My home State of North Carolina hosts the third largest military population in the country. Coast Guard Station Elizabeth City, Seymour Johnson Air Force Base, and Cherry Point Marine Corps Air Station are integral parts of their local communities and also help to form the backbone of our national defense.

The sequester has already impacted the Coast Guard, with air operations being cut by 11 percent and maritime operations cut by 24 percent. These cuts have reduced maritime safety and security in the waters off of our coastline.

Furlough notices have already gone out to thousands of civilian employees at Fleet Readiness Center, where maintenance is conducted on Navy and Marine Corps aircraft. The furlough amounts to a loss of $81 million.

The 848 employees at Butner Federal Correctional Center, located in my district, received furlough notices and will lose up to 10 percent of their salaries because of sequestration.

The impacts of the sequester are already being felt in Martin County, where the public school system has lost $400,000. This means that teachers are stretched even thinner and are forced to do more with significantly less.

Madam Speaker, we need to rethink the sequester.

TIME TO GET SERIOUS ABOUT CLIMATE CHANGE

(Mr. HUFFMAN asked and was given permission to address the House for 1 minute.)

Mr. HUFFMAN. Madam Speaker, last week, in a Friday afternoon announcement designed to bury the news, the State Department released a very troubling supplemental environmental document regarding the Keystone XL pipeline, a project that would undo the progress our country has been making in recent years in showing leadership on climate change, in reducing gas emissions and transitioning to a clean energy economy.

Unfortunately, environmental protection seems to be a ''foreign'' policy to our State Department. But even this pro-industry report cannot gloss over the fact that Keystone XL would unlock development of some of the dirtiest, most climate-damaging fuel on Earth, and it would lock the United States into deeper dependence on expensive tar sands fuel that would take this country in the wrong direction for our environment and our economy.

Just this morning in the Subcommittee on Energy and Mineral Resources, we heard about the enormous potential for wind energy to generate jobs and also cost-effectively improve energy independence. Other forms of clean energy hold the same promise.

Madam Speaker, it's time to get serious about climate change and clean energy job creation. Importing dirty, expensive tar sands fuel is the wrong way to do that.

□ 1450

HOUSE GOP DOCTORS CAUCUS

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

Mr. GINGREY of Georgia. Madam Speaker, I thank the majority leader for yielding this time to discuss an extremely important issue facing the patients in this great country of ours that are going to have a very difficult time in finding a physician.

Madam Speaker, in March of 2010, when the so-called Affordable Care Act, or PPACA, was passed into law, the purpose, of course, was to increase access to physicians for all patients across this country and also to bring down the cost of health care. Well, we're 2 years into this bill—which will become fully effective in January 2014—and what are we seeing?

Madam Speaker, the CBO reported just recently that some 7 million people have actually lost their health insurance, the health insurance provided by their employer. For those who do still have health insurance—particularly those who get it maybe not from their employer but from the individual market, a small group policy—the cost has actually increased some $2,500 a year instead of coming down, as anticipated and predicted and promised, in fact, by President Obama, but that just absolutely is not happening.

So what we're going to be talking about, Madam Speaker, is, again, what needs to be done to correct this situation. Because the thing that was never really discussed to my satisfaction when this bill was crafted was, how are you going to get the best and the brightest young men and women in this country to continue to go into the field of medicine, to become the doctors—particularly in primary care, internal medicine, and the pediatricians—to provide that care when the reimbursement system under Medicare, called the sustainable growth rate, year after year after year for the last 6 or 8 years we have actually cut the income to the providers, to the point, Madam Speaker, where they can't provide this care, they can't even break even? So this is what we're going to be talking about, this flawed sustainable growth system. It has certainly contributed to the physician shortage crisis that we see today.

Now, I have a number of slides that I want to present to my colleagues, and we'll go with some specifics on that. But I'm very pleased to be joined today in this House with the cochair of the House GOP Doctors Caucus, my good friend and fellow physician Member from Tennessee, Dr. PHIL ROE, and I yield to Dr. ROE at this point.

Mr. ROE of Tennessee. Dr. GINGREY, thank you, and it's good to see you moving your arm well and recovering from your surgery so well.

I think the question that comes up, and Dr. GINGREY and other Members and I have discussed this, when I got here—and I've been here 4 years, and Dr. GINGREY came a couple terms before I did—we did this for a reason because we wanted to impact the health care system in our country. The problem with the health care system in our country was that costs were exploding.

If you look, as he pointed out, the Affordable Care Act has been anything but affordable. It's suggested that by 2016 the average family of four, when you have to buy an essential benefits package—which the government will determine what that is—will cost a family of four $20,000. That's unbelievable when you think that the per capita income in my district is $33,000. So I think we're at a point or we're going to be at a point where no one can afford it.

Well, what Dr. GINGREY is mentioning in the SGR, sustainable growth rate, what is that? What does that mean, and why should I care if I'm a senior? And Dr. GINGREY and I both have Medicare as our primary source of insurance. Well, Medicare started back in 1965, a great program for seniors who did not have access to care. It met a great need there and has met a great need since then. It started as a $3 billion program. The estimates were from the government estimators that in 25 years this program would be a $12 billion program—we don't do millions here, billions—and the real number in 1990, Madam Speaker, was $110 billion instead of $12 billion. They missed it almost 10 times.

So there have been various schemes throughout this time in which to control the cost, always by reducing the payments to providers. And who are providers? Well, those are the folks who take care of us when we go to the doctor's office—nurse practitioners, it may be a chiropractor, it could be a podiatrist, and it can be your hospital. So when you say providers, those are the folks and institutions that care for us when we're ill.

