I yield to my friend.

Mr. MEEK of Florida. Mr. RYAN, you are talking fact, not fiction. Anyone who wants to talk about balancing the U.S. budget, the Democrats are the only party in the House, Madam Speaker, that have a right to say that we have done it. We have actually done it.

You have a lot of folks saying, well, we are going to try to cut it in half, and maybe we will get it to a quarter or whatever on the Republican side, the Republican majority with all the power, control of the House, control of the Senate, and control of the Presidency. It should be a smooth-sailing process.

If someone wants to call Democrats names and point fingers, call the former Speaker of the U.S. House of Representatives a name. Call him a liberal. Call him someone who is irresponsible, if you want to name-call. And I challenge Members to come down here and talk about what is good about owing foreign countries money, not because they did something to us, but because this Congress gave the whole country a self-inflicting wound of debt. They have been saying we are going to spend your money irresponsibly, and then we are going to allow these other countries to own a piece of the American apple pie.

Mr. RYAN, you did an excellent closing. I want to thank you, sir, for coming down to the floor.

Madam Speaker, I want to thank the Democratic leadership for allowing us to have this second hour.

91ST COMMEMORATION OF THE ARMENIAN GENOCIDE

The SPEAKER pro tempore (Ms. FOXX). Under a previous order of the House, the gentleman from New Jersey (Mr. PALLONE) is recognized for 5 minutes.

Mr. PALLONE. Madam Speaker, I rise this evening to commemorate the 91st anniversary of the Armenian genocide. As the first genocide of the 20th century, it is morally imperative that we remember this atrocity and collectively demand reaffirmation of this crime against humanity.

April 24th marked the beginning of the systematic and deliberate campaign of genocide perpetrated by the Ottoman Empire in 1915. Over the following 8 years, 1.5 million Armenians were tortured and murdered, and more than half a million were forced from their homeland into exile.

Last week I was joined by my cochair of the Armenia Caucus and many of my colleagues in Congress on a bipartisan basis in sending yet another bipartisan congressional letter to President Bush urging him to use the word ''genocide'' in his April 24th commemorative statement. With over 178 signatures, the message in that letter is loud and clear: 90 years is too long to wait for justice to be served and proper recognition to be made.

The President should have used the 91st anniversary of the Armenian genocide to promote the U.S. foreign policy that reflects appropriate understanding and sensitivity to human rights, ethnic cleansing, and genocide. But, instead, President Bush once again failed to honor his pledge to properly characterize the Armenian genocide in his annual remarks. Despite pleas by Members of Congress and the Armenian American community, and recognition by much of the international community, he continues to avoid any clear reference to the Armenian genocide while consistently opposing legislation marking this crime against humanity.

The Bush administration continues to be influenced by the Government of Turkey by placing parts of our foreign policy in their hands. When it comes to facing the judgment of history about the Armenian genocide, Turkey, rather than acknowledging truth, has instead chosen to trample on the rights of its citizens to maintain its lies. The U.S. cannot continue to submit to Turkey's shameless threats and intimidation.

Madam Speaker, the U.S. owes it to the Armenian American community, to the 1.5 million that were massacred in the genocide, and to its own history to reaffirm what is fact. As we have seen time and time again, the United States has a proud history of action and response to the Armenian genocide. During a time when hundreds of thousands were left orphaned and starving, a time when a nation was on the verge of complete extermination, the U.S. took the lead and proudly helped end these atrocities. In fact, Americans helped launch an unprecedented U.S. diplomatic, political, and humanitarian campaign to end the carnage and protect the survivors.

If America is going to live up to the standards we set for ourselves and continue to lead the world in affirming human rights everywhere, we need to stand up and recognize the tragic events that began in 1915 for what they were: The systematic elimination of a people. The fact of the Armenian genocide is not in dispute.

Madam Speaker, regardless of President Bush's inaction, I call on Speaker HASTERT to bring the resolution to officially recognize the Armenian genocide to the House floor. The resolution that passed in committee last September, again on a bipartisan basis by an overwhelming majority, has over 148 cosponsors. Now is the time to allow Members to reaffirm the United States' record on the Armenian genocide.

The U.S. Government needs to stop playing politics with this tragic time in history and take a firm stance for the truth. Genocide must not be tolerated.

□ 2245

HEALTH CARE AND WHERE WE ARE GOING

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

Mr. BURGESS. Madam Speaker, I come to the floor tonight to talk about health care, but I have to spend just a minute or two addressing some of the things that we just heard in the previous hour.

There has been a lot of discussion about the Jobs and Growth Act that was passed in 2003, in fact in May of 2003, a reinvestment of $80 billion back into the American economy, back into the productive sector of the American economy. The American people rewarded the United States Treasury with an increase in collections to the Treasury the next year with $260 billion that were not anticipated. Investment in the productive sector of the American economy works every time it is tried, and I am grateful to be part of the Congress in 2003 that provided that reinvestment opportunity for the American people.

There has been a lot of discussion this past couple of weeks about gas prices. We passed an energy bill at the end of July last year. Part of the deal on that energy bill was that there was going to be no liability protection for a compound called MTBE, a federally mandated oxygenate in gasoline that is sold in this country in order to comply with clean air restrictions.

Without MTBE, we are left with only ethanol as the only oxygenate available for the mixture of gasoline that is required to be sold in States that have clean air issues. We removed the MTBE because it was placed in legal peril.

We had an opportunity in October after the hurricanes hit, after we knew there was going to be trouble, we had an opportunity to address the oxygenate requirements in the blended fuels that are going to be blended and sold for this summer's driving season, precisely the time we are up against right now.

This House passed that bill which would have allowed for that relaxation of oxygenation requirements. We passed it with no Democratic votes. It was only Republican votes that passed the bill, and it has never been taken up by the Senate. The consequences are quite predictable.

Now, we were told during the hearings on the energy bill the prior year by individuals from, and you talk about a special interest group, that is the ethanol lobby; we were told that the ethanol manufacturers in this country had unbelievable success and they were able to produce ethanol that exceeded their wildest expectations. Well, they were wrong and they have not been able to produce the quantity they said, and it is time for this country to look at the tariff that we place on foreign imported ethanol. If we are going to require foreign imported ethanol to be part of our gasoline oxygenate system, we are going to have to import ethanol at least temporarily until we can increase production in this country.

