outs,'' giving those veterans that allow us to salute one flag, we appreciate them, those folks that put it on the line and some that did not make it.

But we look forward to coming back in the second half of this Congress and finish the unfinished business. We want the American people to have faith in this House, have faith in this Senate, and also a level of respect for the Commander in Chief, that we're going to work this thing out here in Washington, D.C., on behalf of those that have sent us up here to represent them.

I look forward to the second half of the Congress. I want to thank the staff, thank the folks in the Clerk's office for doing all that they've done, even the staff over in the minority office for sticking in there over many hours in this first half, because we have not only made history, but we have also put in more hours than any other Congress in the history of the Republic.

With that, Mr. Speaker, we encourage people to go to www.speaker.gov, and we yield back the balance of our time.

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. We probably won't take the entire 60 minutes because it has been a long week and it's been a long year, but I did want to come to the floor of the House this evening and talk a little bit about health care and talk a little bit about some of the things that are going on in Medicare, some of the things that are going on in Medicare as it affects our Nation's physicians workforce, and what, perhaps, I see over the horizon for the next six to 12 months. It's going to be kind of an interesting year. It's an election year in this country, and that means we never want for drama during that time.

This is, of course, the special time of year at the end of the year where we all pause and kind of give a little thanks for living in the greatest country on the face of the Earth, the greatest country the world has ever known. We're blessed with many, many benefits from living in this country. Sometimes we take many of those for granted. Our health care is one of those benefits that I think we do take for granted, we overlook too often.

It is appropriate to perhaps have a little checkup on that little tiny segment of the health care market that is controlled by the Federal Government. Of course, I'm being factitious because the Federal Government has under its direct control and grasp probably close to 50 cents out of every health care dollar that is spent in this country. That is, 50 cents out of every health care dollar that is spent in this country originates right here on the floor of the House of Representatives when you configure or figure the expenditures on Medicare, Medicaid, the VA system, the Indian Health Service, the Federal prison system, the federally qualified health centers around the country, 50 cents out of every dollar starts here on the floor of the House.

But Medicare does have some operational problems with its physician workforce, it has some distributional problems. There are some areas that need attention in our Medicare system. And the problem, Mr. Speaker, is not just money. We've heard a lot of folks talking on my side, folks talking on the other side about the issue of money, but the issue is not just about money, although the money is extremely important. It's not just about money. It is the policies that we create here on the floor of this House and the rules that are written in the Federal agencies under our direction. It's the policies created in this House that actually lead to most of the direct problems in that part of health care that is paid for under the reach and grasp of the Federal Government.

Now, Medicare was created a little over 40 years ago, the mid-1960s. And it was created to make a connection between patients and their physicians, patients and their hospitals and places where they needed to go for care, care that was becoming very expensive, and for some of our seniors was care that perhaps would be out of their reach.

□ 2215

Now, Mr. Speaker, believe it or not, I was not in practice at the time Medicare was instituted. My dad was. And I remember very clearly when Medicare was started in this country and some of the concerns revolving around that. I don't think anyone would have really thought that we would have just done an appropriations bill where here some 43 years later after the enactment of Medicare, I don't know what the total line expenditure for Medicare was, but it is topping $300 billion for a year in Medicare. You add the expenses of Medicaid to that, and the two together with what is spent at the Federal level and what is spent at the State level when you involve Medicaid and we are well over $6 billion a year for what we pay for that. So, again, it is really not so much a question of money. It is a question of policy.

But the lifeline that was created between seniors and their doctors, seniors and their hospitals, that lifeline that has been depended upon by really two generations of Americans now, almost two generations of Americans, that lifeline is frayed. Almost every day there is a little nick, a little cut. It is death by a thousand scalpels, if you will, since we are talking about health care. And it is that constant nicking, it is that constant pressure on that lifeline that is causing the lifeline to fray for many individuals.

