid for health insurance, is going to be significant. Here is the rub: If we pass this bill, this won't be an optional expense in their budget. They will be required to buy this, and the enforcer is going to be the Internal Revenue Service.

Now, Mr. THOMPSON, you brought up the online purchase of insurance for automobiles that has the cute little lizards and cave men on the logos. People will sometimes bring up to me, well, why, why not have a mandate. After all, there is a mandate to buy car insurance in your State, so, what would be the matter with having a health insurance mandate?

Here is the key. In my State, this is a State decision that in the State of Texas, people have to carry insurance if they are going to exercise the privilege of driving on the roads of the State of Texas. Health insurance is a different animal, and for the Federal Government to require, not a State government, but the Federal Government to require the purchase of health insurance is taking us in the direction of loss of liberty that none of us have really ever encountered before. It is a new concept.

So if a State wishes to exercise a mandate, which they have done in Massachusetts, then that's a State decision and that decision will either be supported or rejected by the voters in that State, but for the Federal Government to create for the first time a mandate, a requirement that a person purchase a product just for the privilege of living in this country, again, we are going down the road of loss of freedom that, again, I don't think people really want to go there.

Now, you will also hear, and it's so strange to hear the comparison of we have got to have a mandate as you do with automobile insurance, and you know what, you can buy that consumable insurance online. What if, instead of, if we had our thinking right, we would let the health insurance be available online, let the plan finders be available online and, if people think it's necessary to have a mandate, let that be a State decision. Let that be a State decision if the exchange is—right now you have, and I don't know the precise number, 30 or 34 States whose attorney generals are drawing up legislation to prevent their States from or prevent their citizens and their States from being required to follow an illegal Federal mandate.

Mr. THOMPSON of Pennsylvania. Pennsylvania being one of those, absolutely.

Mr. BURGESS. It just shows you the type of tension that we are going to set up between the State and Federal Governments if we were to pick up and pass either the House or the Senate bill and send it down to the President for his signature.

Mr. THOMPSON of Pennsylvania. Well, you have touched on so many very important issues during that time, during the course of this hour. I certainly want to come back to—you know, when I started in health care, I mean, the patients were not a part of the treatment team, they were, you know, everyone kind of focused their energies on the patient, the individual, the consumer, but they weren't included in health care decisions. So much has changed in at least three decades.

Today, I don't know of any health care professionals that don't consider the patient themselves a very important part of the treatment team, and it's so important that individuals take that, exercise that self-responsibility to be informed and to make decisions and to take control of their health care, extremely important.

You also talked about, you were talking about the stress on physicians, and it's significant. In Pennsylvania, the average age of physicians in Pennsylvania is 50. Many that I talk with, they look at the challenges of practicing medicine today. In Pennsylvania, we have terrible medical malpractice costs. We export our physicians. We train a lot of them, but we export them to States like Texas. You know, we don't keep them. And many of the physicians I talk with that are 50 and older, they look at what they have accumulated in their lives, and they look at how much they are spending each year, whether it's medical malpractice, these additional costs or regulations that are coming, the extra costs they had to put into practice to comply with Federal mandates like the HIPAA law from the 1990s.

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And they are saying, you know what? Why don't I retire now while I

can at least retain a little bit of what I've earned so I can have some type of future enjoyable retirement? That would contribute so much to our access issue in States like Pennsylvania where citizens are not going to have access to quality care. I see that as a significant unintended consequence as a part of what my friends across the aisle are proposing and pushing at us.

REPORT ON RESOLUTION PROVIDING FOR FURTHER CONSIDERATION OF H.R. 2701, INTELLIGENCE AUTHORIZATION ACT FOR FISCAL YEAR 2010

Mr. ARCURI, from the Committee on Rules, submitted a privileged report (Rept. No. 111–421) on the resolution (H. Res. 1113) providing for further consideration of the bill (H.R. 2701) to authorize appropriations for fiscal year 2010 for intelligence and intelligence-related activities of the United States Government, the Community Management Account, and the Central Intelligence Agency Retirement and Disability System, and for other purposes, which was referred to the House Calendar and ordered to be printed.

HEALTH CARE SUMMIT—Continued

The SPEAKER pro tempore. The gentleman from Texas may resume.

Mr. BURGESS. Reclaiming my time, let me just run through a little bit.

We heard right at the end of the 6-hour discussion down at Blair House today, the President and I believe the Speaker of the House said that the time for incrementalism has passed. I felt like I had stepped back in time. I heard that very same argument in 1993 and 1994 when the then-Clinton health care plan was before the House of Representatives.

I never will forget the day that Mike Synar, a Representative from Oklahoma, a Member of this House of Representatives, was down in Dallas. He was talking to a group of us who were American Medical Association members, and he was going to talk to us about this bill. Many people had questions at the time—believe it or not, I was so shy I was scared to say anything—but toward the end, someone asked Mr. Synar, wouldn't it be better to tackle some of these problems on an individual basis and not try to do all of this all at once because it did appear to be frightening people. And Mr. Synar made a very emphatic statement that the time for incrementalism is over, we must have this bill and we must have it this year. Sounds familiar. That was over 15 years ago.

