importance of small businesses, entrepreneurs, and the diversity of businessowners.

In New Jersey, small businesses employ nearly 2 million people and make up 99.6 percent of all businesses in the State. Over the last decade, women-owned businesses have increased by 45 percent and generated over $1.6 trillion in revenue. Minority-owned businesses have produced over $1.3 trillion and created 7 million jobs.

Small businesses are truly the backbone of our Nation and economy. As Members of Congress, we must do our part to support all efforts to open the doors of opportunity for small business growth. Their success is our success.

COMMEMORATING THE LIFE OF JOSEPH STONE

(Ms. KAPTUR asked and was given permission to address the House for 1 minute.)

Ms. KAPTUR. Mr. Speaker, as co-chair of the Congressional Ukraine Caucus, I rise to commemorate the precious life of Joseph Stone of Tucson, Arizona. The 36-year-old American was serving his part of an official international peace team monitoring the border conflict between Ukrainian Government troops and Russian-backed separatists who invaded Ukraine.

Mr. Stone was working with a German and a Czech peace monitor when an explosion—likely a mine—damaged their vehicle in Pryshyb, Ukraine. The two other monitors are hospitalized in stable condition. Stone is the first Organization for Security and Co-operation in Europe monitor killed in that very important mission.

Stone's career in foreign assistance missions brought him to Afghanistan and Liberia before Ukraine. Before entering the aid community, Stone worked at American Medical Response in southern Arizona for 9 years, starting out as an EMT and rising to the level of paramedic. He graduated from Pima Community College. He is survived by his mother, two brothers, a longtime companion, and 13-year-old daughter.

Since its establishment in 2014, the OSCE has played a vital role in monitoring the Minsk agreements designed to bring peace to eastern Ukraine after Russia's brutal invasion of a sovereign neighbor. This fateful tragedy makes clear the absolute brutality of Vladimir Putin's threats to liberty and democracy in Ukraine.

It also instructs us about the unrecognized selfless heroes among us who define the meaning and cost of liberty. May our recognition of his selfless sacrifice bring comfort to those bearing this great loss, and may he be remembered always in the protracted struggle for a free Ukraine.

THE OMNIBUS BILL

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

Mr. ESPAILLAT. Mr. Speaker, I am pleased that we found a solution to keep the government open through October and that this deal does not include funding for President Trump's border wall, nor does it eliminate money for sanctuary cities. These are several issues that I am proud to champion in addition to programs such as the NIH, Child Care and Development Block Grants, Pell grants, nutrition programs for seniors, Planned Parenthood, affordable housing, and Head Start.

However, the devil is in the details, and after further reviewing this total package, I cannot, in good conscience, support it. This bill will increase funding for homeland security and is essentially $1.2 billion of President Trump's original proposed $3 billion request for border security and interior enforcement. We fully know that any funding for homeland security and border security will be used to increase raids and detentions, essentially funding the President's mass deportation agenda.

In addition, this omnibus bill does not provide a long-term solution to Puerto Rico's economic crisis, leaving Puerto Rico's Medicaid funding with only one-third of the funding it needs.

Finally, the bill comes at the same time that Trump and House Republicans continue to push to eliminate ACA. The devil is in the detail, and that, too, will be a nightmare in hell for many of us.

CHANGES TO AMERICAN HEALTH CARE ACT DO NOT REMEDY BILL'S SHORTCOMINGS

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

Mr. CARTWRIGHT. Mr. Speaker, I rise because evidently, in the House of Representatives, we will be taking up the possible passage of a revised but, as yet, unseen American Health Care Act.

I rise to urge my colleagues on both sides of the aisle to vote against this. The CBO has not scored it, so we don't know how much it will cost. We don't know how many Americans will be thrown off their health care.

I want to quote Dr. Andrew Gurman, who is the president of the American Medical Association, who said this today:

''Not only would the AHCA eliminate health insurance coverage for millions of Americans, the legislation would, in many cases, eliminate the ban against charging those with underlying medical conditions vastly more for their coverage.''

This is a bad bill that has gotten worse with time. We haven't seen it. It hasn't been scored for money or how many patients will be thrown off their health care. It will hurt patients, it will hurt medical providers, it will hurt hospitals, and it will hurt this country.

I urge my colleagues to vote ''no'' on this bill.

THE AMERICAN HEALTH CARE ACT

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

Mr. RASKIN. Mr. Speaker, I also rise in opposition to this suddenly undead GOP plan to strip millions of Americans of their health insurance and Medicaid coverage and dramatically increase our monthly premiums. Just when you thought we had actually slain the zombie, the repeal-and-replace plan comes back again with no hearings, no witnesses, no budget score, and no policy coherence. It is like the bloody hand emerging from the grave in ''Carrie,'' even as the credits are rolling and the people in the audience have already left for their cars.

