## GOP DOCTORS CAUCUS: MEDICARE SENIORS AND OBAMACARE

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

Mr. FLEMING. Thank you, Mr. Speaker.

I come before this House tonight to talk about a very important issue—it's been important for years, and it's going to be increasingly important and increasingly a part of the debate—and that is health care, and particularly health care for our seniors. We've got lots going on. ObamaCare, of course, was passed in 2010, and we're running into all sorts of problems. Of course, I and my Republican colleagues here tonight voted against it.

I'm joined tonight, by the way, by two of my colleagues, Dr. PHIL ROE, an obstetrician from the great State of Tennessee, and Dr. SCOTT DESJARLAIS, who is, like me, a family physician.

I thought I would just give a brief introduction about Medicare and how that fits into the budget. I know that Dr. ROE is going to talk in more detail about that.

No speaker would be complete without a chart, and I have several tonight. This is one I think that's important for everybody to understand. This pie chart breaks up spending for the Federal budget. If you will notice, the vast majority of this pie is in what we call permanent mandatory or so-called entitlement spending and interest. What makes up a large part of mandatory spending is Social Security, Medicare, and Medicaid. The size of this pie, this section of the pie, is growing. In fact, if you recall, back in the nineties we actually balanced the budget. The last time we balanced it, I think was in the late nineties. It was a lot easier to do back then because entitlement spending, permanent spending, was not in place to the extent that it is today. It was growing, but not as big.

What is the difference between mandatory spending and discretionary spending, which is the other two pieces of this pie? Mandatory means that if you qualify for a certain type of service or payment, whether you're on Medicare, Medicaid, whether you earned it or not, if you qualify for it, the government must pay. No matter who shows up or how many people show up, the government must pay. So, therefore, the government cannot per se control that cost.

Discretionary cost, on the other hand, is split into two: defense, which is around $600 billion to $700 billion a year; and nondefense discretionary, which is what we run the government on. That we can adjust, although we've not done a good job in controlling this. In fact, that's increased probably 25 percent just in the last 2 years under President Obama.

But I want to illustrate for you what the problem is, and that is that the entitlement spending, which we don't control, with an aging population and the fact that it's dependent on government spending, is growing at a much faster rate than our revenues and inflation.

□ 1910

This is a chart that outlines where we are today with Social Security, Medicaid and Medicare, the part of entitlement spending. Now, let me say, first of all, Social Security is down here in the purple, and you notice that it slants upward and then it flattens out. Social Security is not our problem. Let me repeat that: Social Security is not our problem.

And people who are on it or will be on it, in my opinion, have nothing to worry about. Now, we may have to tweak it, we may have to adjust it, but you'll notice that the cost really rises relatively slowly, and that's just a matter of demographics. And we can adjust this, as we have in the past, and make this sustainable. There are other ways to do it, in terms of allowing Social Security recipients to invest some of their money and so forth, but that's beyond the scope of discussion tonight.

The next group in green is Medicaid and other health care. You'll notice it's going up faster. And Medicaid is health care for the poor. And then finally in red you see Medicare, and you see how that explodes and it goes up continuously. Medicare alone will completely displace all the budgetary spending eventually if we don't bring that under control. And that would mean we'd have to give up on government itself, we'd have to give up on a national defense—everything—unless we begin to control that.

Now, at the rate things are going, Medicare will run out of money, become insolvent by 2020. And that is straight from the CBO, the Congressional Budget Office. Another way to look at it is that our spending is now equal to 15 percent of the total Federal spending is Medicare, blowing out of control. What has made this worse is ObamaCare actually cut $500 billion, that is, half a trillion dollars, out of Medicare to use for subsidies for middle class health care plans.

So let me repeat: Medicare is running out of money; it's exploding through the roof. And what does ObamaCare do, the Members who voted for it, it actually cuts money out of it and depletes it of money in the future so that it becomes insolvent. And here's where the cuts are: $135 billion for Medicare Advantage, which is the private health care version of Medicare, $112 billion, which was taken from hospitals, $39.7 billion from home health, $14.6 billion from nursing homes, and $6.8 billion from hospice care. These are very real cuts.

And the only explanation that the other side gave us, our Democrat friends, is that somehow we'll cut out fraud, waste and abuse. Well, let me warn you, any time a politician tells you he's capable of doing that, watch out, because I've never seen it done and I don't expect to see it done in the future. Because, you see, in order to cut out the massive fraud, waste and abuse, you have to spend even more money to find all the bad actors. The best way to do away with fraud, waste and abuse is to make the system much smaller, perhaps even privatize it, and make the system accountable rather than a Big Government bureaucracy, which wastes money, whether we're talking about the Department of Defense or Medicare. So that should give you kind of a beginning of where we are with Medicare.

Let me just close my opening remarks by saying that there's basically two options when it comes to making Medicare again solvent and available for us in the future. There is a Republican plan, which would allow you, if you are currently on Medicare or 10 years from becoming on Medicare, to keep Medicare as it is. And it is sustainable, as far as the CBO tells us, indefinitely.

However, we would have to reform that for younger adults today who will be senior citizens by opening up the insurance system, creating a marketplace for seniors to buy insurance, and then let government help them with what we call ''premium support,'' and allowing competition in private care to drive the cost down and raise the level of service. In fact, what we in Congress have today is the very same thing.

The Democrats, their plan is this: goose egg, no plan whatsoever. Under their plan—or non-plan—Medicare runs out of money in 8 years. And they've failed to present an idea, much less a bill, as we have, that would even solve that. Well, that gives you an idea of some of our opening discussion.

First tonight, I want to introduce my good friend, PHIL ROE. Dr. PHIL ROE, as I said, is an obstetrician. I think he has some comments about the financing of Medicare and other things as well.

