Speier
Stark
Sutton
Thompson (CA)
Thompson (MS)
Tierney
Tonko
Towns
Tsongas
Van Hollen
Velázquez
Visclosky
Walz (MN)
Wasserman Schultz
Waters
Watt
Waxman
Weiner
Welch
Wilson (FL)
Woolsey
Yarmuth

NOT VOTING—19

Braley (IA)
Cantor
Clarke (NY)
Cummings
Filner
Frelinghuysen
Giffords
Guinta
Hanabusa
Hastings (WA)
King (IA)
Long
Marchant
McCarthy (NY)
McHenry
Pastor (AZ)
Perlmutter
Sullivan
Wu

□ 1432

Messrs. KEATING, TONKO, RUSH, SIRES, Ms. SEWELL, and Ms. MOORE changed their vote from ''yea'' to ''nay.''

Mr. ADERHOLT changed his vote from ''nay'' to ''yea.''

So the previous question was ordered.

The result of the vote was announced as above recorded.

Stated against:

Mr. FILNER. Mr. Speaker, on rollcall 333, I was away from the Capitol region attending the Civil Rights Freedom Riders' 50th Anniversary Celebration. Had I been present, I would have voted "nay."

The SPEAKER pro tempore. The question is on the resolution.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

RECORDED VOTE

Mr. MCGOVERN. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. This is a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 238, noes 181, not voting 12, as follows:

[Roll No. 334]

AYES—238

Adams
Aderholt
Akin
Alexander
Altmire
Amash
Austria
Bachmann
Bachus
Barletta
Bartlett
Barton (TX)
Bass (NH)
Benishek
Berg
Biggert
Bilbray
Bilirakis
Bishop (UT)
Black
Blackburn
Bonner
Bono Mack
Boren
Boustany
Brady (TX)
Brooks
Broun (GA)
Buchanan
Bucshon
Buerkle
Burgess
Burton (IN)
Calvert
Camp
Campbell
Canseco
Capito
Carter
Cassidy
Chabot
Chaffetz
Coble
Coffman (CO)
Cole
Conaway
Cravaack
Crawford
Crenshaw
Culberson
Davis (KY)
Denham
Dent
DesJarlais
Diaz-Balart
Dold
Dreier
Duffy
Duncan (SC)
Duncan (TN)
Ellmers
Emerson
Farenthold
Fincher
Fitzpatrick
Flake
Fleischmann
Fleming
Flores
Forbes
Fortenberry
Foxx
Franks (AZ)
Gallegly
Gardner
Garrett
Gerlach
Gibbs
Gibson
Gingrey (GA)
Gohmert
Goodlatte
Gosar
Gowdy
Granger
Graves (GA)
Graves (MO)
Griffin (AR)
Griffith (VA)
Grimm
Guinta
Guthrie
Hall
Hanna
Harper
Harris
Hartzler
Hayworth
Heck
Herger
Herrera Beutler
Huelskamp
Huizenga (MI)
Hultgren
Hunter
Hurt
Issa
Jenkins
Johnson (IL)
Johnson (OH)
Johnson, Sam
Jones
Jordan
Kelly
King (IA)
King (NY)
Kingston
Kinzinger (IL)
Kissell
Kline
Labrador
Lamborn
Lance
Landry
Lankford
Latham
LaTourette
Latta
Lewis (CA)
LoBiondo
Lucas
Luetkemeyer
Lummis
Lungren, Daniel E.
Mack
Manzullo
Marino
Matheson
McCarthy (CA)
McCaul
McClintock
McCotter
McHenry
McKeon
McKinley
McMorris Rodgers
Meehan
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Mulvaney
Murphy (PA)
Myrick
Neugebauer
Noem
Nugent
Nunes
Nunnelee
Olson
Palazzo
Paulsen
Pearce
Pence
Petri
Pitts
Platts
Poe (TX)
Pompeo
Posey
Price (GA)
Quayle
Reed
Rehberg
Reichert
Renacci
Ribble
Rigell
Rivera
Roby
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rokita
Rooney
Ros-Lehtinen
Roskam
Ross (AR)
Ross (FL)
Royce
Runyan
Ryan (WI)
Scalise
Schilling
Schmidt
Schock
Schweikert
Scott (SC)
Scott, Austin
Sensenbrenner
Sessions
Shimkus
Shuler
Shuster
Simpson
Smith (NE)
Smith (NJ)
Smith (TX)
Southerland
Stearns
Stivers
Stutzman
Sullivan
Terry
Thompson (PA)
Thornberry
Tiberi
Tipton
Turner
Upton
Walberg
Walden
Walsh (IL)
Webster
West
Westmoreland
Whitfield
Wilson (SC)
Wittman
Wolf
Womack
Woodall
Yoder
Young (AK)
Young (FL)
Young (IN)

NOES—181

Ackerman
Andrews
Baca
Baldwin
Barrow
Bass (CA)
Becerra
Berkley
Berman
Bishop (GA)
Bishop (NY)
Blumenauer
Boswell
Brady (PA)
Brown (FL)
Butterfield
Capps
Capuano
Cardoza
Carnahan
Carney
Carson (IN)
Castor (FL)
Chandler
Chu
Cicilline
Clarke (MI)
Clarke (NY)
Clay
Cleaver
Clyburn
Cohen
Connolly (VA)
Conyers
Cooper
Costa
Costello
Courtney
Critz
Crowley
Cuellar
Cummings
Davis (CA)
Davis (IL)
DeFazio
DeGette
DeLauro
Deutch
Dicks
Dingell
Doggett
Donnelly (IN)
Doyle
Edwards
Ellison
Engel
Eshoo
Farr
Fattah
Frank (MA)
Fudge
Garamendi
Gonzalez
Green, Al
Green, Gene
Grijalva
Gutierrez
Hastings (FL)
Heinrich
Higgins
Himes
Hinchey
Hinojosa
Hirono
Holden
Holt
Honda
Hoyer
Inslee
Israel
Jackson (IL)
Jackson Lee (TX)
Johnson (GA)
Johnson, E. B.
Kaptur
Keating
Kildee
Kind
Kucinich
Langevin
Larsen (WA)
Larson (CT)
Lee (CA)
Levin
Lewis (GA)
Lipinski
Loebsack
Lofgren, Zoe
Lowey
Luján
Lynch
Maloney
Markey
Matsui
McCollum
McDermott
McGovern
McIntyre
McNerney
Meeks
Michaud
Miller (NC)
Miller, George
Moore
Moran
Murphy (CT)
Nadler
Napolitano
Neal
Olver
Owens
Pallone
Pascrell
Paul
Payne
Pelosi
Perlmutter
Peters
Peterson
Pingree (ME)
Polis
Price (NC)
Quigley
Rahall
Rangel
Reyes
Richardson
Richmond
Rothman (NJ)
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Schakowsky
Schiff
Schrader
Schwartz
Scott (VA)
Scott, David
Serrano
Sewell
Sherman
Sires
Slaughter
Smith (WA)
Speier
Stark
Sutton
Thompson (CA)
Thompson (MS)
Tierney
Tonko
Towns
Tsongas
Van Hollen
Velázquez
Visclosky
Walz (MN)
Wasserman Schultz
Waters
Watt
Waxman
Weiner
Welch
Wilson (FL)
Woolsey
Wu
Yarmuth

NOT VOTING—12

Braley (IA)
Cantor
Filner
Frelinghuysen
Giffords
Hanabusa
Hastings (WA)
Hensarling
Long
Marchant
McCarthy (NY)
Pastor (AZ)

□ 1440

So the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Stated against:

Mr. FILNER. Mr. Speaker, on rollcall 334, I was away from the Capitol region attending the Civil Rights Freedom Riders' 50th Anniversary Celebration. Had I been present, I would have voted "no."

GENERAL LEAVE

Mr. GUTHRIE. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days to revise and extend their remarks on the legislation and to insert extraneous material on H.R. 1216.

The SPEAKER pro tempore (Mr. BROUN of Georgia). Is there objection to the request of the gentleman from Kentucky?

There was no objection.

REPEALING MANDATORY FUNDING FOR GRADUATE MEDICAL EDUCATION

The SPEAKER pro tempore. Pursuant to House Resolution 269 and rule XVIII, the Chair declares the House in the Committee of the Whole House on the state of the Union for the consideration of the bill, H.R. 1216.

□ 1442

IN THE COMMITTEE OF THE WHOLE

Accordingly, the House resolved itself into the Committee of the Whole House on the state of the Union for the consideration of the bill (H.R. 1216) to amend the Public Health Service Act to convert funding for graduate medical education in qualified teaching health centers from direct appropriations to an authorization of appropriations, with Mr. POE of Texas in the chair.

The Clerk read the title of the bill.

The CHAIR. Pursuant to the rule, the bill is considered read the first time.

The gentleman from Kentucky (Mr. GUTHRIE) and the gentleman from Texas (Mr. GENE GREEN) each will control 30 minutes.

The Chair recognizes the gentleman from Kentucky.

Mr. GUTHRIE. I yield myself such time as I may consume.

Mr. Chairman, I rise today in support of H.R. 1216.

The health care bill that was signed into law last year spent over a trillion dollars and empowered Federal bureaucrats more than it did the American

people. As a member of the Energy and Commerce Committee, I have been working on legislation that takes steps to peel back a few of the many mandatory programs that were instituted in the health care law and limit the Federal Government's unprecedented power.

Section 5508 of the health care law authorizes the Health and Human Services Secretary to award teaching health centers development grants and appropriates $230 million from 2011 through 2015. H.R. 1216 amends the Public Health Service Act to convert funding for graduate medical education in qualified teaching health centers from direct appropriations to an authorization of appropriations.

This bill is not about the merits of graduate medical education or teaching health centers.

Everyone agrees that there is a strong need for more primary care physicians in our health care system, but picking and choosing one program over another to receive automatic funding is irresponsible. Making these programs mandatory spending is unfair to all of the other health care programs that have to compete every year to continue to receive funds.

For example, as HHS Secretary Kathleen Sebelius said during her testimony before the House Energy and Commerce Committee earlier this year, the President's fiscal year 2012 budget eliminates Graduate Medical Education for Children's Hospitals. While children's hospitals must go through the regular appropriations process to fight for funding, teaching health centers will receive automatic appropriations.

We are $14.3 trillion in debt, and our deficit for this year will approach $1.5 trillion. Congress is making difficult decisions about which programs to fund and which to reduce. We must prioritize, and I find it unfair that some programs are completely shielded and do not have to prove their merit to earn continued funding.

I urge my colleagues to vote ''yes.''

I reserve the balance of my time.

Mr. GENE GREEN of Texas. I yield myself such time as I may consume.

Mr. Chairman, I rise today in strong opposition to H.R. 1216, legislation to convert mandatory funding authorized under the Affordable Care Act for Teaching Health Centers to authorized funding.

The Affordable Care Act authorized and appropriated $230 million for a 5-year payment program to support accredited primary care residency training operated by community-based entities, including community-based health centers. This training takes place in community-based settings such as community health centers.

Research shows that CHC-trained physicians, for example, are more than twice as likely as their non-CHC-trained counterparts to work in underserved areas, ensuring that that kind of training takes place, which is what mandatory spending support for programs does. It will help strengthen the primary care workforce in underserved areas, particularly in areas that struggle to recruit and retain a sufficient workforce.

The Teaching Health Center program supports the training of individuals who will practice family medicine, internal medicine, pediatrics, internal medicine pediatrics, obstetrics and gynecology, psychiatry, general dentistry, pediatric dentistry, and geriatrics—those disciplines where we're experiencing significant physician shortages.

It's hypocritical for my Republican colleagues to take away this funding. They continue to argue that there are not enough physicians to provide care to people who need them in primary care services. This program is designed to help address this very problem. But they keep trying to have it both ways in health reform debate, and this is just another example.

Today, the majority is going to say they have an obligation to ensure this program is subject to the appropriations process due to the need for transparency in our spending process and current budget process. Let me remind the majority that we're not the only party who's directed mandatory funding for programs. The majority must have certainly supported autopilot spending, as Representative FOXX described the Teaching Health Center program earlier this afternoon, when they passed the Medicare Modernization Act of 2003, which required mandatory funding for transitional programs. I suppose at that time, the majority certainly felt they knew better than the appropriators that the MMA was a worthy program and deserved mandatory funding, even though they passed it under the cover of night with a lot of arm-twisting.

I can't understand the opposition, particularly from my Republican colleagues. They repeatedly and inaccurately complain that we don't do enough to promote health workforce expansions, and now they're going to cut funding for the health workforce expansion.

Turning the Health Center program into a discretionary one will make it challenging for these 11 programs that have already made the decision to participate in consultation with key stakeholders, like teaching hospitals and their boards, and based on the expectation that continued funding will be available. Converting this program to discretionary funding will also deter other entities from making the business decision necessary to expand residency training, since funding over the next few years could be subject to the annual appropriations fight.

This is yet another political stunt by the majority to attempt to defund health reform—this, through their playing games with funds dedicated to ensure that we have physicians in our country.

Several weeks ago, they couldn't stop talking about how Medicaid will be greatly improved with the Ryan budget because it provides States with block grants to run their Medicaid programs. How great would it be to eliminate Medicare by giving seniors vouchers to purchase health insurance? And this week, we're busy taking away funds to ensure that we train enough physicians to ensure all Americans have access to affordable care. Once again, the majority has their own priorities.

Mr. Chairman, I reserve the balance of my time.

Mr. GUTHRIE. Mr. Chairman, I yield 2 minutes to the gentleman from Pennsylvania (Mr. PITTS), the chairman of the subcommittee.

□ 1450

Mr. PITTS. I would like to thank the gentleman from Kentucky for his leadership on this issue.

Section 5508 of PPACA authorizes the Secretary to award grants to teaching health centers to establish newly accredited or expanded primary care residency training programs. The new health care law, PPACA, provides a mandatory appropriation of $230 million for this purpose for the period from FY 2011 through FY 2015.

You may recall that in the President's fiscal year 2012 budget, he eliminated funding for training at children's hospitals. Because of this, I and the ranking member of the Health Subcommittee, the gentleman from New Jersey (Mr. PALLONE) have introduced H.R. 1852, a bill to reauthorize the Children's Hospitals Graduate Medical Education program for an additional 5 years at the current funding levels.

While the administration couldn't find money in its budget for training at children's hospitals, PPACA somehow was able to provide a direct mandatory appropriation of $230 million for other teaching health centers, with no further action, input, or approval required by Congress. And PPACA did this with a number of funds, mandatory appropriations.

The bill before us today, H.R. 1216, simply converts PPACA's mandatory appropriations to an authorization, subject to the annual appropriations process, just like the Children's Hospital GME program, making it discretionary. Passage of the bill will also save $215 million over 5 years.

I urge support of the bill.

Mr. GENE GREEN of Texas. Mr. Chairman, I yield 2 minutes to my colleague from the Energy and Commerce Committee, the gentlewoman from California (Mrs. CAPPS).

Mrs. CAPPS. I thank my colleague for yielding.

Mr. Chairman, I rise in strong opposition to this reckless bill. I cannot count the number of times Members on both sides of this aisle have decried shortages in the primary care workforce of our communities, and working, often in a bipartisan manner, to develop ways to increase the primary

care ranks. Yet today, the next victim in the Republican obsession with repealing the Affordable Care Act is a program that does deal with these shortages. It increases our primary care physician ranks, and trains them with special expertise in serving the community.

The bill before us would defund this program, taking many qualified Americans out of the primary care workforce before they even have an opportunity to join it. Moreover, cutting these training programs would also affect already existing jobs at the 11 community-based entities that have already expanded their programs to train these new doctors. Taking away this funding will force possible layoffs and have a chilling effect on other sites developing this type of program.

Yes, it is paid for through mandatory funding. But that is not unheard of or even unusual. In fact, the federally funded Graduate Medical Education program, which has had measured success in strengthening our health care workforce, is a mandatory spending program. The program the Republicans are trying to cut today is simply a complement to this GME program, focused on community-based care and prevention.

The choice on H.R. 1216 is clear: if you believe that we do not have a jobs problem and that we have all the doctors we will ever need, then go ahead and vote for this bill. But if you believe that we need to create good jobs and the professionals to fill them, that we need more primary care providers, you must vote against H.R. 1216 and protect this very important program. We can't have it both ways.

I urge a ''no'' vote.

Mr. GUTHRIE. Mr. Chairman, I yield 4 minutes to my friend from Tennessee (Mrs. BLACKBURN).

Mrs. BLACKBURN. I thank the gentleman from Kentucky for his leadership on this bill.

Mr. Chairman, it is so interesting to me. We had a 2,700-page health care bill that basically was a government takeover of health care. What we have heard from so many people in this country is gosh, you know, I wish somebody would have read that bill before they passed it. And the former Speaker said we need to pass the bill, and then we can read it and find out what is in it.

One of the things that many of the people did not like that was in that bill was many of these mandatory provisions that were put in place, programs that had been on the books for years that were discretionary programs that all of a sudden became mandatory. And the confusing thing, Mr. Chairman, is there didn't seem to be any consistency. As the subcommittee chairman who spoke before me had said, Mr. PITTS had said, you know, you don't tend to children's hospitals in the same way, you don't tend to nurses and technicians in the same way. But here was this conversion from discretionary to mandatory for teaching hospitals, a total of $230 million, over $40 million a year.

Now, it doesn't matter if you need the money or not. It doesn't matter if you know exactly where you are going to use it or not. The money is going to be appropriated. It's put on autopilot. Doesn't matter what we say is going to happen with the government, if we need to reduce it. They're going to get that money. That is why this bill is so important.

You will notice, Mr. Chairman, that 2,700-page bill, we are able to delete $230 million of that appropriation, mandatory appropriation with a bill that basically is about 2 pages long. What we do in this 2 pages is responsibly address what the American people want to see us address. They know that the Federal mandates are costing private sector jobs. They know that the Federal Government coming in and taking over health care is costing private sector health care jobs. Indeed, we have study after study that is saying we have already lost over a million jobs.

It seems like every time we turn around, whether it is our health care delivery systems, whether it is our hospitals, whether it is our physicians' offices, we are hearing about the loss of jobs to health care providers and in the health care sector because of the passage of PPACA, or ObamaCare, as many people in our country refer to the bill.

One of the reasons we have to go about repealing these slush funds, Mr. Chairman, is because we simply can't afford this. Every second of every day, every single second of every single day we are borrowing $40,000. We are borrowing 41 cents of every single dollar that we spend. This government is so overspent, we are spending money we don't have for programs that our constituents don't want. And instead of eliminating, what we are saying is, look, let's eliminate a mandatory program and turn it back to what it was for years, discretionary, so that Members of this body bring their discretion to bear on the issues of the day and bring the opinions of their constituents to bear on how this Chamber spends the taxpayers' money.

Mr. Chairman, it is not Federal money; it is the taxpayers' money. This government is overspent. We cannot afford all these Federal mandates. It is time to move these programs back to the discretion of this Chamber.

Mr. GENE GREEN of Texas. Mr. Chairman, I gladly yield 3 minutes to our ranking member of the full Energy and Commerce Committee, the gentleman from California (Mr. WAXMAN).

Mr. WAXMAN. Mr. Chairman, there was so much misinformation just given out by the previous speaker that it's hard to know where to start. The Republicans have said they don't like the Affordable Care Act. But what do they have to replace it with? They said they're going to repeal it and replace it. What are they going to do about the uninsured in this country, about the high cost of health care, about the people who can't even buy insurance even if they have the money because they have preexisting medical conditions?

We have had no proposal from the Republicans, except in their budget they want to take Medicare away from future seniors by making it a block grant. And they want to cut the Medicaid program, which cuts a big hole in the safety net for the poor to get their health care needs, which means people in nursing homes would be dumped out of those nursing homes.

□ 1500

But the bill before us now is to stop the program that would train primary care physicians. Does anybody disagree with the notion that we need more primary care physicians? Evidently, the Republicans do because as we heard from the last speaker, she wants to make it an appropriated program, not a mandatory spending program.

Well, it's been in the mandatory program in spending in Medicare and Medicaid since 1965. Training physicians should be supported with assured funding that we could rely on. We can't train a doctor in just 1 year. Doctors need a number of years where they are going to be assured of their continuation in medical schools, and that's why we have had a short funding through Medicare and Medicaid. And in the The Affordable Care Act, the purpose was to train physicians for primary care in community settings.

That's what the Republicans want to repeal. And if they can afford it from one year to the next, they will put in funds; but if they can't and their mood is to give another tax break to the wealthy, we won't be able to afford it. With all the costs to go to medical school and all the loans that are required, we ought to ensure spending for primary care doctors.

I urge my colleagues to oppose this bill. It's incomprehensible to me why we even have it on the House floor. It's another one of those efforts that Republicans have been putting up to chip away at health care reform. They want to repeal it, they want to chip away at it, but we don't even know what they want to replace it with.

And the American people and our constituents are entitled to know, are they just going to leave people on their own without the ability to buy health insurance because of preexisting conditions? Are they going to tell the elderly they are on their own and see who they want to insure them?

I urge a ''no'' vote on this bill.

Mr. GUTHRIE. Mr. Chairman, I yield myself such time as I may consume.

First there were a number of amendments, I think over 100 amendments, to the health care bill that were offered by the Republicans. An alternative was offered by the Republicans as voted on as we went forward.

Block grants, several Governors have come to Washington and talked about

block granting Medicaid to give them the opportunity to not just deal with Medicaid in their States but there was the other part of their budget.

But I can tell in Kentucky, because I used to be a member of the State legislature, as Medicaid has continued to consume more of the State budget, it becomes more difficult to adequately fund. Higher education tuition rates are going up directly because of the pie of Medicaid that's moving forward.

We passed medical liability reform, which saves the Federal Government $54 billion, as estimated by the Congressional Budget Office. We are going to have the bill tomorrow to purchase health insurance across State lines to make health insurance more affordable instead of more expensive on those who spend money out of their own pocket, as we have seen the estimates for the health care bill.

Now, the one thing about relying on funding for 1 year, we do appropriations for everything from defense to other things on an annual basis. And I will tell you there are not people turning down Federal money because you are only appropriating it for 1 year, we don't want to commit to a long-term program.

But if you buy that argument, you look at what's in the bill. All we are saying is we want the teaching health centers to be treated equally to other parts of the bill. So if the argument is if you don't do it automatically, you are not going to have anybody participating in the program, which I think is what I just heard, then it means training in general in pediatric and public health dentistry, section 5303, is an annual appropriation; geriatric education and training, mental and behavioral health education training; nurse retention, section 5309; section 5316, family nurse practitioner training; section 2821, epidemiology laboratory capacity grants; research and treatment for pain care management, 4305; section 775 investment in tomorrow's pediatric health care workforce.

I mean, obviously, the argument that was made was if we don't have the teaching health centers on a 5-year automatic appropriation, then people aren't going to participate in the program. That argument would have to apply to these directly. And I guarantee you, I would be willing to say, without fear of contradiction, that people will be applying for these programs as this moves forward.

I reserve the balance of my time.

Mr. GENE GREEN of Texas. Mr. Chairman, I yield 2 minutes to a classmate and also the vice chair of our Democratic Caucus, the gentleman from California (Mr. BECERRA).

Mr. BECERRA. I thank the gentleman from Texas for yielding me the time.

Mr. Chairman, to put everything in perspective, we are told by the American Academy of Family Physicians that today, today we can foresee a shortage of some 40,000 primary care physicians in this country in less than 10 years. Within another 5 years, that shortage will grow to about 42,000 to 46,000 primary care physicians.