Of course they didn't get the bill passed, life went on, the health care system in this country improved. We developed the State Children's Health Insurance Program under a Republican Congress with a Democratic President. We established medical savings accounts. We then, several years later, improved them with health savings accounts. We provided a prescription drug benefit in Medicare. For better or for worse, we passed the HIPAA law in 1996. But there was a lot of work that went on in health care.

Health care is an evolutionary process. Medicine is an evolutionary process because the knowledge base changes. The science changes over time. It is not a static event like law, or physics perhaps. But medicine is constantly evolving. In fact, many times we say that's why we refer to it as both an art and a science.

Well, what do the people think about doing this all at once or perhaps taking off some smaller pieces that might be actually doable? Americans agree with Republicans and want a fresh start on health care reform. A CNN poll—now, CNN is not always friendly to conservative principles—in a CNN poll, 73 percent of Americans say lawmakers should work on an entirely new bill or stop working on health care altogether. This was from February 24, 2010. Another poll, 79 percent of independents want Congress to start work on a new bill or stop all work, again from the same time frame.

So maybe it is reasonable that we start over with these small, incremental changes and solve some of the problems that bedevil Americans right now, but not turn the entire system on its head in order to help that smaller percentage that is having difficulty right now.

Starting over does not mean that we have no bill to pass. It doesn't mean that we start into another year-long debate. As I began this hour, I outlined to you, Mr. Speaker, several bills that are already out there, already written, could be called up, could go to committee, could be worked on, marked up, amended, and come to this House to be voted on up or down. We could pass a bill on preexisting conditions before we go home for the Easter recess. It would really be that simple. Instead, what we may get is the Senate bill being passed by the House of Representatives—under great duress for some Members of the House of Representatives—and then when that bill is passed by the House, it goes down to the President for his signature, and then good luck undoing all of the problems that are contained within that bill. It would be far better, since no help is coming for 4 years anyway, to take a little time and do this correctly.

The gentleman from Pennsylvania brought up the problems in Pennsylvania with medical liability. Texas, of course, in 2003 did change their medical liability laws and passed a bill that would allow a cap on noneconomic damages. It is a more generous cap than was passed in California in 1975 under the Medical Injury Compensation Reform Act of 1975, but nevertheless, it has worked well over the last several years and has now solved a lot of the problems that we were encountering in the earlier part of this decade.

Just some statistics to share with you; before the reform, one in seven obstetricians no longer delivered babies, 49 percent of counties didn't have an OB/GYN, 75 percent of neurosurgeons would no longer operate on children. Since passing that reform in Texas, it has really dramatically changed things. We had, in the 2 years before the reform passed, 99 Texas counties—Texas has 254 counties, and 99 counties lost at least one high-risk specialist. With the passage of what was then called Proposition 12, which was a constitutional amendment to provide caps on noneconomic damages and lawsuits, 125 counties added at least one high-risk specialist, including the counties I represent, Denton, Tarrant and Cooke Counties. And you can see of course there are some areas that are still needing to add specialists.

One of the remarkable things about the passage of this law is the number of counties that did not have an obstetrician previously but now do, and the number of counties that did not have an emergency room doctor but now do. Twenty-six counties that previously had no emergency room doctor, 10 that had no obstetrician, and seven that had no orthopedic surgeon, now at least have at least one of those specialists. Charity care rendered by Texas hospitals has increased 24 percent, nearly $600 million since the passage of this legislation. And Texas physicians have saved well over $500 million in liability insurance premiums.

Now, people will argue that passing tort reform does not immediately result in lower cost. Defensive medicine is learned behavior. Defensive medicine is oftentimes learned over a lifetime of practicing medicine. And it does take a while to begin to walk back from that. But as anyone will tell you, the journey of a thousand miles starts with the first step, and Texas has taken that first step. In fact, in Texas, one of our bigger problems now is licensing all of the doctors who want to move to the State. The State Board of Medical Examiners cannot keep up with the demand. It is a good problem to have because we had many counties that were underserved. And now, with the passage of this legislation at the State level, almost 100 percent of Texans live within 20 miles of a physician. That is a remarkable change from even just a decade ago.

One of the last things I want to bring up tonight before we leave, we've talked a lot about cost, and during the course of the discussion down at the Blair House the debate on cost was lengthy and sometimes it became contentious, but just a few points that Representative PAUL RYAN from Wisconsin made today. He pointed out correctly that Medicare has an unfunded liability of $38 trillion over the next 75 years. This is a huge, huge budget pitfall that is facing not just Members of Congress, but every citizen of the United States over the next 75 years.