Now, Mr. Speaker, I have said on the floor of this House before and it bears repeating tonight, Alan Greenspan, the former Chairman of the Federal Reserve Board, when he left his office as chairman just a little less than 2 years ago through one of his sort of exit speeches when he came through to talk to various groups, one of the things when he came to talk to a group of us one morning back in January of 2005, I think it was, and talked about the, well, he was asked about the cost of Medicare, how in the world is Congress ever going to keep up with the ever increasing cost of Medicare; how is Congress going to deal with what is basically an unfunded obligation going into the future. And the Chairman thought about it for a moment, and as always he is very careful about what he says. He said, I think when the time comes Congress will find the courage to do what is necessary to keep the Medicare system up and running. He said, what concerns me more is will there be anyone there to deliver the services when you require them?

Because, Mr. Speaker, January 1 of 2008 will be the year the first baby boomers reach the magic age of 62. They begin entering their retirement period, their retirement time; and as a consequence, we are going to see a lot of pressure put, not just on the Medicare system but on the Social Security system, on our system of long-term care, which is basically the Medicaid system under the current construction.

So there is going to be a lot of pressure put on those Federal programs as more and more people of my generation reach retirement age and again to seek and ask for and collect those benefits that they believe that they have been paying into over time.

But what happens if the supply-demand equation in regards to America's physician workforce, and nurses too for that matter, but what if the law of supply and demand has been drastically skewed so that there is not the supply, we are not keeping up with the supply of doctors and health professionals who are going to be required to take care of those patients as they enter their retirement years?

At the risk of getting too technical, let me just share a few facts. Mr. Speaker, I am sensitive to the fact that I must only address the Chair and not address people who are here on the House floor with us, Members who might be watching from their offices. I know I am not supposed to direct my comments to people who might be watching on C–SPAN so I will confine my remarks solely to the Chair and, Mr. Speaker, this is a poster that I have used in the past, and many people have seen this poster used on the floor of this House. This is a cover from the periodical put out by the Texas Medical Association. Every year they come out with a publication called Texas Medicine. And this is from March of this past year, March of 2007. And the title article was, ''Running Out of Doctors.'' It is a concern, certainly a concern of my professional organization, the Texas Medical Association back in Texas. And it is a concern, I think, or

should be a concern for many of us here in this Congress.

Again, it was a concern of Mr. Greenspan's 2 years ago when he came and talked to a group of us. And, in fact, Mr. Speaker, I asked Mr. Greenspan again when he came back to visit with us just a few months ago, I said, I often quote that statement that you made to me about is there going to be anyone there to take care of the patients in the future, and do you still feel that way, Mr. Chairman? And he said, Not only do I still feel that way, I feel stronger about it today than I did a few years ago. So this is a very relevant point and something that certainly we need to keep in mind.

Now, one of the things that is still up to be done, one of the things that is still on our to-do list here on the House side before we do finally draw this year to a merciful close is we do have to address, basically, what Medicare pays doctors. For whatever reason, we have to deal with that every year, and we don't always do a good job. Certainly when my side was in charge, we didn't always do a good job, and this year I think that performance is being repeated, and perhaps it is even a little bit worse this year.

The fact of the matter is that if Congress doesn't do something before December 31 of every year, there is a scheduled series of payment reductions that physicians will experience as a consequence of the formula under which they are paid under Medicare. It is not a problem that is unique to this Congress. It has been going on for years. It has been going on through several administrations. It is a problem brought to us by a formula called the sustainable growth rate formula which is how physicians are paid under Medicare.

Now, it is different for hospitals, it is different for HMOs, it is different for drug companies. Those expenditures are subject to essentially a cost-of-living adjustment every year. So every year there is perhaps a little bit of an uptick in what the hospitals receive, kind of a what is called a market basket update where the cost of inputs, the cost of delivering the care is figured into what Medicare reimburses a hospital.

