she had cancer and malignancy or a tumor in her, she would have been given that care, would have been given that care. But because this is a mental illness, she's been denied that care.

And we are looking to pass this legislation because we believe it's fundamentally wrong that this is not covered, and it should not be denied care. We know, once again, that the brain is part of the body. We can measure the metabolic changes in the brain now due to modern technology. If people and insurance companies are questioning the science based on determining any of this, all they need to do is go to the National Institutes of Health, National Institutes on Drug Addiction, National Institutes on Alcoholism, or National Institute of Mental Health. They can get all the information they want.

There is no sound basis for discrimination. It's patently wrong. It's based in fear and it's based in essential misinformation. And so we are constantly trying to pass this in spite of the efforts by insurance companies to fight us, and we need the American public to join us in this battle. Otherwise, we'll continue to see these tragedies reoccur over and over and over again in this country.

Mr. RAMSTAD. Will the gentleman yield?

Mr. KENNEDY. Yes.

Mr. RAMSTAD. I'd just like to conclude my portion, Mr. Speaker, by quoting from one of our key advisers on this legislation, somebody who's a true expert, Navy Captain Medical Dr. Ron Smith, who is former chairman of the Department of Psychiatry at the Bethesda Naval Medical Center and who's worked in chemical dependency in the field of treatment for dozens of years.

And Dr. Smith, when he testified at a hearing several years ago, said every time you treat a person for addiction or mental illness, you're really helping seven people: their siblings, spouse, significant others, children, grandparents, uncles, aunts and others close to the addicted or mentally ill person. Why? Because these are family diseases that affect the entire family. And Dr. Smith went on to say at that hearing that the Paul Wellstone Mental Health and Addiction Treatment Equity Act has the potential to favorably impact more American people than any other law passed by Congress since Social Security and Medicare; that this bill, to provide treatment, to provide equity in treatment for mental health and addiction has the potential to help more American people than any law passed by Congress since Social Security and Medicare.

Mr. Speaker, we can't afford not to pass this bill next week, the final week of this year of Congress. This is a historic opportunity for the Congress; and I know, I know in my heart that the President will sign the bill if it gets to his desk.

□ 1600

Again, I urge all Americans who have an interest in this life-or-death issue to e-mail, call your Congress Member, your Senators in the next several days, urge them to pass the Paul Wellstone Mental Health Parity Act. It is absolutely essential that we get it done now.

I thank the gentleman from Rhode Island for yielding.

Mr. KENNEDY. Thank you.

I wanted just to conclude with a couple of stories that I think are uplifting, and they show when people are successful in getting treatment that their lives really do turn around.

Marley Prunty-Lara spoke to us in one of our hearings. She was diagnosed with bipolar disorder. She was first diagnosed when she was 15 years old. And she and her mom were searching for a psychiatrist in her home State of South Dakota, and they were told that she would have to wait 4 to 5 months for an initial appointment. As Marley was stating in her testimony, she did not have that long to live.

Thankfully, she found care 350 miles away, in another State, and was hospitalized for 2 months. However, the residential treatment facility was not covered by her mother's insurance, forcing her parents to take out a second mortgage on their home in order for them to receive the care that their daughter needed for her to survive.

Marley stated that if she had suffered a spinal cord injury requiring long-term hospitalization, the insurance company would have paid for all of her care without any questions asked, but because her hospitalization involved a mental illness, it was deemed unworthy of insurance. Finally, Marley said, ''I understand the power of successful treatment because I am living it today. I have passionately lived with the prison of mental illness and I have also experienced the incalculable emancipation that accompanies wellness.''

How can Congress continue to deny the opportunity to be well and live a full life to tens of millions of Americans every year?

We met with Amy Smith from Denver, Colorado, who also talked about her unmet mental health needs, how it cost her 40 years of her life, shuffling the roads in Denver, Colorado; muttering to herself; people dismissing her on the sidewalk, not talking to her; panhandling, using drugs; in and out of prison; in and out of detox; always being marginalized from society until one day she finally got the help she needed.

Her life is 180 degrees different today. She has a job. She has a house. She's paying taxes. But she said to us, Members of Congress, I lost those 40 years of my life. You can't give those years back to me. I wish I had gotten the treatment earlier in my life, but I didn't. I only hope that more Americans get the help they need earlier in their lives rather than waste their lives the way I did. But I didn't get that help.

We need to make sure that people live out their dreams. Amy Smith said that she had had the dream of getting married and having children. She said, I'm too old for that now. I can't have children now. I'm too old for that. She said, Maybe some day I might still get married, maybe I will adopt. But she said, I had all kinds of dreams of having a really successful career and really making the most of my life. She said, I feel like I've squandered so much of my abilities and talents.

And it was so clear to us that she had so much to offer, and those skills and talents were not realized because of her mental illness. And the fact is we have millions of Americans who have so much to offer in our society, and yet they and their potential is being squandered. Squandered why? Because we as a society failed to open up the door of opportunity to them simply because we reject their illness from being treated like every other illness.

And I think that's un-American. That's not what this country is all about. That's not what we as a nation are all about. And that's why we need to pass the Paul Wellstone Mental Health Parity Act.

HEALTH CARE

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

Mr. BURGESS. Mr. Speaker, why don't we just continue on talking about health care over the next hour. It's a relevant subject, and many of us are concerned about health care in this country. Many of our constituents are concerned about health care.

Mr. Speaker, I was a physician in my former life before coming to Congress almost 5 years ago. Perhaps it's time that we approach this as maybe a checkup on American health care. And like any good physician, as when I approached someone with a medical condition, maybe make a little problem list and try to run through that and see if we can't break things down and come to some problems that are more manageable or come to some solutions that may, in fact, be possible.

The first problem that I want to talk about are problems that affect really the law of supply and demand, the problems that affect the physician workforce in this country. The second problem that I would like to focus on is the one we hear a lot about on the floor of this House, the problem with people who lack coverage for their medical expenses, the people who lack health insurance. The number varies depending upon the source that you check, but by anyone's estimation, the number is too large, and Congress does have an obligation to try to ameliorate that if it can. And then the final problem is how much more government involvement do we want in our health care. And that government involvement, by its involvement, will that lead to the type

of solutions that we'd like to see in America?