Mr. Speaker, let's return this so-called American Health Care Act to its own preexisting legislative condition: dead on arrival.

What makes anyone think it improves the appeal of this plan to strip preexisting coverage from the American people?

The fact that you have a preexisting condition is why you need medical attention. It is not the reason to deny it to someone.

In the last round, I heard colleagues complain that, under the current system, healthy citizens have to pay for other citizens when they get sick. Yes, my friends, that is what insurance is. Any Member who believes that the currently healthy should not help insure the currently sick must believe no one in his or her family will ever get sick. That is magical thinking. But in America, as Bruce Springsteen says: We take care of our own.

MATH AND FACTS

The SPEAKER pro tempore. Under the Speaker's announced policy of January 3, 2017, the gentleman from Arizona (Mr. SCHWEIKERT) is recognized for 60 minutes as the designee of the majority leader.

GENERAL LEAVE

Mr. SCHWEIKERT. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days to revise and extend their remarks.

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

There was no objection.

Mr. SCHWEIKERT. Mr. Speaker, we have a whole hour here, and we may actually use the whole hour. This is an opportunity to actually walk through three areas that I care an awful lot about.

One, I actually want to walk through something called math, and math in regards to health care. Some of this is actually to deal with—and I don't want to be mean, because I am going to try to do this in as nonpartisan a way as possible, but some of the things that we have just heard moments ago that lack just sort of basic roots in math and facts.

□ 1700

Let me move this easel back just a little bit so we can get this. We are going to do a little bit of show-and-tell here to sort of help.

First off, a conceptual problem, since, I believe, it is 1986, we in the United States have had statutes that say, if a sick person walks into a hospital and they have cancer, they are bleeding, they are going to get health services.

This is a really important concept for us all to get our heads around. There is no such thing as not receiving care in this country. It may not be the care you want at the place you want, but it is the law. It has been the law for 30 years.

If we are going to be brutally honest, much of the debate and discussion we are having here, whether it be the ACA or prior to the ACA where it was uncompensated care, where it was disproportionate share within our hospitals, or our reform legislation, it is not whether someone gets coverage or doesn't get coverage; it is who and how it is paid for and where is it paid for.

Remember, these costs are already in the system. Does it go as a loss on a hospital balance sheet? Does it get pushed over to other populations within an insurance pool? That is the math we are actually working on.

A couple of moments ago, you had a handful of Members come up and talk about preexisting conditions. If you hear someone use the term ''preexisting conditions,'' they basically are years out of date. There functionally is no such thing anymore. There is guaranteed issuance of insurance.

We are going to go through this in more depth.

Someone like myself, I am a severe asthmatic. I walk around with an inhaler in my pocket. I can grab any insurance today and I get guaranteed issue.

Whether it be in the current ACA—ObamaCare, as many know it—there are variations in what we refer to as community rating. There are age levels. If you are a smoker, you get a different pricing.

Some of those same mechanics we are doing in our reform bill. We are going to walk through why the way we are doing it we think actually will ultimately lower prices. We are trying to get that efficiency of the young and healthy to participate in the insurance pool, because they are not participating today.

We are going to keep this board close by because this is important for everyone to understand conceptually. I know the chart is hard to see, but 5 percent of the population is 50 percent of the healthcare cost.

Think about this. Of our brothers and sisters who have chronic conditions, they are 50 percent of the healthcare costs, even though they are only 5 percent of the population. That is why we did the risk-sharing model that is being attached to our legislation. We are going to walk more through that.

If you start to think about this curve—for those who want to do some math—it looks like a hockey stick. The healthiest 50 percent only use 3 percent of healthcare dollars. So 50 percent of the population only use 3 percent of the healthcare dollars. Then it comes along and explodes up like a hockey stick. The top part of this hockey stick, this 3 percent of the population up here, whether it be because they are hemophiliacs or uncontrolled diabetics or have other types of great difficulties, that population is 50 percent of the entire cost.

What happened in the current ACA is, let's face it, the model did not work. You remember the whole discussion: keep your doctor; $2,500 savings; fewer visits to emergency rooms, which, actually, emergency room visits have skyrocketed or gone up substantially.

Their model did not work, and mathematically it is imploding. We are going to go through some data, particularly from my home State of Arizona, on how much trouble we are in.

One of the reasons it has not worked is less than half the population of those buying in that individual market are buying. Particularly, if you look at our healthy 20-year-olds, our 30-year-olds, that 50 percent of the population that only uses 3 percent of health care, they are not participating in the insurance pool.

