FUNDING RECOMMENDATIONS

CONFERENCE TOTAL—WITH COMPARISONS

The total new budget (obligational) authority for the fiscal year 2010 recommended by the Committee of Conference, with comparisons to the fiscal year 2009 amount, the 2010 budget estimates, and the House and Senate bills for 2010 follow:

[In thousands of dollars]

New budget (obligational) authority, fiscal year 2009	$120,966,466
Budget estimates of new (obligational) authority, fiscal year 2010	123,919,720
House bill, fiscal year 2010	123,843,248
Senate bill, fiscal year 2010	124,520,248
Conference agreement, fiscal year 2010	121,230,291
Conference agreement compared with:	
New budget (obligational) authority, fiscal year 2009	+263,825
Budget estimates of new (obligational) authority, fiscal year 2010	−2,689,429
House bill, fiscal year 2010	−2,612,957
Senate bill, fiscal year 2010	−3,289,957

DAVID R. OBEY,
ROSA L. DELAURO,
SAM FARR,
ALLEN BOYD,
SANFORD D. BISHOP,
LINCOLN DAVIS,
MARCY KAPTUR,
MAURICE HINCHEY,
JESSE L. JACKSON, Jr.,
JO ANN EMERSON,
RODNEY ALEXANDER,
Managers on the Part of the House.

HERB KOHL,
TOM HARKIN,
BYRON L. DORGAN,
DIANNE FEINSTEIN,
RICHARD DURBIN,
TIM JOHNSON,
BENJAMIN NELSON,
JACK REED,
MARK PRYOR,
ARLEN SPECTER,
DANIEL K. INOUYE,
SAM BROWNBACK,
ROBERT F. BENNETT,
THAD COCHRAN,
KIT BOND,
MITCH MCCONNELL,
SUSAN COLLINS,
Managers on the Part of the Senate.

HEALTH CARE REFORM

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 2009, the gentleman from New York (Mr. WEINER) is recognized for 60 minutes.

Mr. WEINER. Mr. Speaker, before I proceed with the subject I want to talk about, I just want to summarize the last hour.

Apparently ACORN is going to kidnap your children and drag them to Planned Parenthood where they're going to be forced to have national health care.

That sounds pretty frightening. But if you were having trouble following that, Mr. Speaker, so were the rest of us.

And for you, Mr. Speaker, and my colleagues and for anyone watching, if you're looking for a 1-hour screed about the ghosts that lurk in the closets of our government, I can't help you.

But I would like to have a little bit of a conversation about the discussion that we're having around dining room tables and diners and church basements all throughout this country about the health care we provide Americans, how we pay for it, and what we should do to make it better. And to any of my Republican colleagues who are watching in their offices, who are watching off somewhere in the congressional campus, and this is kind of quiet at this hour, I am interested in having a real discussion and a real debate.

There are things that we disagree with. There are philosophical schisms that have emerged in this. But, frankly, a lot of the debate, unfortunately, has been too much like the last hour, which is just something bordering on nonsense.

But let me just start with the notion that we're really trying to solve with health care three problems, two of which are relatively easy to solve and one of which is very difficult to solve.

The first problem we're trying to solve is that there are a lot of people that don't have health care. Well, I shouldn't say that. There are a lot of people that don't have health insurance. They get health care. Everyone in this country, everyone who's got insurance, not insurance, documented, undocumented, old, young get health care. And what I mean by that is if someone right now outside the steps of this Capitol falls down with a stroke, we're going to come and there's going to be an ambulance that's going to rush to get them. They're going to take them to an emergency room. A doctor is going to do everything medically possible to revive them and to make them healthy. The only question is, How do we pay for that service?

If you have health insurance, you pay for it one way. If you have Medicare or Medicaid, you pay for it another way. If you pay for it out of your own pocket, you pay for it a third way. But if you have no health insurance at all, we the taxpayer by and large pay that bill. And it's a lot of money. It's a relatively small number of people who are uninsured, but the expenses that they have are very, very high because when you go into a hospital emergency room for care, that is usually pretty expensive care. And it might not come directly back to us in taxes, although a lot of it does.