Mr. ROE of Tennessee. I thank you, Dr. FLEMING, and I appreciate you hosting this hour tonight and a chance for us to discuss in detail the health care of this Nation.

You know, about 4 or 5 years ago I made a decision, after 31 years of practice, to think about running for Congress. And one of the reasons was I knew that the health care issue was going to be huge in the debate in this Nation's future. And, boy, has that turned out to be prophetic.

Secondly, the thing that I noticed in my patients when I practiced, the single biggest factor for both Medicare patients and my other private patients and patients without health insurance, was it was too expensive; it cost too much money to go see the doctor and go to the hospital. If it were more affordable, more of us would have health care coverage.

Thirdly, we had a group of patients in my practice that couldn't afford expensive health insurance premiums.

They both worked. Let's say it was a carpenter, perhaps his wife worked at a local diner or at a local retailer that may not provide health insurance coverage, and they make $35,000 or $40,000 a year, but they could not afford $1,000 a month for health insurance coverage. And, lastly, we have a liability crisis in this country.

The other thing that we're going to get into a little later in this discussion today—and this is the absolute sacrosanct in health care—is that health care decisions—and I'm going to say this a couple of times—health care decisions should be made between a patient and the doctor and that patient's family. It should not be made by an insurance company, and it should not be made by the Federal Government. And we're going to talk a little bit later about the Independent Payment Advisory Board that will be making those decisions in the future.

Do we need health care reform in America? Absolutely. Do we need this type of health care reform? Absolutely not. It's a disaster. And we'll go into that a little later about what my major concern is for my patients that I left in Johnson City, Tennessee, which was how are they going to access a Dr. JOHN FLEMING, how are they going to access a Dr. SCOTT DESJARLAIS, who are family practice primary care physicians. And the group I have at home that I'm in that I left to come here had over 80 primary care providers. How are they going to access those?

Well, let's go look at where we were in the sixties when I was a young college student, which was that we had a group of people, my grandparents and so forth, who would be retiring. And at that point in time, because their insurance was tied to their employment—if they had health insurance coverage—there was no way for them to get any coverage. They couldn't buy it; there was no way it could be provided for. So the Federal Government then got involved in this by forming Medicaid and Medicare in 1965.

Our Medicare program in 1965 was a $3 billion program. There was no Congressional Budget Office at that time, but the estimates were that in 25 years—so in 1990—this program was going to be a $15 billion program. The actual number was $110 billion. They missed it by seven times. And in your initial graph right here, if you had placed in that graph, Dr. FLEMING, interest on the national debt—the one you showed with Medicare, Medicaid and Social Security—by 2020 or 2022, even at current interest rates, it will absorb the entire Federal budget. And that is why we're having this discussion today, to save Medicare.

I want to mention just briefly, because we'll kick this off later, in the current health care bill there have been many changes to Medicare. There are increased taxes on medical devices. The President said the other day—and we're going to talk about it next week, I think, and debate the payroll tax—about how he was a tax cutter. Well, I would suggest that the President read his own health care bill because there are massive tax increases in that bill.

The Independent Payment Advisory Board is a bureaucratically appointed board, 15 people appointed by the President—and I don't want a Republican President appointing them and I don't want a Democrat President appointing them—approved by the Senate to do what? To look at this Medicare, as we've pointed out, with millions of Medicare recipients each day and—as Dr. FLEMING pointed out—$500 billion to $550 billion less going into the system. More people going in, people living longer—much longer, which is a very good thing—we're looking at a catastrophe for our Medicare program if we don't make some proactive changes now.

□ 1920

And how can you talk about how can you fix a system that everybody in this Chamber knows is broken—all 435 of us know it—if you can't even discuss it, if you're accused of dumping Grandma off a cliff if you even talk about a system that—I personally am on Medicare. Right now I'm a Medicare recipient, so I have a vested interest in seeing that this program works for current seniors.

I was at Furman University Monday night speaking to a group of college students on health care. It was a privilege to be there. It's a great college. A big turnout of young people. And it was embarrassing for me to look at those young people who are just beginning their careers and to think that we're going to not leave them the same access to care that I have available to me right now.

If you look at these numbers, Dr. FLEMING, you see that it is not sustainable, so we have to have this conversation. I want to thank you for holding this 1-hour.

I see we have numerous other colleagues here tonight.

Mr. FLEMING. I thank the gentleman.

We have also been joined, in addition to Dr. SCOTT DESJARLAIS, by Dr. PHIL GINGREY, also an OB–GYN; Nurse ANN MARIE BUERKLE; and NAN HAYWORTH, an ophthalmologist from New York. So we've got a full cadre. If anybody here has a headache or, certainly, a heart attack, I think they would be very well taken care of on the floor of the House.

With that, I'm going to ask Dr. DESJARLAIS to talk to us a little bit. I think you have an interest in some of this discussion on IPAB and perhaps other things, so I'd love to hear what you have to say, sir, on that.

Mr. DESJARLAIS. Thank you, Dr. FLEMING. And I, like Dr. ROE, appreciate you holding this tonight because I think there's so much fear, frustration, and confusion among our Nation's seniors right now about what's really going on. There's a lot of misinformation out there. And I think it's good that we, as health care providers, can get together and help clear up some of the misinformation because, as Dr. ROE said, we should never let the government or bureaucrats get between the doctor and the patient. That's a very important relationship, and I think most all patients would agree.

How did we get into this mess?

It's really kind of mind boggling that it has come this far. And as you stated earlier, the Democrat plan is doing nothing; and we know that the consequences of that as, per the CBO, the actuary of CMS, Mr. Foster, has said Medicare will be bankrupt by 2020. So we cannot afford to do nothing. And we got into this mess really just by kind of the head-in-the-sand approach that sometimes occurs here in Washington.