But I did not come to the floor to talk about gas prices and ethanol, although that is important. I came to the floor tonight to talk about health care. I want to talk about where we are and where I see us going. I would like to spend a considerable time on the affordability of health care because I believe that is the central issue. Whether you talk about a single payer, government-run system or a system that embraces the private sector, affordability of health care is going to be one of the main drivers that we need to keep in our uppermost consideration.

We need to talk about the uninsured and federally qualified health centers. We will have a bill in the next couple of weeks in the committee that will authorize the federally qualified health center statute. Those are an important aspect of our delivery of medical care in the 21st century in this country.

We have to talk about liability reform. We have talked about it a lot in the past 3 years. We have yet to produce a satisfactory result, and it is going to continue to be a part of a major discussion on health care until we get something done in that regard.

We have to talk about provider relief and paying our doctors and health care providers what they rightfully earn, and not continue to cut their reimbursement rates year after year in the Medicare system and ask them to shoulder a greater and increasing burden of the health care costs when, after all, we turn to them to take care of the uninsured at no compensation and then we continually cut their Medicare compensation. We are driving good doctors out of practice and that is wrong. We need to address that.

There has been an explosive growth in information technology in virtually every sector of the American economy. Health care is no exception. We need to make certain that we have the right kind of informational technology at the disposal of people who provide health care.

Of course, you cannot look at the last year with the problem with the large hurricanes, the problems that loom on the horizon as hurricane season is upon us again, and the problems that loom on the horizon from an infectious disease, the likes of which none of us have ever seen in our lifetimes, the specter of the avian flu. We have to talk about preparedness.

When ethicists talk about health care and health care in this country, they always seem to talk about affordability, access and quality. I remember an ethicist that spoke to one of our classes years ago said affordability, access and quality; we have only learned how to handle two of the three at any one time.

Since I do not want to pick the one that is going to be left out, let me concentrate on affordability. We will leave quality and access discussions to other days. And I might add that I trust the American medical system to provide us with the quality that we have come to expect.

We already have a system that is paid for by, to a large degree, by governmental agencies and by the Federal Government with a GDP of $10 trillion to $11 trillion and $1.4 trillion spent on health care. In fact, in the HHS appropriations bill that we passed last December, over $600 billion was spent on Medicare and Medicaid alone. So clearly, almost 50 cents of every health care dollar spent in this country arises right here in the halls of the United States Congress. The remainder, the other 50 percent, is largely carried by private insurance, commercial insurance. There is also some amount of that is carried by self-pay. Again, we cannot forget the charitable care that is delivered by hospitals and doctors and nurses all over the country every hour of every day of the year.

The problem that I see if we do not address affordability of health care, the default position on the horizon is going to be a single payer, government-run system. Would that necessarily be a bad thing, to vastly expand the public expenditure on health care? I look to our neighbors to the north that have an entirely government-run, single-payer system, and I think it was just in late 2004 or perhaps 2005 that the Canadian Supreme Court ruled that their system, with its long waiting lines, was no longer adequate. In fact, I think the Canadian Supreme Court, their statement was access to a waiting line is not the same as access to care.

In that system there are the problems with long waits for so-called elective surgeries. Now, an elective surgery may be something as serious as replacement of a diseased hip or fixing a problem that someone has with a ruptured disk in their back or neck. It may even include coronary artery bypass grafting. It may include some things that we may not think of as being entirely elective. I would submit that health care in Toronto would significantly suffer if they did not have the safety net of Henry Ford Hospital in Detroit, Michigan to take care of some of their excess.

On the other hand, in the United States, if we had a single-payer system with long lines for access to care, I do not think we could count on a hospital on our southern border to bail us out in a similar fashion.

So in short, I believe we need the private sector, and in fact I believe we need to encourage and expand the private sector as far as delivery of health care in this country. Congress can take action by promoting policies that keep the private sector involved in the health care marketplace. Indeed, we have done exactly some of those things in the short 3 years that I have been here.

One of the most significant things I think that has happened in the last 10 years, in 1996 with the passage of the Kennedy-Kassebaum Act, and the allowance for the first time for what is called medical savings account. These were those high-deductible insurance policies where you could put money away towards that deductible into a medical IRA, if you will; allow that money to grow tax free to be a medical nest egg for someone who may need it in future years, or to pay that high deductible out of the medical savings account.

Now, medical savings accounts had a lot of restrictions upon them. But even at that, when they were first offered back in 1996 and 1997, I very quickly went out and signed up myself for a medical savings account. I made one available in my medical practice to anyone who wanted it, because I saw this as the tool for the future. It put the decision-making for health care decisions back in the hands of the health care consumer. I thought that was such a powerful concept.

Even though at the time medical savings accounts were kind of an untried and untested premise, I thought that concept of putting the health care decision back into the hands of the health care consumer was so important, I was willing to take a chance on that. Mind you, 1996 and 1997 and 1998 was a time we saw explosive growth of HMOs in this country. And more and more medical care was being dictated by the chief executive officers of HMOs or medical review boards in a HMO, and I saw this as a wonderful chance to reclaim the health care decisions for myself and my family. I gratefully took that option. I am glad I did because that policy served me very well until I came to Congress.

Now, coming to Congress in 2003, medical savings accounts were not available in the Federal Employees Health Benefit Plan. Again, medical savings accounts had a number of restrictions on them and they were capped. Only 750,000 could be offered across the country, and they were not that heavily subscribed.

When we passed the Medicare Modernization Act in November of 2003, we expanded medical savings accounts in a way that I frankly did not think was possible. But kudos to the Ways and Means Committee and Chairman THOMAS; they got the job done and vastly expanded the access to health savings accounts not just for recipients of Medicare, but for anyone who wanted to participate in that kind of high-deductible policy, and having a savings account that is dedicated entirely to their medical expenses.

There are some other improvements that can be made, and indeed there are several pieces of legislation out there currently to allow for a hybridization, if you will, between flexible spending accounts, health reimbursement accounts and health savings accounts. I think those are important steps that yet need to be taken. But with the expansion of health savings accounts in 2003, making them more generally available to the population, we unleashed a very powerful tool for providing insurance to more people in this country.