So in 1997, the Ways and Means Committee brought together something called the Budget Control Act. This is a very complex formula based on how you're going to pay doctors—their zip code, where they live, the cost of an office, the humidity in the air—I know it's an incredibly complicated scheme to pay doctors. The idea is this: We have this much money to spend in Medicare, and so we've put a formula together to only spend this much money. If we spend less than that money, that will go as a savings. If we spend more than that much money, then we will cut the doctors and the providers that amount of money to make that line balance.

Mr. GINGREY of Georgia. Dr. ROE, if you would yield just for a second, I wanted to point out to my colleagues and to Dr. ROE the poster that we have before us. Because this is exactly what the good doctor is talking about right

now in regard to what's been going on since the year 2000. Dr. ROE, you may want to refer to this slide.

I yield to the gentleman.

Mr. ROE of Tennessee. Well, the particular slide that Dr. GINGREY has down there is very telling. Basically what it says is that each year that we've recalculated what our physicians will be paid, we haven't met those metrics, which means that we have to cut.

Well, what has Congress done? Well, Congress has realized that what we're talking about is not payments to doctors; what we're talking about is access to care for patients. What happens is if you go back to 2003—I think it was 2003—when there was a 5 percent cut in Medicare payments, we realized at that point right there that if you continue to do that, that access would be lost.

So let's fast forward to 2013, what we're just facing. Doctors were facing a 26.5 percent cut, the providers were.

Mr. GINGREY of Georgia. Dr. ROE, that would be right here.

Mr. ROE of Tennessee. That's correct, that number right there. That was avoided by a 1-year so-called ''doc fix.''

What has happened over the last 15 or so, 16 now, years is that the Ways and Means Committee line—now law—says we have to spend this much money, but we've actually spent this much. That is a deficit in spending that we've got to make up somewhere in our budget or add it to the budget deficit.

Now, I go back to when I was in practice just 5 years ago now in Johnson City, Tennessee. Dr. GINGREY, I don't know about you, but I was having a harder and harder time finding primary care access for my patients that I had operated on, or maybe someone who had been my patient for 30 years—if she was 40 years old when I started taking care of her, in 30 years she's 70 years old and needed a primary care doctor. That was getting harder and harder and harder to do.

Now, when you look at today's young medical students, we're having a much harder time convincing these young people to go into primary care. What is primary care? Well, it's pediatrics. If you want someone to take care of your baby, it's family medicine. It's also internal medicine and also OB/GYN. I certainly served as a primary care doctor, as Dr. GINGREY did for his patients, for many, many years. That would be the only doctor that they would see. But that's getting harder for our patients to do. And Dr. GINGREY, that's my primary concern—access for seniors to their doctors.

Mr. GINGREY of Georgia. Dr. ROE, if you will yield for just a second and then I will return to you, again, I wanted to point out to our colleagues that this poster, this slide that's on the easel before us is exactly what the gentleman from Tennessee is talking about in regard to shortage of primary care physicians. And as he pointed out, primary care is a family practitioner, is a general internist—of course pediatricians provide primary care to our children. But so many of these doctors are the very ones that take the Medicare, take the Medicaid, take the SCHIP, the State Health Insurance Program for children. They see them.

□ 1500

And what Dr. ROE is referring to, before I yield back to him, on this poster it shows in the dark blue the areas of these States, several States, including my own of Georgia—Tennessee is not quite as bad—but in my State of Georgia, there are anywhere from 145 to 508 areas of the State of Georgia where there are an insufficient number of doctors to take care of these folks. Tennessee is a little bit better. There are only 67 to 99 areas. But all of this blue are critical areas, are they not, Dr. ROE? And I yield back to you.

Mr. ROE of Tennessee. That is correct. And so much so that in California, what they're recommending, I don't know whether they've carried it out or not, but they've recommended expanding the definition of ''primary care'' to a lower-level provider, that would be a nurse or nurse practitioner or PA or this sort of thing, this sort of designation.

I think the other thing, Dr. GINGREY, that we haven't talked about, and we probably should spend some time on, is the age of our practitioners. In our State of Tennessee—where you see that we're not quite as dire in need as Georgia, our friends to the south—the problem with it is that 45 percent of our practicing physicians in the State of Tennessee are over 50 years of age. I'm concerned that with the advent of the Affordable Care Act, the complexity of that, the frustration that I see when I go out and talk to our providers is that I'm afraid that many of them are going to punch the button for the door.

I know in my own practice, where we have now about 100 primary care providers in my program, in my OB/GYN group, in the last several years we've had over 120 years of experience walk out the door and retire. That's not a good thing for the American health care system that just lost access. Quite frankly, the crux of it all is that access. If you do not have access, you will decrease quality, and you will increase cost. That is our concern. Ultimately, the cost will go up if our patients can't get in to see us.

Mr. GINGREY of Georgia. I thank the gentleman, because what the gentleman from Tennessee is talking about is having an insurance card, a health insurance card—and indeed even having a Medicare card—does you very little good if you have to spend 2 hours going through the Yellow Pages trying to find some physician, primary care doctor in your area that you wouldn't have to get in your car and drive 50 miles—if you could even drive. If you don't have that access, then you don't have anything.

So here again, this bill, this massive bill was passed 2 years ago at the cost of almost $1 trillion. Unfortunately, a lot of that money was taken out of Medicare to create this new entitlement program, if you will, for younger people so that they can have health insurance. But what we've done is we've just made the crisis in the Medicare system that much more difficult.

What Dr. ROE was talking about, colleagues, is in regard to not just a shortage of the physicians, but what happens in the waiting rooms all across our country. This slide shows the number of primary care physicians per 1,000 population, the number of primary care physicians per 1,000 population.