So starting with problem number one, it, again, addresses some of the physician workforce issues that we face in this country. And, again, it's one of those fundamental supply and demand questions, and if we don't have the correct supply of physicians, it is going to affect the overall cost, price and quality of the health care that we receive.

Probably now almost 2 years ago, right before he left as the Chairman of the Federal Reserve Board, Alan Greenspan came and talked to a group of us one morning, and the inevitable question comes up about Medicare: Mr. Chairman, how do you see us as ever being able to fund the obligations that Congress has taken on in the Medicare system with the baby boomers now retiring, and starting January 1, 78 million of us will be coming through over the next 40 years?

And the Chairman thought about it for a moment, and he said, It's going to be difficult, but I think when the time comes, Congress will make the correct decisions and the Medicare system will be preserved and it will endure.

Then he stopped for a moment, a thoughtful pause, as the Chairman always has wont to do, and he said, What concerns me more is will there be anyone there to deliver the services when you require them?

And that was a very insightful comment and one that has stayed with me over the past 2 years.

Now, my State medical association, the Texas Medical Association, every month they put out a periodical or journal that talks about some of the issues affecting medicine in the State. And this is the cover from the March issue of 2007, and the title of the article is ''Running Out of Doctors.'' The Texas Medical Association is concerned about the number of physicians that are in the State that are being educated in the State and that are staying in the State to enter their practice lives. And it is, indeed, a problem for the State of Texas, but it's a greater problem. It's a ubiquitous problem across the country.

Now, some of the things that we do here actually have a direct and consequential bearing on the number of physicians. And here we are bearing down very quickly on the very last of this year. We passed a bill today called a continuing resolution, and that continuing resolution was passed because tomorrow all of the funding for all of the Federal agencies and all the Federal programs, with the exception of the Department of Defense, all of that funding was going to expire because we have not passed 10 of our 11 appropriations bills. So today we passed, really, a deceptively short bill that actually funds the government for those 10 appropriations bills for another week. So perhaps not a great lift, but when you consider that this Congress spends about $3 trillion a year, you can imagine what 1 week's pay amounts to.

As we did that, there, of course, is an acknowledgement that we may indeed have to pass another continuing resolution on into next week if we can't indeed pass our spending bills. And that continuing resolution, because of the fact that Congress is going to wind down one way or the other toward the end of next week and then not be in for the remainder of the year, we are indeed going to have to ensure that the funding for those Federal programs continues.

But, Mr. Speaker, there's one aspect of that continuation that you really can't punt, you really can't just push it down the road and put it in the ''too hard'' box and we'll deal with that in January or February, and that one aspect is how Medicare compensates the physicians that see our Medicare patients. They are physicians that we've asked to see our Medicare patients. We require them in some instances to see our Medicare patients. And the fact is that Congress for the last several years has had a program in place that actually reduces year over year what we return to physicians in terms of payment for delivering those services.

Stop and think about it. A physician's office is a small business. Most people don't think of it that way, but it is a service industry business. It is a small business. And any other business that faced year-over-year cuts in projected revenue or cuts in what the reimbursement rates were going to be would have a difficult time surviving, because guess what? The energy costs for a physician's office are no different than the energy costs for the hospitals or for the bank across the street. They've gone up every year just as they have for our homes and our businesses across our communities.

What about the cost of paying the people who work there in the physician's office? That has gone up year over year. What about the cost of insuring those employees that work in the physician's office? Well, that has gone up year over year. But it's kind of ironic that the same time the cost of providing health insurance for the employees in that physician's office goes up every year, the actual return on investment goes down. The reimbursement rate from those insurance companies goes down. And one of the reasons for that is, again, how we compensate physicians in the Medicare system.

There is a very technically complicated formula that calculates physician reimbursement rates, and last night I went through that in some detail. I have heard from some of my colleagues that perhaps that's a little too complex and maybe something that doesn't project well on television and doesn't project well here on the floor of the House, but let me give you just a flavor of what's involved with our calculating the reimbursement rates for America's physicians who choose to participate in the Medicare system because we have asked them to who take care of, arguably, some of our most complex and some of our most fragile patients.

□ 1615

And the reason this is so important, if we don't do something before midnight, December 31 of this year, there is a 10.1 percent payment reduction to America's physicians who participate in the Medicare system. Not a really great way to go about rewarding them for doing the work that we've asked them to do.

And the truth is, every year there has been a projected reduction in reimbursement rates for America's physicians who participate in the Medicare system. Every year for the 5 years that I have been here, Congress has come riding in at the last minute and stopped those reductions in reimbursement rates. But the fact is, Congress has to act before December 31 or those rates that were posted by the Center for Medicare and Medicaid Services November 1, which this year is a 10.1 percent across-the-board reduction in physician reimbursement rates, if Congress does not do something affirmatively before midnight December 31, those cuts go into effect, and physicians wake up on January 31 earning 10 percent less for doing the same amount of work that they did the week before. Again, no other business would be asked to absorb this type of activity.

You can just imagine how tough it is to plan for the future. Here you think about a physician's office and they've got the rent, they've got the employee cost, they've got, or course, liability insurance, and various and other sundry things, one of the toughest things for a small physicians' office, and I would talk to you in terms of a group of between two and five individuals, which compromises a vast number of the physicians' offices in the country, one of the biggest expenses they have is the cost of capital when they want to do what? Expand.

And what does expansion mean? Hire another doctor to come in and help them do the workload because, again, 78 million people are entering the retirement age where they will be eligible for Medicare, and that starts January 1 of this year. What a coincidence. How ironic. January 1 of this year we start into the baby boom surge, and at the same time, oh, by the way, Doctor, we're going to be reducing your reimbursement rates by 10 percent.

That cost of capital to bring in a new physician is one of the biggest hurdles that a small physicians' office has to overcome. Granted, there may be large pieces of equipment that are purchased from time to time, and those also incur a cost of capital, but planning for the future, planning your own future workforce within your office is one of those things that keeps managing partners up at night in those types of practices. And it becomes even more complex and certainly more difficult to predict the future on what future earnings and what future requirements are going to

be when every year Congress comes in and says, oh, by the way, at the end of the year we are going to be enacting a physician reimbursement reduction which will significantly affect your ability to pay your bills and perhaps have something at the end of the month to take home to your family.