So part A of Medicare, which is the hospital payment, funded out of payroll deductions, part A of Medicare, the hospitals do receive a little bit, it is not terribly generous, but they do receive a little bit of an uptick every year. For part C of Medicare, which is the Medicare HMOs, they are perhaps even a little more generous than the hospitals. They get a little positive update so they can continue to meet the obligations that they have in taking care of our Medicare patients. We are asking the HMOs to provide that care. We are asking the hospitals; in fact, we are asking the doctors. Congress asks them to provide the care so hospitals, HMOs and now drug companies receive a little bit of an additional payment every year under the current formula structure.

But for whatever reasons, physicians have been calculated differently. And the physician rate of compensation for Medicare patients is based upon something that has a little bit to do with the gross domestic product and the idea that we are only going to be able to control the expenditure on volume and intensity of Medicare services if we really ratchet down what we pay doctors year over year. But the negative consequences of that are significant, and the price that doctors pay if we do not do our work by December 31, and it looks now like we will sort of, and we will get to that in a minute, it looks like we will do that work and accomplish that task before December 31; but if we don't do that, then this year the Center for Medicaid and Medicare Services came out with a report November 1 saying doctors would receive payment reductions of a little bit over 10 percent, I think it was 10.1 or 10.3 percent, for 2008 compared to what they received in 2007. Well, stop and think about that for a minute, Mr. Speaker. These are small businesses. The physician practices that most of us were familiar with back in our communities, I was a physician in my previous life. I am very familiar with this concept. We are small businesses. And year over year, it is not costing us less to keep the lights on in that office. It is not costing us less to hire our employees to be able to provide the services that you want us to provide. It is not costing us less for liability insurance year over year.

Yet Congress in its infinite wisdom says that we should be able to make do with a little bit less in compensation for the Medicare patient year over year. This year that payment reduction was 10.1 percent.

Now, you might say, well, a physician's practice isn't just Medicare patients. There is commercial insurance. There is self-pay. Why are we so concerned about the Medicare aspect? What percentage of a physician's practice will be taken up by Medicare patients? And the answer is, it varies and it depends on different places in the country and what the patient mix is in various places in the country. Arguably, it might be higher in a State like Florida than it would be in a State like Wyoming.

But nevertheless, the other effect of these Medicare compensation, Medicare reimbursement reductions that happen and are scheduled to happen every year for the next 15 or 20 years, the other effect is that every commercial insurance company in this country, almost, not all of them but almost, pegs their rates, pegs what they compensate, the level of what they compensate doctors to the Medicare formula. So they pay a formula such as 110 percent of Medicare usual and customary. Some will pay less than Medicare. But most pay a little bit more, not a generous amount more, but a little bit more than Medicare.

But if Medicare cuts its rates by 10.1 percent, then guess what? The commercial insurance company will be only too happy to reduce their compensation rates by 10.1 percent. And I don't think it was ever the intent of Congress to legislate an improved business plan for America's insurance companies. They are perfectly capable of doing that on their own. They are perfectly capable of going into the physician community and negotiating a lower rate if they need to do that if that is what needs to happen so they can continue to provide the care for the patients, continue to provide the coverage for the patients.

They are perfectly capable of going to the physician community and saying this is what we need to do with the new rate structure; but they kind of get a little gift every Christmas from the United States Congress that says, well, we are going to reduce our Medicare rates if we don't do our work. And guess what? All of you patients who are covered under private insurance, your doctors are going to get paid a little less even though they are going to do exactly the same work on January 3 or 4 that they did on December 27 or 28.

Again, Mr. Speaker, I know I need to confine my remarks to the Chair, and I will keep my remarks confined to the Chair. But it does happen that sometimes people actually do watch C–SPAN this late at night and they do see these discussions, and I have gotten some feedback, Mr. Speaker, when I have put up this poster before. I actually have three posters that delineate the actual payment formula for physicians under the Medicare system. I have only brought one tonight in the interest of time.

And I bring this not to elicit sympathy but I just want people to be understanding and cognizant of just how complicated, how complicated this process is under the actual gyrations that we go through to come up with these physician formulas.