Well, how do you spread risk when you have millions and millions and millions and millions of Americans who are choosing not to purchase because it is too darned expensive or, because the contribution before you receive health care is so expensive and the number of waivers, it is just cheaper to pay the penalty?

So what happens when you are trying to do the math and you have your brothers and sisters here in this body on the other side who either make up facts or just say, ''Well, just keep it as it is''? I am going to make the argument that the cruelty of that is just stunning.

We are going to start to walk through a little bit more of these so we can actually help folks sort of understand this is the underlying math, this is why we must have a substantial change.

Let's go back prerecession, just before the recession. Let's go back here to 2007. We had about 14.6 percent of our population going uninsured. That is unacceptable. Today after having spent almost—as some data says, as much as $1 trillion, but we will stick with a half trillion because that I can absolutely document—$500 billion of subsidies, losses, if you actually add up the losses insurance companies have had, if you add up the copays individuals had, if you actually add up the money that has been spent through the bureaucracies, we have dropped, say, a half-trillion dollars, today we are at 10.9 percent.

If you are on the left, this is the grand success of ObamaCare. The grand success of the ACA is that you have gone from 14.6 percent of the population is uninsured, and today it is 10.9? Where is some of the intellectual credibility around this place to at least tell the truth of the math?

If you start to divide up how much we have spent—and we were just doing this on the back of a napkin a little while ago. If you add up the population that has now gained insurance through the exchanges that did not have insurance or access to insurance before, some of the math comes to around only 6 million people.

If you divide that by a half-trillion dollars, that is $84,000 per life for 3 years of coverage. We could have bought them their health insurance and a really nice car. You understand how absurd the current model is.

I am not questioning the good intentions of wanting to help our brothers and sisters have access to health coverage. Great. Now let's make the math actually work.

This chart is really important. This is actually not coming from me. This one, I think, is from Gallup. Most of the other data we are going to get is going to come from Kaiser or the Congressional Budget Office.

I want you to understand I am going to be Arizona-centric because that is my home State. I am blessed to represent the Phoenix-Scottsdale area. But let's take a look at my little State down here. We are going to burn through these fairly quickly.

I have about 6.7 million residents in Arizona. Okay. There are 6.7 million residents in Arizona. This is from Kaiser.

Let's switch to the next board. Of that 6.7 million residents in Arizona, my citizens, how many buy their health care on that individual market? That is what we are talking about.

When you keep hearing the grandiose ''the world is coming to an end,'' how many of my brothers and sisters buy on the individual market? About 278,000 people. That is a lot of people. But if you divide it by our population, it is 4 percent of my population. In my congressional district, it is somewhere around 2 percent of my population.

The elegance of actually being honest about that piece of math is that it helps you understand we can fix this. This is the individual purchasing market.

Let's take one step backwards.

The majority of Americans receive our health care from our employers. Then we come over here: Medicare, VA, Indian Health Service, TRICARE, a number of these things. What we are talking about in the ACA and our replacement is that sliver of our population that is in the individual market and how to reform Medicaid. That is all.

But often when something is complicated, it comes ripe for political hyperbolic language, acting like the world is on fire, instead of being honest and making the math work so we can

serve our brothers and sisters with the health coverage we want.

Remember, we have just come back here to Arizona. Only 4 percent of my population is in the individual market. In my congressional district, it is only 2 percent of the population.

Now, you need to understand that when you hear many of us get behind these microphones and we talk about the system, the current ACA—ObamaCare, as it is known; but I think that is unfair, so let's just call it the ACA—is imploding. For my State, it is. We are going to show you how few choices happen in my State. This is only between 2016 and 2017.

Do you see this blue right here? If you were in that county, if you were in that individual market, you would have three or more choices.

Do remember that, when this law went into effect, we were promised dozen of choices. Should we hold the left to their own promises? It hasn't happened.

What is happening now, if you take a look all over the country, when you see this chart, county after county after county now has one choice. I want you to see what has happened in my home State.

First off, statewide in my State, if you were buying the mean exchange plan, that Silver plan, statewide, last year, a 116 percent price hike. That is if you are in Maricopa County and you are buying the mean Silver plan.

Maricopa County is the fourth most populated county in the United States, so it is not just a little outlier. It is the fourth most populated county. It is 64 percent of my State's population in one county.

If there were ever an example of a county that should have had health care efficiency and pricing, it is Maricopa County. It is a large population. If you were in that mean Silver plan, you had a 145 percent price hike last year.

How can I see people get behind these microphones and act like this system is working? Do you understand the crushing you are doing to people in my State, hardworking people who just want to say: I am the neighborhood plumber; I would like to buy health care?

