After the chaos we just experienced a few short months ago after the downgrade of our Nation's credit rating, not because of our debt but because of our lack of ability to lead and govern, I would think, Mr. Speaker, that we would try to avoid an identical future situation. A BBA would exacerbate the same issues we saw in the August debt ceiling debacle.

Third, Mr. Speaker, a BBA would lead to reductions in needed investments for the future. Since the 1930s, our Nation has consistently made public investments that improve long-term productivity and growth in education, infrastructure, research and development. These efforts encourage increased private sector investment leading to budget surpluses and a thriving economy.

A balanced budget amendment which requires a balanced budget each and every year would limit the government's ability to make public investments, thereby hindering future growth.

For years, conservatives have abused the debt and the deficit as a springboard from which to argue for smaller government and cuts to programs that serve as social safety nets to the American families. Although we must consider the debt and deficit, the larger and more significant issue is the nature of the debt and what it created.

If you invest $50,000 in a business, a house, or an education, you can expect future returns on your investment. If you invest the same $50,000 in a gambling debt, what is the future return? Both expenditures result in a $50,000 debt. But only one results in a return that can transform that debt into a long-term asset or gain.

Social investments provide the potential for greater returns in the long run in the same fashion as personal investments. Even small expenditures on social programs lay a foundation for great wealth in the long term. If the Nation chose to invest over a 5-year period $1.5 trillion in building roads and bridges and airports and railroads, mass transit, schools, housing, health care, we would create a debt. But the increased ability of companies to interact and shift their goods over well-paved and planned roads, the new businesses that would sprout around freshly built or newly expanded airports, the high wages of a student who is well-educated and able to attend college resulting in more tax revenue, the improved productivity of employees at their healthiest would eventually result in greater returns for our country.

The extension of Bush-era tax cuts for corporations and the rich brought about some short-term stimulus for consumer spending; but similar to the Reagan tax cuts, which resulted in record government deficits and debt, the long-term damage outweighs the immediate effects. Reagan's tax cuts for the rich came at the expense of investing in our Nation's need for long-term, balanced economic growth.

The Reagan administration neglected and cut back our Nation's investment in infrastructure, education, health care, housing, job training, transportation, energy conservation, and more.

The inclination of most conservatives in both parties—I'm not picking on Republicans today—in both parties, is to cut the debt by cutting programs for the most vulnerable amongst us—our poor, our children, our elderly, our disabled, and minorities. This approach, however, has proven false too many times. A balanced budget amendment would take us back to this archaic and ineffective system permanently.

Fourth, Mr. Speaker, a balanced budget amendment favors wealthy Americans over middle- and low-income Americans by making it harder to raise revenue and easier to cut programs. Under current law, legislation can pass by a majority of those present and voting by a recorded vote.

The BBA requires that legislation raising taxes must be approved on a rollcall vote by a majority of the full membership of both Houses. Before I even finish this point, Mr. Speaker, I want to make this point: look at the supercommittee. Look at what they're wrestling with. We don't even have a balanced budget amendment. Look at who they're targeting. Look at the emphasis of their cuts.

So instead of a balanced budget amendment in the Constitution, we already see that Congress is ineffective in light of what we've already passed. Imagine if it were a constitutional requirement.

The point is so simple, Mr. Speaker. The BBA would make it harder to cut the deficit by curbing special interest tax breaks of the oil and gas industries and making it easier to reduce programs such as Medicare, Medicaid, Social Security, veterans benefits, education, environmental programs, and assistance to poor children.

Wealthy individuals and corporations receive most of their government benefits in the form of tax entitlements while low-income and middle-income Americans receive most of their government benefits through programs.

As evidenced by the cuts that both parties agreed upon recently, it's far easier to cut social welfare programs than to cut spending on our military or to increase taxes. As long as spending is a political issue, cuts to those programs that assist those with the smallest voice in Washington will always happen first.

Raising taxes, the only option to address a budget deficit aside from cutting programs, is already a burdensome issue. The additional requirements of a BBA further complicate the process of raising taxes. This means the richest Americans will likely keep the benefits they receive from our government via tax cuts.

Meanwhile, the poor, they lose their programs that provide them with housing, with food, with health care, and the means to survive. This will further reinforce the growing gap between the rich, the rest of our society, middle class, working poor, and the destitute alike.

□ 2020

The BBA insists that the total government expenditures in any year, including those for Social Security benefits, not exceed total revenues collected in that same year, including revenues from Social Security payroll taxes. Thus, the benefits of the baby boomers would have to be financed in full by the taxes of those working and paying into the system then. This undercuts the central reforms of 1983.

Finally, Mr. Speaker, the BBA weakens the principle of majority rule and makes balancing the budget much more difficult. Most balanced budget amendments require that, unless three-fifths of the Members of Congress agree to raise the debt ceiling, the budget must be balanced at all times. They also require that legislation raising taxes must be approved on a roll call vote by a majority of the membership.

Mr. Speaker, in no way is this an exhaustive list. I know that my time is up, but this is my second attempt to bring my conservative friends to their senses. The only parties served by a balanced budget amendment are corporate interests and the wealthy, whom they seem to be serving instead of everyday working Americans.

My answer is ''no,'' Mr. Speaker, to the balanced budget amendment tomorrow. My answer is ''yes'' if my colleagues agree there is no way that they can pass the balanced budget amendment unless we, ourselves, agree that we must invest, build, and grow this economy and work our way out of this problem as Americans.

Mr. Speaker, I yield back the balance of my time.

