rest between deployments. They're stretched. They've been deployed two times, three times, four times. The length of their deployments have been stretched. And we've adopted the military's own guidelines to say that before troops are sent to Iraq they must be properly equipped, they've got to be trained, they've got to be ready to go.

I can't understand why the President would veto a bill that adopts the military's own guidelines for troop readiness. Because by his veto, he will therefore be rejecting the military's guidelines for troop readiness. He will be saying to the American people, I am perfectly satisfied with sending troops that aren't ready into combat.

The second thing this does is it fully funds the troops, as we have said. In fact, it provides $4 billion more than the President asked directly to the troops. So if he vetoes the bill, he will essentially be saying I'm vetoing, I'm rejecting funding for our troops. I am rejecting the funding that he asked for. I don't understand how he will do that, but that's what his veto will mean.

And finally, we provide a responsible way to redeploy that actually answers the concerns that people had about flexibility for our military commanders on the ground. Because what we do is we set a date based on benchmarks for the Iraqis that the President himself set out in a January 10 speech for the beginning of a strategic redeployment, and we give the military commanders the flexibility on the other end to reach the target goals. So if the President vetoes his own announced benchmarks for the Iraqis, I just don't understand it because he will be vetoing what he said in a speech to the American people on January 10 as his idea about what the Iraqis ought to be doing for themselves. He set the benchmarks, and now he said that he intends to veto his own benchmarks. It's beyond me to understand why he's going to veto what he said he wants to do.

If I can just go on for one more moment. I want to talk about some of the other money in this bill because this is really important. People have complained, I've heard it at home, about what they think is excess domestic spending in this bill. But here's what this bill does in terms of funding that is related to supporting our troops.

This bill provides $3 billion more for mine-resistant ambush-protected vehicles for troops in Iraq.

Mr. MURPHY of Connecticut. That doesn't sound like pork.

Mr. HODES. That's not pork. This bill provides $2 billion more for a Strategic Reserve Readiness Fund to meet the troops' readiness needs.

Mr. MURPHY of Connecticut. That doesn't sound like pork either.

Mr. HODES. That's not pork either.

It provides $1.1 billion more for needed military housing. Does that sound like pork?

Mr. MURPHY of Connecticut. That doesn't sound like pork to me, Mr. HODES.

Mr. HODES. The bill honors our returning veterans by providing $2.1 billion more for military health care than the President requested, including $900 million for post traumatic stress disorder and traumatic brain injury care and research, and $661 million to prevent health care fee increases for our troops. Because what they are now facing under this President's policies is getting sent off to war to fight for their country and coming home to find that their health insurance costs more, that the military health system is too overloaded to take care of them, and that the veterans' system has been overloaded beyond capacity.

Now, if the President vetoes these increases for the veterans and wounded warriors that his policies have created, it will be something that I don't understand and I don't think the American people are going to understand. And so he has a challenge in front of him. He has a challenge and a choice to make. And maybe between now and when this bill hits his desk, he will have one of those moments on the road to Damascus and decide that he will face the reality and do right by our troops, do right by the American people, do right by this country and set a new direction in Iraq.

I will kick it back to you, Mr. MURPHY.

Mr. MURPHY of Connecticut. We've got a few minutes left, so I'm going to throw it over for some closing remarks to Mr. ALTMIRE.

Mr. ALTMIRE. I wanted to change the subject here just momentarily here, if I could, here at the end and just mention something, because unfortunately, since we're not in session on Monday due to the unfortunate funeral that many of our colleagues are going to be attending for one of our colleagues, I wanted to mention the fact that Monday is going to be Paul Hayes, the House reading Clerk's last day. Paul has been here for 20 years, and to many viewers around the country of C–SPAN, he is the voice of the House of Representatives. I was going to do a 1 minute on Monday, but I will just do it today because we're not going to be in session on Monday and just say what an honor it has been for me, Paul, to be able to spend a few months as a Member with you here.

I was a staffer, as Mr. MURPHY knows, on Capitol Hill for 6 years in the early 1990s, and we used to watch Paul Hayes at work. And it has just been a great experience for me to come back as a Member of Congress and briefly be able to, for about 4 months, to be able to serve and work with you, Paul. So I just wanted to say congratulations, and we wish you all the best.

Mr. MURPHY of Connecticut. Well, it pains me to admit that I spent far too much of my life watching this House from a distance. And so I share those thoughts and I am so glad Mr. ALTMIRE would bring that up on this day.

With that, before we end our hour, we're going to allow our honored guest, who we hope is joining us for the first of many visits with the 30-Somethings.

As our veteran Members abandon us, our new Members step up. And Mr. HODES, if you might inform folks how they might find us via e-mail and via the Web.