As Dr. ROE mentioned, Medicare was initiated in 1965, and at that time the life expectancy for a male was 68. Well, thankfully, through good medicine, good follow-up, good care, better drugs, better techniques, the life expectancy has gone up at least by a dozen years. But that being said, there really wasn't any planning for that increase. A program that was designed for, on average, 3 years of coverage is now 12 years more, and so that's part of the problem.

A second big factor is we all knew about the baby boomers. Everyone knows about them. And the bottom line is they have started hitting the system at an alarming rate. Ten thousand new members every day are entering the Medicare system. Again, something that we've all seen coming, but it wasn't accounted for in terms of cost; and Dr. ROE explained how it was underestimated greatly what it would cost in the first place.

We know that people pay into Medicare because that is going to be their health care plan when they retire. That's what was promised to them. So we can't do nothing.

In the Paul Ryan plan, we laid out that those 55 and older won't have to worry about it. We know that we can't do nothing, so those 55 and under will have to make changes, as you discussed, and I'm sure we'll discuss more.

But for those seniors out there that are concerned that the Republican plan is cutting them off or killing Medicare as we know it simply isn't true. We're trying to preserve, protect, and save it for future generations as well as take care of them.

Right now you can take an average couple who makes $80,000 a year and they pay, over a lifetime, about $109,000 in Medicare taxes into the program. But with health care costs the way they are now, the average extraction for that same couple is $343,000.

Mr. FLEMING. If the gentleman will yield on that point, I want to be sure that that's not missed, and that may be the most important statement made tonight. I believe you said that, through a lifetime, a Medicare recipient will pay in an average of 100,000 or so dollars but will take out, on average, $300,000.

So what we really have with Medicare is somewhat of a subsidy system which does not subsidize according, necessarily, to need. My point in saying that is: Warren Buffett, today, because he's over 65, qualifies for Medicare, and if he gets care, I assume would get the same subsidized care, subsidized by whom? Taxpayers—middle-class, working-class people who pay the private insurance rates.

In some ways, Medicare has become not just help for the poor and the elderly, but just subsidy for people over 65. And so we're going to have to look at: Is there a way in the future that we can even this out, where we're not necessarily subsidizing for those who are capable of paying some of their own costs?

Mr. DESJARLAIS. Right.

As you say, it's clear that $1 in for $3 out doesn't add up by anybody's math, even Washington's math. So those factors make it very clear that Medicare is on an unsustainable path.

I find it very frustrating that so many people are living in fear right now with this misinformation. And if any of the other Members—I'm sure they experienced, as my office did, the AARP here, a few weeks ago, had seniors calling Congressmen to say, you know, Don't cut our Medicare. They're referring to the SGR cuts, which actually pertains to the doc fix. But the seniors are confused thinking that their Medicare was actually going to be cut 30 percent or 29, 27 percent, whatever it is. And so when they were calling my office, I was glad to tell them, Yes, we get it. That actually is a cut to physician reimbursement.

But what it does to seniors, more concerning, is that it's going to limit their access to care, because physicians right now are in a position where they can't afford the overhead to even keep their practices open.

I think it was good that the AARP brought that to their attention, but it certainly is great that we have the opportunity tonight to clear that up for our seniors, that it's not a cut, a direct cut to their Medicare benefits, but it is going to directly impact their access to care.

Mr. FLEMING. Absolutely. I thank you for the wisdom of your experience, Dr. DESJARLAIS.

I'd like to turn to Dr. GINGREY here. He's joined us and, of course, has conducted a number—I can't even count the number that I've participated in with Dr. GINGREY with respect to Special Orders that we've had.

And before doing that, just to follow up on what Dr. DESJARLAIS said about the 100,000 in, 300,000 back, I can recall one day in my own practice sitting there and thinking about the three patients that I just saw. In Room 1, I saw a little lady who's on Medicare who could barely scrape by by the end of the month, and she's on Medicare and getting the benefits of Medicare, and God bless her, she was getting them. And then I thought about the second room where there was a gentleman who's a multimillionaire. But you know what? My charge to both of them and what Medicare did for both of them was precisely the same.

I just couldn't quite understand that, especially when I thought about the little mother in Room 3 who's on private insurance, two-paycheck family, baby, barely scraping by, paying far more in their premiums than someone in Medicare and having to raise children. It was her insurance premiums that were subsidizing both the little old lady who was poor and the multimillionaire.

We're going to have to do something about that to make the economics of this system work. It is unsustainable, as we know.

Dr. GINGREY, I would like to ask you if you could give us a few words, sage wisdom on what your perspective of where we are with health care, ObamaCare, Medicare, and all the other cares that we're talking about.

Mr. GINGREY of Georgia. I thank the gentleman from Louisiana, Dr. FLEMING, for yielding, Mr. Speaker, and I thank our leadership for giving us this hour to focus in on Medicare and ObamaCare, formally, I guess, called Patient Protection and Affordable Care Act. We all know it to be the Unaffordable Care Act.

But I think it's very important, Mr. Speaker, and instructive for the folks back home, especially our seniors, to look at this body and the other Chamber as well, Congress as a whole, and you look at the Members who are health care providers. In this House of Representatives, there are 435 Members, and 21 of them on the Republican side are health care providers: nurses, doctors, psychologists, dentists.

□ 1930

On the Democratic side of the aisle, three. You look at the other body, at the Senate, and you see four doctors on the Republican side. None on the Democratic side.

So as we get into this season, this political season, of course the Presidential election cycle, Mr. Speaker, you know, we all know, that we're already seeing the ads. I think Dr. DESJARLAIS referred to this add about cutting Medicare 30 percent. Don't let Congress cut Medicare 30 percent. And who cares more about seniors.