In New York City, for example, about $2 billion each and every year we pay for the uninsured that come into our emergency rooms. Some of it is paid for by everyone else that has health insurance paying higher premiums, but a lot of it is just passed along to the hospitals and doctors and saying, hey, you foot the bill. As a result, in my home county, there are three fewer hospitals than there were just a year ago. It's an unsustainable dynamic that the people who are not insured, frankly, if they can afford to pay, well, in some cases they do, but in a lot of cases, they pass along the expense to us.

But that problem is pretty easy to solve. What do you do? You give them some money or you give them some tax benefit or you give them some tax credit and you say go out and go shopping for health insurance. Go buy some. We'll require you to do it. You go out and buy some.

It gets a little bit complicated in how much you provide the subsidy, and it does get complicated when you're trying to figure out will they be able to afford that health insurance plan. And that's where the public option discussion comes in, but I will get to that in a moment. But that problem is a relatively easy one to solve. As some of my colleagues have pointed out, it's only 10 percent of the American public. How hard can it be?

The second problem is also relatively easy to solve, but it's important: for all of us who have health insurance, making sure our health insurance company treats us relatively well. When we need care, do we get it? Do we get dropped because we have preexisting conditions? When they're deciding how to set a price for it, do they price it in an unfair way where effectively we're locked out of the market? That too is relatively easy to solve, and I think there is some agreement.

Look, no one should be able to drop someone for preexisting conditions, and now that we in the Democratic Party are in charge of this Chamber, we're going to pass something to fix that. Those things are relatively easy. In fact, since insurance companies are regulated in all 50 States, a lot of States have tried to do those things, some with more effect than others.

But the third problem, and it's the mother of all problems, is the overall cost to the system. The overall cost to those of us who have insurance, the overall cost to those of us who are taxpayers is getting so large that it's drowning everything else in the economy. And the question is, How do you solve that problem?

Now, what has been suggested by the President and the majority party in Congress through the various committees is essentially what you try to do is if you require everyone to get insurance, meaning insurance companies will have more people to cover, that hopefully what that will mean is they'll have more money coming in from lower-cost people, meaning people that don't have a lot of illnesses, and that the insurance companies will be magnanimous and they'll lower their prices. That's basically what the argument is. Maybe it's right. Maybe that's what will happen here.

Now, I believe, and what I would like to devote a little time to today, is I believe that we are using a bank shot when we should go directly at the problem. I say we are using a bank shot because we are basing all of this on private insurance companies to help us.

I ask you, ladies and gentlemen, what is it that health insurance companies do? They don't provide checkups. They don't provide clinical services. They certainly don't operate on you. What do they do? We know they take your money. They take my money. We know they take the money from your employers. But then what do they do? Unlike any other insurance plan, they don't apportion risk because they don't cover anyone over 65. All of those people are on Medicare. They price a lot of people out of the market by saying to people like those who are of my father's age when he retired, we're going to charge you $15,000 or $16,000 for a policy. So the question becomes, What is it that insurance companies do?

What they do is they make money. They take money out of your pocket, give it to doctors, and along the way they take some money for themselves. How much? Up to 30 percent. And the question that many of us are asking in the context of this debate is, Why do it that way? Why not try something different? Why not try to say if you're going to take your money and give it to your doctors and give it to your insurance companies, why not do it a little bit more directly? Why not do it the way we fund, I don't know, the fire department or the department of sanitation in your town? Why not treat it as if it's a service?

Frankly, the fire department model is a pretty good one. If you think about it, it's very similar. You don't need the fire department every day. Day in and day out, you go without needing the fire department to be there. But when it's there, you really want it to be there for you. You need it. You can't put out the fire yourself. You need brave men and women of your local fire department, and maybe they're volunteers, to come to your home and put out your fire. So we all put in money into the fire department hoping that it won't be there; and when it does, we understand and it's a service that we willingly pay for.