Well, what is the formula? And let me just back up for a moment. Let's talk about the Medicare system in the broad perspective for just a moment. Because the Medicare system, every time you hear somebody talk about Medicare, they say it's an integrated system that works seamlessly and flawlessly. But the reality is that Medicare, in many ways, is stove-piped or siloed. You have part A, part B, part C and part D, which was just enacted a few years ago. Part A pays the hospitalization expense. Part B pays the physician expense. Part C is the Medicare HMO. And part D is the prescription drug benefit that was enacted back in 2003.

If you look at the other funding silos, A, C and D, each year those undergo sort of a cost-of-living adjustment for hospitals that's called a ''market basket update.'' So the cost of inputs is calculated by the Center for Medicaid and Medicare Services. They probably have a complicated formula for that, or at least I would imagine that they do. They calculate what the cost of inputs is and they come back to the hospital and say, well, next year we're going to pay you this much more than we paid you last year. The same is true for the Medicare HMOs; the same is true for the Medicare prescription drug account.

Physicians, part B, is constructed entirely differently. And I have to confess, I don't quite understand why it's constructed differently; but when Medicare was first enacted over 40 years ago, this seemed to be a sound way to approach the problem. Part A, hospitalization, funded out of a payroll deduction, just the same as Social Security tax every month. There is that 1.5 percent Medicare charge, your employer kicks in a similar amount, so about 3 percent of your gross pay is deducted to cover Medicare expenses for the future.

Part B is funded from two sources, one is general revenue, and the other source is premiums that are paid by people who are Medicare recipients. By law, the Medicare recipient's premiums must account for 25 percent of the total expenditures in part B; the remaining 75 percent is made up in the general revenue.

Part C and part D, again, have different funding streams. Part D, when we created the prescription drug a few years ago, has dedicated funding to that. You may recall there was some argument about what the total cost of that would be. Thankfully, it has come in under cost, and that's been a great boom and a great savings; but nevertheless, there is a dedicated stream of money for the Medicare prescription drugs. Part C, the Medicare HMOs, also has some dedicated funding, plus some cost-of-living adjustments that occur there as well.

So physicians are clearly in sort of a class by themselves when it comes to Medicare reimbursement. So, how does the Center for Medicare and Medicaid Services, how does it calculate what the payment rate for physicians is going to be? It's calculated under a formula called the sustainable growth rate formula, referred to as the SGR. And you will probably hear people talk about the SGR a lot next week because, again, if we don't do something about the SGR, it is going to automatically proceed with a 10.1 percent reimbursement reduction for the Nation's physicians who choose to see Medicare patients.

Now, for the people who are very astute, there is a typographical error on this page, and I cannot take ownership of the typographical error; this was actually a pdf file simply taken from a CRS report to Congress about physicians' payment. But here's how we calculate physicians' payments: the relative value unit of work times essentially what is a geographic factor, or fudge factor for the geographic location of the practice, a relative value unit for the practice expenses, and then, again, the geographic adjustment for practice expenses in that area factors in things like the cost of labor force and what have you in different areas of the country.

And then a relative value cost for providing liability insurance. And as you might imagine, there is also some geographic discrepancies there across the country, so that is factored in, times CF, which actually down here is written as CV, but that's the conversion factor. And we'll get to the conversion factor in just a moment.

But I think you can see a pretty complex formula. And perhaps that's why I was criticized for going through that last night. And I will abbreviate the discussion of the formula, but I just want to give you a sense of how complex this is and why, certainly, the average person doesn't understand it, the average physician doesn't understand it, and I will submit to you that most average Members of Congress don't understand how this formula is calculated either.

Here is a calculation again of the update adjustment factor, perhaps a little bit different way of looking at some of the same sort of data. But the thing that I want to point out on this, because it is extremely important to understand this, the update adjustment factor here is equal to the prior year adjustment component, what we did last year, plus a cumulative adjustment component. Why is that important? Well, every year that we sweep in at the last minute and we say we're going to fix this reduction in reimbursement for physicians and we're going to make that go away, or maybe even provide a little bit of a positive update, every year that we do that, because of the cumulative nature of this formula, we make the overall expense of eventually repealing the formula, we make that expense increase. And every year the amount of increase actually grows, it snowballs, if you will.

To give you an example, when I first came to Congress in 2003, the year before, in my practice, we had sustained a 5.4 percent reduction in Medicare reimbursement rates. A great hue and cry from across the country and Congress recognized that and said, we're going to do something this year to prevent that from happening. And that something did, indeed, occur in an omnibus bill right as I got to Congress in January of that year.

The cost of repealing the sustainable growth rate formula at that time was calculated by the Congressional Budget Office to be $118 billion, give or take a billion here or there; $118 billion, a significant amount of money, but that actually is a 10-year figure. So it's about 11 to $12 billion a year that we would have to come up with in Congress to offset the cost of repealing that formula. Big sum of money to be sure.

But every year now, over the last 5 years, we've done something at the last minute, and that something has increased the cost of the ultimate repeal of the sustainable growth rate formula, such that now it is calculated by the Congressional Budget Office this year as being $268 billion over 10 years' time. If, indeed, we get our work done and prevent that cut from going into place at the end of this month, the cost, again, that cumulative adjustment factor will come into play, and that cost will be bigger in 2008 than it was in 2007. And it will be bigger by a larger amount than it was in 2007, depending upon the amount of rescue that Congress chooses to bring to the table.

And then again, I just can't help myself, one last slide, talking about the complicated nature of this. And again, I show you this not to invoke sympathy from someone who has spent some time studying this, but I show you this because I want to give you a sense of how complicated the problem is. Again, I will submit to you that many Members of Congress just simply do not, cannot, will not understand this. And as a consequence, it kind of gets put in that ''too hard box'' over here and we'll think about that later. That's why there is always the temptation to try to kick it down the road.

The fact is, we have to do something by December 31. If we don't, that 10.1 percent reduction comes into play. You might say, well, okay, that's for Medicare patients, but doctors see more than just Medicare patients in their office, so they will be able to deal with that in some way, won't they? Just raise the rates on someone else. Here's the deal: almost all of the major insurance companies in this country peg their reimbursement to what Medicare reimburses. So the contracts may be a

little more generous than Medicare, they may reimburse at 110 percent of Medicare, 115 percent of Medicare, 120 percent of Medicare; but they peg to what the Medicare reimbursement rate is. So if we come in with a 10.1 percent reduction in physician services reimburses, guess what happens to private insurance at the same time? That same reduction goes into play.

