to do in terms of passing an emergency extension. It really should be the first step in taking bold steps to create millions of jobs for Americans.

So we should be working to pass a jobs bill that would help people find this pathway out of poverty. We should help keep middle-income individuals from falling into poverty. We should be looking at a budget and a plan that, yes, will help pay down our debt. Yes, it is part of deficit reduction—that incorporates deficit reduction as part of it. But no, that does not cut Medicare, Social Security, or Medicaid. And we should really be trying to figure out a way to create some jobs for people. I mean, that's the bottom line. That's what we need to do.

Thank you again, Congresswoman CHRISTENSEN, for calling this Special Order today. We should make sure that the world knows that the Congressional Black Caucus continues to call attention to the games that Republicans are playing that will threaten our national security interests as well as our economic interests. And the fact that we're here working to try to create some jobs and to help ensure that this debt ceiling is raised, that's the bottom line.

Mrs. CHRISTENSEN. Thank you, Congresswoman BARBARA LEE.

I just want to mention that when we had our job summit about a week and a half ago, we passed out some information to those in attendance that added up about 30 job-creating pieces of legislation that just the CBC has introduced in this year. I don't believe that the Republican majority has brought any job-creating bills to the floor, and in this recovery, that's what we need, jobs.

I know sometimes we were accused of class warfare, but we're not pitting the poor against the rich or the middle class against the rich. We just think that everyone needs to be on the side of our country. We are calling for shared sacrifice and for fairness.

And really, this ought to be a clean raising of the debt ceiling. The cuts we're talking about that are going to hurt the people of this country are too important for us to be rushing through and using to hold the debt ceiling hostage.

□ 2030

So let's not hold such a critical thing as our ability to pay our bills and take care of our seniors, our children, our people with disabilities, and preserving our creditworthiness not only for Americans but the whole world depends on us, and we cannot let them down. We cannot let the American public down, including my constituents. We cannot let our country down and all of the countries in the world who depend on us.

With that, I thank my colleagues for joining me. I want to, once again, thank the AARP for their petitions and for their strong advocacy on behalf of not only seniors but all Americans and our country.

I yield back the balance of my time.

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, the Unitell States has reached the current debt ceiling, which is set by law at $14.294 trillion, and Congress must act by August 2, 2011 to avoid defaulting on its loans. If Congress fails to reach an agreement on raising the debt ceiling, it will cripple our economy, halt our recovery and end up costing taxpayers more in the long-run. For those reasons, I agree with financial analysts and experts who say that raising the debt ceiling is necessary to ensure our fiscal stability and continued economic recovery.

Although the bill to raise the debt limit did not pass in the U.S. House of Representatives in May, I voted in favor of the measure because the consequences would have been disastrous for our economy.

The Republican leadership brought this bill to the floor, but ironically urged their Members not to vote for it. The national debt limit is not a joke and needs to be taken very seriously. Normally, the periodic raising of the national debt limit is a noncontroversial legal necessity to ensure that the U.S. does not default on its debt obligations to foreign creditors and maintains its credit rating.

Raising the debt limit does not authorize new spending—it simply allows the government to finance existing legal obligations that Congresses and presidents of both parties have made in the past. The United States Congress has acted 78 times to raise, extend, or revise the debt limit; 49 times under Republican presidents and 29 times under Democratic presidents.

While no one is more frustrated than I am about our current fiscal state of affairs, I support responsible efforts to bring down our national debt. I firmly believe that it is a mistake to compound past irresponsibility with further irresponsibility on this issue. If Congress fails to increase the debt limit, the government would start to default on its foreign owned debts, which would have "calamitous" consequences for the U. S. economy. Not to mention it would be unprecedented in American history.

In addition, if the United States defaulted:

Investors would be less likely to lend to this country; borrowing costs, not only for the federal government, but for families, businesses and local governments would increase; and so would interest rates for municipal bonds, mortgages, car loans, and student and business loans.

Mr. Speaker, America's debt is a non-partisan concern. Both parties share responsibly for ensuring that this nation's bills are paid. I stand ready to work with all of my colleagues to meet our obligations and put forward a productive plan to reduce the deficit.

GOP DOCTORS CAUCUS

The SPEAKER pro tempore. Under the Speaker's announced policy of January 5, 2011, the gentleman from Georgia (Mr. GINGREY) is recognized for 60 minutes as the designee of the majority leader.

Mr. GINGREY of Georgia. Mr. Speaker, I thank my leadership, the majority leader on the Republican side, the Speaker of the House, and our conference chairman, Representative JEB HENSARLING, for giving us the opportunity—us, the House GOP Doctors Caucus—to have the Special Order hour this evening.

It's kind of convenient, Mr. Speaker; my colleagues on the other side of the aisle, the well-respected Members, my friends from the Congressional Black Caucus, were talking about the budget and what we're trying to do with regard to moving forward, talking, of course, about safety net programs and entitlement programs, such as Social Security and Medicare. And that's a great segue into the topic of our discussion this evening because it's going to be about the Medicare program.

We, on our side of the aisle in the Republican-passed House budget, take a responsible approach to solving the Medicare crisis, which the trustees have said to all Members of Congress—not Republicans, not Democrats, not House Members, not Senate Members, but all of us—that according to the trustee report, by the year 2024, if we don't do something about the Medicare program as it currently exists, as it's currently funded, the amount of spending that occurs year after year—and will only increase as more and more of our baby boomers are reaching age 65—if we don't do something about that, then that Medicare part A hospital trust fund is not supported by any constituent premiums, it's going to go broke. It absolutely is going to go broke.