And I think those statistics are pretty darn telling in regard to who cares more about our seniors. Many of us, in fact, have practiced so long that we're seniors. Thank God we've got good health and vigor and enthusiasm for giving up what has been a wonderful profession, whether we were nurses or doctors or whatever, but caring for people and the compassion that goes with it, to come to Congress, come here inside the Beltway and really work on behalf of our seniors, work on behalf of getting the health care policy right. But particularly in regard to our senior citizens and the millions that depend on Medicare either because of a disability or their age.

So it's the Republican Party, Mr. Speaker. It is the Republican Party that is really working on behalf of our seniors.

What did the Democrats do when they were in control for that brief period of time and Ms. PELOSI was the Speaker? They brought the country a whole new entitlement program, ObamaCare. It had nothing to do with seniors. It had nothing to do with the poor, who are covered by Medicaid and the Children's Health Insurance Program, the SCHIP program. In Georgia it's called PeachCare. They did nothing to strengthen Medicare.

In fact, to pay for this new entitlement program, health insurance for all, young and healthy people, they gutted the Medicare program.

Mr. Speaker, the gentleman from Louisiana has a poster before us right now, the first slide, if you will, and we need every one of us on both sides of the aisle to focus on that. And as he points to the first bullet point, cutting $575 billion from the Medicare program. And most of it, in the next bullet, is from the Medicare Advantage program. And of the 40 to 45 million people that are on Medicare, most of them, because they're 65, maybe 10 million of them because they're disabled and younger, but so many of them, Mr. Speaker, get their health care on the Medicare program through something called Medicare Advantage. And that's the key word.

Why is it Advantage? Because it gives them comprehensive care, it gives them an emphasis on wellness, prevention. It's not just treating disease. It gives them a drug benefit even before Medicare Part D was enacted by a Republican Congress back in 2003. And what do the Democrats do? They took—what was it, Dr. FLEMING?—$135 billion out of the Medicare Advantage program over a 10-year period. That is a 14 percent cut.

And President Obama says if you like what you have you can keep it. Well, you can keep it if it's still available, but it won't be.

We're here tonight to let the American people know and let our colleagues know, and if we have to hit them over the head with a 2-by-4 to get their attention, we're going to do it. Because they are ruining a great program. And we're health care providers. It breaks our heart. We know. We see the patient. We are at their bedside in sickness and in health when they come to our office for routine checkups.

But we're here now I guess as policy wonks. It's our colleagues back home—we want to keep them in the Medicare program, particularly primary care doctors seeing those patients. It just breaks my heart to see what's happening.

I thank the gentleman from Louisiana for managing the hour tonight on behalf of our leadership to make sure that these points are made and

made very clear to the American people, particularly our seniors.

Mr. FLEMING. I thank the gentleman. Dr. GINGREY serves on the House Energy and Commerce Committee, a committee that has oversight and jurisdiction in this area, very important, looking at a lot of legislation.

Next, I want to turn to another of our freshmen. We've had a wonderful cadre of freshmen we appreciate so much and a wealth of physicians and dentists as well bringing in their years of experience, training, and education.

Next I would like to recognize Dr. HAYWORTH, NAN HAYWORTH from New York, and would be very interested to hear what you have to say this evening.

Ms. HAYWORTH. Thank you, Dr. FLEMING, and I add my thanks to our distinguished colleague from Georgia in gratitude for your hosting and managing this session tonight.

We just had a Medicare telephone town hall today with our constituents in the beautiful Hudson Valley. We had a Medicare administrator with us because it's open enrollment season for Medicare throughout the country, I believe, up through December 7. So we were very grateful to have a Medicare administrator with us who helped answer some of the questions about some of the complexities of Medicare because there are a number of them, as you might imagine.

But we did get one question that was conspicuous because the gentleman asked me, and it's one that we've all been asked, as Dr. DESJARLAIS was saying not long ago, ''NAN, why are you against Medicare?'' I explained to my constituent that gosh, sir, it's exactly the opposite. I want to preserve and protect Medicare. I want to make it secure and sound. This is very important to all of us, to me as a doctor. I had the privilege of practicing for 16 years. I'm an opthamologist. So many of my patients were seniors. I'm the daughter of two elderly parents, both of whom rely on their Medicare benefits. So the last thing that I would want to do, the last thing that any of us want to do is to harm Medicare. We know how important it is.

More specifically, this nice gentleman was asking about our vote on the budget this past spring. And as all of us here know and as our listeners may not be fully aware, we did pass a budget in the House of Representatives this past April. They may not have heard quite as much about it as they otherwise should have, if you will, because the Senate did not pass a budget. They did give ours 47 more votes than the one proposed by the President. Nonetheless, that was not enough to pass a budget so we've been waiting now, the American public, for at least 2½ years for the Senate to pass a budget.

But in our budget, and Dr. GINGREY and Dr. FLEMING have just been referring to the $575 billion that was removed from Medicare by the massive 2010 health care overhaul. In our budget, we restore those funds to Medicare. That is a very, very important fact.

We all voted here as doctors, as caring legislators, as representatives of our districts to restore funding to Medicare, to strengthen Medicare, not to weaken it. That's the last thing we want to do and the last thing we can afford to do.

So I think it's very important for the American people to understand that as things stand now, the Medicare benefits that people are counting on are threatened in ways that they don't have to be.

So that's something that people should think about, people who cherish Medicare, who receive Medicare and who have loved ones who depend on Medicare; that Medicare is, unfortunately, as our colleagues have discussed, running out of funds.