Madam Speaker, in the year 1994, I had a family member who was no longer able to get insurance off my employer-based insurance. I set out to get an insurance policy for that family member and it was all but impossible to do at any price. I was a practicing physician at the time, willing to write a large check for that insurance coverage, but I could not find anyone who would write a single policy for a young, single, uninsured person.

Well, fast forward 10 years to 2004, the year after we passed the health savings account legislation and the Medicare Modernization Act. And that summer you could go on the Internet, you could go to your favorite search engine and type in ''health savings account'' in the window, click ''go,'' and it would immediately return all kinds of options to that person for the potential purchase of a health care policy. I do this periodically to see what is available in my State for a 20- to 25-year-old single person for single coverage, and you can get a very reasonable, I do not want to say an insurance company's name, but a large insurance company that has a color as part of its first and second name; you can get a reputable insurance company's policy for around $50 a month. Again, a young person age 20 to 25, with a high deductible.

But think of that, a young person getting out of college who wants to, instead of going to work for a large corporation, wants to work for themselves. They want to do an Internet start-up company or any type of self-directed entrepreneurial-type activity. No longer do they have to turn their back on that as a career option because insurance is not available. They can purchase a policy on their own, a policy that is reasonably priced. Yes, it has a high deductible; but they also have the ability to put money away towards that deductible, do so tax free, and the money grows tax deferred.

□ 2300

And if it is used for a medical expense, it is not going to be taxed under any circumstance. We have another tool at our disposal. And the House has passed what are called association health plans. We have passed this two times a year, every year that I have been in the House of Representatives.

The Senate very recently passed an association health plan bill out of their committee. And this, again, is a powerful tool that allows for small businesses, small businesses of a similar business model, to band together and accrue the purchasing powering of a large group. The association health plan is envisioned to be sold across State lines such that a group of realtors in Texas could band with a group of realtors in Oklahoma and combine and pool their resources in order to get a lower price on their insurance coverage. Again, a very powerful tool, one we have passed in the House on several occasions. It did finally pass out of the health committee over in the Senate side, and I do look forward to them taking that issue up to the floor of the Senate, passing that successfully, and let's get to conference and let's get the differences worked out, because this is something we need to provide to our small businesses, the engine that drives productivity in this country. We need to put this tool in the hands of small business in this country.

When you think of consumer-directed health care, like a health savings account, there has to be some method that the consumer, that the purchaser has of evaluating different hospitals, different doctors. There has got be a measure of transparency brought into the overall purchase of that insurance plan. Right now there is opacity in the system, and I understand there is opacity in the system because opacity has value. It is perhaps worthwhile for a health care facility, a hospital, surgery center, doctor's office, to have a little bit of opacity in their pricing structure so that it is a little bit hard to figure out what something costs. But we need to move and make an honest effort to provide the information that the health care consumer needs to make a well-founded, consumer-oriented decision. After all, we are asking for consumer-oriented health care. We can't very well deny the consumer the opportunity to be able to evaluate two health plans side by side, two hospitals side by side, two surgery centers or two doctors' practices side by side. They need the ability to do that.

Finally, a concept that has been around as long as I have been here, and, I suspect, longer, is the concept of tax credits for the uninsured or the underinsured, a voucher system, perhaps, if you will, just helping someone who didn't make enough money to be able to pay for insurance, helping them pay for insurance with an EITC-type tax credit that is prefundable, not refundable. That is at the beginning of the tax year that money would be made available to that person.

Some of the proposals that are out there would fund $1,000 for an individual, $3,000 for a family. A lot of people will say, well, you can't buy much in the way on the health insurance market for $3,000 for an individual. But if you go to the health savings accounts Web sites, you certainly can find products that are available that would allow someone to purchase insurance coverage, again, for well under $1,000 for an individual, perhaps for 6- or $700 a year, and to begin to put money away towards that high deductible. And I think that is a worthwhile product, a worthwhile activity.

And I do look forward at some point to this Congress or the next Congress taking up the concept of tax credits for the uninsured because I believe that will, over the long term, all three of those concepts taken together, health savings accounts, association health plans and tax credits for the uninsured. Mort Kondracke in an editorial in the Roll Call Magazine really 2 years ago estimated that you could cut the number of uninsured by perhaps 13 million by those three entities alone. I actually think the number on his estimate on health savings accounts is a little low, because we have seen, over the last 2 years, an increasing number of people select that type of health insurance, such that now there are over a million people enrolled in health savings accounts. The vast majority of these are individuals over the age of 40, and a great number of these are people who would not be regarded as high-income. Probably 40 percent of people earn under $50,000 a year. So it is not just for the healthy and the wealthy; it is a program that does have high utility for Americans across the spectrum of all age groups and all earning capabilities.

As far as the uninsured is concerned, the U.S. Census Bureau, and it seems like this number is higher every week when I read it, right now between 43- and 45 million people who are estimated to be uninsured. Now, this number is a little bit tricky because it does include people who are uninsured for any portion of the year. So someone who is uninsured for part of the year, but has insurance for the balance of the year is going to be counted uninsured for the entire calendar year.

Does it count people who are perhaps in this country without a valid Social Security number, people who are in this country without the benefit of a valid visa or immigration papers? And the fact is that it does, and it is going to be difficult to provide coverage to someone who breaks the law by entering this country illegally.

But that doesn't remove the fact that there are a lot of people in this country who lack health insurance. One of the things that causes it, of course, is the high cost of health insurance. And when I talk about the affordability of health insurance, I acknowledge that for every dollar that health insurance premiums go up, a certain number of people are going to be excluded from the rolls of the insured. And we have done things that cause the cost of insurance to inexorably go higher and higher, and as we do that, we are going to drive more and more people away from the ranks of the insured onto the rolls of the uninsured.

Now, one of the things that is not often talked about in context with uninsured individuals is the concept of federally qualified health centers. Now, the President talked about federally qualified health centers on at least the last two occasions when he delivered his State of the Union Address, and I believe the last time he was here he said he wanted to see a federally qualified health center in every poor county in the United States.

I submit that is a worthy goal, and I would also submit there are some counties such as in my district back home in Texas that you wouldn't necessarily record as poor, but they have areas of

poverty within them that are as large as counties, and indeed as large as some States back East, and these populations would benefit from access to a federally qualified health center.