GOP DOCTORS CAUCUS: THE EFFECTS OF THE AFFORDABLE CARE ACT ON AMERICA'S HOSPITALS

The SPEAKER pro tempore. Under the Speaker's announced policy of January 5, 2011, the gentlewoman from New York (Ms. BUERKLE) is recognized for 60 minutes as the designee of the majority leader.

Ms. BUERKLE. Thank you, Mr. Speaker.

Here in Washington, we are divided on many issues, but whether we are a Republican or a Democrat, Members of Congress recognize the essential role that our hospitals play in our communities.

Hospitals provide care for the sick, and the clinics provide essential care to many. They are engaged in important medical research, and teaching hospitals are educating doctors and nurses to provide care for future generations. In many districts across the country, including mine, New York's 25th Congressional District, our hospitals are our major employers.

They're perhaps the largest single employer a congressional district may have.

The health care sector constitutes nearly 18 percent of the United States' economy, and it is one of the more stable portions of our economy. American hospitals employ more than 5.4 million people; and as hospitals and hospital employees buy goods and services from other businesses, they create additional jobs. The economic impact is felt throughout the community. Hospitals are a vital part of our local and our national economy. In New York State, particularly in my home district, hospitals are the largest single employer.

I want to call your attention to this chart, Mr. Speaker, with data provided by the Hospital Association of New York, which shows the importance hospitals have on my district's local economy. Five hospitals in my district employ over 18,000 people. Together, payroll and purchases in my district alone amount to over $2.4 billion. They generate over $100 million in State and local income sales taxes. This is in my district alone with regard to the economic impact of our hospitals.

Looking at New York State as a whole—and I hope some of my New York colleagues will join me here tonight—the hospitals contribute nearly $108 billion to our State and our local economies. Mr. Speaker, it is no exaggeration to say hospitals are a mainstay of our New York State economy; so when our hospitals are hurting, the effects extend to the entire community. Our hospitals are under assault. Not only will it affect our local and State economies, but it will also affect access to health care, to some of the most basic services that our hospitals provide to our communities.

I now yield to the gentleman from Georgia, Dr. GINGREY.

Mr. GINGREY of Georgia. I thank the gentlelady from New York for yielding to me.

Mr. Speaker, as I think most of my colleagues know, Congresswoman BUERKLE is a member of the House GOP Doctors Caucus. There are 21 of us, all health care providers—some doctors, some nurses, some dentists, some psychologists. We've got a really good, diverse group that has—I would hate to say, Mr. Speaker, the total number of years of clinical experience that we all have in the aggregate, but it's several hundred. I have thoroughly enjoyed having Congresswoman BUERKLE as a member of the House GOP Doctors Caucus. She is a Registered Nurse, who has worked for years in hospitals in the New York area.

As she has pointed out, the four hospitals in her district are probably, if not the major employer, one of the major employers; and it's so important to her community, the 25th District of New York. That is so true, Mr. Speaker, across so many of our districts. I happen to be an OB/GYN physician, having practiced in my congressional district, the 11th of Georgia, for some 26 years.

In our hospital system there, in the main town in Cobb County, Marietta, Georgia, where we have lived for the last 36 years, just as in Congresswoman BUERKLE's district, the hospital system is one of the main drivers of the economy—that and the public school system. The hospital systems are employers, and we sometimes forget that.

I think, as a physician, a lot of times I may be guilty of concentrating on issues that mainly affect my colleagues in the medical profession—the practitioners, the MDs; yet Congresswoman BUERKLE is pointing out—and I know she has got a number of posters and slides for us to look at tonight—the devastating effects that the so-called Affordable Care Act—the unaffordable care act, indeed—has had on our hospitals like hers, the four hospitals in the 25th District of New York, and on the WellStar Health System and its, I think, six different facilities in the metropolitan Atlanta, Cobb County area. It is devastating.

So I really appreciate the opportunity to join with her tonight, along with some of my other colleagues in the House GOP Doctors Caucus, to make sure that people understand that it's not just the doctors and the health providers outside of the hospitals who are suffering because of this unaffordable care act, but it's our hospital systems all across the Nation.

I thank the gentlelady for yielding to me, and I plan to be with her during this next hour.

Ms. BUERKLE. I thank the gentleman from Georgia for being here this evening.

Mr. Speaker, as my colleague mentioned, the President's Patient Protection and Affordable Care Act, which became law in March of 2010, included some welcome provisions, such as allowing people to stay on their parents' insurance until the age of 26 and prohibiting insurers from denying coverage based on preexisting conditions. These positive provisions, which proponents quickly point to when facing criticism, are far outweighed by the negative consequences that the Affordable Care Act has on our providers and the health care system.

These measures could have been accomplished in a much simpler manner. I say to you, Mr. Speaker, so many roads are paved with good intentions, but the unintended consequences are devastating to our hospitals.

As a health care professional, my opposition to the Affordable Care Act has never been solely based on philosophical grounds, but on strategic and tactical ones. Most Americans—myself included and my colleagues here in Congress—recognize that health care needs to be reformed and that health care costs continue to rise. We need to figure this out. We disagree as to what the health care reform should look like. If I thought that the Federal Government could be the necessary agent of change, that would be one thing; but I don't believe the government can change health care.

The Affordable Care Act affects our hospitals and our providers. This is not a Republican or a Democratic issue, but an American one—as access to health care affects every American.

□ 2030

Mr. Speaker, I yield now to the gentleman from Michigan, Dr. BENISHEK.

Mr. BENISHEK. I thank the gentlewoman for yielding to me.

Mr. Speaker, I have spent 28 years as a physician practicing rural medicine, even serving on the board of my local hospital. I am well aware of the great financial difficulties most rural hospitals and clinics experience each year.