Graduate medical education funds does something very simple. It says to some of these clinics, some of these health care providers, that if you guarantee that you will make graduate medical training available to our future doctors, then we will guarantee that there will be money behind that training so that there will be a consistency so that medical students can finish training.

Well, we just heard that this money that's available to these health care providers, these clinics, should no longer be guaranteed. And so the question you have to ask, if you want to become a physician and you are going to medical training, and certainly the question you have to ask if you are one of these clinics throughout the entire country where you want to train someone to be a family medical doctor, an internist, a pediatrician, an obstetrician/gynecologist, a psychiatrist, a dentist, a pediatric dentist, someone who specializes in gerontology, you have to ask yourself, if I am going to try to train someone, but I don't have the resources to fully provide the education, how do I guarantee that medical student that I could be there with the funds to pay them for education, to pay them for the work they are going to be doing? You can't. And that's why GME is so important.

But we were just told a second ago that this is a slush fund pot of money. Furthest thing from the truth. We are told the real truth, when we heard one of the speakers on the Republican side say we are going to delete this money—that's exactly what's going to happen, because if you don't guarantee it, it's gone.

So, Mr. Chairman, the truth is we have to make sure we can train the next generation of medical leaders; and, therefore, I urge my colleagues to vote against this legislation.

Mr. GUTHRIE. Mr. Chairman, I yield myself 1 minute.

The merits of having training in general in pediatric and public health dentistry, I agree that we have to have that training. The issue here is if you do it in a teaching health center, then you guarantee funding for 5 years. If you do it in a children's hospital, if you do it in a regular hospital, profit or nonprofit, then you are subject to the annual appropriations.

Someone came before our committee to testify, a State Senator from New Jersey, said we need this provision because we need more nurses.

I will agree with that. However, this provision doesn't cover nurses. If you are going through a nurse training program, it's authorized in the bill, and you go through an annual appropriations process.

All we are saying here is that we should treat graduate medical education at children's hospitals, hospitals and teaching health centers exactly the same and not give one an advantage over the other two.

I reserve the balance of my time.

Mr. GENE GREEN of Texas. Mr. Chairman, I yield myself 15 seconds.

I will be glad to cosponsor the bill to make it mandatory funding for children's hospitals. I think if health care is a priority, we ought to do that.

I reserve the balance of my time.

Mr. GUTHRIE. Mr. Chairman, I have no further requests for time, and I reserve the balance of my time.

Mr. GENE GREEN of Texas. Mr. Chairman, how much time remains on each side?

The CHAIR. The gentleman from Texas has 19¼ minutes remaining, and the gentleman from Kentucky has 18½ minutes remaining.

Mr. GENE GREEN of Texas. I yield myself such time as I may consume.

When Congress dealt with The Affordable Care Act last year and the year before, our subcommittee on Energy and Commerce spent exhaustive hearings, late-night hearings, we had markups overnight, and so we knew what we were doing. We knew we were going to make a priority in providing primary care for our country.

That's why it's mandatory spending. I would assume in 2003, when we passed the provision for the prescription drug act for Medicare, my Republican colleagues did the same thing at the time in the majority: they wanted to make sure that that was mandatory spending.

□ 1510

And here we are today trying to take away mandatory spending from primary care physicians in community-based settings. I have a great example of this in our own district, and I know the chairman knows this.

We have a community-based health center in Denver Harbor in east Harris County. They have had a partnership with the Baylor College of Medicine for a number of years, and what they have been able to do is provide those residencies to come out to a nonwealthy area of town so those doctors can learn that they can make a living serving folks that are not wealthy. That's what this is all about. We found out that the statistics showed that if they do their residency through a community-based health center, they will actually be more likely to come back and serve those communities. And that's why there needs to be mandatory spending, Mr. Chairman.

I reserve the balance of my time.

Mr. GUTHRIE. Mr. Chairman, I yield 2 minutes to the gentleman from California (Mr. BILBRAY).

Mr. BILBRAY. Mr. Chairman, I wasn't planning on addressing this item, but I heard so many of my colleagues, especially those on the other side, talk about the crisis of providing the doctors that are going to be essential for health care, and finally we are talking about health care, not health care insurance.

As somebody who spent 10 years supervising the safety net for a community of 3 million in San Diego County, I just wish my colleagues on the other side, when they're worried about pediatricians and primary health care people, would understand that if you really want to protect those providers, why don't we sit down and talk about true tort reform, especially for the pediatricians. This is a cost that is bearing down. And when you're asking young people to get an education to be a primary health care provider, especially a pediatrician, explain to them why somebody on public assistance, on welfare, has more right to sue their physician than those men and women who are serving in uniform.

The fact is there is no way that we should be sitting up here saying that we really want the next generation to get into health care unless we're willing to tell our friends who are the trial lawyers that we're going to take the physicians off the counter; we're not going to allow lawsuits to be part of the overhead that is driving people out of the health care business.

And I hope to say to both sides, if you really want to make sure there are future doctors, then let's have the bravery to stand up today and do something about the tort that those future doctors are looking at before they go into school.

Mr. GENE GREEN of Texas. Mr. Chairman, I yield myself as much time as I may consume.

My colleague from California must have this bill confused with medical malpractice. In fact, the State of California and the State of Texas already have medical malpractice reform. That's not what this bill is about. This bill is about training primary care physicians to be able to serve everyone. I want them to serve the military. I want them to serve our veterans.

In fact, again, I have a VA hospital in Houston that has a cooperative arrangement with the Baylor College of Medicine for a residency program. That's great. I want them also to be able to do that in their clinics. But I also want it for community-based health centers. And our statistics show us that if we have that example and it's mandatory spending that they make these agreements, that those folks will come back. They may go back to a military clinic, they may come back to a community-based health center, or they may come back and open up their practice in an area that's not the wealthiest part of town. That's why this mandatory legislation is so important.

If you put a priority on making sure our constituents can go see a doctor, I can't imagine repealing this—voting for this bill.

I reserve the balance of my time.

Mr. GUTHRIE. Mr. Chairman, I yield an additional 2 minutes to the gentleman from California (Mr. BILBRAY).

Mr. BILBRAY. Mr. Chairman, I want the gentleman from Texas to understand that when a physician or a student is planning on getting into a field, they not only look at will the government guarantee that I'll be able to get the tuition, but they're looking at what field am I moving into. And let me just tell you, as a fact, in California, even with our tort reform, somebody who wants to volunteer as a Medicaid volunteer has to file an $80,000 or $90,000 insurance policy just for volunteering.

So when the gentleman talks about the educational side, that it's essential that we encourage people to get into the field, my point for being here is you cannot talk about the educational when you ignore the environment that you're asking them to go into. And the fact is: What parent would ask somebody to go into this field and be a physician with all the education and all the expenses when they can tell their kids to be a lawyer and sue those physicians for every cent they have ever been able to earn?

That's why we've got to talk about both of these together. But you can't stand up and say we want these essential services but not be willing to get the trial lawyers off the backs of these physicians so they can provide those essential services.

Mr. GENE GREEN of Texas. Will the gentleman yield?

Mr. BILBRAY. I will yield to the gentleman.

Mr. GENE GREEN of Texas. I thank the gentleman for yielding.

Again, this is not a medical malpractice bill, but I would be glad to offer you to be a cosponsor. We passed the bill out of this House twice and sent it to the Senate which would allow volunteers to go into community-based health centers and be covered under the Federal Tort Claims Act. Congressman MURPHY from Pennsylvania is a lead sponsor of this Congress. I've been the lead sponsor when Democrats have been in control because we need to do that. If I could do it under this bill, I would do it. But this came out of your conference that you want to repeal mandatory spending to try and train primary care doctors to serve in primary care clinics or whatever.

Mr. BILBRAY. Reclaiming my time, look, the fact is these physicians are being held with a liability that is inappropriate, way over the head, and it is not justifiable——

The Acting CHAIR (Mr. FORTENBERRY). The time of the gentleman has expired.

Mr. GUTHRIE. I yield the gentleman 1 additional minute.

Mr. BILBRAY. We're talking about the fact that those who want to stand up and say we'll spend Federal funds to create an environment to provide health care but then are not willing to say, not just the fact that we find special tort coverage—and I know that the gentleman from Texas knows because I was at a county level providing those services. We have Federal programs that protect those in the community clinic. But we're not just talking about the little bit of protection we get with our Federal protection. We're talking about the whole tort exposure needs to be considered.

And if you want to talk about access and stand up here and have the moral high ground on access, you've got to be willing to take on the big guy, the powerful trial lawyers, and say, look, physicians are going to be held harmless from your lawsuits. We're going to find a reason to encourage young people to go to school not just by providing Federal subsidies to their tuition, but also telling them, once you get your degree, you'll be able to go into a field where you'll be able to practice your art of medicine without having somebody who has never had to make a life-and-death decision drag you before a judge and a jury and attack you for your decisions.

Mr. GENE GREEN of Texas. Mr. Chairman, my colleague from California again is confused. We have H.R. 5 that the majority has to federalize medical malpractice insurance in our country. Some States have taken care of it. The State of Texas has done it by constitutional amendment. And that debate may come up if the majority brings up their H.R. 5.

With that, Mr. Chairman, I yield 2 minutes to my colleague from New York, Congressman TONKO.

Mr. TONKO. Mr. Chair, the underlying legislation guts funding for vital teaching health centers across the country. Teaching health centers are residency programs for primary care physicians. They provide community-based training for doctors who will go on to work in rural and our underserved areas.

Mr. Chair, my amendment is very simple. It requires that we find out exactly how many primary care physicians we will lose if Republicans succeed in cutting teaching health centers across the country. My amendment commissions the Government Accountability Office to report on these findings so that the American people can see how drastically these cuts will eliminate jobs and hurt the quality, access, and affordability of primary care health options.

I'm interested to know, Mr. Chair, if some of my Republican colleagues are aware that if H.R. 1216 is adopted, there will be fewer primary care doctors working in their communities. For example, this bill guts funding for 23 physicians at the teaching health center in the heart of Scranton, Pennsylvania. These 23 individuals are being trained to provide basic health care for constituents in the greater Scranton area. If my Republican colleague from the Scranton area joins the Republican leadership in eliminating this program, his community will lose training for 23 new primary care physicians. That's 23 jobs, jobs that they support, and 23 individuals who help serve constituents with their health care needs.

Again, Mr. Chair, my amendment is a matter of effective oversight. It asks that we find out from a nonpartisan source exactly how many primary care physicians we will lose if the Republican leadership moves forward to cut teaching health centers across the country.

Mr. GUTHRIE. Mr. Chair, I yield myself as much time as I may consume.

I want to point out, as we went through, what we're talking about doing is graduate medical education in teaching health centers will be identical to the graduate medical education in hospitals and children's hospitals.

And I remember, I was not on the Energy and Commerce Committee but in Education and Labor. We worked on the health care bill. And the description that we went in through the night and went through the bill line by line is absolutely true. I think we were 24 or 25 hours direct on that. And I wasn't on Energy and Commerce when you went, but they went through the night, as well, Mr. Chairman. And when this bill passed out of the House of Representatives, the teaching health centers were authorized subject to appropriation.

□ 1520

The change was made in the Senate. So working late into the night and going through the bill, we are just asking and what we are proposing is to treat teaching health centers as the House-passed version of the health care bill did, which is exactly the same as hospitals and children's hospitals and many of the other programs, nurse training and other things as well.

I reserve the balance of my time.

Mr. GENE GREEN of Texas. Mr. Chairman, I yield myself such time as I may consume.

I have no problem with including children's hospitals , and I think we could probably pass it on the suspension calendar if we had legislation that would expand that mandatory funding for teaching hospitals, and particularly children's hospitals, but that is not what this legislation does today. It takes away that help we are providing to train more primary care physicians in our country. That is what this bill does: It takes away the mandatory funding.

Now there have been examples all through history of mandatory funding. We realized during the Affordable Care Act that we need more primary care physicians. We need a lot more health care providers. We need more nurses. We need everything. In fact, it is a great job growth area. But we know we need primary health care providers because we know when somebody needs a doctor, they will see that primary care doctor. They may need a specialist, but they still need to go to that primary care doctor. That is why this mandatory funding is so important, and that is why this bill is the wrong way to deal with it. That is why it shouldn't be considered today. I would hope everybody would realize that if you support health care and primary care physicians, you would want that mandatory training so we can get those physicians out in the community where they are really needed.

Numbers show that if we have a program like this where primary care physicians will go into a community based health care center, they will go into that area as part of their residency program, they are more likely to come back to that community. That is why that was part of the Health Care Act. We have people who their primary care physicians now are the emergency rooms in hospitals in my district. I would much rather they be able to go see a doctor down the street for their sinus infection than showing up at midnight in an emergency room where we are going to end up having to pay for it, even at a public hospital, where the local taxpayers are paying for it. That is why this mandatory spending is so important. And that is why I think it is so the wrong way to go in health care, to take away mandatory spending for primary care physicians. That is something that is so important in our country, it should be mandatory.

I reserve the balance of my time.

Mr. GUTHRIE. Mr. Chairman, I want to point out again, the mandatory spending was not in the House version of the health care bill that was passed. Teaching health centers were treated exactly like general pediatric and primary care physicians are in hospital settings and in children's hospital settings—general hospitals and children's hospitals. We are saying we are going back to the way it was established in the Affordable Care Act as it was passed out of the House of Representatives.

We are talking about primary care physicians as well. I agree we need more primary care physicians. Their training at children's hospitals and hospitals is in geriatric, pediatric, internal medicine, all the primary care physician specialties that we know. We are just saying one shouldn't be treated differently than the other. They are important, and we should go through the annual appropriations process and present the validity of programs and let the appropriations process determine the level of funding.

Mr. Chairman, I yield 4 minutes to the gentleman from Georgia (Mr. GINGREY).

Mr. GINGREY of Georgia. I thank the gentleman from Kentucky for yielding me this time.

As everyone knows, the financial health of this Nation is in a very precarious State. Unfortunately, it was made worse by the spending decisions and actions of this last Congress. Today, the Federal Government borrows 41 cents of every dollar it spends. We are facing a $1.6 trillion deficit for this fiscal year, the third straight year of trillion-dollar deficits, an all-time record in nominal terms and a new post-World War II record as a share of the economy.

The reckless spending of the last Congress has only exacerbated this problem. The so-called stimulus bill—that didn't stimulate much besides a lot of wasteful spending—and ObamaCare, the Patient Protection and I think un-Affordable Care Act, are two such examples of legislation that spent recklessly.

Mr. Chairman, among the 2,400 pages of ObamaCare, the last Congress created $105 billion in secret slush funds that can be used to advance the political goals of President Obama and his administration without our oversight, congressional oversight.

At a time when our country is facing financial ruin, my concern is how much damage to our national budget the White House can do with these funding streams. The time for blank checks is over. The time for leadership is now.

Section 5508 of ObamaCare provides a $230 million direct appropriation for teaching health centers residency programs. H.R. 1216 would simply convert the direct appropriations into an authorization of appropriations. The legislation allows for teaching health centers to receive funding through the normal appropriations process with proper Congressional oversight.

Mr. Chairman, many Members of this Congress have supported medical education—I certainly count myself among them—including graduate medical education for children's hospital programs. However, in her testimony before the House Energy and Commerce Health Subcommittee earlier this year, HHS Secretary Sebelius stated that the President's fiscal year 2012 budget eliminates children's hospital graduate medical education programs because they duplicate the teaching center funds in ObamaCare.

Mr. Chairman, is this the future of medical education that we want for our children? Teaching our medical professionals in clinics that might not be equipped to properly train them to handle emergency situations versus in hospitals regarded as centers of excellence like Children's Healthcare of Atlanta in my own home State of Georgia. This is why the appropriations process is so important—we need congressional oversight to help decide what the priorities of tomorrow should be.

This Congress, the 112th Congress—is focused on reining in spending and reducing our deficit. We cannot do the job of the American people and make the spending cuts necessary unless the legislative branch has oversight over Federal spending. If this is truly the people's House, give back what the last Congress gave away—control over the budget. If this body is sincere in its wishes to restore fiscal sanity in this country, I see no reason why this body should not be voting in a bipartisan manner to prevent this President—or any President, for that matter—from spending our Nation into insolvency.

So I urge all of my colleagues to support H.R. 1216. I thank the gentleman from Kentucky for his bill and for yielding me this time.

Mr. GENE GREEN of Texas. Mr. Chairman, I yield myself such time as I may consume.

Let me correct some of the statements that have been made. We have had mandatory hospital training residency programs since 1965. By taking away direct or mandatory spending for community-based residency programs, it is a direct attack on community-based programs. Let me list for you the teaching hospital programs that are under mandatory that was part of the Affordable Care Act. I joked on the floor one night to my colleague from Georgia, I wish they would name it the Green Act, GreenCare instead of ObamaCare, because I am so proud of that law.

The teaching hospital program supports the training of individuals who practice in family medicine, internal medicine, pediatrics, internal medicine pediatrics, obstetrics, gynecology, psychiatry, general dentistry, pediatric dentistry, or geriatrics. These are disciplines where we are experiencing significant physician shortages. That is why we need the mandatory spending. It does cover children.

□ 1530

Now, we have had mandatory spending for hospital training, again, since 1965. All this bill would do would be to take it away from community-based health centers where we know there is a shortage. The statistics show, if you have doctors who do their residencies or residency programs through community-based centers, they are more likely to go back there and practice, whether they be pediatricians, whether they be in family practice, whether they be in internal medicine. That's where we need the growth and to have primary care physicians. This is a direct attack on health care in our own country.

Why wouldn't we want it mandatory for community-based facilities if it's already mandatory for hospital-trained physicians? We need physicians in the community, not just in the hospitals.

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

Mr. GUTHRIE. Again, Mr. Chairman, it is important that we have an adequate supply of primary care physicians, and it is important public policy for this country. It is important that we also have oversight and control over the budget in the way the money is spent, and we do that through the appropriations process.

I just want to point out, in the last Congress, there was great effort in putting together the health care bill. When we passed out of this Congress the House-passed version, this was an authorized ''subject to appropriations'' section of the bill. I know it has been described as being against health care throughout the country, but that was the way, through much debate, it passed out of this House of Representatives. It treats it similarly to hospital-based education in primary care and to children's hospital-based. It puts it on an equal footing with nurses' programs, nurse practitioner programs and other programs, which we all agree have shortages. We need more people in those fields.

I just want to reiterate that this does not eliminate the program. It authorizes it. It changes it from a direct appropriation to an authorized appropriation through the regular appropriations process.

Mr. DINGELL. Mr. Chair, I rise today in strong opposition to H.R. 1216. As a declining number of physicians in our Nation are entering into primary care fields, my colleagues on the other side of the aisle are working to pass legislation that will irresponsibly impede critical training of the next generation of primary care physicians.

A primary care physician shortage is a very real and alarming problem looming before us. The Association of American Medical College's Center for Workforce Studies anticipates a shortage of 45,000 primary care physicians and a shortage of 46,000 surgeons and medical specialists in the next decade.

Since 1965, the Medicare Graduate Medical Education program, which has been supported by mandatory funding, has trained the majority of resident trainees across the country in a hospital-based setting. The Teaching Health Center program is the first medical graduate program of its kind to allow future physicians in primary care fields to train in the actual setting they will be practicing in—community-based health centers.

My colleagues claim that converting the Teaching Health Center program from a mandatory appropriation to an authorization—subject to the annual appropriations process—will not endanger the program. We saw during the debate on the fiscal year 2011 budget that could not be further from the truth.

During that dreadful debate it became painstakingly clear that my colleagues know the cost of everything, but the value of nothing.

Subjecting this program to the annual appropriations process will not allow for a predictable and stable funding stream needed to assist community-based health centers and resident trainees in planning and preparing for this training.

We all recognize and agree with the need to reduce federal government spending, but making the Teaching Health Center program a pawn in the appropriations game is foolish at best.

Further, I find it ironic that during debate in the Energy and Commerce Committee my colleagues expounded on their desires for more investment in our health workforce, yet at the first opportunity they are placing the Teaching Health Center program in the vulnerable position of future funding reductions.

Mr. Chair, H.R. 1216 is another plan in the Republicans' repeal health reform platform. Passing this legislation will jeopardize funding for the Teaching Health Center program, further delaying the fundamental training needed for our primary care physicians.

I urge my colleagues to stand up for the training of our primary care physicians and vote no against this reckless piece of legislation.

Mrs. CHRISTENSEN. Mr. Chair, I rise today, fully disappointed that my colleagues on the other side of the aisle are trying to move forward with this bill. This bill has no merit; in fact, it is little more than a part of a larger, ill-conceived strategy to undermine the progress we have made and will likely continue to make as a result of the historic health care reform bill that was enacted last year.

While on its face it seems harmless, we all know the reality of what this bill will do. And, it is crucial that the very individuals who elected us to represent them—the large majority of whom will be directly and indirectly affected by this and in a very negative way—also know that this bill does nothing to ensure fiscal responsibility or improve the medical education system in health centers, and does even less to ensure that there are trained and qualified health care providers in their communities to serve their communities.

In fact, it jeopardizes ongoing and forthcoming efforts to ensure that there are highly-trained and qualified health care providers practicing in every community—especially those that suffer due to a shortage of health care providers—across the country.

If this bill were to pass and become law, then the already-planned primary care training programs that will be operated by community-based entities, like community health centers, will not likely continue beyond their first planned year because turning this program into a discretionary one offers no guarantee of future funding. Further, making this program discretionary will serve as a disincentive to other community-based entities that are considering launching similar graduate medical education programs for the same reasons.

The unfortunate element in all of this is this: These programs train individuals who will practice in family medicine, internal medicine, pediatrics, obstetrics and gynecology, general dentistry and geriatrics—the very areas of medical care where the provider shortages are the greatest.

Further, the individuals trained by these programs are very likely to serve most underserved communities—a disproportionate number of which are rural, low-income and/or racial and ethnic minority—across the Nation.

Why, I must ask, would we want to end these programs, when provider shortages are not issues that affect only our side of the aisle; it is a public health crisis that touches every district across the Nation. In fact, during the health care reform debates, my friends on the other side of the aisle continually argued that there are not enough physicians in the country to meet our current primary health care needs and to address our current primary health care challenges. So, it seems counterintuitive to, then, seek to compromise and put an end to the very programs that were designed and funded to address this very problem.

We have had and continue to have very serious health care challenges in this country, and our primary care workforce shortages fall into that category. All of these serious health care challenges warrant even more serious solutions—many of which are being implemented thanks to the Patient Protection and Affordable Care Act.

However, this bill—H.R. 1216—is not a serious solution and, if passed, will only become a serious part of a serious problem.

I, therefore, urge my colleagues to vote, ''no'' on this bill. And, in doing so, you will be voting yes for the improved and strengthened primary health care workforce across the Nation.

Mr. BLUMENAUER. Mr. Chair, I rise in opposition to H.R. 1216, which rescinds funding for graduate medical education in qualified teaching health centers. The Affordable Care Act provides funding for the training of medical residents in qualifying health centers, which will strengthen the health care workforce and support an increased number of primary care medical residents trained in community-based settings across the country. This bill undermines that key objective and in so doing, undermines public health efforts, limits access to doctors in communities around the country, and weakens our medical workforce.

Teaching health centers are community-based patient care centers that operate primary care residency programs, such as family medicine, internal medicine, pediatrics, and general and pediatric dentistry. Physicians trained in health centers are more than three times as likely to work in a health center and more than twice as likely to work in an underserved area than are those not trained at health centers.

