Mr. LINCOLN DAVIS of Tennessee. In essence what that component says is that in a bipartisan way we want to be sure that the Iraqis have a surge in leadership for their own country, take over the control of their own country; that the Iraqis develop the military that they need to occupy their own country themselves. And, secondly, that they become the policemen in the field, on the roads, riding the Humvees, and not our soldiers. I thank my friend from Arkansas for each week that you bring to the American public the views, the ideas of the fiscal conservative Blue Dog Democrats, deficit hawks and defense hawks here on the House floor.

Mr. ROSS. Again, these views on Iraq are not necessarily those of the Blue Dog Coalition. We require a two-thirds vote for an endorsed position. These are our views, those of us that believe we need a new direction and how we think we can get there in a bipartisan way.

Another one of the bills being put forth by the Blue Dogs, and this one was written by Heath Shuler from North Carolina, Charlie Melancon from Louisiana, and Charlie Wilson from Ohio, and it's called a Resolution Strengthening the Budget Process. It strengthens and increases transparency of the budget process. It ensures that Members have a sufficient amount of time to properly examine legislation and determine its actual cost. No more of being forced to vote on these 300- and 400-page bills after seeing them for 15 minutes and knowing the cost of what we are voting on. PAYGO rules now require that.

It requires that a full Congressional Budget Office, CBO, cost estimate accompany any bill or conference report that comes to the House floor and ensures that lawmakers have at least 3 days to review the final text of any bill before casting their votes.

We can't make Members of Congress read the bills they are voting on; but if you give them 3 days from the final text to the day of the vote, it gives them the opportunity to read them. Right now, and many times under the Republican-led Congress in the past 6 years, there wasn't an opportunity to read the bills because they would let us see the bills 15 minutes or an hour before we were voting on them, sometimes 300- and 400-page bills.

Commonsense ideas that we are putting into legislation.

Another integral part of the Blue Dog fiscal accountability package is this, and I have done my best to go through it and explain to you what it is that we are trying to do there. It's a resolution aimed at strengthening and increasing the transparency of the budget process. All too often Members of Congress are forced to vote on legislation without knowing its true cost implications. This measure will ensure that Members have a sufficient amount of time to properly examine legislation and determine its actual cost.

And then, finally, the balanced budget amendment. And I want to thank the Blue Dog leader Kirsten Gillibrand from New York for authoring the balanced budget amendment, which would provide for a constitutional amendment requiring Congress to balance the Federal budget every year. Forty-nine States do it. Most American families do it. And it is time that the United States Congress did it. It allows for flexibility during times of war, natural disaster, or an economic downturn, and it prohibits cuts in Social Security benefits from ever being used in order to balance the budget.

Mr. Speaker, these are just three pieces of legislation that have been endorsed by the Blue Dog Coalition, authored by the members of the Blue Dog Coalition, that we believe can put us on a path toward restoring common sense, fiscal discipline, and accountability to our Nation's government.

THE STATE OF HEALTH CARE IN AMERICA

The SPEAKER pro tempore. Under the Speaker's announced policy of January 18, 2007, the gentleman from Texas (Mr. BURGESS) is recognized for 60 minutes.

Mr. BURGESS. Mr. Speaker, I am coming to the floor tonight to talk, as I often do, about health care, the state of health care in America, some of the things that we face as a country, as a Congress. And, Mr. Speaker, we have reached a point where it is kind of a unique time, and it occurs from time to time in our Nation's history in political cycles that we have the political reality of unfettered election-year politics meeting head on with the perennial challenge of redefining or reforming America's health care system.

Mr. Speaker, the history of health care in America over, say, the past 60-plus years going back to the 1940s is that of a very highly structured, highly ordered scientific process coupled with a variety of governmental policies, policies each aimed at achieving a specific objective; but rarely do we get the opportunity to reexamine the policies and what follows on from those policies and how they continue to affect things years and decades into the future.

Mr. Speaker, if we go back to that time in the middle 1940s, the time of the Second World War, some significant scientific advances occurred. In 1928, for example, Sir Alexander Fleming rediscovered penicillin. It actually had been discovered in the late 1800s, but Sir Alexander Fleming in England discovered that the growth of a bacteria called staphylococcus could be inhibited by the growth of a certain type of mold on the auger plate. Well, it took some additional research. It took some additional input from other scientists who actually came to this country and developed the process of fermentation that allowed for the large-scale production of that compound that we now know as penicillin, a compound that when it was first discovered was priceless. You couldn't get it at any cost and by 1946 had come down to about 55 cents a dose, all because of American ingenuity coming into play in the mid-1940s. In fact, soldiers injured during the invasion of Normandy on D–Day were oftentimes treated for their wartime-acquired wounds that became infected with penicillin.

Another individual, an individual we have honored on the floor of this House during the last Congress, Dr. Percy Julian, an African American scientist or, actually, an organic chemist, who didn't discover cortisone. Cortisone had been discovered earlier. But the extraction of cortisone from the adrenal glands of oxen was a laborious time-intensive process, and as a consequence, cortisone was only available as a curiosity, as an oddity. But Dr. Julian perfected a methodology for building cortisone out of precursor molecules that were present in soybeans and, as a consequence, ushered in the age of the commercial production of cortisone.

So there in the 1940s, we had the development of two processes that allowed for the commercial application of an antibiotic, an anti-infective agent, that previously was unavailable on the scale that it was made available after the Second World War, and an anti-inflammatory, cortisone, for treating things like rheumatoid arthritis, Addison's disease. Cortisone now on a commercially available basis. These changes profoundly affected the practice of American medicine starting at about the time of the Second World War.