Either the deductibles have gotten so huge or the underlying price has gone up so high, we are actually seeing something fascinating in the uninsured curve. The uninsured population has now moved into our hardworking middle class because of the number of them that work for themselves that can no longer afford to participate.

We will just say it was one of the unintended consequences of the current ACA. But it is one of those occasions we all see the data, and yet how many people get behind these microphones and tell the truth about how many people we are crushing from these deductibles to the current pricing?

You saw the previous chart. We have gone from 14.6 percent of our population uninsured before the ACA to, now, 10.9 percent. We dropped about a half-trillion dollars. That is $500 billion. That is not counting Medicaid expansion. That is just the numbers over here.

We have had testimony in the Ways and Means Committee that we believe only about 6 million Americans were newly insured, newly covered for that half-trillion dollars. Look, it is great they have coverage, but the math doesn't make sense. We could have done this so much more elegantly.

So let's actually take a look at Arizona. This is 2014. If you go before that, it was even bigger, but take a look at my county. See all those little squares? Those were health insurance providers that were available to you in 2014.

If you go a couple years before that, we had counties that had 15, 18 different possible insurance choices, companies who would provide; today, 2017, you see one little blue square.

We are being told that we are going to have entire counties in my State—and Arizona is unique in that we have only 15 counties in the entire State. We are going to have entire counties with no insurance provider to that individual market. This is a system that is working?

Take a look at my State. This is one of the reasons we have been working so hard, why we did the risk-sharing model. This is reality. This is Arizona. This is my home. My folks have had these massive, triple-digit price hikes. Now they have a single choice, and they are being told next year they may have no choice. This is the reality we are at.

□ 1715

So let's actually talk about solutions. How do you deal with this? How do you actually help our brothers and sisters be able to afford insurance? How do you encourage providers to come in and actually participate in providing coverage to that individual market so there are options, there is competition, there is choice?

If you actually think about what drives that price, so why the explosion in price? Well, the current ACA, because of the way it has these three tiers within, we will call it, the community rating—that is where you take all the people in your community who are participating in this insurance population, and say: You don't all get the same price. There are certain adjustments, and some of the adjustments were for age.

So the ACA, ObamaCare, the current law, had three adjustments plus adjustments for smoking and a couple other externalities, and it made the concentration of cost and risk so expensive that—remember our 50 percent of the population who only use 3 percent of health care—they have chosen not to buy, which, in some ways, is a perfectly economically logical reaction to the current cost, to a world where it is so expensive it is cheaper to pay the penalty, so we have to find a way to drive down that cost for that population so they participate.

When you were in school and you would hear the story in your economics class of there are occasions where by lowering the price you make more profit because you sell more units? The concept is pretty much the same here in insurance. If we can lower the price for our healthy population, more participate; we spread the risk over a larger, healthier population; we lower the price for that 5 percent of our brothers and sisters who are in that chronic category; plus we are going to overlay a couple other things to help mitigate that cost to get the price efficiency for everyone. It is important.

I know some of these slides are a little hard to get our heads around, but we have put together something called an invisible risk pool. If you are that American who has bought, who is participating in this individual market but has a chronic condition, you never do a traditional risk pool today because what we learned from the data over the last 30, 40 years of risk pools, there have been a couple successes, but most risk pools, hey, the cost goes up, you hit that sort of threshold, and you dump that person, saying: Hey, you are now the risk pool's problem, or you are the State's problem.

We wanted a continuity of care. We wanted the sick person to receive services where the medical provider, the insurer, and the patient themselves all have skin in the game. They all have a need to participate, to manage, whether it be the individual's diabetes or some other ailments. That is the beauty of sort of this risk-sharing model, that for the population that is our sickest brothers and sisters, as their cost graduates up, there will be participation from this risk-sharing pool.

Why is this absolutely fair? Remember how we talked about how most Americans receive their health care in the employer market? Well, your employer gets a fairly substantial tax deduction for providing that health care. They get to take it off their taxes. Well, we don't do that for when you are in that individual market. When you are in that individual market, for you to be able to take it off your taxes, so we have tried to come up with this methodology to make it fair, so we have come up with this tax credit. But we want you to have the money to help purchase your policy in the beginning, so there is this whole term, sort of this made-up new language that says a prefundable tax credit so you can buy your health insurance in that individual market. So that is on the front end. On the back end, to make sure the premiums, what we call premium efficiency, have stayed low and affordable, we are actually doing this risk sharing up here to help mitigate that spiking of cost so we can lower the prices for everyone so we maximize participation.

