Americans' feelings of powerlessness in the face of economic, social and political forces radically altering or terminating their traditional, typically agrarian lives. Writing years later in his book A Humane Economy, the economist Wilhelm Ropke examined the impacts upon human beings by these forces, which he collectively termed ''mass society'':

''The disintegration of the social structure generates a profound upheaval in the outward conditions of each individual's life, thought and work. Independence is smothered; men are uprooted and taken out of the close-woven social texture in which they were secure; true communities are broken up in favor of more universal but impersonal collectivities in which the individual is no longer a person in his own right; the inward, spontaneous social fabric is loosened in favor of mechanical, soulless organization, with its outward compulsion; all individuality is reduced to one plane of uniform normality; the area of individual action, decision and responsibility shrinks in favor of collective planning and decision; the whole of life becomes uniform and standard mass life, ever more subject to party politics, nationalization and socialization.''

In that industrial epoch, the root public policy question was how to protect Americans' traditional rights to order, justice and freedom from being usurped by corporate or governmental centralization.

□ 2145

The advent of virtual corporations and transient international capital has ended the old industrial welfare state model of governance, wherein solutions to Americans' economic and social anxieties were the shared burdens of centralized corporations and government. The stark choice is now between increasing the centralized power of the Federal Government or decentralization of power into the hands of individuals, families and communities.

In their urgency to replace their lost or slashed corporate benefits, Americans will be sorely tempted to further centralize the Federal Government to do it. But expanding the authority and compulsory powers of the Federal Government will be injurious to the American people. Big Government doesn't stop chaos; Big Government is chaos.

By usurping the rightful powers of individuals between its bureaucracy's steel wheels, highly centralized government alienates individuals and atomizes communities. Once more, Ropke speaks to the heart of the matter:

''The temptation of centrism has been great at all time, as regards both theory and political action. It is the temptation of mechanical perfection and of uniformity at the expense of freedom. Perhaps Montesquieu was right when he said that it is the small minds, above all, which succumb to this temptation. Once the mania of uniformity and centralization spreads and once the centrists begin to lay down the law of the land, then we are in the presence of one of the most serious dangerous signals warning us of the impending loss of freedom, humanity, and the health of society.''

Only liberty unleashes Americans to establish the true roots of a holistic American, the voluntary and virtuous individual, familial, and communal associations which invigorate and instruct a free people conquering challenges. In contrast, centralized and, thus, inherently unaccountable government suffocates liberty, order and justice by smothering and severing citizens' voluntary bonds within mediating, nongovernmental institutions, and so doing, stifles our free people's individual and collective solutions to challenges. In consequence, the temptation for more centralized government must be fought to prevent turning sovereign Americans from the masters of their destiny into the serfs of governmental dependency.

Fully versed in this verity, restoration Republicans have made their decision: power to the people. Thus, in this age of globalization, restoration Republicans vow to empower the sovereign American people to protect and promote their God-given and constitutionally recognized and protected rights; promote the decentralization of Federal Governmental powers to the American people or to their most appropriate and closest unit of government; defend Americans' enduring moral order of faith, family, and community and country from all enemies; foster a dynamic market economy of entrepreneurial opportunity for all Americans; and honor and nurture a humanity of scale in Americans' relations and endeavors.

Further, while these restoration Republicans will be releasing a more detailed program in the future, the above will form the basis of any concrete proposals brought forth.

Madam Speaker, my constituents are honest, hard-working and intelligent people who are bearing the brunt of the generational challenges facing our Nation. They have lost manufacturing and every manner of jobs due to globalization and, especially, the predatory trade practices of Communist China. Throughout these economically anxious times, they spend sleepless nights wondering if they will be able to afford to keep their jobs, their houses, their health care, their hopes for their children.

In the war for freedom, they have buried, mourned and honored their loved ones lost in battle against our Nation and all of civilization's barbaric enemies. And every day, they struggle to make sense of an increasingly perverse culture that's disdainful of and destructive to faith, truths, virtue and beauty, if the existence of these permanent things is even admitted.

True, my constituents differ on specific solutions to their pressing problems, but they do agree Washington isn't serving their concerns. They agree this storied representative institution is increasingly detached from the daily realities of their lives. And they remind me that when we enter this House, their House, we enter as guests who must honor the leap of faith they took in letting us in and allowing us to serve them.

With my constituents, I utterly agree. While it is not my purpose here to discuss the majority party, let me be clear as to my own. House Republicans have no business practicing business as usual. My constituents, our country and this Congress deserve better, and we will provide it.

Our Republican minority has Members who know America isn't an economy; America is a country. Our Republican minority has Members who know the only thing worth measuring in money is greed. Our Republican minority has Members with the heart to put individuals ahead of abstractions, people ahead of politics, and souls ahead of systems. Our Republican minority has Members who have seen sorrow seep down a widow's cheek and joy shine from a child's eye.

Yes, Madam Speaker, my Republican minority has Members who know our deeds on behalf of our sovereign constituents must accord with Wordsworth's poetic prayer: ''And then a wish: my best and favored aspiration mounts with yearning for some higher song of philosophic truth which cherishes our daily lives.''

It is these Republicans whose service in this Congress will redeem our party by honoring the sacred trust of the majestic American people who, in their virtuous genius, will transcend these transformational times and strengthen our exceptional Nation's revolutionary experiment in human freedom.

With these Republicans, I hereby throw in my lot and pledge my best efforts on behalf of my constituents and our country.

May God continue to grace, guard, guide and bless our community of destiny, the United States of America.

HEALTH CARE

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. Madam Speaker, I come to the floor tonight to talk, as I often do, a little bit about health care, the state of health care in this country, where we are, where we've been, where we're going.

Tonight, I do want to focus on one particular issue that is before this Congress. It's a critical issue facing our doctors in this country who provide care for Medicare patients, because if this Congress does not act before midnight on December 31, those physicians are facing a rather significant reimbursement reduction, and that would have an adverse affect on their ability

to see patients, to care for patients and, indeed, would have an adverse effect upon access.

So I do want to spend some time talking about that, why that is the case and what we in this Congress can do about it and what we need to do about it. And again, that action has to take place prior to December 31 of this year. It's not something we can punt into next year and then come back and try to collect our thoughts and make another run at it. We have to fix it with the time we have remaining in this first half of this Congress.