Mr. HODES. Well, as I said at the beginning of the hour, Mr. MURPHY and Mr. ALTMIRE, I'm on the ''something'' side of 30, but I am glad to be with you because I am hoping that we, together, have brought an energy to this Congress that really has set a new tone and will help us set a new direction for this country, not just on the war on Iraq, but on health care, on energy, on education and all the policies that the American people want us to get to work on and we've been working hard on.

Before we go, I do want to say that Speaker PELOSI's 30-Something Working Group can be e-mailed at 30somethingdems@mail.house.gov. The 30-Somethings, whom I am now a proud guest, being on the something side, can be visited, and here is the Web site address on this chart, www.speaker.gov/30something/index.html.

So I invite everybody who has been working tonight to visit the 30-Something Web site for information on what the agenda for America is that Democrats have been working on. And I thank you for the opportunity to be with you.

Mr. MURPHY of Connecticut. Thank you very much. I thank the Speaker for giving us this opportunity once again.

THE FUTURE OF MEDICINE

The SPEAKER pro tempore. Under the Speaker's announced policy of January 18, 2007, the gentleman from Texas (Mr. BURGESS) is recognized for 50 minutes as the designee of the minority leader.

Mr. BURGESS. Madam Speaker, I come to the House tonight to talk about something that isn't number one or number two or perhaps even number three on the list of things that people are concerned about, it is number four, it is health care, health care in our country that is provided by the private sector, that is provided by the public or the government sector. It is a debate that we will be hearing a lot more about as we get deeper into a year that's going to be consumed by presidential politics.

Right now in our country we have an amalgam, if you will, of health care, part paid by the government, part paid by the private sector. I am oversimplifying for the purposes of debate, but the public or government sector, in pure dollar amounts, accounts for about 50 percent of the health care expenditures in this country. The private is sector insures about 160 million Americans, and that is roughly 50 percent of the lives covered by private insurance in this country. And we will have the debate, as the presidential

year unfolds, more government, more private sector. But tonight, what I really want to do is focus on the physician workforce, the physician workforce that we have now and the physician workforce that we might expect to have in the future.

Alan Greenspan, about a year and a half ago, right as his last days at the Fed were winding down came and talked to a group of us one morning, and inevitably the question came up about Medicare. In fact, we saw the trustee's report yesterday; everyone is concerned about the funding for Medicare, the future obligation that is there in Medicare. And Mr. GREENspan was pretty circumspect, he said, ''At some point I expect the Congress to deal with the problem of funding.'' And then he went on to say, ''What concerns me more is will there be anyone there to provide the services when you want them?'' That really struck a cord with me. And in fact last month, the month of March, back in my home State of Texas my Texas Medical Association puts out a periodical every month called ''Texas Medicine,'' and the cover story was in fact dedicated just to that concept, ''Running Out of Doctors.'' And the thrust of the article is how do we keep the medical students that we graduate from Texas schools, how do we keep them practicing in Texas, particularly in the high-need areas in Texas? And concentrating on the physician workforce is what I want to do during this discussion, in the time that I have available for the discussion this evening.

My perspective, of course, 30 years ago I graduated from medical school in Houston, Texas, so I do have the perspective of looking back over the last 30 years. But I also want us to look over the horizon to the next 30 years. What about the young man or woman who is graduating from medical school this year, what kind of world do they want to find themselves practicing in? What type of practice environment do they want to see that we have laid out for them 30 years from now? It is going to be important that we take the correct steps today in order to provide the correct practice environment 30 years from now.

Since we're talking about the physician workforce, the part that the government pays for is paramount, that is critical. And really the thing that I want to focus on of that government sector is the pricing and the payment schedule in the Medicare program itself.

□ 2315

Medicare, a good program, just celebrated its 41st or 42nd birthday. We had the second anniversary of the prescription drug benefit part D, which in my first year here we passed in 2003 and was added on in the year 2006.

Medicare is an integrated program. Part A is the hospital, part B is the doctor's care, part C is the Medicare, what is now called the Medicare Advantage Plans or the HMOs, and part D is the prescription drugs. But while it is an integrated program, the funding for Medicare actually exists in funding silos.

If we look at the comparative payment updates from the year 2002 to projected 2007, you see that there is something wrong with this picture. And what is wrong with the picture is that physician reimbursement in part B is significantly lagging behind the payment updates for the Medicare Advantage Plan's hospitals and nursing homes are shown on this graph. And there is a reason for that. It is really not a very difficult reason: Medicare Advantage Plan's hospitals and nursing homes receive every year essentially a cost-of-living update. It is a market-basket update that they receive based on the cost of inputs from the previous year. CMS has actuaries that go back and figure this out: What did it cost the hospitals to provide the care that they delivered to our seniors?