There is some elegance in the math, and I think actually there is a great

love for our brothers and sisters who have preexisting conditions up here because it is an invisible risk pool. They never know whether their cost is being subsidized by this pool, nor should they. We made a societal decision 30 years ago that someone walks into an emergency room, someone walks into a hospital with a condition, they get services, so the cost is already in the population.

What we have been debating now for years is how do we pay, how do we move the chairs around? But if we are going to get efficiency in lowering premiums for everyone, remember, we need our healthy population over here to participate in this, and then there is a couple other things we are going to talk about.

So functionally what we have done with the risk sharing, it actually accomplishes a couple really great things. One is the obvious part, if you are the insurer, and let's say you are the actuary at the insurer, and you are doing your math, you actually know what your risk exposure is on each life. Why that is important is you don't have to build what is often referred to as a shock absorber in your rates, saying: Dear heaven, what happens if tomorrow I get a handful of folks with a very difficult chronic condition that blows the cost off the charts? I have to build cushion into my rates.

Well, with the risk-sharing model, they no longer have to have the rates padded for that externality that might happen. It becomes this multiplier effect where if I don't have to put that in the rates, I have lower costs over here. If I have lower costs over here, the model says I get a lot more participation in the health care pool, and everyone benefits. That is what we are trying here.

So what do you actually do, if the argument I am making, whether it be the ACA, whether it be our replacement, in many ways what we are discussing is how to pay for the health care that is already in our society. Remember, as we have been talking, there is no such thing, if you are going to be completely honest, as a preexisting condition denying you coverage. There are some cost stratas, but that is in the current ObamaCare ACA, just as in our replacement, but some of that is by age or if you smoke or other things.

How do you actually lower costs? Some of that comes in the next piece of legislation because, as you all know, in the bill we are trying to move now, we have to deal with the rules of we have no one on the left in the Senate who is going to work with us. We are on our own. So we have to find a way to do this with 52 votes in the Senate. We don't have eight Democrats who are going to work with us. That means we have to do it through reconciliation. Probably those of you who are interested in this stuff, you have read how reconciliation limits the things we can put into a piece of legislation. If you would like us to have more things, go find us eight votes on the Democratic side in the U.S. Senate.

So what do you do to lower costs? We all know information. How many of you can grab your supercomputer you carry in your pocket right now, log into the hospital surgery center—your doctor—and immediately hit a button and say, Hey, the retina detachment, the cataract, the kidney problems I have, here is my cost for the services, here is my cost for the procedure?

We need information. That is going to come, I believe, later this year.

The next thing is, with that information, you create competition. That is incredibly important. Competition in health care comes as much from the price as it does the quality. We have done some great things in collecting quality data. With quality data and price information, we are hoping there becomes now this incentive to actually compare and move around. But what is the next revolution? I am going to make you the argument—and this is one of the elegant things I believe that is also now happening on the Medicaid side of our piece of legislation, and that is to allow creativity at our State levels.

Arizona may have one of the most creative Medicaid systems, we call it AHCCCS in Arizona. We buy functionally capitated HMO policies for our indigent population. But every time we want to make a change, every time we want to try something new to service our brothers and sisters in Arizona, we have to march over to the Federal Government and get a waiver. We have to get permission from the Federal Government. Well, here is my question to you: Does a poor person—as a matter of fact, anyone, if you are in the individual market, if you are on Medicare, Medicaid, do you have the right to talk to your primary care physician on this? Of course you do. Do you have the right to wear the sensor on your body that helps you manage your high blood pressure? How about this contact lens that is going to be out probably next year that will actually sit in your eye and manage your blood glucose? No more punching a hole in your finger and doing a blood test to check for your blood sugars, your blood glucose. It will be constant, talking to your phone, talking to your pump. If that keeps some of our brothers and sisters with diabetes from crashing, it is great for all of us. It is great for society. It is great for them. It is great for healthcare costs.

There is a revolution coming technologywise. One of the things I found fascinating is they actually have a little thing now where you can put your fingers on it and it does a full EKG. There is disruptive technology that is now available and is rolling out. How many of us now wear a Fitbit that helps you manage parts of your health care? This right here is about to bring a revolution in health care.

A simple example, just a thought experiment for anyone who actually cares about these things: In Arizona, the majority of babies are born in our Medicaid system. Even my little girl who we adopted a year and a half ago, I believe she was born in my State's Medicaid system. Most perfect little girl ever.

We know we have a problem in this country and in Arizona, a substantial number of the moms don't show up for their prenatal visits. When we have surveyed them, we get information back that says: It is hard waiting for the bus. It is hot out. Dial-a-Ride makes me wait. Why wouldn't you allow that poor person to hit a button on their phone and have ridesharing pick them up? There are solutions. If we could get our brothers and sisters on the right and the left here to actually talk to each other about solutions, but instead right now health care is such a potent political issue, I can show you article after article after article where the facts that are being disseminated to the American public are completely wrong. We heard some of that just minutes ago behind these microphones where the facts are absolutely made up. It is just incredibly cruel.