When we think about payroll taxes, and we hear a lot about payroll taxes in the news these days, payroll taxes go to pay for Social Security and for Medicare. And the way these programs were set up, as we all know but just so that everybody understands, they were supposed to be, people would contribute from their paychecks, and the money would be kept by the Federal Government and then returned to them in their benefits in their senior years, when they would need them.

□ 1940

That could be a very helpful thing; but as Dr. DESJARLAIS has pointed out, thank the good Lord, people are living much, much longer than they were when Medicare was first made law.

So we are facing a challenge because, for several decades, contributions to Medicare from the payroll taxes were built up. People weren't taking out as much in their Medicare benefits as they were paying in. The baby boomers were not part of the Medicare-eligible senior group yet, and now they are. Now our seniors are living many years longer, thank the good Lord—and I wouldn't trade a day with my parents nor with any of our seniors—and our health care is wonderful in the United States, but it is costly for a number of reasons.

The Medicare funds that were built up have now started to be depleted, and they're going to run out, it's projected, anywhere from 2024 to now 2021. What we all know is that the estimates are probably off the mark. So, to take an extra $575 billion out of Medicare is the last thing we want to do.

It's very important for everybody to understand that because, although there are workers in this country who are contributing their payroll taxes now—and those are going to help fund Medicare—when those folks become retirees, Medicare is going to be very different in terms of the funds it has. That Medicare trust fund is going broke.

So folks have been thinking about—Dr. DESJARLAIS in particular mentioned it, I think—and may have heard three letters, SGR, about the doc fix. What is that? What does that mean?

When patients go to visit their doctors and when they receive Medicare, as Dr. FLEMING was saying, our Medicare patients have a certain fee schedule that we are obligated to follow. In a lot of cases, depending on their insurance and other factors, that fee schedule is far less than the fee schedule that is set up for our other patients. So Medicare pays doctors and other providers, and it generally pays less than other programs do. We accept that when we participate in the Medicare program, but to provide Medicare in the United States is very expensive. We have staff that we have to pay. We have overhead. Everybody who has a business—and I had my own practice, a small business—has rent and supplies and staff and insurance to pay.

One of the unique aspects of America in terms of our medical care is that we do have what's called a ''liability system,'' which is very costly, to cover lawsuits for malpractice. We should, indeed, do everything we can to prevent malpractice, but lawsuits in this country are very expensive.

Mr. FLEMING. If the gentlelady would yield, I think Dr. GINGREY has something he would like to add.

Mr. GINGREY of Georgia. I thank the gentleman from Louisiana for allowing me to take up a little time—maybe just a minute—to interrupt the gentlelady from New York.

Ms. HAYWORTH. Absolutely.

Mr. GINGREY of Georgia. She has made such great points.

The thing that I wanted to mention to my colleagues is that if we do nothing—and I think Representative HAYWORTH pointed this out—it is really not an option. She talked about those dates—2024, maybe, but probably closer to 2021—when part A becomes fiscally insolvent. If we do nothing, then what would happen is our seniors under the Medicare program would take a 22 percent cut in their benefits package, or else we would have to raise the payroll tax 22 percent.

I'll yield back after making this comment as I think this is important.

Medicare was enacted as an amendment to the Social Security Act in 1965. I guess it's title XVIII. We didn't have all of the information we needed back then. As Representative HAYWORTH points out, situations were different. Back then, people were not reliant so much on medication. It was more surgery and that sort of thing. Now we have Medicare part D. The point is that things change; and if we hadn't changed with the times, we would still be watching analog television. It's just as clear and as simple as that.

For people to criticize what the Republican budget called for in regard to making changes to Medicare so that it remains solvent for our children and grandchildren—and, as Dr. HAYWORTH pointed out, to protect it, preserve it

and strengthen it for those who are already on it—it would not do anything in regard to them but would be a phased-in change for our children and grandchildren so they'll have it like we've had it.

I thank the gentlelady for letting me interrupt briefly.

Mr. FLEMING. Since we are beginning to run a little short on time—and I want to make sure we get to all of our doctors and nurses—I'm going to recognize Ms. BUERKLE, a very excellent nurse and a wonderful addition to our freshman class.

Ms. BUERKLE. I thank my colleague from Louisiana.

Mr. Speaker, I just want to say what an honor it is to be here tonight on the floor with my colleagues and the members of the Doctors Caucus.

I do stand here as a nurse and also as the daughter of a 90-year-old mother. So Medicare for her, I know how she depends on the system.

One of the things we didn't talk about and one of my roles in life was as an attorney, as an attorney who represented a large teaching hospital. About 2 weeks ago, I joined with some of my colleagues on the House floor, and we talked about what this health care law is going to do to our hospitals. When our hospitals and our doctors are affected by reimbursements, by Medicare cuts, that really affects our seniors. That reduces their access to care.

So the first thing I want to do tonight as a health care professional and as someone who cares deeply—and I think that's the beauty of this tonight, of our getting together as people who have invested their lives in health care, who love people, who care about people. This isn't a Republican or a Democratic issue. This is an American issue because health care affects all of us. This is a group of people who really believes that there is a better way, that there is a much better way to provide access to health care in our country without jeopardizing that access and without jeopardizing the quality of care that our country has to offer.

So the first thing I want to do tonight is reassure our seniors that we are talking about protecting and allowing the Medicare system to continue on. What they need to understand is that the health care law has changed Medicare forever. Medicare is different now than it was before the health care law passed. The health care law cuts, Mr. Speaker, $500 billion from Medicare.