But you don't have to fantasize what it would be like in health care to have a government-run health care plan. And when I say ''government run,'' to some degree I am borrowing the language of our opponents because when I say ''government run,'' I mean really government running the reimbursement system. We do have some experience with that and it's called Medicare.

Now, people have different views of Medicare. People either love it or they like it a lot or they think, oh, my goodness, it's never going to be there for me or it's unsustainable or it's growing broke. In a way both sides are right, both groups are right about that. Medicare has been an exquisite model of efficient government care and government services for 44 years. It didn't start out being all that much of a bipartisan program, but now it is, as you see from my Republican friends who thump their chests about how they are trying to defend Medicare. But the problem is at the very same time they say, But I'm against anything that's government run. I'm not quite sure I see the disconnect.

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Now some of them argue, but, wait a minute. Isn't Medicare on an unsustainable financial track? No doubt about it. All health care is on an unsustainable financial track. I'm going to borrow some of the charts that have been used previously to give you a sense of what that means. This is the average health insurance premiums from 1999 to 2008. It went from about $5,800 to $13,000 from 1999 to 2008, in 7 years. It essentially doubled. That is unsustainable. And this is private insurance.

Now, it is true that Medicare is also seeing that type of strain. Why? Well to some degree, it is a victim of its own success. Today the average life expectancy of someone is about 10 years longer than it was 44 years ago when Medicare was created. And by the way, Mr. Speaker, you're not getting those 10 years when you're a teenager. You get them at the end of your life. So that is adding to a lot of expense. Technology has added to a lot of expense. And there's a lot of things that we do in Medicare that don't make a lot of sense that we could do to save money. A lot of them I hope we are going to do in our national health care fix that we are going to do. But one of the things you can absolutely say is that no money is going for profits. Very little money is going for overhead, only about 3.5 percent, according to a Rand study, compared to 30 percent for health care for health insurance companies.

So the question has to be, what are the benefits that we are getting from those private insurance companies? Well, my colleagues frequently say, it gets you competition. Really. Competition? Explain to me how competition works in the health care business. If I fall down here, not to keep using morbid examples, but if I fall down and I have an appendicitis attack right now and I have to get my appendix replaced, tell me about competition. Do I get to shop around to see maybe I will have a liver or a spleen instead? Of course not. Do I get to say, I'm not going to get my appendix done right now, I'm going to wait and I'm going to get it done in December when I hear they go on sale? No. In fact, I also can't go out and say, wait a few years, don't operate on me. I'm going to go to medical school and learn how to do it myself in my garage to take out my appendix.

The notion of competition is further folly in that for most people that have health insurance at their work, they don't have a choice of plans. The employer comes in and says, on the floor of the warehouse, they say, guys, gather around, you are going to get Oxford or you're going to get Aetna. That's our plan. I'm going to pay 60 percent, you're going to pay 40, that's it. You don't get to say, no, I'm going to do it different. I'm going to go to Blue Cross instead. There is not real effective competition in that context as well because most people get their insurance through their work.

Remember something, the basic element of competition does exist within Medicare in a very important way. Patients have their choice of what doctor to go to. They have their choice of what hospital, what clinician to go to. They have absolute choice. So we are right back to where we started that both private insurance and Medicare both have financing problems. The private insurance, as I said, is worse. They both have some elements of choice, Medicare more choice than the private insurance companies. But the difference, and this is that third problem we are trying to solve, the difference is how much private insurance companies take out of the pot for their shareholders, for advertisements, for overhead. It's an enormous amount. And we should want it back.

Now some have suggested, and I keep trying my best to do the other side of the argument, since none of my colleagues on the other side of this argument have taken me up on my offer to come down and discuss it with us tonight, but some have said, well, those insurance companies, the money that they are taking, they employ a lot of people, their shareholders have a right to take that money from the taxpayer, to take that money from patients. That might be an argument that you make at a shareholders' meeting, but it shouldn't be an argument you make on the floor of Congress. We shouldn't be standing up fighting for shareholders.

