□ 1540

DOCTORS CAUCUS

The SPEAKER pro tempore (Mr. MASSIE). Under the Speaker's announced policy of January 3, 2013, the gentleman from Tennessee (Mr. ROE) is recognized for 60 minutes as the designee of the majority leader.

Mr. ROE of Tennessee. Mr. Speaker, before starting this Special Order, I'd like to yield as much time as he may consume to my friend from Mississippi, STEVEN PALAZZO.

SEQUESTRATION EFFECTS

Mr. PALAZZO. I want to thank the good doctor from Tennessee for yielding me some time.

Mr. Speaker, in 2 weeks we face one of the most devastating cuts to our military that our country has ever seen, literally, a worst-case scenario for our men and women in uniform, all in just 2 weeks.

For a year and a half, several of my colleagues and I have been discussing with anyone who will listen the devastating impact of these automatic budget cuts, but still we have stalled and delayed till we are where no one in their right mind would want to be.

If these cuts are not stopped, not only will our military be hollowed out, but a number of other agencies will be severely impacted as well. Defense cuts are bad enough. Unfortunately, these cuts affect a lot more than just defense. These automatic cuts affect food inspections at the Department of Agriculture, FBI investigations, TSA screening at airports, and others. No agency is untouched.

One example in Mississippi alone is it is anticipated that these automatic budget cuts could cost as many as 845 jobs in the education sector alone. These are the people we task with educating our future generations and ensuring our country's success.

We're now hearing of furloughs across the government agencies. This would mean that families that are dependent on that paycheck to put food in their children's mouths and clothes on their backs will be forced to stay home as much as 1 day a week for up to 22 weeks.

This means millions of dollars in lost pay for dedicated public servants because Congress and this President cannot get their act together and do what is right for our country.

At this point, the House has passed two separate plans that were never even considered by the Senate. Ultimately, inaction by the President and Senate are allowing us to inch closer and closer to the disgusting reality of these cuts.

Even more disappointing than the Senate and the President's inaction is the ridiculous position of many that seem completely content to throw their hands up and say that we have done all we can do.

But I am perhaps the most disappointed in my colleagues that want these cuts to take place in the name of spending cuts only. What good are spending cuts when you can't defend the Nation you are trying to save and destroying our economy in the process?

I am in favor of reducing our national debt and balancing our budget as much as anyone in this Congress, but I refuse to do it on the backs of our men and women in uniform and their families. I will not jeopardize their safety and security, yet some in this body want to do just that.

It is foolish—no, naive—to believe that allowing $1 trillion in spending cuts to our national defense is responsible or sustainable. Many of my colleagues seem to have forgotten that these automatic cuts were intended to be the absolute worst thing we could do. It was designed to force bipartisan action on addressing our spending addiction in this Congress. It is the unintended consequences of an absolute failure by the supercommittee. So, instead of using a scalpel, we're using a meat-ax, and the impact of our failure to act will soon be all too apparent unless we avert this irresponsible action.

Despite repeated requests for over a year for more details on what effects these details will have, only now, 2 weeks before they are scheduled to take place, have we received any information from this administration.

The military services have let us know exactly what effect they think sequestration will have, and it is not a pretty sight. We are talking about one of the biggest drivers of small businesses, a major employer of our Nation's veterans, and a major economic driver in our economy. And some here are willing to see it slashed for no benefit whatsoever.

But civilians are not the only issue here. We are downsizing our force to deal with the cuts already in place—$487 billion worth. We will have to cut further into our active duty if these cuts are not rolled back and replaced responsibly.

In my district, over 10,000 people walk through the gates of Ingalls Shipbuilding in Mississippi every day. If just one ship contract is cancelled as a result of sequestration, we are talking about thousands of people being immediately unemployed and layoffs at small businesses in over 49 States. These are some of the most patriotic and hardest working people I have ever met in my life. They have dedicated their lives to building the greatest naval ships the world has ever seen.

So this week, I spoke with our most senior military leaders, and they told us very directly, if you want our military to continue doing what it's doing today, then we can't give you another dollar.

There are similar stories across the Nation at plants building the largest planes to the smallest component parts. These are the stories of real people who go to work every day to make America a better place. These skills are not easily relearned. Once they go away they are gone forever, and I will not stand by and allow inaction by my colleagues to kill American jobs.

I ask my colleagues: Is this what you want? Do you honestly believe this is for the best?

I beg anyone to explain to me how we're a better country if these cuts take place.

Mr. Speaker, I implore our leaders, the Senate, and the President to act. The future safety and security of our Nation is at stake.

Mr. ROE of Tennessee. I thank the gentleman.

Mr. Speaker, we're going to take the next hour or so, the Doctors Caucus, Dr. GINGREY, myself, Dr. HARRIS, and we're going to speak about the Affordable Care Act, how we got where we are, the plan to save Medicare, and other health care issues.

I came to this Congress after a 31-year medical practice in Johnson City, Tennessee, just a doctor out each day in east Tennessee taking care of patients; and I made a decision that I didn't like the direction that the country was headed in health care, and I wanted to run for Congress to be here for that reason.

Well, it turned out that two Congresses ago we did have a debate on the health care issue. We have nine physicians in our health care caucus, and not one of us was consulted about that health care bill. Not one of us was brought in the loop and said, What do you think?

Well, we had an extensive debate, I will admit, in the House. This bill was passed on a pure party-line vote in November of 2009; and on Christmas Eve, the Senate passed a bill that had not been vetted, had not been heard in the House, was not debated in the House, a completely different bill. But because of the rules in the Senate, it never got heard here and was not debated fully in the Senate.