But what about on the policy arena? Did anything significant happen during the Second World War? Well, you bet it did. What happened during the Second World War is President Roosevelt said in order to keep down trouble from inflation, he was going to enact some very strict wage and price controls on American workers. And he felt it was necessary to do that because, after all, the country was at war.

Well, employers were looking for ways to keep their workers involved and keep them on the job, and they came up with the idea, well, maybe we could offer benefits. Maybe we could offer health insurance, retirement plans. It was somewhat controversial as to whether or not these could, in fact, be offered at a time of such strict wage and price controls, controversial as to whether or not these added-on benefits would be taxed at regular earnings rates. Well, the Supreme Court ruled that they could, indeed, be offered; that they did not violate the spirit of the wage and price controls, and, in fact, they could be awarded as a pretax expense.

Fast forward another 20 years to the mid-1960s, and now the administration and the Congress are locked in the discussion and the debates that ultimately led to the passage of the amendment to the Social Security Act that we now know as the Medicare program. Suddenly we have a situation where the body of scientific evidence,

the body of scientific knowledge is expanding at an ever-increasing rate. We have got some fundamentally different ways of paying for health care, some in the private sector and now some in the public sector, all leading to what is happening currently at the present time.

Now, again, going back to the Second World War, most health care was paid for at the time of service, and that was a cash exchange between the patient and the physician or the patient and the hospital. Now, with the advent of employer-derived health insurance and with the interposition of now this large government program, most health care is now administered through some type of third-party arrangement.

Now, this is useful. It protects the individual who is covered from large cash outlays. But there is a trade-off, and this covered individual is generally unaware of the cost of the care that is rendered, as well as the provider who is quite happy to remain insensitive as to the cost of the care that is ordered. This arrangement has created an environment that permits rapid growth in all health care sector costs.

We have a hybrid system. America's challenge then becomes evident. How do we improve upon the model of the current hybrid system, which involves both public and private payment for health care and which anesthetizes most parties involved as to the true cost of this care? It's also wise to consider that any truly useful attempt to modernize the system, any attempt to modernize the system, the primary goal has to be, first off, protect the people instead of protecting the status quo.

Now, we must also ask ourselves if the goal is to protect a system of third-party payment or provide Americans with a reasonable way to obtain health care and allow physicians a reasonable way to provide care for their patients. Remember that the fundamental unit of production is the interaction that takes place between the medical professional, the physician, and the patient in the treatment room. That fundamental interaction is the widget that is produced by this large health care machine, and sometimes that concept gets absolutely lost in translation.

Now, the current situation subsidizes and makes payment to those indirectly involved in the delivery of that widget, and ultimately that drives up the cost. Now, currently in the United States, we spend, depending upon what you read, 15, 16, and 17 percent of the gross domestic product on health care, amounting to about $1.6 trillion a year. Within that total amount of spending, the government accounts for approximately half. When you add together the expenditure of the Medicare, the Medicaid system, the Federal prison system, VA system, Indian health service, all of those things together equal about 50 cents out of every health care dollar that is spent in this country.

The other half is made up by commercial insurance, self-pay, and I would include health savings accounts in that grouping of self-pay. Certainly some percentage is made up by services that are just simply donated or never reimbursed. We might call it charity care.

A lot of money is spent in health care, but only a fraction on direct patient care and oftentimes too much on an inefficient system.

□ 2030

Now, the test before us, the test before this Congress, the test before this country is to protect the people instead of providing protection to special interests. Define that which ought to be determined by market forces, market principles, and that which of necessity must being left in the realm of a government or public provider; that balance between the public and private sectors, and how in all of this process we preserve the individual self-direction instead of establishing supremacy of the State.

Additionally, we must challenge those things that result in the extortion of market forces in health care and acknowledge that some of that extortion is endemic, some of it's built into the system, some of it's hidden and not readily changed, and some of it is, in fact, easily amenable to change. And we need to know the difference, and we need to know what is worthwhile to try to effect change.

Now, the key here is how to maximize value at the production level; again, where that widget is produced, the doctor-patient interaction in the treatment room. How do we place a patient who exists on a continuum between health and disease, how do we shift that balance more in the favor of a state of continued health, which is obviously less expensive than paying for disease? Do we allow physicians a return on the investment, which opens up a host of questions relating to future physician workforce issues, and I am going to touch on those in more detail in just a minute.

How do we keep the employer, if the employer is involved, how do we get them to see value in a system, things like a quicker return of an ill employee to work, increased productivity, better maintenance of a healthy and more satisfied workforce? In regards to health insurance, how to provide a predictable and manage risk environment, remembering that insurance companies are, of necessity, they tend to seek a state of a natural monopoly; and if left unchecked, they will, indeed, seek that condition.

And finally, how do we balance the needs of hospitals, ambulatory surgery centers, long-term care facilities and the needs of the community, as well as the needs of doctors, nurses and administrators?

Now, Mr. Speaker, some legislation has already been introduced to try to effect some of these changes. I want to make reference at this point to a publication that's produced by my home State organization, the Texas Medical Association. Last March, this was the cover of their publication, Texas Medicine. It referenced that the United States may, in fact, be running out of doctors.