So I called my old medical practice yesterday and I just asked them, what do you think about this? And of course they were more or less unaware that this was happening, and that's really not unusual. Most physicians' offices don't pay a lot of attention to what we're doing up here in Congress because they're busy, they're taking care of sick people. And that's what we want them to do. We don't want them necessarily watching every move we make here in Congress.

But when I related that, no, we actually need to do something or there will be a 10 percent reduction at the end of this year, then I got their attention and then they were very interested. And I said, well, give me an idea of what this will do to your commercial insurance. And very quickly the response came that almost all of our contracts that we have with commercial insurance actually pegged to Medicare. So it will have more than just a ripple effect. It will be almost like a tidal wave effect through the rest of the reimbursement rates for the other plans and insurance companies that this office, for which they receive reimbursement for taking care of those patients.

Now, what happens if we don't do it by January 1? The cuts go into effect. But maybe we go ahead and do it and take care of it in January or February, we kick the can down the road a little bit and then we come back later and do it. Actually, this happened in 2005. We had the fix in a big bill that was being passed that year. It was called the Deficit Reduction Act. And we kind of ran out the clock at the end of the year and on a technicality the bill had to come back to Congress, but we weren't in session anymore, so it had to wait until January. And the effect was that those cuts did go into effect January 1 of that year. And I know that because my fax went crazy. There was no one in the office that day to answer the phone, but the fax machine went crazy from physicians across the country sending me notices, Congressman, I want you to see the letter I sent out to my patients this week. I will no longer be able to provide Medicare services because of the cumulative effect of these reductions on my practice. It had a very immediate and detrimental effect on practicing physicians across the country.

The same would be true this year. In fact, it would be worse because that year the reduction was 5 percent; this year it is 10 percent. And I would just imagine that it would at least double, if not more, the anxiety that's felt within our physician community across the country.

Moreover, the Center for Medicare and Medicaid Services said, we will come back and make whole those practices that continue to see Medicare patients without interruption, and we will go back and reimburse them the difference when Congress finally passes a law. And that's all well and good, but there's very little way to control if those private companies come back and make the adjustments retroactively the same as Medicare did.

Again, very, very difficult to know that because we're talking about very small amounts of money. It's very difficult for a practice to actually track that through the overall cycle of a patient's care, but the result is, cumulatively across the country, the numbers could have been quite, quite large.

And it was never the intent of Congress to provide a benefit for commercial insurance by reducing the Medicare rate. It's just an unfortunate consequence of having what are essentially Federal price controls on Federal reimbursement rates.

□ 1630

Well, again, I promised not to spend too much time on the formula, but I think it is important. I think it is important for Members to understand. I have had several bills over the years trying to deal with this. One thing that I have introduced just this week is a resolution in the House of Representatives. And I will admit this resolution does not have the force of law. It actually doesn't spend any money. It almost is like sending a get well card to the doctors who take care of our Medicare patients. But the resolution is multiple whereases detailing the problems that I have just been through followed by a single, Resolved: That it is the sense of the United States House of Representatives to immediately address this issue and halt any scheduled cuts to Medicare physician payments and immediately begin working on a long-term solution and implement it within 2 years that pays physicians in a fair and stable way, that ensures Medicare patients have access to the doctor of their choice.

Mr. Speaker, I know I have to confine my remarks and I only speak to the Chair, and I will do that, but if I could speak to my colleagues, the Members on both sides of the aisle, I would ask them to take a very serious look at House Resolution 863. Again, it spends no money. It does not have the force of law. But I think if a significant number of Members were to participate in signing on to this particular resolution, it would be a powerful message to send to House leadership on both sides of the aisle that we want this problem fixed before we go home at the end of the year. This is one of those things on our to-do list that we must address, that we must take care of.

Now, one of the other things that I do want to spend just a minute talking about, and in some of the physician workforce bills that I have introduced in Congress, I have provided some additional help for doctors who will voluntarily participate in improvements in their office's investment in health information technology. In fact, the last bill that I introduced dealing with the sustainable growth rate problem had it in two components for a voluntary positive update for physicians who, again, participate on a voluntary basis in upgrades in health information technology and for physicians who voluntarily participate in quality reporting measures.

Let me just tell you something. Mr. Speaker, it is just human nature, anyone who works for a living always likes to be kind of pulled into the process and asked to help work on a problem. Most people don't like to be told what to do. Most people inherently reject orders that come from the top down. A lot of times, it is better to build things from the bottom up. Now, I have to tell you, when I was a practicing physician, I wasn't a big advocate of electronic medical records. I dabbled in it a little bit. I had a run or two with electronic prescribing. These things were complicated. They were expensive. They added time to my day that wasn't reimbursed. But the reality is I have come to accept the concept more since I have been in Congress.

Let me just share with you what one of my revelations was. Many of us who serve in this body will never forget the week that Hurricane Katrina roared into the gulf coast and struck the gulf coast areas of Mississippi, Louisiana and Alabama. It was the result of the effects of that hurricane and the subsequent flooding in the City of New Orleans and subsequent trips to that area, once just as an individual to see if I could be helpful, and once as part of a field hearing with my Subcommittee on Oversight and Investigations as part of the Energy and Commerce Committee.

This is a picture that was taken on that second trip, January of 2006. So we are now 5 months after the hurricane hit, 5 months after the dewatering of the City of New Orleans, if ''dewatering'' is actually a verb. Here is a picture of the basement of Charity Hospital. Charity Hospital, one of the venerable old institutions in our country that has been long associated with teaching doctors, teaching new doctors, here is the records room at Charity Hospital. You can't really see it from this picture, but there is still water on the floor, water about up to the level of the top of our shoes. Do you see these records? And there is just oceans and oceans of records. This is one stack. There are stacks that go on, 50 behind and 50 in front. There are a lot of records in the basement of Charity Hospital because they take care of a lot of patients, and they have for a lot of years.

Look at these records. It almost looks like they have some smoke or soot damage on them, but, in fact, that is black mold that is growing on them

on the manila folders and growing on the paper in the charts, and as a consequence, you could not possibly send anyone in here to retrieve a chart. It would be too hazardous. In all likelihood, the ink is washed off the paper anyway during the couple of weeks that these things were submerged.