That bill was passed, it will soon be, 4 years ago—3 years ago, I mean. We thought that we'd have an opportunity after the Supreme Court looked at this—those challenges were brought to overturn this bill—and we're going to spend the next hour explaining why we don't think it was the right prescription for the health care of the citizens of this country.

I bring an extensive knowledge about a health care reform bill we did in our State of Tennessee. The biggest problem with the health care in this country is not the quality of care. Certainly, we can always do better, and physicians want to do better and have new techniques and new innovative medicines that we use. But the biggest problem with health care in America is the cost of that care. I got to see it every day in my practice, where going to the hospital could bankrupt families if they didn't have proper insurance, it was more expensive to come in, and so the number one driver was cost.

□ 1550

Number two, there's no question we had a group of people who worked

every single day of their lives and could not afford health insurance. It was not affordable for them. I would see it in my community where you would have, let's say, a carpenter who would work and during the winter they didn't get to work too much. They would work and maybe make $20,000 or $25,000 a year. Their wife may work at a local diner, maybe, and make $20,000 or $25,000. Together, where we live, they could make $40,000 or $50,000, maybe, in combined income and they could live okay. But they could not afford a thousand dollars a month for health insurance coverage. It was just out of their reach. And thirdly, we had a liability crisis in this country.

So what did the Affordable Care Act actually do? Well, it did increase access. But it increased access mainly, the best I can tell, through a massive expansion of a failed system called Medicaid. The Medicaid system right now in this country is broken and needs to be reformed. We did not reform it with this bill. So that's one thing it did.

Two, it did not touch liability. And we can go into that a little bit later. But the liability crisis still exists. My State of Tennessee has done something, as has the States of Texas and California. Other States have been successful in liability reform. And that has helped. But the President was here Tuesday night. We were all sitting in this Chamber. And amazingly, in the seat right below you here on the dais, the President said with a straight face that his bill, his Affordable Care Act, so-called ObamaCare, had lowered costs. I was astonished by that because it clearly has not done that at all. And let me just go through a few things.

I serve as the chairman of the Health, Employment, Labor and Pension Subcommittee in the Education and Workforce Committee. So if you have a private health insurance plan, that issue, that plan will come through my subcommittee. Let me just go over a couple of things that we found. We've had numerous hearings over the past 3 years about this. And this is recent data right here. President Obama's health care law will push about 7 million people out of their job-based insurance coverage, nearly twice the current estimate. That was just in the last week or two, that estimate, according to guess who? The Congressional Budget Office. Not PHIL ROE and not some Congressman. But the CBO believes that. So twice what they thought it would do.

Spending on health care is up. And we estimate it's as much as $4,500 per family since this bill has come into play. That is not pushing the cost of health care down. So we see that. And one of the things that this bill did, I think which was good and bad, Mr. Speaker, is we allowed millions of young people under the age of 26 to be on their parents' health care plan. That sounded like a good idea. And if you have a mom and dad that paid for that, it probably is a good idea if they pay for. I know one of the great points of my life were when my three children got out on their own and paid their own health insurance. That was the biggest raise I probably ever got, them getting out of college and paying their own health insurance.

But what happened was, the way the bill was written, actuaries can no longer charge the actual cost of that care. Let me give you an example. If a person my age is out buying an individual policy, it will cost about six times what a young person under 26 pays because actuarially I'm much more likely to need health insurance or need my health care plan. This bill only allows a 3-to-1. So that means a young person is going to pay two to three times, that person out there paying for that health insurance coverage, than they otherwise would have.

I've had a good friend of mine who's in the health insurance market at home, and for all three of my children I bought them individual plans, and I specifically remember exactly how much I wrote the check for. He said, Dr. ROE, I was having these plans for about $100 a month, just a basic health care plan. Some less than that, depending on risk. Immediately after that bill passed, those rates tripled—they were $280 a month. All of a sudden now, if you're an individual, that isn't affordable. Most people don't have an extra $200 or $300 right now in a tight economy to do that. So we've made it less affordable for a lot of young people. More accessible but less affordable.

I'd like to introduce my colleague and cochair of the Doctors Caucus and fellow OB/GYN physician from Georgia, my good friend, Dr. PHIL GINGREY.

Mr. GINGREY of Georgia. I thank the gentleman from Tennessee for yielding to me. He has already alluded to some of the things that I am going to say in my remarks but the most important thing that he stated: On Tuesday night, President Obama stood here in this Chamber and he gave his State of the Union address and said:

Patients enjoy stronger protections than ever before. Already, the Affordable Care Act is helping to slow the growth of health care costs.

Well, President Obama obviously didn't get the memo. We must not have read the same CBO report, Mr. Speaker. ObamaCare is not slowing the growth of health care costs. ObamaCare is driving up the costs, jeopardizing insurance coverage, and placing excessive burdens on small businesses, limiting their potential for growth.

In 2010, President Obama and the Democrats assured us that their health care law would lower costs, it would cover millions of uninsured Americans. Well, as Dr. ROE said, fast forward 3 years and we have seen nothing but broken promises and this enormous pricetag. Just last week, the CBO—the Congressional Budget Office—the unbiased scorekeeper that works for Congress, reported that under ObamaCare—PPACA, health care costs will increase and 7 million Americans will lose their coverage. These are the facts, despite any State of the Union rhetoric.

Young Americans will also be severely impacted with an exorbitant rise in health insurance premiums due to a provision in ObamaCare. A lot of people are not aware of this, Mr. Speaker. This provision requires insurance companies to reduce their rates for seniors—a laudable goal. Premium costs for individuals under the age of 40, though, are going to significantly rise to even out that balance. By limiting these—we call them age ban discounts—that are called for in ObamaCare, a 3-to-1 ratio. So someone, let's say as an example, that is in their very early sixties and they're not eligible for Medicare at age 65, and they already possibly have multiple systems diseases, as we say in medical parlance, and are on many prescription drugs, expensive drugs—they're a much greater risk in regard to an insurance premium coverage of busting the ceiling on that every year. But under ObamaCare it says their premiums cannot be more than three times the premium of someone who is 28 years old, 10 feet tall, and bulletproof.