Oregon's community health centers—29 clinics offer care at more than 150 delivery sites—provide high-quality, comprehensive health care to more than a quarter-million people across my state. Services range from medical and dental care to prescription medications to behavioral health care. Many centers also provide such support services as transportation and translation to ensure that everyone who needs healthcare can access it. This legislation, however, would undermine the ability of these centers to attract doctors and other health professionals so vital to providing community-based care.

The Institute of Medicine reports that already there is a need for more than 16,000 new physicians in currently underserved areas. Unless we invest in medical education that closes this shortfall, it will worsen in future years. The Association of American Medical Colleges estimates that, by 2024, we will need 46,000 additional primary care physicians. This legislation makes it more difficult to close this gap.

A recent study by Dartmouth investigators published in the Journal of the American Medical Association found that beneficiaries living in areas with better access to primary care physicians had lower mortality and fewer hospitalizations. By eliminating funding to train doctors in community-based settings, this legislation makes it less likely that patients in underserved areas will be able to see a doctor or to get the care that they need. This legislation will worsen health outcomes in underserved areas.

Rather than making refinements to improve the Affordable Care Act, H.R. 1216 merely eliminates funding. It fails to advance the key objectives of the law to improve healthcare while lowering costs and it fails to offer alternative solutions to meet these important objectives. I oppose this legislation.

Mr. GUTHRIE. I yield back the balance of my time.

The Acting CHAIR. All time for general debate has expired.

Pursuant to the rule, the bill shall be considered read for amendment under the 5-minute rule.

The text of the bill is as follows:

H.R. 1216

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. CONVERTING FUNDING FOR GRADUATE MEDICAL EDUCATION IN QUALIFIED TEACHING HEALTH CENTERS FROM DIRECT APPROPRIATIONS TO AN AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—Section 340H of the Public Health Service Act (42 U.S.C. 256h), as added by section 5508(c) of the Patient Protection and Affordable Care Act (Public Law 111–148), is amended—

(1) in subsection (b)(2)(A), by striking ''under subsection (g)'' each place it appears and inserting ''pursuant to subsection (g)'';

(2) in subsection (d)(2)(B), by striking ''in subsection (g)'' and inserting ''pursuant to subsection (g)''; and

(3) by amending subsection (g) to read as follows:

''(g) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $46,000,000 for each of fiscal years 2012 through 2015.''.

(b) RESCISSION OF UNOBLIGATED FUNDS.—Of the amounts made available by such section 340H (42 U.S.C. 256h), the unobligated balance is rescinded.

(c) TECHNICAL CORRECTION.—The second subpart XI of part D of title III of the Public Health Service Act (42 U.S.C. 256i), as added by section 10333 of the Patient Protection and Affordable Care Act (Public Law 111–148), is amended—

(1) by redesignating subpart XI as subpart XII; and

(2) by redesignating section 340H of the Public Health Service Act (42 U.S.C. 256i) as section 340I.

The Acting CHAIR. No amendment to the bill shall be in order except those received for printing in the portion of the CONGRESSIONAL RECORD designated for that purpose in a daily issue dated May 23, 2011, and except pro forma amendments for the purpose of debate. Each amendment so received may be offered only by the Member who caused it to be printed or a designee and shall be considered read.

AMENDMENT NO. 2 OFFERED BY MR. TONKO

Mr. TONKO. Mr. Chair, I have an amendment at the desk.

The Acting CHAIR. The Clerk will designate the amendment.

The text of the amendment is as follows:

Page 4, after line 12, add the following:

(d) GAO STUDY ON IMPACT ON NUMBER OF PRIMARY CARE PHYSICIANS TO BE TRAINED.—The Comptroller General of the United States shall conduct a study to determine—

(1) the impacts that expanding existing and establishing new approved graduate medical residency training programs under section 340H of the Public Health Service Act (42 U.S.C. 256h), using the funding appropriated by subsection (g) of such section, as in effect on the day before the date of the enactment of this Act, would have on the number of primary care physicians that would be trained if such funding were not repealed, rescinded, and made subject to the availability of subsequent appropriations by subsections (a) and (b) of this section; and

(2) the amount by which such number of primary care physicians that would be trained will decrease as a result of the enactment of subsections (a) and (b).

The Acting CHAIR. The gentleman from New York is recognized for 5 minutes.

Mr. TONKO. Mr. Chair, my friends on the other side of the aisle seem steadfast and determined in their attack on access to affordable, quality health care. Couple that with their plan to end Medicare, and our Nation's seniors are put in quite a bind. Meanwhile, they want to place our health in the hands of Wall Street and Big Insurance, not between doctors and their patients. The seniors in my district and across the country know that vouchers will not cover their health care needs. They see the tax breaks for millionaires and billionaires and handouts for Big Oil, and are vehemently opposed to this plan.

Today, we have yet another assault on affordable access to health care. My Republican colleagues have found their next boogeyman: family practice physicians. This is surprising as we have a dire shortage of primary care physicians in our country.

The American Association of Medical Colleges has estimated that an additional 45,000 primary care physicians are required by 2020 just to meet America's health care needs. A few short months ago, both sides of the aisle agreed on the need to build our Nation's primary care workforce. This is a proven way to bend the health care cost curve by decreasing health spending through prevention and early, simple treatment.

Unfortunately, Republicans have since changed their tune. They have declared that the problem is not that we have a shortage of these crucial doctors. Instead, they must believe we have too many primary care physicians, and so we face this call to eliminate training for those on the front lines of the fight for quality care.

The underlying legislation guts funding for vital teaching health centers across our country. Teaching health centers are residency programs for primary care physicians, providing community-based training for doctors who will go on to work in rural and in our underserved areas. From Medicare to high gas prices to tax rates, my friends on the other side have proposed time and time again policies that put middle class Americans on the line and let Wall Street, Big Oil and Big Insurance take over and earn big. The constituents in my home district, in the Capital Region of New York State, need a break. They are looking at the price of gas, at the price of food and at the price of prescription drugs, and are just wondering how they will make it through the month.

Do we need to balance the budget? Yes. Do we need to balance the budget on the backs of hardworking Americans who play by the rules? Absolutely not.

Mr. Chair, my amendment is very simple. It requires that we find out exactly how many primary care physicians we will lose if Republicans succeed in cutting teaching health centers

across the country. My amendment commissions the Government Accountability Office to report on these findings so that the American people can see how drastically these cuts will eliminate jobs and will hurt the quality, access and affordability of primary care health options.

I am interested to know, Mr. Chair, if some of my Republican colleagues are aware that, if H.R. 1216 is adopted, there will be fewer primary care doctors working in their communities. For example, this bill cuts funding for 23 physicians at the teaching health center in the heart of Scranton, Pennsylvania. These 23 individuals are being trained to provide basic health care for constituents in the greater Scranton area.

If my Republican colleague from the Scranton area joins the Republican leadership in eliminating this program, his community will lose training for 23 new primary care physicians. That's 23 jobs, the many jobs they support and 23 individuals who will serve constituents in need.

Mr. Chair, if my colleague from Pennsylvania would like to come to the floor to defend the rights of the teaching health center in Scranton against this shortsighted and unjust attack by the Republican leadership, I would gladly yield him time.

The same challenge is faced by my colleague from the Billings, Montana, area, whose district will lose funding to train seven primary care physicians specifically for the health care needs of rural Montanans. In Idaho, Illinois, Texas, and Washington, it's the same story. All of these communities are seeing good American jobs put at risk—and for what?—to fund handouts to insurance and oil companies? to pay for even more tax breaks to millionaires, billionaires and some of the wealthiest corporations on Earth?

I would gladly yield my Republican colleagues from these districts time to defend their constituents.

Again, Mr. Chair, my amendment is a matter of effective oversight. It asks that we find out from a nonpartisan source exactly how many primary care physicians we will lose if the Republican leadership moves forward to cut teaching health centers across our country.

When it comes to ensuring our constituents have access to basic primary health care, when it comes to protecting Medicare and Social Security for our seniors and to ensuring they have healthy and comfortable retirements, there should be no disagreement.

Please join me in supporting this amendment and in standing with middle class Americans across the country.

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

Mr. GUTHRIE. Mr. Chairman, I rise in opposition to the amendment.

The Acting CHAIR (Mr. CAMPBELL). The gentleman from Kentucky is recognized for 5 minutes.

Mr. GUTHRIE. Mr. Chairman, first, I want to point out the list that was read of teaching health centers.

The text of the bill is very clear: that we only rescind unobligated funding. If the funding has been obligated, then it continues to move forward. So, as to the list that was read, those will be funded.

The amendment before us directs the GAO to determine the number of physicians who will be trained by this program if funds are not kept mandatory. I oppose the general premise that a program must have mandatory funding in order to be effective. This type of thinking has led us to massive budget deficits as far as the eye can see.

During the debate on the continuing resolution, I can remember more than a few Members complaining that reductions in discretionary spending would have little impact on the deficit. There is some truth to the fact that discretionary spending which Congress has more control over comprises an increasingly smaller share of the Federal budget.

□ 1540

It seems to me that some people's solutions to reining in the discretionary ledger of our Federal budget is to simply shift programs from discretionary to mandatory and let the spending cruise on auto pilot. That is not responsible governing. In a time of $1.5 trillion annual deficits, we must make spending priorities. However, setting priorities involves tough choices. The people that oppose this bill do so because they are unwilling to make the tough choices on what programs the Federal Government should fund and what they should not.

So let's review what happened. Certain programs for training were made mandatory in the health care act and others were subject to future appropriations. Listening to the debate today, it is apparent that some believe any provision in the health care act that authorized a program subject to appropriations is essentially meaningless and did nothing at all. I have heard Members extol the virtues of dental education programs or training for nurse education contained in the health care act, but they are subject to further appropriations.

Where was the amendment to the health reform bill that asked GAO to look into how the lack of mandatory spending in section 5305 of the health care act would affect geriatric education? There wasn't one, and not a single Member of the other side brought the issue up. The reason the other side didn't bring it up is because the programs were constructed in a way to go through the normal authorization and appropriations process. The underlying bill simply puts teaching health centers on equal footing with a myriad of other programs.

I also oppose the amendment because it is a waste of Federal resources. We are asking the GAO to conduct a study that is almost impossible for it to complete. The GAO cannot determine the number of physicians that will be trained because so much of the program is under the discretion of the Secretary. In fact, the contours of the program have not yet even been set. The Health Resources and Services Administration does not even anticipate issuing a Notice of Proposed Rulemaking on the Teaching Health Center Graduate Medical Education Program until December.

Under my bill, supporters of the program will continue to be able to make the case on an annual basis that the program is not duplicative, it is effective, and warrants continued funding over other programs like children's hospitals which the President's budget zeroed out.

I urge my colleagues to vote ''no.''

I yield back the balance of my time.

The Acting CHAIR. The question is on the amendment offered by the gentleman from New York (Mr. TONKO).

The question was taken; and the Acting Chair announced that the noes appeared to have it.

Mr. TONKO. Mr. Chairman, I demand a recorded vote.

The Acting CHAIR. Pursuant to clause 6 of rule XVIII, further proceedings on the amendment offered by the gentleman from New York will be postponed.

AMENDMENT NO. 9 OFFERED BY MR. CARDOZA

Mr. CARDOZA. Mr. Chairman, I have an amendment at the desk.

The Acting CHAIR. The Clerk will designate the amendment.

The text of the amendment is as follows:

Page 4, after line 12, add the following:

(d) GAO STUDY AND REPORT ON PHYSICIAN SHORTAGE.—The Comptroller General of the United States shall conduct a study to determine—

(1) the impact that expanding existing and establishing new approved graduate medical residency training programs under section 340H of the Public Health Service Act (42 U.S.C. 256h), using the funding appropriated by subsection (g) of such section, as in effect on the day before the date of the enactment of this Act, would have on the number of physicians that would be trained if such funding were not rescinded and made subject to the availability of subsequent appropriations by subsections (a) and (b) of this section; and

(2) the impact that the enactment of subsections (a) and (b) will have on the number of physicians who will be trained under approved graduate medical residency training programs pursuant to such section 340H.

The Acting CHAIR. The gentleman from California is recognized for 5 minutes.

Mr. CARDOZA. Mr. Chairman, I rise today to offer an amendment that would require the GAO to conduct a study that highlights the impact that elimination of funding would have on the number of physicians that would be trained if this program were allowed to continue as intended.

Countless studies have demonstrated a serious and growing shortage of health professionals facing the United States—most critically a shortage of primary care physicians and dentists. However, where I come from, there is a

shortage of specialties as well. With an existing shortage well established and an aging population increasing, our country desperately needs investments in the health care workforce, not rescissions.

In my home State of California alone there are 567 designated health professional shortage areas, which include a population of more than 3.8 million medically underserved individuals. In California's San Joaquin Valley, there are already fewer than 87 primary care physicians for 100,000 patients of population. The doctor/patient ratio in my region is not getting better; it is getting significantly worse. That is why I have consistently advocated for the need to improve access to care and address this vital shortage.

All eight counties in the San Joaquin Valley have been designated as medically underserved by the Department of Health and Human Services, including Merced, Stanislaus, San Joaquin, Madera, and Fresno Counties. At one point a few years ago, we were down to one pediatrician for the entire county of Merced. With the passage of the Affordable Care Act, we were able to include additional funding for these medical residency programs to help address the mounting health care profession shortage in already established underserved areas.

The new Teaching Health Centers Graduate Medical Education Program is intended to be an investment that helps struggling underserved communities deal with the reality of increasing demands on an already strained health care system. Studies have shown that the most effective way to attract and retain new doctors in underserved areas is to allow medical students to complete their medical residency programs in the communities that are in need. Graduating physicians most often practice in the communities where they have completed their residency training, which is why this program is uniquely important. My wife is a perfect case in point, a primary care physician who stayed in our community and practiced for 18 years after she finished the program.

Without these critical investments, the lack of care will most certainly have a costly price on the health and well-being of many rural underserved communities, including those I represent.

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

Mr. GUTHRIE. Mr. Chairman, I move to strike the last word.

The Acting CHAIR. The gentleman from Kentucky is recognized for 5 minutes.

Mr. GUTHRIE. Mr. Chairman, this amendment is very similar to the previous amendment we discussed, so I will be brief.

One, as I said before, it is difficult for the Government Accountability Office—almost impossible for them—to perform this study moving forward because there is so much discretion that is given to the Health and Human Services Secretary. And as I said before, the Health Resources and Service Administration does not even anticipate issuing a Notice of Proposed Rulemaking on teaching health graduate centers until December.

And then again, as a lot of the comments today, I don't think that moving an authorized and mandatory spending program to an authorized and discretionary spending program renders that program meaningless. If it does do that, then all the other programs that I have listed earlier in the debate—training in general hospitals, training in children's hospitals, training in behavioral education and health, training in nurse retention, training in nurse practitioners—that means that those programs that were in the health care act would not have as much strength as well. And so the comment that by moving this from one part of the budget to the other makes it meaningless, to me, is just not accurate.

And, second, I also want to stress again that the language of the bill is clear: we do not rescind obligated funds; it is only unobligated funds. So again, it wasn't my friend from California, but someone earlier mentioned that there were programs that have already been in place that would be hurt by that. If the funds have been obligated, those programs move forward.

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

Mr. GENE GREEN of Texas. Mr. Chairman, I move to strike the last word.

The Acting CHAIR. The gentleman is recognized for 5 minutes.

Mr. GENE GREEN of Texas. Mr. Chairman and Members, I know there has been talk only about obligated money. I would like to introduce into the RECORD a press release issued on January 25 of this year from Health and Human Services announcing the new Teaching Health Center Graduate Medical Education Program. And of those programs, it lists the ones; and that money is obligated, but there will be no future funding for them. So you get a few months of funding, but you don't get any more funding.

These centers—six of them are in Republican districts, five in Democratic districts—will get a very short 3 months' worth of funding if this bill becomes law. And it doesn't do any good. The graduate medical education pays for the training of that physician. These community centers will only receive a short term funding. So it may only be talking about that obligated money, but they won't get any more after this year if this bill becomes law. That's why it is so important that this bill be defeated or that we adopt an amendment similar to our colleague from California.

HHS ANNOUNCES NEW TEACHING HEALTH CENTERS GRADUATE MEDICAL EDUCATION PROGRAM

ELEVEN CENTERS WILL SUPPORT PRIMARY CARE RESIDENCY TRAINING IN COMMUNITY-BASED SETTINGS

HHS Secretary Kathleen Sebelius today announced the designation of 11 new Teaching Health Centers in the Teaching Health Center Graduate Medical Education program, a 5–year program that will support an increased number of primary care medical and dental residents trained in community-based settings across the country. These Teaching Health Centers will be supported by funds made available through the Affordable Care Act and will help address the need to train primary care physicians and dentists in our nation's communities.

With the funds, these Teaching Health Centers can seek additional primary care residents through the National Resident Matching program this month and will train 50 additional resident full-time equivalents beginning in July 2011. While 3 months of funding totaling $1,900,000 is being awarded this first program year, in future years the annual funding will increase to cover the full-year costs, as well as additional residents. These investments provide an important platform for expanding the primary care workforce and creating more opportunities to prepare physicians to practice primary care in community-based settings, while ensuring primary care services are available to our nation's most underserved communities.

''The Teaching Health Center program is an integral part of our mission to strengthen the nation's primary care workforce and ensure that all Americans have adequate access to care,'' said Secretary Sebelius.

The new Teaching Health Centers are distributed around the nation and will train residents in family medicine, internal medicine, and general dentistry. Teaching Health Centers will receive up to 5 years of ongoing support for the costs associated with training primary care physicians and dentists. HHS' Health Resources and Services Administration (HRSA) will administer the program.

''Participating in this program not only provides top-notch training to primary care medical and dental residents, but also motivates them to practice in underserved areas after graduation,'' said HRSA Administrator Mary Wakefield, Ph.D., R.N.

Eligible Teaching Health Centers are community-based ambulatory patient care centers that operate a primary care residency program, including federally-qualified health centers; community mental health centers; rural health clinics; health centers operated by the Indian Health Service, an Indian tribe or tribal organization; and entities receiving funds under Title X of the Public Health Service Act.

For additional information, visit Teaching Health Centers.

2011 TEACHING HEALTH CENTERS

Organization	City	State	Award
Valley Consortium for Medical Education	Modesto	Calif.	$625,000
Family Residency of Idaho	Boise	Idaho	37,500
Northwestern McGaw Erie Family Health Center	Chicago	Ill.	300,000

2011 TEACHING HEALTH CENTERS

Organization	City	State	Award
Penobscot Community Health Center	Bangor	Maine	150,000
Greater Lawrence Family Health Center	Lawrence	Mass.	112,500
Montana Family Medicine Residency	Billings	Mont.	37,500
Institute for Family Health	New York	N.Y.	150,000
Wright Center for Graduate Medical Education	Scranton	Pa.	225,000
Lone Star Community Health Center	Conroe	Texas	37,500
Community Health of Central Washington	Yakima	Wash.	75,000
Community Health Systems	Beckley	W. Va.	150,000
Total			1,900,000

Mr. ELLISON. Mr. Chairman, I move to strike the last word.

The Acting CHAIR. The gentleman from Minnesota is recognized for 5 minutes.

Mr. ELLISON. Mr. Chairman, I rise in opposition to this underlying bill.

As the Senate votes this week on the Republican scheme to end Medicare, I am standing up to protect health care for our seniors. Our seniors, they blazed the trail for all of us. They fought the wars, they've earned the money, they've come and made America a great place; and we have inherited what they've done. We have inherited what our senior citizens have made for us. And now we see our Republican colleagues want to end Medicare for these same seniors. To spend nearly $1 trillion on handouts to millionaires not only harms American seniors, but threatens our economic future.

□ 1550

Medicare guarantees a healthy and secure retirement for Americans who pay into it their whole lives, Mr. Chairman. It represents the basic American values of fairness, decency and respect for our seniors that all Americans should cherish.

Last month, our Republican colleagues voted to end Medicare as we know it. According to the Congressional Budget Office—and, Mr. Chairman, that's the office that is bipartisan and calls it straight as they see it—this plan, this Republican plan, would raise seniors' health care costs by more than $6,000 a year—that's a lot of money, Mr. Chairman—more than doubling their costs. Instead of fulfilling a promise to our seniors, a promise that the people who gave everything for us would have something in their golden years, the plan would bring about a corporate takeover of our health care. Insurance company bureaucrats would be able to deny seniors care that they had paid into for their entire lives. The GOP plan no longer guarantees seniors the same level of benefits and choice of a doctor that they have today under Medicare.

Mr. Chairman, this debate is not about the deficit. Only if it were. This debate is about something else, and it is about whether we are going to meet the promises of our seniors, of our children, of our students, of our public employees, or not. It's a choice of whether we're going to put America to work or not. It's a basic choice about how we're going to live together.

Mr. Chairman, this debate is not about a deficit. And as my fellow colleagues pound on this idea that we're broke, we're not broke. What we are is unwilling to do the basics for people who have given America so much. This debate is not about a deficit, because we can reduce the deficit by putting America back to work. Two-thirds of American corporations don't pay any taxes, including General Electric, Bank of America, and others. If we ask people to just do their fair share, America's not broke.

By siding with insurance industry lobbyists to raise Medicare costs only increases the burden on our seniors while doing nothing to address the deficit. As I said, this is not about the deficit.

Raising taxes for 95 percent of Americans to pay for a trillion-dollar tax cut for CEOs who ship American jobs overseas sides with the rich at the expense of the middle class.

Spending billions on handouts for corporate special interests, including $40 billion on Big Oil, only drives up prices at the pump for families who are already hurting the most.

The Progressive Caucus, Mr. Chair, has a plan that puts people's priorities first. Our budget, which we call ''The People's Budget,'' strengthens Medicare and Social Security. It lets Medicare negotiate cheaper drug prices so insurance company bureaucrats can't deny you the medication you need. And it creates jobs by eliminating the deficit by 2021. That's right. The Progressive Caucus eliminates the deficit. That is the fiscally responsible budget. That's a budget that Americans can get behind. Not some budget that rewards the rich at the expense of everybody else and doesn't do anything to end the deficit.

I'll not stand for a vision of America that throws American seniors under the bus. We have a vision of honoring our seniors, honoring those people, the Greatest Generation, the generation that brought us civil rights, women's rights, human rights, the generation that brought us Medicare. We are in a generational fight, Mr. Chairman, and generations in the future will look back on us and ask us why did we let the Republican Caucus take away the basic promises of America, and we will be able to stand now and say, We didn't. We fought them back and we fought for America where everybody does better because everybody does better, including our seniors.

I yield back the balance of my time.

The Acting CHAIR. The question is on the amendment offered by the gentleman from California (Mr. CARDOZA).

The question was taken; and the Acting Chair announced that the noes appeared to have it.

Mr. CARDOZA. Mr. Chairman, I demand a recorded vote.

The Acting CHAIR. Pursuant to clause 6 of rule XVIII, further proceedings on the amendment offered by the gentleman from California will be postponed.

AMENDMENT NO. 7 OFFERED BY MS. FOXX

Ms. FOXX. Mr. Chair, I have an amendment at the desk.

The Acting CHAIR. The Clerk will designate the amendment.