These records are, for all intents and purposes, lost to the ages. There is no way of knowing what is included in those medical records. There may have been a treatment for leukemia here. There may have been a kidney transplant down here. We don't know. This may have been someone on a waiting list for a transplant. No way of knowing. Those records are lost forever.

Here is the deal. Those individuals who were brought to the Dallas-Fort Worth area who were displaced after Hurricane Katrina and arrived at Reunion Arena in sort of a little triage area set up by doctors from the Dallas County Medical Society, there was a small trailer outside, and one of the chain drugstores said, Well, for those people who had prescriptions at our drugstore, we can at least help you reconstruct what medicines they were on. It was enormously helpful to have that information so those patients who had their prescriptions at that particular pharmacy, they could go online into their master list and at least reconstruct the medication list. And a lot of times, if you have the medication list, you have a pretty good idea of the problems that were under treatment. Certainly, you would have a better idea than if you were waiting for the City of New Orleans to be evacuated of water and then get down to the basement of Charity Hospital, run the health risk of pulling out one of these records and breathing in the spores of the black mold.

So I have become a believer. You have to have some way of, especially in times of great national upheaval, you have to have some way of getting that data that has been accumulated on patients over the years. You have to have ways of getting it into the hands of the caregivers. I don't know that we have the perfect system yet. I don't know if the Federal Government is capable of developing the perfect system, or perhaps that may be something that comes to us from private industry, but I do know this. The time for electronic medical records is nigh at hand, and as difficult as it is for doctors my age who did not grow up with this technology, it is time that we are going to have to come into the 21st century and acknowledge this type of technology is a benefit and delivers value to the interaction that occurs between the doctor and the patient.

But how much better is it to bring those physicians along who are in practice and allow them to participate in the solution, allow them to participate in the construction of these platforms? Contrast that with the typical congressional activity, which would be a top-down approach. In fact, just last week we had the unveiling of an e-prescribing bill with a lot of fanfare over on the Senate side. And it was vaunted as a ''carrot and a stick'' approach, that, Doctor, we will give you a little something if you participate, but we are going to have a little something to say to you if you don't participate. So the carrot was we are going to increase your reimbursement rate by 1 percent if you participate in an e-prescribing program. And what is the stick? A 10 percent reduction if you are not participating in an e-prescribing program in 5 years' time. So that was seen as a way to rapidly get physicians' attention. Yes, we will offer them perhaps a little bit up front and we will have a significant penalty if they don't participate.

Well, what does it really mean when you say we will offer a 1 percent increase? Well, I will just tell you that for those Medicare patients that I saw as an office patient, the office reimbursement visit typically wasn't as generous as $50, but for the sake of argument, to make the math easy, let's say it was a $50 reimbursement for a moderately complex Medicare patient return visit, which would be the bulk of the patient load that a physician would see during the day. And the average physician can probably see four of those moderately complex return visit appointments in an hour's time, sometimes a little bit more, sometimes a little bit less if those visits turn out to be more and more complex. That 1 percent increase that the doctor will receive amounts to about a $2 an hour, 50 cents per patient, four patients an hour. So that is a $2 an hour increase that we are willing to provide the physician who is willing to participate.

Now, what happens if in 4 or 5 years' time they are not participating, they are not partaking? I have to tell you, you look at the cost of installing an e-prescribing program in your office, putting a handheld device of some kind in the hands of perhaps every doctor and perhaps every nurse that is working in that office. This program that was unveiled last week would allow a $2,000 credit or grant to the physician to buy the equipment, but the reality is the equipment costs many times that. But we are going to give an extra $2 an hour to that doctor for participating in this program. But if they don't do it within 4 or 5 years, the stick is going to be a 10 percent reduction, which doing the same math, you are going to come up with about a $20 an hour reduction in reimbursement.

Now, wait a minute, this is the same doctor you said we were going to cut 10 percent at the end of this year, and at the end of next year and the year after that. How many doctors do we expect to see, going back to my first slide, ''Running Out of Doctors,'' how many doctors do we expect are going to be participating in the Medicare system if we keep treating them like that? Well, they would be foolish to stay. You would have to wonder about their mental stability if they did indeed stay.

So we need to have a better approach. It was talked about as a ''carrot and stick'' approach. To me, it almost seemed like spinach and a whooping. You know, it is not going to be that attractive on the front end, but it sure is going to be bad on the back end. So I can't see that physicians will rush out and embrace this. And I really would caution the Members of Congress who are working on this end-of-the-year Medicare fix, whatever it is, to really be careful, to really be cautious about including this type of language in whatever type of Medicare fix that we come up with at the end of the year.

Is the theory good? Yes, it is. E-prescribing is something that certainly younger physicians in medical school and residency, they are going to be exposed to on an ongoing basis. And they are going to look for practices that have this to offer, or they are going to come to work in practices where it is not offered and wonder why it is not there and ask their older partners to please provide them an e-prescribing platform because it is the right thing to do. It reduces errors. It reduces some of the complications of prescriptions that are filled poorly, of doctors' handwriting can't be read, the pharmacist has to call the doctor back and say, did you mean Zanax or Zantac? And these types of problems can be avoided with e-prescribing.

It is not a panacea. There will be different types of errors that come to light as more and more people use e-prescribing, but it clearly is the way of the future. But do it correctly. Remember, there is not a single dollar that is spent in the health care system unless it is ordered by a physician. So our physicians are the gateway through which all of the medical reimbursement, all the medical pricing, all the medical cost flows through the physicians. So let's make sure that they are on our side with this. Let's not alienate them the first shot out of the box as we go forward with these types of programs.

Let me just give you an example, too. And I talked a little bit about I am not sure if the Federal Government is exactly the correct entity to have involved with creating this new electronic environment that we want medical practices, in which we want them to exist. Perhaps it would be, perhaps there will be improvements from the private sector that we ought to investigate. Perhaps we need to remove some of the regulatory burden. I won't go into great detail, but they are called the Star clause. Maybe we ought to remove some of the regulatory burden. Maybe we need to have some medical justice, some medical liability reform so companies aren't afraid of this. But the fact of the matter remains, I am not sure the Federal Government is the correct avenue to proceed with this.