So I say to my Democratic colleagues who just spoke, the compassionate thing—and I know they have great compassion for those who, maybe through no fault of their own, can't help themselves; but the compassionate thing, Mr. Speaker, is to save the program, to guarantee, preserve it for current Medicare recipients. Indeed, even for folks that are only 55 years old today, Medicare, as we know it, would be protected, would be strengthened for all of those individuals. And by the time those who are 55 years old today become 65, in 10 years, around 2024, there would be something like 65 million seniors and a smaller number of disabled individuals in the Medicare program as we know it. They would be in that Medicare program as we know it for the rest of their natural lives. And thank God, because of good health care in this country, women, I think, are living on average to age 82 and men maybe to age 78. So these 65 million people will be on Medicare for a long time. Medicare as we know it.

My colleagues didn't mention this in their hour; but what we do in our budget is go forward with a plan for younger folks—indeed, even for my grandchildren, my 10 grandchildren, the oldest two are 13-year-old twins—but let's say them, or 25-year-olds, 35-year-olds, 45-year-olds, indeed, we create the adult approach, the mature approach to solving the Medicare problem so that it will be there for them instead of nothing come 2024. And maybe some of us have paid for 25 years that FICA tax that's taken out of our paychecks every week or every month.

So I say to my friends, this idea that President Obama has and the leadership of your party of just simply kicking the can down the road doesn't get the job done. It's what we call sometimes—and I know all of us know the expression ''whistling past the graveyard,'' in other words, pretending that a problem doesn't exist. And that's an unconscionable approach.

I am very pleased tonight, Mr. Speaker, to have a number of my colleagues who have joined with us. Some of them are a part of the House GOP Doctors Caucus. We are mostly medical doctors. There are a number of registered nurses in our caucus. We have a lot of health care providers. There are dentists. But in the aggregate, the members of the House GOP Doctors Caucus are medical professionals who spent a lot of their lives practicing medicine and providing care, indeed, under Medicaid and the Medicare programs, seeing those patients mostly at a financial loss, but still very willing to try to help those folks who need us to be there for them in these safety net programs.

I think in the aggregate, the membership of the House GOP Doctors Caucus may have over 350 years of clinical experience. Some of us are getting a little long in the tooth and a little gray by the sideburns. But we are now Members of Congress, and we are trying to do things for our constituents and the seniors of this great country of ours to make sure that we preserve and protect programs like Medicare and Medicaid. And that's what this is all about tonight.

I want to first yield to my friend from Tennessee, my co-OB/GYN doctor. Dr. PHIL ROE has been a Member of this body now for 4 years and has been a great asset. And I know that Dr. ROE has a bill that he wants to address concerning some problems that were enacted under ObamaCare.

I would gladly yield to Dr. ROE from Tennessee.

Mr. ROE of Tennessee. I thank the gentleman for yielding. It's a pleasure to be here tonight.

Mr. Speaker, I go back to when Medicare first began. In 1965, there was a problem identified in America where we had a group of our citizens, as they became 65 years of age and older, that didn't have access to quality health care. So a plan was put in place, along with Medicaid for our poor citizens at that point, to access quality care.

In 1965, the Medicare program was a $3 billion program. There was no Congressional Budget Office at that time. The estimates were in 25 years that this would be a $15 billion program. It actually turned out to be over a $100 billion program in 1990. In 2010, it will be somewhere about $550 billion.

We also have, as has been pointed out in our previous hour by our friends from the Congressional Black Caucus, that we have a tremendous deficit. We're borrowing 42, 43 cents of every dollar that we spend in this country. So that's why the discussion was started.

I came to Washington—really, I practiced medicine, as Dr. GINGREY said, for over 30 years and realized that we had a serious problem not just in Medicare but in health care. So we came to work on health care reform. In the Physicians Caucus in the previous Congress, there were nine of us in the caucus. Not one of us was consulted on the Affordable Health Care Act. I mean, decades worth of experience, over 200 years of experience in the Congress at that time, and no one—not one of us—was actually consulted.

□ 2040

The way I looked at the problem in our health care system was we had three problems:

One is we had a problem where the system was too expensive. When you go to the doctor, it cost too much money to go see a physician. Number two, we had a group of people out there who didn't have affordable health care coverage. Maybe the husband is a carpenter, as in our area, maybe the wife worked at a local diner or somewhere else that didn't provide insurance coverage. Thirdly, we had a liability problem in this country.

So what did we do? We had an over 2,000-page bill that got through the House and got to the Senate and failed. The Senate dusted a bill off that was 2,500-plus pages, that never went through a committee hearing, that nobody on the House had a chance to do, and I know that the three physicians that are here tonight all read that bill. When I read that bill, Mr. Speaker, I found some things in there, as did my colleagues, which greatly worried us.

How do they fund this bill? Only Washington could fund anything like this. Dr. GINGREY has pointed out that we're trying to save Medicare. Medicare is a system that the Congressional Budget Office says by 2020 will be out of money; 2024, by the actuaries at CMS say will be broke.

There are four parts of Medicare:

Medicare part A, which is paid for by your premiums. That's your hospitalization.

Medicare part B, that's doctor services and some lab services. That's only funded 25 percent from your premiums. The other 75 percent comes from the general fund, the taxpayers.

Medicare Advantage, which was cut drastically by the Affordable Care Act.

And Medicare part D, which is a prescription drug plan, also is only funded 25 percent by our premiums. I'm a Medicare recipient myself, as of last year.

So what did the administration do and the Senate do to fund this Affordable Health Care Act? They took out of an already underfunded program, as I just pointed out, $500 billion, and Dr. GINGREY just pointed out moments ago that we're adding about 3 million baby boomers per year, so 10,000 per day or more. We're adding millions of new recipients while pulling out of that over $500 billion, and we call this ''saving Medicare.''

We're not talking about tonight, on our hour, the budget impasse. We're talking about what's already been passed. And one of the things I found in there, Mr. Speaker, was a very little known board called the Independent Payment Advisory Board. Before, Medicare has had this board in there, which was strictly that, MedPAC. It was an advisory board to Congress, to say, hey, we've got some problems here with funding; maybe we should look over here. Congress would then have the ability to make those decisions.

