for a positive solution to a real challenge that we have in America, that would bring about a positive solution for all Americans and a better system of electoral process that we have in our Nation and allow each individual American a better opportunity to decide.

With that, Mr. Speaker, I am pleased once again and want to thank the leadership for allowing us to participate. I thank my colleagues from Tennessee and North Carolina and Virginia for participating today.

HEALTH CARE

The SPEAKER pro tempore (Mr. FITZPATRICK of Pennsylvania). Under the Speaker's announced policy of January 4, 2005, the gentleman from Texas (Mr. BURGESS) is recognized for 60 minutes.

Mr. BURGESS. Mr. Speaker, I wanted to take this time tonight to talk to the House about the subject of health care, something that I have been involved with for the last 30 years of my adult life, taking in that time that I spent in residency and private practice.

I think the single most important issue that we need to keep foremost in our minds as we talk about issues surrounding health care in this body over the next year and, indeed, over the foreseeable future is the overall affordability of health care. If we do not keep health care within the affordable grasp of the average American, we not only keep people away from care that they need, but we also put the overall prosperity of our country in peril, and in fact, the overall system that has been created, the health care system that has been created in the United States over the last 227 years will itself be in peril.

Right now, the Federal Government pays about half of the health care bills in this country. It is a big chunk. About 16 or 17 percent of the gross domestic product of this country is spent on health care, and of that, the Federal Government picks up about half the cost through Medicare, Medicaid, VA, Federal Prison System, Indian Health Service. All the various federally qualified health centers, all of the various groups gathered together all make up an expenditure that is just shy of 50 percent.

Well within that money that is spent by the United States Congress, we need to be sure that that money is spent wisely. We need to be sure we get value for our dollars. So I want to spend some time this evening and talk about where we are in health care, where we are in fact going, always keeping in mind that affordability has to be first and foremost in our mind.

We have got to discuss, we have got to come up with some solutions for the uninsured. Federally qualified health centers, the President has mentioned them in every State of the Union address that I have heard since I arrived in this body 3 years ago. Federally qualified health centers have been mentioned by the President, how he wants to see a federally qualified health center literally in every poor county in this country.

There is no question that liability reform is going to be part of the picture of the overall reform of the health care system that deals with affordability. We have to find some relief for our providers. We historically underpaid or cross-subsidized our providers, doctors and hospitals alike, by underfunding government systems that pay for health care, and the result is we now have people dropping out of the system at a time when we, in fact, need more people coming into the system.

The information technology that is available to health care systems in some ways is old, is past its prime. In some areas, it was never, in fact, developed at all. So we are going to have to pay some attention. There is going to be some expense borne with recreating and creating information technology that our health care system, in fact, requires.

Then, finally, as we have seen so many times over the past 3 years, preparedness is going to be part of not just the overall security of the country but the overall security of our health care system.

When I talk about affordability of health care, I think back to a time when, just a few years ago, I was, of course, in private practice in medicine, but I went back to school and went back to graduate school at the University of Texas at Dallas and studied for a Masters Degree in medical management at their school of management there. Their graduate school of management is a very good school, and one of our professors one day, Dr. John Burns, came and talked to our class and said, Within medicine you will always want to focus on affordability, access and quality.

Now the dilemma facing us is we have only been able to deliver on two out of those three. Mr. Speaker, I do not want to identify the one that I am prepared to leave out so I am just going to talk about affordability.

I do think that the American medical system will always provide us quality, and I believe if we can improve affordability, we are, in fact, going to improve access.

With the amount of money that the Federal Government spends on health care, you have to ask yourself, would it be better if the government just picked up the whole charge, if the government just picked up the whole tab? In fact, that was discussed in this very House some 10 or 12 years ago. I did not think it was a good idea then. I do not think it is a good idea now, but that is going to be part of the discussion.

Certainly, you look to our neighbor to the north, and the Canadian health care system is oftentimes held out to us as something to which the Americans ought to aspire. In the interest of full disclosure, my dad was a doctor in Canada and fled to this country because he did not like the Canadian health care system, and as a consequence, I was born while he was doing his residency in this country.

But he never went back because the system there was too onerous, the waiting lists were too long, and even the Canadian Supreme Court, about a year and a half ago, ruled that access to a waiting list is not the same as access to care. I would submit to you that the resident in Toronto, Canada, who suffers a heart attack may be just as likely to get their angioplasty or coronary artery bypass graft done at Henry Ford Hospital in Detroit as Toronto, Canada, because the length of time spent on the waiting list is just far too long.