Today I was pleased that the State of Michigan celebrated Rural Health Day. On behalf of the thousands of Michiganders that call small towns and farming communities home, my State's Governor chose to recognize the hospitals and community-based centers that provide for the diverse and unique health care needs of these areas. Tonight I would like to join the State of Michigan in raising awareness about the importance these providers bring to the communities that I represent.

While we recognize the importance of rural health today, I would be remiss if I did not mention one of the great rural health facilities in my district. Many of my colleagues may have visited the Straits of Mackinac during a summer vacation, or perhaps they've seen the Mackinac Island featured on a ''Pure Michigan'' ad. The Rural Health Clinic in St. Ignace is the single largest employer in the community, supporting not only the local township but, in addition, the 900,000-plus seasonal visitors that depend upon the hospital for services each year.

I recently received a distressing letter from Mr. Rodney Nelson, the CEO of Mackinac Straits Health System. Mr. Nelson is very worried about the impact Medicare cuts may have on his patients, employees, and ultimately the ability to keep the doors to the hospital open. Mr. Speaker, the Mackinac Straits Health System is one of 25 hospitals in my district that is considered either critical access or sole community hospital. Of these, 56 percent are already operating in the red.

Unlike urban areas, my constituents often do not have another option when seeking health care. In the case of the St. Ignace Hospital, the next closest clinic is 50 miles away. What you may not know, Mr. Speaker, is that caring for patients in rural facilities is far more economic than providing urban care. In fact, rural patients cost less to treat in eight of the nine CMS regions.

As my colleagues and I discuss possible ways to trim the budget, I feel it's important to remember that without rural hospitals, many of my constituents would not have access to medical care. A 2 percent reduction in Medicare

spending is estimated to cost 389 jobs in my district as a direct result of the cuts to rural hospitals. If this number were raised to 10 percent, the figures would only get worse. At that point, 76 percent of the hospitals would be operating in the red; and the total impact is expected to be nearly $68 million, with 1,900 jobs affected. Mr. Speaker, I don't need to tell anyone that northern Michigan can't afford to lose another 1,900 jobs.

Mr. Speaker, if we force these cuts, not only will we lose these jobs, but we will lose access to many people's sole source of health care. We are forcing rural patients to travel longer distances to seek more expensive care. This just costs everyone more money.

I urge my colleagues to exercise caution when considering reductions to Medicare programs, especially those specific to physicians, critical access, and sole community hospitals.

Ms. BUERKLE. I thank the gentleman from Michigan.

Mr. Speaker, we've touched upon it, and I want to continue having this conversation about the effect that the Affordable Care Act is going to have on our hospitals in our Medicare population. Now, Mr. Speaker, you may have heard over and over again from our colleagues from the other side of the aisle, demagoguing our budget proposal that came out in April. They say we want to kill Medicare; we want to kill Social Security; we don't care about our seniors.

Tonight I stand here, Mr. Speaker, and I tell you, and I want to tell the American people, that the Affordable Care Act, in fact, cuts Medicare spending by $500 billion. Those are actual cuts that are now in the Affordable Care Act, or what is known as the health care law. One of the most negative effects is the result of reductions in hospital Medicare payments and the CMS code, offsetting reductions to hospital payment plans.

I have a chart here, Mr. Speaker. And as I go through my notes, I want it to be clear that you can see 2010 and what happens to Medicare reimbursements, down until 2018. Our hospitals can't sustain these cuts. The five hospitals in my district have come to me, and they said, This Affordable Care Act—and many of these hospitals were big proponents of the Affordable Care Act because they know in our country we need to reform our health care system, we need to make some changes, so they were in support of the law.

But what they didn't realize was this law is going to cut their Medicare reimbursements, which so many of them depend on. It's the mainstay—by 28.6 percent. I've had hospitals in my district say to me, We cannot sustain these cuts. We will go bankrupt. Because you see, Mr. Speaker, it's not only this Medicare, the reduction in these rates, but it also is a series of other cuts which we will get into as the evening proceeds.

I yield to the gentleman from Georgia.

Mr. GINGREY of Georgia. I thank the gentlelady for yielding to me.

I wanted to take an opportunity, Mr. Speaker. I have an article from the Atlanta Journal-Constitution, Atlanta's main newspaper—this was several months ago—referencing one of our best hospitals, Piedmont Health Care. The title of the article is ''Piedmont Health Care Cutting 5 Percent of Workforce.'' And this is what Misty Williams of the Atlanta Journal-Constitution says in this op-ed piece:

''Faced with a rising number of uninsured patients and unknown impact of the new health care law''—that would be the so-called Affordable Care Act—''Piedmont Health Care announced Thursday evening''—this was 5 months ago—''plans to cut 464 jobs as part of an effort to save an estimated $68 million. Totaling roughly 5 percent of its workforce, the cuts include 171 positions that were vacant or altered because of scheduling changes. Layoffs are coming from across the board, including Piedmont's four hospitals, physician groups, heart institute and corporate division, spokeswoman Nina Day said.''

And I quote Ms. Day: ''This is heart wrenching. This is not easy stuff when you're talking about people.''

''The move is, in part, a reaction to hurdles''—the hurdles that Congresswoman BUERKLE and Congressman BENISHEK were just talking about—''to hurdles many hospitals are facing, including a growing number of uninsured patients, a new State hospital bed tax, anticipated cuts to Medicare reimbursements, and the Medicaid expansion in 2014.''

The article goes on, talking more and more about how devastating this would be. And in conclusion—without reading the entire article—I'll finish up and then yield back to my colleague.

The last paragraph of this article by Ms. Williams: ''While hospitals will get more insured patients as a result of the Medicaid expansion in 2014, it's a big trade-off with Medicare cuts. State officials have estimated Georgia''—my State—''could add more than 600,000 enrollees to its Medicaid program as a result of this expansion.'' Again, under ObamaCare. ''It's a challenge in time just trying to navigate all of these changes.''