Mr. GINGREY of Georgia. If the gentleman will yield, I would like to call my colleagues' attention to this poster, because this is exactly what Dr. ROE, Mr. Speaker, is talking about now, this IPAB, Independent Payment Advisory Board. I want all my colleagues to see this poster because this is what Dr. ROE is taking us through at this point.

Mr. ROE of Tennessee. Mr. Speaker, what I did when I read this, I looked at it and thought, how was this created and why was it created?

This board has 15 members that are appointed by the administration, by the President, and, quite frankly, I don't want a Republican President or a Democratic President doing this. These people are then approved by the Senate for a 6-year term. They're paid about $165,000 a year.

And what is their charge? Well, their charge is, is if Medicare spending hits certain targeted limits, that cuts occur first to providers and for prescription drugs and then later to hospitals. What worries me about this is right now we have a problem—and Dr. PAUL BROUN is here tonight, who's a primary care physician—with our patients with their Medicare, finding a physician to take care of them.

What happens is if you hit these targeted limits and physician payments are cut, access to care is going to be cut, quality of care is going to be cut, and, thirdly, the cost to our seniors is going to go up. What also worries me is that this board very much mimics the board that's in England called NICE, the National Institute of Clinical Excellence. This board makes recommendations to their health board there about what care is provided to patients. President Obama has taken this board, he's going to use this, and he actually wants to increase the power of it to help hold Medicare costs down. Ultimately what will happen, when you have more demand for services than you have money to pay for it, is your care will be rationed. That's the fear that we have.

Our concern is, and I've gone to seniors in my district and been very clear and pointed this out at town hall meetings and have held town hall meetings with seniors and said, We want to provide you quality access of care. That's what I do as a doctor. I want to be able to see those patients and have them

help us solve this problem. I think that's the issue that we have, Mr. Speaker, is how do we provide the care for the money we have and provide quality of care and access for our patients? I am extremely concerned that the IPAB will do just the opposite of that.

Mr. GINGREY of Georgia. I thank the gentleman very much for his presentation on the IPAB, that board which Dr. ROE describes, Mr. Speaker and my colleagues. Again, I'm going to refer back to a previous poster that I wanted to present as Dr. ROE got into talking about the Democrats' solution to so-called ''save Medicare.''

They wanted initially to ignore the problem, the fact that Medicare is going broke. As I pointed out in my opening remarks, Medicare today will be broke in less than 10 years. Without action, the Social Security trustees report that Medicare seniors will either see a 22 percent benefit cut or workers will see a 22 percent hike in payroll taxes. So basically, not really completely ignoring the problem, but what the Democrats want to do is create this so-called IPAB board, which Dr. ROE describes. They say there will be no rationing, yet they're restricted in the recommendations that they can make in regard to cuts, and those cuts will be to providers; they will be to pharmaceutical companies that provide the drugs that so greatly keep people alive today that in the past were ending up in the emergency room with strokes because of uncontrolled high blood pressure, needing amputations because of uncontrolled diabetes or needing to be on a dialysis machine because of uncontrolled renal disease. All of these have been helped by Medicare part D. So, clearly, the plan that the Obama administration and our Democratic colleagues have is not for saving Medicare.

At this time, let me yield the floor to my colleague from Georgia, fellow physician and member of the House GOP Doctors Caucus, Dr. PAUL BROUN.

Mr. BROUN of Georgia. Thank you, Dr. GINGREY. I appreciate you yielding a few minutes.

I wanted to kind of break all this down so that the American people could understand very clearly what we're talking about tonight. I've got a little poster here that shows President Obama's and the Democrats' Medicare solution.

This is their Medicare plan. They deny the problem. They deny the problem that the gentleman from Georgia was just talking about with this huge, huge problem, where Medicare is going to go broke in a matter of just a decade. They want to delay any fixes. In fact, Medicare as we know it today exists no longer. ObamaCare took care of that. And they want to destroy it. They will destroy it by letting it go broke.

So this is the Democrat Party's health care plan: Deny It, Delay It, and Destroy It by letting it go broke.

Just recently, one of the government accounting groups released something that should scare every senior, every taxpayer, and every American.

□ 2050

They said that Medicare, within the next couple of decades—that's a lot of zeroes in this; 63 and a lot of zeros. This is the unfunded liability of Medicare over just the next several decades.

Mr. GINGREY of Georgia. If the gentleman will yield, that would be $63 trillion, if I'm not mistaken.

Mr. BROUN of Georgia. Well, I just tried to make it so that the zeroes didn't confuse folks. The unfunded liability for Medicare is $63 trillion. This is unsustainable. There's no way to take care of this.

We need to shore up Medicare. We need to make sure that it's strengthened so that our future generations, not only the senior citizens today, can continue to get Medicare, but the future generations also.

Now, what does $63 trillion of unfunded liabilities mean to everybody in this country? I mean, that's too big a number for everybody to really consider. So I broke it down to every family in the United States. Every family's part of this $63 trillion of unfunded liabilities for Medicare, as it exists today, is over $500,000 per family, $500,000 per family of unfunded liabilities for Medicare just in the next several decades.

Now, I don't know about most families, but my family can't afford to pay $500,000 and neither can the government.

Mr. GINGREY of Georgia. I've got a poster that points out just exactly what the gentleman from Georgia, Dr. BROUN, is saying.

If you look, colleagues, at the bottom of this poster, CBO estimates individual and corporate income tax rates would have to rise by 90 percent through the year 2050 to finance Medicare and Medicaid. And if Medicare is not fixed, millions of workers today will lose the money that they have invested. And, indeed, they have invested with that payroll tax over those many years of their employment.

Mr. BROUN of Georgia. Thank you, Dr. GINGREY. What the American people need to understand is that we need to strengthen Medicare and Social Security for future generations.