Can we, in fact, keep the private sector involved in health care? It is a question that we are going to have to ask, and we are going to have to be able to answer it. I believe that it can. I believe that it can, and I believe Congress can and should have a part in promoting policies that do help keep the private sector in the health care marketplace.

Look at, if you would, the history of medical savings accounts. Medical savings accounts were basically born 10 years ago in the Kennedy-Kassebaum bill that came through the House and the Senate. That is the same bill that gave us HIPAA unfortunately, but it also did give us what is called a medical savings account, this old Archer MSA. I very happily bought one when they became available in 1977, made one available for everyone in my practice of medicine. Some people took it, most did not because not much was known about medical savings accounts at the time, but think of what a medical savings account does.

Instead of the power of medical decision-making being in the hands of some distant medical director or somebody somewhere or even in the hands of the government bureaucrat, the medical decision-making power was in my hands, and that was the most important part about having a medical savings account.

To be sure, I was issued a high deductible policy, and I was able to put money away to cover that deductible year over year in what was called then a medical IRA, a tax-free contribution to a medical savings account year after year. The interest in that was not taxed, and even though I gave up my medical savings account when I came to Congress in 2003, that money remains in that medical savings account, continuing to draw interest, and will be available to my wife and I when I do retire, however many more years I have at this job.

But the medical savings account is an important tool because it does give the power back to the consumer, and it makes a consumer an involved participant in health care decisions.

A lot of concern on some people's part is, well, people delay getting medical care if they are going to have to

spend their own money. They will spend someone else's money, but they do not want to spend their own.

□ 1745

Well, in fact, the National Center for Policy Analysis, a think tank that is located in Dallas, Texas, not too far from my home, had a study done around the time the medical savings accounts first came out in the 1990s looking at other countries that had allowed medical savings accounts to compete head to head with private indemnity insurance. And, in fact, what was found in a comparison of medication usage in one of those countries was that drugs such as Ritalin that might be regarded as a life-style drug, the usage of Ritalin was in fact decreased. But the usage of a drug such as Fossomax, that is a drug that is given to individuals who are thought to be at high risk for osteoporosis, to prevent calcium loss from the bone and prevent osteoporotic fractures in the future, a drug like Fossomax to prevent osteoporosis, that usage increased. So life-style drugs perhaps had some diminution, but drugs that are really there to prevent problems in the future, the usage of those drugs was not curtailed at all. In fact, it was somewhat increased.

I look back to the experience that I had as an individual back in the mid-1990s, in 1994, trying to get health insurance for a family member who didn't have it and the difficulties, the intractable difficulties involved with finding an insurance policy, a single insurance policy for a single individual. It just was not available, not at any price. I was prepared to pay top dollar. I knew I would have to pay top dollar for such a policy. But no such policy was available.

Well, contrast that with now, where perhaps a young person just getting out of college, no longer on their parents' health insurance plan, wants to start their own business rather than working for a company. One of the big obstacles to that is, well, no health insurance. But today, that person can go on the Internet, go to their favorite search engine and type in health savings account, hit search, and they will be returned a vast number of choices of high-deductible health insurance plans that are available to them.

In fact, the most recent time I did this, there are some insurance companies to be sure that I didn't recognize the name, and I would always be certain to check out the company before entering into a policy with them, but a well-known insurance company name, a high-deductible PPO-type policy, $50 a month for a male in Texas, age range 20 to 30. Well, this is a pretty powerful tool that people have at their disposal. And prior to our passage of the Medicare Modernization Act in November of 2003, this tool was in fact not available. But it is now and many more people have insurance because of the availability of these high-deductible plans that can then be rolled into a health savings account.

I think from the first year, January 2005, the first year the figures were available, a million people had sought that type of insurance. By January of 2006, that was up to 3 million people. Over half of those individuals were over the age of 40. So it wasn't just the young that were looking at those types of policies; it was people in the prime of life as well, and perhaps most importantly, 40 percent of that number had previously not had health insurance. That is nearly a million people that were taken off the rolls of the uninsured and put into a health savings account.

Now, I recognize that as we make a move to enhance so-called consumer-directed plans, and that is what a health savings account is, a consumer-directed type of health care, as we make the move to consumer-directed health care, we are going to have to give people the ability to evaluate not just their insurance policy but their health care providers and their hospitals. They are going to have to have the ability to evaluate health care on the basis of price, cost, and quality. It is unreasonable to ask someone to make those types of decisions while that information remains obscure.

That is a concept, the concept of transparency, that I believe that this body should investigate. We have had one hearing in our Energy and Commerce Committee. I trust we will have more, and I trust we will see some type of transparency-related legislation before the end of the year, either as a stand-alone bill or coupled with some other process. But that is going to be one of the keys to really furthering the cause for consumer-directed health care.