Again, it's just so important that we're having the opportunity tonight on behalf of our leadership to tell our colleagues on both sides of the aisle—Congresswoman BUERKLE moments ago said, It's not a Democrat or a Republican issue. It's a people issue. It's a community issue. And it's devastating. And it's sad news that we're bringing to our colleagues, but we need to do that. And the American people need to understand what's coming. The worst has not yet hit.

Ms. BUERKLE. I thank the gentleman from Georgia.

I have spent most of my professional career in the health care industry. I have represented a hospital for a number of years, so I know up close and personal how these issues have affected and will affect our hospitals and our providers. And despite the best intentions of this health care law—whether we disagree with it or we agree with it—despite the best intentions of this health care law, what we are seeing are the unintended consequences.

□ 2040

The fact that our hospitals, our health care providers, will not be able to proceed, will not be able to perform the services that our communities need and expect and have come to expect. That certainly wasn't the intent of the health care law, but ladies and gentlemen and Mr. Speaker, that's exactly what is happening.

I would like to yield and recognize the gentlewoman from North Carolina.

Mrs. ELLMERS. Thank you, Congresswoman BUERKLE, for holding this Special Order tonight, along with my colleagues on the Doctors Caucus. And thank you, Mr. Speaker, for being here. We are all here because we are health professionals. We know the real world of health care, and we know the real world solutions. It's the reason I'm here in Washington now, that and the fact that I'm concerned about where the future of the country is going for our children.

Many times in our health care practice as a nurse and in my husband's surgery practice as small business owners, over time we have always looked at these issues, whether we're talking about Medicare, whether we're talking about the possibility of having real, good, concrete tort reform, all of these different issues that we've said if we could put these in place, health care could have a much more solid foundation moving forward.

We already know that we have the best health care in the world. But being in the industry, having that small business and understanding where Medicare and Medicaid reimbursements—which were down—were going, you have to ask yourself, how can this continue? How can we provide health care into the future? Well, of course we know that the health care bill was passed in the 111th Congress, and now we are seeing the effects of it. One of the effects, as you've pointed out, are to our hospitals. You know, it's important that we are able to articulate this to the American people, connecting the dots.

When we talk about the importance of why ObamaCare is devastating to physicians, it's because it affects their ability to be reimbursed for their services. When Medicare will be cut—as we know in ObamaCare, it was cut by $500 billion. Today our seniors are saying to us, we're worried that you're going to cut our benefits. Well, their benefits will not be cut by any of us in Washington. However, because the dollars have been taken out in a significant amount, Medicare will have to say, I don't know what we'll cover. What are we going to cover?

And as we know, again, in the President's health care bill, the 15-person panel has been put in place. This 15-person panel will decide what Medicare will and will not pay for. That will be direct payments to hospitals, not just physicians but hospitals, based on the services that they're providing. And if they decide that a service cannot be paid for, there are penalties that can be assessed.

There are solutions to this issue, and I pointed out one would be significant tort reform. Not only for our physicians, but again for hospitals. Why is that important? Sometimes I'm afraid we don't explain well enough to the American people why something like malpractice reform would help the situation.

Well, we know that in our Nation's hospitals if you go into the emergency room, you're going to receive care whether you can pay for it out of pocket or not, whether you have an insurance card or not, whether you're on Medicare or Medicaid, it doesn't matter. You're going to receive the care. The problem is someone does have to pay for those services because services are rendered. You go into the emergency room, and many tests are ordered. Physicians order more tests out of pure fear for missing something. You can't go into an emergency room and get the good care that you need to get if you cannot identify the problem. So as we know, physicians and hospitals, physicians and doctor's offices, tend to cover all their bases rather than simply relying on the medical education that they have received, the ability to diagnose with just that—with the ability of their practice.

So here we are. We talk about health care costs every day, and the escalating cost of them. A good contributor to that is another piece of the President's health care bill which basically puts a tax on all medical devices. Well, think about the cost for any hospital, any provider. What do we do in hospitals? We do surgery. We provide health care. These are medical devices. These are instruments that have made our lives better and help us live longer, but yet now they will be taxed. This is a tax that will have to be assessed. Someone will have to pay for it. If the effort is truly to decrease the cost of health care, how can we continue by increasing the cost? It doesn't make sense. It doesn't add up.

So again, the importance is for us to connect the dots for the American people; to show that if we are able to pull back on ObamaCare, that we are able to remove it, repeal it, as we have already voted here in the House, then we can make the significant changes.

There is one more point that I would like to touch on, and it has to do with the ability to pay for services. There was a consulting firm, Mercer Consulting Company, and they did a study that shows that 9 percent of employers with 500 or more workers say they are likely to cancel health benefits in 2014 after State-run health insurance exchanges begin offering coverage under the health care law. There again, once again, it will become the government paying for it, which is paid for by the American taxpayers' dollars. We simply cannot continue on this path with health care or any other issue. It has to come with free-market solutions, and we have those solutions and we are ready to put those in place.

I just, again, want to reassure our seniors who are receiving Medicare now or in the near future that we are doing everything we can to rescue Medicare from the President's health care bill and put those necessary pieces in place so that we can continue those services into the future that they have paid for their entire lives.

I again thank my colleague from New York for holding this Special Order.

Ms. BUERKLE. And I thank the gentlelady from North Carolina for being here this evening.