Another issue that I want to address is the issue of the physicians workforce. Of course, the Medicare reimbursement rates directly affect the physician workforce, but we can't forget physicians who are at the very beginning of their training, physicians in residency, and we certainly can't forget those individuals who might even be contemplating a career in health care and how can we help them make the correct decisions.

I do want to talk a little bit and focus a little bit on medical liability reform because that does play an integral role in the overall quality and makeup of the physician workforce.

I'd like to talk a little bit about the history of medicine, some of the things that have happened in the last 100 years and some of the things I see just happening and just over the horizon as we begin the dawn of the 21st century.

And finally, I do think we need to talk a little bit about the status of the uninsured and, again, some of the other current events that surround health care in this Congress.

Madam Speaker, we pay doctors in our Medicare system under a formula known as the sustainable growth rate formula, and this has been the case for the past several years, and it has led to problems, certainly every year that I have been in this Congress, and I took office in January of 2003, and the problems actually predate that for some time.

The difficulty with that formula is it ties physician reimbursement rates to a number based upon the gross domestic product which, in fact, has no bearing on the cost of delivery and the volume and intensity of medical services delivered.

And Medicare, of course, many people know Medicare is supposed to be an integrated program but, in fact, in many ways it is high load. You have part A that's paid for with a payroll deduction just much the same as Social Security. Part A, of course, covers hospitalization expenses.

Part B covers physician expenses. That is paid for out of member premiums that citizens purchase every year, and it is paid for out of, 25 percent by law by the premium dollar and 75 percent comes out of general revenue.

Part C, the recently enacted Medicare prescription drug benefit, had money budgeted for that purpose. Remember that was all the fight of November of 2003 when we enacted that law, but money was actually on the budget and dedicated for that purpose. And those moneys exist and, indeed, are appropriated automatically year over year. I beg your pardon, part C is the Medicare HMO. Part D is Medicare prescription drug. Part C is funded again, likewise, out of the general Treasury.

Part A, part C and part D each have essentially a cost-of-living adjustment that's made every year. So that the cost of delivering the care doesn't exactly keep up, but it more or less keeps up with the costs and with medical inflation, but not so part B, which pays the physician. And the part B part of Medicare is governed under this sustainable growth rate formula.

And really, Madam Speaker, I know I'm not supposed to talk to Members directly, only supposed to address the Chair, and I will confine my remarks to the Chair, but just talking to the Chair, if I were able to talk to people directly, I know I run some risk of people turning off their televisions, but I do want to take you through what is known as the sustainable growth rate formula because I think it's instructive. Even though not every person can understand every nuance of the formula, I think it's instructive to actually look how the formula is constructed and how we come up with the dollar figure every year.

Madam Speaker, I know people who are particularly astute will notice there is a typographical error on this graphic. I would point out that the typographical error was actually made by the Congressional Research Service and not by my crack staff. Again, the very gifted will be able to pick that up right away, but we'll get to that in just a moment.

Here's the calculation of the payment formula under the physician's fee schedule. Here we see payment equals and here's a whole bunch of letters that follow along, and the explanations are given underneath the formula. The relative value unit for work versus, rather multiplied by a geographic index; a relative value unit for practice expenses, again multiplied by another fudge factor for geographical location and geographical practice expenses; a relative value unit for the cost of medical liability insurance, again also adjusted for geographic location; all multiplied then by what's called the conversion factor, CF, at the end. And this CV down here actually should say CF, and that would stand for ''conversion factor.''

Well, that's all very interesting, and obviously the conversion factor plays a big role in this, so let's just dig a little bit deeper into how that conversion factor or that adjustment factor is calculated. And here we see a sample calculation for the formula for the year 2007, and again, we won't get into all of the nuances of this formula, but you see the update adjustment factor, UAF, the prior year adjustment component plus a cumulative adjustment component, and the formula for 2007 is calculated as follows, where the target 2006 minus the actual spending in 2006 divided by actual spending in 2006 multiplied again by conversion factor.

I want to draw your attention, Madam Speaker, though, to the fact that every year the prior adjustment component, and then added into that is the cumulative adjustment component, that's significant, because every year for the past 5 years that I have been here the United States Congress has come in at the last minute, at the last minute with some way to prevent these physician cuts from going into effect.

But as the Congressional Budget Office calculates this number year over year, this cumulative adjustment component grows over time such that we are told in order to repeal the cost of repeal of the sustainable growth rate formula, when I first came to Congress in 2003 was around $118 billion over 10 years.

□ 2200

A pretty significant amount of money, no question about it. But that number has increased with every year that we have postponed the cut, that we have come in at the last minute, the last of December and prevented the cuts from happening. Those moneys actually don't just go away. The moneys that were to be saved in that cut don't just disappear. The Congressional Budget Office adds them onto the total expense of the repeal of the sustainable growth rate formula such that the price tag for repeal of the sustainable growth rate formula last year, the last session of Congress, when I introduced a bill to repeal the sustainable growth rate formula, was $218 billion. It increased almost $100 billion over 3 or 4 years' time, and this year is calculated to be $268 billion. If we do manage to get something done before the end of the year, those moneys again the Congressional Budget Office will add on with that cumulative adjustment component.

One last graphic on this issue is the calculation of the update of the conversion factor, where, again, we see the current year is equal to the prior year plus the conversion factor update. And the conversion factor update is calculated as being 1 plus the Medicare economic index increase divided by 100, multiplied by 1 plus the updated adjustment factor.

You can see this is pretty complicated stuff, and for that reason many Members, when you try to talk to them about changes in the sustainable growth rate formula, will just simply tune you out because we all have a little place where we put in our minds things that are too hard to deal with. And the SGR formula is one of those things that most Members will put into the too hard box. It's something that I have got to come back to later because I really don't understand it. And it is

an understandable human reaction to a situation that's terribly complex.

But, Mr. Speaker, let me just illustrate for you what will happen if Congress does not do its duty and does not do something to prevent the physician cuts, the Medicare payment cuts, that are already on line to occur January 1 unless Congress acts legislatively prior to that time. The Center for Medicare and Medicaid Services on November 1 of this year, after running through the formula, they said, okay, this year based on what we budgeted for and what the actual spending was, we are going to have to downwardly adjust physician payment rates by 10.1 percent. That's 10.1 percent, a pretty significant amount of money. If we don't do something, that's what is going to hit January 1.

