Falcon Lake. His body remains missing, and those responsible for this border murder remain at large.

Shamefully, the only American peace officer apparently still working on this case is Sheriff Sigi Gonzalez of Zapata County. He has identified four of the seven shooters as Zeta Cartel members.

At least there's still somebody on the case.

The local sheriffs cannot do the job that they are supposed to do of protecting their counties while doing the Federal Government's job of protecting the border as well. Sixty-five Americans were murdered in Mexico last year, and not one case has been solved. Unfortunately, some of the Mexican border law enforcement personnel are in cahoots with the drug cartels. That relationship breeds incompetence and corruption.

Until the FBI, the State Department and Homeland Security get fully engaged in the murders of Americans in Mexico, it will be the responsibility of local sheriffs to keep the peace on the border.

And that's just the way it is.

THE STATE OF OUR ECONOMY

(Mr. BARLETTA asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. BARLETTA. Mr. Speaker, last week I had a chance to gain feedback from my neighbors in Pennsylvania's 11th Congressional District, and what I heard should concern us all.

From my ''Home to House'' town hall forum to the numerous meetings I held all over the district, my constituents are deeply concerned with the state of our economy and its effect on our communities.

Just one week after I submitted an amendment to restore $42 million to the Community Development Fund, I had the chance to get a firsthand look at some of the food banks and after-school programs that benefit from this critical resource. I also had the opportunity to hear from many who share my apprehension about spending reductions to the Low Income Home Energy Assistance Program, LIHEAP. I learned that 3,036 requests for LIHEAP grants were received from Wilkes-Barre and Hazleton in the past 2 months alone.

I thank all of those who have made the effort to share their thoughts and concerns with me, and I look forward to receiving more feedback in the future.

TURN THIS SHIP AROUND

(Mr. KINGSTON asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. KINGSTON. Mr. Speaker, imagine in your own household if, for every dollar you spent, 40 cents was borrowed. Obviously, you would sit down with your family at the kitchen table and say, Okay, for every dollar we spend, 40 cents is borrowed. We're going to have to change our purchasing habits.

That's what American families do; that's what farmers do; that's what small businesses do each and every day. Yet, for some reason, the U.S. Congress thinks it can defy gravity and not worry about this deficit, which is now $1.5 trillion. The debt is nearly 90 percent of the GDP, and we owe much of this money to China.

We have got to make tough decisions. It is not time for partisan politics. We need to come together as Democrats and Republicans and do what American families, farmers and small businesses do every day, every year. We need to reduce spending and turn this ship around.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF H.R. 662, SURFACE TRANSPORTATION EXTENSION ACT OF 2011

Mr. SESSIONS, from the Committee on Rules, submitted a privileged report (Rept. No. 112–20) on the resolution (H. Res. 128) providing for consideration of the bill (H.R. 662) to provide an extension of Federal-aid highway, highway safety, motor carrier safety, transit, and other programs funded out of the Highway Trust Fund pending enactment of a multiyear law reauthorizing such programs, which was referred to the House Calendar and ordered to be printed.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF H.R. 4, SMALL BUSINESS PAPERWORK MANDATE ELIMINATION ACT OF 2011

Mr. SESSIONS, from the Committee on Rules, submitted a privileged report (Rept. No. 112–21) on the resolution (H. Res. 129) providing for consideration of the bill (H.R. 4) to repeal the expansion of information reporting requirements for payments of $600 or more to corporations, and for other purposes, which was referred to the House Calendar and ordered to be printed.

THE DOCTORS CAUCUS

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

Mr. GINGREY of Georgia. Mr. Speaker, I thank you, and I thank Speaker BOEHNER and my leadership for giving me an opportunity and my colleagues an opportunity during this next hour to talk about something that, yes, indeed, is still fresh on everybody's minds.

That is, of course, the passage on March 23, 2010, almost a year ago now, of something that some might affectionately refer to as ObamaCare, I guess officially we would say the Patient Protection and Affordable Care Act. Some people struggle with the acronym of PAPA Care. Whatever you call it, this health care reform act that was passed last year is something that a preponderance of the American people have been and continue to be opposed to.

Mr. Speaker, as the designee of the majority, I am taking this opportunity during this hour to talk a little bit more specifically about why we feel the way we feel, why the American people—why our constituents—keep telling us even a year later they are still worried about it and are opposed to it after President Obama signed the Patient Protection and Affordable Care Act into law. I think the bill number was 3590. That's what we're going to be spending our time on here in the next hour. We will be discussing that issue.

□ 1630

I have a number of my colleagues, Mr. Speaker, who are members of the GOP House Doctors Caucus. Now, in that Doctors Caucus, we have all health care providers—not all M.D.s, a lot of M.D.s, but we also have some dentists. We have a clinical Ph.D. psychologist, and now, with our new freshman class, we have three registered nurses on our side of the aisle, Mr. Speaker. So the Republican GOP Doctors Caucus is growing, growing almost double in the 112th Congress as compared to the 111th. So many of my colleagues in the Doctors Caucus will be part of this discussion.

I would like to point out to my colleagues on both sides of the aisle a couple of slides before yielding time to the other members of the Doctors Caucus. This first slide that I'm pointing out to you—GOP Doctors Caucus, of course—''ObamaCare hurts States and patients.''

I know that a lot of the discussion today will be about the strain that certain provisions of this bill place on our 50 States, not just my home State of Georgia. I do want to talk a little bit about that and the strain that my Governor and the members of the Georgia General Assembly are experiencing in trying to balance a budget when they have all this added requirement under the sections pertaining to Medicaid. So that's what I mean when I say in this slide the GOP Doctors Caucus feels that ObamaCare hurts States, and certainly potentially hurts patients.

I'd ask my colleagues to also—again, on both sides of the aisle, because our purpose here is to inform. We're not to be overly critical, but I think it's very important that we state the facts as we see them, as we know them.

In this slide a little bit further to my left, ''ObamaCare,'' it says, if you can't see it, ''You can have whatever you like as long as the boss approves it.'' And the boss, if you remember from that pretty popular TV series ''The

Dukes of Hazard,'' that would be Boss Hogg. Now, if you're wondering who I'm referencing in regard to ''the boss,'' I'm referencing the Federal Government, Mr. Speaker, not any individual, but the Federal Government.

It was said many times in the markup of this bill and the lead-up to this bill—which, as I say, we call ObamaCare—''You can have whatever you like as long as the boss approves it.'' And just in this year alone, the boss—and the boss in this instance happens to be Secretary Sebelius and the Department of Health and Human Services—has had to grant—now listen to this, my colleagues—has had to grant 733 waivers to make sure that this pledge of ''if you like what you have you can keep it''; otherwise, without those waivers, you couldn't—733 of them.