Now, we've already gone over, we're talking about, again, general internists and family practitioners, primarily, and pediatricians for SCHIP and Medicaid. If you look at that map across the country, again, look at my State of Georgia in the deep red, and there are several States, Texas, Oklahoma, Mississippi, Alabama, Utah, Nevada and Idaho in the West where the number of primary care physicians per 1,000 of the population is fewer than one. So less than one doctor per 1,000 people that need that care. Many other States, including Tennessee, it is somewhere between one and 1.2. Now, I don't know how you get 1.2 physicians. I don't know exactly what that provider looks like. But you know how that math is calculated. Clearly, the shortage is acute, and it's only going to get worse and worse.

With that, I want to yield to one of my good colleagues, good friends on the Energy and Commerce Committee whose father actually was the chairman of the Health Subcommittee of the Energy and Commerce Committee for many, many years before he retired and his son took his place, and now the gentleman from Florida, GUS BILIRAKIS, is serving on that Health Subcommittee with me on Energy and Commerce.

I yield to Representative BILIRAKIS.

Mr. BILIRAKIS. Thank you, I appreciate it, Dr. GINGREY. Thank you, Dr. ROE, I appreciate it. Thanks for bringing up and sponsoring this Special Order that is so very important to our constituents. Thank you for informing them.

This is a very, very serious issue. We must repeal this SGR and replace it. Again, since coming to Congress more than 6 years ago, doctors in my district have consistently stressed the unsustainability of the SGR and how it impedes them from developing long-term business models.

Each year, Congress has implemented, of course, a temporary stopgap measure to avert the payment cliff, but the doctors have to have certainty. Again, we have a shortage of doctors in the State of Florida, and it's only going to get worse. We must repeal this SGR and replace it. It has led to uncertainty for medical providers, again, as I said, which threatens patient care. Again, access to care is what it's all about. I'm glad that the chairman of

the Energy and Commerce Committee, of course, Chairman UPTON, has made this a top priority in fixing, again, the SGR.

Again, not only is the uncertainty associated with reimbursement rates impacting physician practices; it also impacts how the Centers for Medicare and Medicaid Services plans to update Medicare Advantage rates for 2014. That's a huge issue. I know that the seniors in my district love their Medicare Advantage. Even though, year after year, Congress has not only allowed the devastating SGR cuts to take effect, CMS is assuming these cuts will take place as it determines the Medicare Advantage adjustment. So in other words, we always fix it at the end of the year, but they're assuming that the cuts will take place. I worry this will result in reduced benefits and increased premiums for the many seniors who like—really love—their Medicare Advantage.

Mr. GINGREY of Georgia. If the gentleman would yield, I want to thank the gentleman from Florida because what he is addressing right now goes back to the creation of this law, the Affordable Care Act, PPACA—sometimes referred to as ObamaCare—where money was taken out of the Medicare program, the existing Medicare program, which is already strained almost to the bursting point, and the Medicare Advantage program. Probably 20 percent of Medicare recipients select that model because it gives them more bang for the buck. It gives them more coverage, and it includes things—and the gentleman from Florida knows this, and this is what he is referencing—it includes more than just an annual physical when you turn 65. It includes more than being able to go to see a doctor and have it reimbursed under Medicare when you have an episode of illness.

There is a strong emphasis on Medicare Advantage to wellness. Let's say you do go and see the doctor because of an episode of illness, and maybe several prescriptions were written. It's very important that the patient take the medication on a regular basis and not run out of medication. So under Medicare Advantage, there would be a nurse maybe in the doctor's office who within just a few days of that encounter would call the patient to make sure that he or she could afford to get those prescriptions filled and they were taking them in the right way. That's what the word ''Advantage'' was all about, Medicare Advantage, rather than just a traditional fee-for-service Medicare.

But this new law created 2 years ago, and will go into full effect in January, 2014, literately gutted that Medicare Advantage part, did it not, Representative BILIRAKIS? It cut that program 12 to 14 percent. I mean, it's just literally gutted. I'm talking about $130 billion was taken out of that one program.

□ 1510

So now seniors that were on Medicare Advantage are having to look for new doctors, look for new programs, try to again go through those Yellow Pages and find somebody that will see their momma who's been going to this other group for years and is totally satisfied.

When the President said to the American public, If you like the health insurance plan you have, don't worry, you can keep it; you will not lose it, that just wasn't true. I don't think he deliberately told an untruth, but it clearly is not true. And as I said at the outset of this hour, some 7 million people have already lost insurance provided by their employer, and many more of these people that were getting their Medicare through the Advantage program, they have lost that through no choice, Madam Speaker, of their own. They have been forced out of those programs.

I yield back to my colleague, and we will continue this colloquy.

Mr. BILIRAKIS. I couldn't have said it better myself, Dr. GINGREY.

Again, I have constituents in Florida, and it's above 20 percent in my district and closer to 40 percent, who have chosen Medicare Advantage.

It's all about choices, as far as I'm concerned. If I want to get hearing aids, if I want to get a gym membership or eyeglasses, I should have the choice to choose my plan. It works so very well in our area, and we want to continue to give seniors that choice.

I want to thank you guys.

My father, as you referenced, worked so many years to fix this SGR, and I'm very proud now to serve on the Health Committee to contribute.

But I appreciate the two doctors here and all the doctors who have really sacrificed to run for Congress and do what's good for our people, patients. Treating patients is what it's all about. So thank you very much for allowing me to participate.

Mr. GINGREY of Georgia. I thank the gentleman from Florida and I thank his dad, Representative Mike Bilirakis, Madam Speaker, who served in this body for so many years with distinction. I hope that he is enjoying a happy and healthy retirement in the Sunshine State. And I hope he's able to find care, but I bet you it's not under Medicare Advantage, as his son just told us.

At this point, I would like to yield back to the gentleman from Tennessee (Mr. ROE).