Now, transparency doesn't exist just because it is inconvenient to remove it. Transparency, or opacity, in the health care pricing system exists because there is some value to it. There is some protective value to it. So it is not without some pain that transparency is going to be provided.

Again, I go back to the issues of cross-subsidization of hospital costs and doctor costs, Medicare and Medicaid. We don't pay the full freight as far as provider fees, so hospitals and doctors do need to cross-subsidize with the more traditional indemnity plans. Removing transparency or removing opacity from the system is going to expose that, and in some cases it won't be especially attractive or pretty what we find. But to get to the ultimate goal of having transparency within the system, where health care consumers can make proper decisions for themselves and their families, I do believe that we are going to have to provide that. And I may speak a bit more about transparency a little later as time permits.

One of the other concepts that has been introduced as legislation for the past several years, though we have never really taken it up and done so in a serious way, is the concept of a prefundable tax credit, sort of an EITC, if you would, for people of low-income levels for the purchase of an insurance policy: a prefundable tax credit that occurs at the beginning of the year rather than a refund at the end of the year; money exclusively earmarked for the purchase of health insurance. Several proposals have been put forth in the past. I know my neighbor down in Texas, Ms. GRANGER, has had a bill about tax credits for the uninsured for several years, allowing $1,000 for individuals as a tax credit, or $3,000 for a family.

Again, you might look at that and say, in today's market that is not going to buy much insurance. But if you couple that with a high-deductible policy that costs $50 a month for an individual, you can, in fact, price policies that would be easily within someone's reach by providing such a tax credit. And if the individual were able to bring a little bit of the money to the table themselves, they would find the availability of a health savings account with an account that would grow over time and eventually would have significant capital within their reach that they could use for medical expenditures should they happen later in life.

Well, Mr. Speaker, all of this is great discussion. We do have to consider the job, the very big job ahead of us in this Congress, and probably many Congresses to come, on how to deal with the problem of the uninsured. The Census Bureau will give us figures from time to time on that. Whether that number is 42 million more or less, we can argue the actual number. This is not something that has happened overnight. I remember when President Clinton was running for office in 1992 on a platform of health care reform, he talked about the number of uninsured in the country being at 37 million during his run for office.

No question the number has increased. No question that the recent recession this country went through was in fact responsible for some of that. The good news is that jobs are on the rebound, and more people are receiving insurance as a consequence of their employment, so the number hasn't gone up in the past year or two as fast as it might otherwise have been projected. And also, as I alluded to earlier, some people are buying health savings accounts that previously were uninsured. But the number continues to grow.

The true number people will put anywhere between 9 to 10 million to in excess of 45 million, so I will have to acknowledge that there is a good deal of opacity here as well as the number of uninsured. But that doesn't prevent us from working on a solution to the problem.

Now, the President has talked about a number of solutions during his State of the Union addresses. He has of course talked about consumer-directed health care with health savings accounts, which we have already covered.

He has talked about association health plans. And I was very relieved to see Senator ENZI and his committee finally making some movement on an association health plan bill over in the Senate earlier this month. We have passed an association health plan bill here in this House every year that I have been here, so that is at least over the past 3 years.

Association health plans and achieving that goal is not going to suddenly deflate the number of uninsured in this country, but it is certainly going to help arrest the growth curve as the number of uninsureds increase, because employer costs increase for providing that insurance.

What an association health plan does is allow small businesses, the backbone of business in this country, association health plans allow small businesses of a similar business nature, it allows them the ability to band together and attain the purchasing power of much larger companies, even going across State lines if necessary to get the power of that large group to negotiate with an insurance company. So that means that a group of Realtors, for example; a group of employees of your local chamber of commerce, for example; a group of doctors' offices, or a group of dentists' offices might ban together to be able to grab that purchasing power and get a better deal on insurance, a deal such as a much larger corporation might be able to command.

Federally qualified health centers are a reasonable way of providing health care to people who otherwise would not have that health care available and would not have health insurance available. Federally qualified health centers are present in a number of areas in the country. Unfortunately, my congressional district does not contain a federally qualified health center. States that border the Mississippi River and those east have a number of such facilities available. Western States on the coast have a number of such facilities available. But we do have some fairly big gaps in the presence of federally qualified health centers throughout the middle part of the United States.

One of the things that I think is so powerful about a federally qualified health center is that it gives a person a medical home. It gives them a place where they can go to receive their care. There is some measure of continuity of care, of seeing the same person on an ongoing basis, and overall reduces the cost of care for the uninsured in that community because that person is no longer dependent upon an emergency room for their hospital care. They in fact have a health center nearer their home. And because it is nearer their home, it is not just a question of access; sometimes it is a question of utilization. Utilization isn't always what it should be, but by placing these centers close to a person's home, it does increase not only the access but utilization as well.