So this is what we're going to talk about tonight, and I thank my colleagues for being on the floor and joining with me.

At this point, one of the members of the GOP Doctors Caucus, in his second term, a gastroenterologist of a number of years practicing in Louisiana, my good friend, Representative and Doctor BILL CASSIDY.

Mr. CASSIDY. Thank you, Dr. GINGREY.

Now, Dr. GINGREY, I'm struck. Sometimes folks think that when we speak about health care, we're only speaking about health care. That seems kind of a simplistic statement. But let's think about it.

Right now, States are having these huge budget crises. We see in Wisconsin where there's a protest. We see in some States where there may be as much as a $10 billion budget deficit. In my State of Louisiana, there is a $1 billion to $2 billion budget deficit. And if you think about this a little bit deeply, you understand that this can be related to health care.

Now, specifically, for Medicaid. Medicaid, for those watching who are unfamiliar with it, is a combined program in which the State puts up some money and the Federal Government puts up some of the money, and with this it is used to care for the elderly, for pregnant women, for children, typically people of low income. Well, as it turns out, it is this program which is bankrupting the States. In a State, if you're paying this amount for health care and this amount for roads and this amount for education, as the amount for health care increases, you either raise taxes or you decrease spending on the other areas. Now, as it turns out, this has had tremendous impact.

Today, the Governor of Massachusetts came and spoke to one of our committees regarding the impact of their health care program, which is very similar to the bill just passed last Congress, in Massachusetts, and I was struck by what a nice view he gave. If you heard Governor Patrick speak—I didn't have a chance to ask him questions, but if you heard him speak, there's no problems with it whatsoever. But as I logged on and, say, read the Boston Globe, I learned different things.

First, I learned that Massachusetts, which has already implemented a program like this, the amount of money spent on health care has gone from 21 percent of the State budget in the year 2000 to 37 percent now. So from 21 percent to 37 percent is the amount the State of Massachusetts is now spending on health care. Well, you can only imagine the crowd-out effect that has on spending for other issues.

Well, the Governor again, as he went on and praised their program, said that there has been no problems paying for it. Well, as it turns out, and according to the paper, there's about a $1.5 billion to $2 billion shortfall in the Massachusetts budget. And in Massachusetts, the Governor of Massachusetts has said that the Medicaid spending is unsustainable. Hmm, that's different. So this is, if you will, the beta version of the Affordable Care Act—or as I call it, the unaffordable care act. This is the beta version of it, but it gives us an idea of what our future is going to be like.

Now, in order to deal with these costs—again, I'm quoting the Globe—it says that ''most recently dental benefits have been slashed for hundreds of thousands of Massachusetts Medicaid patients and they have lost access to their dentists.''

Now, by the way, the goals of health care reform are to provide affordable, quality health care that is accessible to all; but if you can't afford it, you eventually lose access. And I think what we found in Massachusetts is that the inability to afford is, of course, decreasing access. And it's not just the fact that these folks lost access to their dentists. Last year, folks who are recent immigrants to the United States who have been enrolled upon Medicaid in Massachusetts were disenrolled. So, if you will, this Massachusetts Medicaid program that has grown from 21 percent of the Massachusetts budget to 37 percent and still growing, now the cost is being controlled by denying access.

Now, we also mentioned a third goal of health care reform, which is quality care. You know, there's actually now concerns about the quality of health care afforded by Medicaid. If you will, there's a study recently reported in the Archives of Surgery in which someone looked at the outcomes of patients covered by Medicaid, Medicare, private insurance, or uninsured. As it turns out, they say, of all four groups, the cost and length of stay associated with Medicaid was longer than the rest.

Also, mortality rates—now, that's a way to say how many people die. Mortality rates associated with uninsured, Medicare, private insurance, and Medicaid was highest for Medicaid. So if you had Medicaid, you had a higher death rate from your hospitalization than if you're on private insurance, if you're on Medicare, and if you're uninsured.

Now, it's so counterintuitive that being on Medicaid is worse than being uninsured in terms of outcomes. Clearly, this is an issue that has to be studied further, but it certainly calls into question the very premise of using Medicaid as the basis for health care reform.

Just to make a point, under the Affordable Care Act—or the unaffordable care act—many people are insured; 20 million Americans are put on Medicaid as a way for them to be now insured.

□ 1640

And yet if we see that it's bankrupting States, it's clearly not affordable. If we see that because it's not affordable States are now denying access to care, as is the case in Massachusetts, and the care that is provided is of problematic quality, we can say to ourselves that this is not the basis for reform. It's like the antithesis of reform.

So I will yield back to you, Dr. GINGREY, just pointing out that this not only involves health care but also involves our ability as a State to afford other things, like roads and education. And to use that State government-Federal Government program as a basis for reform does not serve patients, does not serve the States.

Mr. GINGREY of Georgia. I thank the gentleman from Louisiana, Mr. Speaker.

At this time, I want to yield a little bit of time to our colleague, a freshmen Member, a new member of the Doctors Caucus, a registered nurse from the great State of North Carolina, RENEE ELLMERS. Representative ELLMERS has worked in a medical practice with her husband, who is an M.D., and we look forward to her comments.

And at this time, I yield as much time as she may use to RENEE ELLMERS.

Mrs. ELLMERS. Thank you.

I'd like to just contribute a little bit more on the overall burden that ObamaCare places on our States in covering patients on Medicaid.

As we've seen, this has grown, especially with the recession and the undue costs to our States' budgets to provide Medicaid at no cost sharing from the patients. I think that this is a key issue. It's basically free health care for those individuals at taxpayer expense. And it's just a huge strain on our States' budgets, as my colleague has pointed out.

One of the key factors—and very important, certainly very important in health care—are the preventative mandates. Certainly preventative medicine is a way that we can all heal, that we can all be looking for those issues that can down the road prevent excessive costs. But such things as no copays or deductibles for colonoscopies, mammograms, such things like this is there again, an undue cost to our States at taxpayer expense. It's just too much of a burden.

You know, I want to help everyone. I think that everyone should be able to have health care. As we know, if you pull up to an emergency room in any hospital across the country, you will receive health care. So the misnomer that there are those individuals who are not receiving health care is really an untrue statement.

Now, of course, you're going to receive a bill for that care. And I think that just as if you go to the grocery store and you have your cart full of groceries when you check out, you have to pay for it. It's the same thing with health care. Health care is a business, and someone has to pay for it.