Mr. ROE of Tennessee. I thank you.

And thank you, Mr. BILIRAKIS, for being here. I appreciate your leadership on the committee, too.

Why should I be concerned about this, and what experience do I have to say that if this is not fixed it will affect access and quality? I've had, I guess I could say, the misfortune in Tennessee of going through health care reform 20 years ago.

What happened? What happened was we had a large group of people in our State who didn't have access to quality, affordable health care. We reformed our Medicaid program and opened it up. We had an open enrollment time where we were going to have these various plans compete against each other. It was very much like the public option I heard discussed during the debates 4 years ago.

What happened? What happened to us was that our costs tripled in 10 years in that plan. It went up three times. And you can already see in the Affordable Care Act, even before it's been fully implemented, the estimates of costs have already doubled. The costs to patients are going up and the costs to businesses are going up. It didn't do what it had to do to really help solve the problem, which is lower the cost, bend the cost curve down. It did not do that.

When we saw those costs go up, what did we do? We started cutting our providers, and we cut our providers and we cut our hospitals and our doctors and our nurse anesthetists and our nurse practitioners and PAs and so forth. Guess what happened? Access got cut off. They stopped seeing those patients.

Now, our practice where we were, we, as an obstetrician as you were, we took everyone, because pregnancy is one of those conditions where you either are or you're not. We felt like if those folks needed care, we kept seeing those critical-care patients like that. But many elective-type things—orthopedics and dermatology and those kinds of things—got cut off, and people would have to drive hours to see a specialist.

So I saw access get denied in that system when the cost of the whole system went up to where no longer the State could afford it. I've seen that happen. That's why patients should be worried.

Dr. GINGREY, you and I know these numbers. We have 10,000 people a day hitting Medicare age. That's 3½ million people this year that are going to be Medicare age. These are new people on the plan with less money. And if we have more people and we're not producing more doctors, do the math. In 10 years, we're going to have 35-plus more people on Medicare, and who is going to care for those people?

Another thing I want to bring up is that we're not just talking about how doctors are paid. We're talking about increasing quality. One of the measures we're going to look at when we look at the new payment formula—right now the way you and I were paid when we were in practice was a patient came in and you got a fee for that visit. That's called fee-for-service medicine. That's going to change. We're going to look at quality outcomes and measures. I'll give you an example about why that's important.

One percent of our Medicare recipients use 20 percent of all Medicare dollars, so we have to look at how we manage the care of those patients better. For instance, with congestive heart failure, when someone leaves the hospital, we know that certain metrics are taking place: weights are taken

every day, blood pressure and so on. If you check in with a provider, you can prevent rehospitalizations and save tremendous morbidity, mortality, and cost. It also increases the quality of life that patient has and the quality of care they receive. So doctors are going to be evaluated on the kind of outcomes we have and the quality of care we provide our patients, which we all agree should be done.

I think coordinating care, hopefully, with better electronic records—and I could spend an hour talking about that. If we have a coordinated electronic system where, when you order a test at your office or the hospital, we have access to it so that test is not repeated and duplicated, that will make a huge difference in cost.

I just had a duplicated test, myself, done. You may have, too, when you had your procedure. I had a surgical procedure done 2 weeks ago this last Monday, and there was some testing on myself that really didn't have to be done. But because of various rules and regulations and the inability to get that information easily, it was easier to repeat it and pay for it than it was to go find it. I think that happens to 300 million people. Actually, it is 47 million of us who get Medicare now. We need to do that, better coordinate that information with sharing and transparency.

Mr. GINGREY of Georgia. If the gentleman will yield for just a second, I want to weigh in on that issue of electronic medical records.

I'm normally, as the good doctor from Tennessee knows, walking around here in a sling, as I have been for the last couple of weeks. Madam Speaker, I probably should have it on right now, but I'm resting my arm on the podium.

But I just recently had rotator cuff surgery back home in Marietta, Georgia. Madam Speaker, I was blessed with a great physician who did a wonderful job and has a fabulous staff, but going through the process of doing the paperwork, I bet I filled out the exact same form four different times. That was wasting my time and that was wasting their time. Of course, what they want to make sure is that no mistakes are made. Obviously, they want to make sure they operate on the correct arm. So I understand why, and I'm sure many of you, your parents, your grandparents, and you yourselves, my colleagues, as patients have gone through all of that.

But what Dr. ROE is talking about—and I will yield back to him—electronic records are indeed, in my opinion, the wave of the future. Honestly, I believe if we had concentrated on that 2 years ago to make sure that it was fully implemented so that duplication of testing, unnecessary procedures, maybe medications prescribed to which the patient had a dangerous allergy, you really do ultimately save lives and save money by having an electronic medical record system.

The other thing is if we had had medical liability reform. The President promised that before this ObamaCare bill of 2,700 pages was put into law, but there was nothing in there about medical liability reform.

Here again, those were two things, and I think the gentleman from Tennessee would agree with me on that.

I just wanted to interject my thoughts about electronic medical records, and I yield back to the gentleman.

Mr. ROE of Tennessee. I had the misfortune of going from paper to an electronic record. I was in the process, at our practice, of converting. It's a very difficult conversion. I think if you started with just an electronic medical record, it would be much easier than transferring tens of thousands of patient charts to an EMR. But when you start from scratch, it's a little easier.

Certainly I think the electronic ePrescribe, which I like, I didn't have the pharmacist call me and tell—I can't believe he couldn't read my prescription. Anyway, they claimed they couldn't, and this solves that problem.

□ 1520

I think there are some disadvantages to it, but overall, I think it is the wave of the future. I think you are correct.