The text of the amendment is as follows:

Page 4, after line 12, add the following:

(d) PROHIBITION AGAINST ABORTION.—Section 340H of the Public Health Service Act (42 U.S.C. 256h) is amended by adding at the end the following new subsection:

''(k) PROHIBITION AGAINST ABORTION.—

''(1) None of the funds made available pursuant to subsection (g) shall be used to provide any abortion or training in the provision of abortions.

''(2) Paragraph (1) shall not apply to an abortion—

''(A) if the pregnancy is the result of an act of rape or incest; or

''(B) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed including a life endangering physical condition caused by or arising from the pregnancy itself.

''(3) None of the funds made available pursuant to subsection (g) may be provided to a qualified teaching health center if such center subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.

''(4) In this subsection, the term 'health care entity' includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.''.

The Acting CHAIR. The gentlewoman from North Carolina is recognized for 5 minutes.

Ms. FOXX. Thank you, Mr. Chairman.

My amendment is designed to protect life and the livelihood of those who defend it.

Since 1973, approximately 50 million children have been aborted in the United States. This is a tragedy. According to a CNN poll last month, more than 60 percent of Americans oppose taxpayer funding for abortion. This number includes many of my constituents and is consistent with my strong

pro-life convictions. I am offering my amendment today to ensure that their hard-earned money will not be used to pay for elective abortions or given to organizations that discriminate against pro-life health care providers.

Earlier this month, the House passed H.R. 3, the No Taxpayer Funding for Abortion Act, which codifies many longstanding pro-life provisions and ensures that taxpayer money is not being used to perform elective abortions. H.R. 3 is now awaiting consideration in the Senate, but I will not cease to fight to protect the unborn children in America at every turn.

This amendment ensures that the grants being provided to teaching health centers are not being used to perform elective abortions and makes it crystal clear that taxpayer money is not being used to train health care providers to perform abortion procedures.

Mr. Chair, when the liberal Democrats rammed through their government takeover of health care, in an unprecedented fashion, they refused to include longstanding pro-life provisions. With this bill, House Republicans are seeking to restore a grant program for residency programs to the regular appropriations process, and my amendment explicitly and permanently ensures that should the appropriations committee fund this program, taxpayer money will not be used to pay for elective abortions or train abortion providers.

In addition to the need for a permanent prohibition of taxpayer funding for elective abortions, it is also important that scarce resources are allocated to the most worthy applicants. An applicant that demands that individuals and institutions provide or refer for abortions is simply not the kind of applicant that should be funded under this program. Numerous doctors, nurses and other health care providers refuse to perform or participate in abortions because they believe it is wrong to kill a child. Congress should ensure that these individuals are not discriminated against because of their beliefs. Any form of discrimination is abhorrent, and individuals should not be forced to act against their convictions. This amendment is similar to previous efforts to protect pro-life health care providers and is consistent with these efforts.

To be eligible for funding under this grant program, centers have to agree that they will not discriminate against pro-life health care providers.

My colleagues across the aisle may argue that we already have the Hyde amendment that prohibits taxpayer funding for elective abortion for programs that are included in the Labor, Health and Human Services and Education appropriations legislation. However, this amendment must be included every year. My amendment ends the uncertainty for this program by providing a permanent prohibition on taxpayer funded elective abortions and protects pro-life health care providers. Until we have a permanent prohibition on taxpayer funding of elective abortion and protections for health care providers who cherish life, I will continue to offer and support efforts to support taxpayers, families and children from the scourge of abortion.

The unborn are the most innocent and vulnerable members of our society and their right to life must be protected. Therefore, I urge my colleagues to vote in favor of this amendment.

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

Ms. DEGETTE. Mr. Chairman, I rise in opposition to the amendment.

The Acting CHAIR. The gentlewoman from Colorado is recognized for 5 minutes.

Ms. DEGETTE. Thank you, Mr. Chairman.

Well, here we are again, forced to stand up again to protecting women's health care against an extreme agenda. I disagree with the whole underlying bill, Mr. Chairman, but even so, even so, how one could tie restricting a woman's right to choose to graduate medical education is sort of beyond me.

□ 1600

Let me explain why this is just an extreme and direct attack on women's health.

What it would mean is that across the country residents would be barred from learning how to perform even a basic medical procedure required for women's health. This amendment would jeopardize both education and women's health care by obliterating funding for a necessary full range of medical training by health care professionals.

And here's the thing. The Hyde amendment is the law of the land right now. I don't like the Hyde amendment. I would repeal the Hyde amendment. But frankly, the Hyde amendment has been in place for over 30 years, and it's not going away. And what it says is no Federal funds shall be used for abortions except in the case of rape, incest, or the life of the mother.

Now, there is nothing in the Hyde amendment about restricting medical doctors' training to legal medical procedures. There's nothing about graduate medical education in the Hyde amendment whatsoever. And if we pass this amendment, we will not allow basic medical training that would even allow doctors to provide the procedures that are allowed under the Hyde amendment—life, rape, or incest.

And let me talk about why this is so incredibly dangerous for women's health.

Ensuring that doctors and nurses are fully trained in abortion procedures is essential to ensuring that they can be providing lifesaving care when abortion is a medically necessary procedure to save the life of a pregnant woman.

Now, most pregnancies, thank goodness, progress safely. But sometimes there's an emergency. And sometimes a medical abortion is necessary to protect a woman's health or life. For example, Mr. Chairman, in cases of preeclampsia, hemorrhage, and severe pulmonary hypertension, or bleeding placenta previa, which can be fatal if left untreated, an abortion is a life-saving procedure. In addition, in managing a miscarriage, sometimes an abortion procedure is essential to saving the woman's life.

Now, under this amendment, virtually any type of health care facility could face the loss of funding if they needed to provide abortion care in an emergency situation. And moreover, Mr. Chairman, residents need to be trained in how to handle these very complicated conditions that could necessitate an abortion.

I'm afraid to say these examples are tragically real. The case involving a woman experiencing severe hypertension that threatened her life at St. Joseph's Hospital made the news when a nun, Sister McBride, was excommunicated last year for allowing the woman's life to be saved through an abortion.

The Foxx amendment would also greatly expand the reasons why health care entities should give in to refusing care.

So, Mr. Chairman, here's the thing. Maybe we don't like abortions, and all of us wish abortions would be rare. But sadly, even in the case of a wanted child with a loving home and everything else, even in the case of an exception under the Hyde amendment, sometimes abortions are necessary. And if we say we are not going to train doctors how to provide a range of women's health care services, then we are basically allowing women to bleed to death in the emergency rooms of this country. And I don't think that's what this Congress is about. It is certainly not what the medical profession is about.

I would urge just for reasons of mercy for this House to reject this amendment. It's mean-spirited and it's far, far beyond current law.

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

Mr. GARAMENDI. Mr. Chair, I move to strike the last word.

The Acting CHAIR. The gentleman from California is recognized for 5 minutes.

Mr. GARAMENDI. Mr. Chairman, I find myself in opposition to the underlying bill and the amendment.

You just heard a very cogent argument. I don't understand why we ought to have ignorant doctors. It doesn't make any sense to me. Abortions are sometimes necessary for saving the life of a pregnant woman. And to have a medical system in which the doctors don't know about that procedure is really stupid. I won't say this amendment is that, but it's really not wise to have ignorant physicians. And it's really not wise not to have physicians at all.

What in the world are we thinking here? What's the purpose of this

amendment and this particular resolution? To deny American men, women, and children the opportunity to go to a doctor? We know all across this Nation that there is a shortage of primary care physicians. In most every community of California, there is a shortage of primary care physicians. Plenty of dermatologists, but not primary care physicians.

So what are we going to do here? Eliminate the funding to train primary care physicians.

Now, that in itself is bad enough. But this is just one piece of a much larger plan to dismantle health care in America. The repeal of the Affordable Health Care Act will increase the cost of medical services all across this Nation and particularly increase the cost to government. Not my projection. The independent Congressional Budget Office said clearly that the Affordable Health Care Act will reduce the cost of Medicare and Medicaid.

So repeal it. Increase the deficit. Huh? Is that what this is all about? I don't get it guys and women. Makes no sense to me.

And now in your budget, the Republicans go after Medicare and terminate Medicare for every American who is not yet over 55 years of age? Terminate it. And turn it over to the rapacious, greedy, profit-before-people health insurance industry, an industry that I know a great deal about. I was the insurance commissioner in California for 8 years, and I know those characters. It is about profit. It's not about caring for people.

And when you say the government shouldn't make decisions, the government does not make decisions in Medicare. The physicians make decisions. But if you turn Medicare over to the insurance companies, it will be the insurance companies that make decisions about medical services.

And by the way, you also voted to repeal those sections of the Affordable Health Care Act that protect all of us from the rapaciousness of the health insurance industry. Eliminating a law which eliminates such things as preexisting conditions, age, sex discrimination, and the rest. So you repeal that and give back to the insurance companies the opportunity to discriminate. And now you want to throw tomorrow's seniors into that same pool of sharks.

I don't get it. It makes no sense whatsoever. It perhaps is the worst idea I've heard in the 35 years I have been involved in public health and in public policy. It makes no sense whatsoever.

And this bill on top of it? Come on. We're not going to train primary care physicians? What in the world are you thinking? I don't get it. I don't get the whole strategy. It is a strategy that will put America's health at risk. It is a strategy that will deny benefits. It is a strategy that will provide us, with this latest amendment, doctors that are ignorant about basic women's health. And it is a strategy that will deny us the necessary primary care physicians.

What in the world are my Republican colleagues doing here about the deficit? Come on now. What you're doing is going to increase the deficit. You're going to increase the deficit. If there are not primary care physicians, then you'll go to the emergency room. And everybody knows that the emergency room is more expensive than a doctor's office.

What are you doing? I don't get it, guys. I don't understand. You're worried about the deficit; yet you take action that increases the deficit? It makes no sense to me.

Madam Chair, I yield back the balance of my time.

Mr. GENE GREEN of Texas. Madam Chair, I move to strike the last word.

The Acting CHAIR (Mrs. CAPITO). The gentleman is recognized for 5 minutes.

Mr. GENE GREEN of Texas. First of all, I have utmost respect for Congresswoman FOXX of North Carolina. But her amendment is a solution in search of a problem. Graduate medical education does not do abortions.

□ 1610

The teaching hospital center program funds training for primary care residents. There is no payment for services in the law. It's about salaries, benefits, and paying faculty. Teaching health centers will pay for abortions no more than Medicare Graduate Medical Education has paid for abortions for the last 45 years.

The President signed the executive order to make all the provisions subject to the Hyde amendment, all the provisions of the Affordable Care Act subject to the Hyde amendment. The executive order establishes a set of policies for all provisions of the Affordable Care Act to ''ensure Federal funds are not used for abortion services'' consistent with the Hyde amendment. The Presidential order reinforces what we all agree on. No one is here claiming that we should use Federal funds for abortion, except in very limited circumstances, whether they are under this program or elsewhere.

There is another layer of protection codified in permanent law under section 245 of the Public Health Service Act. The Coats amendment clearly prohibits the Federal Government from discriminating against any physician, post-graduate physician training program, or participant in a program of training in the health care professions because the entity refuses to participate in abortion training. That's not an appropriations vehicle; it's not an executive order. It's the law of the land.

That's why I say this amendment is a solution in search of a problem. There is not a problem with Graduate Medical Education, whether they be teaching hospitals, whether they be community-based centers that this bill is subject to.

I yield back the balance of my time.

Mrs. CAPPS. Madam Chair, I move to strike the last word.

The Acting CHAIR. The gentlewoman from California is recognized for 5 minutes.

Mrs. CAPPS. I rise in strong opposition to this dangerous amendment.

Last month, the Republican majority brought us to the brink of government shutdown over its disapproval of Planned Parenthood. But here we are again, a new week, but the same obsession with reopening the culture wars. This time, instead of saying that Congress knows better than a woman and her family about her reproductive health care, this amendment takes one step further. It says that Congress knows better than our medical doctors and medical educators about what our medical training curricula should look like. This is an unprecedented restriction, one that goes against the Accreditation Council for Graduate Medical Education's guidance and against medical ethics themselves.

Medical education is supposed to prepare our future doctors for whatever they may come across in their practice. This includes women whose lives are in danger due to their pregnancy, for whom terminating a pregnancy is the only way that woman will stay alive. Keeping future providers from learning these procedures—and it is an option that they may choose only if they choose to learn it—puts these women at risk. Regardless of what one's views are on women's reproductive rights, I think we can all agree that our future medical providers should be trained and ready for any medical emergency that they might encounter. To play politics with their education and the lives of women is an embarrassment.

Madam Chair, it is time for this Congress to learn to trust the American people, to trust our doctors, to trust our families, and to trust women.

THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS,
Washington, DC, May 24, 2011.

ACOG OPPOSES THE FOXX AMENDMENT TO H.R. 1216

The American Congress of Obstetricians and Gynecologists (ACOG), representing 55,000 ob-gyns and partners in women's health, opposes the Foxx amendment to H.R. 1216, an amendment to the Public Health Service Act.

The Foxx amendment would disallow GME funding for abortion training, part of ob-gyn educational curricula in accredited medical residency programs, and unnecessarily duplicate already recognized protections for medical students and teaching hospitals who choose to not participate in abortion training.

Residency education standards are set by the universally recognized Accreditation Council for Graduate Medical Education (ACGME) whose Residency Review Committees (RRCs) accredit residency programs. These standards, supported by the American College of Obstetricians and Gynecologists, require that ''experience with induced abortion must be part of residency training.''

These standards already fully accommodate institutions, programs, and individuals

who choose not to participate in abortions or abortion training. Every ob-gyn residency program may opt out of providing in-house training, and is required only to offer their residents an opportunity for abortion training at an outside facility. Similarly, residents with religious or moral objections may opt out of receiving abortion training, and are required only to be trained in management of abortion complications—not the provision of abortion, but the care of potential consequent medical complications.

Training in abortion, for those institutions, programs, and individuals who choose to participate, is important to women's health. Federal funds may be used for abortions in cases of rape, incest, or when a woman's life is endangered. Girls and women who are victims of rape or incest, or whose lives are endangered by their pregnancies, must have continued access to this surgical procedure, and this care must be safely provided by trained medical specialists.

The Nation's women's health physicians urge a no-vote on the Foxx amendment. Should you have any questions, please contact Nevena Minor, ACOG Government Affairs Manager, at nminor@acog.org or 202–314–2322.

I yield back the balance of my time.

Mr. TONKO. Madam Chair, I move to strike the last word.

The Acting CHAIR. The gentleman from New York is recognized for 5 minutes.

Mr. TONKO. Madam Chair, I rise in opposition to H.R. 1216, the underlying bill. As a resident of upstate New York, where much attention has been given to today's special election for a congressional seat, people are saying loud and clear, Hands off my Medicare.

Republicans are determined again to put us on the road to ruin with their plans to end Medicare. Despite outcries from their constituents, they are pushing forward to end a program that 46 million seniors and disabled individuals depend on for their health care. This gross injustice is made immeasurably more egregious and offensive by the fact that this is being done not to balance the budget, but to expand and permanently guarantee even bigger tax cuts for millionaires and billionaires, and to give new tax breaks to some of the world's most profitable companies, including oil.

I have heard a lot of talk in the last few months about the need to make tough choices these days. The average senior on Medicare earns just over $19,000 a year. About one quarter of Medicare beneficiaries suffer from a cognitive or mental impairment, and most have at least one or more chronic medical conditions. So I ask my Republican colleagues, what exactly is it about stripping these Americans bare of their health and economic security that qualifies as tough? There is nothing tough about stealing from the poor or the weak to give to the rich.

Our seniors, on the other hand, know all about tough choices: Do I buy groceries, or do I buy prescriptions? Do I pay rent, or do I pay medical bills? It hurts, but how much will it cost? These are those tough choices. These are life and death choices. With the passage of Medicare in 1965, we entered into a covenant with each and every American citizen.

The Republican voucher plan ends Medicare. Instead, seniors will be on their own with a measly voucher and forced to buy insurance in the private market, where all decisions will be profit-driven. More profits for insurance companies on the backs of seniors. Sounds like a Republican plan to me. This new voucher program amounts to a ration card. The value of the voucher is not linked to increases in health care costs in the private market, yet the costs of private health insurance have risen over 5,000 percent since the creation of Medicare—5,000 percent.

The analysis of the nonpartisan Congressional Budget Office has estimated that in less than 20 years these vouchers would pay just 32 cents on every dollar that a senior would spend on health care premiums. Now, the Republican leadership has repeatedly stated that this budget gives seniors the same coverage as Members of Congress. Well, as a Member of Congress myself, I know that our health plans pay for about 72 cents on every dollar of health coverage, not 32 cents.

America knows that legislation in Congress carries a statement of priorities and values, not purely dollars and cents. And what sense does it make to cut funding for training primary care physicians who are on the front lines not only of keeping our constituents and communities healthy, but also of lowering health care costs with early, simple treatments?

I urge my colleagues to stand with our seniors and stand up for middle class priorities. Let's defend our middle class. Let's defend our working families. I urge my colleagues to oppose this bill.

Madam Chair, I yield back the balance of my time.

Ms. TSONGAS. Madam Chair, I move to strike the last word.

The Acting CHAIR. The gentlewoman from Massachusetts is recognized for 5 minutes.

Ms. TSONGAS. Madam Chair, I rise in opposition to the underlying bill, H.R. 1216, and to the ongoing efforts by my colleagues across the aisle to undermine our constituents' access to affordable health care.

I recently heard from my constituent from Haverhill, Massachusetts, named Phil Gelinas, who relies on Medicare for his health coverage. His wife's diabetes treatment and prescription drugs are also covered through Medicare, and they have both paid into Medicare all their lives through payroll deductions. He remarked to my office that there was no way that they could meet the cost of health care today without Medicare.

He and his wife are not alone. Each day, thousands of seniors like the Gelinases use Medicare to cover the costs of doctors' appointments, prescription drugs, as well as routine tests and treatments.

Under the budget that House Republicans passed in April and that the Senate is set to consider this week, the Medicare program that seniors have relied on for more than 50 years to meet their medical needs and expenses would be eliminated. In its place would be a voucher system that pays a small lump sum to private insurers to cover seniors. Any costs not covered by that payment would fall to seniors to pay or forego coverage.

My colleagues on the other side of the aisle argue that elimination of Medicare is needed to help reduce the deficit, and that the same benefits that seniors now enjoy under Medicare will be replicated in the private insurance market. Not so. In reality, their plan will result in a far lower standard of care for seniors, while trillions of dollars continue to be added to the national debt. Rather than taking steps to reduce the underlying increases in health care costs, which in turn drive up the cost of Medicare, their plan simply shifts those costs to seniors.

The value of the vouchers that would replace Medicare would not keep pace with rising health care costs, so seniors will be increasingly required to make up the difference. Just 8 years after the program starts, a voucher will cover less than one-third of the cost of a private health insurance package with the same benefits as Medicare currently provides, leaving seniors to cover the rest.

□ 1620

According to the nonpartisan Congressional Budget Office, the average senior will end up spending nearly twice as much of their income on health care than under the current Medicare system. That is why AARP released a statement warning that the budget ''would result in a large cost shift to future and current retirees. The Republican proposal, rather than tackling skyrocketing health care costs, would simply shift those costs onto the backs of people in Medicare.''

Instead of focusing on cost control measures that would bring down the cost of Medicare, the budget claims cost savings but only by passing those costs directly on to our seniors.

Furthermore, because costs have typically grown faster in the private market than in Medicare, the costs faced by seniors under the Republican plan will be much higher than the costs faced by the Federal Government now.

My colleagues have argued that seniors won't be affected by these costs for years to come, but this is simply not true. For example, the House budget immediately reopens the prescription drug doughnut hole for current seniors that was fixed with passage of last year's health reform law. It also significantly increases costs for seniors now residing in nursing homes and for their adult children who may not be able to afford their parents' care.

Despite being presented as a solution for our deficits, the budget proposal

would still add $8 trillion to the national debt over the next 10 years. These new debts are incurred in part because their budget proposal also slashes taxes for the wealthiest Americans while continuing to provide billions in tax breaks for oil companies and other preferred industries.

Real deficit reduction will require a blend of spending reductions, new revenue, and additional reforms to control rising health care costs. But simply shifting those costs onto seniors by eliminating Medicare will prove as unsustainable for our Nation's well-being as the current budget crisis we face.

Mr. DAVIS of Illinois. Madam Chair, I move to strike the last word.

The Acting CHAIR. The gentleman is recognized for 5 minutes.

Mr. DAVIS of Illinois. Madam Chairman, I rise in opposition to the Foxx amendment and to the underlying bill, H.R. 1216, to amend the Public Health Service Act, to convert funding for graduate medical education in qualified teaching health centers from direct appropriations to an authorization of appropriations.

This bill would eliminate mandatory funding that establishes new or expanding programs for medical residents in teaching health centers and unobligated funds previously appropriated to the grant program.

Under policies currently being considered by some in the House majority, academic medical centers and teaching hospitals face as much as $60 billion in cuts over the next 10 years to Medicare funding for indirect medical education and direct graduate medical education. These cuts would reduce indirect medical education payments by 60 percent from the current level of 5.5 percent to 2.2 percent, capping direct graduate medical education payments at 120 percent of the national average salary paid to residents.

It would reduce Federal funding for medical residency training, as wrong public policy. Given our present situation with the shortage of primary care and family practice physicians, and the expected future growth of our population, it makes no sense for the Republicans to end the present structure of Medicare. In 2010, 47.5 million people were covered by Medicare. We have 39.6 million at the age of 65 and older and 7.9 million disabled.

The Republican budget plan is a voucher plan that would raise health care costs and would immediately create higher costs for prescription drugs for our seniors and disabled. This plan would end Medicare's entitlement of guaranteed benefits and promote rationing by private insurance companies, who would make decisions on approving or disapproving treatments for our seniors and the disabled.

The Medicare program is efficiently managed, devoting less than 2 percent of its funding to administrative expenses. Medicare has dramatically improved the quality of life for seniors and the disabled. It is the largest source of health coverage in the Nation. Democrats are committed to strengthening Medicare, not tearing it down.

Under the guise of reform, Republicans desire to end Medicare as we know it today.

Last year, the Republicans promised the American people that jobs would be their number one priority. Well, I ask, where are the jobs? But, instead, they want to make draconian cuts to programs to help seniors and the disabled, the middle class, the poor and the needy, and yet provide tax cuts of over $1 trillion to millionaires and billionaires.

And so we ask, where are the jobs and where are the opportunities? The estimated 1-year impact of anticipated graduate medical education cuts for Illinois is $144 million for indirect medical education and $39 million for graduate and medical education, which totals $183 million. If there are no doctors, there can be no medical care.

I urge that we vote against these measures.

Ms. WATERS. Madam Chair, I move to strike the last word.

The Acting CHAIR. The gentlewoman from California is recognized for 5 minutes.

Ms. WATERS. I rise in opposition to the underlying bill, H.R. 1216, which would undermine the teaching health centers program, which trains primary care physicians.

Madam Chairman and members, this is just one more trick by Republicans to dismantle health care reform. They are going after the training of primary doctors. We need more primary doctors, even if there was no health care reform. There are many communities throughout this country that have no primary health care physicians.

Our Nation is facing a serious shortage of primary care physicians. Primary care physicians are an essential part of a successful health care system. They are the first point of contact for people of all ages who need basic health care services, whether they are working people with the employer-provided health insurance, low-income children on Medicaid, or seniors on Medicare.