So I've introduced three pieces of legislation geared toward the physician workforce and how do we keep the workforce involved and engaged. Alan Greenspan, talking to a group of us right before he retired as chairman of the Federal Reserve, came in and talked to a group of us one morning and was asked the question: How in the world are we ever going to pay for Medicare going into the future? And he thought about it for a moment and he said, if I recall correctly he said, ''Well, I'm not sure. But I think when the time comes, you will do what is necessary to preserve the system.'' And I believe he is right. But he went on to say, ''What concerns me more is will there be anyone there to provide the services that you require.''

Well, Mr. Speaker, in an effort to be certain that there are the people there to provide the services that we require, I introduced legislation such as 2583. This establishes low-interest loans for hospitals seeking to establish residencies in high-need specialties, primary care, general surgery, OB/GYN, gerontology in medically underserved areas. It turns out one of the thrusts of this article is that doctors tend to have a lot of inertia, they tend to go into practice close to where they had trained. So if we can establish residency programs where none currently exist in communities of moderate to small size and allow those physicians to undergo their training in those community hospitals, they're very likely to settle in or very close to those communities, thereby driving the equation in favor of supplying physicians in high-need specialties in medically underserved areas.

Another piece of legislation, H.R. 2584, is more geared at the medical student or perhaps even the student in college, the student who's considering a career in health professions. And this expands the old health professions scholarships, provides the availability of scholarships, provides the availability of low-interest loans, provides the availability of favorable tax treatment if an individual is willing to go into practice in a medically underserved area in a high-need specialty.

And then finally, the third piece of legislation, 2585, deals with more of what I would describe as the mature physician, that physician who has been in practice. But one of the problems of our publicly financed side of health care, one of the problems in the Medicare side is that reimbursement rates for doctors are decreased year over year as an effort to control costs in the overall program, but the result is it tends to drive doctors away from practice. So this bill would have at its heart the repeal of a payment formula that is referred to as the ''sustainable

growth rate,'' or SGR formula, which I believe is critical. I believe we have to repeal that formula if indeed we're going to keep physicians involved in the process.

Mr. Speaker, another component of this bill, 2585, does allow for some voluntary compensation if a physician or group wishes to participate in a system to upgrade health information technology. And I put this slide up here, Mr. Speaker, because this is the records room at Charity Hospital in New Orleans taken in October of 2005. You can see that, although the records themselves were not disturbed by the wind of that particular storm, that records room is in the basement and it was completely under water for several days. And you can see there, this is 2 months after the storm, probably a month after the water was removed from the downtown area of New Orleans and removed from the basement, you can see the destruction evident on those paper records. And clearly, that's a situation that has to be addressed. If we are going to move America forward into the 21st century, that's a condition that has to be addressed. And I have attempted to do that in H.R. 2585, as it deals with the medical workforce; it also deals with some bonus payments to allow physicians who wish to voluntarily participate in an upgrade of health information technology, allows them the freedom to do that.

Other legislation that is out there, H.R. 3509. H.R. 3509 is a medical liability bill. And this bill was crafted after legislation that was passed in my home State of Texas in September of 2003. This was legislation that was crafted, it was styled after the Medical Injury Compensation Reform Act of 1975 passed by the State of California and then modernized for the 21st century. And what this bill does is provide a cap on noneconomic damages. It is a cap that is shared between physicians, hospitals, a second hospital or a nursing home, if one is involved. Each entity is capped at a $250,000 payment for noneconomic damages, or an aggregate cap of $750,000.

Now, the reason I bring this up, the reason I introduced this legislation that is similar to the Texas-passed legislation in the House of Representatives, is, after all, our Founding Fathers said that the States should function as laboratories for the country. So here we have the State of Texas functioning as a laboratory for meaningful liability reform in the health care sector. And the results are in and the results are clear; 4 years after this legislation was passed we have held rates down for premiums for medical liability insurance for physicians. More importantly, a State that was losing insurers at a rapid rate, we had gone from 17 insurers down to two by the end of 2002, which was my last year of active practice, and now we're back up to numbers in the twenties or thirties. And these liability insurance carriers have come back to the State without an increase in premiums. In fact, the Texas Medical Liability Trust, my old insurer of record, has lowered rates by about 22 percent at the time of my last calculation.

This is critical for getting the young individual who is in high school or college interested in a career in the health profession. The crisis in medical liability that exists in many areas of the country serves as a deterrent, a repellant that keeps young people from even thinking about a career in health care. And that is, in fact, one that we do desperately need to change.

Let me, just for a moment, go back to the Texas Medical Association hypothesis, ''are we running out of doctors,'' and the comments of Chairman Greenspan as he spoke to our group early that morning, now probably some 18 months ago. Will we run out of doctors? No. The answer is we probably won't. I guess we should ask ourselves: If we make the climate too inhospitable, if we make the climate too difficult, what will the doctors of the 21st century look like? Well, I don't know. But from time to time I allow myself some internal speculation as to what the medical workforce of the future might resemble, and sometimes I come across this young individual, kind of a health care entrepreneur from a famous American sitcom that is seen on the Fox Network. I don't know. But it's not worth running the risk of running out of physicians and not attracting the best and brightest into the practice of medicine.

Now, that brings me to what I would describe as a set of principles that for any health care legislation that I endorse, that I embrace, that I put out there myself or that I cosponsor, what are the principles that I need to see? Well, certainly, first and foremost, you have to have freedom of choice. American patients, they want to see who they want to see, they want to see them when they want to see them, and if hospitalization is required, no one objects to an incentive. But freedom of choice must remain central to any system, whether it is private or public, in this country.