Now, this is actually the first part of what really should be three slides, but I did promise some people that I wouldn't bring all three slides tonight. But the payment for physicians is figured by taking the relative value unit for work, geographical factor, a relative value unit or the cost of inputs, the practice costs which is the subscript P C in the middle parenthesis there, again, the geographic factor that is figured in, and then the relative value unit for liability insurance, and again a geographical factor figured in. Then the whole thing is multiplied by a conversion factor down here, there is a misprint, that should be C F, which is ''conversion factor,'' and the calculation of the conversion factor is every bit as complicated as this first part of the formula

Again, I don't want to lose people with this discussion, but I want you to understand how difficult this is conceptually. As a consequence, Members of Congress on both sides of the aisle,

when you sit down and say, I want to talk to you about how we compensate physicians under the Medicare system, literally their eyes glaze over and roll back in their head because this is simply too hard for many people to think about.

Again I have spared, Mr. Speaker, the House from looking at the other two slides which also are filled with various parts of the formula.

And too, let me, Mr. Speaker, this will give you some idea of how long I have been doing this particular talk, because actually this slide was current this time last year when I was doing this very same discussion. And I need to update, because now we have completed fiscal year 2007, so no longer will 2007 have an asterisk beside it. We actually have the actual figures for that, and the figures for 2008 need to be added on.

□ 2230

This illustrates the problem we have. Now, last year right before the end of Congress, we hadn't quite figured out what we were going to do, so it was projected that doctors would have a little over a 4½ percent payment cut. It turns out that that didn't happen. We actually at the last minute came in and held doctors at what we euphemistically call a zero percent update.

Well, I am here to tell you that anywhere else in Washington, if you come in saying we are going to hold you at level funding, they will say, Wait a minute, the cost of inflation, the cost of doing business has gone up so much, that is actually a cut. Well, that is exactly right, and doctors did receive essentially a cut, but we called it a zero percent update, and we did not score it as a cut, but they were scheduled to get a 4½ percent payment reduction.

This year, if we don't take up the legislation that the Senate just zipped through at the last minute here at the end of the day on Tuesday, if we don't take that up and pass that before we leave town to have Christmas with our families, this negative projection will actually be twice as far, down past the end of the page, because that is a 10.1 percent reduction that doctors are facing this next year.

What happens, Mr. Speaker, is every year that we come in at the last minute with that fix, that money that we come in at the last minute to provide our physicians, guess what? It gets added on to the end of that very complicated formula that I just showed you. So every year that we don't fix the fundamental problem, which is to repeal the sustainable growth rate formula, every year we don't do that, we make the problem harder to solve next year, and at some point we will simply reach the point where it is too hard to solve, it's too expensive to solve, and people will either restructure the formula because it just collapses of its own weight, or just say we are not going to even try to solve it any longer because it is just too hard. It's an odd concept because it's money that has already been spent.

Going back to 2002, when there was a 4.4 percent negative update, and I was in practice then, and that did happen, but the moneys that were paid in the Medicare system in 2002 have already been paid, they have already been spent. So when they say it costs more to repeal the sustainable growth rate formula every year, it's because we are actually going to have to account for that money on our books, but the money has already been spent.

There's not any magic here. We have paid the money to the physicians for that given year. We just haven't quite accounted for it on our books, and that is why there is that additive factor that goes on year after year that kind of makes it impossible to ever dig out of this hole. We certainly won't be able to if we don't ever start, and that is the direction I have tried to take in the last Congress and tried again in this Congress. I wasn't really successful in getting a lot of people to understand the significance of this.

The reality is that as we continue, continue to cut at the compensation rate for physicians in the Medicare program, what happens is more and more physicians say, You know what? I just can't do it anymore. I can't keep the lights on. I can't pay the help. I can't buy my liability insurance and continue to see Medicare patients. And worse than that, there's the pernicious effect of, come on, we are right on top of the end of the year here and we are asking doctors around the country to kind of trust us on this; we are going to fix it.