I would just like to continue on because of my concern, and I know my colleagues have such concerns, about the health and the well-being of their hospitals. As I mentioned earlier, they are the largest employer in my district. We refer to it as ''eds and meds.'' We have a large university there and some colleges, but we also have five hospitals in my district. So our reliance for our local economy and for our State economy is just so very important.

I want to talk a little more about what this health care law is going to do to Medicare and do to our hospitals. There is $112 billion in reduced market basket updates to hospitals. There is a $36 billion reduction to Medicare and Medicaid disproportionate share hospital payments.

Now, Mr. Speaker, disproportionate share may sound a little confusing. I'm going to explain what that is. In a district such as mine, we have hospitals that have missions. And I'm sure across the country, many hospitals have missions. They want to make sure that the indigent population, folks who can't afford insurance, who are self-pays or maybe are on Medicaid, that they have access to quality services. So the government says to these hospitals, we understand that Medicaid reimbursements or self-pay patients will not cover your services. So what we're going to do is, we're going to try to make you whole with this disproportionate share. Mr. Speaker, the health care law eliminates the disproportionate share for hospitals, and so hospitals that have a high indigent population or a high number of self-pay patients or those who are on Medicaid, they are not going to get that disproportionate share.

The hospital in my district came down here. It is a large teaching institution. They made a special trip down here to tell me that provision of the health care law will bankrupt them. They probably receive somewhere around $80 million a year to make them whole because of their mission. And isn't that what we want? We want to make sure—and wasn't that the original intent of the health care law?—to make sure that there was accessible care for all Americans. But here again we reached the unintended consequences, and the effect that this law is going to have on our hospitals.

□ 2050

There is a $7.1 billion reduction for readmissions. We will talk about that in a little bit.

Hospitals, and many of the ones in my district, and I know throughout this country, they are heavily dependent on Medicare and Medicaid dollars. And with that narrow margin, Medicare and Medicaid don't even cover their costs. And so there's such a small margin for them to operate that there's really little capacity for improvements. Realistically, hospitals—especially teaching hospitals and hospitals that are treating the underserved—cannot bridge that gap, and they won't be able to bridge that gap because of this new health care law.

Hospitals must be able to invest in their infrastructure. Having such a narrow margin and/or no margin operating in the red, they're not going to be able to do that. They're not going to be able to invest in infrastructure, systems improvements, new techniques to reduce hospital-acquired infections, new models of delivering health care and electronic health records.

And I want to talk about electronic health records because they were mandated in the health care law. The Affordable Care Act mandates that hospitals must move to electronic health records. Now, from a patient safety standpoint, that's a good thing, but getting hospitals up to speed and getting them ready for business has very high IT costs for our hospitals. So, again, you've got this health care law mandating electronic records, and you've got these drastic cuts to our hospitals in their Medicaid and Medicare reimbursements.

I yield to the gentleman from Georgia.

Mr. GINGREY of Georgia. Mr. Speaker, I thank the gentlewoman for yielding once again.

Just a few minutes ago, one of our colleagues spoke also about this problem with hospitals, Representative ELLMERS from North Carolina, who knows of what she speaks. She works in an office with her husband, a general surgeon. They see patients every day in the office, but they also have a largely hospital-based practice because it's surgery and you just don't do that in the office. But she had listed some of the things in ObamaCare, in this so-called Affordable Care Act, Patient Protection and Affordable Care Act of 2010, when it was passed a year and a half ago.

We all realized that this was a new entitlement program, Mr. Speaker, and the American people need to understand that it's not about strengthening

and saving Medicare for our seniors. That entitlement program is struggling mightily. And as Representative BUERKLE mentioned, to take $500-plus billion out of that program to pay for a whole new entitlement program, ObamaCare, for in many cases the young and healthy, and also to put some of the burden of paying for that new entitlement program on the Medicaid program, the safety net program for the poor, it only weakens that program. So you literally gut Medicaid for the poor and the disabled and Medicare for our senior citizens, when both programs need strengthening and saving, not gutting.

It was this whole idea of having Medicare for all, really, or national health care, there are all kinds of euphemisms to describe this, especially, not the least of which is the name of it, the Affordable Care Act. And as I said earlier, Mr. Speaker, and I know my colleague from New York would agree with this, it is the unaffordable care act. And both she and Representative ELLMERS from North Carolina said, look, we know on both sides of the aisle that health care in this country is too expensive, and we need to go about changes that will lower the cost and not hurt the quality. And we can do that.

President Obama keeps denying that there are any ideas and certainly didn't listen to the physicians in this body or the health care providers or physicians and the nurses that said, look, let us come over and sit down and talk with you or any of your folks in the Executive Office of the Presidency and let us explain, because we have—and I said it earlier—several hundred years of clinical experience. We do have some ideas, and we really believe we want to be part of the solution and not part of the problem.

But my colleague who is leading the hour and doing such a great job of it, I know she will agree that I haven't been called, I haven't been invited over. I will ask my colleague and yield back to her and ask her the same question. And I know what the answer will be.

Again, the important thing for our colleagues, Mr. Speaker, to understand, is that the creation of this new program, this new entitlement program so that everybody can get health care, whether they want to buy health insurance or not, is so detrimental to Medicare and Medicaid that I fear for the future of those programs. I really, really do.

That's what it's all about here tonight, to take an opportunity to explain so people really understand the ultimate consequences of this.

Ms. BUERKLE. I thank the gentleman from Georgia.

Mr. Speaker, I want to just emphasize again with regards to this health care law and the fact that this law—and, Mr. Speaker, this is a law, this isn't a budget proposal, this is a law—guts Medicare by $500 billion. It should be of concern, Mr. Speaker, to our seniors because this law, in fact in 2014, will begin to gut Medicare. I again would look at this chart and the Medicare reimbursements. There will be no hospitals that will be able to provide health care. If you look at what the trend is for Medicare reimbursements to our hospitals, they cannot continue to exist based on what is set forth in the Affordable Care Act.