You say, well, okay, Medicare payments aren't that great anyway and a lot of physicians' offices don't rely just strictly on the Medicare reimbursement they get to keep their doors open; so it won't really affect my doctor's practice. But one of the things that we forget in this House of Representatives, one of the things that we just conveniently again stash away in that part of our brains where we put things that are too hard, almost every commercial insurance company in the United States pegs their reimbursement rates to Medicare. So what happens when Congress or the Center for Medicare and Medicaid Services mandates a 10 percent physician fee cut in Medicare and we don't do anything to correct it before the end of the year? That has an extremely deleterious effect on almost every practicing physician's office in this country. There are very few who will be absolutely isolated from that. I realize some in academic medicine may not actually feel it. Some doctors who practice in federally qualified health centers may not see that or may not feel it. But the bulk of the practicing physicians, the men and women who are out there every day seeing us when we get sick, seeing our kids when they get sick, those are the ones who are going to feel the brunt of this inactivity by this Congress.

I bring this up tonight not because we were inherently any better at doing it when the Republicans were in charge, but it's so important to get this work done and to get it done in the limited time that we have left this year.

I introduced just this week a resolution in the House of Representatives, House Resolution 863 for those who are keeping score at home, and House Resolution 863 is a pretty simple bit of legislative language. I will be honest. It doesn't do a whole lot. It doesn't really save any money. It doesn't spend any money. It's more or less like sending a get well card to the doctors who participate in our Medicare system and take care of our seniors. But the sentiment, just like when you send a get well card, the sentiment is important. And for Members who feel they could sign onto this bill, I think it would send a powerful message to House leadership over the next several days if we could, in fact, put a number of names with this House Resolution because I think that would get the attention of leadership. Even though leadership is of the other party than myself, I think they would have to pay attention if the bulk of the Members of House of Representatives sign onto this resolution.

And the resolution, as most go, is multiple whereases followed by a ''resolved.'' And the resolved says that it is the sense of the United States House of Representatives to immediately address this issue, the physician pay cuts under SGR, and halt any scheduled cuts to Medicare physician payments and immediately begin working on a long-term solution, and implement it by 2010, that pays physicians a fair and stable way and ensures Medicare patients have access to the doctor of their choice.

Fairly simple language. What does it mean? It means stop the cuts, repeal the SGR. We know we can't repeal the SGR straight up right now, that it will take a time line in order to do that, and that is why I suggest 2010. I would be open to other suggestions. But that seems like a good time line for us to follow. It gives us a little over 2 years to get that done.

When we face a problem as complicated as the formula that I put up in front of you tonight, some of those things are just too difficult to tackle head-on all at once. So you need a near-term, a mid-term, and a long-term strategy to deal with these very complicated problems, and I have outlined it here tonight. The near-term, the short-term strategy, stop the cut. Find some money. There's plenty of money. In a $3 trillion budget, you tell me we can't find someplace to save some money in a $3 trillion budget to pay the doctors what they are fairly owed for taking care of the patients we have asked them to take care of.

So the near-term solution is stop the cuts. The mid-term solution is we sit down and work together with the common goal of the long-term solution, which is the repeal of the sustainable growth rate formula, and begin to pay physicians on the same sort of schedule that we pay our hospitals, that we pay our HMOs, that we pay our drug companies. Put them on a cost-of-living-type adjustment. It's called the Medicare economic index. It's not something that is unique to me. I didn't make it up. I didn't make up the term of how it is calculated. But this is a known number put out by the Medicare Payment Advisory Committee, and year over year it suggests a modest update in physician reimbursement to keep up with the cost of delivering care.

Let's be honest. From a Federal Government standpoint, Medicare reimbursement rates were never meant to match private insurance rates. Someone explained to me one time if you practice medicine and do a lot of Medicare, you're going to go broke. You'll just go broke a little more slowly because we bleed you to death more slowly. Not a pleasant analogy, but Medicare never has been designed to completely cover the cost of delivering the care. The problem is we have now ratcheted that number down so far that physicians across the country are honestly looking at the situation and saying I don't think that this is something that I can legitimately continue to do. I've got to find other ways to make a living.

It's House Resolution 863, and I do urge Members to look that up on-line. It's up on Thomas. Have a look at it and see if it is not something that you can't support because, again, I think it would send a powerful message to House leadership. If over the next several days prior to the time that we are slated to adjourn for this year, I think it would send a powerful message that Members of the House want this fixed. And I know they do because every time I talk to a Member of the House, whether it be on my side of the aisle or the Democratic side of the aisle, if you just ask a simple, straightforward question: Do you ever hear from your doctors? Do your doctors ever talk to you about what is happening to them in Medicare reimbursement? And the answer is almost immediately, Oh, yes, I hear it all the time. Do you have something that will fix that? And the answer is, Yes, sort of. I've got something that will focus our attention, I hope, on getting this problem resolved.

It's a shame we didn't take this up earlier in the year. I introduced several pieces of legislation to try to do that both in the last Congress and in this Congress. It's a shame we didn't take it up this year. It seems like many times this year we'd rather fight about almost anything we can think of to fight about and not solve the problems that the American people sent us here to solve. Well, here's one we can work on, and cosponsoring House Resolution 863 would go a long way toward moving us in that direction.

Let me just put up another slide, and this one is a little bit dated. This slide is a year old, and I should update it for the current year except that I don't know what is going to happen in the current year. But this is illustrative. This is demonstrative of what happens to physician reimbursement rates under the sustainable growth rate formula for physicians. And this is a comparative payment analysis of the various updates that have gone on since 2002, the year before I came to Congress. And this particular graph goes up through an estimated fiscal year 2007. And, again, actually it needs to be updated for this year.

But as you can see, Medicare Advantage plans, they're doing pretty good. Hospitals, it's up and down a little bit, but generally their market basket update that they receive every year is hitting about 3.6 to 3.8 percent, and all

in all the hospitals are doing generally well under that scenario. Nursing homes, a little less generous. And, again, it does bounce up and down a little bit. But as you can see, year over year a positive update, certainly a positive update that's in excess of 2 percent. And many times for nursing homes it approaches 3 percent.

