

(Mr. CUMMINGS addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Michigan (Mr. STUPAK) is recognized for 5 minutes.

(Mr. STUPAK addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Texas (Ms. JACKSON-LEE) is recognized for 5 minutes.

(Ms. JACKSON-LEE of Texas addressed the House. Her remarks will appear hereafter in the Extensions of Remarks.)

THE STATE OF HEALTH CARE: REPUBLICAN EFFORTS FOR HEALTH CARE REFORM

The SPEAKER pro tempore. Under the Speaker's announced policy of January 4, 2005, the gentleman from Pennsylvania (Mr. MURPHY) is recognized for 60 minutes as the designee of the majority leader.

Mr. MURPHY. Mr. Speaker, I will be joined in a little bit by my friend and my colleague, Dr. PHIL GINGREY of Georgia, for this next hour. It is important that we lay out a large segment of what we believe is a critically important agenda to reform health care in America.

We know that few things are more valuable to us than the health of our families. When the health of our families is threatened, we feel frightened, we feel vulnerable, and we desperately search for help. I think few would challenge that the United States provides, as available, the best health care in the world, dedicated and caring physicians and nurses and hospitals and professionals, and we have made huge technological advances in fighting disease and prolonging life. Our research and medical technology is second to none. It significantly advances every year.

However, despite these many accomplishments, the American health care system is burdened by severe problems that lower quality and increase costs and too often make this system unaffordable and inaccessible for millions of Americans. Too many families, unfortunately, are only able to window-shop for health care coverage, and they feel as though they cannot go into the store.

Tonight, those colleagues of ours on our side of the aisle, who are part of our health care team, will be talking about a number of important issues to advance this cause. Mr. Speaker, before I go into this, let me pause, if I may, for a moment, and say usually when I have been here for Special Orders to talk about issues, I traditionally was walking up to the Capitol to make a call to my mother to let her know. She then would get on the phones and call

all her friends. My mother was a nurse, worked for many years at hospitals in Cleveland, as well as in industrial settings.

I am sad to say that since I last spoke in the Chamber, my mother had died, but I am sure she is still doing her own method of notifying her friends, and meeting my father now to talk to him and to say, make sure you pay attention to this message.

It is a message that I hope Americans will attend to as well. Because while there are those who talk about the costs of health care, what we are going to be talking about tonight is ways of changing health care and not simply shifting the burden of health care to one or the other.

Let me talk about a few of the costs that we need to pay attention to. Health care costs are skyrocketing. In 2005, the Federal Government spent over 45 percent of mandatory spending on health care programs, including almost \$300 billion for Medicare and \$181 billion for Medicaid. Medicaid costs now consume about 70 percent of States' budgets, and it is rising more than the rate of inflation. This, nearly half a trillion dollars, does not even include the billions that we spend at the Federal level in discretionary health care spending for Department of Veterans Affairs, \$31 billion; the National Institutes of Health, which has increased over 100 percent in the last 10 years under President Bush, to \$28.5 billion; the Centers For Disease Control and Prevention, \$8.2 billion; the Indian Health Services, \$4 billion; Early Head Start, \$6.8 billion; and the Women, Infants and Children program, \$5.3 billion.

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When we add to this also the costs paid for by employers and paid for by families across the Nation, the numbers are staggering.

The Federal Government has made a number of attempts over the years to deal with some of these increased costs, such things as dealing with the budget, where we try and increase co-payments on prescription drugs, or we deal with premium costs in private or federally or State-funded health care programs, which have all been geared towards trying to share the costs.

This higher cost-sharing requirement, in many cases, is designed to not only reduce some of the overall costs to the Federal budget, but also to help encourage patients to change some behaviors, such as not going to expensive emergency room settings for common ailments, such as colds and flu and scrapes and bumps, but instead to see their doctor. These increased copays are usually enacted to change these behaviors, and yet we need to be doing other things in order to actually change some of the flaws in our health care system.

But let us make a point of this: whenever Congress has enacted those important issues to try and change

some behaviors and actually save money, unfortunately, the Congressional Budget Office, which is there to tell us how much we are spending and give us some accurate numbers, simply is unable to do this at all.

The Congressional Budget Office can only talk about savings when more money comes out of pocket, but they cannot and are unable to talk about savings that come from trying to prevent the problems we are talking about tonight.

Since the CBO does not provide what is called dynamic scoring, a potential cost savings, the Federal Government in essence ties its own hands so we can only focus on cost sharing and not directly change efficiency and reduce errors in health care. We do not deal with the biggest drivers of these costs. We did not have a way here to look at this.