Let me explain the cruelty. A couple weeks ago, we were doing just coffees with residents. A group of my constituents who are on the left brought a woman, and she has tears running down her face. She is standing in front of me wanting to know why we are about to take the health care away from her husband who is across the street in the hospital. How cruel does the left have to be to lie, to say something like that to someone because none of that was true. Our bill, their bill, that just can't happen in the language that if you are already in the hospital, if you have a preexisting condition, these things are covered, whether it be from the right or the left's language. But to manipulate someone who is already suffering like that, what sort of cruelty is in someone's soul to get a political advantage to manipulate a wonderful woman who is already suffering with the difficulties of her husband in the hospital?

I beg of you, whether you be on the right or the left, actually read the amendments, actually read the language, understand what reality is, understand we live in a society now where all preexisting conditions have coverage. We already live under a law that has age brackets, if you smoke, variances, but very small variances. Even in the latest amendments, the discussion is, if your State wanted to do a statewide prenatal program, or my State where we have a disproportionate share of our population with diabetes, particularly with my Native-American population, if my State wanted to get everyone together, whether it be Indian Health Service, the VA, private insurers, our Medicare, Medicaid system wanted to try to put together a statewide program to reach out to our brothers and sisters with diabetes, that

would be—if the actuaries and the math works—maybe wonderful. That would be an occasion where my State would reach over to the HHS Director and say: Can we have a waiver? We no longer need to have this type of coverage mandated in these individual policies because we are going to do it at the statewide level. I beg of you, think creatively.

How do we cover our brothers and sisters? How do we deal with the reality that a huge number of our population right now is choosing not to buy because of price or have been able to receive waivers substantially because of price?

□ 1730

And if we succeed here at driving the price down by our actuarial efficiency, the risk sharing up here, and spreading out, a couple of years from now, we are going to be standing behind these microphones and saying math won out over hyperbolic rhetoric.

So can we talk about a couple of other things that are really, really important?

I am blessed to be on the Ways and Means Committee. So why is tax reform so incredibly important to all of us?

Understand, those of you who want to see Medicare, those of you who want to see Social Security stay solvent, do you understand what is happening with economic growth and the pressures right now and what is going on?

So this little pie chart up here is functioning 9 years from now. You have got to understand, in 9 years, only 22 percent of the spending will be what we call discretionary, stuff I really get to vote on, stuff that is not in the formula. Eleven percent will be nondefense. Everything you sort of think of as government—the Park Service, FDA, Education—those things where moneys come to the Federal Government that go to these things is only going to be 11 percent of our spending. Another 11 percent will be defense. Everything else is either Social Security, Medicare, Medicaid, interest on the debt, or some of the other unearned entitlement programs.

This is substantial because we are graying. You all heard of baby boomers. But the reality of it is, in less than 9 years, every dime of Federal revenues—and we are going to be taking in $1 trillion more. We are going to go from $4 trillion to $5 trillion of revenue. Every dime of Federal revenue will be consumed by what we call mandatory spending, entitlements. Military and every other part of government is going to exist on borrowed money.

So if you are someone who really likes education, if you are someone who really thinks drug research is important, if you are someone who thinks NASA is important, if you are someone who thinks the parks are important, you should care about this.

The reality of it is the math curve, even with a substantial growth in the economy, we are going to have to look at entitlement reform. And I know that sets people off because they are fearful, but it is a lot better than hiding from it.

The thing that makes it less painful is a growing economy. Tax reform, we know, is the single greatest engine, the single greatest lever we have here as Members of Congress to get the economy growing. Fixing the healthcare issue will go a long way to help. Dealing with regulatory, dealing with immigration, dealing with embracing technology into our society and government can all be very powerful for economic growth, because our future does not have to be one buried in debt.

But without a revolution in the way we think around here and a willingness to do tough things—and tax reform is going to be hard, but without it, you are basically sentencing my little 18-month-old girl to a future buried in debt, buried in slow growth.

For those of you who may be my age, who are hoping to receive Medicare and Social Security, you are putting those programs at financial risk, and it doesn't need to happen. We can fix this, but you have got to move it away from the hyperbolic politics and actually start to be willing to own a calculator and start looking at the math.

Why this is so important, right here on this chart, is start to understand, as you get down here—remember, 2027 is functioning 9 years from now, and, actually, only 8 budget years from now. One more time, every dime is consumed by Social Security, Medicare, Medicaid, interest on the debt, and the other handful of mandatory, what we call, entitlements. This is your future. It happens in less than a decade. It is here.