But look over here at the doctors in 2002, and this was the last year I was practicing medicine. And sure enough, we got a 5.4 percent pay cut just right across the board for any Medicare procedure that we performed.

Now, for the next several years, 2003, 2004, and 2005, we did manage to find the money to provide a little bit of a positive update. Notice even in these years when physician practices were flush with cash from Medicare payments, they really never even approached what nursing homes were receiving in updates and certainly were nowhere near what hospitals and Medicare Advantage plans received. Medicare Advantage plans, I would point out, did not exist prior to 2004. That's why they start with that darker line there.

Then in 2006 there is nothing recorded on the physicians. We euphemistically termed that a zero percent update. Anything else that we do in the Federal Government, if we say we are going to hold you at level funding for this fiscal year, people would be coming out of the woodwork crying that's a cut, that's a cut because you're not keeping up with the cost of living. It didn't seem to bother us a bit to do that to America's physicians. But at least a zero percent update is a whole lot better than that what was originally proposed in 2007, which was, again, about a 5 percent negative update. We actually were able to stave this one off and keep that again at a zero percent update for 2007. And now for this next year, 2008, whatever color we decide to put on the bar for that will dip down to almost the bottom of the chart because a 10.1 percent negative update is going to have a significant deleterious effect, a significant pernicious effect on our practicing physicians. Again, our physicians that we have asked to take on the burden of seeing our Medicare patients.

Now, I do spend a lot of time on the floor of this House talking about physicians workforce issues. This is the cover of the March 2007 periodical that is put out by my State medical society, the Texas Medical Association, appropriately titled ''Texas Medicine.'' And the cover story last March was ''Running Out of Doctors.'' And this was a fairly significant graphic for me when I saw that at the time.

□ 2215

About a year before this publication came out, Alan Greenspan, in one of his last trips around the Capitol right as he was retiring as Chairman of the Federal Reserve Board, Chairman Greenspan came and talked with a group of us one morning. And the inevitable question came up, how are we ever going to find the funding for the unfunded obligations that Congress has taken on? How are we going to pay for Medicare when the baby boomers retire? And the Chairman thought about it for a moment and he said, you know, ''when the time comes, I trust that Congress will make the correct decisions, and that the Medicare program will continue.'' He stopped for a moment, thought some more, and then added to that, ''What concerns me more is, will there be anyone there to deliver the services when you want them?'' And that is one of the critical issues facing us today.

And of course it's this inequity in supply and demand, supply and distribution of the physician workforce that's driving a lot of the problems that we find in health care today. And no question it has some effect of elevating prices, and just the fact that it takes so long to get in to see some types of physicians. There was a very compelling article here in the Washington area a few months ago about the travails and toils a reporter had with trying to get their child in to see a pediatric neurologist. You hear these sorts of stories. I travel, not a lot, but some around the country to visit with medical groups in the country, and you will hear all those stories from all over the country. It's not unique to one geographic location.

Three bills that were introduced earlier this year to deal with physician workforce issues, H.R. 2583, H.R. 2584 and H.R. 2585. Now, H.R. 2585 deals with what I like to term ''the mature physician.'' So, it deals a lot with the sustainable growth rate formula and the inequities of the sustainable growth rate formula as it pertains to how the Federal Government compensates its medical workforce.

The thrust behind 2585 was to, again, take that short-term, mid-term and long-term approach to the problem such that we would fix the problem, we would stop the cuts in 2008 and 2009 and 2010. We would gear towards absolute repeal of the SGR formula. Again, remember I said that it's going to cost money when that time comes. And that has always been the difficulty when trying to talk to Members about, I want you to help me repeal the SGR. The next question always is, Well, how much does it cost? You tell them, and, oh, my gosh, it's a bridge too far. We've got other priorities and we just can't get there. Well, let me tell you a little secret. That money that we have to come up with to repeal the sustainable growth rate formula, guess what? We've already spent that money. We've already sent that money to physicians' offices across this country and they've already spent it.

So, it is merely a bookkeeping adjustment that the Congressional Budget Office has to make to reconcile its books to compensate for, remember, that cumulative index that I showed you, one of those earlier poster boards. That is the difficulty. It's essentially a bookkeeping entry that has not yet been made. The money has been spent, it's gone. It's not sitting somewhere in the Federal Treasury drawing interest. It is a bookkeeping entry that has yet to be made.

We have to take this on. We have to do this. It's the moral thing to do; it's the right thing to do. We want our Medicare patients taken care of. They are arguably some of the most complex clinical situations that a doctor encounters on a daily basis, and we ought to do the right thing.

Now, how do you do that and be able to encourage Members to look at this seriously when the published price tag is so large? When I initially tried to do this in the last Congress, a bill I introduced called 5866, when, remember the cost of repeal was $216 billion, I thought at that time perhaps the correct way to go about this was just to work on the repeal straight up, maybe look for the pay-fors later as we got toward the conclusion of the process. And I was hopeful that hospitals, nursing homes, other medical entities that draw on Medicare funding would perhaps come forward with their own suggestions of where savings could be made because I don't think there is a single person in this Congress who doesn't feel that there are some inefficient ways that the Federal Government spends money in the Medicare system, and perhaps if we collected those together, we could find the monies to help cushion the offset expense of repealing the sustainable growth rate formula. But I was wrong, no one was willing to come forward. And as a consequence, I never really got the traction or the momentum that I needed on 5866. And again, the 109th Congress ran out before we could get anything done.

So, early in this Congress I thought, I need to get something out there quickly. I need to get people to understand this problem. We certainly don't need to leave it until the last minute this year, but unfortunately that's what has transpired. So, the idea behind 2585, introduced earlier this year, was to get that concept out there earlier, get Members talking about it.

How was I going to approach it? Well, 2008 and 2009, remember, we don't repeal the SGR. So, many doctors looked at that and said, Well, if you don't repeal the SGR formula in 2008 and 2009, I'm going to take significant hits those years, and I can't afford to do that. But actually, there is another bookkeeping entry you can do; it's called readjusting or resetting the baseline on the SGR formula. And by doing that, you actually then can score a modest positive update for 2008 and 2009 for physicians who participate in this program. In fact, interestingly enough, in 2008, it's almost equal to the Medicare Economic Index update. In 2009, it's a little bit less than that, but still a positive update, a fairly generous positive update of just under 1 percent for 2009.