This picture right here is a picture of my two grandchildren, Tillman and Cile Surratt. I love these two kids greatly. They won't see Medicare, and they're going to see an America that's quite different from the one that we see today if we don't make some major changes, major changes in Medicare and Social Security. If we don't shrink them and make them economically viable for my grandchildren, that are 6 and 7, my grandchildren won't see Medicare. They won't see Social Security. And, in fact, people who are 45 or 50 today won't see Social Security or Medicare if we don't strengthen them, if we don't do the necessary hard work of bringing about those changes to strengthening Medicare and Social Security to make them economically viable.

I hear our Democrat colleagues all the time talk about it's the children. I've heard our former Speaker talk about it's about the children so much that I wanted to throw up.

But the thing is, when you talk about it's the children and their future, we've got to deal with this debt. We've got to deal with Social Security and Medicare and make them economically viable by strengthening them, by making them so that they're still available when my kids get grown.

And we're going down a road right now—this President and the Democrats in the Senate and the Democrats here in the House have a three-word plan. Their plan is a three-word plan for Social Security and Medicare: deny the problem. They're denying it. They're delaying doing anything about it. And they're going to destroy it, because both Medicare and Social Security are going broke if we don't strengthen it, if we don't make it economically viable, if we don't do the necessary hard work that this Congress and Republicans are trying to do.

But what do we hear from our colleagues on the other side? Demagoguery and trying to play politics. It's time to stop the politics. It's time to stop playing games.

The American people deserve the truth. No more accounting gimmicks. No more playing with numbers. No more double talk, political speak.

This is the Democrats' plan—deny it, delay it, destroy it—for Medicare, Social Security and this country economically. We've got to change it, and that's what Republicans are working very hard to do.

Mr. GINGREY of Georgia. Mr. Speaker, I thank the gentleman very much. And while we're on the ''D'' word, if you will, deny, delay, demagogue, I'll use another, D word, and it's really the softest thing I can say about the Democrats' plan, and that is disingenuous.

For them to stand up, or for the President to stand up and say that he's going to fix Medicare, at the same time, Dr. ROE talked about this earlier in the evening, I'm going to refer back to him in just a few minutes, but at the same time, in the creation of a whole new entitlement program in March of last year, we know it as ObamaCare. Officially, I guess I should say, it's called the Patient Protection and Affordable Care Act. I think it's the unaffordable care act in that it cost $1 trillion.

But where did the money come from to pay for this new entitlement program that really has nothing to do with seniors?

Well, my colleagues, look at this poster to my left, your right. Here's where at least half of the money came from. Cutting Medicare, cutting Medicare by $575 billion. I mean, right out

of the Medicare program. That included home health care; it included Hospice. But the biggest cut was $130 billion, that's bullet point No. 2, $130 billion from the Medicare Advantage plans. And my colleagues know this, and I'm sure they'll want to comment on it, of the 47 million people, 45, 47 million people today who are on Medicare, about seven to 10 million of them receive their medical care on the Medicare Advantage option, which gives them more benefits, more bang for the buck; and it covers a lot of preventive services that are not given, not offered in traditional Medicare as we know it.

So that cut, $130 billion, that's something like a 14 percent cut out of that program. That means that at least half of these seniors are going to have to go back into Medicare as we know it and get a lesser benefit.

In fact, it's been said by the actuary of Medicare, Richard Foster, on April 22, 2010, that 15 percent of hospitals, nursing homes, and home health care providers will close because Medicare pays less under ObamaCare.

Mr. BROUN of Georgia. Will the gentleman yield?

Mr. GINGREY of Georgia. I want to yield just briefly again to the gentleman from Georgia before I yield some additional time to my colleague, our cochair of the House GOP Doctors Caucus, the gentleman from Pennsylvania.

Mr. BROUN of Georgia. I thank you for yielding just a moment to me because I want to add to that statistic; 15 percent of hospitals, nursing homes, and home health care will close because Medicare pays less under ObamaCare. That's absolutely true. A lot of those hospitals are going to be in rural communities because rural communities are going to be hit the hardest.

Right now I'm a primary care doctor. As the gentleman knows, I'm a family doctor. I've done general medicine for almost 40 years now.

The American Academy of Family Physicians said right now, today, one in eight family docs will not accept Medicare at all. Only one in three doctors, according to the American Medical Association limits how many Medicare patients that they take.

□ 2100

That is a marked rise. Back in 2004, only 6 percent of all doctors limited their Medicare patients. In 2008, it went up to 8 percent. Now it's almost one-third limit the amount of Medicare patients that they see. And one in eight family docs don't take Medicare at all; they can't afford to because of the low reimbursement rates. And IPAB is going to hit those folks that much harder.

During our Special Order when we were discussing ObamaCare I made a comment that somebody may have a free health care card in their pocket, but it's going to be as worthless as a Confederate dollar after the War Between the States because nobody will take it, and that's exactly where we are headed. So I just wanted to add that.

Mr. GINGREY of Georgia. I thank the gentleman from Georgia.

I now yield to my cochair of the House GOP Doctors Caucus, the gentleman from Pennsylvania, Dr. TIM MURPHY.

Mr. MURPHY of Pennsylvania. Thank you, Dr. GINGREY.

I want to talk for about 5 minutes here on an issue that you brought up, Dr. GINGREY, about the $575 billion from the Medicare program that also cuts $135 billion from Medicare Advantage plans, forcing over 7 million seniors out of their current Medicare plan unless they pay more.

I wanted to help point out that while the President and others are out there saying we're trying to cut Medicare and what it does, nothing could be further from the truth. What we're trying to do here is show how if Medicare is handled differently—not by IPAB or a board of bureaucrats, but by letting the plans work and letting doctors work, they can drive down cost by improving quality.

Let me explain what happened in the Medicare Advantage program that was gutted in the health care bill that was passed out of the House. Well, seniors are able to make choices right now—with Medicare, they can get Medicare part D drug coverage and supplemental Medigap policies with the Medicare Advantage plan. What the Medicare Advantage plan does is allows some management of diseases that are chronic illnesses, which is very different from the current fee-for-service where somebody would get paid based upon the number of procedures they do. Under the regular Medicare fee-for-service plan, hospital readmission rates—that's 30 days post-discharge for the country—in 2007 was over 18 percent, but the average readmission rate across Medicare Advantage was 13.5 percent. Why? Because it allowed physicians and nurses to talk to the patient, to follow the patient, to work with the disease, to make sure whatever complication they had—an infection or heart disease or lung disease or an orthopedic problem—to pay that physician and staff to work for them.