I'm going to bring up something now about: let's say we go ahead and we do fix the SGR payment that's based on quality and that's based on outcomes and transparency, on hospital re-admissions, and so forth—on all those metrics we've talked about to better serve our patients. There will still be fee-for-service. I'm sure, Dr. GINGREY, you're a rural Georgia Representative as I'm a rural east Tennessee Representative. I have counties that have one doctor, and you can't do an accountable care organization—or all of these things—in a small, rural county. So fee-for-service medicine will still be there for those patients so they can have access in small, rural counties and don't have to drive long distances.

Let's say we do all of this wonderful stuff and that we fix this payment model and that it all looks good. The Affordable Care Act has in it one little thing called the Independent Payment Advisory Board. This Independent Payment Advisory Board trumps what we just did—all of the things that you're going to do in your Energy and Commerce. Also, thank you very much for what you're doing on that. As to all of these cuts that you see right here, let me just give you the data.

Mr. GINGREY of Georgia. The top of the green line is where we in the Congress mitigated these cuts because we can do that. That's what it says in the Constitution, that we're in charge of the purse strings. So, when there is a recommendation, as Dr. ROE is referring to, Madam Speaker, of the cuts in the pink—below the line, from 2001 to 2012, there is almost every year a 5 percent, 3 percent, 4 percent, 10 percent—then in the aggregate, that number just keeps getting bigger and bigger.

What Dr. ROE is about to explain to us is how we were heretofore able to mitigate, which is by making these changes above the line and by saying, no, we're not going to cut the doctors because we know, if we do that, they won't be there, that they won't be there for our parents and our grandparents and ourselves and our children.

Mr. ROE of Tennessee. I think correctly the Congress, in its constitutional authority, has overridden the SGR 15 times since 2002. I think that's the correct data.

What this IPAB does in the Affordable Care Act—it sets the same metric. It has a very complicated formula, which is the same as SGR, and if you have expenditures above those projections, cuts will be made. There is no judicial review, no administrative review, and it takes a 60-vote margin in the Senate to override this. Let me tell you how important this is, what Dr. GINGREY just pointed out.

Whether you agree with the plan or don't agree with the plan, there was a great article in the New England Journal of Medicine, one of our premier medical journals, that was published in June of 2011. I would recommend this for anyone to read as it will take you 30 minutes or less. They went back with the CMS and looked at the last 25 years and said, What if we had IPAB then? What would it do? In 21 of the 25 years, cuts would have occurred to providers—and I know exactly. Because of what I have seen in Tennessee, I know exactly what would happen. What would happen is you cut those providers right there. As you're seeing up there, Dr. GINGREY, I can tell you that, as to the access to care, that entire map of the United States right there would be a bright red because you would not have the providers to take care of those patients.

That is a tremendous concern for me because it is current law. This year, those 15 bureaucrats are supposed to be nominated by the President. What happens if he doesn't nominate those 15 people? One person—that's the HHS Secretary, Secretary Sebelius—makes those decisions and recommendations. I hear it all the time. I go on the talk shows like you do, and they say, Well, in the bill right here, it says that you cannot ration care. That's true. This board can't ration care. What they can do is just not pay the providers. In 2017, I think, or in 2018, the hospitals are included in this. They're not included first, but they will be in 5 short years.

Mr. GINGREY of Georgia. Dr. ROE, what will happen in reference to this slide right here—if you look at these blue areas, these States that have the acute shortage areas, like Georgia and Florida—is that this whole map of the United States will be blue.

Mr. ROE of Tennessee. That is correct, Dr. GINGREY.

Unless you are very deeply buried into this—meaning, if you're a Medicare recipient out there today—you don't see this. I go home, and I see my physician friends and talk to my friends who are on Medicare. They

don't know this has happened or that it could potentially happen to them, but it can and it will, and it is the law right now unless we change the law.

I would strongly encourage my colleagues on both sides of the aisle—and we have bipartisan support for the appeal of the IPAB—to put that constitutional authority back in the hands of the people who are directly responsible and responsive to the American people—us, the Representatives. Let us make those changes and, the Senate, the same thing.

Mr. GINGREY of Georgia. I thank the gentleman, and I want to continue a colloquy with him and maybe even ask a question of him. Dr. ROE, Madam Speaker, explained very clearly how that is a section of ObamaCare, a very important section of a group of 15 bureaucrats appointed by the President.

In regard to the IPAB, they basically can now say from year to year, Well, the doctors and the hospitals are going to be cut so much reimbursement. These cuts are going to occur.

We showed in the first slide how over the years Congress has been able to mitigate. Read the Constitution. We, the Members of the Congress, control the purse strings. So, fortunately, we were able to make these changes into what was suggested; but this IPAB board of 15 bureaucrats, they're not making a suggestion. They're telling us what has to be done.

The question I wanted to ask of Dr. ROE, Madam Speaker, was: when this case went before the Supreme Court, questioning the constitutionality of the law and saying that if a Governor of a State, like the Governor of Georgia, Governor Nathan Deal—an 18-year Member of this body, by the way—makes a decision not to expand Medicaid because the State can't afford it as the State's already going broke on the current Medicaid program, is it constitutional for the Federal Government to say, If you won't expand the Medicaid program, we're going to make sure that you can't participate at all and that all of your current recipients of Medicaid in the State of Georgia are out on the street?

That was a question that was asked of the Supreme Court as well as: was it constitutional to force people to engage in health care if they didn't want to, if they did not want to purchase health insurance? Now, I'm not recommending that they don't; but the question before the Supremes was: is it constitutional under the Commerce Clause to make people engage in commerce if they don't want to do it? The Supremes said, in a very pained, strained, pretzel-like decision, that that was constitutional.

Dr. ROE, do you know whether or not this question about IPAB was addressed by the Supremes: is it constitutional or not? I'm not sure. I'm thinking it wasn't addressed. Would you speak to that.