During those 2 years' time, the run-up to the repeal of the sustainable growth rate formula, we recognize that we are saving money, we are doing things better in medicine today than we did yesterday. And how do I know this? What is a metric that I can use? Well, the Medicare Trustees Report that came out in June of this year pointed out that the bad news is Medicare is still going broke, but the good news is it's going to go broke a year later than what we told you the year before. So in other words, somewhere along the line there had been some savings in the Medicare system. And where did that savings occur? Well, one of the places it occurred, as identified in the Trustees Report, was 600,000 hospital beds weren't filled in the year 2005 that were expected to be filled. Why weren't they filled? They weren't filled because, again, the doctors were doing things on a more timely basis, more accurate diagnoses, the whole ability to timely treat disease with the prescription drug benefit now available for seniors in the Medicare program. All of these things had a bearing, and as a consequence, more patients were treated as outpatients, treated in the doctor's office, perhaps treated in an ambulatory surgery center, perhaps treated in a day surgery center, but these patients were kept out of the hospitals, and so those hospitalizations were avoided.

Remember when I talked about the funding silos for Medicare. Although we will talk about Medicare as an integrated program, part A, which pays for the hospital expense, is funded out of a payroll deduction just like the FICA tax, just like Social Security. Part B is funded out of member premiums and general revenue. By law, only 75 percent of it can be funded out of general revenue; 25 percent of that number has to come from member premiums.

So, if we're saving money on the hospital side, we're saving money for part A. But why are we saving the money? We're saving the money because we're working better, smarter, faster in part B. So it would only make sense to have CMS identify those savings that right now are going on the books as savings for part A, identify those savings, aggregate those savings, collect those savings, and use them to offset the cost of repealing the sustainable growth rate formula in part B.

You know, remember, Madam Speaker, the lock box from the year 2000, in the Presidential race everyone was talking about a lock box and they were going to put Social Security in a lock box, and with all the discussion of whose lock box was bigger than whose? But we've still got the lock box. We can put these savings that we're creating in part A, put them in a lock box, 2 years later open it up, and we offset some of the cost of paying down the so-called debt in repealing the SGR formula.

There were some other things that I identified in the bill as other ways to perhaps enhance savings. Certainly we asked CMS to try to identify the 10 diagnoses where most of the money was spent, and let's really focus our efforts on those 10 diagnoses and see if we can't create greater and greater efficiencies in treating those 10 conditions that lead to the greatest expenditures in the Medicare system. And let's look honestly at what we can do on the preventive side. Remember what our mothers always taught us, an ounce of prevention is worth a pound of cure. If we want that pound of cure, let's go ahead and spend a little bit for that ounce of prevention on the front end so we don't have to spend so much for that pound of cure on the out end. And then let's take that pound of cure that we've saved and use it to offset the cost of repealing the sustainable growth rate formula.

Well, another way we could save some money is, any of the monies that are recovered by the Department of Justice, the Inspector General for Health and Human Services, and the so-called Medicare audits, money that is fraudulently taken from Medicare and then recovered, again, that's money that's stolen from part B. Let's not just put that money into the coffers of somewhere else. Let's let that accrue as part of the savings that we put in that lock box that we use to offset the cost of repealing the sustainable growth rate formula.

Two other things that I did in the bill, which I think are important as far as gaining some overall efficiency in the system, was added some voluntary positive updates for physicians who were willing to voluntarily participate in quality reporting exercises, and physicians' offices who were willing to voluntarily participate in improvements of health information technology.

We don't have, and certainly in Congress, certainly the Federal Government does not have all the answers as to what creates the perfect health information technology platform. In many ways, private industry is light years ahead of where the Federal Government is. And maybe, you know, Madam Speaker, some days, honestly, I just wonder if we should get out of the way with some of our regulatory burdens, some or our stark laws and let private industry develop these platforms, because clearly, in the last 5 years that I've been here, we've had a lot of talk, we've had a lot of bills introduced, we've had a lot of debate, we've even passed some bills in the House during the last Congress, but we are no closer to having any sort of a national standard for health information today than we were when I first got here 5 years ago. I believe the individual's name was William Brailer who was in charge of that project. He is now, unfortunately, no longer with Health and Human Services.

The project has, for all intents and purposes in my mind, been a disappointment, but it doesn't mean that health information technology has just been stagnant. Other stakeholders, other participants in the health care system in the United States have created and drafted and are working on their individual platforms. And at some point they will reach critical mass in the private sector where there will be general acknowledgement that, yes, this is the health information technology platform of the future and the one to which we all should subscribe. It would have been a useful function of the Federal Government had we been able to do that, but honestly, I don't see us there yet, and I don't see us there in the foreseeable future. You would think the Federal Government would have had a significant role to play in that because if you look at health care expenditures in this country, almost 50 cents out of every health care dollar that's spent in this country has its origin right here on the floor of the House of Representatives.

When you consider what we spend in Medicare, what we spend in Medicaid, what we spend in the VA system, what we spend in Indian health service, the Federal prison system, a lot of health care dollars are generated through the authorization, the appropriation process in this Congress. And as a consequence, Congress has a big stake in trying to get some efficiencies and some improvements. But in this instance, in developing the health information technology platform of the future, I almost think that we need to get out of the way and let the entrepreneurs, let the bright folks who can do these tasks, let them proceed with that.

Let me just talk about a couple of things that will illustrate that.

□ 2230

I will just tell you, Mr. Speaker, I did practice medicine for 25 years. In fact, I started medical school 30 years ago this year in 1974. I can't tell you that I was a big acolyte of electronic medical records when I was a practicing physician. I dabbled in it some. I would listen to people talk who came to sell us various packages.