One of the things that I think this body needs to consider is why are there so many people uninsured. Well, of course, one of the reasons is the cost of health insurance has gone up so much over the past 10 years' time. And one of the reasons that health insurance has gone up over the past 10 years' time, surely there is advancing complexity of what we are able to do, so health care just simply costs more. To some degree it is that cross-subsidization with Medicare and Medicaid and picking up the tab for the uninsureds in the community hospitals.

But another reason that the cost of care increases, or the cost of insurance increases, which is different from the cost of care, is that in some places States mandate that certain procedures or certain diseases require special coverage or additional coverage. So placing a number of mandates on a State insurance policy can certainly drive the price of that insurance policy ever higher and make it more unavailable to more people in the population who cannot afford that degree of health coverage.

We have talked in our committee about some of the solutions for that. In fact, association health plans will provide some relief for that problem. But the issue, Mr. Speaker, is no one wants to take away from people what they really need. And if a procedure or if a type of coverage is truly basic to human need, no, of course it shouldn't be withdrawn from an insurance policy. We have the ability in front of us to identify those procedures, those things that should be required in an insurance policy. We have already agreed on that list, and that list are the procedures, the diseases that are covered through a federally qualified health center.

□ 1800

If we were to work off of that list, if we were to decide what are the can't-haves, what are the can't-live-withouts on that list and develop a template for an insurance policy that could be sold from one State to the other to allow someone at a lower income level to be able to afford an insurance policy, it is absolutely ludicrous to think that a family of four with a yearly insurance tab of $9,000 where the principal wage earner earns a over little twice that, that they are going to be able to be in the market for health insurance. It is just not going to happen.

But if we can make a product affordable and within their reach, my belief is that most families want to have insurance coverage if a child gets sick or if a principal wage earner is involved in an accident and needs a prolonged hospitalization.

I have been involved in numerous situations in the hospital where an injured person does not have insurance. It is an uncomfortable feeling for the family. Forget how the hospital feels about it or any of the doctors feels about it, but someone who is in a hospital knowing they are running up a big bill and knowing they have no means at their disposal to cover that bill, it is terribly uncomfortable and adds to the discomfort of any accident or disease process that brought them to the hospital.

Mr. Speaker, I believe most people want to have that type of coverage for their family. And in fact, we are denying it. We are denying it by allowing insurance policies to be sold that no one could afford.

My belief is that some of the larger insurance companies would look at that number of 42 million uninsured as potential market share if they simply had a product that was priced in a range where people could afford it. I think this body ought to look at the procedures outlined in the federally qualified health center legislation and make available to people a basic policy of benefits. Again, we have already identified what those would be, make a basic policy of benefits available to people, a policy without all of the bells and whistles that ends up costing patients and constituents so much in the way of out-of-pocket money.

The country is looking to us to provide this type of leadership. They are tired of the tennis match between our side and their side and who has the better ideas. We have already agreed on what that basic package of benefits should be. Why not have a federally qualified health center without walls that is a basic insurance policy that a husband and wife can buy for their family and have that peace of mind and knowing if that child gets sick, has an asthma attack, develops diabetes, they are going to be covered.

There could not be any discussion of health care reform in this body that did not cover liability reform.

We need a national solution. We have several States that have done a good job at correcting the problem at home. My State of Texas certainly is one of those, but that protection that is now provided by the State of Texas has only been there since 2003. It is under attack during every legislative session.

We need to step up and do this job. In fact, we are always looking for places in our budget where there might be some savings, where we might get a savings of a billion dollars here or a billion dollars there. And as famous Senator Dirkson said, pretty soon you are talking about real money.

We passed a bill called H.R. 5 in 2003. H.R. 5 was the Medical Liability Reform Act. At that time, 3 years ago, the Congressional Budget Office scored that bill not with a cost but with a savings of $15 billion over 5 years. That is $3 billion a year. In fact, the amount is probably higher today. If we were to take that same bill back to the CBO and ask them to score it again, I suspect it would be a higher figure. I do not think the number of dollars spent on medical liability and defensive medicine have come down in the last 3 years.

We are wasting money. We are wasting the country's money by not pushing for national medical liability reform. In my mind, those are precious

health care dollars, and it is unconscionable that we continue to waste that money.