Ownership. We hear a lot about the ownership society, things both good and bad. But I will tell you something, from having myself had a medical savings account starting back in 1997, when they first became available, until the time I left private practice in 2002. The whole concept of having a health savings account or, if you will, a medical individual retirement account, a medical IRA, and being allowed to accumulate savings in that account to offset future medical expenses, that's a fundamental desire of many people in this country. And many Americans in this country feel the same way, and, in fact, I'm of the opinion that that should be encouraged. The dollars accumulated in those accounts, and this is the great thing about them, even if you no longer have the account, which I no longer am insured through an HSA because when I came to Congress they weren't generally available. Now they are and I haven't switched back, but that money is still there. It still grows month by month at the regular savings rates. Right now I think it's about 4.5 percent, so a reasonable rate of return on that investment. But that money is there for me and my family to use in the future should any medical expenses arise that maybe aren't covered by other insurance.

Well, what happens if I get to the end of a long and happy life and I've never had to tap into those savings, what happens to them then? They stay in my family. They're available to my heirs and assigns for the coverage of their care going into the future, and all the while continuing to grow in value, tax deferred because that's the way the law was written back in 1997 when I first opened that account.

These dollars are dedicated to health care, they're owned by the individual, and they don't, by default, go to some governmental entity upon the death of the individual who's covered.

Now, another principle that I think is just critical to any discussion of health care is independence. There has to be preservation of autonomy. The patient or the patient's designee should ultimately be responsible for their care and the ability to accept or decline medical intervention.

High standards, one of the things that we pride ourselves on in this country, one of the underpinnings of the American medical system has always been high standards of excellence, and nothing in any future change should undermine that. And, in fact, pathways to facilitate future growth in excellence really ought to be encouraged.

Mr. Speaker, we have to preserve innovative approaches. American medicine has always been characterized as embracing innovation, developing new technologies and treatments. Clearly innovation must be preserved in any process going forward.

Another key is timeliness. Access to a waiting list does not equate to access to care; so spoke the Canadian Supreme Court to its medical system in 2005. We must diligently seek not to duplicate the most sinister type of rationing, which is a waiting list. And that can be, unfortunately, involved with any large health care system, whether it be a nationalized single payer system or, indeed, a very, very large private system.

□ 2045

We have to keep it market based and not administrative. Pricing should always be based on what is actually indicated by market conditions and not what is assumed by administrators. Remember, in general, mandates lead to a restriction of services. State mandates cause more harm than good, impede competition and choice, drive up the cost of care and can actually limit the availability of health insurance. Another type of mandate, we heard a lot

about it in 1993 when health care reform was discussed last decade, employer mandates and individual mandates are likewise restrictive. A discussion of mandates should include an accounting of cost and whether the mandates limit the availability of insurance for those who may operate a small business, for example, for those who may be self-employed or self-insured.

Mr. Speaker, it is worth remembering that Medicare part D in its first year of existence, the year 2006, achieved a 90 percent enrollment rate. They didn't do that with mandates. How did they do it? With education, incentives, competition, but certainly not mandates. Well, what about premium support? That is something you hear about from time to time. In fact, premium support was a big part of when President Bill Clinton talked about how to modernize the Medicare system. Bill Thomas who recently was chairman of the Ways and Means Committee, Bill Frist who was Senate majority leader, BOBBY JINDAL who serves as a Member of this House currently, these individuals were on a task force appointed by President Clinton to try to improve the Medicare system. One of the concepts they came up with was premium support to help someone who doesn't make quite enough money to pay a health insurance premium, help them, support them in purchasing that premium or buy down the cost of that premium. A subsidy, yes, but I prefer to think of it in terms of support.

Now, people also talk about tax credits. It is a similar rationale for helping an individual who can't quite afford the premiums on their health insurance. Mr. Speaker, I just submit that our Tax Code is currently complicated enough. We don't need to do anything that further complicates the Tax Code. That is why I move in the direction of premium support as opposed to tax credits or other incentives. One of the things we ought to do, though, when we do talk about mandates, and certainly that has been one of the stories coming out of Massachusetts, the plan that Governor Romney talked about when he came and addressed our House Policy Committee a couple of years ago when that program was first established, one of the mechanisms they had at their disposal was the ability to, because they have a State income tax, the ability to help someone understand the validity of buying insurance. I don't know. Maybe we ought to look at that when we provide money to individuals through the earned income tax credit. Perhaps a portion of that money ought to be earmarked for at least a catastrophic policy or a high deductible policy, those that can be had generally at lower expense. Maybe it is time to think outside the box in that regard and provide those individuals an earmark, if you will, of that tax credit so that they, in fact, do purchase health insurance if they are going to be covered under the earned income tax credit.

Then finally, and this is a terribly difficult concept and a lot of people just tune me out when I talk about it, but we have to balance the way we handle our anti-trust laws. We have to balance anti-trust enforcement, and we have to prohibit overly aggressive anti-trust treatment under the law. Exemption or enhanced enforcement is only likely to further distort the market. It means the desired results are never obtained because we are always providing this market distorting influence by either protecting one side or one group and potentially punishing another side. Creating winners and losers via our anti-trust law erodes the viability of our American health care system. Again, I think we would do well to pay some attention to that and prevent that from being part of our lexicon in the future.

Now, as far as the specific policies for health care within the public sector model, the transformation after the experience with Medicare part D has, in fact, been instructive. Six protected classes of medication were required of all companies who wish to compete within the system. That allowed for greater acceptance by the covered population and certainly greater medical flexibility as far as the physicians were concerned when treating patients. At the same time, the competitive influences brought to bear in that part of the program, in fact, managed to bring down cost.