We had to buy a new computer right before the Y2K scare where all of our computers were going to lock up at midnight and we wouldn't be able to get anything done the next day. So like everyone else, I went out and bought a new computer system. I asked what it would cost to add an electronic medical records package on to the basic computer system that I purchased for my five-physician office. The basic computer system itself cost about $60,000 or $70,000. Some other contracts we had to sign for maintenance and upkeep were not cheap. Adding a medical records package to that was 30 to $40,000 for a five-physician practice. Quite honestly, at the time, it seemed way too expensive for a small group such as mine to participate in. So I really wasn't sold on the concept of electronic medical records. Then in the end of August 2005, we saw probably the

worst hurricane to hit the United States that certainly has happened in recorded history, Hurricane Katrina that hit New Orleans, and then the subsequent flooding after the levees broke. Touring New Orleans 5 months later with the Energy and Commerce Subcommittee on Oversight and Investigations, we were permitted to go into the basement of Charity Hospital into their records room. This was the basement of Charity Hospital. You can see the temporary lighting that they have got strung along the ceiling. There is actually still, it doesn't show in this photograph, there is still water on the floor 5 months into this process. And you can see the paper medical records. There was shelf after shelf after shelf.

Remember that Charity Hospital was one of the venerable old institutions in this country. It was one of the hospitals that has trained many of the premier physicians in this country. Charity Hospital had been there for a long time. They had multiple racks and stacks of medical records. But look at these things. This isn't smoke damage. This isn't fire damage. This is black mold that is growing on the paper, on the manila folders and on the paper in the medical records. Clearly, these are medical records that in all likelihood now are lost to the ages. I don't know. The water was up to the top shelf when the building was underwater. A lot of the ink and writing may well have washed off. But you honestly could not ask someone to go in here and pull a record and provide you some of the medical information that might been contained therein, because clearly it would simply be too hazardous to ask anyone to go in there and retrieve it.

Well, when I visited the basement of Charity Hospital that day, I became a convert for recognizing that medicine does need to come into the 21st century. It is going to be expensive. There is going to be a learning curve for, again, mature physicians like myself to have to learn this new technology and to have to learn how to use a keyboard. But it would be an investment that we would have to make.

I think we have to pay for it. I don't think we can simply say to a doctor's practice, you are going to have to just do this. It is part of the cost of doing business. And although you can't attribute any direct revenue increase to the fact you are making this $100,000 expenditure for a five-physician practice, you are just going to have to spend the money. Well, we are probably going to have to help that. Number one, we are not paying doctors enough, anyway, and number two, if we ask them to go out and do this, there will be a lot of resistance, and a lot of practices just simply won't do it. They will drop out of Medicare and whatever insurance company requires electronic medical records.

If we pay for it, if we allow an increase in reimbursement for physicians who voluntarily undertake this kind of training and upgrade, I think that's a very reasonable return on investment. So included in the bill that I introduced to initially repeal the sustainable growth rate formula was a 3 percent positive update for physicians who voluntarily undertake to modernize their recordkeeping and to embark upon the 21st century sojourn of creating electronic medical records.

But I think that is the way we have to do it. It has to be voluntary. You can't force people to do these things. You can't force them to learn these techniques. You can't force them to devote the time necessary to learn these techniques. It does have to be done on a voluntary basis. That is the correct way to learn things, not through mandates, but through creating programs that people actually want and getting their participation voluntarily, not because the Federal Government has said thou shalt.

Now, it stands to reason that after a certain period of time, part of that funding for that infrastructure will be completed. And this positive update does go away after a period of time, but it does provide a bridge for physicians who are using paper records today. It provides them a bridge, an opportunity to go into a electronic medical record system.

The reason I spend so much time on this is we had introduced in the Senate last week a bill that would require electronic prescriptions. Well, it's a good idea. The theory is a sound one, electronic prescriptions. The Institute of Medicine says that doctors' handwriting is terrible. I am here to tell you mine is. The ability, though, to whip off a written prescription takes about 10 seconds. The time involved for filling out an electronic prescription, even on a little handheld is going to be somewhat longer than that, particularly at the beginning of the learning curve.

Well, the average physician practice as I had back in 2002, you would have to see between 30 and 40 patients a day in order to pay the overhead and have something to take home at the end of the day. You add a minute or 2 on to every patient's encounter, and that is going to be adding about an hour a day on to that physician's practice time, an hour that they are simply going to be filling out an electronic form for E-prescribing. Clearly, again, they have to be compensated for that time.

The bill that was introduced I think recognized that and said there would be a 1 percent update for doctors, a 1 percent bonus for doctors who indeed undertook that. Well, just doing a little bit of the math, a moderately complicated Medicare patient return visit probably didn't pay as much as $50 a visit, but let's say for the sake of argument that is what it paid. Well, a 1 percent bonus for that patient's encounter if you use an electronic prescription will be, what, 50 cents. So you can see about four of those patients in an hour's time, so that is an additional $2 an hour that we are paying for that. It doesn't seem like a lot. I say that, too, because you look at all of the various stakeholders and interest groups, the insurance companies, the pharmacy benefit managers, the community pharmacists who want this done see value in it, and they see the potential for deriving great value, particularly the vendors who are selling the electronic prescribing modules. There is going to be significant financial return for them.

So why are we low-balling it at the doctor's end with simply a 1 percent bonus? And then the other part of that concept that I found disturbing was, it was kind of billed as a carrot and stick approach, the carrot was the 1 percent bonus, the stick was when 5 years, 4 years or 5 years, I forget which, Doctor, if you're not doing this, we're going to penalize you 10 percent. So wait a minute. I go from if I do this, I am going to make an extra 50 cents on that patient encounter or $2 an hour additional if I do this. If I don't do it in a few years, I am going to be down $20 an hour for not participating. The inequity of that just strikes me as being, again, ''disturbing'' is probably the kindest word that I can use in this context. I honestly think while, again, I will agree with the theory, the application is flawed, and we have to think of a better way to do that. That is why when I was crafting 2585 it was a voluntary participation. It stayed voluntary.

I think if you show physicians that you are able to deliver something of value, eventually, we are a very competitive lot. That is why we become doctors. And we will want to have the practice that has the newest and latest and greatest, and if other physicians' offices, hey, they are doing this e-prescribing and it is great, by the time I get to the pharmacy after my doctor's visit, the order has already been e-mailed to the pharmacist, it's been filled, it is sitting there waiting for me, and the insurance stuff is already filled out, patients are going to see value in that, and they will begin to ask that of their doctors. But to do this in a terribly punitive way, I think we are going to drive more doctors out of taking care of our Medicare patients, and that really should not be our goal.