How do you plan in your business for expansion? How do you plan to take out loans, take capital risks? How do you plan when year over year over year in the Medicare system you have cuts stretching out ahead, and, oh, by the way, commercial insurance is going to follow suit if Congress keeps those cuts intact and keeps them in place, because we don't really have a free market for health care in this country. We have Federal price controls, and it's essentially cloaked in the Medicare program, but, nevertheless, the end result is Federal price controls on medical reimbursement rates for procedures all over the country.

Now, one of the things that really disturbs me about this is it really also is a pernicious effect, a chilling effect on young people who might be thinking about a career in health care. I remember as a young man in high school and college thinking about what a great thing it would be to be a physician, to be worthy to serve the suffering, to serve my fellow man. Yeah, I expected to make some money doing it, but that wasn't the primary reason for going into the field.

But, at the same time, I didn't face the kinds of student loans that the young individual today will face at the end of their 4 years of getting their BA degree, let alone the loans going through medical school, and then they have got to really defer earnings the years that they are in residency. Yes, they are paid something during residency, but nowhere near enough to pay the freight on those lines they have through undergraduate school and through medical school. Basically, we are talking about a person who may spend between 10 and 18 years after high school getting through all of their education and their training.

Well, you think about that. Someone is graduating from high school and 15 years later some of his classmates have already built and sold a business and they are sort of semiretired. You give up. You postpone those active earning years by a decade, a decade and a half, and that is just one of the things that you expect when you take on a career in medicine.

Well, young people are looking at that and saying, You know what? That postponement of my active earning years, and the Federal Government being so injudicious with what it is doing in the Medicare system, and that affecting other areas in the commercial aspect of medicine, maybe that is just something that I shouldn't do. Maybe I will do something else with my life, because that is a little iffy, and I don't really know if I will be able to afford the liability insurance to go into practice.

So we have got to do something to help young people understand that we value, we value their service in becoming a physician or becoming a nurse, that this is something that we in Congress encourage them to do and want them to do. But right now I have got to tell you they look at it and say, I don't know if that is for me.

One of the other things, and this has come up just in the last two weeks here in Congress, is we kind of worked with this concept of what are we going to do to make things right for the doctors before we get to the end of the year. Along comes this bill to require physicians to begin e-prescribing. Well, that is a good concept. Certainly, no one wants to argue with the theory. But it reminds me of an old professor I had in undergraduate school. When he was asked a question too tough for him to answer, he would look you back in the eye and say, Do you want the theory or the application?

This is one of those instances where the theory is pretty good but the application, at least as has been discussed in the last two weeks, the technical term for it would be it stinks, Mr. Speaker, because we want physicians, we want them to come into the 21st century, we want them to use electronic medical records and things like e-prescribing.

Any one of us can cite chapter and verse all of the good things that will come from e-prescribing; yet the number one group that we have got to get to buy into this concept, well, we don't treat them very well when we come at them with legislation, as the legislation that was brought out a couple of

weeks ago over on the Senate side, but it's also been talked about over here on the House side, the so-called carrot-and-stick approach. We'll give you a little something nice now if you do it and, by golly, we are going to make you pay in a couple of years. The carrot-and-stick concept in this case really is more like, I don't know what vegetable I would associate with it, probably something more along the lines of spinach, or if we're talking about the first President Bush, perhaps broccoli. But the other end, the stick, is extremely onerous for physicians who are in practice.

Let me just give you the very quick version of what this legislation, as provided to us, would entail. For doctors who participate in the Medicare system, we are so anxious for them to prescribe in the e-prescribing regimen, we are going to generously provide them an additional 1 percent, a 1 percent upgrade on what we provide in Medicare compensation.