In fact, the projection of $130 billion over the 10-year budget window less than was originally outlined was a success story. That is solely the result of competition. I feel certain that, in the future, we are going to get benefits for more efficient treatment, timely treatment of disease. I think there are additional successes out there to be had, but certainly competition within the first year or two of the existence of part D program certainly showed where competition can pay off.

Now, one of the most important points of lessons learned in the Medicare part D program is that coverage can be significant without the use of mandates. Ninety percent of seniors now have some type of prescription drug coverage. That was achieved by creating plans that people actually wanted. It was achieved by providing the means and incentives to sign up in a timely fashion. This emphasized that personal involvement and responsibility was there, was important to maintain, and it was important to maintain credible coverage. There was, in fact, a premium to pay if someone signed up after the initial enrollment cycle.

Mr. Speaker, employer-derived insurance will continue to be a significant player in the American health care scene. It adds value. It adds value to the contract between the employer and the employee. It rewards loyal employees and builds commitments within the organization. Businesses can spread risk and help drive down cost. A feature of the proposed association health plans have been, in fact, proposed in this House in every Congress that I have been a Member of since the beginning of 2003. In fact, the first time I heard about the concept of association health plans, Mr. Speaker, was when it was actually delivered from the rostrum here in this House of Representatives. The concept was delivered by President William Jefferson Clinton in September of 1993. It is a concept that I believe we ought to explore. We ought to be able to discuss it rationally without impugning each other's character, because after all, it was brought to this Chamber by a Democratic President. It has been endorsed and supported by Republican Congresses in the past.

Again, the concept of association health plans is one that I think going forward could provide a great deal of utility as far as preventing the inexorable increase in health insurance premiums that are faced by small businesses and individual employees. These are people who don't get the benefits of spreading out the risk through a large insurance market.

Now, Mr. Speaker, regardless of whether the system is public or private, vast changes in information technology are going to occur. They are going to need to be facilitated. We are coming up to a time of rapid learning. Because of improvements in health care technology, the ability to manage databases and retrieving data in a timely fashion are going to be critical for the delivery of health care and for the protection of patients.

Mr. Speaker, let me share this picture with the House of Representatives. This is Master Sergeant Blades. I met the master sergeant at building 18 at Walter Reed Hospital last January. Of course, everyone remembers The Washington Post story about building 18 and how there was great concern that some of our soldiers were not being properly cared for, individuals who were on medical hold at Walter Reed and awaiting a ruling on their request for going back in with their unit or their request to have a disability claim evaluated.

Those individuals on medical hold became the subject of a good deal of discussion in the press here in Washington, D.C. Well, like many Members of Congress, I decided to go see for myself. I went out to Walter Reed. I went through building 18. The paper was right: it was crummy. But Master Sergeant Blades drew to my attention something that he said was, in fact, more significant and more important and, in fact, more of a frustration for him and his men who were there on medical hold. And that is the fact that there was no interoperability between medical records contained within the Department of Defense and that of the Veterans Administration.

You see here the master sergeant is preparing his medical record. It may not show up that well, but here is a medical record that he is going

through with a yellow highlighter. He is making his case for, again, either going back and joining his unit or making his case for perhaps a future disability claim. What he told me that day is that he can go through a medical record that may be the size of several stacked phonebooks on top of each other, go through and painstakingly pull out the bits of data that he thinks will be important to his case. This paper record will then go to someone's desk. It might sit there for a week, two or three, before it is opened. And then at some point it gets lost, and he has to start all over again, or his men have to start all over again.

So his admonition to his men who are under his command there at the medical hold unit at Walter Reed was to prepare several copies of your medical record. Don't leave your future, whatever it might hold, don't leave your future in the hands of a single medical record and at the discretion of someone who might be cleaning off a desk one night, think they are doing everyone a great favor by moving some charts or papers off to the side or some other location, where, in fact, they become lost and not retrievable. Again, I bring this up to just point to some of the problems that are out there.

We are in the 21st century. Rapid learning and rapid turnaround of data is something that is just expected. We go into an ATM in a foreign country. We swipe our card. We punch the number in. If it takes more than 12 seconds for the money to come out at the other end, we wonder what the problem is. We need to be moving to that same type of system within our medical information system because it is truly to the point where it is untenable. We saw that as, again, Master Sergeant Blade so eloquently pointed out to me that day at the Walter Reed Hospital. But we see it over and over again replicated in tests that have to be duplicated. Someone goes into a hospital emergency room late at night. They have had a CT scan earlier in the week in the physician's office, but it is not available to the emergency room doctor who then orders another test and, oh, by the way, there is another $1,000 spent by some insurance company, government or perhaps even the hospital itself if that patient is uninsured.

Another thing that I think really is something that we are going to have to really concentrate on in the future is introduced legislation, H.R. 1046, to modernize some of the quality reporting systems that are present in this country. I think quality reporting is going to be part and parcel of medical care going forward. I think it should be voluntary at this point. I think while we are in the mode of gathering data, a physician or group who wishes to voluntarily associate themselves with some type of quality reporting scheme, I think that should be rewarded at this point. I don't know that we have developed enough of the systems to require that. Now, State Quality Improvement Organizations, QIOs, were actually developed back in the '80s and early '90s across the country. They were developed to primarily deal with quality issues within the Medicare program itself.