I guess the equivalent would be in the 1980s when we discovered we were paying $700 for toilet seats in the Department of Defense, I guess I would have heard my colleagues stand up and say, yes, but there are many hardworking people making those toilet seats. You can't take that money away from them. Of course not. We said, you find a way to get a $10 toilet seat like everybody else because we are here fighting for the taxpayers' money, and we are here fighting to improve the lot of patients.

So I believe that where we have to start is taking an example of something that worked, which is Medicare. Now Medicare, as you all know, begins when you turn 65. So the Speaker has about another 30 years before he has to worry about it. But frankly, I don't understand what the magic is about the 65th birthday that makes it a plan that works. Ninety-six percent, every year we do a survey of people on Medicare. We ask them to grade the care that they get, the efficiency of the care, the quality of the care. They gave it a 96 this year, 96 percent. By the way, we also asked the contractors. We always hear how terrible Medicare is for providers. We also ask each year, CMS

asks the providers, they call them contractors, the doctors and the hospitals, they gave them a 4.5 out of 6. So basically both elements are pretty happy with it. We started at age 65.

Try this little experiment next time you go to the supermarket. Tap someone on the shoulder who looks like they are 55 or 60 and say, would you like to have Medicare now when you're 55 or 60? They will say, heck, yeah. Because those are the people for whom health insurance is the most expensive. Many of them have trouble getting it. Those are the people more likely to be laid off in this economy, that kind of in between group. Yet we don't offer it to them. Why? We have a system that works, Medicare, and yet instead of trying to figure out a way to take a system that works and expand it to more people, we say, no, it has got to be 65. Why don't we provide Medicare for those that are like 21 to 25 who are just off their parents plan or just out of college? Those are people that we would like to have covered. Those are the so-called invincibles. Those are the people who have trouble finding health care. Why don't we provide them with Medicare? Now, some have suggested oh, wait a minute, you're taking over health care, socialized medicine. Well, putting aside for a minute that socialism has a meaning, and it means that government controls the means of production and no one is suggesting that, the doctors are still going to be the doctors, the hospitals are still going to be the hospitals, if you take a look at that argument, you realize that, I don't know, what do you think, Mr. Speaker, 50 percent of this place has Medicare? Sixty? I don't see them complaining. They don't seem to mind socialized medicine when they are getting it. I don't hear anyone saying, we have heard a lot in this discussion, well, how come Members of Congress don't take the public plan? They already do have the public plan. They have got Medicare. And by the way, when I turn 65, sign me up. It's going to be a while, Mr. Speaker, so don't rush me. But look, the fact is we have a model of something that works.

Now, as I said, and I want to stipulate to this, that it's expensive. And we need to contain that cost. But this brings us to the ideas about how you do it. And I will say this at the risk of antagonizing any of my colleagues or breaching the rules—I just wanted to see if the Parliamentarian would perk up at the suggestion I might be breaching the rules. But my Republican colleagues have not been honest in trying to deal with the cost of the argument. They have said a couple of things repeatedly. They say, oh, if only we had tort reform. We have tort caps in 46 of the 50 States. In some of the States that have the toughest cap, you have got the greatest rates of increases in health insurance and the malpractice insurance. Why? Well, it's obvious why. The health insurance companies lobby for the caps, and then they keep the money. They don't pass it along to us. And their shareholders cheer. Tort reform they say. Well, we asked them, by the way, we said to the Congressional Budget Office, the CBO, we said what would happen if you overnight can reduce 30 percent of all tort claims? What would happen? They said you get some savings, .4 percent. And we went back and said how can this be if you reduce 30 percent of all the tort claims, you don't do better than that? And they said to us—These are propeller heads. They are pencil pushers. They are not politicians. They said, yes, because we looked at the different States, and what did we find out? We find out that when you get caps, the insurance companies keep the money. So that's one thing they said about cost containment, and that clearly doesn't prove to be right.