Now, we are going to be taking up the bill that will reauthorize federally qualified health centers within the next few weeks in the Energy and Commerce Committee. I suspect it will come to the floor perhaps the latter part of June during Health Care Week. This is a worthy exercise and one that the committee needs to take up, and indeed the whole House needs to take up. I hope there are some improvements that we can make upon the system.

One of the things I learned last year with the large number of evacuees that came to my district from Louisiana, to my district in Ft. Worth, Texas, it takes a long time to set up a federally qualified health center. And if you have a large number of displaced persons who, by virtue of the fact that they are low-income, by virtue of the fact that they had to leave their homes under the worst possible of conditions, and it is taking some time to get them set up in a new life, or perhaps they are just temporarily going to be displaced in my district, it takes too long to set up that federally qualified health center structure to be able to help individuals like this in the time frame where they need the help. So some streamlining of the federally qualified health center application process, I believe, would really go a long way towards helping these individuals. Backstop it. Make certain that within 2 years time all of the other regulations that surround federally qualified health centers have to be complied with, but ease up the rules just a little bit in an area that is desperately medically underserved to allow the setup and startup of one of these centers in a timely fashion.

We have to provide that degree of flexibility. Otherwise, we are only driving up the cost of health care in the hospital emergency rooms in the area, in the doctors' offices in the area, where they are going to see more and more uninsured patients and deliver more and more uncompensated care, which they, in turn, will have to pass that cost off to other patients and other health care consumers.

But the beauty of a federally qualified health center is it allows a patient to have a medical home even though the patient does not have insurance, and that is the least expensive way of delivering health care to that group of individuals. Again, it keeps them out of the emergency room. It keeps them from accessing health care at the most expensive entry point into the health care system. It allows them to enter in at the level of the medical office or medical clinic, as opposed to the emergency room. And they frequently see the same doctor for visit after visit, so that a problem such as high blood pressure, diabetes, congestive heart failure, chronic long-term problems again are going to be better managed if you see the same provider time and time and time and time again. That continuity of care really is worth something in that environment.

Now, there are a number of federally qualified health centers in this country. I don't know the precise number. I believe that the number of people who are actually served by federally qualified health centers is going to number in the 15 million range, so that 15 million individuals who are maybe uninsured but have access to health care through a federally qualified health centers, it may not be actually accurate or fair to carry them on the ranks of the uninsured. And that is why I say that number of 42 to 45 million that is always reported by the Census Bureau may be overreported because it doesn't take into account the millions of people that get their medical care through a federally qualified health center, which is a very reasonable, cost-effective way to get good medical care for someone who doesn't have access in some other form.

We have State governments that have, over the years, required that a lot of things be covered on insurance policy, the so-called mandates that are added to insurance policies. And tonight, not really the purpose to get into what mandates are good and what mandates are bad, but recognize that adding enforced coverage to insurance policies does increase the cost of insurance policies. And again, for every dollar that we drive up the cost of an insurance policy, we are excluding people from insurance.

If it were possible to come to some agreement on what mandates were absolutely necessary, people just can't live without, and which are more optional, and come to a conclusion about is it possible for us to designate a type of insurance, what would be covered under that type of insurance that could be sold from one State to the other, sold on the Internet, get the benefit of that type of competition across the country, if it were possible to come to that type of conclusion about what we have to have, what we can't live without in an insurance policy, and allow insurance companies to market lower-cost products to people who fall into the ranks of the uninsured, I believe that our American insurance companies would look at that 42 to 45 million uninsured as a market opportunity and would want to market an insurance policy to that segment of Americans if they only were allowed to do so.

The good news, Madam Speaker, is we have actually kind of already come to that agreement. And I go back again to the federally qualified health center template. We have already decided within the federally qualified health center structure what procedures have to be offered, what conditions have to be covered, what benefits have to be offered in the federally qualified health center structure. And if we could take that template as a starting point and come to agreement amongst ourselves, Republican and Democrat alike, stop the tennis match of my mandate is more important than your mandate; stop the arguing over this process, and simply come to an agreement, here is an insurance policy that is good enough to be sold to America's uninsured, it covers the things that should be covered, it doesn't add a lot of additional expense for things that might be considered as optional; and then allow American insurance companies to compete to sell to that segment of the market, I think we would find that that is a very powerful tool and one that, quite honestly, we do need to explore. And we need to explore it in this Congress. We don't need to wait. The guys an hour ago were talking about how different things are going to be a year from now.

□ 2315

Well, it does not need to wait for a year from now. This is work that we can do today, this month, this year. And I submit that it is good work and one that we must take up in this Congress.

Madam Speaker, when I was originally talking about this, the concept of liability reform is one that we visited on the floor of this House many, many times since I took office in the beginning of 2003, I believed before and I still believe now that we do need a national strategy for medical liability insurance reform.

And I am from Texas. Texas has done a great job with medical liability reform. Texas has done a great job with putting a cap on noneconomic damages and has, I think, built upon and strengthened some of the earlier programs such as the California program of the Medical Injury Compensation Reform Act of 1975. I think the Texas compromise of 2003 really built on that earlier experience and is a very valuable program. In fact, it is delivering cost savings on liability insurance for the doctors of Texas. One of the unintended consequences was that it really brought the cost of liability down for self-insured, not-for-profit hospitals. They have been able to make more investments in capital and equipment and nursing personnel than they thought possible because of the cost savings they have gotten off of the Texas medical liability reform that was passed in 2003.

Now, in this House we passed H.R. 5, which was a major medical liability reform bill, in 2003. And when we passed that bill, Madam Speaker, the Congressional Budget Office scored that as a savings of $15 billion over 5 years' time. Now, it is not just the lower cost of liability insurance that they are talking about and doctors passing that cost on to their patients. No. The real savings in that H.R. 5 was because of the perceived reduction in what is called defensive medicine: I do not think this person has this condition, but I need to

do this test in case I am wrong and this case comes into court and I want to be certain that I have got this evidence to back up my decision-making process.

A study done back in 1996 at Stanford University estimated that out of the Medicare program alone, just the Medicare program, the cost of defensive medicine in 1996, that was 10 years ago, the cost of defensive medicine for Medicare in this country was nearly $30 billion a year. I submit that that 10-year-old study, if it were done again today, would find that dollar figure to be actually much higher. CBO did not score it as high, but still acknowledged that there was significant savings to the Federal budget every year if the Congress, House and Senate, would pass meaningful, meaningful medical liability reform.