As a result, these are some of the problems that that creates within these exchanges. It will absolutely discourage the younger people from buying insurance. They'll pay the fine. They will not pay those higher premiums so that they stay within that 3-to-1 ratio. It will likely force young healthy individuals out of the insurance market. That's some of those 7 million we're talking about that are going to lose their insurance because of this.

Let me just give a real specific, and then I'll yield back to the gentleman so he can yield time to our other colleagues. For a 27-year-old earning $33,500 a year, premiums are expected to jump from $2,400 a year to almost $3,200 a year. This is an outrageous increase in costs that young people can't afford. If they get a job in this current climate where we've had 7.6 percent or higher unemployment—the entire time that President Obama has been in office—they're not going to be able to afford these premiums. And they clearly are not going to pay for them. ObamaCare is negatively impacting the insurance market on two fronts: it forces rising premium costs on the young, and it increases the total uninsured population, as I stated earlier.

So at this point I'll yield back to the gentleman from Tennessee and I hope to remain with my colleagues for the remainder of the hour as we continue this colloquy.

Mr. ROE of Tennessee. I thank the gentleman.

I'd now like to yield time to my good friend, Dr. ANDY HARRIS from Maryland. ANDY is an OB anesthesiologist. And I say this to my good friend: I

spent a good bit of my adult life waiting for anesthesia to put my patients to sleep so I could operate. So I now yield to Dr. HARRIS.

□ 1600

Mr. HARRIS. I want to thank the gentleman from Tennessee and the gentleman from Georgia.

Following up on what the gentleman from Georgia said, Mr. Speaker, the President stood there and told America that health care costs have gone down. Now, I don't know if the President has been in a pharmacy lately or been to the doctor or bought a health care insurance policy lately, but the fact of the matter is the price has gone up—in some cases, dramatically—and it's going to go up more, especially for the young, who actually are the highest percent of the uninsured of any age group.

Look, it's just the facts. Folks, when they're 18, 19, 20, 25, they don't think anything is ever going to happen to them, so they don't buy a policy. And the policies now, I sat down with someone whose daughter was insured, and she had one of the HSA accounts, those health savings accounts, and $2,500 goes into the health savings account. The first $2,500 she would pay, and above that, the insurance would kick in. It was an affordable policy. It used to be less than $100 a month. Imagine that, $100 a month, guaranteeing that young person, God forbid they get into a bad accident, God forbid they develop a tumor at an early age, they have coverage for the really expensive things that you may need. That was affordable. I think most people would say $80 a month is affordable.

That policy went up to $110, and this time the renewal was 22 percent more than that. And it's going to get worse because the President now, in the Affordable Care Act—ObamaCare, as he prefers it to be called—actually reduces the amount that those health savings accounts can hold. It's now limited to $2,500. You can't get your premium lower by saying, Okay, I'll take a little more risk, increase my health savings account. So those costs are going to skyrocket. And when they skyrocket, the gentleman from Georgia is absolutely correct, a young person is going to say, I'll pay the penalty.

So a young person who may have had insurance before because it was only $80 a month—and it protected us from having to pay for those medical costs, God forbid that young person had a catastrophic illness or injury. That person is going to make what looks like a logical choice now and say, You know what; I'll pay the penalty and drop my insurance. It's going to have exactly the opposite effect of what was intended, and predictably so, when you force those premiums up.

Again, the President stood here and said that health care costs went down. I've got to tell you, I still have yet to run into someone at one of my town hall meetings that says, Good job, ANDY; my health care costs or my insurance is going down. It's not, it's going up.

Let me address, because the gentleman from Tennessee touched on it, one of the problems that the President didn't consider—tort reform. You have three physicians here, two of whom spent their professional lives in the labor and delivery suite delivering babies, practicing obstetrics. I practiced obstetric anesthesiology, do those epidurals, those spinals, relieve women of their pain in childbirth.

Over my career, my generation—I finished my training in 1984, 28 years ago. At that time, to show you what the effect of not having tort reform is, the cesarean section rate for American women having a baby was 15 to 17 percent. One in six to one in seven women would have to have a cesarean section. Now, 28 years has passed. I don't know if the Speaker is aware, but the cesarean section rate is now 33, 35 percent, in some hospitals 40, up to as high as 70 percent in some hospitals. That's in one generation.

I will tell you, as a physician, not much has changed to patients in one generation. What has changed is that you don't find an obstetrician who's willing to take the risk of doing a delivery in a high-risk patient, a normal delivery, because of the medical malpractice exposure—not that they would commit it, but they would be charged with it, that a baby doesn't come out perfect, because that's the way the world is. Yet they would be charged, brought into a court of law, and lose millions of dollars in a settlement. So what do they do? They choose, when there is any question, to do a cesarean section, and who can blame them to do it.

Mr. Speaker, those women who are watching, they know exactly what I'm talking about, because they know if it was their daughter or granddaughter or a friend of theirs, they all know someone who has had a cesarean section. If the women who are in the audience now think back to one generation ago, it was much more rare. So what's happened? We haven't had tort reform.

But that's not all. By the way, the cost to the system is billions of dollars a year for those extra cesarean sections, billions of dollars direct cost to the health care system.

If that was all, we'd say maybe we can tolerate that, a doubling of the rate of cesarean sections, but that's not all. When those women go to see their obstetrician now, one generation ago when I started, when I had my first child, my wife went to an obstetrician. It was a solo practice. And that obstetrician apologized to my wife and said, You know what, I'm sorry, but every other weekend someone may have to cover my practice, so I may not be able to guarantee you that I'm there with you at your delivery.