The Republicans have made it clear that they are not concerned about access to basic health care services. The Republican budget for fiscal year 2012 turns Medicare into a voucher program, slashes Medicaid by more than $700 billion over the next decade, and cancels the expansion of health insurance coverage, which was included in the The Affordable Care Act last year.

The Republican budget cuts to Medicare are especially detrimental to current and future Medicare recipients. Under the Republican budget, individuals who are 54 and younger will not get government-paid Medicare benefits like their parents and grandparents. Instead, they will receive a voucher-like payment to purchase health insurance from a private insurance company.

There will be no oversight to these private programs. We will not be able to contain the cost. We will not be able to mandate what the basic services should be. As a matter of fact, we know the stories about the HMOs and the fact that they had accountants who determined what care you could get, not physicians who had the knowledge and the ability to determine what you need.

When the first of these seniors retire in 2022, they will receive an average of $8,000 to buy a private insurance plan. That is much less than the amount of the subsidy Members of Congress receive for our health plans today.

The coverage gap in the Medicare prescription drug program will continue indefinitely. Under the Affordable Care Act, this so-called doughnut hole is scheduled to be phased out. The Republican budget will allow seniors to continue to pay exorbitant prices for their prescriptions when they reach the doughnut hole. The Republican budget also gradually increases the age of eligibility for Medicare from 65 to 67 years of age.

Madam Chairman, the Republican budget is also detrimental to Americans who depend again on Medicaid, including low-income children, disabled Americans, and seniors in nursing homes. The budget converts Medicaid into a block grant program and allows States to reduce benefits, cut payments to doctors, even freeze enrollment. Medicaid funding is slashed by more than $700 billion over the next decade.

□ 1630

That is over one-third of the program's funding.

Meanwhile, the Republican budget extends the Bush-era tax cuts beyond their expiration in 2012 and cuts the top individual tax rate down to 25 percent from 35 percent. According to the Center for Tax Justice, the Republican budget cuts taxes for the richest 1 percent of Americans by 15 percent while raising taxes for the lowest income 20 percent of Americans by 12 percent.

The national shortage of primary care doctors is not a problem for multimillionaires. They will always be able to find a doctor who will treat them and pay them whatever they ask for. But most American seniors need well-trained primary care physicians and Medicare benefits that they can rely on.

I urge my colleagues to oppose the underlying bill, oppose the drastic cuts to Medicaid, and oppose the Republican plan to dismantle Medicare. They're trying to dismantle health care reform piece by piece, inch by inch. Today it's an attack on training needed by primary care physicians. What is it tomorrow?

We know that they have a strategy that includes hundreds of bills that would dismantle, again, piece by piece Medicare reform. It's not fair, Madam Chair and Members. Health care reform

so that all Americans are covered is something that we should all support.

Ms. WOOLSEY. Madam Chair, I move to strike the last word.

The Acting CHAIR. The gentlewoman from California is recognized for 5 minutes.

Ms. WOOLSEY. Madam Chair, I rise in opposition to this amendment and the underlying bill, H.R. 1216.

This is just the last attempt, the latest and newest attempt, by the majority to stall health care reform and undermine the health security of the American people. We had barely taken our oaths in January when they voted to repeal the Affordable Care Act; now trying to eliminate title X funding that provides critical primary care for women, and last month they went after the funding for the health care exchanges, and they voted to cut grants for school-based health centers that served young children.

But worst of all is the Republican budget resolution that was passed last month. It rips the heart out of Medicare, eviscerates and disfigures a program that would no longer be recognized. It's one of the more radical proposals I've seen during 18 years in Congress. They want to strip guaranteed benefits and break the Medicare promise that has served our seniors so well for nearly half a century.

And what do they replace it with? A voucher. A voucher that won't be able to keep up with soaring health care costs, a voucher that will give seniors no leverage in the health care marketplace, a voucher that will put older Americans at the mercy of the insurance companies.

Madam Chairwoman, the CBO has concluded that the Republican proposal will double health care costs for seniors. So if you are 54 years old today, you will need to save an additional $182,000 to make up for the Medicare benefits you will lose under the Republican plan.

And they are not content to destroy Medicare. Medicaid comes in for brutal treatment as well. By converting it to a block grant, they would be throwing as many as 44 million Americans off the insurance rolls, eliminating coverage for the poorest people, most nursing home residents and people with disabilities.

My friends on the other side of the aisle who say we have to do this to balance the budget, they know they're wrong. I say they're dead wrong. We do not need to put seniors and low-income Americans on an austerity program in order to rein in the deficit. We do not need to shred the social safety net or to squeeze the middle class in order to get our fiscal house in order. In fact, we can save taxpayers $68 billion over 7 years and expand the menu of health care choices by instituting a public option. If you ask the American people, they would rather see some shared sacrifice than cutting spending. They would rather see us eliminate tax breaks for CEOs who have no idea what it's like to choose between taking their medication or eating their next meal.

Madam Chairwoman, I will vote ''no'' on H.R. 1216. It's just another example of Republican negligence and callousness on health care. They clearly prefer the broken system that leaves millions uninsured, imposing crippling costs that bankrupt families and bankrupt small businesses. The majority doesn't want to solve the health care crisis. They want to exacerbate it.

Ms. RICHARDSON. Madam Chair, I move to strike the last word.

The Acting CHAIR. The gentlewoman from California is recognized for 5 minutes.

Ms. RICHARDSON. I rise to speak in opposition to H.R. 1216.

Under the guise of deficit reduction, Republicans, through H.R. 1216, are attempting to attack our Nation's vital support system for our seniors. The Republican budget would deny seniors, and those who are coming forward after those that are currently taking advantage of these benefits, health care, long-term care, and the Social Security benefits that these seniors have earned.

Sunday evening, I just got back from my district where I had an opportunity to have our annual senior briefing, and there were over 900 seniors who were there and they were concerned. I spoke with several of my seniors in my district, and they're worried about how they and even some of their parents who are in their nineties today will be able to get by once RyanCare—which is what I'm going to call it, the attack on Medicare—destroys something we all need. By following RyanCare and turning Medicare into a voucher program, Republicans would gradually eliminate the peace of mind that many of our seniors have grown to be able to count on.

We don't want to go back to the old days of calling seniors ''poor'' and not having an opportunity to live in dignity in the last years. These fixed value vouchers, which are being suggested in RyanCare, would not only not keep up with the rising costs of health care, but it would cost seniors an additional $7,000 more per year by 2020.

In California alone, which is where I'm from, under the Republican budget, seniors would pay $214 million more on prescription drugs in 2012 alone. That's next year.

The Republican budget would return our country to a time when being old was something that people would be afraid of, not look forward to.

The Republican budget would also turn Medicaid into a block grant system. Haven't we seen what that's done with community development block grants? It wouldn't work. Under a block grant system, Medicaid would no longer be able to support the elderly. By converting the current Medicaid system into a block grant index to inflation and population growth, Congress would shift the burdens of rising health care costs and aging populations to the States. All you have to do is look at the Los Angeles Times to see what's happening to my State, and I don't think we'd be able to help the seniors.

The deficit must be addressed. In fact, I've supported many bills and amendments that have been brought forward on the other side. But it should be done in a fair way. We should not balance the budget on the backs of our Nation's seniors, not after Wall Street and our car manufacturers got a bailout.

I will, and Democrats will, continue to work to protect, strengthen, and save Social Security, Medicare, and Medicaid.

Ms. EDWARDS. Madam Chair, I move to strike the last word.

The Acting CHAIR. The gentlewoman from Maryland is recognized for 5 minutes.

Ms. EDWARDS. I rise in opposition to the underlying bill.

Madam Chair, Republicans have returned to the Hill after a hard week at work in our districts really trying to explain away the plan to dismantle Medicare to their constituents. But I want to tell it to you really straight, Madam Chair, and that is that the reason that it's hard to explain is because there really is no explanation. The plan that Republicans have under consideration would indeed end Medicare as we know it. It would end Medicare, and it's just that simple. The plan would turn Medicare into a voucher system that would leave seniors paying more and more out of their pockets for health care.

I was out at a town hall meeting at a senior center in my congressional district. It's one where people have gone—they come from every level of the private sector and business—to enjoy their retirement. And they receive Medicare benefits. And I asked them, who in this room, a room of about 100 or so seniors, how many of you would like to go into negotiations with an insurance company about how much you're going to pay for your health care? And no surprise, not a single one of those seniors stood up. But that's exactly what the Ryan plan, the Medicare dismantling plan, would do for seniors. It would say to seniors, we want you to go on your own and negotiate with the big insurance companies.

□ 1640

Well, we know that that can happen for those of us who are younger, but it certainly cannot happen for our seniors. It would shift the burden on to retirees to make the system much less efficient and increase administrative costs that are eventually passed on to all consumers.

According to the Congressional Budget Office, the Republican plan would raise the eligibility age for beneficiaries from 65 to 67. And it repeals provisions of the Affordable Care Act that are actually designed to make the system even more efficient. This just

doesn't make sense. I think seniors have caught on. In fact, I think all Americans have caught on.

The thing about Medicare is it is not just about our seniors, Madam Chair. It is also about the contract that each of us, one generation, makes to the next generation. It is the contract that I have made with my mother and my son makes with me, and it is to make sure that we are taken care of in our old age because we have paid into it and we have paid for it.

According to the Center for Economic and Policy Research, a 54-year-old worker would need to save an additional $182,000 to pay for the higher cost of private insurance with the government elimination of Medicare; $182,000, let's just absorb that for all of those 54 year olds. How long is it going to take you to get to age 65 and save $182,000 to pay for your health care costs? Well, we know that that would be an impossibility.

I want to tell you what is happening in Maryland because it will happen all across this country. It is that our seniors are recognizing that the GOP plan would require seniors to pay an additional $6,800 out of their own pockets for expenses for health care, and that is not including the fact that they will have to negotiate and probably pay even more than that.

So at a time when our seniors are vulnerable and they are struggling and they have seen a depletion in their savings, it is really not fair to threaten them and to threaten their quality of life by ensuring that they are going to have to pay these out-of-pocket costs.

So I would ask us, Madam Chair, to really examine what it is that we are asking the American people to absorb.

I was up with a group of seniors in New Hampshire, and throughout my congressional district; and our seniors are saying to us, It is not just about us, and don't count on us supporting this plan just because we happen to be over age 55. We support Medicare because we understand what it means for future generations.

So this is a link, a bond between the young people in this country who are working, our seniors and our retirees, to protect Medicare and to protect the benefits that come with it.

I would ask us on this underlying bill—I think some of my colleagues have spoken to this—we need more primary care. Already we are seeing what is happening in our system where 26 year olds, up to 26 year olds, can be covered on their parents' health insurance. Do you know what that is doing? It is actually bringing down the cost. It is making sure that we have more resources to absorb the care that people need as they get older.

And so let's not stomach a dismantling of the Medicare protection that we have known for 46 years in this country, this contract from one generation to the next generation, to ensure that our seniors who have worked so hard are able to enjoy their retirement without sacrificing everything that they have to pay the cost for additional benefits while health insurance companies walk away with record profits, and certainly while oil and gas companies walk away with theirs.

Mr. GUTHRIE. Madam Chair, I move to strike the last word.

The Acting CHAIR. The gentleman from Kentucky is recognized for 5 minutes.

Mr. GUTHRIE. I rise in support of the Foxx amendment. We have been debating the bill throughout the day, and I support the bill.

I just want to comment, I was also back home last week, and I went to a 100th birthday party for a group of people in northern Kentucky in the Louisville area and part of my district who were turning 100 years old. There was a lady there who was 103. She was born during Teddy Roosevelt's Presidency. I went there to thank them. I am one who is a big believer in what the Greatest Generation has done for us. I am a member of the baby boom generation. I was born in 1964. I am 47 years old. From 1946 to 1964, if you were born in 1946, you are in Medicare this year; you are 65 years old. I wanted to thank them and let them know that what we are doing is making a sustained and secure Medicare system for them.

We all know as of the end of last week that 2024 is the date put out that Medicare goes bankrupt. So what we have put together is a real proposal for 10 years to allow people the opportunity to adjust that are 54 and younger because there is not a member of the Greatest Generation—and if anybody says different they are wrong—there is not a member of the Greatest Generation that is affected. As a matter of fact, half the baby boomers are covered, are not affected by the changes that we have to make to make a secure and better future.

I am 47 years old. This means a lot to me because my daughter is 17. And you ask a lot of people my age: Do we have a better life-style than our parents had? Well, the Greatest Generation gave us a better life-style than they had because they wanted us to have a better life-style than they had. You ask a lot of people my age: Do we think our children will have a better life-style? It is amazing and it is disappointing to think how many people think that our children are not going to have the same quality of life that we had.

I didn't come to Washington, D.C. to be part of a government that doesn't address the fact that we want our children to have a better future than we had. In 30 years when my daughter is my age—she graduates from high school in 2 weeks—we can pay off the national debt.

So think about it. I am 47 years old. We have got a $14.3 trillion debt. You ask a lot of people my age: Do you think our children will have a better future? A lot of people say ''no'' because they say we keep piling on debt and deficits as far as the eye can see.

Madam Chair, if you ask me now if I thought my daughter at 47 years old is living in a country with zero national debt, do you think my children, grandchildren and her grandchildren will have a better future, they will. That is what we are talking about. We are talking about saving and securing Medicare for the Greatest Generation. We are talking about saving and securing it for people as they become older and more mature.

So anybody that says the Greatest Generation is affected by this is just not saying what was passed out of the House of Representatives. If anybody is saying that seniors are affected by this, they are not saying what was passed out of the House of Representatives. To say that we have to reform the program to make it stronger and better for them, that is accurate. And making it stronger and better for those who come forward, that is what we are talking about doing. That is what the facts are.

People deserve the facts. People are tired of hearing rhetoric. They want facts. And the facts are that we are sustaining and securing it for the Greatest Generation, and reforming it so it will be there as our children mature. And if we pass the budget, if the Senate would pass the budget that we passed out of the House, when my daughter is my age, we will have zero national debt, and we will have a better future. And then ask her if she thinks her children will have a better future than she did, and I guarantee you that she will say that.

Mr. MILLER of North Carolina. Madam Chair, I move to strike the last word.

The Acting CHAIR. The gentleman from North Carolina is recognized for 5 minutes.

Mr. MILLER of North Carolina. I rise to oppose the nonsensical pending amendment and the underlying bill, although the underlying bill doesn't really do all that, but most of all to disagree with the remarks of the gentleman from Kentucky just now, and from other remarks like that, that what the Republicans have done is not going to affect the people on Medicare now or the people who are older than 55, 55 and older.

What it does, in fact, is shift more and more of the cost of health care to people who cannot afford it so that the richest Americans will not have to pay taxes. They will cut taxes for the richest Americans by even more, and they will protect insurance company profits and the profits of everyone else in the health care field who are making vulgar profits that are causing American health care to be twice as expensive as health care anywhere else in the developed world.

The arguments and what the Republican Congress has done in these last few months have made very clear how cynically dishonest everything Republicans said about health care in the last 2 years really was, especially about Medicare.

When Democrats really did find a way to get control of costs without affecting the quality, the availability of care, the access to care, the quality of care, all Republicans would say, even when it was specifically and narrowly targeted at fraud, they said that we were cutting Medicare. Now we see what they really think about Medicare. Now we see how little they really do understand how important Medicare is to the financial security of older Americans, of Americans in retirement.

They say it will not affect you if you are over 55; if you are 55 or older. Well, I just turned 58. It is nice to know that Republicans care that much about me; but let me tell you, that is not the way it is going to work.

□ 1650

Well, when I turn 65, I'll qualify for Medicare. Presumably, I'll get Medicare. My 96-year-old mother, who I also did visit this weekend, will get Medicare. I feel pretty confident she'll get Medicare for the rest of her life and that, when I turn 65, I'll get Medicare. For the guy who is 53 now, which is just 5 years younger than I am, at 60 he'll be paying taxes for my Medicare, and he won't be getting it. He'll never get it. What he will get instead is a coupon, a voucher. He'll get an allowance to go buy private insurance, and private insurance is simply not going to pay for what Medicare pays for. It's going to be far more expensive.

The Congressional Budget Office estimates that in just 10 years those folks will have to pay 60 percent of their own health care costs if this plan goes through, what they call a ''path to prosperity,'' which should be called the ''path to insurance company profits.'' In 20 years, it will be two-thirds of their health care costs. They'll be paying for it. They'll also be paying taxes. Working Americans, people who are still in the workforce, will be paying taxes so that I get Medicare, and they know that's not the deal they're getting. The deal they'll be getting is that little voucher, that puny little voucher, that puts them at the mercy of insurance companies.

Now, Republicans thrive on resentment. All of Republican politics seems to be built around resentment. I don't want to have a Nation so filled with resentment between generations. Ms. EDWARDS spoke just a moment ago about the contract between generations, that just as our parents took care of us in our childhoods, we will take care of our parents and their generation when they retire. We'll take care of them with our Social Security taxes and our Medicare taxes. They will get those benefits. Yet under the Republican plan, the path to insurance company profits, they won't get Medicare. They'll get that little voucher.

How long is that going to go on before that resentment builds up? How long is that going to go on before the people who are paying the taxes for it and who know they'll never get it are going to say, No, no more of this. We have got to change this?

Madam Chair, what we want is for all Americans to get the same deal. We want the people who are 65 and the people who are 96 to get the same deal, the people who are 70 to get the same deal, the people who are 58 to get the same deal, the people who are 50 and 30 to get the same deal. If this Congress is willing to control costs, even though that means limiting the profits of some of the people who are getting really rich from our dysfunctional health care system, we can do that.

I yield back the balance of my time.

Mr. CICILLINE. I move to strike the last word.

The Acting CHAIR. The gentleman from Rhode Island is recognized for 5 minutes.

Mr. CICILLINE. I rise in opposition to the amendment and in defense of our Nation's seniors, who are really under attack.

Why is that? Because the current Republican budget proposal passed by this House and up for Senate consideration pulls the rug out from underneath our seniors. It ends Medicare by making huge cuts in benefits and by putting insurance companies in charge of our seniors' health care, letting insurers decide what treatment and what tests our seniors will receive.

Under the Republican plan, Medicare will end. It will not only impact our seniors; it will impact the family members of our seniors, who will now have those responsibilities. It will reopen the doughnut hole, making it more expensive for our seniors to get their prescriptions, the prescriptions they need to keep them healthy; and under their plan, they will slash support for seniors in nursing homes while continuing to give subsidies in the billions of dollars to big oil companies.

And what else? More than 170,000 Rhode Islanders, which is my home State, rely on Medicare; and they will literally be paying to give additional tax breaks to the wealthiest Americans in our country. To make matters worse, the nonpartisan Congressional Budget Office determined that this budget actually adds $8 trillion to the national debt over the next decade because its cuts in spending are outpaced by the gigantic tax cuts for the richest Americans.

Our seniors cannot afford this Republican budget. It would deny them health care, long-term care, and the benefits that they have earned. The Republicans' choice to end Medicare by cutting benefits and by turning power over to the insurance companies for the important health care decisions of our seniors will result in reduced coverage and an exposure to greater financial risk for Medicare recipients, costing seniors an estimated $6,000 more each year for their care.

The Congressional Budget Office determined that, under this Republican budget, seniors' out-of-pocket expenses for health care would more than double and could almost triple. They concluded: ''Most elderly people would pay more for their health care under the Republican plan than they would pay under the current Medicare system.''

To put that into context, the CBO found that, in 2030, seniors would pay 68 percent of premiums and out-of-pocket costs under the Republican plan compared to only 25 percent under current law; and it found that the Republican plan means seniors will pay more for their prescription drugs because it reopens the doughnut hole, costing each of the 4 million seniors who fall into that coverage gap up to $9,300 by 2020.

The conservative Wall Street Journal concluded that this plan ''would essentially end Medicare, which now pays for 48 million elderly and disabled Americans, as a program that directly pays those bills.''

Under the guise of deficit reduction, this Republican plan is recklessly attacking vital support systems for our seniors. We all agree that we have to address the deficit. The issue isn't whether we should reduce it but, rather, how we do it. Let's repeal subsidies to Big Oil. Let's eliminate fraud and waste. Let's end the wars that are costing us more than $2 billion a week. We should not be balancing the budget on the backs of our Nation's seniors.

The Federal budget is about more than just dollars and cents. It is a statement of our values and our priorities as a country. The Republican budget reflects the wrong priorities. It would rather cut benefits to our seniors than cut subsidies to Big Oil or corporations that ship our jobs overseas.

By ending Medicare, this Republican budget breaks the promise we made to our seniors to protect them in their golden years. We must do better for our seniors. Medicare has met the health care needs of seniors while providing them with financial stability for more than 40 years. Ending Medicare would pull the rug out from underneath the feet of our seniors during their golden years.

So I ask my colleagues, if we can't protect our Greatest Generation, what's next?

I yield back the balance of my time.

Mr. MCHENRY. I move to strike the last word.

The Acting CHAIR. The gentleman from North Carolina is recognized for 5 minutes.

Mr. MCHENRY. Madam Chair, I've heard my colleagues give volumes of words here today, but I've seen little action. In the 4 years they controlled the U.S. House, they proposed nothing in the way of meaningful entitlement reform: nothing to preserve Social Security, nothing to preserve Medicare, nothing to improve Medicaid and ensure that it's there.

Madam Chair, I ask, where is the plan of these House Democrats who are speaking today? Where is their plan for entitlement reform?

Mr. ANDREWS. Will the gentleman yield?

Mr. MCHENRY. I yield to the gentleman from New Jersey.

Madam Chair, I would ask my colleague, where is his plan on entitlement reform?

Mr. ANDREWS. Does the gentleman favor permitting Medicare to negotiate the price of prescription drugs, the way the VA does, and save $25 billion a year?

Mr. MCHENRY. In reclaiming my time, I would ask, does the gentleman favor the Medicare part D prescription drug benefit, which has a lower cost basis than what your colleagues proposed at the time of enactment?

Mr. ANDREWS. Will the gentleman yield?

Mr. MCHENRY. I'm going to finish up here, my friend.

Madam Chair, in this discussion, there are lots of questions but little substantive action—no policy proposals—to make sure that Medicare is there for the next generation, much less for the end of the Greatest Generation.

I would ask my colleagues to come forward with a substantive plan, not just to take up time here on the U.S. House floor, not to take away time from these important amendments that we have under this open rule here on the House floor. I would ask my colleagues to do something real and substantive rather than to push us to a debt crisis, which their policies and their spending are pushing us towards.

I yield back the balance of my time.

Mr. ANDREWS. Madam Chair, I move to strike the last word.

The Acting CHAIR. The gentleman from New Jersey is recognized for 5 minutes.

(Mr. ANDREWS asked and was given permission to revise and extend his remarks.)

Mr. ANDREWS. My friend who just spoke asked us where the plan is to reduce the debt and deficit. If he is here, I would be happy to yield to him, but I would ask him to consider these ideas.

□ 1700

One, Medicare pays more than twice as much for a Coumadin pill than the Veterans Administration does because we have a law that the majority supported that says that Medicare can't negotiate prescription drug prices. I favor repealing that law and saving at least $25 billion a year. I would ask my friend if he supports that, and I would yield if he would like to answer.

Mr. MCHENRY. Will the gentleman yield?

Mr. ANDREWS. Does the gentleman support that idea?

I yield to the gentleman from North Carolina.

Mr. MCHENRY. Why didn't the gentleman do it when he was in the majority? And I would be happy to yield back the balance of my time. Why is this not in ObamaCare? It's just everything else.