I spoke with the CEO of one of our local hospitals, Crouse Hospital in Syracuse, and he spoke with one of my health care staff; and he indicated to us today that Crouse Hospital, one hospital in the district, is facing a projected loss of $18 million in reimbursement reductions. That number goes to access to care. We can have the most comprehensive health care law on the books, but if we don't have hospitals who are able to provide that care, and we don't have physicians who are able to provide that care, we will have access-to-health-care problems.

Mr. Speaker, earlier I talked about hospital readmission penalties. This is another concern hospitals have to deal with. And tonight we've talked a lot about what the Affordable Care Act will do to hospitals, the effect that it will have on our hospitals, the drastic cuts in Medicare and Medicaid reimbursements and the disproportionate share being eliminated.

But our hospitals are under assault from all sides, and that's part of the difficulty. Maybe they could somehow figure out how to deal with these cuts in the Affordable Care Act; but taken in its totality, our hospitals are having a very difficult time. In fact, as I mentioned earlier, many are concerned that they will be unable to sustain and unable to continue on with their services, given the whole assaults that are coming from all directions.

And this actually is part of the Affordable Care Act. It establishes a punitive policy for our hospitals when they readmit a patient. And I will explain that, Mr. Speaker. Under the health care law, the Affordable Care Act—we call it the Affordable Care Act, we call it ObamaCare, we call it many things—but under this new law that is taking effect gradually, under this to their expected readmission rates, if even more than one readmission occurs—and that readmission means that you discharge a patient, the hospital sends a patient home and then for some reason they have to come back. If that happens with one of three diagnoses within the Medicare scheme, the hospital will be penalized for all of the Medicare reimbursements, not just that one case where there was a readmission, but all of the Medicare reimbursement cases. You can imagine the magnitude and how that will affect Medicare reimbursements.

□ 2100

The other part of this provision in the health care law is that it really doesn't discern between what's avoidable and what's not avoidable readmission. So sometimes a hospital may discharge a patient and it was premature, or something wasn't done and the patient needs to come back. And certainly that should be considered, and we should figure out what went wrong because readmissions are expensive, and so Medicare doesn't want to pay for them. And I understand that. However, some readmissions are unavoidable, and a hospital shouldn't be penalized for an unavoidable readmission; and yet the Affordable Care Act does exactly that.

The Secretary of the Department of HHS, Health and Human Services, which has the authority now to expand what were three diagnoses, now has the authority to expand that list of conditions with regards to readmissions. Hospitals nationwide, Mr. Speaker, are projected to face more than $7 billion in Medicare reductions over 10 years because of this policy, $7 billion to our hospitals.

We began this discussion tonight, Mr. Speaker, talking about the importance to our local economies, the employment numbers, what hospitals pay into our community with their purchases and with their employees, the taxes that they give back to the community; and now we're talking about cutting them again because of this policy.

You know, the issue of hospital readmission is complex, and I hope I did a good enough job tonight of explaining it. And while health care providers agree there's always room for improvement across the continuum of care, readmissions occur for many reasons. And punitive action via reduced reimbursements is not only counterproductive, but it's also potentially harmful to our hospitals, to our patients, and to our communities.

Mr. Speaker, as we work hard to make sure our seniors get the Medicare benefits from the system that they have paid into—and, Mr. Speaker, I want to emphasize that over and over again during the course of this hour, our seniors have paid into Medicare, into the health care system all of their life. And now, as they reach the Medicare eligibility age, they deserve to get Medicare coverage that they expect, that they deserve, and that they've paid into.

But this health care law, this $500 billion cut to Medicare, is going to change that for our seniors. It's not the budget proposal in April that's going to—that was a budget proposal. And you've heard my friends and colleagues across the aisle demagogue our budget proposal in April, saying we want to cut benefits to seniors, Medicare, and Social Security.

The fact is, Mr. Speaker, this health care law, passed into law in 2009, will devastate Medicare. And our seniors, Mr. Speaker, should be very, very concerned about this Affordable Care Act. Not only will it affect our hospitals—as we've spent so much time talking about tonight—but it will also affect

the care and the access to care for our seniors.

Hospitals, Mr. Speaker, already operate on such thin margins, and we talked about this earlier, that for many providers, especially specialized programs, treating patients struggling, say, with substance abuse or helping the developmentally disabled, they will be reduced or they will end those programs. Hospitals cannot operate on such a thin margin and then run the risk of all of these devastating Medicare and Medicaid reimbursements.

Mr. Speaker, I also want to speak tonight a little bit about graduate medical education. As I mentioned earlier, I was an attorney in Syracuse, New York, and I represented a hospital that was a large teaching hospital. And so I know how much they rely on what's called graduate medical education. We often refer to it as GME, sort of the acronym for it, the initials. I'm going to explain what GME is because it's so important to our hospitals. And even hospitals that don't have a medical school attached to them, we'll talk about some of the reimbursements they get because medical students and residents train within these facilities.

Graduate medical education is the training medical school graduates receive either as a fellow or an intern or a resident. Medicare is the largest contributor to the GME. Now, why do I even bring this up? I bring this up because we talked earlier about the many assaults on health care providers, the many assaults that hospitals are concerned about. This is not per se in the health care law, so I want to make that clear. But when it comes to cutting, when it comes to finding and helping this terrible national debt that we have that is now $15 trillion, often we look to Medicare. And one of the areas in Medicare, the low-hanging fruit—whether it's a hospital or a physician—that seems to be the easiest place to go to rather than really looking at our health care system, making it a free market, allowing the market to compete, getting the government out of health care and letting folks buy insurance across State lines. Rather than letting the free market in it, we have the government involved. So Medicare is the largest contributor to this GME.