Mr. Speaker, when I was a very new Member of Congress just a few short years ago, in my first August recess, we had a field hearing in northern Alaska up where the ANWR oil fields are proposed to be. On the way home, we stopped in Nome, Alaska. And Nome is still a fairly small town so you can imagine, a military plane with several Congresspersons on board landing at their airport caused quite a stir. In fact, their whole Chamber of Commerce turned out and had a nice lunch for us. When it turned out that one of the people from the Chamber of Commerce was also a physician, every member of their medical staff, all 19 of their medical staff showed up for that lunch and were eager to ask me questions.

The man sitting next to me at lunch said, I hope you are going to be able to do something about medical liability this year. Do you think you will?

I said, I do not know. It is a tough problem.

He said, We really need some help in Nome, Alaska. We cannot afford an anesthesiologist at our hospital because we cannot afford the liability policy.

Well, that certainly limits your ability to deliver services. I said, What type of medicine do you practice?

He said, I am an OB–GYN doctor, just like you.

I said, wait a minute, an OB–GYN doctor without an anesthesiologist at your hospital. Forget about pain relief during labor, what do you do if someone needs a C-section? He said, We get them on an airplane and send them to Anchorage. Well, that is an hour and a half away by air. I think there are probably a lot of days with probably pretty bad weather in Nome, Alaska, where air travel is not possible. So I do not know how we are furthering the cause of patient safety by not providing medical liability reform. I do not see how we can tell ourselves that this is unimportant when we have a hospital in Nome, Alaska, that has to put a pregnant woman in labor on a plane and send her to Anchorage, Alaska, to have her C-section under anesthesia and not feel every portion of the operation.

Mr. Speaker, another time I had an opportunity to have dinner with a woman who is head of one of the residency programs at one of the larger hospitals in New York. I trained at Parkland, and I know it is the best residency program in the country, but they have some good residency programs in New York as well.

I asked her how the liability issue is affecting her residency program. She related that they are taking people into their residency program that 5 years ago they wouldn't even have interviewed. The applicant pool has fallen off so much because of fears of young medical students getting out of school with a lot of debt because it took a lot of work to get through medical school and they had to get student loans. Now they are getting out of medical school and looking at what they want to do with their lives and practice, and they say I cannot afford to go into OB-GYN. There is no way I can do 4 years of training in OB-GYN and then go out and buy the kind of liability policy that I will have to have to set up in private practice, and also deal with all of these educational loans.

So the best and brightest are no longer going to this hospital in New York for the residency program in OB-GYN. These are our children's doctors. These are the doctors that are going to be delivering our children and great grandchildren. How can we say we are furthering patient safety and patient rights by continuing to allow this to happen? And coupled with that, the money that is spent in the practice of defensive medicine because of the liability situation in this country, it is unconscionable that we do not change this. I hope we can. I honestly think the way we are actually going to have to go about doing that may be during the budgetary process, perhaps during reconciliation. But this issue is too important to wait for the 110th or the 111th or the 112th Congress.

In Texas, we passed a Statewide medical liability reform bill in 2002. It required a change in the State constitution to allow the bill to actually take effect. The bill was passed at the end of May or the first of June during the beginning of the 2003 legislative session, and then a constitutional amendment was called for an election that happened on September 12 or September 13 of that year. That constitutional amendment passed, not by much, but it did pass. What a difference it has made in Texas.

When I was first campaigning for office, we were in a situation where we had gone from 17 liability carriers down to two. That meant that there were a lot of doctors in the State of Texas who could no longer get medical liability insurance or they were paying top dollar for that insurance. In fact, I ran into a young woman one night during the campaign at an event for Senator CORNYN. This young woman said, I hope you can get something done about liability. I can't get insurance. It is not that I have had any lawsuits, but my company went out of state and I can't get anyone to cover me.

So here was a woman in her mid-forties, trained at State institutions. Taxpayers had subsidized her education, and she is now a stay-at-home mom and not practicing her specialty of radiology because of the medical liability issue.

The good news is that after Texas passed that law and passed that constitutional amendment, we went up from two liability carriers back up to 14 today. The liability reform that we passed in Texas was kind of unique. It was a cap on noneconomic damages, the same as the one that we talked about here in the House. We bifurcated that cap so that part was borne by the doctors and part was borne by the hospitals. It was in some ways different from the bill that we passed in the House but not substantially different. It is perhaps a template that we might follow here in the House of Representatives to see if we can't get something done on this issue because I will tell you, Mr. Speaker, the country is ready for us to take action on this.

People said, well, and certainly we heard this on the debate in H.R. 5 in 2003, the insurance companies are not going to reduce their rates. If you get this cap on noneconomic damages, it will not bring rates down. Well Texas Medical Liability Trust, my last insurer of record when I was in practice in 2002, my insurer has lowered rates by a total of 20 percent and provided dividends to their plan holders so that there has been between 20 and 25 percent savings to providers in Texas. Clearly, the people who said that the insurance companies would not provide relief to doctors were mistaken in that assumption.