But when we continuously pass this cost on to our taxpayers and, of course, our State budgets, it is just unbelievably difficult; and, of course, that is what ObamaCare does. It increases the number of patients on Medicaid, and it is just an unsustainable cost.

Mr. GINGREY of Georgia. If the gentlelady would let me reclaim my time for just a second, and then I will yield back to her.

Colleagues, look at this first slide again, the heading, ''Who Is the Boss?'' And of course we've already talked about Boss Hogg. And I said at the outset, the Federal Government is the boss. But there are one, two, three, four, five bullet points under that. And this is really what Representative ELLMERS is referring to in regard to the Federal Government putting all of these mandates onto the State budgets.

159 new boards, agencies, and commissions created by ObamaCare to support the boss, the government—159 new boards. Sixteen thousand new IRS agents help the boss, the government, enforce the new law. That's a report from the House Ways and Means Committee.

The Secretary of Health and Human Services, Kathleen Sebelius, under this law, this 2,400-page monstrosity, is given broad new powers to run ObamaCare—rulemaking, regulatory authority. No wonder the doctors and their patients are scared to death.

And then, of course, the new Director of CMS, the Committee on Medicare and Medicaid Services, Dr. Donald Berwick, a brilliant man, a Harvard-trained doctor, M.D., written several books. Unfortunately, in those books, Mr. Speaker, he talks about rationing of care. This is a paraphrase of a quote: It's not if we ration; it's how we ration.

And, again, these are the things that we have great fear of.

The CBO actually, in this last bullet point, Congressional Budget Office, nonpartisan, says it will cost between $5 billion and $10 billion just to hire all of these new employees needing to help the boss, the government, run ObamaCare.

Mrs. ELLMERS. I would like to expand on some of the points that you're making there.

We're basically talking about the same issues, and we can see what an increase in costs this is going to be and how incredibly difficult it would be to put this in place. And, you know, this isn't yet another situation where the good intentions and well-meaning intentions that are put forward to help this situation are just truly not the answer.

You know, basically, how do we increase the access to health care coverage? Medicaid is not the route to take. There again, it passes too much cost on to our States and it is not—it is an imperfect situation. And I'll expand a little bit on the Congressional Budget Office numbers.

Very conservative estimates indicate Federal spending for Medicaid is expected to reach $427 billion by 2019. And the Congressional Budget Office notes the program will consume more than 4 percent of GDP by 2050.

You know, one of the unintended consequences to this—you know, we were talking about some of these bad situations, poor outcomes. One of the things that we're seeing right now, unfortunately, in health care as we move into this transition into ObamaCare is the decrease in Medicaid reimbursements to physicians. They're not very good to begin with, and I would say that that's probably going to decrease to doctors and hospitals as we decrease the reimbursement to hospitals especially.

This will basically—we were talking about the possibility of rationing of care and knowing that this is down the line and the quotes, of course, that we see from Centers for Medicare & Medicaid. But basically what we're seeing here is that physicians will be forced to have to stop taking Medicaid patients.

As we all know, physician offices are businesses. They're small business owners. They have staff that they have to pay. They have payroll that they have to meet. And, unfortunately, when faced with a situation like this—we're already seeing it with Medicare as well; physicians, you know, having to dial back on the number of Medicare and Medicaid patients that they're seeing. This ultimately will not help the situation and get that health care for the American public that we're looking for.

If this is the answer—well, let's just say it's not the answer. We're creating another problem with this solution. And once again, how will we deal with that down the road, with these incredibly large numbers of costs that we're passing on to our taxpayers?

Mr. GINGREY of Georgia. Reclaiming my time, Mr. Speaker, again, I thank the gentlewoman from North Carolina and hope she'll stay with us during the remaining portion of the hour, and I'd like to yield additional time to her later in the hour.

At this time, I would like to yield to another freshman Member, another physician Member, Mr. Speaker, and also I'm proud that he is a member now of the House GOP Doctors Caucus. And I will yield time now to my good friend from Indiana, Dr. LARRY BUCSHON.

Mr. BUCSHON. Thank you, Dr. GINGREY.

Mr. Speaker, I rise today to talk about how ObamaCare will hurt my State and ultimately hurt my patients. And I would like to start with an example of the Medicaid program.

As a cardiothoracic surgeon in Evansville, Indiana, I see a lot of patients from neighboring States because we're right in the corner next to Illinois and Kentucky.

□ 1650

Many of these patients are Medicaid patients and, without treatment, face grave results. However, every year the Illinois Medicaid program runs out of money in September, October. They don't have enough money to fund the entire year. And what does that mean? That means that without denying any patients care that they need and deserve, my practice was forced to delay billing to the Medicaid system of Illinois. And then once the new fiscal year came into play, about 50 percent of those claims were subsequently denied by Illinois Medicaid. So those patients that came over for our services, they don't have quality health insurance, Mr. Speaker.

Some physicians in my community don't even bother to bill the Medicaid program in some States at all. This is an example of the broken Medicaid system, a system that has many issues focusing on the access to quality health care. And it was said earlier you see the outcome difference between Medicaid and private insurance patients because we have an access and quality problem with these patients, a system that ObamaCare will break even more by adding millions of Americans to the States' Medicaid rolls. It's estimated that this may cost the State of Indiana as much as $3.6 billion to cover these folks.

From Indiana we have an innovative and effective solution, and that's called the Healthy Indiana Plan. Beginning in January 2008, uninsured Hoosiers between the ages of 19 and 64 started enrolling in this plan, a consumer-driven health care plan. The Healthy Indiana Plan operates on an 1115 demonstration waiver from CMS, the Center for Medicare and Medicaid Services. Due to the program's success, the State of Indiana would like to use the Healthy Indiana Plan as a coverage vehicle for the newly eligible population under ObamaCare. This has been requested by my State Department of Health and Human Services, but to this point we have not heard a response about whether this will be possible. And I am hoping that we get a response in the positive direction because this is a great program.

The plan is for citizens that earn less than 200 percent of the Federal poverty level and works on a sliding scale for individual contributions, based on the ability to pay, that cannot exceed more

than 5 percent of his or her gross family income. Each participant is enrolled in a health savings account valued at about $1,100, and will not make copays except for non-emergency use of the emergency room. And believe it or not, this program reimburses providers at a Medicare, not Medicaid, level. This gives citizens a financial incentive to adopt healthy lifestyles and personal responsibility to make their own health care decisions.