When I came here 5 years ago, I was told that the Federal Government controls 50 cents of every dollar that is spent in health care and we are going

to develop a platform. We are going to develop what electronic medical records should look like, and private industry will follow our lead. Five years later, where is it? I don't know.

But I do know this. Do you remember a year ago all the trouble we had out at Walter Reed Hospital and all the negative headlines that were coming out in the Washington Post? And yes, there were some real physical problems in a place out there called building 18. But here is the real problem. Master Sergeant Blaine, who was kind enough to give me a tour through that area at the end of showing me the peeling paint in the building under question which was no longer at that point occupied by our soldiers out there on medical hold, he said, Here is the real problem. I have guys who have been in the service for sometimes 20 years. They are trying to decide whether or not they are kept in the service, whether they can be returned to their unit, or whether they need to be discharged because of whatever their medical condition is, and if they are discharged, what is the disability, what is the correct disability designation to give them? And how can we put that information in the hands of the VA system so that patient's transition to retirement status is made easier?

The problem is, the master sergeant told me, that someone who has been in the service for a number of years is going to have a great big, thick medical record. And the problem is, that even the part of the Department of Defense records that are electronic don't talk to the electronic medical records that are kept by the VA system.

□ 1645

So the result is they have got to go through a paper interface to go from one platform to the other, and there is this great stack of papers that the soldier will collect themselves, go through with a yellow marker, yellow highlighter, and mark and identify those things that will perhaps make their case for themselves, as to whether or not they should go back to their unit, be discharged on a disability, transition to the VA system. All of that data has to be done by hand by the soldier, and it may take many manhours to accumulate that data.

The real problem, the master sergeant said, was after collecting this voluminous data that may look like the Washington, D.C. phonebook, when it's all said and done, that goes and sits on someone's desk for two weeks' time, and then it's lost and the soldier has to start all over again. So their time in medical hold is increased, their frustration level is certainly increased, and, yeah, the peeling paint and crickets were a problem, because the building was a crummy building.

But the real problem was the difficulty that the soldiers were experiencing because one electronic medical records system within the Federal Government didn't talk to the other medical record system within the Federal Government. Just an indication of, to me, perhaps government doesn't have the entire solution here.

Mr. Speaker, a couple of other things that I just want to touch on, and I know time is growing short. The medical liability condition in this country is something that really adds to the frustration list. When you talk to doctors about what are some of the things that really bug you, what would be some of the things that shorten perhaps your number of years in practice, your number of years in service, certainly the medical liability issue will come front and center.

Mr. Speaker, our Founding Fathers were very wise, and they talked of States as being great laboratories where different ideas can be tried and tested; and I am happy to say within the arena of medical liability, my home State of Texas made some changes a little over 4 years ago that have resulted in a significant, a dramatic improvement in the medical-justice environment in the State of Texas.

Consider this: my last year of active practice was 2002. We had gone from 17 medical liability insurers in the State down to two. I am here to tell you, you don't get much competitive advantage when you only have two medical liability insurers. But the claims are going up, the amounts of dollars awarded in claims is going up, and you only have two insurers. Guess what is happening? Premiums for doctors, doctors who historically had not had much in the way of any activity, still, those doctors were being asked to fork over increasing amounts of premiums, and we are talking about significant increases year over year, such that my premium might go up from $18,000 one year, $25,000 the next year. My last year in practice, it was likely to be $28,000. You multiply that by five doctors in a practice, and that is a pretty hefty check to have to write at the beginning of every year. In an OB/GYN practice, as I was in, that's a lot of babies that you have got to deliver just to pay the freight, to pay the tab on medical liability.

The State of Texas recognized that they were in crisis. The State legislature in 2003, at the end of their legislative session, passed a medical liability reform bill, and it was patterned after what was called the Medical Injury Compensation Reform Act of 1975, passed out in California. It essentially was a cap on non-economic damages, patterned after the California law from 1975; but it was a little bit different, a little bit different in that there was a cap on non-economic damages as applied to the physician, a cap on non-economic damages as applied to the hospital, and a cap on non-economic damages as applied to a second hospital, or nursing home, if one was involved.

So the cap was trifurcated, each maximum being fixed at $250,000, but an aggregate of $750,000 for non-economic damages. Punitive damages and actual damages were not affected by the law and the subsequent constitutional amendment that was passed in Texas that allowed this law to go into effect. Indeed, it went into effect on September 12, 2003; and since that time, Texas Medical Liability Trust, my old insurer of record, doctors who were insured with Texas Medical Liability Trust, between dividends and reductions in premiums, have seen a return of about 22 percent, a reduction of 22 percent of their premiums that they paid with Texas Medical Liability Trust. Remember, this was an environment that was going up by 10 or 15 percent or more a year. So a significant reduction for the physician.

The other unintended beneficiary was the small, not-for-profit hospital that typically was self-insured and had to put vast sums of money in reserve against the unknown aspect of what they might be hit with in a medical liability suit where the non-economic damages were not capped. These small not-for-profit hospitals were able to move some of that money that they were holding against a loss in a legal action and put that into the very things you want your small, not-for-profit community hospital to be doing, like capital improvements, paying nurses, hiring more nurses; perhaps doing some of the very things that would result in better care that would reduce the number of medical-legal claims. So this was a good thing across the spectrum for physicians, for hospitals, for patients in the State of Texas.

Now, we have tried several times to do that similar sort of law here on the floor of the House. We have never managed to quite get it done. But House bill 3509 is a bill that is patterned after the Texas law. Again, Mr. Speaker, I know I need to speak directly to you and not to other Members of the House of Representatives, but if I could speak to them directly, I would ask them to have their staffs seriously look at H.R. 3509 and see if there wouldn't be some way for them to cosponsor it. Because, again, I think the weight of significant cosponsors, taking it to the House leadership both on my side and the Democratic side of the aisle, might help tip the balance that we really want something done on this issue. We will still have a tall order in the Senate, which has always been the stumbling block, but the time has come to do some type of sensible medical liability reform, medical justice reform.

Well, I have spent a lot of time talking about physician workforce. Let me touch on the other two problems that I alluded to as I began this. Certainly, the second problem we always hear a lot about is the uninsured, and we can argue about what the number is, and the census number will come up with different numbers and different people will have different figures. But by anyone's estimation, it is higher than it should be in this country.