Let me give you an example. If we were to ask the Congressional Budget Office how much it costs to immunize children in America or to inoculate them with several important inoculations that they receive in their infancy and young childhood, the CBO could give us that number. But ask them what this saves, what this saves in reduced hospital visits and the other medical complications, and they simply are not able to tell you.

Ask the Federal Government CBO what treatment programs for alcohol and drug abuse save, and they cannot tell you.

Ask them what Early Head Start's medical programs save when we get children to the doctor early. They cannot tell you.

Ask also what would happen if we made our medical records system more efficient and eliminated many of the costly errors in the system. They cannot tell you.

The CBO can tell us that, in the Deficit Reduction Act passed by the House, that \$150 million was placed in there, through efforts of my office and others, in order to help hospitals in high Medicaid areas use electronic medical records in order to reduce costs. But, unfortunately, the CBO cannot tell us what those costs are.

I am going to be talking a little bit more about these costs, but first I would like to yield to the gentleman from Georgia, Dr. PHIL GINGREY, to lay out some general outlines of some other things we are going to be talking about tonight. Dr. GINGREY, a friend and colleague, who we often are on the floor together talking on these health care aspects, will lay out in general some of the things we will be talking about.

As I said, I opened up naming some of the huge cost increases in health care, but Dr. GINGREY will lay out the general plan of where we need to go to make some substantive reforms in the health care system so that we are no longer talking about cost shifting, but really talking about saving money, and, more importantly, saving lives.

I yield to Dr. GINGREY.

Mr. GINGREY. Dr. MURPHY, thank you so much and thank you for starting this Special Hour and allowing me to get over, as we have a great line-up of members, I think five members, of the Republican Healthcare Public Affairs Team that we formed, with Dr. MURPHY and I cochairing that subcommittee of the Republican Conference at the beginning of this 109th Congress. We have been talking about a number of issues during the past year relating to health care, the Medicare Modernization Act, Prescription Drug part D, tort reform, which we passed in this House many times and are still laboring to finally get that into law.

But this gives us, really, a great opportunity to follow on to what our President said in the 2006 State of the Union address in regard to health care. Now, he did not spend a lot of time on health care, but what he said in just a couple of pages was significantly an important part of his address to the Nation.

This Presidency and this Republican majority are fully, fully committed to making sure that we bring health care into the 21st century and we continue to maintain the edge that we have in regard to health care. But we are not going to maintain that edge if we continue to use a 20th-century model. It is just like the radio and the television set and the computer. We have to do this. We absolutely have to do it.

Dr. MURPHY probably in his opening remarks talked a little bit about one of the issues that I want him to address in regard to electronic medical records, or health IT, if you will, information technology.

I was recently in Antarctica, and I was able to take my American Express card, actually, no, one of my bank cards, and swipe it and get U.S. dollars to buy some souvenirs. But God help me if I had been hit in the head in Antarctica by a snowball and couldn't speak to the doctors, because they wouldn't know a thing about my health care record. I know that Dr. MURPHY and others have taken a leadership role on this particular issue.

So I want to just go ahead at this point and begin allowing my colleagues to talk about some of these issues that are so hugely important. Dr. MURPHY has already made some remarks and will speak further about health IT. Dr. MURPHY is on the Energy and Commerce Committee, where the Health Subcommittee does so much work on Medicaid and other issues, as I previously have co-chaired the Healthcare Public Affairs Team.

Dr. MURPHY, I would be happy to yield back to you, or we can go to the long-term care issue and come back, whatever you would prefer.

Mr. MURPHY. I would like to talk a little bit, if I may, about some of these issues about errors in hospitals.

I opened up by saying we clearly have the best health care available in America, but I would like the Speaker and others to imagine this: when you go

into a hospital or doctor's office, generally you will see filing cabinets packed with paper records of a patient's care. Now, imagine also if the patient has seen multiple doctors, there are multiple files, and probably stacked somewhere on top of those filing cabinets are reports waiting to be filed, and chances are pretty good that the records between doctors' offices are disconnected, that is, one doctor may not know what the other physicians or treatment specialists have seen. Perhaps the patient has not gone for the lab tests or consultations they have been asked to do. Perhaps they have, and those records have not been returned, x-rays have not come back over, whatever that is.

But you have a situation of voluminous paper records, oftentimes scattered within a hospital in different departments or between different offices, and that results in the likelihood that important medical records could be lost or not retrieved at that moment when someone needs to be making decisions.

Having worked in both neonatal intensive care units, pediatric units, and my own private practice as a psychologist, it was often critically important to be able to access records and review them quickly. But a simple statement one was looking for in a file that was multiple volumes and oftentimes multiple inches thick, it could take hours to retrieve critically important data.

The risk of that is that some information may be missing. The risk is that important information may be missed. One study even found that one in seven medical records was missing vital information, and this could then lead to redundant tests or misdiagnoses, redundant treatments or inappropriate treatments.