The problems of the expense of defensive medicine and the high cost of the medical liability system as it exists today means that we are taking money out of the health care sector of our economy and pushing it off to somewhere else. And that somewhere else is too often paying a contingency fee for a trial lawyer. And as harsh as it is to say it, we can no longer afford that kind of luxury. We can no longer afford to divest that kind of money in order to continue the medical liability system that we have in this country. We need a fairer medical justice system than we possess today.

The bill that we passed, H.R. 5, back in 2003, again basically put a cap on noneconomic damages. It capped noneconomic damages at $250,000. I believe it was a good bill. I voted for it in 2003. I voted for it in 2004. I voted for it in 2005. In fact, I will vote for it again if we bring it to the floor of the House again this summer. But when you look at the Texas bill that was passed in 2003, it actually structured itself a little bit differently. Yes, there is a $250,000 cap for noneconomic damages, but that cap exists for the physician, for the hospital, and for a second hospital or nursing home if one is involved. So the total aggregate cap is $750,000. I would have been concerned back in 2003 if someone had said this is the way we are going to go about the cap, that that was too high, that that would not bring the cost of medical liability insurance down, that that would not reduce the cost of defensive medicine. But, in fact, the story in Texas is that it has brought costs down.

I will give you an example. In 2002 when I was running for office the first time, we went from 17 insurers in the State of Texas, medical liability insurers, 17 of them in the State of Texas at the start of the year, 2 in the State at the end of the year. And the problem was the high cost of medical liability and the draining of those insurance companies by lawsuits.

The effect of passing that bill in June of 2003 and then the subsequent constitutional amendment that was required to allow that bill to become law in September of 2003, by the middle of 2004, less than a year later, we had gone from 2 medical liability insurers in the State of Texas back up to 13 or 14, and they had come back into the State without an increase in rates. That is pretty powerful, because if you go from 17 insurance companies down to 2, you have not got much in the way of competition. You pretty much have to take what they say as the going rate. So getting those insurers back into the State of Texas was critical as far as keeping doctors involved.

I remember an event that I went to during the fall of 2002 when I was running for Congress, and a young woman who was a radiologist came up to me and said, ''I really hope you get something done on medical liability. I have lost my insurance, not because of a bad case but simply my insurer left the State of Texas and now I cannot get liability insurance, and as a consequence I am a stay-at-home mom now. I am not practicing radiology.'' Because, obviously, she cannot without the protection of a medical liability insurance policy. So the State of Texas had paid for her medical education. The State of Texas had subsidized her during her radiology residency down at the University of Texas at San Antonio. And now just a few years later, she was out of medicine altogether and raising her children. I am sure she was very happy in that role, but at the same time, what a waste of that woman's talents. What a waste of that woman's training that she would not be able to practice radiology in Texas simply because her insurer left the State and she could not get someone else to cover her. That is the kind of very stark reality that we were up against in Texas in 2002. We were one of the top crisis States as designated by the American Medical Association of that year.

Fast forward to June of 2003, a major liability provision was passed. Again, it capped the pain and suffering damages at $250,000 for the doctor, $250,000 for the hospital, $250,000 for a second hospital or nursing home if one was involved, and very quickly there was a turnaround, the insurers coming back into the State, hospitals saving money. Doctors from Texas Medical Liability Insurance Trust, my old insurer of record, the savings now, the accumulative savings, from when that bill was passed to the present day is in excess of 20 percent savings on their medical liability policies. These are policies which, by the way, were going up by 10 and 20 percent every year for the 2 or 3 years that preceded that event.

So I think the Texas plan is a good one, and I like to sing its praises every time that I come to the floor of the House. I think any medical liability reform that we pass in this House, we could do worse than to base it off of the Texas plan and the Texas compromise, the so-called trifurcated cap. I would like to see us champion that concept over in the Senate and see if we could not get their attention with the trifurcated cap and perhaps get a bill that we could get to conference that way.

But one of the critical things about medical liability insurance issues, people say, you are from Texas and if you have solved the problem in Texas, why do you continue to worry yourself about it in the House of Representatives? And I will tell you why. Because that bill is under attack every legislative session in Texas. There are special interests. And, yes, addressing the Democrats, there are special interests that work on your side as well as our side. There are special interest groups that want to roll back that legislation. But there are other issues as well.

During my first term, my first year in Congress, we took a visit up to the ANWR up in Alaska. And coming back from ANWR we came through Nome, Alaska. Nome, Alaska is a pretty remote place out there. So you can just imagine that when a big plane with a bunch of Congressmen land, it is a big deal in Nome, Alaska. They wanted to have a chamber of commerce-type lunch for us, which they did. And when they learned that there was a Congressman who was also a doctor on the plane, all the medical staff got real excited and all 19 doctors on the medical staff of the Nome, Alaska hospital came out to that lunch that we had.

And one of the doctors who was there said, ''Boy, I sure hope you get that medical liability law passed up in Congress, because we cannot afford the medical liability policy for an anesthesiologist here at the hospital; so we need your help and we need you to get that done so we can afford to have an anesthesiologist.''

I said, ''Well, gosh, what kind of medicine do you practice, sir?''

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

''An OBGYN. How in the world do you practice obstetrics and gynecology? How do you deliver a baby without the availability of anesthesia? Forget a labor epidural and pain relief during labor. What do you do if you have to have do a C-section?''

And he said, ''Congressman we get that woman onto a plane and we get her down to Anchorage as fast as we can.''

Anchorage, an hour and a half away from Nome, Alaska. And I am not entirely sure about this, but I believe there is a significant amount of bad weather in Nome, Alaska. I do not want to upset the people at the chamber there, but I believe there is a significant amount of bad weather in Nome, Alaska, particularly in the winter months. How do we further the cause of patient safety by requiring that that doctor put his patient on a plane and send her to Anchorage to get a C-section done with the care of an anesthesiologist? That system makes no sense.

Another opportunity I had was to visit with someone who was in charge of the residency program of a large New York hospital. I trained at Parkland Hospital, but I was aware of their

training program, and certainly it is a good second to Parkland Hospital in Dallas. But this individual was in charge of the residency program. And I said, ''How has the liability issue affected your ability to recruit medical students for your OB–GYN residency there in New York?''