Healthy Indiana Plan is an innovative, market-based, consumer-driven plan that is working. In a recent survey, 94 percent of Healthy Indiana Plan participants are satisfied with the program, and 99 percent indicated they would re-enroll. There is data in the fact sheet that I have included in the CONGRESSIONAL RECORD showing the success of this plan both for patients and for the State of Indiana.

It's a commonsense, market-based solution to a broken Medicaid system that ObamaCare does nothing to fix, but only further burdens my State, and all States, and will ultimately continue to hurt patients' access to quality health care in America. So I would urge everyone to review what the State of Indiana has done with its Healthy Indiana Plan.

With that, Dr. GINGREY, I thank you.

The Healthy Indiana Plan is a consumer-driven health care plan for uninsured Hoosiers between the ages of 19–64. The program began enrollment in January 2008, and operates under an 1115 demonstration waiver from the Centers for Medicare and Medicaid services (CMS). During the first two years of the program, HIP served 61,797 Hoosiers.

WHO IS COVERED?

HIP is for uninsured Hoosier adults between the ages of 19–64. Parents or caretaker relatives of children in the Hoosier Healthwise (CHIP) program are likely candidates for HIP.

Eligibility Requirements: 1. Earn less than 200% of the federal poverty level (FPL). A single adult earning less than $20,000 or families of four earning less than $40,000 likely meet the basic financial requirements. 2. No access to employer sponsored health insurance coverage. 3. Uninsured for the previous six months.

PLAN STRUCTURE

A POWER (Health Savings Account) Account valued at $1,100 per adult. Contributions to the account are made by the State and each participant (based on ability to pay). No participant pays more than 5% of his/her gross family income.

Sliding scale for individual contributions (based on % of gross family income): 0–100% FPL: 2%; 100%–125% FPL: 3%; 125%–150% FPL: 4%; 150%–200% FPL: 4.5%–5% (Caretaker relatives/parental adults in this income bracket contribute 4.5%, and the childless adults contribute 5%).

No co-pays except for non emergency use of the ED.

Providers are reimbursed at Medicare, not Medicaid, rates.

PLAN BENEFITS

A basic commercial benefits package, once annual medical costs exceed $1,100.

Coverage for preventive services up to $500 a year at no cost to participants.

Services include: physician services, prescriptions, diagnostic exams, home health services, outpatient hospital, inpatient hospital, hospice, preventive services, family planning, and case and disease management.

Mental health coverage is similar to coverage for physical health, and includes substance abuse treatment, inpatient, outpatient, and drugs.

HIP does not cover vision or dental. HIP also does not cover pregnancy services, as these services are available through the existing Medicaid program.

WHY A POWER (HSA) ACCOUNT?

Personal Wellness and Responsibility (POWER) Accounts give participants a financial incentive to adopt healthy behaviors that keep them out of the doctor's office. When they do seek health care, participants will seek price and quality transparency so they can make value conscious decisions.

If all age and gender appropriate preventive services are completed, all (State and individual) remaining POWER Account funds will rollover to offset the following year's contribution. If preventive services are not completed, only the individual's prorated contribution (not the State's portion) to the account rolls over.

PROGRAM RESULTS & PERSONAL RESPONSIBILITY

HIP members, in general, have demonstrated the personal responsibility emphasized by the program.

Lower ER Use: Some HIP members do not make POWER account contributions due to CMS income-counting guidelines. HIP members required to make POWER account contributions: 9% decrease in ER use in 3 months; 15% decrease in ER use after 6 months. HIP members not required to make POWER account contributions: Initial 5% decline in ER use after 3 months; no additional decline in ER use.

High Generic Drug Utilization:

HIP generic drug utilization: 80%; comparable commercial population: 65%.

High Use of Preventative Care: 76% of HIP members received their required annual physical in the first year of the program. Use of preventive services was significantly higher than the traditional Medicaid population in Indiana: 445.4 well care visits per 1,000 (HIP caretaker adults); 281.8 well care visits per 1,000 (HIP childless adults); 195.2 well care visits per 1,000 (Indiana Medicaid adults).

Strong Personal Responsibility: 97% of members made their required POWER account contributions during program year one. Individuals can be removed from the program for failure to make POWER Account contributions within 45 days. Once removed from the program, an individual may not re-enroll for 12 months.

High Member Satisfaction: 94% of HIP participants surveyed said they are satisfied with the program, and 99% of respondents indicated that they would re-enroll in the program.

IMPACT OF THE AFFORDABLE CARE ACT

The Affordable Care Act maintenance of effort requirements turned HIP into an entitlement program for adults. Despite funding limitations (HIP was funded through an increase in the cigarette tax), the State cannot limit the number of parental enrollees. Therefore, the State is not currently enrolling childless adults on the wait list.

Due to the success of the program, the State would like to use HIP as the coverage vehicle for the newly eligible population. Indiana has asked for direction from CMS (May letter to Cindy Mann) and has not received any official guidance.

The success of the program depends on its innovative market-based, consumer-driven structure. There is concern about whether or not CMS will allow the program to continue in its current form.

For more information: www.HIP.in.gov.

Mr. GINGREY of Georgia. I think, Mr. Speaker, the good doctor is pointing out some things that our colleagues on both sides of the aisle and the American people need to understand. This plan that was just described to us by Representative BUCSHON, the Healthy Indiana Plan, it's so typical of what the States are capable of doing, Mr. Speaker, if they're allowed to do that.

But we have great concerns, and when I say ''we,'' I am talking about the governors of all 50 States, be they Republican or Democrat, and the territories, to be told by the boss, again, that, no, you can't be an incubation center, you cannot be innovative in regard to developing a health care plan for those who can't afford to purchase health insurance on their own and they qualify for safety-net programs like the Federal-State shared program Medicaid.

And the States, Indiana, my own State of Georgia, Governor Herbert testified before the Energy and Commerce Committee today in regard to what he is doing in Utah. In fact, they had already set up exchanges at the State level 5 or 6 years ago, long before this Patient Protection Affordable Care Act even was on the drawing board.

But when you have things in the bill, when the boss writes a section of the bill that says States, it doesn't matter that you have to balance your budget, we don't at the Federal level, but we're going to dictate to you that you're going to have to start covering Medicaid constituency up to 138 percent of the Federal poverty level. We're going to put that into law. That's part of this new law ObamaCare. And you have no choice. Now, we're going to give you a little breathing room, and we're going to say it's not going to start for a couple of years, indeed January of 2014 you have got to expand your Medicaid rolls from the typical State covers 100 percent of the Federal poverty level. This goes up to 138 percent of the Federal poverty level.