Let's fast-forward one generation, 28 years. You can hardly find an obstetrician in solo practice anymore. They simply cannot afford the medical malpractice premium. They may never have been sued in their life, and they may have to pay over $100,000 a year just for the medical malpractice premium, never having been sued in their life. So what happens? They're all forced into large groups.

Now, that same conversation, if my daughter now goes in to see an obstetrician, that conversation would run like, You know, ma'am, you're going to have to see everyone in the group during your pregnancy, and we have seven or eight people in the group. So every time you're going to have to see someone else so that everyone gets to see you because we don't know who's going to be there the day you deliver.

Now, is that good care? Is that a good relationship that woman develops with her obstetrician when she doesn't even know who's going to be there to deliver her? In fact, she doesn't even know who might see her the next time she's in the office, one of the most important times in her life. We have completely changed the doctor-patient relationship because we don't have tort reform in this country.

If it was just the rate of cesarean section doubling or just the fact that you have to see seven or eight people and you don't really know who's going to deliver you on a given day, we might accept that, but it goes beyond that, Mr. Speaker. Because what's happened now, a good, highly trained obstetrician stops delivering babies in their forties or fifties because they have developed their practice, they have seen those patients. They just take care of their gynecology problems and they spend the last 20 years in their career not delivering a baby. Having delivered them for 20 years, gaining all that experience, the most experienced obstetricians don't deliver our babies anymore. And why don't they? Because if they stop delivering babies and promise their insurance company they will not deliver a baby, all of a sudden that $100,000 premium becomes $20,000. If you were in your forties and fifties and could afford to do that in your practice, you might say, You know what; it makes sense for me to stop doing this.

So when you add up all the things that have happened because the President, in his Affordable Care Act, refused to have real tort reform—and it's possible, because it happened in California. I mean, there are areas in the country that have it. But nationally, he refused to have it—and the gentleman from Georgia is very familiar with this because his bill deals with this. Because of that, we have a cesarean section rate that's twice as high as it ought to be, and some people will tell you it might be three or four times as high as it ought to be. We have women who never develop a close doctor-patient relationship with their obstetrician because you really can't. I mean, you're seeing a group of seven or eight purely because the malpractice premiums are now spread out. Frequently, somebody else even pays.

They may be part of a hospital group, for instance.

Finally, our most experienced physicians for women in a time—you know, you talk about taking care of children. You've got to start right at the beginning. You've got to have the most experienced person there. See, I've been at thousands of deliveries.

□ 1610

Ninety-nine percent of the time they go all right. But when they don't go all right, you want the most experienced person there. And, Mr. Speaker, our lack of tort reform means we no longer have it. We have entirely changed the way we deliver obstetric care. So if you even said, look, we're not even going to worry about costs, let's not talk about costs, let's talk about access to experienced, personalized care for our women having babies, it's virtually gone because the President and our counterparts across the Capitol in the Senate refuse to take up the issue of tort reform and restore some commonsense, good medical care to Americans.

Obstetrics is an example. We could go into neurosurgery and many other examples, and I'll leave it with that. We have so many opportunities to reduce the costs and improve the quality and access to medical care, and it was lacking in the State of the Union Address.

Mr. ROE of Tennessee. I thank the gentleman for his comments. I felt a little deja vu there, Dr. HARRIS, after walking out of the delivery room after about 5,000 deliveries for some of the very reasons that Dr. HARRIS brought up. I'd now like to yield to my friend from Georgia, Dr. GINGREY.

Mr. GINGREY of Georgia. Mr. Speaker, the gentleman from Tennessee is generous with his time. I did want to follow on to what the gentleman doctor from Maryland is just talking about in regard to tort reform. Yes, he covered that very, very clearly and pretty completely.

But there are other things in this law, the so-called Affordable Care Act—well, Patient Protection and Affordable Care Act. And, yes, I think President Obama proudly likes to have it called ObamaCare. Maybe he hopes that one day that will be his legacy. There are provisions that, particularly in these exchanges that are being set up in all 50 States, the States that are doing it, the territories and the District of Columbia, that basically say what best practices are for the different physician specialties, including the specialty of obstetrics and gynecology which Dr. ROE and I practiced many years. But in these descriptions of what's the best practice for a general surgeon or an internist or a pediatrician, in some cases, they're not a carbon copy of what our specialty societies recommend. The American College of Obstetricians and Gynecologists, as an example, does a wonderful job of making sure that each one of their members gets a monthly bulletin and current updates on what the best practices are for our specialty. It's based on science by the best and brightest. And, yet, this law may ask us to do something that goes against that.

I have introduced a bill, Mr. Speaker, to protect our physicians. If they are following the guidelines of their specialty, or, on the other hand, if they're following the guidelines of the government that some government bureaucrat says is the best standard of care, if they're doing that and they have a bad outcome, this provider shield would protect those physicians from liability. It's something that's desperately needed because of this law.

There is another bill that I have introduced called the SCOPE Act. SCOPE is an acronym for the Safeguarding Care of Patients Everywhere. What would prevent the Secretary, Ms. Sebelius, or whomever, from saying what qualifies a physician to be on a provider group in one of these exchanges? Is it what she says or what their specialty society says?

So, again, these are things that we're working on very hard to correct, I think, a very bad situation. We members of the Doctors Caucus, we on this side of the aisle will continue to fight for that. I thank the gentleman.

Mr. ROE of Tennessee. I thank the gentleman for yielding. Just to carry on with what Dr. GINGREY and Dr. HARRIS have brought up, let me share with you about affordability. When Dr. HARRIS was talking about young people, it's obvious that the President—I don't know who writes the check for health insurance in his home, but he hasn't looked at the check, whoever is writing it, if he hasn't figured out that costs have gone up.