Mr. ROE of Tennessee. That's correct.

I had the privilege of being in the chambers when a good part of this health care debate was going on in front of the Supreme Court. It was the first time I'd ever been there. Fascinating. I'd totally misread it.

As you pointed out, it was the first time in American history that the Supreme Court said that you had to purchase a good or service—even if it's good for you, that you had to purchase it. We've never forced anybody into commerce before like this. As an individual, I think you have a right to make good decisions and bad decisions. I agree with you. I think a good decision is, if you can afford health insurance coverage, you should purchase it. I think there is no question. I have for my family my entire life, and I would recommend it strongly and encourage people to protect themselves in that way.

But does the government have the right to do it?

This Court said 5–4 that they did. The Court also said that they did not have the right to force States into expanding their Medicaid if they did not want to, and the IPAB specifically was not brought up.

I believe it will be challenged and should be. No one has standing yet because it hasn't gone into effect. In other words, they haven't issued any rulings—or the Secretary hasn't—to say that I've been harmed by that ruling so that, therefore, now I have standing in the Court and that I can bring a case.

□ 1530

Mr. GINGREY of Georgia. So you're saying that it's in the law, but because it hasn't been applied yet. And, in fact, indeed, as Dr. ROE pointed out, Madam Speaker, the board, the IPAB board, 15 bureaucrats, have not even—not even one of them, their salary has been set, I think they're scheduled to make $150,000 a year and probably have a car and a driver and health insurance and retirement plan, and not too bad a gig if you can get it, but not so far I don't think any have been appointed. And so that's what Dr. ROE, Madam Speaker, was referring to when he said there's not standing yet. If you went to the Supreme Court, they would say the case is not ripe. I'm standing here as a physician trying to sound like an attorney, and I'm going to get myself in a lot of trouble here in a minute, Madam Speaker, and Dr. ROE explained that very well, but I do agree with him, colleagues. I do agree with Dr. ROE that that will be challenged and certainly should be struck down. You look at the Constitution, our fifth and sixth graders probably could make that decision, and it wouldn't be a 5–4 split decision; it would be 9–0.

Mr. ROE of Tennessee. Actually, the IPAB board of 15 bureaucrats will make $165,000 a year with a 6-year term, and they can be appointed twice to that term. And it's something, and what bothers me about it is, no, it says in the bill you can't ration care, but we are the elected representatives. We should be able to go back home, as Congressman BILIRAKIS said, we should be able to go back home and face our constituents, and they're going to say: Dr. ROE, we have a situation where I can't go see my doctor. I can't go in and see them because they aren't accepting patients, and they aren't accepting patients because of this particular board that's cut their reimbursements enough to where they can't afford to see patients.

Now, another couple of things I want to talk about in the Affordable Care Act, not just SGR formula effects, but there is a tax out there in the Affordable Care Act that hasn't been very well discussed, and that tax is on individual insurance accounts. For instance, there are companies out there that are self-insured, and they're going to get a bill for each person that has insurance. Let's say a family of four or five, they'll get a bill for four or five people, and one company in particular, this will add—and they have no reinsurance. They cover everything. They're totally self-insured, but this basically is a tax that will go into a fund to indemnify insurance companies so that they won't have a loss of more than $60,000 a year, and this is billions of dollars when you stretch it across the country.

And these insurance companies are going to not have the loss to encourage them to accept patients on the exchange. That's as wrong as it gets to take a company that is doing everything right, they're going ahead and providing the health insurance coverage for their employees, and to penalize them for that.

So there are many, many issues in the Affordable Care Act we could talk about, but I want to basically finish my comments on the sustainable growth rate by saying in the past, since 2001, just so that our viewers out there will understand this, since 2001, your Medicare doctor at home has gotten an average increase in his or her payments when you come see them of 0.29 percent per year, 0.29 percent per year. When you look at all that graph that Dr. GINGREY has down there and you do all the math, that's how much of an increase. It's a very minimal increase. It hasn't even come near to covering the cost of inflation.

So again, Dr. GINGREY, I want to conclude by saying that the major concern I have, and I saw it in my practice, is the cost of care, and, number two, access to care. I'm concerned as our patients age and our population ages—and look, a good thing is happening in America: almost every 10 years we live, we're adding 3 years to our life expectancy. In 1908, the life expectancy in America was 48 years old, 47–48. In 1922 when my mother was born—and she's still living, I might add. She's living alone, by herself, doing great. She has Medicare. And I'm going to tell my mother now that later today I'm going

to call her prescription in. She notified me today that she needed some medicine called in, and so I will do that for her today. I look at her and I think about her need for access to care, and if it's cut off, what does she do.

Mr. GINGREY of Georgia. I thank the gentleman, Madam Speaker. And as he talked about his mom, I stand here thinking about my own mom, who's 95 years old. Her body is getting a little frail, but Mom's mind is perfect. Perfect, Madam Speaker. She has enjoyed the benefit of Medicare and Social Security for many years. Many years. So these legacy programs are hugely important. They're hugely important to our side of the aisle.

Madam Speaker and my colleagues, all of this Mediscare stuff, and things that you get all of this rhetoric about, they don't care about seniors and they're going to push somebody's grandmother over the cliff in a wheelchair, that's just a bunch of bull. I think every Member of this body and every Member of Congress cares about seniors and cares about these programs.

But I also, Madam Speaker, have 13 grandchildren. I have 13 grandchildren, and I want this Medicare program to be there for them some day, just like it has been there for Mom all these years.