Please, big, bold, dynamic tax reform is the first thing we can do this year, and then we are going to have to continue to move on to technology and everything else to sort of do whatever is necessary to get this economy growing.

This one is a little more difficult, but we wanted to actually hold it up just so that there is an understanding of how fast we move from right now. Today, in 2017, about 7 percent of our total spending is interest. In a couple of decades, we start getting up to where it is 20 percent, a quarter of all of our spending.

And this chart, think of this. In 9 years, interest is 19 percent of the budget. Okay. In 9 years, Medicare is 22 percent of our budget, of all of our spending; Social Security is 29. Just add that up. Think of that. Interest, Medicare, Social Security, the three of those start to consume the majority of this institution's spending.

And then you add in what we call mandatory spending, other entitlements, and you start to see, in 9 years, it consumes every dollar of tax revenues. That is really, really important to understand why we need to have this two-phase approach.

Right now we do everything that we can to maximize economic growth and opportunity. And when we talk about economic growth, this isn't just for the top line, big corporations. We need that economic growth of those people that pay the FICA tax. Our brothers and sisters that pay Social Security, our brothers and sisters that pay the unemployment tax, our brothers and sisters that pay into Medicare, we need their jobs to pay more. We need more of them. We need them to have more options in the workplace.

So this is a tax design of how you maximize economic growth not just for big corporations, but for everyone. That concept of: Remember when we were all in school, that sort of velocity of economic opportunity, that mobility? We have been stagnant for a decade. We must, must, must bring it back.

And why these numbers become so difficult—and this chart is a little hard to understand at first. These are the predictions of what economic growth was going to be this year, to understand how much trouble we are really in.

In 2013, the brilliant—excuse me. Yes, let's just make fun of them. The economists around this town were saying: Hey, it is 2013; but by the time you hit 2017, all this stimulus, all this spending, all this debt, you are going to get a 4 percent GDP growth.

You all saw what we had last quarter. What was it, 0.7?

Now, honestly, first quarters the last couple of years have had a distortion, I think, in the seasonally adjusted numbers. But do you think we are going to hit 4 percent GDP this year? Because that is actually what a lot of the budgets were projected on.

So sometimes we will be here in a debate with my brothers and sisters on the left, and they are holding up these charts saying: Well, it is 2013; we are going to be just fine over the next 10 years. And you get into those next 10 years, and you start to realize we are going to be lucky to hit 2 percent.

So much of what we have shared with the American people in the previous decade, the numbers were blatantly wrong, and not to the good side, to a much more difficult side. So when we start to look at this chart—and, once again, 2026 isn't that long from now—you start to realize we are going to be approaching $30 trillion of debt. Why this becomes incredibly important, once again, for all my Keynesian economists out there who think we should just go more into debt, spend and we will get stimulus, now we have built up so much debt that the ratcheting effect you get if you start to raise interest rates and half your debt needs to be refinanced within a 5-year period—they call it a weighted daily average—all of a sudden any new revenues you may be getting from that Keynesian stimulus are being consumed by interest.

Every day we wait to deal with this we lose options on how we can protect Medicare, on how we can protect Social

Security, and on how we can protect our economic future. The sooner we do what is necessary in tax reform and all the other reforms and stop some of the crazy squabbling—I am sorry the left lost; well, actually, I am not, but I am sorry it hurt their feelings so much—and maybe come to the table and prove to the American people you actually care about them in a fashion where you are being honest with the math, hold up a calculator and demonstrate that we actually are going to do what is right.

Back to the last part. We are going to do this slide over again because this is really important. Remember, we said part of this is just math.

The economic growth. The part of our society that uses 50 percent of the healthcare dollars is 5 percent of our population. It is all fixable.

So there are two themes here on the first parts of this. In health care, the expense, the cost is already in the system. Whether it be our reform, whether it be the ACA, whether it be before the ACA, the total cost is already there.

What we have been working on are two things. How do you move the cost around so that we can actually lower the cost for that 50 percent that only uses 3 percent so they will actually participate in the insurance market, lowering everyone's rate, instead of what is happening today where they just don't participate?

Remember, you saw the slide. 10.9 percent of the population is not buying health insurance today. They don't have coverage. They are uninsured. Some of that is because of the cost; some of that is because of the waivers. The only way you get them in is that thing we call premium efficiency. We have got to drive down that cost. But if we do that, I am actually pretty optimistic good things are going to happen.

Now, I want to actually take you to something that there really are bipartisan solutions. I am going to make you this argument that technology is the great optionality around this, it is the great unifying thing. I am going to walk you through something, and later I want you to tell me whether this is Republican, Democratic, right, or left. I am going to make the argument it is data.