One of the other things that we talk about a lot in this body is the concept of pay for performance, reform of health information technology and how these two things taken together will return so much money to the medical system that our expenditures on medical care can in fact be met. I do not know that is something that I completely buy into at this point, but I do know this. We have been paying physicians under a formula called the sustainable growth rate since 1997 or 1998. This formula, the so-called sustainable growth rate, and bear in mind hospitals are reimbursed under a different formula which is the medical market basket formula. The sustainable growth rate has gone down every year for the last 5 years.

During the month of December when we were working so hard on the Deficit Reduction Act, one of the reasons we were working hard on that was because the Deficit Reduction Act did contain language that would prevent that negative 4.4 percent update that physicians were to take January 1 if we did not pass the act. Passage of the act did not bring doctors any more money, it just held them at zero. And of course we all know, here in Washington, D.C., if you do not increase something year over year, you are in fact cutting it. Well, basically, we cut doctor's pay in January. Even holding them at a zero level negative update, we were cutting their pay. But even worse, we passed the Deficit Reduction Act but then because of a technical glitch it didn't get passed, it didn't get signed and doctors did get hit with a negative 4.4 percent update.

January 4 in my district office in Texas, my fax machine was about to run out of ink because of the number of doctors sending me letters stating that they wanted me to see the letter that they were sending out to their patients: ''I will no longer be able to see

Medicare patients in my practice. The cost of seeing the patients is far greater than the amount of reimbursement. We just got our pay cut by Congress, and I cannot afford to continue to see you.''

□ 1815

And this is really a tragedy. In fact, when I did my first series of town halls, my first year I was in office, I did 65 town halls around in my district. And I heard people talk to me about the difficulty with purchase of prescription drugs. This came up time and again.

But what I heard without question in every town hall that I did, someone would come up to me afterwards and say, how come when you turn 65 you have got to change your doctor? And the reason, of course, is because the doctor they were seeing before now is no longer taking Medicare. Now this was 3 years ago. It is getting worse year over year. What is happening is we are driving doctors out of the business of seeing Medicare patients. Doctors who in all likelihood are at the peak of their careers, doctors who have the best diagnostic ability, doctors who have the best technical skill, whose operations take the least amount of time, whose infection rates are best, we are driving these doctors out of the practice of taking care of our most vulnerable citizens, our senior citizens, individuals who will typically have multisymptom disease and chronic ailments for which they need the best care.

But we are taking the best doctors out of the system. I submit that by doing so, if we then try to loop back and say, well, we are going to pay for performance, we may be paying for performance not with the first tier of doctors in this country, but with the second or third group. And it is going to cost more to pay for that performance.

I submit the time to take care of this is now. We don't necessarily need to tie reform of the sustainable growth rate formula, which is not working, to some pay-for-performance formula, which quite honestly is not ready for prime time yet. But we do need to give providers some measure of relief and some degree of stability in the pricing of the procedures that they perform for us. It is difficult to make decisions about, well, how, am I going to expand my office, am I going to hire another partner, am I going to hire another nurse, am I going to offer this new procedure, when we here in Congress every year are threatening them with a 4.5 percent pay cut year over year until we reach a total of 26 percent, which, to me is unconscionable. We are driving the best doctors out of business; and then we expect to say, but we only want to pay for quality out of the doctors that are left.

You know, the same could be true for the investment in information technology. If we drive our best doctors out of practice, then paying for information technology, but we don't have the best providers there anymore, so we are going to end up paying more for the technology, or paying more for the training for that technology. We, in fact, are harming ourselves by postponing this decision for another year or another two years.

I submit this is the year to get this done. Reform that formula, place it on the Medicare economic index, which has been recommended by MedCap, which is the group that we tasked with dealing with this program and providing us a solution to the problem. Just like the hospitals who get a positive update year over year, we need to provide the same for physicians. Then we can get on the business about investigating the pay-for-performance issues and the information technology issues.

I will just have to tell you, Mr. Speaker, my own experience with information technology, with an electronic prescribing unit that a company placed in my office for beta testing. They wanted our group of five physicians to try this out and see how it worked for them, to see if they could make it work better. But the problem was that it added 1 to 2 minutes to every patient encounter. Well, when you are having to see 45 patients during the course of an average day in order to pay the light bills, pay the help, pay the rent and take a little bit home at the end of the day, if you have got to see 45 patients in order to do all of that and you add 1 or 2 minutes to each patient's encounter, you are adding 1 or 2 hours to that practitioner's day.