Dr. HARRIS, I may be a little more than a generation past where you are, but when I left, when I quit operating and doing obstetrics, I had an 8 percent primary c-section rate. You've seen that. And why did that happen? When I came back from the Army to Memphis, I trained at the University of Tennessee in Memphis. I had 2 years of training, and then I had to go in the military for 2 years and came back and finished my training. All the malpractice carriers left the State of Tennessee. In 1975, they all left. So the doctors and the Tennessee Medical Association set up an organization called the State Volunteer Mutual Insurance Company. This insurance company was a mutual company, so money that we didn't pay in came back to us at the end of a year. It wasn't owned by some stock-traded company. Strictly, it was just to give us malpractice liability insurance coverage, which I've kept until this day.

In the entire time that that company has been in existence, over half the malpractice premium dollars have not gone to injured people. They've gone to lawyers, both plaintiff and defense lawyers. What a terrible system that is; to try to compensate someone who has actually been injured, we have no way to do it. Less than 40 cents on the dollar that we paid in for 35 years has actually gone to people who have been hurt. That's a terrible system. We need a better system.

As Dr. HARRIS pointed out, when I started my practice, my malpractice premiums were $3,000 a year. Five years ago, when I left, a young physician who replaced me was paying $7,400. And guess what? The patients didn't get better quality and better access. They just got higher costs. So that's why we need to address that issue. I think you're spot on, Dr. HARRIS. I yield to the gentleman from Maryland.

Mr. HARRIS. I thank the gentleman from Tennessee for yielding. To follow up on his point, Mr. Speaker, I don't know if Americans realize, the gentleman is absolutely right. If you have a case litigated, a birth injury claim, and it goes to a jury and there's an award, let's say, of $6 million—not an unusual award—40 percent of that award, $2.4 million plus expenses, goes just to the attorney. Is that fair? You have an injured baby—and we're not going to decide what the injury is. But is it fair that when the court renders a decision that half the money doesn't go to take care of that baby? It doesn't seem fair.

I want to briefly go back to some of the issues in the Affordable Care Act. One that really struck me is the medical device tax. Now, I know the President likes taxes. There are 21 in the Affordable Care Act. He stood up there 2 days ago and talked about taxes, increasing taxes as a solution to our problems. But let me tell you what the problem with that medical device tax is. And I'm going to hearken back to my experience, again, over 28 years. I remember training in the early eighties. Some of the people watching, Mr. Speaker, might know if they had a kidney stone 30 years ago and had to have an operation for that kidney stone just how serious that was. And I remember, I did anesthesia for many of them. There were big incisions on your back, on your side, a week in the hospital, and you could get infections from it. It was a terrible experience if you needed an operation to remove a kidney stone.

So 2 years ago, I had the opportunity to work in one of the urology operating rooms. It was a kidney stone removal. And here I'm going, wow, I haven't seen one in a while, I'm going to give the anesthesia for it, I'm going to prepare for a big operation. The surgeon said, no, no, no, no. We're doing this with a laser. I said, a laser? That kidney stone is deep inside. It's inside your body. He said, no, you've got to see what we got.

They brought a laser machine in, and I apologize I didn't bring a sample of these catheters. It's a catheter, a wire that's about a yard long, and it's fiber optic. Oh, my gosh, it's thinner than the lead in a pencil, and it's flexible. They thread this up—and I won't go

through the exact anatomy—they thread it up to where that kidney stone is. They fire a laser through this, and they break the kidney stone up into tiny little pieces, or evaporate it, and it just comes out. There's no incision. These patients go home the same day.

□ 1620

Why? Because of medical innovation, because some company took a risk to develop that laser product. I tell you, it's not cheap. I'll also tell you it's a whole lot cheaper than several days in the hospital.

The President stood there and said, We don't want to pay by the hospital day; we want to pay by the quality. Let me tell you something: if I have a kidney stone, my hand is going up for that newest method because it's the quality method. What does the Affordable Care Act do? It taxes it. If that person had the old operation, there's no taxes involved; but if they have that new device, there's a tax on it.

I learned in the legislatures that there's a saying that if you want to discourage something, tax it. We have these arguments over tobacco. You want to discourage tobacco? Let's tax it. Most States have taxed it, the Federal Government taxed it, and sure enough we have less. I don't understand. Is that the same thinking we have about innovative medical devices? Are they all of the sudden not a good idea? That's exactly what this bill does, it taxes them.

One of two things is going to happen: either that tax is going to be passed on—because that's what businesses do: when you tax businesses, they pass them on—or we won't innovate as much. That would be a disaster because the key to improving our health care quality, going into the future, especially with American ingenuity and innovation and expertise, is innovating. We're taxing innovation. It makes no sense, Mr. Speaker.

I hope we move a bill through this Chamber to remove that taxation. It's a very bad idea for the quality of health care in the United States because some of these new products, whether it's for treating diabetes or whether it's for treating kidney stones, are amazing new technology.

Mr. ROE of Tennessee. I think we all could stand here for hours talking about—I certainly could—the innovative new devices that I've used through laparoscopy that have helped patients shorten their length of stay, shorten their pain. I hope we don't go into the Middle Ages of health care in technology because we could spend literally hours talking about what we've seen. We're the place in the world that people come for this.

Before I go back to costs, the estimates are that this device tax will cost 43,000 jobs. The fear is that we'll start producing these offshore and lose jobs in this country. That makes no sense whatsoever. Actually, it was Dr. Milton Friedman who said:

If you want more of something, subsidize it; if you want less, tax it.

That's a fairly simple concept.