Here is another interesting thing: The Medicare fee-for-service rate of preventable emergency department visits was 15.5 visits per 100 beneficiary months in 2007. But the average rate across Medicare Advantage plans and study was two visits per 100 beneficiary months—86 percent lower than Medicare's national average.

Here's another point: Actual cost for the drug plan we know, Medicare part D, comes out 40 percent under budget because insurers are forced to compete with each other. Now imagine this: Seniors can choose Medicare supplemental plans, and those plans compete for seniors' coverage. The drug plans compete for seniors' coverage. What happens if seniors are allowed to also choose their main Medicare plan? Well, listen to this additional issue about drugs: The Intercontinental Marketing Services, IMS—I should say this comes from the Deloitte & Touche Web site—the Institute for Healthcare Informatics study concluded: The average cost for drugs frequently used by Medicare prescription drug part D beneficiaries declined since the implementation of the program in 2006. Between January, 2006, and December, 2010, for the top ten therapeutic classes, part D drugs decreased by over one-third, from $1.50 to $1. The study projected that costs will continue to decline by 57 percent from 2006 to 2015, reaching 65 cents by the end of 2015. That's a massive decline. Why? Because plans are competing against each other. Plans innovate, they try and do things better and smarter, with better quality, and they ask seniors to choose their plan. Seniors then, by signing their name, can choose a plan that works for them.

Why not allow seniors to have Medicare choice with their major Medicare plan? Why not allow seniors to have Medicare Advantage instead of gutting the program? This is the very thing we're saying; by improving efficiencies and qualities within the program, a lot of cost can be reduced. It can't be reduced, however, by the status quo. As you pointed out, Dr. GINGREY, and my colleagues, keeping the status quo means there won't be Medicare. There will be Medicare for those currently on it. It won't be there for their children and certainly not for their grandchildren. We want to save Medicare, but you can't save it by the continued way it's being done now.

Quite frankly, the system that's being done out there now to frighten seniors, to say that if we don't simply pass this debt limit increase without strings attached, that seniors won't have Social Security or Medicare, this is such a falsehood. And it's a serious problem in two ways: One, it's serious because it's telling a falsehood to seniors; and two, it looks down upon seniors thinking that they're susceptible, not smart enough to figure out that this is false.

It is so important, and we want the American public to understand: We are trying to save Medicare because we do want it to be there for the future, but it means making it more efficient. And what's wrong with letting doctors be the ones who call the shots on improving care?

Mr. GINGREY of Georgia. Mr. Speaker, I appreciate so much the gentleman from Pennsylvania, who has spent his professional life providing medical services to his patients, just as so many of the doctors in the caucus.

Talking about this cut to Medicare Advantage, as Dr. MURPHY described that method of getting care, Mr. Speaker, it is exactly what we continue to talk about today of wanting to reward health care based on quality and

not necessarily quantity. Just strictly fee-for-service—the number of times you go to see a provider and that provider getting paid, albeit a small amount—is not a very efficient way. And certainly a much more efficient way—and we continue to talk about this—is to provide quality of care. And Dr. MURPHY correctly pointed out, Mr. Speaker, that's exactly what Medicare Advantage does; it offers a quality of care and a wellness provision. Were we paying these plans a little too much for those services? I don't know, maybe, possibly. But if you're going to cut any amount, certainly 14 percent, $130 billion, is too much because that guts those plans.

But whatever savings you get out of Medicare, shouldn't they stay in the Medicare program, if you believe the Medicare actuary and the trustees that say that if we don't do something by 2024, the trust fund, the hospital trust fund is depleted, there is no more Medicare as we know it or any other way. So if you're going to find savings in the Medicare program, you don't take that money, $575 billion, and use it to create a whole new entitlement program so that everybody in the whole country has health insurance whether they need it or not, whether they want it or not. I can think of a lot of things in the Medicare program where this money could be well spent. How about long-term care, extended care facility coverage to keep that money in Medicare? Instead, what ObamaCare comes up with is something called the CLASS Act—which is a classless act, Mr. Speaker, because it is a misleading program that can't fund itself, that absolutely can't fund itself.

So there are so many things about ObamaCare and Obama's plan to save Medicare—which really, as Dr. BROUN pointed out, is no plan at all, other than what Dr. ROE has pointed out in regard to this Independent Payment Advisory Board that is going to cut spending for the most vulnerable seniors, those that are the sickest, those that incur the highest cost. And they say there is no rationing, but it will indeed, as my colleagues have pointed out, Mr. Speaker, be denial of care.

At this point, I would like to yield back to the gentleman from Tennessee to talk a little bit more about that.

Mr. ROE of Tennessee. I thank the gentleman for yielding.

Mr. Speaker, I do want to point out one thing that Dr. GINGREY just pointed out, which was one of the reasons that the American people don't trust politicians. The CLASS Act may be a good idea. The CLASS Act began this year where you have some money taken out of your paycheck and put in a savings account over here. It's supposed to be about $87 billion in 5 years, and we can't get it out until that 5-year period of time occurs and this money has accumulated. At that time it's supposed to pay for long-term care, about $50 per day. But guess what happens, Mr. Speaker? What happens is that we borrow the money out and spend it on current health care and call this an asset.

□ 2110

We have counted that money twice; two times. We have done that with Social Security already. I find this absolutely offensive, on August 2, 10 days, about a week from now, we have had the audacity to tell people who have paid into Social Security for 40 or 50 years they will not be able to get their check. Why? Because the Federal Government has spent that money. We are doing the same thing again with the CLASS Act. There has already been legislation to perhaps overturn that.