If you look at kind of the breakdown of the uninsured, one of the big problems I think we make is we always approach that as some sort of amorphous demographic, where everyone is identical throughout the spectrum of the patients who are uninsured in this country, and the reality is there are vastly different groups contained within that number.

Now, a bill that I introduced just a couple of weeks ago that, again, Mr. Speaker, I will address to you, but if I was able to talk to other Members of the House of Representatives, I would suggest they have their staff look at H.R. 4190. Now this is a simple little bill that actually takes Members of Congress and takes them out of the Federal Employees Health Benefit Plan, in other words, makes Members of Congress uninsured. How else are we going to be able to really understand and really deal with the problems of the uninsured when we have very good health insurance?

So if every Member of Congress suddenly found themselves without health insurance and placed into that demographic, however large it is, perhaps we could think of some more creative solutions, whether it be a change in the Tax Code, perhaps a tax credit, whether it be some additional help, whatever. Members of Congress would have a renewed vigor with approaching the problems and providing solutions and options for patients who find themselves uninsured.

Perhaps it is a health savings account, perhaps an individually owned insurance policy. And, oh, by the way, the tax treatment for that for those provided by an employer and those provided by an individual, the tax treatment is vastly different. Maybe we could come up with some creative ways of looking at that if we ourselves were not kept in this cocoon and anesthetized by the Federal Employees Health Benefit Program.

Suffice to say, Mr. Speaker, I have not had a lot of people showing up outside my office to sign on as cosponsors, but it is an intriguing idea, and I do ask Members, I will not ask them to necessarily sign up as cosponsors, but realistically, Mr. Speaker, if I could speak to my colleagues about this, I would ask them to give some thought to how they would approach the problem if they themselves or their families were actually members of the group in this country that did not have health insurance.

You break the number down, and the individual demographics, suddenly you start looking at numbers of people where perhaps there are some choices and options. There are some things we could do. Some people tell me that as many as 10 percent of that uninsured demographic are people in universities or just recently graduated university students who, for whatever reasons, don't have health coverage.

Well, there is a group of individuals that is fairly easy to insure because they tend to be healthy. Yes, they can have some bad things and they tend to be very expensive when they occur, but almost the ideal population to think about some type of catastrophic coverage, again along the lines of the HSAs that we expanded a few years ago.

Perhaps if we equaled out the tax treatment a little bit, because a lot of these individuals are entering the workforce for the first time, they are finding what it is like to pay taxes for the first time, maybe we could get their attention with a little bit more favorable tax treatment. Certainly that is one option we could look at.

A number of people in this country actually make enough money to purchase health insurance, but choose not to. Perhaps there would be ways of pricing health insurance so the costs were not so daunting, that the cost was not such a barrier to entry for those individuals; and there are a variety of ways of perhaps approaching that. Congress just simply again perhaps needs to remove some regulations, needs to provide a little bit more level playing field between some of the States and allow this to occur.

There is no question that there is a lot of people in this country who are here without the benefit of having a valid Social Security number. That is a large number of our uninsured. Perhaps there are ways that we need to be thinking about how to address and how to approach that population, because clearly it is a difficult issue that we can't just keep putting in the too-hard box and we are going to think about it later. If we don't address that issue, we will never solve the problem.

Mr. Speaker, let's not forget, we had a hearing on the Federally Qualified Health Centers in my committee on Energy and Commerce earlier this month. Fifteen million people actually get their health care through a Federally Qualified Health Center. Well, they have a medical home. For all intents and purposes, although they may lack an actual insurance policy on paper, they have access to medical care, they have access to a medical home through a Federally Qualified Health Center. So let's stop counting those as members of the uninsured, because they all obviously do have access to care.

One final point that I do need to make, Mr. Speaker, and, again, I realize that time is short and it has been a long week: Do we increase the participation of the Federal Government in health care? Is that the answer for us in dealing with a lot of the problems that we face today?

Well, I would ask us to look at a couple of things. You look at what is still on our to-do list as Congress wraps up this year, and what are some of the big things you see? First off, we haven't funded the money for veterans services and veterans health care. That is still up there on the to-do list.

I have talked about it already, but we have not dealt with the looming reduction in physician reimbursement rates that is out there and fixing to happen to doctors across the country in just a few short weeks' time.

We haven't dealt with whatever our final resolution is going to be on continuing the State Children's Health Insurance Program, a program administered by States, but they receive a significant amount of money from the Federal Government. And we have as yet not been able to come to a conclusion as to what we are going to do about funding the future for the State Children's Health Insurance Program.

Take a step back and look at that. We haven't funded veterans, we haven't figured out what we are going to do for our Medicare patients, because the doctors may leave because we decided not to pay them, and, oh, by the way, we still haven't done anything to cover our kids.

Do we want to be giving the Federal Government an increased reach and grasp of our health care in this country? Are we doing such a good job here that you want to reward us with more?

You see Members of Congress write op-eds in the Washington Post where they talk about expanding Medicare to people that are age 55. But, by the way, good luck on finding a doctor, because we are not paying them anymore and they are dropping out of the system.

So we have people in this Congress who want to sort of drag and drop people into Federal programs, take people off of private health insurance in the State Children's Health Insurance Program. One of the big issues there, we want to expand the program so big that it pulls kids off of private insurance, because, you know what, it is too hard to go down and find those really poor kids that we are supposed to be covering. That is a lot of work. They move around a lot. They may not really live with their parents any more. It is just a lot of hard work to find them. It would be a lot easier to go get some middle-class kids and pull them in to have a number of 10 million and say, look, aren't we great, what we did with the State Children's Health Insurance Program.

I don't know. I don't know. You talk to pediatricians who work in private practice in this country. You ask them how they are reimbursed in the State Children's Health Insurance Program versus private commercial insurance. And guess what? Private commercial insurance, for all its faults, is still a better reimbursement rate than the State Children's Health Insurance Program by about a two to one margin. So are we going to be helping our pediatricians by pushing more kids on to the state-run program and pulling them off of those private programs? I don't think so.