Back to the initial problem we have in health care, which is cost. Let me just go over a couple of things, and not just behavioral things. In a recent Gallup survey, the top concern cited by small business owners was rising health care costs. Remember, the President stood right here—and I listened to the debate and so did Dr. GINGREY—for hours on end about how this was going to lower the average person's health care insurance premium by $2,500 a year. Remember that? You remember that, Dr. GINGREY. I heard it over and over right in this well and right at this dais. Guess what? Exactly the opposite happened, which is exactly what we predicted would happen. It did not bend the cost curve down, and it's making it less successful and affordable for people.

Anyway, on with this Gallup survey. So three-fourths, 74 percent, of respondents reported that rising health care costs were hurting their businesses; and 61 percent of small business owners, who are not hiring, point to worries about potential costs of health care as a reason for why they're not hiring. That ought to be a clear signal to everyone here that we need to deal with costs.

What I should have stated at the outset of this hour is what we do not need to do. Health care decisions should be made between physicians, the family, and that patient. That's who should be making them. It should not be insurance companies and certainly not some bureaucrat here in Washington or some policy wonk up here that thinks they know what's best, as Dr. HARRIS just pointed out what is best for that patient. He saw and he knows what's best because that's what he's done for the last 30 years.

I think our cost issue is clearly what we're not dealing with with this care. Are there good things in this bill? Sure. There are things in here that I like in the Affordable Health Care Act, and we can talk about that.

Dr. GINGREY, I would like to yield to you at this point.

Mr. GINGREY of Georgia. Again, I thank the gentleman from Tennessee for yielding because I wanted to follow on in this line of discussion with regard to costs.

The way doctors were paid by Medicare in 1965 was, to my understanding—I think I'm correct on this—just like private insurance: an 80/20 indemnity kind of coverage, and the cost was accelerating.

Then in 1998, I believe, the Balanced Budget Act of 1997 put in this formula to control Medicare spending, particularly the spending that goes to the health care providers, which by the way is only about 12 percent of total Medicare spending.

In any regard, that seemed to be the greatest concern, controlling how much the doctors were getting paid. So they put in this formula that's called SGR, sustainable growth rate, based on some calculus. But it was flawed. It was flawed badly. And for the last, I would say, 10 years, when you calculate that formula for the expenditures for doctor fees for the previous year, the formula would call for a cut of 1 percent, 2 percent, 4 percent. Over those 10 years, it's up to 26.5 percent. Well, thank goodness Congress, we Members of Congress on both sides of the aisle, have the ability to mitigate that; and we have done that because we know the formula is flawed and it needs to be repealed and replaced. Yet we have not been able to do that.

I'll tell you this, though: in this House of Representatives, in this 113th Congress, with Republican control under Speaker BOEHNER and Leader CANTOR and committee chairmen like FRED UPTON in Energy and Commerce and DAVE CAMP on Ways and Means, we are going to fix that flawed formula once and for all. We're not going to keep putting Band-Aids on it, mitigating a little bit at a time, and kicking the can down the road. That is our pledge to the American people.

I hope our colleagues in the other Chamber, controlled by the Democratic Party, will go along with us on this because what we realize is that all of the doctors in the House and in the Senate, they understand that if you enact those cuts that will come due again at the end of this year, almost a 30 percent cut in what you reimburse for Medicare providers, then there will be no doctors. People will have a Medicare card, but they will not be able to find a physician to take care of them.

This ObamaCare bill did nothing except, in fact, enact a provision, which I know my colleague from Tennessee wants to talk about, that makes it worse, that doubles down on it. We need to repeal SGR and figure out a better way to reimburse, to pay physicians based on quality of care, rather than volume. I think that's a good idea. But there's a provision in ObamaCare that could trump all of that and make all of our efforts in that direction go for naught.

So I want to end here so the gentleman from Tennessee can explain what I'm talking about because he has the repeal bill for that.

Mr. ROE of Tennessee. I thank the gentleman.

I do want to say to the American people that 47 million people, including Dr. GINGREY and I, are on Medicare.

We made a solemn promise to our seniors in 1965. When that program came out, it was a $3 billion program. Why was it put in place? Because many people retired from their business at that point in time, they no longer worked, and they had no access to care. Again, lack of access to affordable health insurance.

It was a $3 billion program. There was no Congressional Budget Office at that time, but the estimators here in Washington said we believe in 25 years

this will be a $12 billion program and maybe even balloon to $15 billion. The actual number in 1990 was $110 billion. Today, in 2013, it's going to be over $550 billion.

Now, we've made a solemn promise to people who paid premiums—2.9 percent of their income, basically. The employer pays 1.45, and they pay 1.45. Of all the income you make, all of your paycheck goes to that.

□ 1630

One of the things that we've discovered and found out is that we pay in, as I have—as the average person does—about $117,000 or $118,000 over a lifetime, a family does, but they get out over $300,000 in services. So we know we can't pay $100,000 in and get three times that much service out. What are the reasons? It's the same issue with Social Security. We have fewer and fewer people paying in and people living longer and longer and longer. By the way, each day in this country, over 10,000 baby boomers hit age 65. That's 3.5 million people a year who are getting to be about 65 years of age.

You have to laugh at the lingo up here, when ''savings'' means that you take money out of something and when an ''investment'' means you spend it into something. So you have to learn the language up here to understand what people are talking about.

About $700 billion was taken out of the Medicare program—savings—and we've got 3.5 million more people being added every year. Well, you do the math. How they were going to control this cost was with a little plan called the Independent Payment Advisory Board. What that is is a board of 15 unelected bureaucrats who are appointed by the President and confirmed by the Senate. Here is a little tricky part of the legislation. The President is supposed to be appointing these people this year. If they are not appointed to that board, one person—one—the Director of HHS, Kathleen Sebelius, has the power to enact all this. We have given that bureaucratic power to one person if those members and that board are not confirmed. Most people don't know that.