Well, Mr. Speaker, I don't remember exactly what I received for a moderately complex patient return visit. I am going to wage it was not as much as $50. But let's stipulate, because the math is easy, let's stipulate that that is a $50 reimbursement rate from the Medicare system. And a good physician who is practicing careful medicine and doing all the right things they are supposed to do as far as history taking, good careful physical exam, patient education after coming to a diagnosis and a treatment plan, you can probably see that patient in 15 minutes. So four an hour are what we are talking about, and we are talking about a physician generating, not making, but generating $200 in income for that hour they spend in their office seeing those four moderately complex return visit Medicare patients for which the Federal Government pays them the generous sum of $50.

Now, if we add a 1 percent update to that, let's see, each patient, that is about 50 cents. So for that hour's work we are going to add $2 to the compensation for that physician.

E-prescribing takes a little time. It takes some investment. It takes some time to learn. It is not something you can just pick up. It is quicker to scribble down a handwritten note. Now, no one may be able to read it, but nevertheless you have performed that record-keeping requirement, and it is much quicker to scribble down that handwritten note in the treatment plan and write out a prescription and rip it off and hand it to the patient.

The reality is e-prescribing takes some time. It adds time to that patient encounter. It is time that realistically someone should compensate that provider for providing. That would be a fair assessment.

Now, what do we do if, after three or four years' time, the doctors just haven't cottoned to this idea that we are going to pay them an extra 50 cents per patient on average to do this work for us? Well, then we come in with the stick phenomenon, and that will be a 10 percent reduction on that patient's services. So here we have gone from a $2 increase for those four patients for that hour's work, or, perhaps if the doctor hasn't done it, then that will be a $20 fine for those patients for that hour's work.

Once again, our physician community is going to look at that and say, No, thank you. I don't think I will participate in that. You can keep your Medicare patients and you can keep your e-prescribing and I will go off and do something else, and the patient is the one that suffers.

But it is a good concept. It is a good concept, and it is worthy of Congress spending the time, and it is worthy of Congress providing the proper compensation for physicians who are willing to invest in this technology.

Right now, the bill as rolled out would provide $2,000 to buy the equipment. It probably costs $25,000 in reality. Even if you gave it to a physician's practice free, there is still going to be ongoing costs of the maintenance of the software, the ongoing costs of educating the physicians in that particular practice, and it takes longer to fill out that electronic medical record and to fill out that form for e-prescribing than what the doctors historically are used to in an old paper system. But we have decided that is not a value and we are not going to pay for that.

Now, some people think that this is such a good idea because they are, in fact, going to make a significant amount of money. Certainly the people that sell the software are likely to make a significant amount of money. Certainly the pharmacy benefit managers, the big pharmaceutical mail-order houses, they are likely to reap some benefits from this.

But for whatever reason, all of this good stuff that is going to come from e-prescribing, no one is really thinking that it is worthwhile to share that with the physician. But the physician is the one we want to buy into this new system. And it is a new system. It is a new way of learning and it is a new way doing things.

Now, indeed, if nothing happens, younger physicians, as they go through their training, they will be exposed more and more to electronic prescribing and electronic medical records. There will come a time in probably the not-too-distant future where this evolution will just take place on its own. But the bill that was rolled out a couple of weeks ago was an effort to make it happen a little faster, to get some of those good benefits from e-prescribing, and they are significant, to get some of those good benefits out there and established early.

Again, it is going to make a significant amount of money for some people who will be involved in this. But again, for whatever reason, the Federal Government does not see value in allowing the practitioner, the physician, to participate in that distribution of all of that value that we are going to derive from this system.

Now, I don't mean to give the impression that I don't believe in e-prescribing and electronic medical records. Let me just go with one last poster, Mr. Speaker, and then we will wrap this up for tonight.

I haven't always been a big believer in electronic medical records. Again, I have tried a couple of different systems in my time in private practice and I didn't find them all that intuitive or user friendly, but this is the day I became a believer in electronic medical records.