Health administration paperwork costs almost \$300 billion annually, equal to about \$1,000 per person in America, or actually 31 percent of all health care expenditures in the United States; and yet we have hospitals with 21st-century technology that can use a 64-cut CT scanner that can give us three dimensional films of patients' hearts, but we are still using an 18th-century paper system to keep track of these things.

The RAND Corporation reported that these critical errors that come from redundant, unnecessary, and missed information adds \$162 billion in health care costs per year, a huge avoidable expense. Part of our move as the Republican conference here is to make sure that we encourage and fund through incentives hospitals and doctors' offices to move towards health information technology.

Medication errors alone cost Medicare about \$29 billion in costs. Whenever we talk about cost savings in programs such as Medicare and Medicaid, it is not slashing care, it is improving care; it is not denying access to care, it is bringing access to care. And that is vitally important.

Anyone who has ever had a prescription that could not be read or the pharmacist had to call back or the patient wasn't sure if it was duplicating another medication recognizes how these errors cost the system. The best, the best doctors and the best hospitals and the best specialists have their eyes blindfolded when it comes to trying to deal with these.

In the Deficit Reduction Act, as I mentioned a few minutes ago, \$150 million was put in there for hospitals to use grants in high Medicaid populations, but throughout the Nation we see many health information technology companies emerging at hospitals and insurance companies investing billions of dollars, a critically important issue.

So next time when one goes to the doctor's office and sees the papers gone, but to see, for example, in VA hospitals now the doctor putting records on a computer, calling up x-rays on a computer, looking at CT scans and MRIs, and, yes, even watching films of surgery on their computer screen, recognize that this is part of where we need to go with 21st-century medical technology.

But also know this: the physician who did the test or radiologist who did the x-ray can immediately send it over secure and confidentially to one's physician, who can then review the record.

In fact, I have been in physicians' offices, since, unfortunately, a few months ago I had an accident in Iraq and then had a CT scan in Baghdad and an MRI done in Germany, and found that what could happen here is the records could then be spent over on computer disk to physicians in Washington, D.C. and Bethesda who could then review those and easily consult, without having to call for new tests and repeat those. It wasn't just the wording that they had of what was taking place in the medical test. They could actually see it themselves.

Repeat this story millions of times a day across America, and you can see why the RAND Corporation says we could have savings of \$160 billion; and in addition to that, when you look at the savings that comes from otherwise lost days in the workplace, another \$150 billion in savings.

Let me mention one other area that we can track with electronic medical records, and that is infection rates. A bill that I am working on to actually give incentives to hospitals and medical practices to reduce infections is critically important.

Health care-acquired infections cost the United States about \$50 billion in annual medical costs. Now, these infections are such things as staphylococcus, methacycline-resistant staphylococcus aureus, urinary tract infections, pneumonia, et cetera, where what happens is through such low-tech issues as hand-washing or cleaning equipment, because we take these things for granted so much, they are not done. Sadly, this leads to somewhere up above 75,000, some estimates

even as high as 90,000, deaths per year, so says the Center For Disease Control, and these, in many cases are preventable. Now, in some cases they are not, if someone comes in with an open wound or someone is taking immunosuppressant drugs.

But what we need to do here is actually help patients get better care. We can save massive amounts if we use Medicare and Medicaid to provide incentives and pay for performance for hospitals that reduce these.

But this is where, again, using electronic medical records helps, by having this information available that hospitals can review and pull up information and saying what is happening? Are we seeing trends within the hospital? Should we take action? Information that can come up as an immediate alert to the hospital medical staff, to medical directors and hospital personnel, hospital administrators, to say infections are now detected within the hospital, we need to take affirmative, aggressive, and thorough action to isolate and deal with this. That being the case, we can save tens of thousands of lives a year and tens of billions of dollars.

Now, we point these out because it is so critically important. I hear time and time again people misleading the American public that somehow we are trying to cut Medicare and Medicaid. That is not true.

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What we are trying to do is improve the system. And any American family knows that whether it is your car or your house, that when you deal with using inefficient and cheap ineffective ways, you can end up paying much more because the tools you use may break or the system you are trying to use to fix the problem may actually be ineffective, and it is going to cost you more in the long run.

Doing poor health care, making wrong decisions in health care, is what is expensive. Making the right decisions in health care and making sure we have the highest quality is what lowers costs. And once and for all, we have to put these tools back into the hands of health care providers across the Nation, give them the information that is needed on every patient, every time, making sure those records are secure and so that physicians are competent and hospital personnel are competent.