I live in Maricopa County, the fourth most populous county in the United States. It is what we call a nonattainment county. It means certain types of pollutants are in excess, and on occasion it spikes up. In the past, we would get a phone call from EPA saying: Hey, one of our monitors shut off. We think we are going to shut down your building permits.

Well, remember how we were just talking about we live in a society where we must have economic growth if we are going to be able to finance and pay for our promises? So I came to you and said there is a much more elegant way to keep the air clean and actually have economic growth: reward those who are following the rules and catch those who are breaking the rules when it comes to polluting our air quality. And it is data.

So right now, here is how we regulate.

You want to open a business. Let's say you want to do a powder coating business in Phoenix. You have to go out and get a bunch of permits from the county, from the State DEQ. You also submit to the EPA. Depending on the types of volatile organics and other things you are using, you may have to file reports every quarter. You have to do a major audit every year.

Does filling up file cabinets full of paper make the air quality cleaner in your community? Seriously, because this is our regulatory model. We basically have a 1938 regulatory model where we make people fill out lots and lots of pieces of paper. We send them in. We hire lawyers and auditors, and we hire consultants to help us fill out this paper, and we shove it in file cabinets down at the air quality regulator or environmental quality regulator. Do full file cabinets make the air quality cleaner in your community?

It is an absurd model when we are all walking around with supercomputers in our pocket. There is now technology coming on the market where you, through Bluetooth, through an actual plug-in, you can actually be walking around with your own air quality monitoring system.

Well, think about my community. If I could have a couple thousand people driving around, traveling around, walking around, hiking around my community getting air quality samples every 5 minutes, at the end of the week I have a couple hundred thousand data points. You put it up on a GIS map, and you catch those who are sinning.

Think about it. It basically is a combination of crowdsourcing citizen science. And the tradeoff is don't make that company fill out lots and lots of pieces of paper or that organization over here fill out lots and lots of pieces of paper and fill up a file cabinet, because if I have enough monitors and sensors moving around the community, if they screw up, you catch them instantly.

It is not like today's world where a couple of years later maybe an auditor catches them; you go to the file cabinet and use the file cabinet as a tool to sue them, but yet you have had 2 years of pollutants in your air. Let's catch the bad guys immediately and leave the good guys alone.

We can do that by this sort of crowdsource data model, the idea that the entire community gets to participate in the collecting of the data. You get to look on the GIS map. The air quality regulator gets to look and say: Hey, we have a hot point over here. Let's go find out what it is. Hey, we found some clowns painting cars in the back of a lot.

Are those clowns out there getting air quality permits to do it? The folks down the street that are using the filters and are in the booth, if they are following the rules, they get left alone, but you catch the ones that have been escaping. It is a use of crowdsource data. We actually have a whole video of this on our website.

We now have introduced a piece of legislation that is over at Energy and Commerce. This should be a bipartisan piece of legislation because that Republican or Democrat—it uses data to let you know what is happening in the air quality in your community. It uses data to catch bad actors, and it uses data to let you know you can leave good actors alone so they can grow their businesses, so they can pay people more, so there are more job opportunities, instead of spending the money filling up file cabinets and hiring consultants. It is an elegant solution.

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Is that Republican or Democrat? I will make the argument it is data. There are solutions that both sides around here can use.

So the next time you have someone getting behind these microphones and saying, well, we are deregulating this—no. It is time for a revolution in the way we think.

We are all walking around with these. With the new sensors, you can manage your health care, you can test your water, you can test your soil, you can check the ambient sound, but you can also do the air quality in your community.

I am going to make you an argument there are actually solutions moving around here, and if I can get beyond the hyperbolic rhetoric, maybe we can start to move some of these solutions forward.

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

PROGRESSIVE CAUCUS

The SPEAKER pro tempore (Mr. FRANCIS ROONEY of Florida). Under the Speaker's announced policy of January 3, 2017, the gentleman from Wisconsin (Mr. POCAN) is recognized for 60 minutes as the designee of the minority leader.

Mr. POCAN. Mr. Speaker, I am here on behalf of the Progressive Caucus, which is the largest values-based caucus within the Democratic Party—74 members strong—who are helping to lead the legislative arm of the resistance in this country.

We, every year, put forth a Progressive Caucus budget, which is really a statement of the values of the Progressive Caucus and the values of the American people. This year, this week, we released our budget. But before I talk about it, let me just take a step back.

One of the things that people have asked us to do, asked so many of our Progressive Caucus members in this Congress to do, is to really fight and to lead the resistance here in Washington, D.C. And we are fighting many of the