And who pays for that additional 1 or 2 hours? Well, in the situation that we found ourselves in, that question just simply went unanswered. And what happened was the technology, for the most part, went unused. I will admit that I did use it because I like technology and I like fooling around with things like that. But my other partners were absolutely uninterested in anything that would slow them down or make them less productive.

When we get to the point that we are willing to spend vast amounts of dollars for bringing this information technology to, say, a hospital or a doctor's office, we are going to have to be prepared to compensate individuals, doctors and nurses, nurse practitioners. We are going to have to be prepared to compensate them for the time involved in learning that process.

Mr. Speaker, I was in a hearing in our Committee on Energy and Commerce just the other day where we talked about this. I will have to tell you, two of my worst days as a practicing physician: one was the day that this body passed the Stark laws, and one was the day this body passed the HIPAA laws. It certainly did not make my practice life any easier, and, in fact, made life a lot harder and, as a consequence, made the overall cost of delivering that care go up.

I couldn't help but think that, as we were talking about crafting legislation to require doctors and hospitals to use advanced information technology, that that may well go down as the third worst day in the practice of medicine. We have to be very careful about how we structure this. In fact, the Stark laws right now prevent a hospital from providing that equipment or that infrastructure to a private doctor's office because that would be an unjust inducement to put patients in that particular hospital.

We need to look at these 1980s health care laws and look at them in light of the 21st century. We are far past the point of punishing every doctor and every hospital for imagined transgressions by this body. We have to look at reforming those restrictions and those regulations so we can, in fact, allow doctors' offices and hospitals to come into the 21st century.

Mr. Speaker, any discussion of medical care would not be complete without talking a little bit about what is going on in the gulf coast in this country. Now, Hurricane Katrina, in Louisiana and Mississippi, Hurricane Rita in my State of Texas and our neighbor, Louisiana, did tremendous damage to all sectors of the infrastructure in those States. But especially hard hit was the health care infrastructure. And of course in the State of Louisiana, in the city of New Orleans, where, unfortunately, poverty was so prevalent, these storms did vast damage to the health care infrastructure that was at some days before the storms only tenuous at best.

And it continues to be a problem, despite all of the dollars. Just last week, we did that supplemental bill, and all of the dollars that we have appropriated from this Congress, but you go down on the ground in New Orleans, Louisiana, and it doesn't look like we have done a darn thing for the folks down there, particularly in the realm of health care. Same with Beaumont, Port Arthur area in my State of Texas.

I can remember watching those hurricanes, both of them, on the Weather Channel the nights that they were drawing their bead on the various towns in the gulf, and you just knew they were so big and so powerful that nothing good is going to come of this.

My two trips to New Orleans this past year certainly have showed me what devastation those storms were capable of inflicting upon those areas. The city of New Orleans itself, of course, a virtual ghost town. You go into the lower Ninth Ward and you just cannot imagine the destruction if you haven't seen it.

And furthermore, the task ahead, it has not even been decided yet whether rebuilding is something we should do in those areas. Certainly they continue to be flood-prone because of the number of feet they are below mean sea level. When you are standing in the street and you look up and you see a boat traveling by in the canal, that just gives you a graphic of how far down those communities are. And in a hurricane-prone area, to repopulate, it is a

question that we are going to have to ask.

But when you go into the health care facilities there in New Orleans, LSU Hospital, Charity Hospital, one of the venerable teaching institutions in this country, my professors at Parkland Hospital in the 1970s, many of them trained at Charity Hospital in the 1950s and 1960s. It is truly an icon as far as medical care in this country.

But when you walk through that facility, you realize that it quite likely will never be, ever again, what it was before. And it is a sad state. There is equipment that is relatively new equipment, but it has been ruined by water, ruined by mold, not likely to be salvageable under any circumstances.

One bit of good news that I do need to share with Congress is that across the street at Tulane Medical School, the hospital there, under private ownership, has come a long way since the storm hit and since the forced evacuation of that hospital. We toured the facilities there at Tulane, at the HCA hospital. New paint on the walls, new sheet rock where sheet rock had to be replaced. The emergency room, the day we were there was about a week before Mardi Gras. It was not open that day, but they were going to open for Mardi Gras; and I believe that is, in fact, what they were able to do. It was a stark contrast to what was going on across the street.

Now, the difference was that from a corporate level, that hospital, that private hospital had made the decision that no matter where the disaster happened anywhere in the country, they were going to be ready and they were going to respond. As a consequence, insurance money and new investment, new capital invested in that hospital brought it back much more quickly than any of the other facilities that I toured down there.