Mr. ANDREWS. Reclaiming my time, we did not do so because we couldn't get two Republican Senators to support it on the other side. We would have done it over here.

Second thing; does the gentleman support stopping the spending of $110 billion a year to occupy Iraq and Afghanistan and instead spend that money here in the United States? Does the gentleman support that? I would ask him if he would like to answer that question.

Mr. MCHENRY. I'm sorry, I didn't hear the question.

Mr. ANDREWS. I'll repeat it. We are spending about $110 billion a year to help finance the Government of Iraq and Afghanistan. I would rather see that $110 billion a year reduce our deficit. Would the gentleman support that?

Mr. MCHENRY. Does the gentleman support the President's war on Libya?

Mr. ANDREWS. I, frankly, do not. But reclaiming my time, I especially don't support paying the bills for Baghdad and Kabul that we could be using to reduce our deficit here at home.

Third, we're going to spend at least $60 billion over the next 10 years to give tax breaks to oil companies that made record profits—$44 billion last year alone—as our constituents are paying over $4 a gallon at the pump. I support repealing those giveaways to the oil industry and putting that money toward the deficit. I don't see the gentleman anymore, I'm not sure how he stands on it, but we support that.

Four, I support the idea that people who make more than $1 million a year might be asked to contribute just a little more in taxes to help reduce this deficit. Now I know the other side is going to say, well, this will hurt the job creators in America. There is an echo in this Chamber. In 1993, President Clinton proposed a modest increase on the highest earning Americans to help reduce the deficit. The former Speaker at the time, or Mr. Gingrich—he wasn't the Speaker at the time, he became the Speaker—said this would cause the worst recession in American history. He was wrong. The gentleman who became the majority leader, Mr. Armey, said that this was a recipe for economic collapse. He was wrong.

When we followed the supply-side trickle down the last 8 years under George W. Bush, the economy created 1 million net new jobs. But when we asked the wealthiest Americans to pay just a little more to reduce the deficit in the 1990s, the economy created 23 million new jobs.

So when they ask, where is the plan, here is the plan: Don't abolish Medicare the way they plan to; negotiate prescription drug prices; stop paying the bills for Iraq and Afghanistan; stop the giveaways to oil companies that make record profits; and ask the wealthiest in this country to pay just a bit more to reduce our deficit. Let's put that plan on the floor and reduce the deficit that way.

Madam Chair, I yield back the balance of my time.

Ms. LEE. Madam Chair, I move to strike the last word.

The Acting CHAIR. The gentlewoman from California is recognized for 5 minutes.

Ms. LEE. Madam Chair, I rise in strong opposition to the underlying, very reckless bill, H.R. 1216.

Republicans, and we've heard this over and over again, want to destroy and to deny seniors long-term affordable health care by eliminating programs that are training the future health workforce of our country.

This legislation is really part of an ongoing Republican attack on Medicare under the guise of deficit reduction and fiscal responsibility. It really is about privatizing Medicare, and of course that means that there will be some winners and there will be some losers. The Republican plan to end Medicare threatens the healthy and secure retirement that we promised American seniors. In fact, an end to Medicare is an end to a lifeline that millions of seniors rely on. Medicare gives peace of mind to millions of Americans who pay into it all their lives.

The Republicans want to give aging Americans a voucher, mind you, that will not come close to covering the cost of health care instead of maintaining and improving Medicare. Sure, waste, fraud and abuse must be addressed wherever we find it, including the Pentagon, but we disagree with the Republican agenda that the program must be killed. The Republicans want to end this program when millions of Medicare beneficiaries are struggling to make ends meet, and when we know that Medicare-eligible beneficiaries will double over the next 20 years.

Republicans have the wrong priorities—focused on letting the rich get richer on the backs of the middle class and the most vulnerable in our Nation. Under the guise of reform, Republicans would increase costs for seniors and cut benefits while giving tax cuts to millionaires, subsidies to oil companies, and sending desperately needed jobs overseas.

If the Republicans get their way, millions of seniors would immediately begin paying higher costs for prescription drugs. The impact of killing Medicare will be the most severe on vulnerable and underserved populations, including our seniors of color, while negatively impacting all seniors who rely on Medicare to protect their health and economic security. An end to Medicare is really an end to a lifeline that millions of seniors rely on.

If Republicans have their way, millionaires will continue to get big bonuses while millions of Americans fall deeper into poverty. Madam Chair, approximately 43.5 million Americans were living in poverty in 2009, but did you know that nearly 4 million of

those are seniors? Given our challenged economy, we can't expect these numbers to have improved since 2009.

Medicare is part of a promise made to hardworking Americans to ensure that they would not lack the security of having health care. And so rather than stand silently while Republicans destroy a program that protects vulnerable populations, we are here to speak up and stand up for our mothers and our fathers, our grandmothers and our grandfathers, our aunts and our uncles, and yes, our young people and our children, to be their voice in the House of Representatives. We are here to declare that Medicare should be protected and improved to protect our Nation's seniors and most vulnerable populations, and we are here to say that we want to secure it for future generations.

Ending Medicare really does end this promise and the security for millions of Americans today and in the future. So we are here today to defend Medicare and the support that it gives to our seniors. We must ensure that those who have worked hard their entire lives strengthening our Nation have the health security that they need and deserve in their later years.

Mr. SESSIONS. Madam Chair, I move to strike the last word.

The Acting CHAIR. The gentleman from Texas is recognized for 5 minutes.

Mr. SESSIONS. Madam Chairman, I have seen shameless acts on this floor before, and we are watching another one with the last few speakers that we have seen here today.

The facts of the case are—and people know this—we passed a budget resolution which is a construct to ask this House of Representatives to consider a plan so that we do not bankrupt Medicare—which is exactly what anyone who voted for the health care plan on March 21 or 22 1 year ago did. The plan which President Obama and Speaker PELOSI at that time supported took $500 billion out of Medicare to support a plan—which could not be sustained either—which cost $2 trillion for health care. So this year, Republicans have a plan to sustain Medicare that is a market-based plan. It's not a voucher program. Not one person who is presently on Medicare today nor anybody that is 55 years old or older today would be impacted by this plan. It is a plan that says we should challenge the Congress of the United States—including the administration also—to come up with a plan about how we can sustain Medicare, as we do see a doubling over the next 15 years of people who will be expected to participate in that plan.

So that we get this right for once, let me say this: It is not a voucher program. It does not impact anyone that is presently on Medicare. So the shameless things we've heard today about everyone's grandmother and everybody's grandfather and all these people that will be thrown off Medicare, they will be unaffected.

Here's what the plan calls for: It calls for the United States Congress to begin a process with hearings that would allow people who would be on Medicare, instead of a one-size-fits-all plan of Medicare, to have a plan that looks just like what government employees would have, a realistic opportunity for them to choose among several plans, whether they want a basic plan all the way up to a plan in which they could fully participate themselves.

□ 1710

Today, Medicare is a closed, one-size-fits-all process, just like we heard Mr. MILLER, ''We're going to treat everybody the same way.'' It does not work, because not everybody has the same needs as each other. We will have a plan which is market-based, which does not bankrupt this country nor the system, which will allow the individual an opportunity to come into a process and have their own health care just like somebody who works for the Federal Government. It would allow people who were in that program to take money out of their own pocket, to choose their own doctor if they chose to, and to be allowed to supplement those payments. We would probably set a mark, a bar, that said if you make above a certain amount of money, that's not determined yet, but if you had the ability to pay for yourself, you shouldn't rely upon the government. That is another way to make sure that we support the system, because if people have the ability to pay for their own health care, we should allow them to do that and encourage them to do that.

Then we look at how doctors are paid. Doctors today have not only been mistreated by both sides, but in particular as we see doctors not being compensated, they are not available, and it means seniors are being denied coverage because physicians are not being reimbursed properly. It allows us to have a great system, where doctors would want to serve seniors, a great and better system that is market-based whereby the ability that a person has to pay, if they do, then they would pay their own physician and their own way with the minimum support from the government.

The bottom line is, the gentleman from North Carolina asked a relevant question, and the answer that came back was, when he said, what is your plan, the answer that came back was, what about the war and what about oil companies? Well, the facts of the case are, we're talking about Medicare here today, a system that is draining this country from not only its ability to provide outstanding and excellent health care but also a system that takes away choices from seniors.

I yield back the balance of my time.

ANNOUNCEMENT BY THE ACTING CHAIR

The Acting CHAIR. Members are reminded not to traffic the well when other Members are under recognition.

Mr. RYAN of Ohio. I move to strike the last word.

The Acting CHAIR. The gentleman is recognized for 5 minutes.

Mr. RYAN of Ohio. Madam Chair, I rise in opposition to the underlying bill, and I think it's important for us to go back, as we hear about market-based solutions, to why Medicare was started in the first place. There is no market to provide health care for older people, because there's no money to be made. Insurance companies can't make money off of covering old people who get sick, really, really sick.

What this plan does, Madam Chair, and the analysis was, well, it's just going to be like the Federal employee plan, where Members of Congress and Federal employees get a premium support. Well, the premium support that Federal employees get is about 70 some percent of the health care costs, and that number goes up and down with inflation for health care. So no matter what the health care costs are, the Federal employee has 70 some percent of that covered.

The problem with the Republican plan is that the voucher, or the premium support, is hooked to the CPI, the Consumer Price Index, which is 2½ percent, maybe, so the voucher is going to go up at CPI, say, 2½ percent, while health care costs are usually a percent or two above GDP growth, so say we have 4 percent growth, then health care costs are going to go up at 5 percent, maybe 6 percent. So your premium support, or your voucher, is going to increase every year by 2½ percent, while health care costs are going up at 5½ percent. It doesn't take rocket science to figure out that over the course of several years, that voucher becomes worthless, and it will only probably cover 30 percent, maybe, of the cost of the health care that these seniors are going to get.

So let's not sit here and pretend like the senior citizens in the Medicare program are going to somehow be living large and getting some kind of great health care. This dismantles the Medicare program. Period. Done. At least have the courage to come out and say, we want to dismantle the Medicare program.

If you want to look at how far to the right that the Republican Party has gotten on this issue, I've never seen former Speaker Gingrich do a faster or more complete Potomac two-step in my entire life than when he even insinuated that this may not be good for seniors, because the goal now of the Republican Party, Madam Chair, is to dismantle the Medicare program.

They tried years ago to try to privatize Social Security. This is no surprise. And so my question is, Madam Chair, if you're a 55-year-old guy in Youngstown, Ohio, who statistically, over the last 30 years, your wages have been stagnant with no increase in real wages over the last 30 years, now you're saying to them that they've got to come up with another $182,000 to be able to pay for their health care.

You can nod your head ''no'' all you want, Madam Chair. These are the facts. The Congressional Budget Office

says, neutral third party, that the average person going into this Medicare proposal will pay $6,000 more a year. That's not the Democratic study committee or our policy wonk saying it, it's CBO. Six thousand more a year. While the guy's wages have been stagnant for the last 30 years?

And that's where the issue of the oil companies does come in, because we're giving huge breaks to oil companies. We'll take more arrows to protect, on the other side, to protect even thinking about possibly asking the wealthiest 1 percent to pay just a little bit more to help us address this issue. The sky is falling. The world's ending. It's so bad that we can't even muster up the courage to ask Bill Gates and Warren Buffett to just help us out a little bit while we have all these problems and three wars going on at the same time? I mean, come on, Madam Chair, this is not right. This is not right.

So, at the end of the day, the Democratic plan is for Medicare. We keep it to cover senior citizens and their health care when they get older, and if we've got to make adjustments, we make adjustments. But you don't dismantle the entire plan, and you don't at the same time give tax breaks to the oil companies.

The Acting CHAIR. The time of the gentleman has expired.

Mr. RYAN of Ohio. Don't dismantle Medicare, Madam Chair. Don't do it.

Mr. BURGESS. Madam Chairman, I move to strike the last year.

The Acting CHAIR. The gentleman from Texas is recognized for 5 minutes.

Mr. BURGESS. I thank the Chair for the recognition.

You know, if we're going to tell stories here, let's start out with ''once upon a time'' and maybe we can end with ''and they lived happily ever after.''

Whose budgetary plan puts Medicare at the most risk? Is it the responsible Republican plan that was debated on this floor for hours over a month ago? This was a plan that for the first time we had laid out for us a road map, a pathway, for how to save Medicare for people who are going to enter into the program in 20 years', 30 years' time.

Now what is the plan on the other side? Well, there was no plan from House Democrats. There is no plan from the Senate Democrats. There is a plan from the President. The President laid out his aspirational budget, just as the Republicans laid out their aspirational program which was their budget, and the President's aspirational document laid out a very clear path. The President believes in 15 people, not elected by anyone but appointed by him, and their ability to control costs in the Medicare system. It was written into a bill called the Patient Protection and Affordable Care Act. You may remember it.

I have a great deal of sympathy with those on the other side who do not like the Independent Payment Advisory Board. In fact, one of their number wrote an editorial for USA Today yesterday decrying the nature of the Independent Payment Advisory Board, but the sad fact of the matter is, this is the Democratic alternative to the Republican plan to save Medicare into the next 50 years.

□ 1720

That plan, the Democrats' plan, the President's plan, with the Independent Payment Advisory Board, says 15 people are going to be picked, they will be paid well, they will then decide where are the cuts going to occur in Medicare.

Now, true enough, Congress gets an opportunity. This 15-member board will come back to the United States Congress and say, ''Here is the menu of cuts that we believe are necessary to have this year in order to keep Medicare solvent.'' By law, they have to come up with a certain dollar number of cuts. But as the President himself said in his speech to Georgetown here earlier this year, that's a floor, not a ceiling. If we need to save more money, we can go back to the Independent Payment Advisory Board and save more money.

Now, Congress looks at the cuts that are brought to them by this unelected independent board and says, We don't like those cuts. Some of those cuts are going to be very damaging to poor seniors on Medicare. Do we have a choice? Yes. We can vote it up or down. If we vote it down, we have to come up with our own menu of cuts to then deliver to the Secretary of Health and Human Services. What if Congress can't agree? I know. When has that ever happened before? But what if we can't agree amongst ourselves? Do we get to do something like the doc fix that we do every year? No, we do not. That's the whole purpose of the Independent Payment Advisory Board. We cannot intervene on behalf of America's patients because the President's board has spoken.

So Congress can't agree on what these cuts should be.

So what do we do? We continue to fight. But guess what happens? April 15 of the next year, the Secretary of Health and Human Services, whoever he or she may be at that time, gets to institute those cuts that were brought to you by the Independent Payment Advisory Board. Now, is that a good idea?

And I've heard discussion here on the floor today about $6,000. You know what? If you don't fix that sustainable growth rate formula, guess what's going to happen to every senior, rich and poor, who is on the Medicare program? Either they're not going to be able to find a doctor to care for them when they require care, or they're going to have to pay more money. How much money are they likely to pay? About $6,000 per senior.

But look. The Independent Payment Advisory Board, something like that has never happened in this country. In a free society, we've got now an unelected board who is going to tell us what kind of medical care we can get, when we can get it, where we can get it, and most importantly, when you have had enough. And when they say you've had enough, that's it. No more. Dialysis, insulin. It doesn't matter. You're full. You've had your share. That is the problem with the Independent Payment Advisory Board.

And Congress then becomes powerless because frequently we do disagree with each other, and if we can't come to a consensus, the Secretary makes that decision for us. And then the next year starts all over again.

I've got a great deal of sympathy with my friends on the other side of the aisle because they did not include this language in their bill. And we all remember a year ago the very bad process that brought us the Patient Protection Affordable Care Act. And what was that process? It was the Senate on Christmas Eve that passed a House-passed bill that then came back over to the United States House and will the House now agree to the Senate amendment to H.R. 3590? You all remember 3590. It was a housing bill when you passed it in the summer of 2009. It was a health care bill when it came back to the House.

You did not include the Independent Payment Advisory Board in H.R. 3200 for a very good reason. The reason is it's un-American, and you know it, but now you're left to defend it.

I yield back the balance of my time.

Mr. MARKEY. I move to strike the last word.

The Acting CHAIR. The gentleman from Massachusetts is recognized for 5 minutes.

Mr. MARKEY. You know, this is a crazy debate that we're having here right now because the Republicans, they keep saying to the Democrats, Well, what's the plan? So we say to the Republicans, Well, what's your plan? Your plan just seems to be saying to Grandma and Grandpa that they're taking too much. That they really—they're taking America for a ride, and we have to cut Medicare. Their health care is too good. And Grandma and Grandpa, they didn't do enough for America.

So the Democrats, we turn around and say, Hey, how about looking at it this way: How about before you go after Grandma and her Medicare card and how about you say to Warren Buffet, Hey, how about not taking those extra tax breaks?

And the Republicans say, We can't take away any tax breaks from Warren Buffet and all of the other multi-multi-millionaires and billionaires. Because they've contributed so much to America, we don't want to touch their money, even though that would give us hundreds of billions of dollars.

And then we say to them, Well, how about prescription drugs? How about we negotiate the price for prescription drugs, for Medicare, the way we do

with the VA? That would save about a quarter of a trillion dollars over a 10-year period. They say, That would be unfair to the drug companies. We can't touch them either.

Then we say to them, Well, you know, the war in Iraq, the war in Afghanistan, it's winding down now. Maybe we could look into the defense budget and save a few billion dollars there before we ask Grandma to sacrifice on the health care that she gets from Medicare? And the Republicans say, We can't do that either. We can't look at any cuts in the defense budget. That would be much too hard on those defense contractors.

So then we say to them, How about the oil industry? At least the oil industry, the $40 billion in tax breaks which they're going to get over the next 10 years? I mean, does anyone in America really believe that they need tax breaks in order to have an incentive to go out and drill for oil when people are paying $3, $3.50, $4 a gallon at the pump?

But the Republicans say, No. You can't touch the oil companies either. You've got to give big tax breaks to the oil industry as well, even as they're tipping Grandma and Grandpa upside down at the pump when they're coming in to put in their unleaded $4 a gallon gasoline—self-serve, by the way—at the pump.

So what do they do instead? What they do is they put an oil rig on top of the Medicare card so that the oil industry can drill into Grandma's Medicare and pull out the funding in order to provide the tax breaks for Big Oil, for Warren Buffet, for the prescription drug industry, for the wars in Iraq and Afghanistan. It's all off of Grandma. She's the one. We've targeted the person responsible for all of the wasteful spending in the United States. It's all Grandma's fault. Let's cut Medicare. She didn't do enough to build our country through the 1930s, the 1940s, the 1950s, and the 1960s. It's all on Grandma.

So this drill rig that they are building into the pocketbooks of Grandma in order to find that funding, that's what their plan is all about. It's an oil pipeline into the pocketbooks of the seniors. They want to cut checkups for Grandma while they cut checks for the oil companies. They want to cut health care to Grandma and give wealth care to big oil companies and to billionaires and to prescription drug companies.

Their plan is big tax breaks for Big Oil and tough breaks for Grandma and for the seniors in our country.

And the CEO of Chevron? He says it's un-American to think about increasing taxes on the oil industry. You know what I say to him? It's unbelievable that you could make that argument. But even more unbelievable that the Republican Party would accept that argument and cut Medicare for Grandma. To privatize it, to hand it over to the insurance industry, to increase the cost by $6,000 per year for their costs even as they say to Warren Buffet, the oil companies, the big drug companies, the arms contractors, Don't worry. We're going to protect your programs. It's just Grandma that's on the cutting block.

So, ladies and gentlemen, this is a debate of historical dimensions. And until the Republicans come forward with a plan—which they don't have in order to make Medicare solvent—by raising the revenues out of these other areas from millionaires, from the oil industry, and from others, do not expect us to say to Grandma it's her fault. It's not her fault. She built this country. She deserves this benefit. And we should not be cutting it.

This Republican plan to end Medicare is just something that wants to turn it over to the insurance industry. Vote ''no'' on the Republican plan.

Mr. COURTNEY. I move to strike the last word.

The Acting CHAIR. The gentleman from Connecticut is recognized for 5 minutes.

Mr. COURTNEY. I rise in opposition to the underlying bill, which, by the way, is a bill that would repeal a provision of the Affordable Care Act that was aimed at trying to strengthen the primary care infrastructure of this country, which is in fact a huge challenge for the Medicare program, but for some reason over the last couple of months or so, Medicare just seems to be the target.

I think it's important for people to remember that in 1965 when Medicare was passed and signed into law on Harry Truman's front porch, only half of America's seniors had health insurance.

□ 1730

Part of it was because of the cost, but part of it was because the insurance companies would not insure that demographic. It was just simply too high a risk to write insurance policies by individual companies for people who, again, because of nature carried the highest degree of risk in terms of illness and disease. Over time, the genius of Medicare, which was to pool risk, to create a guaranteed benefit, to fund it through payroll taxes, to fund it through Medicare part B premiums, demonstrated that we could raise the dignity and quality of life for people over age 65 and in fact extend life expectancy.

But the Republican Party has been targeting this program over and over again. In the 1990s, they came out with Medicare part C, Medicare Plus Choice, which was again giving insurance companies a set payment who promised to provide a more efficient, lower cost product for seniors. And what happened? Insurance companies enrolled millions of seniors in Medicare Plus Choice products. And realizing in a short space of time that they did not in fact have the funds to create a sustainable product, they canceled coverage for seniors all across the country.

I was at hearings in Norwich, Connecticut, in 1998, where seniors who had signed up for these programs suddenly got notification in mid-policy year that the insurance companies changed their minds, and they dropped them like a hot potato. In many instances, seniors who were in the middle of cancer treatments and chronic disease treatments were left high and dry without coverage. So that program failed.

Later, we had Medicare Advantage. Medicare Advantage was sold on, again, the premise that it would provide coverage for seniors cheaper than regular Medicare. And what in fact happened? The Department of Health and Human Services had to offer insurance companies 120 percent of the baseline costs for Medicare in order to entice insurance companies to participate in the Medicare Advantage program; a ridiculous overpayment, treating unfairly seniors who were in traditional Medicare and paying for Medicare supplemental insurance.

Last year we did something about that unfairness by equalizing the payments to seniors on traditional Medicare and Medicare Advantage. And today what we have is the Ryan Republican plan, which says you get an $8,000 voucher if you are under age 55, and good luck in terms of trying to find coverage, again, in a market that is going to be very, very careful about not extending actual coverage because of the risk that's attached to it.

Now, the rank unfairness of saying that we are going to create a two-tiered system for people over the age of 55 and people under the age of 55 is obvious even in my own family. I am 58 years old. My wife Audrey, who is a pediatric nurse practitioner, is 51. I get one version of Medicare; she gets stuck with the loser version of Medicare under this proposal. Again, the unfairness of it is so obvious to all families across America. And again, it is one that is why I think the public is turning so quickly against the Republican agenda.

And we are told and we are asked: What's your alternative? Well, look at the trustees' report that came out last week. Look at it. What it said was that the Affordable Care Act in fact extended solvency for the Medicare program by 8 years. We did suffer some reductions, but that was because of the economy. Read the trustees' language. The smart efficiencies which were introduced into the Medicare program through the Affordable Care Act in fact have made the Medicare program healthier.

And if you look at the Ryan Republican budget plan, they took every nickel of those savings from the Affordable Care Act. Even though that caucus demagogued all across the country, campaigning about so-called Medicare cuts in the Affordable Care Act, well, the Ryan Republican plan incorporated every single one of those changes in the Affordable Care Act.