I've heard all the pros about how wonderful this is. I go back to my scholarly journals, and I want to refer people to the New England Journal of Medicine. An attorney in the New England Journal of Medicine, Timothy Stoltzfus, wrote an article in June of 2011, not pro or con, but just about the Independent Payment Advisory Board.

In addition, my friend Dr. GINGREY just said—and he is absolutely correct—that Congress changed this payment to doctors, the so-called SGR—the sustainable growth rate—so that patients would maintain their access to their doctors. We've had a retrospective look at the last 25 years. Let's say we fix SGR, like we're talking about, so that patients maintain their access. In a retrospective look in his report, the CMS actuary questioned—this is not me saying this—whether this goal is achievable to maintain these cuts, noting that the IPAB-targeted growth rates would have been met in only 4 of the last 25 years and would have approximated the sustainable growth rate, meaning that a cut would happen. We have almost no power to change this.

Now, here is what I found interesting. In the bill, it's absolutely correct that you can't ration care, that you can't do any of those things. That's maybe true, but if patients don't have access to their doctors, you, in effect, have rationed care. It's that simple.

This is what Peter Orszag said, the former Office of Management and Budget Director here in the Obama White House:

> The IPAB is the single biggest yielding of power to an independent entity since the creation of the Federal Reserve.

That is an astonishing statement when you hear it. That's one of the reasons I'm so passionate about maintaining the decision-making power with patients and with their families and their doctors and not with some bureaucratic board up here and also, certainly, not with the insurance companies. I agree with that.

Another comment that I've seen made:

> The Independent Payment Advisory Board puts important health care payment and policy decisions in the hands of an independent body that has far too little accountability.

That's one of the things. You may like it or not, but we in Congress have been able to change these things, and it would require 60 votes in the Senate to do it. Quite frankly, with my good friends on the other side of the building here, you couldn't get 60 Senators hardly to agree whether the Sun came up in the east, so the benchmark is very, very high.

Mr. Speaker, how much time do I have remaining?

The SPEAKER pro tempore (Mr. MULLIN). The gentleman has 8 minutes remaining.

Mr. ROE of Tennessee. I want to finish by spending the last little bit of time on Medicare. It is such an important part of our health care system. I want to strengthen this program—and I certainly know the folks on my side of the aisle and, I think, on the other side of the aisle want to—for future generations. We've made a promise to our citizens in this country that when they are at retirement age they'll have at least an affordable health insurance product available to them.

Let me tell you, the funny thing I found out about myself when I turned 65 was, the day before, I had a health insurance plan. It had a prescription drug benefit plan; it had a hospitalization part; it had a part that paid for my physician services. The day I turned 65, I got a part A, a part B, a part C, and a part D I could have. Well, nothing happened except I got 1 day older. Why, when a person turns 65, wouldn't you just have a health insurance plan that offered you those various options in your plan? You should be allowed to pick what's in your best interest and need.

Remember, in the Affordable Care Act, the Federal Government now decides what's an essential benefits package. You don't make that decision with your family and your doctor. A Federal bureaucrat makes that decision—what you must buy, a good or a service that you must purchase.

Some of the facts I've mentioned already about Medicare, and one of the things that we have to do, I think, in Medicare—and I know my colleagues will confirm this—is that, currently, one in 10 physicians is not accepting new Medicare patients. In some areas, it may be as many as three in 10 primary care or as many as half won't. We have a huge shortage of primary care physicians in this country. We know that the hospital insurance trust fund is insolvent. It may run out of money as soon as 2016.

I yield to my colleague, Dr. HARRIS.

Mr. HARRIS. I thank the gentleman from Tennessee for yielding.

The gentleman is absolutely correct. We made a promise to our seniors. To the people who've worked all their lives, we made a promise that we're going to take care of you, but we have to be honest with how long we can do that. What are we going to do for my children? for people who are in their twenties or thirties? How are we going to preserve that system and preserve their ability to choose their physicians and allow their physicians to choose what's best for them? Because that's really what's critical, that we preserve that in the system.

The gentleman is right. For the seniors who are watching this afternoon, they know that, in many parts of this country, if their primary care providers, their internists, their family doctors retire or move to other States, it's going to be hard to find someone, not because doctors don't want to take care of Medicare patients. We all do—we've taken care of thousands of them in our lives, in our professional careers—but the fact of the matter is that, every year, the government threatens to cut the reimbursement, the payment for services, by 25 percent, and it hasn't had an increase for inflation in 10 years.

This kind of uncertainty means that we may end up looking like the other program the Federal Government runs, Medicaid, where the statistics are dire and where fewer than one-half of specialists can afford to see a Medicaid patient because the government simply has decided we're just not going to pay. It's where fewer than half of the primary care providers don't see Medicaid patients because the government has said we just can't pay, and we're not going to. It's where hospitals now are wondering how they're going to staff and how they're going to keep up with the best medical equipment and the

best medical delivery because they're afraid the government is not going to pay. Who can blame them? Every year, the government threatens to cut the pay to our seniors' doctors 25 percent, and, every year, the government threatens to cut the pay to our hospitals that are taking care of our seniors. Every year, this goes on. It has to stop.

I hope the Speaker and the gentleman from Tennessee will agree that we have to address this seriously, honestly, with a view to two things: preserving the benefit for people who are in retirement and keeping the system going for every American. An American born today, February 14—a child born today—should have a system that he knows is going to be there, not bankrupt, but a system that's there when he reaches those golden years, and we can do it if we all work together.