But even with that hospital coming back, the service available to the residents who have come back to New Orleans, the medical care available, has been decimated. Doctors in private practice, when I visited the first time in October, would tell me, I have got no mail for 2 months. My accounts receivable, I have no idea. No money is coming in across the counter because everyone I am seeing, and the schedule is full, no one has any money, no one has any insurance. No one even knows if the company that they are working for is still in business. Things were so disrupted by that storm that day.

Doctors are leaving the area. The hospitals that remained open may not be able to stay open because of the vast debts that they are incurring. Again, they are busy, patients are coming in, but nobody has any visible means of paying them. It has been a slow, slow process getting our Federal agencies to provide the reimbursement for seeing those patients that should be there. And it just continues to be a sad tale.

There is no question that State involvement, as well, their response has been weak to nonexistent in several of those areas.

Now, we saw a number of people that fled from the storm path in Katrina came to my area of north Texas. Some great stories there about how people opened their hearts and their homes to people who had been displaced by the hurricane. One of the great stories is, of course, from the Dallas County Medical Society. When they heard that 17,000 people who had previously been in the Super Dome were going to come to a similar facility in downtown Dallas, even though it was on a Labor Day weekend, the doctors in Dallas, through the Dallas County Medical Society, sent out a blast fax to all of their members, and out of a 3,600-member medical society, 800 showed up on the steps of Reunion Arena to help those people and make certain that they had medical care.

But we need to learn our lessons from this crisis. There are areas where our medical system performed valiantly. But there are areas within our medical system and particularly in our Federal agencies where the response was weaker than it should have been. And the reason to be concerned about that is we also hear discussion of an illness called the avian flu that, while fortunately not in this hemisphere yet, may be here before we get back from our August recess because of the distribution of the distributive path along the migratory flyways of birds.

A lot of doctors showed up when they were asked to come down to Reunion Arena to receive the people from the hurricane. But what is going to happen if, instead of a natural disaster like a hurricane, the disaster is a communicable disease like the bird flu?

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Can we expect first responders to show up for that when they, in fact, themselves may be placed in peril by doing so?

Well, fortunately, the President and the Department of Health and Human Services and the NIH have worked very hard to come up with an Institute of Preparedness plan. We have provided some of the funding for that right at the end of December in the Department of Defense appropriation bill. There is still more money that we are likely having to put forth for that. And it is one of those things that it may turn out to be another Y2K. It may never materialize. But if it does materialize, it could be so severe and so harsh on our country that not being in a state of preparedness really makes no sense.

Mr. Speaker, the House has been very kind with its time tonight. It has given us an opportunity to talk about what I see are a number of issues ahead for us in health care.

I want to stress again that affordability of health care is a thing that we need to keep first and foremost in our minds. Every bill that we introduce, every vote that we take, every committee hearing that we hold, we need to keep affordability of health care uppermost in our minds. We need to work on the problem with the uninsured. We need to make insurance products available so that people can afford them. We need to expand and perhaps embellish federally qualified health centers. There is no question that we are going to need some type of liability reform in this country, and there is no question that we need some type of provider relief and to keep the best doctors involved and to continue to be involved in the practice of medicine, particularly where it is concerning our seniors.

Information technology will be something that we talk about now and for several years to come, but we need to be extremely careful how we implement that.

And then, finally, every hour that we spend thinking about preparedness, every dollar that we spend on preparedness is going to be money well spent. We can ill afford to have a poor response to the next crisis when it happens to this country. Unfortunately, the events of the last 5 years, I think, have shown us that bad things do happen to good people.

Mr. Speaker, the House has been very generous with its time.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. SWEENEY (at the request of Mr. BOEHNER) for today until 1 p.m. on account of illness.

SPECIAL ORDERS GRANTED

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

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

Ms. WOOLSEY, for 5 minutes, today.
Mr. DEFAZIO, for 5 minutes, today.
Mr. EMANUEL, for 5 minutes, today.
Ms. KAPTUR, for 5 minutes, today.
Mr. BUTTERFIELD, for 5 minutes, today.
Mrs. MALONEY, for 5 minutes, today.
Mr. CUMMINGS, for 5 minutes, today.
Mr. SCHIFF, for 5 minutes, today.
Mr. VAN HOLLEN, for 5 minutes, today.
Mr. UDALL of New Mexico, for 5 minutes, today.
Mr. HOLT, for 5 minutes, today.
Ms. CORRINE BROWN of Florida, for 5 minutes, today.

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

Mr. DELAY, for 5 minutes, today.
Ms. FOXX, for 5 minutes, today.
Mr. GOHMERT, for 5 minutes, today.
Mr. JONES of North Carolina, for 5 minutes, April 4, 5, and 6.

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