But at the same time, it took away all the benefits of the Affordable Care Act in terms of helping seniors with prescription drug coverage, annual checkups, cancer screenings, smoking cessation, all of the smart changes which the Affordable Care Act made to provide a better, smarter, more efficient Medicare benefit for seniors.

The fact of the matter is that the Democrats do have an alternative. We have a program which we passed last year which, for the first time in decades, extended the solvency of the Medicare program.

Let's not abandon it. Let's preserve the guaranteed benefit for seniors. Let's reject the Ryan Republican Medicare plan.

Mr. MCDERMOTT. Madam Chairman, I move to strike the last word.

The Acting CHAIR. The gentleman from Washington is recognized for 5 minutes.

Mr. MCDERMOTT. Madam Chairman, I rise in opposition to this underlying bill.

It reminds me, as I listen to this debate, of debates around the Vietnam War. I remember a village that was napalmed by a military unit, and the officer who had them do it, he was asked why he did it. He said, well, I destroyed it to save it. Now that's the argument we are hearing today on Medicare. We have to destroy it to save it.

Now ask yourself—and there are a lot of people watching, Madam Chairman. If I were sitting at home trying to figure out what's this all about, well, why would Representative RYAN suggest that a voucher system is the way to save Medicare because of the rising costs? Everyone knows that the costs of Medicare and medication and health care in this country are totally out of control.

Now, President Obama came up with a plan which he brought out here. It wasn't like he created something that nobody had ever thought about before in the whole United States. He looked at the State of Massachusetts. It's been a place where a lot of great things have come from. And he saw what Governor Romney, a Republican, a Republican thought that we ought to have a universal plan for Massachusetts, and so they passed the law and they covered everybody in Massachusetts.

Now, then came the question: Once you have got access for everybody, how do you control the costs? Well, then the problems developed. And the problem was they found in Massachusetts they didn't have enough primary care physicians. Now, what does that have to do with it? That's what this bill is about. This bill is about the training of primary care physicians.

What everybody in this country needs is a physician that knows them and is a medical home. When they get sick, they go to that person. The doctor knows them. If they need some preventive care, the doctor takes care of it. The doctor does it in a very cost efficient way, before the catastrophes.

Now, for the many people in this country who don't have a primary care physician, they sit at home and say, well, I've got to wait until I am really, really sick, and then they go to the emergency room. Now, if you have your blood pressure monitored and you take medication, you can live a long life; but if you don't, you are very likely to wind up with a stroke.

Now, we spend millions of dollars in hospitals on stroke victims that could have been prevented by good primary care. And we say to ourselves, well, why don't we have more primary care physicians? Well, because the health care system is designed to take care of people after the big event. After they have got the cancer, we will spend millions of dollars on cancer treatment. We will spend millions of dollars on heart problems, on all these things where prevention could have prevented it all and cost less. That's what every industrialized country in the world has done.

It's why the Swiss are able to provide universal coverage to everybody in Switzerland for a little over one half of what we spend in the United States. Because they provide good preventive care in the form of general practice, general medicine. That's true in England, in Norway, in Canada, in every other country except the United States, where we are dominated by specialists.

Now, in this country, if you get sick or you have a pain, if you don't have a primary care physician, a doctor who knows you, you call up your friends and you say, I've got a pain in my leg. What should I do? And they say, well, I saw an orthopedic surgeon, and his name is such, and so you go to a specialist. And that specialist looks at your leg. He doesn't look at all the rest of you. He doesn't know what's going on with you. He doesn't know your whole history.

When I started in medical school, the maxim we were taught at the very beginning was: Listen to the patient. He is telling you what's the matter with him. And everybody knows that doctors are running on a conveyor belt today, one right after another, no time to listen because we have not invested in primary care physicians.

□ 1740

Now, the average kid going to medical school would like to take care of people; but when he comes out, or she comes out, they are $250,000 in debt. This bill is making that problem worse and, therefore, is bad for Grandma and everybody else.

Mr. GINGREY of Georgia. Madam Chairman, I move to strike the last word.

The Acting CHAIR. The gentleman is recognized for 5 minutes.

Mr. GINGREY of Georgia. Madam Chairman, sitting in my office and listening to this debate, and I can't help but feel that this is nothing but a bunch of demagoguery on the part of our colleagues on the Democratic side of the aisle.

I take this opportunity to oppose the amendment, but, more importantly, to ask my colleagues to stop this demagoguery in regard to throwing Grandma under the bus in reference to the Medicare program and what our side of the aisle has proposed in the Republican budget.

You know, the average age of this body is 58 years old. Almost all of us are Grandma and Grandpa, and you are running these ads all across the Nation, I guess, particularly in New York 26, showing a reasonable facsimile of our fantastic chairman of the Budget Committee pushing Grandma in a wheelchair off the cliff.

Look, New York 26 is over. You don't need any more votes. Stop all this demagoguery.

You have done nothing in regard to the Medicare program. What is there in the 2012 budget, in the Obama budget, that does anything toward trying to solve the Medicare program, which will be bankrupt in 2024 if nothing is done? That is the total irresponsibility and the hypocrisy of this side of the aisle, Madam Chairman.

And the responsible side of the aisle is the Republican side of the aisle which says, look, let's save this program for our children and our grandchildren, guarantee, protect and strengthen it for Grandma and Grandpa, our current seniors, and not only the current seniors who are 65 and those who are disabled and already on the Medicare program, but anybody who will come into the Medicare program within the next 10 years.

And, you know, Madam Chairman, at that point, in 2022, you will have about 65 million people on the Medicare program as we know it, traditional Medicare; and they will be on that program until their natural death and many of them, thank God, because of our great health care system in this country, will live to be 90 years old.

So this idea of killing Medicare is an absolute misinterpretation, and you know it. You are misleading the American people.

This program that we are proposing, and it's a proposal, it's something that we can work together on both sides of the aisle, we can negotiate, you know, it's not set in stone—but what we say, what Speaker BOEHNER says, what Chairman RYAN says is, look, let's try this program in 2022 where people who are coming into Medicare at age 65, many of whom are working and in excellent health, we will simply give them a premium support, but not a voucher in their hands, but to send to the insurance company of their choice. Let them get their medical care where Members of Congress get their medical care. Let them have the same options to choose from, Madam Chairman.

That's what's this is about. And the average, if it is $8,000, it will be adjusted every year for inflation and that average 8,000 will be higher for an individual who comes into the Medicare

program at age 65 that is already sick, that already has heart disease or diabetes or is on dialysis. It's somebody, as they get older, that premium support will increase.

This is the way we save the Medicare program; and, oh, yes, by the way, folks like us, like members of the subcommittee, our premium support will be significantly less because we are not Warren Buffett, but we can afford to pay more, and we should pay more. If that's $4,000 a year more, so be it. We save the program for those who need it the most, those who are middle- and low-income seniors, and that is the compassionate thing to do.

So, colleagues, stop this demagoguery. Let's get together, let's work together and solve this problem once and for all.

I yield back the balance of my time.

ANNOUNCEMENT BY THE ACTING CHAIR

The Acting CHAIR. Members are reminded to address their comments to the Chair.

Ms. SCHAKOWSKY. I move to strike the last word.

The Acting CHAIR. The gentlewoman from Illinois is recognized for 5 minutes.

Ms. SCHAKOWSKY. I am getting a real kick out of this debate. I really am. You know, we hear one after another of my Republican colleagues coming up here and self-righteously talking about ending the demagoguery and we should end the TV ads.

And I just want to remind you that through the 2010 elections, the Republicans went on television and, yes, how about demagogued, the issue of Medicare, saying that Democrats wanted to cut $500 billion from Medicare.

Well, let's talk about the truth. We were challenged, just a little while ago: What is your plan? Well, here was our plan to save Medicare and that was to say in The Affordable Care Act, yes, we are going to cut subsidies to the insurance companies that meant that we were bilking the government and the taxpayers, and we were having to overpay them, and, yes, we are going to cut waste and fraud from the Medicare program.

And that's how we are going to save $500 billion. But not only would we not cut a single penny from benefits, but we were actually able to increase benefits while trimming Medicare.

We, you know—so you scared the heck out of seniors but never mentioned, of course, at the same time we reduced the cost of Medicare.

We improved Medicare by adding to its solvency; we closed the doughnut hole, making prescription drugs more affordable; and we provided a wellness exam every year at no cost; and we provided preventive services with no cost sharing. But nevertheless, on television, those ads warned against those Democrats who didn't cut one thing from Medicare and improve it. And now you are saying, well, we are not going to do anything to people 55 and under. To me that sounds like 55 and under, you better look out.

Now, the ads in New York are working because people love their Medicare. And what they don't want to see, you know, all but four Republicans voted to literally end Medicare.

You can call it something else, but you can't call it Medicare because those guaranteed benefits are gone. It makes huge cuts in Medicare benefits. Seniors that fall under the new plan would have to pay about $6,000 more a year. That's what the Congressional Budget Office says, $6,000 more a year out of pocket for their health care, and it would put insurance company bureaucrats in charge of seniors' health care, letting insurers decide what tests and what treatment that seniors get, throwing seniors back into the arms of the insurance companies who have shown no love to them.

And so let's look at what the American people think about Medicare. Well, if you are 65 years and older, 93 percent of Americans say the Medicare program as it is right now is very important or somewhat important to them, actually 83 percent very important.

If they are 55 to 64, 91 percent say Medicare is very important; and if you are 40 to 54, we have got 79 percent of Americans who say the Medicare program is very or somewhat important; and if you are 18 to 39, 75 percent.

□ 1750

People get it. Medicare works. Medicare is efficient. Medicare is good for our country, for people with disabilities and for the seniors. And if we are looking to save Medicare, we do have a plan. We know how to make that more efficient. We have done it in the Affordable Care Act. And we are willing to sit down and talk about how we make Medicare more efficient, but not by ruining, destroying and getting rid of Medicare to the point that you've got to find another name. It won't be Medicare anymore.

And so they've admitted, it seems to me, that people 55 and younger, you better look out. Because that program that will allow our seniors to live perhaps to 90 years old, people who are going to be eligible for Medicare as it is right now will no longer be in place. And we are not talking about rich people——

The Acting CHAIR. The time of the gentlewoman has expired.

Ms. SCHAKOWSKY. We're talking about poor seniors and middle class people.

Don't support this plan.

ANNOUNCEMENT BY THE ACTING CHAIR

The Acting CHAIR. Members are reminded to refrain from trafficking the well while another Member is under recognition.

Mr. WOODALL. Madam Chair, I move to strike the last word.

The Acting CHAIR. The gentleman from Georgia is recognized for 5 minutes.

Mr. WOODALL. Madam Chair, like my colleague from Georgia, I too was sitting back in my office. I saw the debate break out on the floor of the House on the Medicare proposal, the proposal to rescue Medicare from certain bankruptcy. And I wondered, because I sit on the Rules Committee, and the Rules Committee has one of the great pleasures of deciding what comes to the floor, how it comes to the floor and what goes on, and I knew that this wasn't Medicare reform day. This was the amendment by my colleague from North Carolina (Ms. FOXX) to protect life. It was an amendment to a bill brought to the floor by my colleague, Mr. GUTHRIE, which restores congressional oversight and regular order through the appropriations process, those things that I ran for Congress to do. And I rise in strong support both of the Foxx amendment and of Mr. GUTHRIE's underlying bill.

But when I heard this talk about Medicare and all the games and what has happened in the past, I have to say, I have only been here—this is, what, month number 5 for me. I'm still brand new, and I'm still optimistic enough to believe that it doesn't have to all be about sound bites, that it really can be about solutions.

And I want to say to my colleagues on the Democratic side of the aisle, when you say that you came up with a proposal in the President's health care bill last year to deal with Medicare, I believe you. I take you at your word. I read through that, too. I saw that Medicare Advantage was removed as an option for seniors. That distressed me. I saw that new benefits, as Ms. CASTOR just referenced, had been added, Madam Chair, added to a program that's already going bankrupt. I saw that that is one direction that you can take the Medicare program.

Now I'm a proud member of the House Budget Committee, the House Budget Committee that worked hard and long to produce the Medicare reform proposal that we're talking about, oddly enough, here today. And it's a program that saves Medicare for everybody 55 years of age and under and provides them with choice.

I just want to tell a personal story. I don't consume a lot of health care. I've been very blessed in that regard. But I had to go in for a chest CT the other day. I have a medical savings account, so I'm responsible for the first couple of thousand dollars of my health care bill. So the first health care I consumed was my chest CT. I got on the Internet and started shopping around. It turns out that the difference between the cheapest chest CT and the most expensive chest CT in my part of Georgia is four times—four times. I got in the car. I drove across town and spent my $4 a gallon for gas to go get the cheap one. It turns out the really expensive one was right next door. I could have walked right next door.

Folks, when we talk about how we, we the United States Congress, we the U.S. House of Representatives voted to

save Medicare in the 2012 budget proposal, we talked about saving it by providing choice. Again, my colleagues are exactly right. We did that in 1997. That was the debate, can we save Medicare in 1997 by providing more choice? Well, we succeeded with adding Medicare Advantage, but we didn't get much further than that. This is that next step. This is that next step because we know that choice matters. We know that choice matters.

The gentleman who held my seat and has been retired used to tell the story of his mother in upstate Minnesota, and every Tuesday she would go to the doctor with a group of friends just to make sure everything was okay, just to get checked out. She was on Medicare. One day, there was a terrible snowstorm in Minnesota. The winds were blowing and the snow was piling up. They all got together on Tuesday, and Edna wasn't there, and they began to get worried. They called around and they asked around. It turned out Edna just wasn't feeling well. She couldn't be there that day.

You make different choices when you're not responsible for the bills. And we do that over and over and over again. This isn't just a Medicare issue. This is a philosophical difference between these two sides of the aisle about what kind of an America we are going to live in going forward. Are we going to live in one where folks take care of you but they tell you the manner they're going to do it? Or do we live in one where we help you along but you get to make those fundamental choices for you?

It's clear to me why my constituents sent me to Washington as a first-time elected official this year. It's clear to me where the 2012 budget proposal takes this House and takes this country.

I implore my colleagues, we can absolutely argue about your plan as it was introduced in the President's health care bill and our plan as it was introduced in the fiscal year 2012 budget proposal, but let's not, let's not make it anything other than what it is. It's a difference in two visions. Yours saves Medicare for 6 years. Ours saves Medicare for a lifetime. And, Madam Chair, I think we owe the voters no less.

Mr. PERLMUTTER. Madam Chair, I move to strike the last word.

The Acting CHAIR. The gentleman from Colorado is recognized for 5 minutes.

Mr. PERLMUTTER. I just say to my friend from Georgia, who really is my friend, that this isn't about demagoguery, sir. And what I would say, Madam Chair, the issue before us is: What got our country into a financial pickle? The Republicans want to pick on Medicare, but Americans know.

I had a Government in the Grocery this weekend, and an older gentleman came up to me. He said, Why is there such a focus on Medicare, something that has been working for 50 years? It's helping seniors have healthier, longer lives. What's the big deal? He said that 10 years ago this country was running a surplus, running a surplus, revenues exceeded expenses. Under Bill Clinton, revenues were exceeding expenses. But then there was a decision under the Bush administration to cut taxes. Okay. If revenues are exceeding expenses, then maybe that's okay. That cost us $1 trillion over the next 10 years. Then came the decision to prosecute two wars. He said to me that two wars cost us about $1 trillion, too, didn't it, Mr. Congressman? I said, Yeah. He said, Okay. Medicare 10 years ago was fine, revenues exceed expenses. Now we've got tax cuts for millionaires and billionaires, $1 trillion dollars; two wars, $1 trillion; and then there was this big crash on Wall Street where we lost revenues and we had bigger expenses. That was a couple trillion dollars, wasn't it, sir? I said, Yeah, that's about right. And he said, So why—that turned our budget upside down. So now why are we focusing on Medicare? Why blame Medicare for $4 trillion of losses to the United States? It wasn't Medicare that is harming the financial success of this country. So why all the blame when this program really has been working for seniors for so long?

So I would say to my friends on the Republican side of the aisle, this is a program that my friends haven't liked since its inception. This is a program that Republicans haven't liked from its inception.

So to turn the target into Medicare and not say to have tax cuts for millionaires and billionaires, that that should be part of the whole equation of balancing our budget, or taking away the incentives and all of the tax benefits for oil companies at $100 a barrel but say, no, we're going to focus on Medicare, in my opinion, that's just wrong.

Mr. GINGREY of Georgia. Will the gentleman yield?

Mr. PERLMUTTER. I yield to the gentleman from Georgia.

Mr. GINGREY of Georgia. I appreciate the gentleman from Colorado, my good friend, for yielding.

I would just rhetorically ask, and maybe he would like to definitively answer, how much of the windfall profit taxes, if you will, against Big Oil, Big Pharma, big anything, are you going to put back into the Medicare program? And, by the way, how much of the Medicare Advantage cuts that came from ObamaCare are actually going back into the Medicare program as we know it?

Mr. PERLMUTTER. Reclaiming my time, I would say to my friend from Georgia, do you know what? If those tax benefits are taken away at $100 a barrel, we can put them into Medicare. We can use them to balance the budget. But I heard my other friend from Georgia say, well, this is what's causing the bankruptcy.

□ 1800

That is just not true. This country was running a surplus, for goodness sake, and Americans understand that. They know what got us into trouble financially, and it wasn't Medicare. So now to take it out of Medicare and just take it out of our senior citizens where a program is actually working, the goal of that program is so Americans could live longer, healthier lives in their senior years. It's working. But no, let's go blame that instead of the tax cuts for millionaires and billionaires. Let's forget about those wars and the cost to the country, and let's forget about the fact that we had a crash on Wall Street.

My friends on the Republican side of the aisle say: Hey, this is a perfect time to go after Medicare. We didn't like it before, we still don't like it; let's get it.

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

The Acting CHAIR. Pursuant to clause 6 of rule XVIII, proceedings will now resume on those amendments——

POINT OF ORDER

Mr. WEINER. Madam Chair, I rise to a point of order.

The Acting CHAIR. The gentleman will state his point of order.

Mr. WEINER. Madam Chair, under the rule, Members are entitled to 5 minutes to speak to the matter at hand. Members are waiting; principally among them is myself waiting at the microphone to be recognized for that purpose. And now it sounds like you are proceeding to shut down debate. I say that it is in violation of the order of the House, as decided by the Rules Committee, to permit Members to speak for 5 minutes on this matter. It is early in the evening, and many Members are waiting to speak.

The Acting CHAIR. Pursuant to clause 6 of rule XVIII, the Chair may resume proceedings on a postponed question at any time, even while another amendment is pending.

PARLIAMENTARY INQUIRY

Mr. WEINER. Madam Chair, point of parliamentary inquiry.

The Acting CHAIR. The gentleman will state his parliamentary inquiry.

Mr. WEINER. So the Chair is deciding, notwithstanding the fact that a Member is standing here to speak about the plan to end Medicare, not to mention Members are here seeking to be recognized, I believe of both parties, the Chair is choosing at this moment that this is the propitious moment to cut off debate, early in the evening when we have plenty of work to do and Members seek to speak and offer amendments?

Is the Chair deciding arbitrarily, or was she given guidance to do this by the Republican leadership who don't want to hear any more critique of their plans to end Medicare?

The Acting CHAIR. The Chair is exercising her discretion to resume proceedings on a postponed question at any time.

Pursuant to clause 6——

Mr. WEINER. * * *

The Acting CHAIR. The gentleman is not recognized.

Pursuant to clause 6 of rule XVIII, proceedings will now resume on those amendments printed in the CONGRESSIONAL RECORD on which further proceedings——

MOTION TO RISE

Mr. WEINER. Madam Chair, I move that the Committee do now rise.

The Acting CHAIR. The question is on the motion to rise.

The question was taken; and the Acting Chair announced that the noes appeared to have it.

RECORDED VOTE

Mr. WEINER. Madam Chair, I demand a recorded vote.

A recorded vote was ordered.

The Acting CHAIR. Following this 15-minute vote, proceedings will resume on those amendments printed in the CONGRESSIONAL RECORD on which further proceedings were postponed, in the following order:

Amendment No. 2 by Mr. TONKO of New York.

Amendment No. 9 by Mr. CARDOZA of California.

The Chair will reduce to 5 minutes the minimum time for any electronic vote after the first vote in this series.