I just want to make clear on this graph what happens to Medicare reimbursements from 2012. You can see where we are. It's a minus, a cut of 9.7 percent; but here in 2018, the cuts to Medicare and the reimbursements to our hospitals are down 28.6 percent. I've had all the hospitals in my district come to me, and they were proponents of the health care law. They wanted reform. They've come to me and they've said, This health care law is going to bankrupt us because not only is the health care law affecting their Medicare reimbursements; it's affecting their disproportionate share reimbursements, which keeps many hospitals afloat that treat indigent patients and that treat Medicaid patients. It also affects their GME and their IME, which we talked about in the last Special Order we had in regards to how we're going to keep our teaching hospitals and keep all of our hospitals viable.

So I just want to leave the message tonight with the American people that we care about preserving Medicare for our seniors. We are not proposing anything in our budget proposal that would affect our seniors and those back to age 55. We want to assure the American people that we care so deeply about health care and about the quality of health care; but we are very concerned about this health care law, and it's why we voted to repeal it several months ago. One of the first things we did when we came to Washington was to repeal the health care law because we know what it will do to our seniors and to our health care providers.

I thank my colleague for organizing our time here tonight on the floor. Again, we just want to reassure the American people that we care about our seniors. We want to make sure they have access to quality care, to good health care.

□ 1950

Mr. FLEMING. I thank the gentlelady for a very compelling discussion, both as a health care provider and nurse, but also as a daughter of an elderly mother. Those words are very heartfelt, and obviously it means as much to you that we protect Medicare and health care in general as it would anybody. There's no reason why, just because you're a Member of Congress, that you would love your mother any less, so I think those are important words.

We're going to move now from a nurse to a surgeon. Dr. BENISHEK from Michigan has joined us this evening, and let's hear from you, Doctor, and see what you have to tell us.

Mr. BENISHEK. Thank you. Mr. Speaker, it's my pleasure to be here this evening to join my colleagues to talk about Medicare.

As you may know, before coming to Congress, I served as a general surgeon in my district for the last 30 years, and many of my patients were on Medicare. And as a practicing physician, I often expressed to my patients—and my understanding wife—about our broken health care system here in America. In fact, that's one of the reasons I decided to get more involved in the political process and actually run for Congress.

Most Americans don't understand that Medicare will be bankrupt within the decade if we don't do something to fix it. I didn't make this up. The actuary for the Centers for Medicare and Medicaid Services actually provided this number. You know, I think if you ask most 65-year-olds just beginning to use Medicare, most would be very worried to learn that their primary health care provider was projected to be bankrupt within the decade.

In fact, according to a recent Social Security Trustees report, Medicare seniors should expect to see a 22 percent benefit cut or workers should expect to see a 22 percent hike in their payroll taxes unless some action is taken. The bottom line is, if action isn't taken today, seniors in the program today, not to mention those looking to retire in the near future, begin to lose their benefits.

Despite these facts, the other side of the aisle has spent the last 6 months attacking us, often saying that House Republicans' attempt to protect and preserve Medicare was, in fact, destroying it.

Are you kidding me? Accusing myself and my fellow physicians in the House of wanting to end Medicare? We spent our careers caring for Medicare patients and are proud now to call them constituents.

The real truth of the matter is that President Obama was elected in 2008 with the promise of hope and change. He did accomplish change in America's health care system, but I don't think it's the kind of change that Americans bargained for.

Mr. Obama's health care law cut $575 billion from an already ailing Medicare system. The name of Mr. Obama's health care bill is the Patient Protection and Affordable Care Act. Mr. Speaker, I ask you: What type of patient protection cuts $14.6 billion from nursing homes, $112 billion from hospitals, and $135 billion from Medicare Advantage?

While I'm on the record extensively for balancing the budget, I do not believe that our health care system should be made affordable on the backs of America's seniors.

If the $500 billion in cuts made by ObamaCare were not bad enough, this bill did nothing to address the nearly 28 percent cuts to physician payments scheduled for January 1 of 2012. I believe in providing access for America's seniors, not taking it away.

I am happy to announce here tonight that I'm working with members of the Doctors Caucus, House leadership, and Members across the aisle to develop legislation that will solve this issue once and for all. Mr. Speaker, tonight I call on all my colleagues to work together to ensure America's seniors that America will continue to be there for them in their time of need.

I have made a pledge to seniors in my district that I will not support any changes to Medicare benefits for those 55 years of age or older. It is my belief that for those age 54 years of age or younger, some reforms will be necessary to guarantee that Medicare remains solvent in the long term for our children and our grandchildren. Mr. Speaker, we are here tonight to show that, as physicians, we want to preserve Medicare for the future.

I thank Dr. FLEMING for organizing this Special Order hour.

Mr. FLEMING. I thank the gentleman from Michigan.

Again, we're getting a world of experience here tonight, all the way from OB–GYNs, ophthalmologists, family physicians, nurses, so much in the way of words of wisdom, and we have so much on our side of the aisle with Republicans, as my friend points out, a dearth of available physicians, health care workers on the other side of the aisle. It seems a shame that we were completely closed out of the creation of and passage of the health care reform act, which certainly suggests that we need to go back and do it.

We also are joined tonight by our colleague from Arizona, Dr. GOSAR, who is a dentist and a very valued member, as well, of the conference. I would love to hear from you this evening.

Mr. GOSAR. Dr. FLEMING, thank you so very much for organizing this hour and being able to have a fireside chat with the American public about health care and what really is coming about and what actually is going on with a broken health care system. I also want to take the time to educate, to understand—have the American people understand what it is about a vibrant economy that actually helps our Medicare system.

Now, I know the holidays are coming up and we're going to be discussing giving a continuation of a tax holiday for many Americans, about the thousand dollars for an individual on their FICA, on their withholding tax, and to employers; but I also want to take the time to explain to the American public that there is a cost involved here. And part of that cost when a withholding tax is taken out goes into Social Security and partly to Medicare, and part of this is particularly Medicare part A, the hospitalization act, which is the closest one to insolvency of all parts of Medicare.