GME payments, as I mentioned, have been targeted. They've become a target for recommended budget savings. In 2010, the President's Simpson-Bowles Deficit Commission recommended limiting hospitals' GME payments to 120 percent of the national average salary paid to residents in 2010, and reducing another reimbursement the hospitals get, the IME, the indirect medical education, by 60 percent, from 5.5 to 2.2 percent.

Mr. Speaker, these two changes—Medicare reimbursement to the GME, Medicare reimbursement to the IME—would reduce Medicare medical education payments by an estimated $60 billion through 2020, $60 billion.

Mr. Speaker, these aren't just numbers. These proposed cuts would endanger the ability of teaching hospitals to train physicians. We must face the fact that cuts to graduate education would result in fewer practicing physicians and ultimately reduced access to care, which is getting back to why there was an Affordable Care Act.

I talked about this road paved with good intentions. And now what we are seeing is that our hospitals, our health care providers, and the training of physicians are both going to be significantly and severely impacted to the point where access to health care becomes a problem. And so seniors—not just seniors, but all Americans—will have to begin to deal with the fact that primary care physicians, there won't be as many of them. There will be fewer doctors being trained, and for a number of reasons.

The GMEs and the IMEs going to hospitals, if there is any reimbursement reductions to those, but also the fact that as a physician goes through all those years of training and he goes through 4 years of college, 4 years of medical school, an internship, 3 years of a residency, and then if he's a fellow because he wants to specialize, all of those years, and then they go into practice. And you see what the Affordable Care Act, you see what all these assaults are doing on our Medicare and Medicaid reimbursements to physicians as well as our hospitals.

Hospitals that are primarily teaching hospitals face an additional challenge that could threaten the stability of their institutions. Hospitals that have residents in an approved graduate medical education—again, that GME program—receive an additional payment for a Medicare discharge to reflect the higher cost of care. Because they are a teaching hospital, their cost of care is higher.

The regulations regarding the calculation of this additional payment—and I talked about this earlier—is the indirect medical education. This is all very complicated, but what I want to say and what I want to make clear, Mr. Speaker, is that if these cuts go through, it has been estimated that it will cost GME and IME reimbursements from Medicare $60 billion.

□ 2110

This could mean a loss of 2,600 jobs and $653 million in State and local revenue. And, Mr. Speaker, a $10.9 billion loss to the U.S. economy.

At current graduation and training rates, the Association of American Medical Colleges projects that the Nation could face a shortage of as many as 150,000 doctors in the next 15 years—150,000 doctors.

We talked about this, and I think whether you're on one side of the aisle or the other, whether you agree with the health care law, we all agree that we want to have, in a country as rich and as generous as ours, we want to have access to health care for all Americans. But if we don't have physicians to provide that care—and this estimate is 150,000 doctors in the next 15 years—a shortage of that many, it will discourage this access to health care and will result in the longer waiting times for patients.

Mr. Speaker, in closing, I want to just emphasize a few points this evening. And it's always an honor to be here on the House floor. It's always an honor to talk to the Speaker. And tonight it's been an honor to be able to address health care.

As a health care professional, I spent years as a nurse and then, as I mentioned, as an attorney representing a hospital. I know that people within the health care profession are dedicated. They have a passion to provide the American people, to provide any people with quality health care, to make sure and ensure that they have quality health care.

Mr. Speaker, the United States of America has the best health care in the world, and so it is so imperative that we preserve this health care system.

My colleague from North Carolina mentioned earlier that we voted to repeal the health care law, the Affordable Care Act, because it's not in the best interest of good health care. And tonight you heard, Mr. Speaker, from several of my colleagues who are health care professionals who dedicated their whole lives to providing medical services to the people in their communities. They care about quality health care. They care about people, and they care that the United States of America has a good health care system.

But we don't believe that good health care, access to health care, reasonable costs within health care, are going to result from the Affordable Care Act. The Affordable Care Act, I want to emphasize this one more time, Mr. Speaker, cuts Medicare to our seniors by $500 billion. To our seniors, that will be a devastating blow to the services and the access to services that you will have.

But beyond that, it affects how our hospitals can provide care, how our hospitals will be paid, how our doctors and our young doctors will be trained for future generations. This Affordable Care Act may have been the most well-intentioned law, but it is devastating for health care and health care delivery services in the United States of America.

Mr. Speaker, hospitals serve us and our communities. The crafting of the Affordable Care Act was carried out with the good intentions of many, as I said. I don't want to indicate or imply that people didn't have good intentions with this Affordable Care Act, but they approached it from the wrong direction. They put the government in the middle of a physician and the patient, and that can never work.

But good intentions are not enough to excuse legislation which has a terrible and far-reaching, albeit unintended, consequence for all sectors of our society, especially our patients, our doctors, and our hospitals.

Mr. Speaker, I yield back the balance of my time.

HEALTH CARE AND THE BALANCED BUDGET AMENDMENT

The SPEAKER pro tempore (Mr. HULTGREN). Under the Speaker's announced policy of January 5, 2011, the gentleman from Texas (Mr. GOHMERT) is recognized for 30 minutes.

Mr. GOHMERT. Thank you, Mr. Speaker.

One thing we've got plenty of around here is paper, unfortunately. We've got bills, we've got laws that we should have taken up that we haven't.

And when we talk about the health care bill, people know we talk about ObamaCare, whatever the formal name is. Cutting $500 billion out of Medicare already. That's a done deal. That was rammed through by the majority when Speaker PELOSI was in charge at the behest of our President Obama—$500 billion in cuts. Our seniors deserve better than that kind of treatment.