And then they said something else that's interesting. They said, why don't we let all health insurance companies compete in every other market, essentially adding to competition? Now this is an interesting one because it kind of argues for the public option in an odd way, but let's take it where it goes. Now, first of all, let me make it clear. There is a reason that a health insurance company in Maine doesn't come in and offer a health insurance policy in New York, because the first thing they have to do is develop their network of doctors in New York. That is very expensive and very difficult. But New York has made it very clear that they are willing, more than happy, there are no applications pending for someone who wants to come in and offer insurance. And that is true of most of the States. Now, why is it you need to apply to a State? This is where my Republican friends tie themselves into a little bit of an intellectual knot. Insurance is regulated by the 50 various States. And why is that? Because, and this is a place where as much as I'm critical of insurance companies, I kind of agree. Health insurance companies say, listen, we need to be able to do things that might be deemed anticompetitive under other laws. We need an exemption from the antitrust laws so that we can share information across State lines and across companies, essentially—it's too strong a word, but I'll use it anyway—essentially collude, share information about patients. You don't want somebody who gets into a car accident in New Mexico being able to hide it by going to New Jersey. So each and every State, since it's not regulated federally, it's not interstate commerce technically, each individual State has it, so each individual State has their own process for allowing insurance companies to come in. Do you know what? Nobody is saying no. You look at the 50 State insurance commissioners, nobody is saying, oh, I'm getting overrun with applications to provide health care in Idaho. No. They are not doing that because insurance companies have no real interest in competing on price. So once all the customers are basically locked up, there is no interest in coming in. But I guess the logical extension of the argument for people who want to have that type of competition is to take away the antitrust exemption from insurance companies. You can do that. I don't think that your patrons, the insurance industry, who provide so much funding for campaigns and some of my colleagues, would be very happy about that though.

So what is it that the President proposes? And what is it that H.R. 3200 proposes? It proposes that for some Americans, not many to be honest, some Americans, meaning those that don't have insurance through their work, are not working but are not eligible for Medicaid, who are individuals, who are just looking to get insurance but are not covered, that is a relatively small group of people, remember, 45 percent or so of all Americans have either Medicare, Medicaid, health care from the Department of Defense, the Department of Veterans Affairs, or the Bureau of Indian Affairs, you have got about 55 to 60 percent who have health care through private insurance, so you're talking 10 percent, 5 percent, 8 percent, who are going to then be able to, we're going to give them a tax benefit, they're going to then go shopping. But in order to make sure that there is some competition so that the rate of health insurance that they're buying doesn't keep going up, we're going to have a public plan like Medicare that is going to be introduced for those people.

Now, it's anticipated that maybe a third of all of those people at most would go into the public plan. So you have a tiny sliver if you are covered by insurance at your work. Theoretically you can say to your employer, keep your money, keep your money, I'm going to absorb all the costs and go try to shop for the public option. But that is not going to realistically happen according to CBO. If you have your own insurance policy, if you have Medicare, you're not going to be able to do it. But you're going to be able to get something resembling a choice if you're one of those people. And the argument that H.R. 3200, which is the bill we have all been discussing, and an argument that President Obama made when he spoke to us before Congress, is that if you have that element of choice, you will have low overhead, you won't be advertised, you won't be given bonuses, you won't be taking money out for shareholders, and that people, that company, that public option will hold down costs.

Now in a strange way, both proponents of the public option and opponents of the public option argue for the Weiner plan, argue for single payer. And I will tell you why. People who argue for it say it's going to be an effective way to hold down costs because people are going to choose that public plan, because they are going to like the low prices, the low overhead and the

like. People who are opposed to it say, no, we are opposed to it because people are going to choose that plan. And if they do, private insurance companies won't be able to get those customers. They won't be able to compete. But in both cases, they are saying the same thing. They are saying that citizens are going to go to the public option. They are going to go to the Medicare for everyone else, whatever we are going to call it.

So the question gets begged, why not just go there directly? Why give people tax benefits that they can go buy in the private market to take 30 percent off the top? Why not just say let's expand a program like Medicare? Let's find ways to get cost savings for Medicare by doing things like not paying $900 for a slip and fall for a night in a hospital for a senior citizen, but maybe $30 to build a handrail next to their shower. Why spend an enormous amount of money in the very final days of life and do nothing in the early days to try to get people living a better life, living a healthier life?