Now, we lost 5 years, particularly on Medicare part A, the hospitalization act, just from the years of 2010. We have yet to start looking at the disastrous parts of the economy to 2011 to be added into the insolvency. But what ends up happening is this takes a further hit in the numbers and amount of money that is actually part of the equation for our seniors in Medicare, so it's going to get worse before it gets better. And when you couple that with this administration taking—I call it stealing—over $500 billion away from the current Medicare program to build another entitlement, that's just not right.

I came into Congress because I was concerned about health care. As a dentist, I love seeing a smiling face, because a smiling face tells me something about vibrancy, about health, and participating in the greatest things that this life gives us. But it also tells me that it has to be a participating sport and that what we have to have is a patient taking care of and being involved actively in the choices and decision processes in their health care, and that's what I want to see.

I'm flabbergasted, to be honest with you, that we see a program rectifying Medicare, or attempting to, through ObamaCare, but then we leave the SGR fix or the physician fix completely separate. It doesn't make sense to the average person why these aren't all integrated and part of the same equation.

I also want to remind the American people, this is not an easy solution. We didn't get here overnight, because we didn't do our due diligence like we had talked about earlier. We didn't change with the times as we grew older. We changed our participation and age and the variables that we had.

We also enveloped technology, unbelievable things that no one in 1965 could have even imagined, they could have dreamed but couldn't have actually imagined. And that's what the other part is is that we also have to look—I come from a very rural district, and what is happening back in my neck of the woods is the primary care doc who was that gatekeeper, they're no longer around. They either are associated with a hospital or a federally qualified health center—if you can get them to see you. And that's the part that also makes me tell the American public we have got another problem.

You were involved in this Joint Committee that had Democrats and Republicans, 12 of them, trying to figure out some type of a debt solution for $1.2 trillion.

I want to remind the American people there's another consequence in this, not only to our military, but to our health care providers as well, because the sequestration, when it goes through, is also going to tap, once again, the providers who are no longer being able to afford to see patients, and our hospitals, particularly those rural hospitals that will be going out of business. So there won't be an access to care. We won't have the ability to be a part of our own health care because there won't be a health care provider out there.

□ 2000

This is the dynamics that we have to look at. This is the equation that is so immense. What I have always said is start a little bit at a time. Make sure that the playing field is level and all of the participants are actually there, increasing the competition, making sure the public health and the private health are all in balance, and then making sure we have some tort reform.

We have to have that. That was absolutely missing within this health care system. That is what we are going to have to get back to. And we're going to have to have sunset clauses that we reactivate and reevaluate each of the process as our aging population gets older and as our technology gets better and there are new advances in medicine. We have to empower people to be part of their health care solution and empowering them to get back with their physician and their health care system. That's what we need to do.

And that's the most vibrant aspect that I can challenge our seniors with. We're here for Medicare. We're here to change Medicare in the right way. We're here to change it for you

Mr. FLEMING. I thank the gentleman, Dr. GOSAR. I'm just going to make a couple of closing comments; and in the few moments we have left, I'm going to allow some of our other physicians to give closing comments.

One of the important things we have learned here tonight is under ObamaCare, $575 billion was cut out of Medicare. Medicare is going broke, becoming insolvent, according to the actuary in 8 years. The Republicans passed a budget earlier this year that would have fixed that for good. And the Democrats have yet to even talk about it or even acknowledge that it exists. But they do know it. So I want to be sure that we leave here tonight with an understanding of the seriousness of the challenges that we have before us.

Now I would like to recognize Dr. ROE for some parting comments.

Mr. ROE of Tennessee. Dr. FLEMING, thank you. I was just looking here, over 200 years of experience. What a diverse group. We have nursing, dentistry, family practice, OB–GYN, surgery, and so on. I think one of the greatest frustrations I had when I came to Congress, and Dr. GINGREY has been here longer than you and I have, and one of the things that I noticed in the health care debate that we had, now going on 3 years ago, was this: with nine physicians, M.D.s in the U.S. Congress, in the 111th Congress, not a single one of us was consulted about this health care bill. This was done on a completely partisan basis.

I have to kind of chuckle. I have never seen a Republican or a Democrat heart attack in my life. I have never personally operated on a Republican or a Democrat cancer in my life. These are people problems, as Congresswoman BUERKLE said a moment ago. These are people problems that affect all of us in this country.

What we wanted to do, as I stated when we started, was to make the cost of care go down. This is not going to do this. Look, this is very simple. When we talked about the IPAB, and I think we'll have to use a different time to discuss the Independent Payment Advisory Board because it is so detailed, but just very briefly, this is how this works.

Several of us have pointed out that $575 billion was taken out. Three million seniors a year going into Medicare, reaching Medicare age, and this group, this group of bureaucrats up here appointed, and I don't want them appointed by a Republican or a Democrat. I think Congress ought to be accountable, and we ought to be accountable to the American people about what happens to Medicare, not push it off to some bureaucrats that are going

to make these decisions, and then we say, oh, I'm sorry, we can't do anything when care is denied because when you have $575 billion less, and 3 million more people added per year, that's 30-something million people in 10 years, you know what that leads to, Mr. FLEMING.

It leads to a rationing of care. Decreased access. And if you have decreased access to your primary care provider, it means decreased quality of your care and the cost is going up. That's what's going to happen with this plan. That's why it's imperative, not just Medicare, but that we overturn the Affordable Care Act because it's not good medicine for patients.

If we simply had been included in the debate, this would not be a plan that you had to run through and get rid of the 1099 form, the IPAB. It's a bipartisan bill now with 214 bipartisan cosponsors. Those folks realize it's a bad idea. I could go on and on and on.