But there is no need to reinvent the wheel here. These organizations are already out there. They exist. They do a credible job. If they need to be modernized for the 21st century, then so be it. But H.R. 1046 is an effort to bring those Quality Improvement Organizations into the 21st century and allow concepts like a medical home and allow concepts like the accumulation and utilization of data so it can be for the benefit of all of the physicians who attend the patient and of course the patient themselves.

Now, this approach was a component of the Medicare physician payment update proposal by then-chairman JOE BARTON on my Energy and Commerce Committee when he offered it right at the end of 2006. I thought it was a good proposal then. I think it is one that certainly bears further exploration.

Mr. Speaker, within the individual market, and that is going to include for the purpose of my discussion both individuals who are paying their freight themselves out of pocket and those individuals who own a health savings account, introduced legislation, H.R. 1666, to provide for increased price transparency within the medical pricing system.

□ 2100

Information is going to evolve rapidly. It's going to evolve rapidly for individuals who are paying cash for their procedures, as was certainly the majority of cases back before the 1940s. But, again, we may see a growing, increasing segment of the population who hold medical savings accounts and will be the primary dispensers of their health care dollars, so those dollars will be spent much the same as a self-pay individual would handle their medical affairs. But it's going to require that the adequacy of reports and the detail of information that is available to patients on things like cost, price and quality, and, yes, there is a difference between what a procedure costs and what its price is, and quality information is going to be increasingly important for health care consumers to make best decisions about the health care of their families and how they wisely spend their health care dollars. This information needs to also be linked to data detailing perhaps complications and other issues, like perhaps infection rates, so that families and individuals are able to make the best decisions.

Now there are some Web-based programs that are out there right now. Again, in my home State of Texas on the Internet there's something called texaspricepoint.org, except it is abbreviated to txpricepoint.org. The individual who lives in the State of Texas can go to that Web site and, after the obligatory legal disclaimers that you have got to scroll through to ensure that you understand the data that you're about to call up, you can get some significant data on the difference in cost and price between hospitals in a given county, different hospitals that perhaps are offering the same procedures, something as simple as a fractured leg without complications. You can click on the appropriate button, scroll through the appropriate number of screens and get a cost comparison between all of the hospitals that exist within a given county and what the difference in cost is at each of those facilities.

Now someone who is truly on a third-party payment such as Medicare, Medicaid, SCHIP, they are not going to be perhaps so interested in that, but they might be from just a quality perspective. If one hospital is a lot more expensive than the others, that may be a quality issue that is driving that increased expense.

So I can see that that information would be useful to individuals who aren't in fact even the target population who's paying out-of-pocket for their own care. But certainly the individual in a family who's paying out-of-pocket, they're financing their health care out of cash flow, or the owner of a medical savings account, that individual is likely to be very interested in what that information on cost, price and quality is as it becomes available. I think we are going to see increasing utility of programs such as these going forward.

As we have talked about crafting a readily affordable basic package of insurance benefits, it's something that this Congress really ought to set itself seriously to do. Now we have had discussions in the 109th Congress. Sometimes those discussions got kind of rough. Let's remember, we, Congress at one time has agreed upon what exactly is a basic package of benefits that ought to be available to an individual who subscribes to a program, and that program is the program under the Federally Qualified Health Center statute. The statute is probably about 35 years old and it details at a significant level of detail what benefits ought to be available to the individual who goes in for their care at what is known as an FQHC, or Federally Qualified Health Center.

What if we were to get together and decide that same basic package of benefits ought to be available to an individual, but they wouldn't necessarily have to go into the Federally Qualified Health Center? Maybe it's embedded in a card that they take into a clinic or provider's office within their community who agrees to participate in the program. Clearly, there is some out-of-the-box thinking that can go on here in trying to provide a meaningful, affordable product for individuals who are currently lacking health insurance.

One of the things, again, that drives the cost up is all of the mandates that

we put on insurance companies. But maybe if we agreed on what should be the basic package of benefits, Republican and Democrat alike, sit down and agree on what should be that basic package of benefits and allow individuals to access that type of care within their own communities.

One of the problems with Federally Qualified Health Centers, and I am a believer in the concept, in fact, I am trying mightily to get a second such facility in my part of Tarrant County. I'd like to see one in Denton County, another county that I represent that doesn't have such a facility available. What has happened is we have picked winners and losers across my State, across the country. Some areas are replete with Federally Qualified Health Centers; other areas are seriously lacking in that type of care.

Maybe we need to take that thinking to the next level. Maybe we ought to, instead of building the bricks and mortar of a Federally Qualified Health Center, simply provide the patient with, ''Here's the card, here's the list of individuals that participate in the program in your community, and they will accept the card at any one of these facilities that you see.''

That would also have the advantage of perhaps separating out, once again, some of that special interest stuff that tends to keep things as they are, to keep things from moving forward, to keep any meaningful progress from coming into any of the arenas and delivery of health care to low-income individuals, but particularly in this particular arena.

The other thing is I will tell you, as a practitioner of medicine, you look at some of the rules under which these facilities have to be set up, and it becomes very, very difficult to construct a business model that will actually be able to stay afloat, given some of the restrictions and regulations that are placed on these facilities. Again, if we would allow perhaps a little bit more of that hybrid-type system that you could have coexistence between a private facility and a government-paid program, providing each side was willing to behave by some mutually agreeable guidelines.