So as we talk about these issues, we would do nothing to harm current recipients of Medicare and Social Security. We used the term, the phrase I guess you'd say, ''hold harmless.'' Hold harmless. Any changes that we would make, whether it is the payment system to our doctors and our hospitals for providing the care, it would not take away any benefit. It would not cause our current seniors to have to pay a higher premium or copay or deductible. All we're doing is trying to come up with something that would save the program for them, but, most importantly, for these youngsters that are coming behind us, the next two generations. So that's what we're all about.

My colleague, if he has some more comments, I would like to refer back to him, the gentleman from Tennessee.

Mr. ROE of Tennessee. Dr. GINGREY, I think one of the things I know you did and I know one of the things that I did was to come here to this body, this great body, to work on the repair of our health care system and improve on it.

One of the major pieces of our health care system is our Medicare system. I cannot tell you the patients I have seen in my career that have benefited, whose lives have been helped and saved by the Medicare system and by the doctors and nurses and hospitals and other providers who've cared for them. You have, too. I've operated on them, and I've seen them get cardiac care, renal, whatever it may be, that has improved the quality, improved and lengthened the quality of their life, not just to live longer, but to live better.

My goodness, look at the number of patients that we see of our orthopedic friends that we have that are mobile, that are active who've had joint replacements and so forth. Look, if you're 80 years old, 75 or 80 years old, you understand that your life is not going to be that much longer, but you also want the quality of that life to be the absolute best it can be. And it cannot be if you can't get your knee fixed if you're in pain, or your hip fixed if you're in pain. One of the things that I think our side of the aisle is committed to, I believe the other side, we may have differences of opinion, but one of the things I want to do is to be sure that we shore up and save this great system of Medicare.

I had a meeting today just after lunch about the Medicare part D program that was passed by the Republicans at some political risk for them. That's been a plan that has actually come in under-budget. It came in under-budget because seniors are able to go shop and purchase exactly what they want that meets their needs. That is exactly what we want to do in the Medicare system.

And when our budget is published next week, we are going to look at a system where we help fix and save and sustain Medicare, as you pointed out, not only for your mother, who's 95, and my mother who is 90, but for my two grandchildren who are 7 and 9. They also deserve the same great system, and we're going to have to change it; but I think we can make it better. I really believe it can be more responsive. You see what patients do when they get Medicare Advantage. You saw what they did. There was a little confusion, I admit, when Medicare part D first came out. There is no confusion now. People shop for the best value that meets their needs, and that's exactly what we should do.

Let me give you an example, Dr. GINGREY. I turned 65 a very short time ago. What happened to me when I turned 65? Nothing. I got one day older. Except what happened was I had a plan now that had an alphabet soup—A, B, C, D.

□ 1540

The day before I had a health care plan. Why, when you turn 65 years of age, don't you have a health care plan? And in that health care plan I can pick out I don't need fertility coverage at age 65, thank you very much. And I think that's the kind of thing—allow seniors to be able to pick what meets their needs and meets their family's needs at that particular point in their life; not just one-size-fits-all, but what they need.

And seniors have done that. They do it with everything else in their life. There's no reason it should change when you hit 65. You should pick out what plan—just like you and I can do up here with the Federal Employees Health Benefits plan. There's no reason that a senior shouldn't have exactly the same plan. It will be cheaper. It will be a better plan for them, and that's one of the things I think we're going to be discussing in the next several months when the Republican budget is published.

Mr. GINGREY of Georgia. I thank the gentleman.

Madam Speaker, as we get near the closing of the hour, I wanted to just mention several things. Dr. ROE has alluded to these, talking about the Medicare Advantage and what a beneficial program that was. Unfortunately, it's now been gutted, literally gutted, cut at least 12 percent, $130 billion, to create this whole new program that we call PPACA, or ObamaCare.

Medicare Part D, Madam Speaker, the gentleman from Tennessee is talking about the prescription drug part of Medicare that we did my first year, when I first came here in 2003, the Medicare Modernization and Prescription Drug Act.

Seniors, for many, many years, have wanted to be able to get their prescription drugs covered by Medicare but they couldn't. And of course, when you have to go to the drugstore and get five prescriptions filled, and most of them, brand name, not generic, some generic, maybe, but these brand name drugs are so expensive. And so we finally did this for our seniors.

Now, we spent what—I don't know, maybe $750 billion—creating that program, and we got criticized for it because it wasn't paid for. We didn't offset by cutting spending somewhere else. And I think maybe that criticism, under the current system, is legitimate.

But really, when you think about it, if you scored dynamically, and you realize that if people, seniors, all of a sudden could take their blood pressure medicine and not have to worry about a stroke, could take their diabetes medicine and not have to worry about eventually having renal failure from diabetes or an amputation, in the long run, what I'm saying, Madam Speaker, is this program, Medicare Part D, Medicare Advantage, electronic medical records, if we scored things in the right way, dynamically, at the end of the day, 10 years, 20 years, whatever, we're going to save money because people are not going to have coronary bypass surgery, they're not going to have to have these amputations, they're not going to end up the rest of their lives in a nursing home because they've had a catastrophic stroke that has left them totally incapacitated.

I'm going to yield back to the gentleman from Tennessee to close us out.

Mr. ROE of Tennessee. I have just one quick statement, Dr. GINGREY. And when you brought this up in 2003—and I want to thank you, because I can remember sitting at my desk in my office in 2003 working, and I could take this pen right here, and in about a minute or a minute and a half, I could write two or three prescriptions that might take up a patient's entire monthly income. That was the decision patients were having to have.

And Republicans stepped up to the plate, made a very difficult decision. Like you said, maybe we should have some criticism for not having offsets. But seniors out there today don't have to make that decision about whether I break this pill in half or whether I don't take it today or whether I buy food.