And she said, ''Well, it is a real problem, and currently we are accepting students that 5 years ago we would not have interviewed.'' In other words, they have lowered their standards in that OB–GYN residency, because medical students coming out of medical school with huge debt do not feel that they can take on the expense and the trauma of a large liability policy when they start their practice; so they just do not go into OB–GYN.

These are our children's doctors. These are our children's children's doctors that we are talking about. How are we furthering the cause of better medical care in this country when we are allowing that system to continue? It truly is unconscionable, and it is time for this Congress to correct that. Both the House and the Senate need to take action on this. We do have a President who has pledged to sign this bill if we will get it to his desk, and I believe that we must do that.

On the concept of physician payment, I will say that we spend a good amount of time in this body discussing health information technology and pay-for-performance scenerios. We talk about them frequently. But we do not address a serious problem that has been plaguing America's physicians for the past 10 years, and that is the issue of the continuing erosion of physician payments under the Medicare system.

Currently, physicians are paid under what is called the sustainable growth rate, or SGR, which provides for a payment cut of 4 percent for every year, year over year, to a cumulative total of some 26 percent. And that has a negative effect upon the number of doctors who continue to provide services for Medicare patients.

Now, I have done a lot of town halls around in my district, and I have heard a lot of discussion about prescription drugs. But I have also had a lot of people come up to me at the end of a town hall and say, ''How come I turned 65 and I have got to change doctors?'' The reason they have to change doctors is that their physician has evaluated the Medicare reimbursement schedule and has decided that it is not in their best interest to continue to provide care for Medicare patients because of this continued erosion of provider reimbursement rates that goes on year over year. Doctors look at that and they think, well, Congress is likely to reverse that at least temporarily this year. But it is very difficult to plan. It is very difficult to hire. It is very difficult to justify equipment purchases if you have got to factor in a pay cut of 4 to 5 percent every year for the forseeable future.

Now, we passed a bill called the Deficit Reduction Act right at the end of the year, but it turned out we really did not pass it until January. Within the Deficit Reduction Act was a provision to keep the doctors from having that negative 4.4 percent update; in other words, just hold payment rates at a level amount and not decrease it.

□ 2330

The effect of not passing that bill in December and allowing January 1st to hit without addressing that problem meant that every physician in the country who does Medicare got a letter from CMS, the Center for Medicare and Medicaid Services, saying your rates just went down 4.4 percent, or our reimbursement to you just went down 4.4 percent. My fax machine lit up, because it was over the holidays and doctors wanted to get word to me, saying here is the letter I accept to my patients, Congressman. I will no longer be able to provide your care after the first of the year because Medicare has again cut my rates.

So doctors not just in my district, but across the State and some even across the country, called me and notified me that they were going to drop their coverage of Medicare patients.

The problem is that these are doctors who are in the peaks of their career. These are doctors who have established practices, the doctors who come to a diagnosis the quickest, the doctors who spend the least amount of time in the operating room, the doctors who are at the pinnacle of their medical expertise, and they are being driven out of the system. The problem is if you drive out your first tier of providers, it is only going to cost you more in the long run.

So when we talk about things like pay for performance, I cannot help but think if we run off our top tier of providers, we are going to have to pay a lot more to get less performance in the future, and it is incumbent upon us to take up that legislation, to take up that concept and pass legislation that will once and for all fix the problems with the sustainable growth rate and not make our provider community face that 4 to 5 percent pay cut every year, year over year.

A concept derived by the Medicare Payment Advisory Council, so-called MEDPAC, was for consideration of what is called the Medicare economic index, which calculates the true cost of providing Medicare health services, and the reimbursements would be based upon a formula which factored in the actual cost of delivering that care, a very powerful concept and an idea whose time I believe is long since overdue.

Another issue that we spend a lot of time talking about here on the House floor and over in committee is the concept of increasing health care technology. This is appropriate for Congress to be considering this. It is an appropriate expenditure. It is terribly difficult for small doctors' offices with one, two, three and four providers in an office, to justify the kind of expense that would be required to purchase that off-the-shelf health care information technology.

A lot of times a hospital would be willing to partner and help offset some of that, because the hospital benefits as well. Currently we have laws such as stark laws and anti-kickback statutes that prevent that from happening. We need to seriously look the a those pieces of legislation. They may have been of some value back in the 1980s, but they are not a great help in the 21st century. They are not really protecting anyone from any malfeasance, and they are preventing getting this technology into the hands of people who need it the most.

The other thing that we have to consider is we have to assure physicians, providers, hospitals, that they are not going to run afoul of some statute in the HIPAA legislation, the patient privacy legislation. Finally we need to concentrate on some coding uniformity so that people will have confidence in these systems and know that they can use them and that they are not only helping their patients, they are helping their practices, they are helping their bottom line, they are helping their hospital. It could be a win-win situation all the way around, but we are going to have to change some Federal regulations to allow that to happen.

One of the things that I talked about when I originally started this evening was that we needed to touch on preparedness. When you talk about preparedness, looking back over the last year, the twin hurricanes of Katrina and Rita that hit Louisiana, Mississippi and then Texas and Louisiana later in the year, it is impossible to talk about preparedness without thinking about some of the lessons that we learned.

When the hurricane was out there churning in the Gulf, the first hurricane, Hurricane Katrina, you just knew it was going to be bad news. It was a hurricane unlike anything that any one of us had seen before, and there is no way in this day and age that it could select a location for landfall along the Gulf Coast where it was not going to affect a significant number of people.

Well, we all know the story. It came ashore. It kind of took a little turn before it came ashore. We thought New Orleans had dodged a bullet, only to find out that it got hit with even a larger bullet than any of us thought possible.

I was back in Fort Worth and Denton, Texas, during the August work period, and it was at that time that almost 25,000 people that were displaced from that storm came to North Texas seeking shelter, seeking medical care. To say that we weren't expecting it would be an understatement. But the people of North Texas opened their homes and their hearts. Hospitals, hotels, church camps did yeoman's work taking in people who were affected by the storm.