The two other bills I introduced dealing with the physicians workforce dealt with physicians who might be contemplating a career in health professions and dealt with physicians who were in their residencies. We recognize that we are facing a shortage of primary care doctors, a shortage of general surgeons, OB–GYNs, gerontologists. And these bills were geared toward getting more of those doctors to consider medical school, getting more of those newly minted doctors into residency programs near their homes. Because doctors do possess a lot of inertia, and if you train those doctors in the places where they are needed, they are likely to stay within a 50-mile, 100-mile radius of where they

have undergone that training. That is one of the thrusts of the article from the Texas Medicine piece, that doctors do tend to locate close to where they are trained, so if we can expand the number of primary care residencies in medically underserved areas with high-need residencies, we will find that we actually attract more physicians to those areas. That is a vastly preferable way of dealing with some of the manpower shortages than just simply telling people where they have to go.

Under the issue of medical liability reform, let me just share briefly some of the experiences we have had in the State of Texas because it has been a good story. The State of Texas in 2003 passed some reforms that were based off of the 1975 law that was passed in the State of California called the Medical Injury Compensation Reform Act of 1975, you see the acronym for Medical Injury Compensation Reform Act, and this has been an astounding success in the State of Texas. Medical liability insurers were leaving the State in droves. We were down to two liability insurers my last active year of practice 2002, and let me tell you, you don't get much price competition when you have only got two liability insurers in your State. By invoking this bill and passing a constitutional amendment that allowed the bill to stand placing a cap on noneconomic damages, $250,000 for the doctor, $250,000 for the hospital, $250,000 for a second hospital or nursing home, if one is involved, by trifurcating that cap for noneconomic damages, we really feel that we have a system in place that does adequately compensate patients who are injured, and at the same time provide some stability in the medical liability insurance market that they needed to be able to look to Texas as a place where they wanted to do business. And they have. They have come back to the State. We have got many more insurers now than we, in fact, had before the exodus started in the early 2000s.

Most importantly, they have come back into the State without an increase in premiums. Texas Medical Liability Trust, my old insurer of record, the premium reductions and the dividends paid back to their shareholders aggregate to about a 22 percent reduction in medical liability insurance. And mind you, my last year of practice, I recall medical liability premiums going up by significant amounts year over year over year, and now we have seen an aggregate 22 percent reduction since passage of this bill in 2003.

A lot of times when I talk about medicine, I talk about the fact that I am optimistic. I think medicine is on the cusp of a significant transformation. When you look at the last century, and there was kind of some instructive periods, the period of 1910 when, boy, we are really coming out of the dark ages of medicine. Prior to that time, the accepted methods of practice, blistering, burning and bleeding were what were practiced by physicians, and everyone thought you were a good doctor if you did those things. We were leaving those days behind. We were coming into the time of anesthesia, we were coming into the time of modern blood banking, vaccinations had become available, new ways of looking at public health and public sanitation. And at the same time, all those advances happening in the science of medicine, we had some social change that was occurring as well, and part of it occurred up here at the United States Congress with the commissioning of a group called the Flexner Commission. Ultimately they produced what was called the Flexner Report that directly addressed the discrepancies in medical training and in medical schools across the country. It was the standardization of medical school curricula as a result of the Flexner Report, and albeit that function was then taken over by States, but it was that standardization of medical curricula that allowed for medicine to capitalize on all those good things that were happening around that time.

Well, jump ahead to the middle of the 1940s, we are in the middle of the Second World War, penicillin had been discovered a few decades before, but it wasn't really commercially available because no one had really perfected the process.

During the war, an American company working in this country was able to produce penicillin on a scale never before imagined. It was cheaply commercially produced for the first time in 1943 or 1944 and, in fact, was available to treat our soldiers who were injured at the landing of Normandy, and many lives and limbs that otherwise would have been lost as a consequence of infection following those wartime injuries were, in fact, saved because of the introduction of penicillin. It went from being a laboratory curiosity to something that was readily available, inexpensive and available to almost any doctor practicing.

At the same time, cortisone, again introduced many years ago before but a commercial process developed by Percy Julian, a Ph.D. biochemist, an African-American that we honored in this House during the last Congress because of his contributions to medicine. He developed a way to mass-produce cortisone using a soybean as a precursor.

So suddenly you had an antibiotic and you had a potent anti-inflammatory. These two powerful medical tools placed into the hands of our practitioners in this country, and, again, at the same time you had a significant social change because of the Second World War and wage and price controls that President Roosevelt put into place to prevent inflation, those wage and price controls were putting a damper on employers being able to keep their employees satisfied and happy. So they said, look, can we offer benefits like retirement plans and health insurance. The Supreme Court weighed in and said yes, you can, and not only that, you can provide those as a pretax expense.

□ 2245

Well, suddenly you go just almost overnight to the era of employer-derived health insurance. And it was extremely popular, extremely popular. It persisted after the war was over and wage and price controls were removed. But, again, it was a time when the science of medicine was changing rapidly and the social structure around medicine was changing rapidly.

The same can be said for the middle 1960s. For the first time we had antipsychotic medications available. Prior to that, we had only restraints to treat people who were badly mentally ill. We also had the introduction of antidepressants.

We had the introduction of newer hypertensive drugs. Remember, just a generation before we lost our President, Franklin Roosevelt, to the ravages of unchecked hypertension. In the 1960s we could treat that.

At the same time, we had the introduction of Medicare and then subsequently Medicaid. Suddenly the Federal Government had a large and profound footprint and a profound influence over the practice of medicine.

Mr. Speaker, I think we are on the cusp of just such a transformational time right now. I think the changes occurring in information technology, the speed with which we learn things, is now unlike any time in this country's past.

Think of this: People are going to be able to go and with a relatively inexpensive test have their human genomes sequenced. They will be able to know, as more and more is found out about the human genome, what diseases may pose a risk for them in the future, what things they are not at risk for, powerful information that is going to be in the hands of our patients.

They are going to come to the office with this information in hand. It won't be a test that we order them to take or that we request them to take, but think of the difference in the practice of medicine. In the 1980s, I would tell someone a diagnosis. They would ask me what I was going to do about it. In the 1990s, I would give a diagnosis. They would go home, look it up on the Internet and come back and tell me what I was supposed to be doing about it. Now patients are going to come in with genetic information in hand say, this is what I am at risk for. What are you going to do to prevent it, doctor?