This is the basement of Charity Hospital in New Orleans. Charity Hospital, one of the venerable teaching institutions in this country. Many of the professors I had at Parkland Hospital in the 1970s actually did their training in this very building at Charity Hospital.

Charity Hospital in 2005, August of 2005, was ground zero for the strongest hurricane probably to ever hit the continental United States in anyone's memory. And the flooding that followed that hurricane obviously dealt a severe blow to infrastructure all over the City of New Orleans, and the basement of Charity Hospital was, in fact, underwater for a significant amount of time. So all of these records were submerged.

This photograph was taken in probably October of 2005. So 2 months after the hurricane, a month, maybe 5 weeks after the city was dewatered, that is a verb I learned from the United States Corps of Engineers, I didn't know it was a verb before they used it, but the city was dewatered.

Here the medical records sit. Now we have black mold growing on the manila folders. Probably the ink on many of these records was actually just washed off in the flooding. Who knows? It wouldn't be safe to have anyone go in there and look at those records, because look the at the mold spoors that are ready to be blown off in a big cloud waiting to be inhaled by a pair of unsuspecting lungs and cause great damage.

□ 2245

So these medical records are in fact lost forever. And who knows what is in there, someone waiting for a kidney transplant, someone's hypertension that has been under treatment for two decades; someone's diabetes that was carefully monitored but not so much anymore. All of these records have been lost forever.

Electronic medical records and medical records that are then controlled in an electronic fashion in a secure fashion up on the Internet where they can be accessed, all of these patients that had to leave the city. Many came to the Metroplex area in north Texas, and many of them were cared for by physicians at Parkland Hospital, John Peter Smith Hospital, and private physicians

in the area. None of their medical records were available, and many of these patients had very complex medical conditions and were on multiple medications at the time. And if it had not been for the good graces for some of the pharmacies that actually had patient records electronically that were able to set up outside some of the triage centers to provide that data to physicians who agreed to see these patients as they came off of the transportation from New Orleans and arrived in Dallas, you can construct a pretty good medical history just going to the pharmaceutical history, and those pharmacy records were invaluable in providing good care and immediate care to those patients.

But it certainly made a believer out of me in January, or when this picture was made after the flooding in New Orleans that paper records have inherently within them a fundamental flaw, and that is, in time of great natural disaster they are not going to be there to provide useful information for those patients if they are suddenly displaced, as these patients were, the medical records themselves. They could have been destroyed in a fire, they could have been damaged in an earthquake in some other parts of the country. And, unfortunately, these types of tragedies do happen, and electronic medical records does take some aspect of that tragedy away because it does provide a way for that record to be accessed in a different location, and all of that data can be pulled off the Internet and be made available to the now receiving physician who is treating that patient.

Mr. Speaker, a little preventive medicine would go a long way in this entire Medicare policy debate. I just can't help but note the irony: November 1, when the Center for Medicare and Medicaid Services came out and said, Doctor, 10.1 percent cut, unless Congress does something before the end of the year. About that same time, the conference Chair on the majority side had an op-ed in The Washington Post that said, you know what, we have done such a good job with providing government health care and Medicare and we are doing a great job now with what we are doing in SCHIP. We know how that has turned out so far. We want to extend Medicare benefits to people who are down to the age of 55. We want to drag and drop this population into what is happening in the Medicare policies right now.

I would just argue, before we expand the program to that degree, shouldn't we ask ourselves are we doing a good job with what we have right now.

I think the mere fact that we are here at the 11th hour of this Congress and we have not dealt with the problem of physician compensation, doctors' offices across the country are looking at Congress and saying, what gives, guys? How am I going to prepare for next year? Do I hire that new doctor or not? Do I buy that piece of medical equipment or not? Do I take out a loan to improve my office or not? Because they don't have any certitude about what the activity of this body is going to be. And even at the best, the best we can do at this point is say we are going to punt for 6 months, and we will see you in June.

Mr. Speaker, that is not acceptable. This Congress has an obligation to this country's physicians to behave in a responsible way. And certainly, certainly let's quell the talk of expanding the reach and grasp of the Federal Government until we take care of what we already have.