Well, providing truly affordable basic coverage to individuals in this country I think is a concept that insurance companies, I think is something they would want. I can't believe that an insurance company doesn't look at a figure like 47 million people who are uninsured and not say, ''that is a lot of market share I could have,'' if we would only allow them the ability to construct a policy that is affordable to the individuals who fall into that group.

Another concept, Mr. Speaker, and this is one that I have held for a long time, a lot of clinics, a lot of doctors, a lot of medical practices, a lot of hospitals simply donate their time and their efforts. Their actions are truly charitable. Well, maybe we could organize and provide a tax credit for those services that are truly charitable and donated. We could provide perhaps additional protection under the Federal Tort Claims Act, maybe a safe harbor from lawsuits, wherein good faith, charitable care is provided, and allow other providers to participate and fill the vacuum for indigent care.

Another area where this might be extremely useful is in times of national emergency, national crisis. Maybe if we had some type of emergency credentialing facility, and I know the CDC is looking into that, but if there were a way for a practitioner to precredential if there were a national emergency in their area, or they traveled to an area where the next Katrina hits so that they could be immediately credentialed within that area and begin to help provide that care. Again, also allow them some relief from liability under the Federal Tort Claims Act.

This could help fill the vacuum that exists sometimes in care. We don't want people to stay away from where actual help is needed in time of a national emergency. We don't want doctors and nurses to stay away from those areas for fear that, number one, they will be sent away because they are not credentialed, or, number two, out of fear that they might bring on some condition of liability that they would then have to defend for months, years, decades after.

The admonition of Ronald Reagan, ''trust but verify.'' Trust the market to make the correct decisions, but to the extent that some distortions are there, acknowledge that they are there. Sometimes there are going to have to be some protections that can only be provided by the Federal level. Some guidance for market principles will always be required, whether the system is public, private, or is a hybrid system.

Finally, as part of this discussion, there needs to be a rational breakdown. We always talk about the number of uninsured. As near as I can tell, this is a formulaic number that simply goes up by the addition of 2 million people every year.

I don't know that any of us really knows what is the makeup of this number. It is pretty hard to craft public policy to deal with the number of 45, 46 or 47 million uninsured when you don't know what makes up that population. Are some of these young individuals who are simply between college and their first job and haven't yet found it a wise investment or necessary to get insurance? Are part of these individuals who have serious long-term medical conditions who find medical coverage unavailable to them at any level, at any place?

Obviously, those are two very different populations. You can't craft a policy to help one that is not terribly distorted by the time it is applied to the other. We need to know what the makeup of that number is. So agencies like the Census Bureau need to do a better job for us as far as detailing and delineating what exists within the parameters of that large number that simply gets added to every year, and a lot of times you wonder if it is not just added to for political reasons. But, nevertheless, we need accurate data on who is encompassed within that population.

Finally, I will just leave this segment with a point of contrast. There are some people in this House who think it is a good idea to expand the culture of dependence, dependence on the State. There are other individuals in this Chamber who want to expand the number of individuals who can actually participate, direct and own their own health care.

Mr. Speaker, I don't have to tell you what side of that question I come down on.

Finally, Mr. Speaker, I want to talk just a little bit about, again, I said I was going to talk about health care in America. I have talked a lot about health care. Let's talk a little bit about America. Let's talk about American exceptionalism.

Mr. Speaker, the American health care system has no shortage of critics, here in this House, across the country, and certainly in foreign countries. But, Mr. Speaker, I would emphasize, it is the American system that stands at the forefront of innovation and new technology, precisely the types of systemwide changes that are going to be necessary to efficiently and effectively provide care for Americans for today and into the future.

Now, Mr. Speaker, I don't normally read the New York Times, so please don't tell anyone in my district that I did. But last year, in fact just about a year ago, October 5, 2006, Tyler Cowen wrote, ''When it comes to medical innovation, the United States is the world's leader. In the past 10 years, for instance, 12 Nobel Prizes in medicine have gone to American-born scientists working in the United States, three have gone to foreign-born scientists working within the United States, and seven have gone to researchers outside of this country.''

Remember, Mr. Speaker, when I first started this discussion I talked about the contributions of Sir Alexander Fleming, albeit an Englishman, but it was a lab in Peoria, Illinois, that developed the ability to mass-produce penicillin, and it was that ability that allowed the clinical trials to go forward. It was that ability that allowed penicillin to become part of our modern lexicon.

Percy Julian, again, an African American biochemist honored in this House during the last Congress. Remember, it was Percy Julian, he didn't invent cortisol, he wasn't the first to identify the compound, but he was the first to delineate a formula by which this compound could be mass-produced and available to much, much greater numbers of patients than would have ever been possible with the old animal

extraction method that had preceded it. All developed within and because of the United States.

Tyler Cowen goes on to point out that five of the six most important medical innovations of the past 25 years have been developed within and because of the American system.

Mr. Speaker, comparisons with other countries may, from time to time, be useful. It is important to remember that the American system is always reinventing itself and seeking improvement. But it is precisely because of the tension inherent in a hybrid system that creates this impetus for change. It drives the change.

A system that is fully funded by a payroll tax or some other policy has no reason to seek improvement, and, as a consequence, faces stagnation. Indeed, in such a system, if there becomes a need to control costs, that frequently is going to come at the expense of who? The provider. Precisely the person you need to stay involved in the system.

Mr. Speaker, I have got one final slide, and I ask your indulgence to let me put this up here.

This just shows the Medicare comparative payment updates for physicians, Medicare HMOs, hospitals and nursing homes. The years are delineated there in separate colors.