Right now the Federal Government has control of about 50 cents out of every health care dollar that is spent in this country. The remainder of that is not all private insurance. The lion's share of it is. Certainly some people

still write a check for their health care, just like they did when my dad was in practice back in the 1950s. Some doctors give of their time willingly. They give charitable care. We never account for that in any of the demographic studies that we do. But half of the health care in this country, the dollars spent on health care in this country, 50 cents out of every health care dollar originates right here in the House of Representatives.

Are we doing a good job with what we already have? Might we not be asked to improve what we are doing in those programs before we are asking you to let us take over even more of how we deliver health care in this country? It is certainly food for thought as we wrap up this year in the United States Congress.

I would emphasize one more time, Mr. Speaker, and again I will address my remarks to you, if I could talk directly to Members who are involved in leadership on both sides of this House of Representatives, Mr. Speaker, I would ask that they seriously look at fixing the problem with physician reimbursement rates that we are coming up on now like a freight train and it is going to have a significant negative impact on the care rendered to our seniors in the Medicare program.

□ 1700

But we have got to pay attention to what we are doing for our veterans. We have got to pay attention with the State Children's Health Insurance Program. Again, lots of areas for improvement, I think, before we talk about expanding the reach and grasp of the Federal Government.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Without objection, the earlier order of the House granting the gentleman from Michigan (Mr. MCCOTTER) 5-minute Special Order speech is vacated.

There was no objection.

THE LIBERTY ALLIANCE: CHAMPIONING LIBERTY AND DIGNITY IN OUR HUMAN COMMUNITY

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

Mr. MCCOTTER. Mr. Speaker, in the immediate aftermath of World War II, at the commencement of our Cold War against the Soviet Union and international communism, in his blunt, son of the middle border manner, President Harry Truman enunciated the eponymous doctrine he would apply to this challenge during his March 12, 1947, address to a joint session of Congress.

''I believe that it must be the policy of the United States to support free peoples who are resisting attempted subjugation by armed minorities or outside pressures. I believe that we must assist free peoples to work out their own destinies in their own way. I believe that our help should be primarily through economic and financial aid which is essential to economic stability and orderly political processes.

''One way of life is based upon the will of the majority, and is distinguished by free institutions, representative government, free elections, guarantees of individual liberty, freedom of speech and of religion, and freedom from political oppression. The second way of life is based upon the will of a minority forcibly opposed upon the majority. It relies upon terror and oppression, a controlled press and radio fixed elections, and the suppression of personal freedoms.

''The seeds of totalitarian regimes are nurtured by misery and want. They spread and grow in the evil soil of poverty and strife. They reach their full growth when the hope of a people for a better life has died. We must keep that hope alive.

''The free peoples of the world look to us for support in maintaining their freedoms. If we falter in our leadership, we may endanger the peace of the world and we shall surely endanger the welfare of our own nation.''

Regarding the Soviet Union, in the face of experts' arguments, Stalin's imperialist dictatorship should be psychologically understood and indulged to purchase an illusory peace, Truman morally comprehended this evil empire's threat to the United States and the Free World. Through the United Nations, multilateral and bilateral treaties, his strategy to contain and defeat inhuman communism called for the United States to champion the cause of human liberty and dignity.

We heeded his call, and, through American leadership and sacrifice, the Soviets' evil empire imploded and Eastern Europeans and the Russian people experienced a new birth of freedom. This victory of humanity over tyranny must not lull us into the conceit liberty is now without enemies or invincible in their face. For we must always remember our Founders' caution: ''We will give you a republic, if you can keep it.'' Today, as we confront a barbarous terrorist enemy and the rise of another Communist superstate, China, it is wise to reexamine President Truman's sound strategy, revise it as appropriate to our circumstances, and defeat the enemies of our free Republic and the free world.

A revision I propose is this: We can no longer rely on any part on the United Nations for the preservation of American or human freedom. For global altruists afflicted with cognitive dissonance, in a likely futile effort, let us remind them of the U.N.'s recent, execrable acts against the human liberty and dignity it was founded to defend.

The U.N. humanitarian aid program, Oil-for-Food, provided little bread for Iraqis but large bribes for Hussein, his regime, U.N. cronies, and likely terrorists. Estimates are Saddam's dictatorship siphoned $10 billion from the program through oil smuggling and systematic thievery, and illegal payments and kickbacks from international contractors, all beneath the nonjudgmental gaze of U.N. bureaucrats who were nevertheless judged culpable for gross incompetence, mismanagement and potential complicity with Saddam in perpetrating the biggest corruption scandal in human history.

Secondly, widespread instances and allegations of the sexual exploitation of Congolese women, girls, and boys were leveled against the U.N. personnel sent to protect them. The particulars of this barbaric sexual abuse are unfit for this forum.

Thirdly, the U.N.'s waste, fraud, and malfeasance has turned tawdry graft into a global art, an epic debacle of avarice less worthy of journalist than a satirist. As one U.N. peacekeeping staffer informed the Inter Press Service News Agency: ''Corruption and kickbacks were taken for granted in most overseas operations.'' Though not in a New York Federal Court where, on June 7, the former top U.N. procurement official, Sanjaya Bahel, was convicted of steering $100 million worth of U.N. peacekeeping contracts to the family of a personal friend. U.N. officials refuse to explain how Bahel was twice exonerated by its internal investigations, while a New York jury convicted him of fraud and corruption in half a day.

These are not the acts of the U.N. envisioned by President Franklin Roosevelt in his March 1, 1945, address before the Congress on the Yalta Conference.

''A common ground for peace ought to spell the end of the system of unilateral action, the exclusive alliances, the spheres of influence, the balances of power, and all other expedients that have been tried for centuries and have always failed. We propose to substitute for all these a universal organization in which all peace-loving organizations will finally have a chance to join.''

Weighed against Roosevelt's words, the U.N. is deemed wanting, and the reason is revealed. A universal organization will include peace-loving nations and tyrannical regimes.

Consequently, all of the exclusive alliances, spheres of influence, balances of power, and all other expedients which occurred and failed for centuries outside of a universal organization have now occurred and failed this century inside the United Nations.

Unlike Roosevelt, Truman viewed the U.N. as a future hope, not an immediate panacea. Though personally honest, Truman was versed in Boss Tom Pendergast's political machine, and so understood the U.N.'s membership's math boded ill for free people. Today, according to Freedom House, of the 192 U.N. member states, 89 are fully free and 103 are not. Thus, a solid majority of 54 percent of member states know