Mr. Speaker, I yield back the balance of my time.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. DAVIS of Illinois (at the request of Mr. HOYER) for today until 2 p.m.

Mr. HASTINGS of Florida (at the request of Mr. HOYER) for December 17 and the balance of the week on account of official business.

Mr. PASTOR (at the request of Mr. HOYER) for today and the balance of the week on account of a death in the family.

Mr. GARY G. MILLER of California (at the request of Mr. BOEHNER) for today and December 12 on account of personal reasons.

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

Mr. BUTTERFIELD, for 5 minutes, today.

Mr. CUMMINGS, for 5 minutes, today.

Ms. WATERS, for 5 minutes, today.

Mr. CUELLAR, for 5 minutes, today.

Mr. ALLEN, for 5 minutes, today.

Ms. WOOLSEY, for 5 minutes, today.

Mrs. MCCARTHY of New York, for 5 minutes, today.

Mr. CARDOZA, for 5 minutes, today.

Mr. SPRATT, for 5 minutes, today.

Mr. KENNEDY, for 5 minutes, today.

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

Mr. GINGREY, for 5 minutes, today and December 19.

Mr. KING of Iowa, for 5 minutes, today.

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

Ms. KAPTUR, for 5 minutes, today.

Mr. FRANK of Massachusetts, for 5 minutes, today.

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

Mr. RUSH, for 5 minutes, today.

Mr. HILL, for 5 minutes, today.

Ms. JACKSON-LEE of Texas, for 5 minutes, today.

Mrs. CAPPS, for 5 minutes, today.

Ms. CORRINE BROWN of Florida, for 5 minutes, today.

Mr. ELLISON, for 5 minutes, today.

Mr. SHAYS, for 5 minutes, today.

Mr. GOHMERT, for 5 minutes, today.

Mr. LEWIS of Georgia, for 5 minutes, today.

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. 6. An act to move the United States toward greater energy independence and security, to increase the production of clean renewable fuels, to protect consumers, to increase the efficiency of products, buildings, and vehicles, to promote research on and deploy greenhouse gas capture and storage options, and to improve the energy performance of the Federal Government, and for other purposes.

H.R. 797. An act to amend title 38, United States Code, to improve low-vision benefits matters, matters relating to burial and memorial affairs, and other matters under the laws administered by the Secretary of Veterans Affairs, and for other purposes.

H.R. 2408. An act to designate the Department of Veterans Affairs outpatient clinic in Green Bay, Wisconsin, as the ''Milo C. Huempfner Department of Veterans Affairs Outpatient Clinic''.

H.R. 2671. An act to designate the United States courthouse located at 301 North Miami Avenue, Miami, Florida, as the ''C. Clyde Atkins United States Courthouse''.

H.R. 3703. An act to amend section 5112(p)(1)(A) of title 31, United States Code, to allow an exception from the $1 coin dispensing capability requirement for certain vending machines.

H.R. 3739. An act to amend the Arizona Water Settlements Act to modify the requirements for the statement of findings.

SENATE ENROLLED BILLS SIGNED

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

S. 597. An act to amend title 39, United States code, to extend the authority of the United States Postal Service to issue a semipostal to raise funds for breast cancer research.

S. 2174. An act to designate the facility of the United States Postal Service located at 175 South Monroe Street in Tiffin, Ohio, as the ''Paul E. Gillmor Post Office Building''.

S. 2484. An act to rename the National institute of Child Health and Human Development as the Eunice Kennedy Shriver National Institute of Child Health and Human Development.

S.J. Res. 13. Granting the consent of Congress to the International Emergency Management Assistance Memorandum of Understanding.

ADJOURNMENT

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

The motion was agreed to; accordingly (at 10 o'clock and 50 minutes p.m.), the House adjourned until tomorrow, Wednesday, December 19, 2007, at 10 a.m.