One of the good parts of the Affordable Care Act, let's point it out, it costs more money, but allowing a 26-year-old to stay on their parents' health care plan, that's a great idea unless your parents are not paying the bill. Currently, if a young person, 22 or 23 years old, gets health care, they'll pay one-sixth what I do. Now what happens with this, it has to be a three-to-one ratio, so their health insurance plan costs double.

We could go on and on about the inconsistencies. I think the previous Speaker, the current minority leader, had it right when she said let's pass it and then find out what's in it. Well, I read it, as most of us physicians did, and we found out all of the things that were in there that were not good for our patients. We're just now discovering it's going to be more costly for businesses out there, and we need to have an entire hour on that.

Mr. FLEMING. I thank the gentleman. Before I recognize another Member in the last minute or two that we have, I would just like to say that we are going to be having a lot more of these sessions. So we've just started. We've just scratched the surface. We're running out of time, so just to wrap things up, we have just barely scratched the surface. And these are not all the physicians or health care workers we have on our side. There are others here who could have been here, but had some other commitment tonight, but will be here next time.

I would love to talk more on IPAB. Even many Democrats see that was a very big mistake. It will be one way that you can get the door closed on your health care and getting the right sort of care in the future.

I thank everyone for being here tonight, and I look forward to doing it again very soon. God bless you all.

I yield back the balance of my time.

## REPEAL OBAMACARE

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

Mr. KING of Iowa. Mr. Speaker, it's an honor to be recognized to address you here on the floor of the United States House of Representatives. And I want to say that I appreciate the presentation that came from just some of the great team of doctors that we have here, especially on the Republican side of the United States Congress. I occasionally sit with these learned individuals, and I learn a lot from them, and I'm grateful that the American people have been able to review their presentation here tonight, looking at the numbers and the dollars that have come out of the health care because of this great burden of ObamaCare.

You know, I was thinking of the necessity for us to continue to remind Americans, ObamaCare is right now the law of the land. It is the law of the land. And until such time as this Congress repeals it or the Supreme Court should find it to be completely unconstitutional, it will remain the law of the land.

Mr. Speaker, the American people need to be reminded that even though it's creeping in on us, and people are realizing what ObamaCare is doing, a few people at a time, it is an insidious creep of a malignant tumor that is metastasizing and consuming American liberty, and it has to go.

If we look back at the special elections in Ohio 2 or 3 weeks ago, on it were several ballot initiatives. The second ballot initiative was one that rejected the collective bargaining initiative that had been initiated by Governor Kasich. It was a tough loss for Governor Kasich. I think he was right, but he lost in the ballot place because there was a liberal-heavy, union-heavy turnout in the State of Ohio for that special election night 2 or 3 weeks ago. And by 61 percent, the Kasich-initiated ballot initiative that limited collective bargaining was shot down by a union-heavy, liberal-heavy turnout. And they spent a lot of money in Ohio to turn out that type of a base.

But in the same ballot, the next item down, ballot initiative No. 2 was collective bargaining. No. 3 was a constitutional amendment to amend the Constitution of the State of Ohio to protect Ohioans from ObamaCare, to be able to reject the individual mandate and a whole series, about three different points there, to amend the constitution to protect Ohioans from the ObamaCare mandate.

□ 2010

And, with a union-heavy, liberal-heavy turnout in Ohio in which 61 percent said ''no'' to Governor Kasich on collective bargaining, sixty-six percent of that voting universe voted to protect Ohioans from ObamaCare and to reject ObamaCare by amending their State constitution. That's a serious step, to step forward and amend the State constitution. But they did so in an effort to reject ObamaCare in the State of Ohio.

Now, Mr. Speaker, that is a resounding rejection, that two out of every three people that went to the polls rejected ObamaCare. I will tell you that the American people are poised to do so if they're reminded that it exists out there. And there are two things that protect the American people, two stops along the way that can keep ObamaCare from becoming the perpetually institutionalized permanent law of the land, and that would be when the Supreme Court hears the case and yields a decision. I would remind you, Mr. Speaker, that there is no severability clause in all 2,600 pages of ObamaCare. No severability clause.

What that means to the lay person is this: If a component of ObamaCare is found unconstitutional by the Supreme Court, then all of ObamaCare is thrown out by the Supreme Court. There's no provision that stipulates that if a component is unconstitutional, then the other components will stand on their own.

That is not just an ignorant omission on the part of the people that drafted and promoted and voted for ObamaCare. They knew it didn't have a severability clause in it. I knew it didn't have a severability clause in it. That means every Member of Congress had the opportunity to know that it didn't have a severability clause. So Congress willfully and intentionally passed an ObamaCare piece of legislation that didn't provide that if a part of it is found to be unconstitutional, the balance of it would be found to be constitutional. And the important component of that then, Mr. Speaker is this. If a part is found unconstitutional, it's all unconstitutional, and all 2,600 pages of ObamaCare then, by a Supreme Court decision, will be rendered null and void.

Yes, Mr. Speaker, there are exceptions to those types of decisions by the Supreme Court. But generally speaking, the court honors and respects a willful decision of the legislative branch. If that willful decision is that there be no severability clause, the Supreme Court should understand that that wasn't an accident. It was an unintentional omission. It was a willful omission because the drafters and the proponents of ObamaCare, of which I am not one, understood that if a part of it is found to be unconstitutional, the rest of it collapses anyway of its own weight.

The components of this that prop up ObamaCare are cutting that $575 billion out of Medicare to fund other parts of ObamaCare and then ending Medicare Advantage. The individual mandate that's in there, all of this is delicately drafted to try to find a way to argue that it could be paid for. And of course, they discovered that the CLASS Act in ObamaCare couldn't sustain itself. The numbers that they had advanced to try to pass it aren't sustainable. And so the administration