And the boss says, well, we'll pay all of it with Federal dollars for the first couple years, but we're going to phase that out. And then, oh, yes, guess what happens, the boss adds eventually at the end of the day $60 billion to State Medicaid costs. And also there is a section in the bill, Mr. Speaker, that tells the States, and it's called maintenance of effort, you can't change one thing that you currently do in your Medicaid program to prepare yourself for this tsunami. If you're covering today 185 percent of the Federal poverty level, you can't all of a sudden say, well, gosh, you know, we're going to have to lower that to 150 percent and put some oats away and get ready for that real rainy day in 2014.

We heard from another governor today in that hearing—there were three—Governor Deval Patrick of Massachusetts was one, and Governor Haley Barbour from Mississippi, Mr.

Speaker, was the other. And Governor Barbour was saying that a couple of years ago he instituted a program in the State of Mississippi that would make sure that people that were on the Medicaid program were eligible, that they deserved to be there. They weren't eating somebody else's lunch, as the expression would go. They weren't illegal immigrants. Their income wasn't too high to make them eligible for this safety-net program.

And of course, Mr. Speaker, as we all know, thank goodness, income from year to year can get better. We're still waiting for that to happen. I think ObamaCare and some of these other policies that we're seeing over the last 4 years is preventing that from happening. So Governor Barbour would make people come and face to face verify that they were still eligible from year to year. As I understand it, this rule, this maintenance of effort would prohibit—he has already done it in Mississippi—but in any other State, as an example, to make sure your rolls were clean and were you covering the people that were eligible and that really needed that care.

□ 1700

This is the kind of thing that we are dealing with, and why we are talking about this tonight and why we are talking about it so passionately.

Mr. Speaker, I yield to my colleague from Tennessee, Representative DIANE BLACK, another new Member, a delightful new Member, also assuming leadership positions and going to do a great job here in the House.

Mrs. BLACK. Thank you.

Mr. Speaker, I rise today as a registered nurse who worked in emergency rooms and caring for patients. I also rise as a former member of the Tennessee General Assembly who saw firsthand the devastating effects of TennCare on our State and was a part of the group, of the effort, to dismantle it.

Finally, I rise today as a representative of the Sixth District of Tennessee, where my constituents have told me over and over how they do not want ObamaCare bankrupting our Nation and getting between them and the doctor.

Mr. Speaker, I know that the health care industry, and I know that the new health care law, is not the solution to our problem. Pretty soon, the health care law will be the problem. I know this because for many of us in Tennessee, the President's new health care law is like a bad dream all over again.

And let me tell you what I mean. Tennessee was the pilot project for universal health care and the experiment was called TennCare. Put simply, the experiment failed.

After TennCare passed, we watched the cost grow exponentially, and those of us in the legislature knew that if we did not do something, TennCare was going to bankrupt our State and, much like ObamaCare, the sheer size of TennCare was more than government could handle. The government could not perform all of the functions of the medical insurance industry. Promises of care and access were made, and promises were far beyond what our State could possibly do.

It didn't take long before TennCare became riddled with waste and fraud and abuse. I can remember talking with people who had gone from doctor to doctor and specialist to specialist using TennCare to fill more than 50 prescriptions. Yes, 50 prescriptions is what they would put in front of me and tell me that TennCare was paying for, and it was all on the taxpayer's dime.

TennCare became the monster that even the creators could not control. Today, TennCare is gutted, only available to a small group of people, and Tennessee has been brought back from the brink of bankruptcy.

Last month, Republican Governors wrote to ask the administration to ''waive the bill's costly mandates and grant States the authority to choose benefit rules that meet the specific needs of their citizens.'' The Governors were asking for commonsense solutions like waiving provisions that punished consumer-driven plans like the most popular plan and the cost-effective plan of health care savings accounts. Give the States the ability to do what States can do best, and that is to determine what's best for them.

But the President shows no sign of granting States some flexibility in how they will apply ObamaCare. And only yesterday, President Obama said he is supporting letting the States propose their own health care plans by 2014. However, that would be only if he will not change the mandates for the States in the current law.

So in one side of his speech he says, yes, he will allow some flexibility. On the other side he says, there still must be certain mandates.

Mr. GINGREY of Georgia. If the gentlewoman would yield, it is kind of like you can keep what you like until you can't. That's what we are seeing, and that's why, as I pointed out earlier, that 733 waivers, just this year in 2011, had been grant happened by Secretary Sebelius to try to fulfill that promise, but they can't do it. They can't keep up with it. There is a need for a new waiver every day.

Mrs. BLACK. Dr. GINGREY, as you said, States will still be forced to comply with benefit levels and mandates that are set by Federal bureaucrats, not by the States themselves. That certainly doesn't give States rights.

Secretary of Health and Human Services Kathleen Sebelius has already said that if the State were to propose its own plan that they will be forced to provide comprehensive, comprehensive coverage, and that coverage will be defined by government. So much for being able to keep your plan or for the States to make a determination on what plan best suits them.

Now President Obama wants every State to live through its own version of TennCare. With ballooning budgets for each State and no way to curb their health care costs that will cripple the States during a time of already strapped budgets, it's simply unacceptable.

Mr. GINGREY of Georgia. I would say it's unconscionable and unacceptable.

Mrs. BLACK. We averted this disaster in Tennessee by dissolving TennCare and now, as a Member of Congress, I will work to stop this financial and fiscal disaster that ObamaCare will bring to our Nation. This health care law must be replaced, and I believe this House can do it.

Mr. GINGREY of Georgia. I thank the gentlewoman from Tennessee. I failed to mention, of course, that she is also a part of our GOP House Doctors Caucus and, as she pointed out, a registered nurse for many years in a great Volunteer State, so we appreciate Representative BLACK being with us tonight.

Before I yield to our next speaker I wanted to, Mr. Speaker, go back to this current chart. I wish I had brought a magic marker. I didn't. But I circled this, I guess, third bullet point because I think it's really telling in regard to what's happened at the State level as a consequence of the provisions of ObamaCare.

And this bullet point says the boss, the Government, the boss prohibits 16 million patients from buying private insurance by trapping them in Medicaid, and that's really what they have done, Mr. Speaker. By expanding the Medicaid eligibility from 100 percent of Federal poverty to 138, that means that a lot of the folks out there today who are uninsured can't afford health insurance; they are not eligible, they are not poor enough, if you will, to be eligible for their safety net program known as Medicaid.

In the Federal Government, the boss comes along with this idea of letting people buy their health insurance in an exchange in each State, maybe over the Internet. If they are low income, then they get a Federal subsidy, not a Federal-State subsidy, but a Federal subsidy.