The vote was taken by electronic device, and there were—ayes 14, noes 397, not voting 20, as follows:

[Roll No. 335]

AYES—14

Capuano	Johnson (IL)	Schakowsky
Cleaver	Kucinich	Watt
Conyers	Lee (CA)	Waxman
Frank (MA)	Miller, George	Weiner
Green, Gene	Payne	

NOES—397

Ackerman	Burgess	Davis (KY)
Adams	Burton (IN)	DeFazio
Aderholt	Butterfield	DeGette
Akin	Calvert	DeLauro
Alexander	Camp	Denham
Altmire	Campbell	Dent
Amash	Canseco	DesJarlais
Andrews	Cantor	Deutch
Austria	Capito	Diaz-Balart
Baca	Capps	Dicks
Bachmann	Cardoza	Dingell
Bachus	Carnahan	Doggett
Baldwin	Carney	Dold
Barletta	Carson (IN)	Donnelly (IN)
Barrow	Carter	Doyle
Bartlett	Cassidy	Dreier
Barton (TX)	Castor (FL)	Duffy
Bass (CA)	Chabot	Duncan (SC)
Bass (NH)	Chaffetz	Duncan (TN)
Becerra	Chandler	Edwards
Benishek	Chu	Ellison
Berg	Cicilline	Ellmers
Berkley	Clarke (MI)	Emerson
Berman	Clarke (NY)	Engel
Biggert	Clay	Eshoo
Bilbray	Clyburn	Farenthold
Bilirakis	Coble	Farr
Bishop (GA)	Coffman (CO)	Fattah
Bishop (NY)	Cohen	Fincher
Bishop (UT)	Cole	Fitzpatrick
Black	Conaway	Flake
Blackburn	Connolly (VA)	Fleischmann
Blumenauer	Cooper	Fleming
Bonner	Costa	Flores
Bono Mack	Costello	Forbes
Boren	Courtney	Fortenberry
Boswell	Cravaack	Foxx
Boustany	Crawford	Franks (AZ)
Brady (PA)	Crenshaw	Fudge
Brady (TX)	Critz	Gallegly
Brooks	Crowley	Garamendi
Broun (GA)	Cuellar	Gardner
Brown (FL)	Culberson	Garrett
Buchanan	Cummings	Gerlach
Bucshon	Davis (CA)	Gibbs
Buerkle	Davis (IL)	Gibson
Gingrey (GA)	Lungren, Daniel E.	Roskam
Gohmert	Lynch	Ross (AR)
Gonzalez	Mack	Ross (FL)
Goodlatte	Maloney	Rothman (NJ)
Gosar	Manzullo	Roybal-Allard
Gowdy	Marchant	Royce
Granger	Marino	Runyan
Graves (GA)	Matheson	Ruppersberger
Graves (MO)	Matsui	Rush
Green, Al	McCarthy (CA)	Ryan (OH)
Griffin (AR)	McCaul	Ryan (WI)
Griffith (VA)	McClintock	Sánchez, Linda T.
Grijalva	McCollum	Sanchez, Loretta
Grimm	McCotter	Sarbanes
Guinta	McDermott	Scalise
Guthrie	McGovern	Schiff
Gutierrez	McHenry	Schilling
Hall	McIntyre	Schmidt
Hanna	McKeon	Schock
Harper	McKinley	Schrader
Harris	McNerney	Schwartz
Hartzler	Meehan	Schweikert
Hastings (FL)	Meeks	Scott (SC)
Hayworth	Mica	Scott (VA)
Heck	Michaud	Scott, Austin
Heinrich	Miller (FL)	Scott, David
Hensarling	Miller (MI)	Sensenbrenner
Herger	Miller (NC)	Serrano
Herrera Beutler	Miller, Gary	Sessions
Higgins	Moran	Sherman
Himes	Mulvaney	Shimkus
Hinchey	Murphy (CT)	Shuler
Hinojosa	Murphy (PA)	Shuster
Holden	Myrick	Simpson
Holt	Nadler	Sires
Honda	Napolitano	Slaughter
Hoyer	Neal	Smith (NE)
Huelskamp	Neugebauer	Smith (NJ)
Huizenga (MI)	Noem	Smith (TX)
Hultgren	Nugent	Smith (WA)
Hunter	Nunes	Southerland
Hurt	Nunnelee	Speier
Inslee	Olver	Stark
Israel	Owens	Stearns
Issa	Palazzo	Stivers
Jackson Lee (TX)	Pallone	Stutzman
Jenkins	Pascrell	Sullivan
Johnson (GA)	Paul	Terry
Johnson (OH)	Paulsen	Thompson (CA)
Johnson, E. B.	Pearce	Thompson (MS)
Johnson, Sam	Pelosi	Thompson (PA)
Jones	Pence	Thornberry
Jordan	Perlmutter	Tiberi
Kaptur	Peters	Tierney
Keating	Peterson	Tipton
Kelly	Petri	Tonko
Kildee	Pitts	Towns
Kind	Platts	Tsongas
King (IA)	Poe (TX)	Turner
King (NY)	Polis	Upton
Kingston	Pompeo	Velázquez
Kinzinger (IL)	Posey	Visclosky
Kissell	Price (GA)	Walberg
Kline	Price (NC)	Walden
Labrador	Quayle	Walsh (IL)
Lamborn	Quigley	Walz (MN)
Lance	Rahall	Wasserman Schultz
Landry	Rangel	Waters
Lankford	Reed	Webster
Larsen (WA)	Rehberg	Welch
Larson (CT)	Reichert	West
Latham	Renacci	Westmoreland
LaTourette	Reyes	Whitfield
Latta	Ribble	Wilson (FL)
Levin	Richardson	Wilson (SC)
Lewis (CA)	Richmond	Wittman
Lewis (GA)	Rigell	Wolf
Lipinski	Rivera	Womack
LoBiondo	Roby	Woodall
Loebsack	Roe (TN)	Woolsey
Lofgren, Zoe	Rogers (AL)	Wu
Lowey	Rogers (KY)	Yarmuth
Lucas	Rogers (MI)	Yoder
Luetkemeyer	Rohrabacher	Young (AK)
Luján	Rokita	Young (FL)
Lummis	Rooney	Young (IN)
	Ros-Lehtinen	

NOT VOTING—20

Braley (IA)	Jackson (IL)	Moore
Filner	Langevin	Olson
Frelinghuysen	Long	Pastor (AZ)
Giffords	Markey	Pingree (ME)
Hanabusa	McCarthy (NY)	Sewell
Hastings (WA)	McMorris Rodgers	Sutton
Hirono		Van Hollen

□ 1830

Messrs. PERLMUTTER, GOHMERT, ACKERMAN and LEWIS of Georgia, Mrs. HARTZLER, Ms. HERRERA BEUTLER, Ms. GRANGER and Ms. SLAUGHTER changed their vote from ''aye'' to ''no.''

So the motion to rise was rejected.

The result of the vote was announced as above recorded.

Stated against:

Mr. FILNER. Madam Chair, on rollcall 335, I was away from the Capitol region attendng the Civil Rights Freedom Riders' 50th Anniversary Celebration. Had I been present, I would have voted ''no.''

AMENDMENT NO. 2 OFFERED BY MR. TONKO

The Acting CHAIR. The unfinished business is the demand for a recorded vote on the amendment offered by the gentleman from New York (Mr. TONKO) on which further proceedings were postponed and on which the noes prevailed by voice vote.

The Clerk will redesignate the amendment.

The Clerk redesignated the amendment.

RECORDED VOTE

The Acting CHAIR. A recorded vote has been demanded.

A recorded vote was ordered.

The Acting CHAIR. This will be a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 186, noes 231, not voting 14, as follows:

[Roll No. 336]

AYES—186

Ackerman	Dicks	Larsen (WA)
Andrews	Dingell	Larson (CT)
Baca	Doggett	Lee (CA)
Baldwin	Donnelly (IN)	Levin
Barrow	Doyle	Lewis (GA)
Bass (CA)	Edwards	Lipinski
Becerra	Ellison	Loebsack
Berkley	Engel	Lofgren, Zoe
Berman	Eshoo	Lowey
Bishop (GA)	Farr	Luján
Bishop (NY)	Fattah	Lynch
Blumenauer	Frank (MA)	Maloney
Boren	Fudge	Markey
Boswell	Garamendi	Matheson
Brady (PA)	Gibson	Matsui
Brown (FL)	Gonzalez	McCollum
Butterfield	Green, Al	McDermott
Capps	Green, Gene	McGovern
Capuano	Grijalva	McIntyre
Cardoza	Gutierrez	McNerney
Carney	Hanna	Meeks
Carson (IN)	Harris	Michaud
Castor (FL)	Hastings (FL)	Miller (MI)
Chandler	Heinrich	Miller (NC)
Chu	Higgins	Miller, George
Cicilline	Himes	Moore
Clarke (MI)	Hinchey	Moran
Clarke (NY)	Hinojosa	Murphy (CT)
Clay	Hirono	Nadler
Cleaver	Holden	Napolitano
Clyburn	Holt	Neal
Cohen	Honda	Olver
Connolly (VA)	Hoyer	Owens
Conyers	Inslee	Pallone
Costa	Israel	Pascrell
Costello	Jackson Lee (TX)	Payne
Courtney	Johnson (GA)	Pelosi
Critz	Johnson, E. B.	Perlmutter
Crowley	Jones	Peters
Cuellar	Kaptur	Peterson
Cummings	Keating	Polis
Davis (CA)	Kildee	Price (NC)
Davis (IL)	Kind	Quigley
DeFazio	Kissell	Rahall
DeGette	Kucinich	Rangel
DeLauro	Langevin	Reyes
Deutch		Richardson

Richmond
Ross (AR)
Rothman (NJ)
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Schakowsky
Schiff
Schrader
Schwartz
Scott (VA)
Scott, David
Serrano
Sewell
Sherman
Shuler
Sires
Slaughter
Smith (WA)
Speier
Stark
Sutton
Thompson (CA)
Thompson (MS)
Tierney
Tonko
Towns
Tsongas
Van Hollen
Velázquez
Visclosky
Walz (MN)
Wasserman Schultz
Waters
Watt
Waxman
Weiner
Welch
Wilson (FL)
Woolsey
Wu
Yarmuth

NOES—231

Adams
Aderholt
Akin
Alexander
Altmire
Amash
Austria
Bachmann
Bachus
Barletta
Bartlett
Barton (TX)
Bass (NH)
Benishek
Berg
Biggert
Bilbray
Bilirakis
Bishop (UT)
Black
Blackburn
Bonner
Bono Mack
Boustany
Brady (TX)
Brooks
Broun (GA)
Buchanan
Bucshon
Buerkle
Burgess
Burton (IN)
Calvert
Camp
Campbell
Canseco
Cantor
Capito
Carter
Cassidy
Chabot
Chaffetz
Coble
Coffman (CO)
Cole
Conaway
Cooper
Cravaack
Crawford
Crenshaw
Culberson
Davis (KY)
Denham
Dent
DesJarlais
Diaz-Balart
Dold
Dreier
Duffy
Duncan (SC)
Duncan (TN)
Ellmers
Emerson
Farenthold
Fincher
Fitzpatrick
Flake
Fleischmann
Fleming
Flores
Forbes
Fortenberry
Foxx
Franks (AZ)
Gallegly
Gardner
Garrett
Gerlach
Gibbs
Gingrey (GA)
Gohmert
Goodlatte
Gosar
Gowdy
Granger
Graves (GA)
Graves (MO)
Griffin (AR)
Griffith (VA)
Grimm
Guinta
Guthrie
Hall
Harper
Hartzler
Hayworth
Heck
Hensarling
Herger
Herrera Beutler
Huelskamp
Huizenga (MI)
Hultgren
Hunter
Hurt
Issa
Jenkins
Johnson (IL)
Johnson (OH)
Johnson, Sam
Jordan
Kelly
King (IA)
King (NY)
Kingston
Kinzinger (IL)
Kline
Labrador
Lamborn
Lance
Landry
Lankford
Latham
LaTourette
Latta
Lewis (CA)
LoBiondo
Lucas
Luetkemeyer
Lummis
Lungren, Daniel E.
Mack
Manzullo
Marchant
Marino
McCarthy (CA)
McCaul
McClintock
McCotter
McHenry
McKeon
McKinley
McMorris Rodgers
Meehan
Mica
Miller (FL)
Miller, Gary
Mulvaney
Murphy (PA)
Myrick
Neugebauer
Noem
Nugent
Nunes
Nunnelee
Olson
Palazzo
Paul
Paulsen
Pearce
Pence
Petri
Pitts
Platts
Poe (TX)
Pompeo
Posey
Price (GA)
Quayle
Reed
Rehberg
Reichert
Renacci
Ribble
Rigell
Rivera
Roby
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rokita
Rooney
Ros-Lehtinen
Roskam
Ross (FL)
Royce
Runyan
Ryan (WI)
Scalise
Schilling
Schmidt
Schock
Schweikert
Scott (SC)
Scott, Austin
Sensenbrenner
Sessions
Shimkus
Shuster
Simpson
Smith (NE)
Smith (TX)
Southerland
Stearns
Stivers
Stutzman
Sullivan
Terry
Thompson (PA)
Thornberry
Tiberi
Tipton
Turner
Upton
Walberg
Walden
Walsh (IL)
West
Westmoreland
Whitfield
Wilson (SC)
Wittman
Wolf
Womack
Woodall
Yoder
Young (AK)
Young (FL)
Young (IN)

NOT VOTING—14

Braley (IA)
Carnahan
Filner
Frelinghuysen
Giffords
Hanabusa
Hastings (WA)
Jackson (IL)
Long
McCarthy (NY)
Pastor (AZ)
Pingree (ME)
Smith (NJ)
Webster

ANNOUNCEMENT BY THE ACTING CHAIR

The Acting CHAIR (during the vote). There are 2 minutes remaining in this vote.

□ 1838

So the amendment was rejected.

The result of the vote was announced as above recorded.

Stated for:

Mr. FILNER. Madam Chair, on rollcall 336, I was away from the Capitol region attending the Civil Rights Freedom Riders' 50th Anniversary Celebration. Had I been present, I would have voted "aye."

AMENDMENT NO. 9 OFFERED BY MR. CARDOZA

The Acting CHAIR. The unfinished business is the demand for a recorded vote on the amendment offered by the gentleman from California (Mr. CARDOZA) on which further proceedings were postponed and on which the noes prevailed by voice vote.

The Clerk will redesignate the amendment.

The Clerk redesignated the amendment.

RECORDED VOTE

The Acting CHAIR. A recorded vote has been demanded.

A recorded vote was ordered.

The Acting CHAIR. This will be a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 182, noes 232, not voting 17, as follows:

[Roll No. 337]

AYES—182

Ackerman
Andrews
Baca
Baldwin
Barrow
Bass (CA)
Becerra
Berkley
Berman
Bishop (GA)
Bishop (NY)
Blumenauer
Boren
Boswell
Brady (PA)
Brown (FL)
Butterfield
Capps
Capuano
Cardoza
Carnahan
Carney
Carson (IN)
Castor (FL)
Chandler
Chu
Cicilline
Clarke (MI)
Clarke (NY)
Clay
Cleaver
Clyburn
Connolly (VA)
Conyers
Costa
Costello
Courtney
Critz
Crowley
Cuellar
Cummings
Davis (CA)
Davis (IL)
DeFazio
DeGette
DeLauro
Denham
Deutch
Dicks
Dingell
Doggett
Donnelly (IN)
Doyle
Edwards
Ellison
Engel
Eshoo
Farr
Fattah
Frank (MA)
Fudge
Garamendi
Gonzalez
Green, Al
Green, Gene
Grijalva
Gutierrez
Harris
Hastings (FL)
Heinrich
Higgins
Himes
Hinchey
Hinojosa
Hirono
Holden
Holt
Honda
Hoyer
Inslee
Jackson Lee (TX)
Johnson (GA)
Johnson, E. B.
Kaptur
Keating
Kildee
Kind
Kissell
Kucinich
Langevin
Larsen (WA)
Larson (CT)
Lee (CA)
Levin
Lewis (GA)
Lipinski
Loebsack
Lofgren, Zoe
Lowey
Luján
Lynch
Maloney
Markey
Matheson
Matsui
McCollum
McDermott
McGovern
McIntyre
McNerney
Meeks
Michaud
Miller (NC)
Miller, George
Moore
Moran
Murphy (CT)
Nadler
Napolitano
Neal
Olver
Owens
Pallone
Pascrell
Payne
Pelosi
Perlmutter
Peters
Peterson
Polis
Price (NC)
Quigley
Rahall
Rangel
Reyes
Richardson
Richmond
Ross (AR)
Rothman (NJ)
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Schakowsky
Schiff
Schrader
Schwartz
Scott (VA)
Scott, David
Serrano
Sewell
Sherman
Shuler
Sires
Slaughter
Smith (WA)
Speier
Stark
Sutton
Thompson (CA)
Thompson (MS)
Tierney
Tonko
Towns
Tsongas
Van Hollen
Velázquez
Visclosky
Walz (MN)
Wasserman Schultz
Waters
Watt
Waxman
Weiner
Welch
Wilson (FL)
Woolsey
Wu
Yarmuth

NOES—232

Adams
Aderholt
Akin
Alexander
Altmire
Amash
Austria
Bachmann
Bachus
Barletta
Bartlett
Barton (TX)
Bass (NH)
Benishek
Berg
Biggert
Bilbray
Bilirakis
Bishop (UT)
Black
Blackburn
Bonner
Bono Mack
Boustany
Brady (TX)
Brooks
Broun (GA)
Buchanan
Bucshon
Buerkle
Burgess
Burton (IN)
Calvert
Camp
Campbell
Canseco
Cantor
Capito
Carter
Cassidy
Chabot
Chaffetz
Coble
Coffman (CO)
Cohen
Cole
Conaway
Cooper
Cravaack
Crawford
Crenshaw
Culberson
Davis (KY)
Dent
DesJarlais
Diaz-Balart
Dold
Dreier
Duffy
Duncan (SC)
Ellmers
Emerson
Farenthold
Fincher
Fitzpatrick
Flake
Fleischmann
Fleming
Flores
Forbes
Fortenberry
Foxx
Franks (AZ)
Gallegly
Gardner
Garrett
Gerlach
Gibbs
Gibson
Gingrey (GA)
Gohmert
Goodlatte
Gosar
Gowdy
Granger
Graves (GA)
Graves (MO)
Griffin (AR)
Griffith (VA)
Grimm
Guinta
Guthrie
Hall
Hanna
Harper
Hartzler
Hayworth
Heck
Hensarling
Herger
Herrera Beutler
Huelskamp
Huizenga (MI)
Hultgren
Hunter
Hurt
Issa
Jenkins
Johnson (IL)
Johnson (OH)
Jordan
Kelly
King (IA)
King (NY)
Kingston
Kinzinger (IL)
Kline
Labrador
Lamborn
Lance
Landry
Lankford
Latham
LaTourette
Latta
Lewis (CA)
LoBiondo
Lucas
Luetkemeyer
Lummis
Lungren, Daniel E.
Mack
Manzullo
Marchant
Marino
McCarthy (CA)
McCaul
McClintock
McCotter
McHenry
McKeon
McKinley
McMorris Rodgers
Meehan
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Mulvaney
Murphy (PA)
Myrick
Neugebauer
Noem
Nugent
Nunes
Nunnelee
Olson
Palazzo
Paul
Paulsen
Pearce
Pence
Petri
Pitts
Platts
Poe (TX)
Pompeo
Posey
Price (GA)
Quayle
Reed
Rehberg
Reichert
Renacci
Ribble
Rigell
Rivera
Roby
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rokita
Rooney
Ros-Lehtinen
Roskam
Ross (FL)
Royce
Runyan
Ryan (WI)
Scalise
Schilling
Schmidt
Schock
Schweikert
Scott (SC)
Scott, Austin
Sensenbrenner
Sessions
Shimkus
Shuster
Simpson
Smith (NE)
Smith (NJ)
Smith (TX)
Southerland
Stearns
Stivers
Stutzman
Sullivan
Terry
Thompson (PA)
Thornberry
Tiberi
Tipton
Upton
Walberg
Walden
Walsh (IL)
Webster
West
Westmoreland
Wilson (SC)
Wittman
Wolf
Womack
Woodall
Yoder
Young (AK)
Young (FL)
Young (IN)

NOT VOTING—17

Braley (IA)	Hastings (WA)	McCarthy (NY)
Duncan (TN)	Israel	Pastor (AZ)
Filner	Jackson (IL)	Pingree (ME)
Frelinghuysen	Johnson, Sam	Turner
Giffords	Jones	Whitfield
Hanabusa	Long	

ANNOUNCEMENT BY THE ACTING CHAIR

The Acting CHAIR (during the vote). There are 2 minutes remaining in this vote.

□ 1845

So the amendment was rejected.

The result of the vote was announced as above recorded.

Stated for:

Mr. FILNER. Madam Chair, on rollcall 337, I was away from the Capitol region attending the Civil Rights Freedom Riders' 50th Anniversary Celebration. Had I been present, I would have voted "aye."

Stated against:

Mr. TURNER. Madam Chair, on rollcall No. 337, I was unavoidably detained and did not vote. Had I been present, I would have voted "no."

Mr. GUTHRIE. Madam Chairman, I move that the Committee do now rise.

The motion was agreed to.

Accordingly, the Committee rose; and the Speaker pro tempore (Mr. WOMACK) having assumed the chair, Mrs. CAPITO, Acting Chair of the Committee of the Whole House on the State of the Union, reported that that Committee, having had under consideration the bill (H.R. 1216) to amend the Public Health Service Act to convert funding for graduate medical education in qualified teaching health centers from direct appropriations to an authorization of appropriations, had come to no resolution thereon.

GENERAL LEAVE

Mr. MCKEON. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and include extraneous material on H.R. 1540.

The SPEAKER pro tempore (Mr. COFFMAN of Colorado). Is there objection to the request of the gentleman from California?

There was no objection.

NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 2012

The SPEAKER pro tempore. Pursuant to House Resolution 269 and rule XVIII, the Chair declares the House in the Committee of the Whole House on the State of the Union for the consideration of the bill, H.R. 1540.

□ 1849

IN THE COMMITTEE OF THE WHOLE

Accordingly, the House resolved itself into the Committee of the Whole House on the State of the Union for the consideration of the bill (H.R. 1540) to authorize appropriations for fiscal year 2012 for military activities of the Department of Defense and for military construction, to prescribe military personnel strengths for fiscal year 2012, and for other purposes, with Mr. WOMACK in the chair.

The Clerk read the title of the bill.

The CHAIR. Pursuant to the rule, the bill is considered read the first time.

The gentleman from California (Mr. MCKEON) and the gentleman from Washington (Mr. SMITH) each will control 30 minutes.

The Chair recognizes the gentleman from California.

Mr. MCKEON. I yield myself such time as I may consume.

Mr. Chairman, I rise in support of H.R. 1540, the National Defense Authorization Act for Fiscal Year 2012, which overwhelmingly passed the Committee on Armed Services on a vote of 60–1. In keeping with the committee's tradition of bipartisanship, Ranking Member SMITH and I worked collaboratively to produce the bill and solicited input from each of our Members.

The legislation will advance our national security aims, provide the proper care and logistical support for our fighting forces and help us meet the defense challenges of the 21st century. The bill authorizes $553 billion for the Department of Defense base budget, consistent with the President's budget request and the allocation provided by the House Budget Committee. It also authorizes $18 billion for the development of the Department of Energy's defense programs and $118.9 billion for overseas contingency operations.

The legislation we will consider today also makes good on my promise, when I was selected to lead the Armed Services Committee, that this committee would scrutinize the Department of Defense's budget and identify inefficiencies to invest those savings into higher national security priorities. We examined every aspect of the defense enterprise, not as a target for arbitrary funding reductions, as the current administration has proposed, but to find ways that we can accomplish the mission of providing for the common defense more effectively.

The National Defense Authorization Act for Fiscal Year 2012 achieves these goals by working to:

Ensure our troops deployed in Afghanistan, Iraq and around the world have the equipment, resources, authorities, training and time they need to successfully complete their missions and return home safely;

Provide our warfighters and their families with the resources and support they need, deserve and have earned;

Invest in the capabilities and force structure needed to protect the United States from current and future threats, mandate physical responsibility, transparency and accountability within the Department of Defense; and

Incentivize competition for every taxpayer dollar associated with funding Department of Defense requirements.

Mr. Chairman, I know there have been many questions raised by the ACLU and others relating to a provision in our bill dealing with the 2001 authorization for use of military force. I would like to address some of those concerns now.

Section 1034 of the NDAA affirms that the President is authorized to use all necessary and appropriate force against nations, organizations, and persons who are part of or are substantially supporting al Qaeda, the Taliban and associated forces.

It also explicitly affirms the President's authority to detain certain belligerents who qualify under this standard I just described, which Congress has never explicitly stated. It's important to note that the U.S. Supreme Court has accepted the President's authority to detain belligerents as within the powers granted by the AUMF.

Moreover, the language in section 1034 is very similar to the Obama administration's interpretation of the authorities provided pursuant to AUMF, in particular, a March 13, 2009, filing in the U.S. District Court for the District of Columbia. While U.S. courts have accepted the administration's interpretation of the AUMF, it is under constant attack in litigation relating to the petitions filed by Guantanamo detainees.

Because of these ongoing challenges, the administration's interpretation may receive less favorable treatment over time if Congress refuses to affirm it. Section 1034 is not intended to alter the President's existing authority pursuant to the AUMF in any way. It's intended only to reinforce it. I believe that our men and women in uniform deserve to be on solid legal footing as they risk their lives in defense of the United States.

Finally, some have suggested section 1034 was included in the dark of night. I note that this language was originally included in the Detainee Security Act of 2011 introduced on March 9 and was discussed during a committee hearing on March 17. We have sought input from the administration, as well as Ranking Member SMITH, his staff and numerous outside experts. Moreover, the process used to craft this legislation is historic in its transparency. In fact, a copy of my mark was distributed to committee members' offices 5 days before our markup. The legislation, including funding tables, was posted online nearly 48 hours in advance of our markup.

It's also noteworthy that there are no earmarks in the National Defense Authorization Act for Fiscal Year 2012. Every Member request to fund a defense capability was voted on and includes language requiring merit-based or competitive selection procedures. To those who are concerned that members may unduly influence the Department of Defense to direct funds to a particular entity, I can only recall the words of my good friend, the former chairman of the Armed Services Committee, Ike Skelton, who would say, Read the amendment. What does it say? If DOD chooses to violate the law and the text of a provision in the