Republicans, I don't think we had any Republicans vote for that. But it was driven through against the will of the American people, and against the will of the Republicans. But Democrats had the votes, so they did it—$500 billion in cuts to Medicare.

So when AARP has all these seniors send in petitions saying, I'm a member of AARP, don't you dare cut anything from Medicare, we try to make sure our seniors know that it was AARP that stood by the President as he cut $500 billion, and we're glad that they're finally waking up to just what the President and AARP, with AARP's assistance, what they did to seniors.

But if you look at how much money we are spending on Medicare, not to even mention right now Medicaid, just look at how much we're spending on Medicare, and you look at the number of households we have, around 17.5 million Medicare households—this was from 2009. You divide that into the amount of money that we're spending, the Federal Government's spending on Medicare—not even Medicaid, just Medicare: We're spending right at $30,000 for every household with somebody on Medicare. $30,000?

Now, for someone who's got bad heart problems or some kind of chronic disease, well, that's not so bad when you consider what all kinds of treatments and medicines they're getting. That's if you look at the bills that are sent out.

If you look at the amount of actual money that are paid for those procedures, or actually paid or reimbursed by insurance companies or the government for that money, it's not near that much for most households, even most households on Medicare.

That's why I was shocked in the not too distant past to find out that in one situation that I'm aware of personally, when there were $10,000 in bills between the hospital, the physicians, the ambulance, the testing, the people reading the tests, and all that stuff, 2 days of hospitalization, $10,000. It turns out that the insurance company, the health insurance company resolved all $10,000 in bills for about $800.

Well, if we knew exactly how much was being paid to pay for those exorbitant health care bills, we could then finally reintroduce something known as free market principles.

Now, the doctors I talk to, the health care providers I talk to, they wouldn't mind that. Their hands get tired. There are some insurance policies or contracts that health care providers have with some of the health insurance companies that said they cannot charge—that's what I'm told—they can't charge somebody paying cash as little as a health insurance company providing the contract gets out by paying.

You can't have competition in health care until people know how much they're paying for their medicine, for their hospital stay. You've got to know what they're paying.

It was a great thing growing up in a small town in East Texas. I loved the town, Mount Pleasant, Texas.

□ 2120

After I finished 4 years out of the Army from a scholarship at Texas A&M, my wife and I settled in Tyler. We've loved it. It's the only home my kids knew growing up. Been so good to me. But my wife and family, we've all been blessed there.

But in the smaller town I grew up in, everybody knew the doctors. And from time to time we would go to a different doctor. And a lot of the times it was because we found out one upped their price so we would go to another doctor who didn't charge quite as much because they were good. That's called free market competition. We don't have that any more in health care. We've got to get back to it. If we're going to bring the costs down, we've got to get back to it.

People have to know what it costs to go to the doctor. People need to know that their medicine that they see a cost of $900, that the insurance companies, when they reimburse for that $900 prescription, don't pay but a fraction of that. So if somebody can't afford insurance, why should they have to pay $900 for a prescription drug that a health insurance company wouldn't pay a fraction of that much? We have to get back to having some competition in the cost of things.

So there's one way, really the only way I see we get off this track to total socialized health care that ObamaCare puts us well on down the road toward arriving on, and that would be through greater use of health savings accounts. We're told by some actuarials that if kids in their twenties and thirties start putting money in a health savings account and it grows and it grows because they don't use much at that young age, by the time they're eligible for Medicare, not only would they not want to use Medicare, they wouldn't need it. They'd have so much money built up in their health savings accounts that they didn't get through every year.

I agree with some of the people that I've consulted over the last 4 years on what would be a better plan that if you could have people putting money every month in a health savings account, building that account, then not allow it to be drawn out for something like buying a boat or anything like that, but it has to be for health care, can't be for anything else. Once its dedicated in a health savings account, and it should be allowed to be put in there pre-tax, then it has to be for health care.

Oh, sure, we ought to be able to allow people to donate that to some charity that keeps health savings accounts for the less fortunate, ought to be allowed to gift it or bequeath it to children, to family and help them grow that big nest egg of a health savings account, and then you have a debit card coded to cover nothing but health care costs. And you use that health savings account until you reach the amount of the high deductible that the health insurance policy has, and then the health insurance kicks in. That would help make health insurance so much cheaper for most folks. That's what a lot of us have gone to, and I have myself. It is a lot better deal. It is a lot cheaper.

But to think about, as these numbers indicate from 2009, that every household with someone on Medicare is costing nearly $30,000, it is just staggering. And that's why instead of continuing to move toward rationed care putting our seniors on lists where they can't get treated very quickly, they have to wait, because let's face it, the way of socialized medicine is rationed care.

And President Obama not only must have known that that was the truth, but he put a man in the position to oversee ObamaCare who had made clear in prior statements that it's not a matter of if we go to rationed care, it is a matter of when. And then he's the guy that ends up in charge of ObamaCare because obviously this President and the Democratic majority in the last Congress intended—expected—that seniors would be getting rationed care.

How much better to say, you know what seniors, you've got a choice. How about that? We've had so many people on the Democratic side of the aisle talk about it should be people's right to choose. They should have choice. How about in health care? How about giving seniors a chance to choose? You want Medicare? You want to be denied some medicines? You want to have to keep buying that supplemental coverage from AARP? Your choice.

On the other hand, if you want to do something different, we'll put—and I'm flexible on the amount, but it appeared $3,500 was a good, effective amount for achieving that kind of high deductible and lower cost for the insurance policy. Then we, the Federal Government, will