Well, clearly as the Democratic majority and President Obama were crafting this thing, they figured out, well, you know, if we can shift more of these people into the Medicaid program where the States have to pick up some of the tab, then we will get them off our back. You know, we will lower the cost. We will make this thing work.

Unfortunately, the poor States, and they are poor, all have to balance their budgets, and the Federal Government doesn't. That's why we owe $13.4 trillion, and now they are even talking about us wanting to raise the debt ceiling so we can borrow some more money. It's a smoke and mirrors game, maybe even a Ponzi scheme, in my opinion, Mr. Speaker.

Mr. Speaker, at this time, I want to yield to another member of our GOP

House Doctors Caucus, the gentleman from west Tennessee. I don't know whether the area is called Pell Mell or Pall Mall—maybe he will describe it to us when he stands to speak—but I am talking about a fine physician, a family practitioner, Dr. SCOTT DESJARLAIS.

Mr. DESJARLAIS. Thank you, Dr. GINGREY. I hail from Marion County, which is South Pittsburg, would be the hometown.

Before coming to Congress I had the opportunity to serve the people in Tennessee as a primary care physician. In 1994 Tennessee embarked on an experiment with the Medicaid program, which became known as TennCare. Unfortunately, it never accomplished its goal of improving on the flawed Medicaid system.

□ 1710

To the contrary, it became a breeding ground for waste, fraud, abuse and inefficiency. I witnessed the frustration of my patients, my staff and myself as we struggled to combat this bureaucratic web that forced us to spend time navigating administrative hurdles rather than focusing on quality care.

Another problem that rapidly evolved was over-utilization of the system. Often, only one family member was ill, but other family members were requesting to be seen simply because it was more convenient than making other arrangements for the non-ill member, such as children, to be cared for elsewhere. This also became, and continues to be, a problem in the emergency rooms. There is no cost difference to the patients, so there is no disincentive to utilize the ER for nonemergent care. In fact, this is a national problem, with up to 80 percent of ER visits being deemed nonemergent. This leads to much longer wait times in emergency rooms for those patients who are critically ill. It should also be noted that ER visits are obviously much more expensive than office visits, further driving up the cost unnecessarily.

A simple solution to improving the problem of over-utilization would be implementing a nominal copay system in which office visits cost something like $5 per visit and ER visits might cost $20. This simple step would likely have far-reaching effects to reduce costs, over-utilization, and thus increase availability of care for those who need it. We should see TennCare as a warning of the many problems that a government-run health care model creates.

There are certainly issues with our Nation's health care system that need to be addressed, and the GOP Doctors Caucus has no shortage of good ideas on how to make health care more affordable and expand coverage. But what we stand firm in saying is that ObamaCare is not the answer to the problem, but, rather, it creates an even bigger problem.

Mr. GINGREY of Georgia. I thank the gentleman from Tennessee, and I thank him for making sure that I know exactly what county and counties he represents. I know it's a great State and a great part of the State, and we are very proud of the good doctor.

At this time, I want to yield to another freshman member of their class of 87 strong. It's a fantastic class, Mr. Speaker. We are awfully proud of each and every one of the new Members, but especially those who have that health care background, that experience to come to this body, to this Chamber and to this town and bring some professional expertise. We don't have all the answers, Mr. Speaker. And I'm proud of these physician colleagues of mine because they're not know-it-alls, but they know what they know and they know it well.

At this point, I would like to yield time to the gentlewoman from New York, an ophthalmologist, Dr. NAN HAYWORTH.

Ms. HAYWORTH. Thank you, Mr. Chairman.

I observed, sir, that you have brought a sign to the floor that talks about stealing America's liberty. One of the fundamental problems that I perceive, and I'm not alone in this, but in this entire scheme, if you will, that is represented by the Affordable Care Act, as it has been called, is that there was a failure to understand the very nature of American medical care. When it's at its best, and we recognize—every colleague of mine, all of my Republican and medical colleagues have also appreciated certainly that we want to see all Americans have access to good, affordable care and to have affordable, portable health insurance. That's not in dispute. So we honor those goals. But the means by which the ACA endeavors to achieve those goals go against the grain of the American culture. Our culture is one that has always allowed us to choose, that has allowed us to pursue, in terms of our medical care, the very best that the world has to offer in terms of innovation and quality, motivation, incentive to invent and to do better. The American medical consumer, our patients, expect no less than the best, nor should they receive anything less than the best.

That's a very different way of thinking about care in a consumer society than is the case in so many other systems around the world that were cited as exemplars when the ACA was being formulated. We do not have, I can tell you from my experience with patients who have had care, who have lived in Europe for variable periods of time, some Americans who have spent sojourns in Europe because of business obligations and working with colleagues from Europe, historically it is rather a different model than we have here. American doctors are accustomed to jumping and doing and doing all they can and doing it fast, and my colleagues can certainly attest to that.

It's a little bit different sometimes overseas. They have a different kind of medical culture. Patients don't expect quite as much. It's not the same sort of thing that we have here. And indeed, that is consonant with the fact that there isn't any other country's dream necessarily as there is an American Dream. My mother is from England. She came to this country in 1948 because she was very distressed by national health care. There is no British dream. There is not necessarily a German dream or Japanese dream. But there is an American Dream.

Mr. GINGREY of Georgia. If the gentlewoman will yield, Mr. Speaker, what the gentlewoman from New York is referencing is something that I have heard from people in other countries that have government health insurance. And they say, well, I'm real happy with my government health insurance. And I know what's going on over here. And I'm thinking, my goodness gracious, you're happy? What are you happy about? Well, you get to see the doctor within 5 minutes, and you always come out with at least three prescriptions.

Now, if that's the definition of success, Mr. Speaker and my colleagues, that's not what American, good old U.S.A. medicine is all about. It's time, quality time, spent with that doctor, and maybe no prescriptions.

Ms. HAYWORTH. Thank you, and precisely the point that I'm agreeing on with you and that I think we all have driven to philosophically is that we need to have solutions that empower our doctors, our patients and our providers to do all of them, to have the best and to do the best. And consumer-based solutions are possible. Our Doctors Caucus is working very hard on providing those ideas. Real liability reform has to be part of this. We cannot possibly continue as we have been. That was a glaring omission from the ACA.

In addition, we need to recognize, appreciate and act upon the knowledge that our medical care can cost less. We do need to pay attention to costs, but we need to empower our patients, our doctors and our providers to use their best judgment, not empower something like the Independent Payment Advisory Board to make those decisions for us. That is a very dangerous thing and something that Americans will find very distressing and disturbing. And the inevitable result of the ACA is that, and you can trace it out, but we will end up having less choice. The government will make decisions for us. They will be decisions we don't like. We need our consumers and our providers to be able to make those decisions.