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Mr. Speaker, so that the question comes back to how you get the savings, and it also comes back to who's accountable for those savings.

Now, I believe we've got to get savings in Medicaid. We've got to get savings in Medicare. We've got to get savings. Frankly, this is not just something that has to be done by the private insurance companies. We have to find savings because, frankly, as the President said when he stood here, virtually our entire deficit right now is health care costs, and the health care costs that are paid for by the taxpayer are going up.

And people say, well, why is that happening? Well, everyone watching this broadcast tonight is not only paying their premiums, not only paying their copayments, but they're paying taxes that are supporting the city workers in your town for health care. You're supporting the State workers, the Federal workers, all of the retirees. You're paying an increasing amount because that health care inflation is coming back to you in a lot of ways.

I had someone stand up at a town hall meeting—and I had 13 of them I think over the August recess—come up to me and he says, well, Congressman, why can't you give all of the uninsured the same plan you have? I don't think the person who made that suggestion realizes he's my employer. He's putting in the 70 percent I think for the health care plan that I and every other Federal employee gets. So you might not see that you're paying it, but you're paying it, and we need to turn that cost down.

But before I yield back the time, I do want to try to address some of the kind of visceral concerns that the opponents to this health care plan have had. One I've already touched upon but I'll do a little bit more now, and that is the notion, you know, that it's going to be a government-run program, and by definition, government-run programs are not good programs. You know, there are some good government programs, and there are some not-so-good government programs.

I think Social Security is a program that worked. You know, people talk how we're falling off a demographic cliff that's unsustainable. Baloney. It's got giant surpluses. It's the only part of the budget right now that does have giant surplus.

I think Medicare has worked. I think that people haven't gotten rich off it, but it took a group of people, seniors, who had about a 28 percent poverty rate and lifted them to the point now that we have single digits, that it's so popular now that the Chair of the Republican national party put out a couple of weeks ago the Republican plan to protect Medicare, which I thought was unintentionally ironic because at the same time he was lamenting the growth of government-funded health care.

There are some maybe government programs that aren't so good. This one works. And there's a certain level of phoniness about going home to our districts, as I know opponents of this legislation do, and they rail against government-funded plans, the government-administered plans, and then embrace Medicare.

But listen to what the choice is. The choice is health insurance companies. Now, some of my colleagues have come to the floor with clever and creative boxes showing different where your money goes, where you go to try to show how bureaucratic health care is. Well, this is the present. This is the way private insurance operates today. You think it's not bureaucratic?

You know, you've got consumers, and then they're passing through their costs to employers who then have copayments. Then they have to go out and try to figure up—by the way, don't forget about this. This system that we right now, it's employers have to go out and get health insurance. Actually, let me spend a moment on this.

You know, why is it that we have health care that's provided by our employer? Where did that come from? Why should a shoe store on one side of Queens Boulevard in my district have a different obligation to its workers than one on the other side? Why should they compete based on what health care plan they have? I mean, that's what happened. If Joe's shoe store on one side decides, you know what, I want to do the right thing and cover my employees; I'm going to put, let's say, $7,000 an employee into the till—yet, he's competing against the guy across the street who says, wait a minute, let me see about this; no, I'm going to provide no insurance; I'm going to send them to the neighborhood emergency room for their health care, but since I'm saying $7,000 an employee, I'm going to cut the cost of my shoes by 15 percent. How is that fair?

Medicare says we're not going to do it based on employers, and that's what, frankly, I think we should do with all health care. Ask your neighborhood employer who's wrestling with trying to keep a business afloat whether having to provide health care is a bureaucratic headache for them. It ain't for Medicare. Medicare's a 4 percent overhead. The doctors say it's efficient; patients say it's efficient.

Getting back to this, this is the way private insurance is modeled right now because they've got to go through all the rigamarole. They've got to go negotiate with hospitals and communities and doctors. They deal with drug companies. They take a couple of dollars off the top there as well. Then they're dealing with the sellers of goods, and you've got administration of costs, then there's profit.