I want to get back to something a little more basic, and that is to the examining room with the patient. The people who should be making health care decisions should be a family, the patient and their physician, sitting around and talking about what their options are, not some 15 people appointed bureaucrats in Washington, D.C.

By the way, Dr. GINGREY and Mr. Speaker, we have over 190 cosponsors, including a bipartisanship cosponsorship to the repeal of IPAB, including every physician, every health care provider on the Republican side and Dr. CHRISTENSEN, who was down here just a moment ago on the Democratic side. It is a bipartisan agreement that we should overturn this. The American Medical Association believes it should be overturned. Over 270 major medical organizations see through this as a very bad thing for patients.

The reason we are worried about it, we have heard Dr. BROUN speak about it, and we have heard you speak about it, Mr. Speaker. Ultimately it will affect the quality of care. Why? Because if you don't have access to your doctor, the quality of your care will go down.

The other thing I want to mention is we talk about changing Medicare. Quite frankly, I'm going to go through just a few of the things that already have been changed in this Affordable Care Act. Beginning in 2010, there were Medicare cuts to hospitals, long-term care and inpatient rehabilitation services.

In 2011, it has been pointed out that the Medicare Advantage plans, the seniors did get a $250 check to fill the doughnut hole. The wealthier seniors began paying higher premiums for Medicare part D; that's in 2011. Medicare imaging cuts, Medicare reimbursement cuts: when seniors get a CT scan or an MRI, Medicare cuts for durable medical equipment began, ambulance services, ambulatory service centers, diagnostic labs, durable medical equipment, wheelchairs. Seniors prohibited from purchasing power wheelchairs unless they rent for 13 months.

In 2012, elimination of the deduction for the employer expenses for Medicare drug subsidies, that is how they raised $4.5 billion. And that is not to improve our current underfunded Medicare plan. That is to create another entitlement. Medical expense deduction, you raise the threshold for deducting medical expenses from 7½ to 10 percent. That raises $15 billion to be spent elsewhere. That is a tax right there.

Hospice care is being cut. Dialysis, Medicare cuts to dialysis treatment will be cut in 2012.

In 2014, this Independent Payment Advisory Board begins. And, by the way, they are getting, I believe it's $12 million a year to fund this right now. If there is any way we can cut off funding to that board right now, it should be done.

In 2015, a permanent cut to the payment rate to home health agencies. On and on. We have felt these cuts because they haven't come to fruition yet. What we are trying to do with Medicare is to salvage the program for future generations.

A promise made is a promise kept. If you are 55 years and older, with Social Security and Medicare, nothing happens. I hear all the time about a voucher. This is a voucher system and so forth. Here is what a voucher is. A voucher is when I go to my mailbox, something comes that says this has so much value. You take this piece of paper and purchase something with it. Premium support is where the Federal Government, through its massive ability to go out and negotiate prices, exactly like they do for you and me, Mr. Speaker, in our health care plan here in Congress, they negotiate with numerous companies through the Federal exchange. Our plan is called the Federal Employees Health Benefit Plan, and they negotiate the best price. And what happens is all during the campaign, the last 2 years I have heard seniors and others say, Congressman, I want exactly what you have. That is exactly what we are trying to do.

A higher income senior like myself, and you and the others in this room, will pay a higher premium. And folks with preexisting conditions and lower income will pay much lower. And they will have those choices. As Dr. MURPHY pointed out, why do we think that will save money and why are we doing it. It has been pointed out that it is a catastrophe waiting to happen if we do not do something.

Mr. GINGREY of Georgia. Mr. Speaker, I thank the gentleman from Tennessee, Dr. ROE. What he was describing, if I can elaborate a little more on that point to our colleagues because I think some still are confused, possibly on both sides of the aisle, but clearly this plan that is put forth in the House budget, and it's the Republican budget because we are in the majority. It is sometimes referred to as the Paul Ryan budget because he is chairman of the Budget Committee. It is sometimes referred to as the Path to Prosperity.

But in that budget which we sent to the Senate; and, unfortunately, the Senate majority leader has deep-sixed it, if you will, but in that budget plan that Dr. ROE was referring to, it has

taken the responsible approach based on the trustees' estimate of the Medicare program going totally broke by the year 2024, and that information is bipartisan. That's the Medicare board of trustees.

To ignore that, as my colleague from Georgia said in his remarks, the ''D'' words, to defund, to deny, what were some of the others, Dr. BROUN? To deny, delay, destroy, demagogue, and I added to those ''D'' words their plan is rather disingenuous, but what Dr. ROE was describing is to protect and preserve Medicare as we know.

Whether it is traditional Medicare, maybe we can salvage Medicare Advantage, and hold harmless anybody that is over age 55, 55 through 65. They were 10 years away from being eligible for a Medicare benefit. So they will be in those plans as we know it. But this approach that Dr. ROE so adequately describes, Mr. Speaker, this premium support program, not a voucher, as he pointed out, the premium support program, which by the way would be administered by the Office of Personnel Management, the same folks that talk to us and find out what kind of health care benefit we want, those Members who are under 65, that you pick and choose and you negotiate. They will do the same thing for future, those under age 55 today, future Medicare beneficiaries. They will get the best bang for the buck, the best care for their individual needs.

Now, it is estimated that in 2022 that premium support amount on average will be $8,000 a year. Now, our Democratic friends, Mr. Speaker, want to say, Well, that's not enough. That's not enough. Seniors are going to have to reach in their pocket.

But what they don't tell you, Mr. Speaker, is that premium will be higher for anybody who comes into the Medicare program who is already sick, who already has several things wrong with them; and that certainly is possible.

When I got Medicare eligible, I had already had open heart surgery. So these people will have a higher premium than the average of $8,000 a year. And as they age, even if their health is perfect the day they come into Medicare, they become Medicare eligible—they may have the Methuselah gene and have wonderful health. They may jog 3 miles a day, don't smoke, don't drink excessively, don't skydive—but as they get older, that premium support will automatically go up because we know statistically that as you get older the chances of something happening are greater.