Mr. GINGREY of Georgia. Mr. Speaker, I thank the gentlewoman from New York, and I appreciate her time.

If my clock watching is accurate, I think we may have 8 to 10 minutes remaining, and I will try to conclude. I would like to see if my colleagues would like to weigh in with additional comments. We do have time if any of

those that are still on the floor would like to bring some more enlightenment into this subject.

I yield to the gentlewoman from North Carolina.

Ms. ELLMERS. Thank you, Mr. Chairman.

I think we've come to the point now where we do need to discuss that ObamaCare is not the answer. We have all discussed this over and over again. I would say that it's probably a good reason that I was elected because I ran on repealing it—that and cutting taxes and cutting spending. And it all ties in together.

Those of us who are in health care have been aware of the need for reform for quite some time. I think any of us can say that we've seen the costs increase. We've seen the cost of health care insurance increase. And yet we've all felt that our hands were tied. We didn't know how to address it. The bureaucratic system, as my colleagues have pointed out, just dealing with billing and trying to get the care for patients alone can just take over your office.

□ 1720

We have seen these things. We know there are problems that exist, but we all agree that it needs to be a patient-centered, doctor-nurse-patient relationship that we have to be putting forward. And it has to be in the private sector. There are ways to do this. There is a role for government in it, especially when we are talking about Medicare, Medicaid, and those who are unfortunate. We want everyone to have health care. But there are ways we can address it.

It is not a health care crisis; it is a crisis of culture. We have to change the culture that we are dealing with. We want everyone to have affordable health care, and there are simple solutions we can put in place to do that.

Mr. GINGREY of Georgia. I am so glad that I called on the gentlewoman from North Carolina and she brought up this point, colleagues, because what RENEE ELLMERS just said is absolutely the truth. We are not on this side of the aisle, and those Democrats who agree with us, we are not opposed to reforming the health insurance industry, to eliminating abusive practices such as canceling policies after the fact or denying children with preexisting conditions, and that is exactly what the gentlewoman from North Carolina was referencing.

The pledge to repeal ObamaCare is because in our humble opinion it is too bad to fix. That doesn't mean that when we replace it, and we may have to do it piece by piece, bit by bit, that we don't incorporate some of the things in there that most people would agree are good, like allowing youngsters, young adults, Mr. Speaker, to stay on the health insurance policy of their parents until they are 26 years old. With this economy and the destruction of jobs because of bailouts and stimulus, trillions of dollars that don't work, unfortunately, our young college graduates have no job to go to; otherwise, they would have health insurance from their place of work. So they darn well need to stay on their parents' policy until they are 26, and maybe until they are 36 if we don't quite get our act together and quit spending and get this economy going.

Let me yield quickly to the gentleman from Tennessee, Dr. ROE, my OB–GYN colleague from Tennessee.

Mr. ROE of Tennessee. I thank the gentleman for yielding.

When I came, as we all did, doctors, physicians tend to look at a problem. When a patient comes in, the first thing we ask them, Dr. GINGREY: Why are you here today? It is a fairly obvious question. It is called the chief complaint.

When I came to Washington, D.C., I asked the same thing about the American health care system. I said: What is the problem with the American health care system? I thought there were probably three.

Number one, it was too expensive. The cost of health care had skyrocketed way above inflation so it is way too expensive to come see a doctor or go to the hospital.

The second issue I saw you just brought up was that there was a segment of our population that didn't have access to affordable health insurance coverage. These are not the very poor who had access in my State to TennCare or in other States to Medicaid, but these are folks who are out working. Maybe they are a carpenter and their wife stays at home. Or maybe they have a job, a small business, where they can't afford it. So there was that segment that didn't have it.

Lastly, there is a liability crisis in America. Our friends on the other side, our trial lawyer friends can tend to say that is not the case, but let me give you a personal example. When I started my medical practice, probably about the same time you did, Dr. GINGREY, it cost $360. That was the first baby I delivered in 1977 that I got paid for. I was out of the Army and out of my training, $360. My first year's salary was $32,000. That is what I made my first year in practice. I delivered 260 babies that year; a lot of babies. The next year I was up to $60,000 a year. My malpractice was $4,000 a year. When I came to Congress 2 years ago, the malpractice in Tennessee for an obstetrician was $74,000. And there is no value that we get, that patients get from that. We will go into that when we have another hour.

But the thing about the ObamaCare plan that bothered me was it did nothing to bend the cost curve. If you looked at this and if you look at plans that have been out there in the past, Medicare, for instance, came on board in 1965 as a $3 billion program; $3 billion in 1965.

The estimators, there was no Congressional Budget Office then or folks who make these estimates, but the government estimators at that time said in 25 years this will be a $15 billion program. The actual number was over $100 billion. And today it is over $500 billion.

In Tennessee, we noticed we had the same problem 20 years ago. We have been through all of this before. Unfortunately, no one here chose to listen to us in our Doctors Caucus. We said we had lack of access and we had prices rising back in the 1990s, the early 1990s, exactly the same debate that we are having today except today it is more severe than it was.

We spent $2.6 billion on TennCare in 1993. In 2004, 2005, just 10 budget years later, it was up to $8.5 billion. The cost had tripled.

So when you see these cost estimates—and remember that the same CBO, and these are good folks. I'm not pointing the finger at them. It is very hard to do what they do. They are given a set of data. They crunch the numbers and they hand them to us. They only missed this year's budget deficit by $400 billion in 1 year. So I am to stand here and believe, looking at these other examples I have just given you, that this is going to be budget neutral in 10 years? There is no way it will be.

I know we have a lot to discuss. I'm sorry I was a little late. I had some folks from the great University of Tennessee in my office to see. I look forward to continuing this discussion.

Mr. GINGREY of Georgia. Dr. ROE, we appreciate you being with us. I know the time is rapidly coming to a close.

But, Mr. Speaker, I guess the last slide basically says it all, cuts right to the chase: ObamaCare steals Americans' liberty. Our forefathers intended certain basic rights—life, liberty, pursuit of happiness—to be inalienable—that means can't be taken away from you—and consider them self-evident and universal.

ObamaCare lets the boss steal liberty from every American by forcing them to buy health insurance whether they want it or need it or not. We can encourage them to have it and try to make it possible and affordable. But to force them to do it, the next thing we know, everybody will be eating broccoli by government edict because it is healthy, it is healthy food. They are going to have a hard time getting me to eat broccoli.