The year 2007, when the slide was developed, was in fact an estimate for physicians. The reality is this number actually came back to zero because of some changes we made right at the end of last year.

□ 2115

Under physicians, you don't see a number for 2006 again because that number in fact was zero for 2006. You stop and think about that, this reduction was planned but never happened, but physicians were held to a zero percent update for the past 2 years.

Mr. Speaker, what do you suppose the cost of delivering that care in a doctor's office, what do you suppose has happened to that over the last 2 years? Well, their electricity prices probably went down because they went down all over the country. Cost for gasoline to go to the office every morning probably went down because the cost of gasoline went down everywhere across the country. I don't think so.

The Medicare system is designated to reimburse at about 65 percent of cost under ideal conditions, but the reality is there has been significant erosion of that. This is important because hospitals, nursing homes, and to some degree the Medicare HMOs, their prices are adjusted every year based on essentially what is called the Medicare economic index. That is a cost-of-living formula. Only this group, the physicians, is under a separate formula that is somehow tied to changes in the gross domestic product.

The sustainable growth rate formula penalizes physicians and has the perverse incentive of driving doctors out of the practice of medicine. As was detailed to us by Alan Greenspan many months ago, there is only so long that can go on before ultimately you reach a place where it is going to be very, very difficult for the people who need the care to get the care.

Mr. Speaker, the United States is not Europe. American patients are accustomed to wide choices when it comes to hospitals, physicians and pharmaceuticals. It is precisely because our experience is unique and different from other countries, and this difference should be acknowledged and embraced, particularly when reform is contemplated in either the public or private health insurance programs in this country.

Mr. Speaker, one final point illustrated in a recent news story covered by a Canadian television broadcaster. It was about a Canadian member of Parliament who sought treatment for cancer in the United States. The story itself is not particularly unique, but the online comments that followed the story, I thought, were instructive. To be sure, a number of respondents felt it was unfair to draw any conclusion because, after all, this was an individual who was ill and seeking treatment and therefore deserving of our compassion, and I wouldn't argue that.

But one writer summed it up: ''She joins a lengthy list of Canadians who go to the United States to get treated. Unfortunately, the mythology that the state-run medicine is superior to that of the private sector takes precedent over the health of individual Canadians.''

The comments of another individual: ''The story here isn't about who gets treatment in the United States. It is about a liberal politician that is part of a political party that espouses the Canadian public system and vowed to ensure that no private health care was ever going to usurp the current system. She is a member of Parliament for the party that has relentlessly attacked the conservatives for their 'hidden agenda' to privatize health care. The irony and hypocrisy is that position supports the notion that the rich get health care and the rest of us wait in line, all because of liberal fearmongering that does not allow for any real debate on the state of health care within the country of Canada.''

One final note from the online postings: ''It has been sort of alluded to, but I hope everyone reading this story realizes we do have a two-tiered health care system. We have public care in Canada and for those with lots of cash, we have private care in the United States which is quicker and better.''

Mr. Speaker, this is a discussion that will likely consume the better part of the next two years of public dialogue, certainly through the next Presidential election. The United States is at a crossroads. It is incumbent upon every one of us who believes that the involvement of both the public and the private sector is best for the delivery of health care in the United States of America. And it is incumbent upon us to stay educated and involved and committed.

Mr. Speaker, we have all got to be at the top of our game every single day. This is one of those rare instances where it is necessary to be prepared to win the debate, even though those of us on my side may lose when it is taken to a vote here in the House of Representatives. But if we adhere to principles, we may ultimately post a win for the health of the American people, and not just the American people today, but for generations to come.

FOCUSING ON MOVING FORWARD

The SPEAKER pro tempore (Mr. MURPHY of Connecticut). Under the Speaker's announced policy of January 18, 2007, the gentleman from New York (Mr. ISRAEL) is recognized for 60 minutes.

Mr. ISRAEL. Mr. Speaker, tonight we do something different, something out of the ordinary. The American people are accustomed to tuning into C–SPAN and watching Democrats yelling at Republicans and Republicans yelling at Democrats. There is a Democratic Special Order and there is a Republican Special Order. C–SPAN has become a channel that requires a parental advisory before kids are able to watch. It has become unsafe because of all the screaming and yelling.

Tonight we do something different. Tonight we have a bipartisan Special Order. Tonight Democrats and Republicans will spend some time not focusing on our disagreements, not fighting with one another, not talking about the left and the right, although this is a place where there should be discussion about left and right, but focusing on moving forward, focusing on specific solutions and ideas with respect to Iraq that will move us forward.

The plain fact is that Democrats and Republicans are are going to disagree on some fundamental issues. Maybe we are going to disagree on 60 or 70 percent of the issues, but we do agree on the 30 to 40 percent that is left. The problem is that we have allowed ourselves to be paralyzed on our agreements because we are so busy disagreeing with one another.

Well, 2 years ago we found the Center Aisle Caucus, a bipartisan group of 50 Democrats and Republicans who meet routinely not to talk about our disagreements, we know where we are going to disagree, but to see if we can carve out areas of agreement. To talk not about the left or the right, but to talk about the way forward.

We have convened a series of meetings specifically pertaining to Iraq. Tonight I am joined by the gentleman from Maryland (Mr. GILCHREST), a Marine veteran who has been involved in those meetings and talked about bipartisanship and finding common ground and important solutions.

I am joined by the gentleman from Texas (Mr. LAMPSON) who has become very active, a leader in the Center