It will be an entirely different way, an entirely new paradigm, an entirely different way of approaching the practice of medicine, a transformational time. Yet, at the same time, if Congress does not, does not invoke the right policies, Congress is inherently a transactional body. We heard the House Policy Chairman talking about that in the last hour. Congress is inherently transactional. We redistribute income. We take things from one group

and give it to another. The transactional can become the enemy of the transformational.

Our former Speaker, Newt Gingrich, is famous for saying ''real change requires real change.'' I believe that to be true. I think that is his second principle of transformation. And, more to the point, this is a time of real change, and medicine is really changing under our feet. Whether we like it or not, whether we think we can control it or not, it doesn't matter. Medicine is changing. That real change requires us to change how we think about and how we approach these problems. The old ways, the SGR formulas of the 20th century, aren't going to work in the 21st century. They cannot be allowed to impede the incredible transformation that stretches before us.

Mr. Speaker, before I wrap up, I do want to mention one additional bill that I introduced recently, and Members may want to consider adding themselves as cosponsors. It is H.R. 4190.

This is an interesting bill, because we talk in this House about what are we going to do about the uninsured. And we all sit back and think big thoughts about what we are going to do about the uninsured. Well, H.R. 4190 actually moves that process along in kind of a different way.

H.R. 4190 would take health insurance benefits away from Members of Congress. Yes, it would provide a voucher to Members of Congress to buy health insurance, but we would no longer be participants in the Federal Employee Health Benefits Plan. We would become uninsured, and it would force us to look at the market, what is available for someone who doesn't have insurance.

It might cause us to be a little more clever about some of the things we do in our Tax Code, and perhaps we wouldn't be so punitive toward people who want to individually own their insurance policy as opposed to someone who wants to get it from their employer. So it would be an entirely different way for Members of Congress to approach this problem. Quite honestly, I don't expect a long line of cosponsors when I get back to my office later tonight, but I would like for Members to think about this.

It is terribly difficult for us to come up with solutions when we are sitting back in a situation where we are insulated, we are anesthetized, where we are never going to have to face those types of decisions and those types of problems that our constituents face on a daily basis.

We also need to be more careful about how we talk about people who are uninsured. We toss around numbers and basically use them as political bludgeons or political wedges. We need to be more specific when we talk about the specific demographic groups that are contained within that large number of people who are labeled ''the uninsured.''

A significant number, 10 percent in some estimates, are people who are university students or just graduated from the university. These are people who are generally healthy and relatively inexpensive to insure. We ought to find a way to make that happen. We ought to find a way to at least allow the possibility and ability for that demographic group to purchase insurance. Twenty percent of the number actually earn enough money to buy health insurance. They just don't see the reason or necessity in doing so.

A lot of that is cost driven. It is price driven. We have done things to insurance policies to make them so expensive. We are unequal in our tax treatment for individuals who want to individually own their policies.

We need to look at those things, because, again, if we made the product affordable, if we made it desirable, again, if we put products out there that people would actually want, then they are more likely to participate. I think that is vastly, vastly superior to simply saying there is going to be an individual mandate or a State mandate or an employer mandate where people will be required to line up and file into these programs.

Let's approach it differently. Let's create the programs so that people want them, rather than creating the condition that forces people into programs that maybe they want and maybe they don't want, but we will never know because we never ask.

But we can be more insightful. In fact, we can be more valuable to the American people if we will think about things in terms of who is involved in the demographics of that large group of the number of uninsured, and how can we best approach that in a way that we are producing or providing the environment for them to be able to have that insurance coverage that they desire.

Well, there is a lot left unsaid at this point. I do appreciate the indulgence of the Chair.

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. CLEAVER) to revise and extend their remarks and include extraneous material:)

Mr. CLYBURN, for 5 minutes, today.

Mr. ALLEN, for 5 minutes, today.

Mr. CLEAVER, for 5 minutes, today.

Mr. LARSON of Connecticut, for 5 minutes, today.

Ms. WOOLSEY, for 5 minutes, today.

Mr. DEFAZIO, for 5 minutes, today.

Mr. SPRATT, for 5 minutes, today.

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

Mr. POE, for 5 minutes, December 19.

Mr. JONES of North Carolina, for 5 minutes, December 19.

Mr. LAHOOD, for 5 minutes, today.

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

Mr. ENGEL, for 5 minutes, today.

SENATE BILL REFERRED

A bill of the Senate of the following title was taken from the Speaker's table and, under the rule, referred as follows:

S. 793. An act to provide for the expansion and improvement of traumatic brain injury programs; to the Committee on Energy and Commerce.

ENROLLED BILLS SIGNED

Ms. Lorraine C. Miller, Clerk of the House, reported and found truly enrolled bills of the House of the following titles, which were thereupon signed by the Speaker:

H.R. 365. An act to provide for a research program for remediation of closed methamphetamine production laboratories, and for other purposes.

H.R. 4252. An act to provide for an additional temporary extension of programs under the Small Business Act and the Small Business Investment Act of 1958 through May 23, 2008, and for other purposes.

BILLS PRESENTED TO THE PRESIDENT

Lorraine C. Miller, Clerk of the House reports that on December 11, 2007 she presented to the President of the United States, for his approval, the following bills.

H.R. 710. To amend the National Organ Transplant Act to provide that criminal penalties do not apply to paired donations of human kidneys, and for other purposes.

H.R. 3315. To provide that the great hall of the Capitol Visitor Center shall be known as Emancipation Hall.

H.R. 3688. To implement the United States-Peru Trade Promotion Agreement.

H.R. 4118. To exclude from gross income payments from the Hokie Spirit Memorial Fund to the victims of the tragic event at Virginia Polytechnic Institute & State University.

ADJOURNMENT

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

The motion was agreed to; accordingly (at 10 o'clock and 53 minutes p.m.), the House adjourned until tomorrow, Thursday, December 13, 2007, at 10 a.m.

EXECUTIVE COMMUNICATIONS, ETC.

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

4522. A letter from the Administrator, Department of Agriculture, transmitting the Department's final rule — Watermelon Research and Promotion Plan; Assessment Increase [Doc. No. AMS-FV-07-0038; FV-07-701] received December 10, 2007, pursuant to 5