And you ran across that in your practice. I mean, I would look in our area, many widows that I would see would have a $600, $700 a month Social Security check and maybe a $100 or $200 a month pension. And you write three prescriptions, and the first thing they say is, Dr. ROE, it's gone. And you could easily do that. So I want to thank you for your vote.

Mr. GINGREY of Georgia. I thank my colleague.

And Madam Speaker, I thank you, and I thank the leadership of the Republican Party for allowing us to bring this information to our colleagues in a bipartisan way.

We are all about solving these problems. We talked basically about the sustainable growth formula, the way we pay doctors for a volume of care.

Clearly, we're going to have to go to paying for quality of care. We don't have time to get into all the details of that today, but in the next Special Order hour that the Doctors' Caucus leads, we'll get into more details about what we're going to recommend to our committees, to our leadership, to both sides of the aisle in regard to solving this program.

And with that, I yield back the balance of my time.

REMOVAL OF NAMES OF MEMBERS AS COSPONSORS OF H.R. 423

Mr. COFFMAN. Madam Speaker, I ask unanimous consent to remove as cosponsors from H.R. 423 the following representatives: Representative ILEANA ROS-LEHTINEN, Representative JANICE SCHAKOWSKY, and Representative STEVE STIVERS.

On February 26, 2013, three names were added as cosponsors that were not intended to be included. They were meant to be added to another bill I introduced, H.R. 435.

Their removal is only necessary due to a clerical error on the part of my office, rather than a decision by the four offices.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Colorado?

There was no objection.

HOLLOW IDEOLOGIES

The SPEAKER pro tempore. Under the Speaker's announced policy of January 3, 2013, the Chair recognizes the gentleman from Iowa (Mr. KING) for 30 minutes.

Mr. KING of Iowa. Madam Speaker, it's always my honor to be recognized to speak here on the floor of the United States House of Representatives, and I'm privileged to hear from the ''Dr. Phil Show'' that we've just listened to over this past 60 minutes.

I have a few things on my mind that I'd like to inform you of, Madam Speaker. And I'd start with this: that sometimes we need to take a look at the bigger, broader direction that this Congress is going and this country is going.

And one of the things that I've learned, being involved in the legislative process, in fact, back in the Iowa State Senate some years ago, one of my colleagues said we're so busy doing that which is urgent that we're not addressing those things that are important. And that should frame all the things that we do.

We should have a long-term plan. We should have a big picture plan, and the things that we do should fit into that. We should be putting the pieces of the jigsaw puzzle together under that broader view.

And how does that broader view fit?

Our Founding Fathers understood it. They understood the perspective of history. They knew where they stood in history, and they acted accordingly. They understood human nature. They understood human universals.

They watched the continuum of history to get up to their point, and they made deep, long-term, broad, deliberative decisions that were difficult and debated, they were hard-fought out, and they put those pieces in place for us. It's clear to me when I read through the documents of our Founding Fathers that they understood history and human nature.

It's not as clear to me, Madam Speaker, when I serve here in this Congress and engage in debates here on the floor and in committee and in subcommittee and around in the places where we're often called upon to comment or listen to the comment of others, that we're looking at this from the big picture.

So something that brought this home for me was on a trip that I was involved in dealing with negotiations with the Europeans, and one of the speakers who was an expert on the Middle East made a presentation about the Muslim Brotherhood. And I'm not here to speak about the Muslim Brotherhood except this: that part of his presentation was that the Muslim Brotherhood is, according to the speaker, a hollow ideology. I put that in quotes, ''a hollow ideology.''

Now he said that they can't sustain themselves over the long term because their belief system isn't anchored in those things that are timeless and real, those things like the core—now, I'm going to expand a little bit—the core of faith, the core of human nature, but a hollow ideology.

So when he used that term and professed that hollow ideologies cannot continue, that they will eventually expire because they're sunk by their own weight, rather than buoyed by a belief system, then I began to look at our Western civilization.

And we are, here in the United States, Madam Speaker, the leaders of Western civilization.

□ 1550

And so when the allegation of a hollow ideology is placed upon the Muslim Brotherhood, I have to wonder: can I make the argument that our ideology is full and wholesome and identifies our values that are timeless? And are the pillars of American exceptionalism restored with the ideology we carry here? And do we strengthen this Nation so that the next generation has the opportunities we had or do we just ignorantly wallow through the day-to-day urgent decisions of Congress without dealing with the broader picture of who we are and, particularly, how we got here?

I look back to the time when I first ran for office. I was putting together a document that I wanted to hand out to my, hopefully, future constituents. I believed that I should put a quote in there that sounded wise, and hopefully was wise.

As I sat in my construction office about 1:30 in the morning, I wrote up this little quote. Part of it is naive; another part of it, I think, is appropriate. And the quote was this: that human nature doesn't change; that if we ever get the fundamental structure of government correct, the only reason we need to reconvene our legislative bodies are to make appropriations for coming years or adjustments for new technology.

Madam Speaker, when you think about what that means, if we ever get government right, if we ever get our laws in place, our regulations in place so that they reflect and bring about the best of human nature, since human nature doesn't change and it hasn't changed throughout the generations, then just make the adjustments for appropriations in new technology, that is a correct statement, I believe. But it is pretty naive about the reality of coming to a consensus on getting the fundamental structure of law correct, let alone the fundamental structure of regulations correct, without regard to the changing technology that always is thrust upon us here.

We are continually going to be in an argument, in a debate, about the fundamental human nature, how people react to public policy and about where we would like to see society go. Those of us on my side of the aisle believe that we have values that are timeless. Whatever was true 2,000 years ago is true today, and whatever was sin 2,000 years ago is sin today.

There are those on the other aside of the aisle, many of them would advocate that society isn't going in the right direction unless you are constantly changing things, without regard to the values we are changing, without having to grasp for a higher ideal, just grasping for change. If