Well, here's what Medicare looks like on a chart. Patients get health care, the patients pay taxes, and then administrators, Medicare pays the doctors. That's it, over and done with, pretty simple. The only thing simpler is taking money out of your own pocket and giving it to your doctors which, frankly, Medicare being able to take this pool of people together has been able to do much more efficiently than you or I could do.

You know, another thing to keep in mind as we take a look at this is that there's a lot of money being spent on health care that we don't see. If you do a single payer plan like I have suggested here, no longer will you have cities and States being left holding the bag for unreimbursed expenses? What happened to my colleagues lamenting the unfunded mandate? Health care is the mother of all unfunded mandates because our States and our cities and our businesses all have to pay because you're doing nothing. That's the ultimate unfunded mandate.

So, hopefully, what we are going to do here as I conclude, hopefully what we are going to do here is try to come up with a plan that does provide additional choices for people that don't have choices right now: the uninsured. We're going to try to improve the circumstances that people that have private insurance find themselves under, and we're going to try to do something to introduce some element of competition to hold down costs.

But I tell you, I don't think that that's the right way to go, and I'm going to offer a different plan when we're on this debate in the next month or so. And I'm going to offer legislation, a modified version of H.R. 676 offered by Congressman CONYERS with many cosponsors, that says, you know what, we're going to take a plan like Medicare and we're going to offer it to all America. We're going to take their payroll taxes and the taxes they pay, and we're going to fund the system. We're not going to do a backdoor way. You're not going to have to dump all your city and State taxes. We're going to say, you know what, we're going to

do it Federally. We're not going to do it based on employer. It's not going to be just based on the luck of the draw; hey, I got lucky, I didn't get born with asthma. That's not the way we're going to choose who's going to get health care.

We're going to take hospitals and we're going to fund them globally. We're not going to incentivize them to run up the bill. We're going to say here is your area, this is the number of people you have in it, this is the number of uninsured people you have in it, this is the number of seniors you have in it, this is the number of people who have higher needs; here's your budget. You come in under budget, you keep the extra money.

Doctors are going to be the same way Medicare is. Patient gets to choose, you come in, you provide the service. And if you think we can't afford to pay for it, this is an old chart from a couple of years ago. $2.2 trillion we're paying for health care in this country, $2.2 trillion. It's actually $2.5 trillion today. This is the dreaded socialized part: Medicare, Medicaid, DOD. So essentially this is what it would like for more Americans. By the way, you're paying this out-of-pocket number, and you're paying about, let's say, let's round it, $200 billion in profits of this guy, for your private insurance companies.

And what we're saying is don't do it that way anymore. Other countries don't do it that way, but put aside other countries. When you hear people come to the floor of this Congress and say, oh, you want to make a system like England, you want to make a system like Canada? No, I want to make a system like United States of America where we tried something 44 years ago that has been an abiding success and that's Medicare.

I want to try that. I want to try that plan that—I don't know, I really do have to get the exact number. It would be a good thing to get—that half my colleagues have. A third of my colleagues have Medicare. If it's good enough for Congress, why isn't it good enough if you're 55 or if you're 60 or if you're 45?

That's the kind of plan that we should have, and if you think we can't afford to do it for less than $2.5 trillion, you're wrong. We can, because the present system is completely unsustainable.

And so the question is not whether we're going to do something. It's kind of like Buddhism. It's not whether you're going to have change but what type of change it's going to be. We can continue along this arc—it's funny, the 30 Something Group's charts aren't nearly as good as mine—but this arc here that says our national health expenditures are going to keep going up and up, they actually have a better one here. Here it is. Share of our GDP, are we going to let it get to 20 percent of our GDP? How about 50 percent? Sixty percent? How far are we going to let it continue to grow?

The answer isn't whether we're going to do something; it's what we're going to do and when. Well, the what we should do is take a system like Medicare that is efficient, that is well-liked, that is understood, that is simple, and extend it to more Americans.