I was hoping I'd hear more from the President. I didn't. The President is still not willing to come and talk about preserving Medicare, because, Mr. Speaker, you know that the trustees have said it goes bankrupt in 10 years. The current system will not be there for everyone retiring. The 10,000 people retiring today, February 14, enter Medicare. That system will not be there in 10 years. It will be bankrupt. So the current system doesn't even protect our current seniors, much less a baby born today.

□ 1640

We have to deal with it. Mr. Speaker, I urge the President to step up to the plate, be serious. Our colleagues on the other side of the Capitol, step up to the plate. This program is too important to let go bankrupt within 10 years.

Mr. ROE of Tennessee. I thank the gentleman. He is absolutely spot on. One of the reasons that he ran for Congress and I ran for Congress is to preserve this great program for our seniors out there, and I am absolutely committed to do it.

Let me give a couple of facts before we end up. The actuary of the Medicare program—this is not me, this is the Medicare actuary—said that congressional action will be required to ensure that our seniors have continued access to care. In May 2012, he said it is reasonable to expect that Congress would find it necessary to legislatively override or otherwise modify the reductions in the future to ensure that Medicare beneficiaries continue to have access to Medicare services.

This is not some right-wing Republican, this is the Medicare actuary, and we're not even talking about it. We have heard nothing from the President about how we preserve this great program other than we just keep doing what we're doing. That's not an honest, fair assessment of where we stand today. The sooner we deal with it, the more likely we are to come to a less painful solution to this.

I do want to finish by saying that I appreciate the hour you've shown us, Mr. Speaker. We will continue this very, very important discussion on Medicare in the future, and I yield back the balance of my time.

PROGRESSIVE CAUCUS MESSAGE

The SPEAKER pro tempore. Under the Speaker's announced policy of January 3, 2013, the gentleman from Minnesota (Mr. ELLISON) is recognized for 60 minutes as the designee of the minority leader.

Mr. ELLISON. Thank you, Mr. Speaker.

Mr. Speaker, my name is Congressman KEITH ELLISON, and I would like to open up by talking about the progressive message. The progressive message is the message articulated by the Progressive Caucus, and the Progressive Caucus is that organization within this body, within this Congress, that is here to unapologetically say that all Americans should have the right to go to the doctor and get basic health care in this richest country in the history of the world. All Americans should have civil and equal rights and be treated fairly based on whatever color, whatever their sexual preference might be, whatever nation they might be from.

We're the ones who say let's have comprehensive immigration reform with a path towards citizenship, and let's absolutely pass the DREAM Act. The Progressive Caucus is that caucus that boldly and unapologetically says Social Security, Medicare, and Medicaid are great programs; and we need to protect them not only for today's seniors but for tomorrow's seniors, too.

I would like to start out, Mr. Speaker, by talking a little bit, as I talk about the progressive message, starting out with just a few observations about the State of the Union speech. I personally thought the State of the Union speech was awesome. I thought President Obama was great, and I was really proud of President Obama as he delivered that State of the Union speech in this very Chamber.

This Chamber was full of dignitaries from all over the world—ambassadors, Senators, the United States Supreme Court. And in front of them, in front of the American people, President Obama specifically identified 24 Americans who joined Members of Congress as their guests. And these folks who President Obama identified were victims of gun violence. I was so proud to see President Obama specifically give these folks encouragement to keep on speaking out, continue to tell their story so that we can arrive at a place where the U.S. Congress will be on their side to bring forth sensible, sane gun violence prevention.

You know, President Obama's wife, our First Lady, Michelle Obama, had seated next to her her own guest, parents of young Hadiya Pendleton whose life was taken away from her. She was shot down in Chicago. But only a few weeks before, she had been performing for her country at the President's inauguration.

And so whether it was ordinary Members of Congress who just brought different people, or it was the President or the First Lady, the people who can speak most eloquently about the need for sane, sensible gun violence reform were here, Mr. Speaker. They were here and were present in this gallery so they could be a witness and a presence on the need.

And what did President Obama say? He said give us a vote. He said give us a vote. Now, I say to the Republican House majority: Why are you afraid of a vote? Let's have a vote. Let's count who is for sane, sensible gun violence prevention and who is not; who is for closing loopholes that allow people to escape background checks; and who's for filling up background checks and making sure that anybody who gets a firearm, an instrument that is dangerous by any account, at least we know that this person is sane and legally qualified to have one. Let's see. Let's have a vote. I don't think that anyone should be afraid of the vote, because if you are proud to say, no, we don't want any background checks, then stand up and say that. Be on Mr. LaPierre's side of the NRA. But if you believe we need to make sure that guns stay out of the wrong hands, that's a vote that the American people should have, and I was so proud that the President made that clear.

I personally think that the President was right in saying give us a vote when it comes to things like high-capacity magazines. You know, these high-capacity magazines, designed for the military, don't have any place on our streets. And the people who want to stand up and defend them, let them defend them. Let them defend them right here on the floor if they have the audacity to do so. And let us talk about millions of Americans, over the course of years, who have been tragically injured and hurt with bad gun policy.

Let us talk about the victims in Aurora who were shot by somebody with a high-capacity clip. Let us talk about people who were victims in Milwaukee. Let us give the message about the folks who were shot down in Tucson by somebody with a high-capacity clip.

The fact is that the President said give us a vote, and I agree 100 percent. We need a vote on these sane, sensible gun reforms.

I'm going to leave this topic now, Mr. Speaker; but I do want to just make mention of my own guest. My own guest was a young man named Sami Rahamin. Sami, 17 years old, a brilliant young man, but really just a regular teenager, he happened to be on a bus going to Madison, Wisconsin, when he saw a message come across his phone which said there was a shooting in what he knew was his neighborhood.

He texted back to his father and said: Dad, be careful because there's supposedly a shooting in the neighborhood. But the text never came back because one of the victims of that shooting was Sami's dad.