Where my district office is in Fort Worth, at the Tarrant County Resource Center, they immediately made provisions to take in 80 individuals. We set up pallets and cots well into the night on Wednesday night and started receiving our first evacuees on Thursday.

A small Baptist camp in Denton, Texas, Camp Copus, opened its gates up and received some 130 people who had driven in buses all night, in two buses all night, from the Superdome in Louisiana when they finally got out of there.

Probably one of the most heartwarming stories in the North Texas area was the way that the Dallas County Medical Society really rallied around and got their members out to provide care for these individuals as they got off the buses. There are about 3,600 members of the Dallas County Medical Society. When they heard the buses were on the way up from the Superdome, we were right on top of Labor Day weekend, so most people were closing their offices early, making plans for a holiday weekend.

The Dallas County Medical Society sent out a blast fax to all its member physicians, and 800 doctors showed up to provide medical care, triage care, urgent care to these people that got off the buses who had been displaced from Hurricane Katrina; people who had chronic medical conditions, who had been off their medications for 3 or 4 days, who with their chronic medical condition were about to have an acute decompensation of hypertension, diabetes, congestive heart failure.

So as these people came off the bus, as the evacuees, they were interviewed. If they thought they were ill enough to have to go to the hospital, they were taken to the hospital, to Parkland Hospital there in Dallas. If they simply needed a shower and a meal and a refill on their medications, that was provided for them.

Of the 17,000 people who got off the bus in those first hours that evening, less than 500, I think the number is actually in the range of about 300, were actually hospitalized at Parkland Hospital, a phenomenally small number when you consider that these were people who had been in the worst of conditions for the past 3 or 4 days, again many of them ill with chronic medical conditions who had been off their medications for several days. Very few required hospitalization because the doctors of the Dallas County Medical Society were there to receive them.

One the great stories of that evening was some of the pharmacies in the area provided mobile communications and mobile computer hookups, and if those patients had received their medicines at one of the chain drugstores in Louisiana, in New Orleans, they were able to actually replicate their medications, duplicate their records for the medications, what they were taking and the dosage schedules, and make sure the right medicines were gotten to the right individuals. A phenomenal story that occurred there on Labor Day weekend.

Another story you will never read about in the newspapers but really was one of the phenomenal good news stories, the way you can save a lot of money with just a small investment, everyone was given a little tube or little canister of hand sanitizer, and every few minutes you would see people sanitize their hands with an antibacterial, anti-viral preparation.

In these kinds of conditions, where you have got a lot of people who have been wet from a storm and then housed in the Superdome and then got wet again when the Superdome flooded, on a bus for hours, you can just imagine the bacteria and viruses find that an environment they can thrive upon.

Diseases like the Norwalk virus, where gastrointestinal illnesses, epidemic diarrheas are very, very common in those types of conditions. They had very, very few people who became ill. Those that did have symptoms were identified early and sequestered off in another facility. But, again, the hand sanitizing that was done by providing low cost hand sanitizing solution to every person within the Reunion Arena shelter there really kept down trouble and spared a lot of human suffering, spared a lot of medical expense for having to treat people then of the subsequent gastrointestinal illnesses, the nausea, the vomiting, the diarrhea, the dehydration that could accompany that.

As a follow-up, I have been to the City of New Orleans twice since Hurricane Katrina hit. The first time was in October. I was there as a guest of one of the hospital administrators who wanted me to see, he had come before our testimony to testify in Washington and he wanted me to see firsthand myself the destruction that is there.

Even if October, two months after the date, it is unbelievable. There is work to be done that realistically will carry on for years. It is a phenomenal task that is ahead of the people of Louisiana, the people of New Orleans, the people of Mississippi and the people of the United States of America as we help that part of the world recover.

I do want to share one other good news story. We toured Charity Hospital and saw the degree of devastation there, and there is a lot of work to be done if Charity Hospital is ever going to recover. Across the street at Tulane Hospital, which is a private hospital, they had invested insurance money, they had invested new capital and were well on their way to having the HCA hospital up and running. In fact, I believe their emergency room was open in time for Mardi Gras. I am not sure if the hospital has opened up any of its wards yet, but it looked like they were well on their way to getting that done.

An entirely different story just across the street from Tulane. They both had the same degree of flooding, they both had the evacuation on the same day, late that week after the storm, but involvement of the private sector really did make a positive difference in the recovery of the Tulane Hospital.

It is my hope that Charity Hospital will be able to recover as well. I hope the individuals there involved in the State Medical System can work with Federal agencies and can work with the doctors and the very capable administrators on the ground, but they have got a long way to go to recover the Charity facility.

I guess one of the main things that was learned down there, one of the main lessons learned, an off-the-shelf preparedness plan that is purchased by a hospital or nursing home is not going to do a bit of good if it is not taken off-the-shelf and put into action. Unfortunately, that did happen in more than one occasion in that area after the hurricane.

I do need to add that just because a hospital was private does not necessarily mean that it fared better than a public hospital. There were other private hospitals that still lag far behind the HCA facility there at Tulane, and it is my hope that more of those will follow the Tulane model and make that private investment, invest those insurance dollars that they receive and bring their facilities up and on line quickly.

We did have hearings. The other side complained this evening about oversight. There were excellent oversight hearings by TOM DAVIS' Special Select Katrina Committee. All Members received or should have received their report. It is called Failure of Initiative. It is a very large book, but it is not a hard read. In fact, it is a very interesting read. For those Members who have received that and not read it, I would urge you to do so.

There is an excellent part in there about medical preparedness, but in fact it talks about preparedness all down the line, and it is a valuable instruction for all of us, especially when we talk about the specter of the avian flu which could be facing us here in this country as early as late August or early September.

When you look at the spread of that illness in bird populations across Southeast Asia and then the Middle East and then in Eastern Europe and now in Europe, clearly there is a continued spread of that disease. When it gets into the flyways of the migratory bird patterns, gets up in the polar regions perhaps by this summer, then down through the upper North American continent in Canada, arriving in the United States, pick the month, but one could easily assume it would be early or late fall of next year.

I must stress that this is still a disease in animals, a disease in birds, but there is a lot about it that is not known. Felines in Germany have contracted the disease. Whether that is because they have come in contact with animal waste or whether they have eaten animals that is diseased, no one

really knows. It does appear to be a different disease in felines than you would expect the avian flu to be in humans if it were to mutate to a human form.