What we're not going to do, what we're not going to do is follow the advice and counsel of my friends on the other side who for the hour preceding mine went on some screed about ACORN, you know, kidnapping, Planned Parenthood, babies, and bringing them into Obama-funded death camps or something. We're not going to have a conversation like that. I mean, you can keep doing it. It didn't stop you for the last 6 years. I guess you've got to do it and you've got to feed the beast of the talk radio and everything else, but the adults of this institution and President Obama and the Senate, we're going to try to solve this problem because that's what we get paid to do.

And we have the luxury in this body of laying down our head tonight with pretty good insurance, Medicare many of my colleagues have, and I see no reason why all Americans shouldn't have that, they shouldn't have what so many Members of Congress have.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF CONFERENCE REPORT ON H.R. 3183, ENERGY AND WATER DEVELOPMENT AND RELATED AGENCIES APPROPRIATIONS ACT, 2010

Ms. MATSUI (during the Special Order of Mr. WEINER), from the Committee on Rules, submitted a privileged report (Rept. No. 111–280) on the resolution (H. Res. 788) providing for consideration of the conference report to accompany the bill (H.R. 3183) making appropriations for energy and water development and related agencies for the fiscal year ending September 30, 2010, and for other purposes, which was referred to the House Calendar and ordered to be printed.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. CARNEY (at the request of Mr. HOYER) for today and through October 13 on account of serving in active duty.

Mr. NEUGEBAUER (at the request of Mr. BOEHNER) for September 29 and the balance of the week on account of medical reasons.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Members (at the request of Mr. NYE) to revise and extend their remarks and include extraneous material:)

Mr. SNYDER, for 5 minutes, today.

Mr. NYE, for 5 minutes, today.

Ms. KAPTUR, for 5 minutes, today.

(The following Members (at the request of Mr. POE of Texas) to revise and extend their remarks and include extraneous material:)

Mr. POE of Texas, for 5 minutes, October 7.

Mr. JONES, for 5 minutes, October 7.

Mr. FORBES, for 5 minutes, today.

Mr. BROUN of Georgia, for 5 minutes, today.

Mr. DEAL of Georgia, for 5 minutes, today.

Mr. WOLF, for 5 minutes, today.

Mr. WESTMORELAND, for 5 minutes, today.

Mr. PENCE, for 5 minutes, today.

Ms. FOXX, for 5 minutes, today.

(The following Members (at their own request) to revise and extend their remarks and include extraneous material:)

Mr. FRANKS of Arizona, for 5 minutes, today.

Mr. JOHNSON of Georgia, for 5 minutes, today.

Mr. GRAYSON, for 5 minutes, today.

ENROLLED BILLS SIGNED

Lorraine C. Miller, Clerk of the House, reported and found truly enrolled bills of the House of the following titles, which were thereupon signed by the Speaker:

H.R. 2131. An act to amend the Foreign Affairs Reform and Restructuring Act of 1998 to reauthorize the United States Advisory Commission on Public Diplomacy.

H.R. 2918. An act making appropriations for the Legislative Branch for the fiscal year ending September 30, 2010, and for other purposes.

H.R. 3593. An act to amend the United States International Broadcasting Act of 1994 to extend by one year the operation of Radio Free Asia, and for other purposes.

ADJOURNMENT

Mr. WEINER. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 7 o'clock and 58 minutes p.m.), the House adjourned until tomorrow, Thursday, October 1, 2009, at 10 a.m.

EXECUTIVE COMMUNICATIONS, ETC.

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

3865. A letter from the Acting Associate Administrator, Department of Agriculture, transmitting the Department's final rule — Nectarines and Peaches Grown in California; Decreased Assessment Rates [Doc. No. AMS-FV-09-0013; FV09-916/917-2 IFR] August 25, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

3866. A letter from the Acting Administrator, Department of Agriculture, transmitting the Department's final rule — Peanut Promotion, Research, and Information Order; Section 610 Review [Doc. No.: AMS-