But I am telling you the judge in Florida, Judge Vincent, and the judge in the Commonwealth of Virginia, Judge Hudson, they got it right. We need expedited processing of those suits so the Supreme Court will tell the American people this is unconstitutional and will not stand.

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

50TH ANNIVERSARY OF THE PEACE CORPS

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

Mr. GARAMENDI. Madam Speaker, today, March 1, marks the 50th anniversary of the United States Peace Corps. In 1961, President John F. Kennedy, together with Sargent Shriver, established the most remarkable, long-lasting, and incredibly successful United States Peace Corps. On the announcement of the establishment of the Peace Corps, countries around the world clamored to have Americans of all ages come to their country and assist in the economic development of those countries.

To date, over 200,000 Americans have followed that call to service and have served in over 130 countries. Today, some 77 countries have Peace Corps volunteers and another 20 countries request the presence of Peace Corps volunteers.

My wife, Patti, and I are proud returned Peace Corps volunteers. Joining me today to celebrate this 50th anniversary are two other returned Peace Corps volunteers. And together with SAM FARR, who unfortunately cannot join us this evening, we comprise the four Members of Congress who are returned Peace Corps volunteers.

□ 1730

I would like to call upon my colleague from California, MIKE HONDA, to join us here to express his own experiences of his work here in Congress and how his Peace Corps experiences may have reflected upon his work.

MIKE, if you'll join us.

Mr. HONDA. Thank you, JOHN.

As a returned Peace Corps volunteer, I rise to recognize the work of the Peace Corps on its 50th anniversary. The Peace Corps has played an instrumental role in establishing prosperous foreign relations while fostering cross-cultural understandings. Countries from all over the globe celebrate the contributions of the Peace Corps and look forward with anticipation to its continued growth.

In representing the Ethiopian Caucus here, I was in Ethiopia a couple of years ago and traveled extensively through Ethiopia during the 8 days I was there. I ran across some folks in the upper part of Ethiopia, and we talked about the Peace Corps. Immediately, a lot of the young people there brightened up, and asked, Do you know GARAMENDI? It was at that moment I remembered that our colleague GARAMENDI had served in Ethiopia. What struck me the most were the memories of people and the fact that we touched them in their youth. The influence that we had on the young people in the different countries had stayed with them, and they have become leaders in their own right in the countries in which we served. The same happened in El Salvador. I'm sure the same happened in Somalia where our other colleagues had served their time.

The Peace Corps provides a unique opportunity for volunteers to help some of the most impoverished people in the world, work that changes their global perspectives.

I had met another person at Stanford University. He was a visiting scholar. He was not much more than 5-foot 1-inch, articulate in English and Spanish, who said that he was an aberration of statistical probability. In saying that, he meant that he was a young boy in the mountains of Peru and that it was a Peace Corps volunteer who had touched his life, who had allowed him to learn more about himself and his country, which pushed him to learn English. Because of the Peace Corps volunteers, he was able to go to school.

His name was Alejandro Toledo. He became the President of Peru. Now he is a visiting scholar and is also looking at running again and perhaps serving his country. He not only serves his country; he serves all people of this world by the fact that he was able to express the idea that he was probably an aberration of statistical probability and that he had attained a position on the global stage, a leadership position, because of Peace Corps volunteers.

This story is replicated over and over again with the over 195,000 volunteers who have served. Yet I just want to pay special attention to Sargent Shriver, the person who made the selfless commitment and took the visionary leadership in creating a pioneering organization that provided opportunities for young people and that provided them opportunities to grow in themselves. Filling Sargent Shriver's shoes will always be difficult.

President Clinton was right when he said that never has America had a stronger warrior for peace and against poverty than Sargent Shriver. Sargent Shriver, himself, said it best when he said that the Peace Corps represents some, if not all, of the best virtues of this society. It stands for everything that America has ever stood for. It stands for everything we believe in and hope to achieve in this world.

So I want to thank my colleague for putting this together. I want to thank my friend Mr. PETRI, on the other side of the aisle, for his friendship. We say ''the other side of the aisle,'' but I think that the aisle does not exist with our relationships and with our commonality within the Peace Corps.

The Peace Corps allowed me to grow up. The Peace Corps allowed me to believe in myself. The Peace Corps was responsible for my being here today to be able to speak fervently and hopefully convincingly in encouraging other young people to serve this country through the Peace Corps. It will be 2 years that you will never ever regret—years I would never exchange for 10 years of regular life in this country.

I thank you.

Mr. GARAMENDI. Congressman MIKE HONDA, thank you so very, very much.

Let me now turn to my colleague on the Republican side, TOM PETRI, who also served.

TOM, if you could share some of your experiences with us.

Mr. PETRI. Yes, I am delighted to have the opportunity to join with my colleagues in recognizing the 50th anniversary of the founding of the Peace Corps.

It was my pleasure some 25 years ago to work with the fellow whose picture is up by the podium, Sargent Shriver, on some of the arrangements for the 25th anniversary of the Peace Corps. They'd had a gala reunion and a program at the Kennedy Center with such luminaries at that time as Harry Belafonte and many others. It was a memorable occasion.

Sargent Shriver, of course, was a great leader in many different areas. I met him in a reception line awhile back. He didn't really much like, though, that I'd said, So great to meet Arnold Schwarzenegger's father-in-law. He really didn't want to be known as Arnold Schwarzenegger's father-in-law. He wanted to be known, and is known, as the most dynamic director of the Peace Corps and for many others of his works—with Mrs. Shriver on the Special Olympics and for a variety of other good works that he did with his life.

We all have our Peace Corps experiences. I had the opportunity to serve in the neighboring country to Ethiopia, which was Somalia—a troubled place now. It was a great experience, though. People ask about the Peace Corps, and I always say that one of the things you have to remember about the Peace Corps is that you get a lot more out of it than you really give. You're serving other people, but you're learning. You're learning about another culture; and at the same time, you're learning about your own country and your own experiences because of the points of contrast.

What a wonderful thing it is that America has now tens of thousands of people who have served in the Peace Corps, who have returned and who now are working in every walk of life—working in international organizations, working in business organizations, knowing different cultures, knowing different languages—thereby providing a dimension to our own national life that we would otherwise not have if we did not have people who had had the experience of serving in the Peace Corps.

There is one other thing. I still can remember the quizzical but interested reaction that so many people in Somalia or, I'm sure, anywhere in the world had: Who are you? Why are you doing it? Explain that to me again.

The spirit was kind of catching, and they would participate in all kinds of little volunteer activities and things that they hadn't necessarily thought of doing themselves.