We have a lot of work to do as far as bolstering our vaccine manufacturing capability within our shores, within our borders. It needs to happen in this country. We need some liability relief to allow that to happen quickly, but we also need to protect and indemnify our first responders.

Those 800 people that came to the Reunion Arena parking lot from the Dallas County Medical Society for Katrina victims may have an entirely different view on the situation if they are being called to come attend a large number of casualties from a disease that might well be an infectious disease that they could catch. They will need to have the availability of anti-virals. We will need to have the availability of vaccines. But if those vaccines are relatively new and untested, we need to have the ability to indemnify those first responders or their families if the first responders are harmed by the vaccines.

□ 2345

The disease knows no boundaries. It does not respect any Governmental jurisdiction. If it does arrive on the upper part of the North American Continent it will spread through the lower parts to the United States.

Can anyone guess how quickly? Suffice it to say that the conditions are a little bit different here than in Southeast Asia and the Middle East. Containment policies that have been somewhat sporadic would likely be much more effective over here on this continent.

But that is not to say that we could not face a very serious problem. It would be economically disruptive if nothing else if large numbers of the poultry population had to be taken off line. But a very serious potential human tragedy if the virus changes in its ability to infect not just bird populations but humans as well.

But in summary, Madam Speaker, we have got a lot of work ahead of us as far as health care is concerned over the balance of this year. I know that the leadership takes this responsibility very seriously. Certainly I want to make certain that the leadership and indeed every Member of Congress knows that those of us who have a background in health care stand ready and willing to help in this regard.

The concept of affordability of health care is one that I just cannot stress enough, because if we do not attend to the affordability of health care we may end up with a default position that none of us really cares for.

And with that, Madam Speaker, I yield back.

RECESS

The SPEAKER pro tempore (Ms. FOXX). Pursuant to clause 12(a) of rule I, the Chair declares the House in recess subject to the call of the Chair.

Accordingly (at 11 o'clock and 53 minutes p.m.), the House stood in recess subject to the call of the Chair.

□ 0000

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Mr. COLE of Oklahoma) at midnight.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF H.R. 4975, LOBBYING ACCOUNTABILITY AND TRANSPARENCY ACT OF 2006

Mr. DREIER, from the Committee on Rules, submitted a privileged report (Rept. No. 109–441) on the resolution (H. Res. 783) providing for consideration of the bill (H.R. 4975) Lobbying Accountability and Transparency Act of 2006, which was referred to the House Calendar and ordered to be printed.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Ms. MILLENDER-MCDONALD (at the request of Ms. PELOSI) for today and Thursday, April 27, on account of attending to important personal and business matters.

Mr. GEORGE MILLER of California (at the request of Ms. PELOSI) for today after 5 p.m.

Ms. MOORE of Wisconsin (at the request of Ms. PELOSI) for today.

Ms. ROS-LEHTINEN (at the request of Mr. BOEHNER) for today on account of a family emergency.

SPECIAL ORDERS GRANTED

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

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

Mr. DEFAZIO, for 5 minutes, today.

Mr. PALLONE, for 5 minutes, today.

Mr. EMANUEL, for 5 minutes, today.

Ms. KAPTUR, for 5 minutes, today.

Ms. WOOLSEY, for 5 minutes, today.

Mr. STUPAK, for 5 minutes, today.

Mr. GEORGE MILLER of California, for 5 minutes, today.

Mr. OWENS, for 5 minutes, today.

Mr. BLUMENAUER, for 5 minutes, today.

Mr. CUMMINGS, for 5 minutes, today.

Ms. MCKINNEY, for 5 minutes, today.

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

Mr. RAMSTAD, for 5 minutes, today and April 27.

Mr. JONES of North Carolina, for 5 minutes, April 27 and May 2 and 3.

Mr. MACK, for 5 minutes, today.

Mr. KENNEDY of Minnesota, for 5 minutes, today.

Mr. BRADY of Texas, for 5 minutes, April 27.

Mr. BISHOP of Utah, for 5 minutes, April 27.

SENATE ENROLLED BILL SIGNED

The SPEAKER announced his signature to enrolled bills of the Senate of the following titles:

S. 592. An act to amend the Irrigation Project Contract Extension Act of 1998 to extend certain contracts between the Bureau of Reclamation and certain irrigation water contractors in the States of Wyoming and Nebraska.

S.J. Res. 28. Approving the location of the commemorative work in the District of Columbia honoring former President Dwight D. Eisenhower.

ADJOURNMENT

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

The motion was agreed to; accordingly (at 12 o'clock and 1 minute a.m.), under its previous order, the House adjourned until today, April 27, 2006, at 9 a.m.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 8 of rule XII, executive communications were taken from the Speaker's table and referred as follows:

6980. A letter from the Director, Regulatory Review Group, Department of Agriculture, transmitting the Department's final rule — Acreage Reports and Noninsured Crop Disaster Assistance Program (RIN: 0560-AG20) received March 29, 2006, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

6981. A letter from the Administrator, U.S. Agency for International Development, transmitting a report of a violation of the Antideficiency Act by the U.S. Agency for International Development, pursuant to 31 U.S.C. 1351; to the Committee on Appropriations.

6982. A communication from the President of the United States, transmitting a request for FY 2006 budget amendments for the Army Corp of Engineers; (H. Doc. No. 109–99); to the Committee on Appropriations and ordered to be printed.

6983. A letter from the Deputy Director, Defense Security Cooperation Agency, transmitting pursuant to the reporting requirements of Section 36(b)(1) of the Arms Export Control Act, as amended, Transmittal No. 06-20, concerning the Department of the Navy's proposed Letter(s) of Offer and Acceptance to Thailand for defense articles and services; to the Committee on Armed Services.

6984. A letter from the Under Secretary for Personnel and Readiness, Department of Defense, transmitting a letter on the approved retirement of Lieutenant General Glen W. Moorhead III, United States Air Force, and his advancement to the grade of lieutenant general on the retired list; to the Committee on Armed Services.

6985. A letter from the Under Secretary for Personnel and Readiness, Department of Defense, transmitting a letter on the approved retirement of Lieutenant General Colby M. Broadwater III, United States Army, and his advancement to the grade of lieutenant general on the retired list; to the Committee on Armed Services.