And last but not least, the higher your income, the lower your premium support.

□ 2120

So our seniors, who need it the most, will get a higher—they won't get the average $8,000. They will get a higher premium support. I think it is a wonderful plan, Mr. Speaker. I absolutely do. It shows the responsibility of the majority party in this House of Representatives.

Of course, as my colleagues have pointed out, what is the plan from the Democrats, the Democrat majority in the Senate and from this President: deny it, delay it, destroy it, demagogue it. Or, as my colleague from Tennessee has pointed out, kill it by creating this Independent Payment Advisory Board, IPAB, which will, without question, lead to denial of care and rationing.

I yield to my colleague from Tennessee.

Mr. ROE of Tennessee. I thank the gentleman for yielding.

One of the things, Mr. Speaker, that I want to emphasize is having no plan is a prescription for disaster for our country. We have a solemn obligation to provide health care for our seniors. We have made that promise. And how do we do it? Again, back to what I said, I do not want a board that is appointed by a Democrat or Republican or any bureaucrat. What I want is I want health care decisions made by physicians, the patient, and their family. The way that is going to happen is through this plan where we use premium support to allow people choice and to have them make those choices, not insurance companies and certainly not the Federal Government.

From what I have seen up here in my two terms is I don't want a bunch of Federal bureaucrats in charge of my bypass operation or my gallbladder operation—or my bunion operation, for that matter. I want my doctor in charge of it. That is who I want making those decisions, along with my family.

I think this is one of the biggest discussions we will have in this Congress is how we do this right. Not only does it affect the budget. Forget the budget. Forget all that right now. We are talking about people's lives. We are talking about the care that they get. And right now, as I mentioned, these changes are already made. This is already in the current law that I talked about just a minute ago.

When you talk about Medicare as it is, folks, it's been changed, big time. When this board kicks in—and there's a very good article if you are sort of a wonk like I am and want to go back to the New England Journal of Medicine, one of our major journals, in, I believe it was, May of 2010. Their estimate was—this is one of our major scientific journals—that this IPAB board would have kicked in 21 of the last 25 years if it had been in place. So it's not some idle threat that this will happen. If you look retrospectively at what's happened, it would have happened 21 out of 25 times.

What would that mean? That would mean, as Dr. BROUN, Mr. Speaker, pointed out just a moment ago, as these payments for physicians go down and down and down below their cost of providing the care, they no longer can see you. You lose access to your doctors, like Dr. BROUN.

Mr. GINGREY of Georgia. What Dr. ROE is talking about, Mr. Speaker, is on top of these cuts that our medical providers are currently facing under this so-called flawed formula sustainable growth rate, which I'm sure I'm correct on this, in the past 9 years every calculation has been a cut to provider reimbursement to the point now that while we in Congress have had the ability to mitigate that, that if these cuts finally in the aggregate come due December 31 of this year, it is a 30 percent cut. So we haven't solved that problem yet for our providers but yet we are adding on top of that this IPAB board that can make additional cuts to provider reimbursement without any ability of the Congress, we the Members of Congress, to stop that injustice.

Mr. ROE of Tennessee. A good point.

Peter Orszag, who was the previous OMB Director here, said this is one of the biggest losses of power the Congress has given up since the Federal Reserve. That's been almost a hundred years ago. What we're doing is the Congress takes two-thirds to overturn what they recommend in this IPAB. We could do it if we get a two-thirds vote. And it is not appealable. You don't have any appeal to a court system to do anything about this.

Mr. GINGREY of Georgia. If the gentleman will yield, still, we can overrule with a two-thirds vote. But we still have to find cuts in the Medicare program somewhere else for the same dollar amount.

Mr. ROE of Tennessee. The gentleman is correct.

What would happen is we could make those cuts, but they have to be made somewhere else. The cuts have to be made. Nowhere should Congress give up its ability to do that. We are, our House, the House side, we're the representatives of the people. We are the closest to them. We have 700,000 constituents that we go talk to every time we get home. And we ought to be beholden to those folks in our districts across this country and not to some board up here in Congress that is not accountable to anybody.

Mr. GINGREY of Georgia. I thank the gentleman.

The gentleman from Georgia is kind enough to have stayed with us throughout the hour, and I would like to yield additional time to him, if he would like.

Mr. BROUN of Georgia. Thank you, Dr. GINGREY. I would certainly like the time.

The American people need to understand that the purpose of ObamaCare, the bottom line really was expressed by the President himself when he said he wanted everybody in this country in one pool. What's that mean for everybody? It means socialized medicine. That's what all IPAB and all these cuts and everything is geared to do is to force doctors out of private practice, make them employees of the Federal Government, make patients subject to some bureaucrat here in Washington

and tell them what kind of health care they can get.

And the Democrats' plan is to deny, to delay, and to destroy Medicare by letting it go broke. But I want to just add, Dr. GINGREY, to your other ''d,'' the demagoguery that we see. I want to give three examples because the facts have really been, by and large, hidden from the American people.

AARP did an ad, a new one, talking about all the places where the Feds could cut spending, like treadmills for shrimp—well, I certainly want to cut that out—but instead, Republicans insist on cutting seniors' Medicare. Well, that's not true. AARP and the Democrats want to cut Medicare by destroying it, letting it go broke.

An ad put out by the Gender Project, a liberal nonprofit group, shows an elderly woman being heaved off the side of a cliff, with her being in a wheelchair, and asks: Is America beautiful without Medicare? Ask PAUL RYAN and his friends in Congress.

That is nothing but bald-faced lies, because we are trying to make sure that seniors get, as Dr. ROE said, a promise made, a promise kept. We want to shore up Medicare and Social Security. We want to strengthen Medicare, not destroy it, like the Democrats are going to do.

Let me give you a third example, then I will yield back.