Dr. David Brailer, the President's appointee to take many of these actions in the area of health information technology, and Secretary Leavitt, the Secretary of Health and Human Services, are leading the charge in some of these advances along with us in Congress.

This is something that we want the American people to know, Mr. Speaker; that in so doing, we will actually be saving tens of thousands of lives and tens of billions of dollars. These are efforts we will not yield on, because we recognize that the number of deaths

that occur per year from us having our eyes blindfolded and our hands and not being able to do the best in health care is actually more that occur in a single year than died in all of the Vietnam War.

We have the tools to do this, and we as a Republican Conference will continue to lead this Nation in moving forward to save lives and save money.

With that, I yield back to the gentleman from Georgia, Dr. Gingrey, to control the balance of my time.

THE STATE OF HEALTH CARE: REPUBLICAN EFFORTS FOR HEALTH CARE REFORM

The SPEAKER pro tempore (Mr. DENT). Under the Speaker's announced policy of January 4, 2005, the gentleman from Georgia (Mr. GINGREY) will control the remainder of the hour.

Mr. GINGREY. Dr. Murphy, thank you so much for bringing that expertise in regard to health IT and health care quality. In fact, I wanted to point out, Mr. Speaker, and my colleagues one of the posters in regard to this.

The Rand study that Dr. Murphy mentioned, a potential savings of \$162 billion annually by going to that system, and also at least 90,000 lives, and possibly more. I wanted to close out that portion before I call on some of my other colleagues to discuss other pertinent issues.

We do have legislation introduced from the Republican Conference to incentivize physicians, particularly small group physicians through our Tax Code, in the 179 section of the Code, to let them rapidly depreciate indeed up to \$250,000. We do this for businessmen and women currently up to \$100,000, but it is so critically important, this cost savings that I point out, that we want to make sure these physicians can afford to do this, because we need every one of them to participate in health IT.

At this point, the next issue that we wanted to talk about, and the gentleman from Florida, my colleague, and classmate, Ms. GINNY BROWN-WAITE, a member of Financial Services, Homeland Security, Veterans' Affairs, a Member of the Health Care Public Affairs Team, as most of us are; in addition to that she leads the Women's Issue Team of the Republican Caucus. She wears many hats.

But tonight the gentlewoman is going to talk about long-term care. And I hope she will include a little bit about the issue of health savings accounts and how they can be rolled into that. I think the President may have mentioned that a little bit.

At this point I gladly yield to my colleague from Florida (Ms. GINNY BROWN-WAITE).

Ms. GINNY BROWN-WAITE of Florida. Mr. Speaker, I appreciate the fact that Mr. GINGREY is holding these to help inform people of exactly what Congress is doing on the issue of health care. I am sure when every Member

here goes back into their district, people ask them about health care.

In my district, of course, the issue is always not only just health care for seniors, but also veterans. And Dr. Murphy was absolutely correct that the VA was the first entity to begin computerizing their records, which is the reason why a veteran can go from New York at a VA facility down to one in Florida, and virtually with a few key strokes, they pull up his or her record. That is a good way to make sure that we have continuity of care.

In Florida, of course, we have many, many nursing homes. People move to Florida, and as they age in Florida, the nursing home industry is a very, very vital part of our economy. When I was a State senator, I worked long and hard on nursing home issues. We did nursing home reform.

And one of the reasons that we did nursing home reform was because we wanted to increase the staffing and make sure that nursing homes provided the kind of quality care that we all want for our seniors who are in nursing homes. But, you know, one of the issues clearly is the cost not just for those living in a nursing home, but also for younger families who have got to care for older parents or loved ones, very often termed the sandwich generation.

You know, long-term care costs can be very, very stifling. And I agree about having them be able to roll into a medical savings account. It is certainly a very important component of what we are trying to do long term.

You know, you do not fix health care forever. The need for health care reform continues as technology improves, as we all age, and also as we take into consideration all of the new pharmaceutical products that are out there that prevent people from going into hospitals, and, many times, nursing homes.

You know, that sandwich generation I was just speaking about, they are the ones who are very often helping to care for their parents. You know, nursing home costs can be upwards of \$60,000 if a person does not have insurance. And home health care costs can sometimes reach \$20,000 a year.

When we look at the demographics, those who are 85 years of age or older are the most likely candidates for long-term care service. But age is not the only indicator. Actually people of any age with limited self-care or mobility issues are candidates as well.

For the average person over age 50, home health care can cost over \$5,800 a year. Even families who have long-term care insurance are facing hefty costs. Kind of base plan premiums run between \$564 a year for a 50-year-old, for example, to \$5,300 a year for someone who is 79.

When families can no longer cover these costs, Medicaid has to pick up the tab for those who do not have long-term care insurance. And when we look at the spending in Medicaid, one-third