On the Republican budget, President Obama said in his speech at George Washington University just last month: ''Instead of guaranteed health care, you will get a voucher. If that voucher isn't worth enough to buy the insurance that is available in the open marketplace, well, tough luck. You're on your own. Put simply, it ends Medicare as we know it.'' President Obama.

It's demagoguery. It's lies, bald-faced lies designed to try to scare the American people, particularly senior citizens. We are trying to shore up Medicare. We are trying to strengthen Medicare. We are trying to save Medicare from going broke. But the Reid-Pelosi-Obama ObamaCare is to deny it, to delay it, to destroy it, and to demagogue it.

Mr. GINGREY of Georgia. As I said earlier, the kindest thing I can say is it is disingenuous.

Stop the Democrats' plan to end Medicare. If left alone, the Democrats' Medicare cut plan created in ObamaCare threatens Medicare seniors today as well as those who will come into the program tomorrow.

So, colleagues, how do we stop the Democrats' Medicare cut plan first and foremost? We need to repeal ObamaCare. But we need to vote and support Dr. ROE's bill to repeal this IPAB board and tell President Obama and Democrats that Medicare reform should not rely on restricting benefits and access for sick and disabled seniors in need.

As we conclude tonight, let me just say, colleagues, oppose the Democrats' Medicare cut board. Visit the GOP Doctors Caucus Web site and sign the online petition. Oppose the Democrats' plan to destroy Medicare.

And here are the Web sites: doctorscaucus.gingrey.house.gov or doctorscaucus.murphy.house.gov, the two cochairs of the House Doctors Caucus.

Mr. Speaker, I thank our leadership for giving us an opportunity to bring to the American public and to our colleagues on both sides of the aisle the true facts of this case—that we have a plan; the President has no plan.

I yield back the balance of my time.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. BERG (at the request of Mr. CANTOR) for today on account of attending the funeral of his good friend, former North Dakota State Senate Majority Leader Bob Stenehjem.

Mr. BACA (at the request of Ms. PELOSI) for July 22 on account of attending a funeral in the district.

Mr. DEFAZIO (at the request of Ms. PELOSI) for today on account of travel delays.

Mrs. NAPOLITANO (at the request of Ms. PELOSI) for today until 5 p.m.

Ms. RICHARDSON (at the request of Ms. PELOSI) for today.

SENATE BILL REFERRED

A bill of the Senate of the following title was taken from the Speaker's table and, under the rule, referred as follows:

S. 300. An act to prevent abuse of Government charge cards; to the Committee on Oversight and Government Reform; in addition to the Committee on Armed Services for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

ADJOURNMENT

Mr. BROUN of Georgia. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 9 o'clock and 31 minutes p.m.), under its previous order, the House adjourned until tomorrow, Tuesday, July 26, 2011, at 10 a.m. for morning-hour debate.

EXECUTIVE COMMUNICATIONS, ETC.

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

2595. A letter from the Administrator, Risk Management Agency, Department of Agriculture, transmitting the Department's final rule — Common Crop Insurance Regulations; Extra Long Staple Cotton Crop Provisions [Docket No.: FCIC-10-0002] (RIN: 0563-AC27) received June 28, 2011, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

2596. A letter from the Director, Defense Procurement and Acquisition Policy, Department of Defense, transmitting the Department's final rule — Defense Federal Acquisition Regulation Supplement; Successor Entities to the Netherlands Antilles (DFARS Case 2011-D029) (RIN: 0750-AH32) received July 28, 2011, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Armed Services.

2597. A letter from the Chief Counsel, Department of Homeland Security, transmitting the Department's final rule — Changes in Flood Elevation Determinations [Docket ID: FEMA-2011-0002] [Internal Agency Docket No. FEMA-B-1195] received June 20, 2011, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Financial Services.

2598. A letter from the Chief Counsel, Department of Homeland Security, transmitting the Department's final rule — Changes in Flood Elevation Determinations [Docket ID: FEMA-2011-0002] [Internal Agency Docket No. FEMA-B-1199] received June 28, 2011, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Financial Services.

2599. A letter from the Secretary, Securities and Exchange Commission, transmitting the Commission's final rule — Extension of Temporary Exemptions for Eligible Credit Default Swaps to Facilitate Operation of Central Counterparties to Clear and Settle Credit Default Swaps [Release Nos. 33-9232; 34-64800; 39-2476; File No. S7-02-09] (RIN: 3235-AK26) received July 7, 2011, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Financial Services.

2600. A letter from the Deputy Assistant General Counsel for Regulatory Services, Department of Education, transmitting the Department's final rule — Final Priority; National Institute on Disability and Rehabilitation Research (NIDRR) —— Rehabilitation Research and Training Center (RRTCs) —— Interventions to Promote Community Living Among Individuals with Disabilities [CDFA Number: 84.133B-1] received June, 28, 2011, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Education and the Workforce.

2601. A letter from the Assistant Secretary for Export Administration, Department of Commerce, transmitting the Department's final rule — Revision to the Validated End-User Authorization for CSMC Technologies Corporation in the People's Republic of China [Docket No.: 1101519290-1298-01] (RIN: 0694-AF25) received June 28, 2011, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Foreign Affairs.

2602. A letter from the Assistant Secretary for Export Administration, Department of Commerce, transmitting the Department's final rule — Addition of Certain Persons on the Entity List: Addition of Persons Acting Contrary to the National Security for Foreign Policy Interests of the United States [Docket No.: 110128065-1135-01] (RIN: 0694-AF12) received June 28, 2011, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Foreign Affairs.

2603. A letter from the Associate Director, Department of the Treasury, transmitting the Department's final rule — Libyan Sanctions Regulations, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Foreign Affairs.

2604. A letter from the Assistant Secretary for Fish and Wildlife and Parks, Department of the Interior, transmitting the Department's final rule — Native American Graves and Repatriation Act Regulations — Definition of ''Indian tribe'' (RIN: 1024-AD98) received June 20, 2011, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

REPORTS OF COMMITTEES ON PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XIII, reports of committees were delivered to the Clerk