Part B is calculated differently. Part B is what is described as a volumetric formula. It weights volume and intensity. But basically you have a fixed amount of money, a finite pie, that if more and more people are submitting claims, the slices get progressively smaller. And in 2002, you can see there was a big drop. The reason 2003, 2004, 2005 are not a downward projection is because in fact at the last minute, Congress swept in and said we are going to do something to prevent this from happening. And, in fact, doctors got a modest update in 2003, 2004, 2005. 2006 doesn't really show up because that was a zero percent update.

Now, Madam Speaker, I have not been in Washington all that long, but I have learned some of the parlance and the lexicon that we use here. And in any other Federal program or any other federally funded program, if you are held to a level funding or a zero percent update for that year, anyone else would regard that as a cut. But we told the doctors that was great, you are going to get a zero update for that year and you will be happy for it.

Projected for 2007, if we don't do something, is going to be a substantial decrease. Once again, we may very well ride in at the last minute and do something to blunt the effect of that; but year in and year out, this problem continues; and the real insidious part of this is the dollars to fix the problem get higher and higher every year.

Last year I introduced a bill to just simply do away with the SGR and replace the SGR with a market-basket update. It is called the Medicare Economic Index. And it is not my idea; a group called MedPac, a Medicare Payment Advisory Commission, worked this out in actuarial fashion some years ago. And the Medicare Economic Index would in fact provide a 2 to 2½ percent update for most years based on the cost of input for the physicians providing the services to the patient.

The cost last year scored by the Congressional Budget Office of replacing the SGR formula with the Medicare Economic Index was $218 billion. Clearly, that is a lot of money, and it disrupts any budget that either party might put up there. So, as a consequence, I didn't get a lot of activity on that bill last year. It is still important to do. And every year that we delay doing something, and even those years that we come in and it looks like we fixed it a little bit, we actually just compound the problem and make it worse in subsequent years.

So in just very general terms for this evening's talk, we have got a lot of people who are going to be joining the Medicare generation. As the baby boomers age and retire, the demand for services is going to go nowhere but up. And if the physician workforce trends continue as they are today, we may be not talking about funding a Medicare program, we may be talking about there is no one there to take care of the seniors.

In my home State of Texas, the number of physicians between 1995 and 2005 increased by 46 percent or nearly 5,000. Okay, that is good, it went up. However, the State is still below the national average, the national average being 230 physicians per 100,000 population. In Texas the ratio, even with the increase, is 186 to 100,000 residents.

The American Academy of Family Physicians predicts serious shortages of primary care doctors in five States, including Texas, and says that all States will have some level of family physician shortage by the year 2020. The Council on Graduate Medical Education, a congressionally authorized entity, estimates that after 2010, growth in the physician workforce will slow substantially; and after 2015, the rate of population growth will exceed the rate of growth for the number of doctors. In other words, we won't be keeping up anymore. At the same time, the demand is only going to increase year over year, resulting in critical shortages, particularly in primary care, but the reality is all specialties may well be affected.

So my thesis, my proposition, is that Congress needs to approach this sort of as a three-pronged attack or a three-pronged solution to mitigate this shortage for the future, to improve payments to current doctors, keep them in practice longer, improve Federal assistance to medical students, encourage students to go into high-need specialties, and increase the number of residency training programs, particularly in rural and suburban areas, and keep the physician pipeline open.

To do that, I am going to be next week introducing three bills to deal with those three areas. The first, to insure the physician workforce, really deals with the Medicare funding and the SGR. You talk to doctors my age, those who graduated from medical schools 30 years ago, and their concerns are really consistent. They are concerned about the liability environment, which is not part of tonight's

discussion but one that we certainly need to have and I hope we do have in this Congress this year. Their concern is the year-over-year reduction in payment that the Center for Medicare and Medicaid Services comes up with for physician reimbursement. And it is not just a question of doctors wanting to make more money; it turns to be a real patient access problem, because there is not a week that goes by that I don't get a letter or fax from someone who says, you know what, I have just had enough and I am going to retire early, I am no longer going to see Medicare patients in my practice, or I am going to restrict the procedures that I offer Medicare patients.

Unfortunately, I know that is happening because I saw it in the hospital environment before I left the practice of medicine to come to Congress. But I also hear it in virtually every town hall that I do back in my district. Someone will raise their hand and say, How come on Medicare, you turn 65 and you have got to change doctors? And the answer is, because their doctor found it no longer economically viable to continue to see Medicare patients because they weren't able to pay the cost of delivering the care, let alone making any money on top of it. They weren't able to cover the cost of providing the care.

So in the bill to address that, the bill that I introduced last year, again, just simply repealed the SGR outright. The difficulty that I had with that was, again, just the cost was too high. But if we do that over time, perhaps we can bring that cost down to a level where it is manageable.

Getting the payment policy right in Medicare is going to be the first order of business for preserving the physician workforce. Paying physicians fairly will extend the careers of many physicians who are now in practice who would otherwise opt out of the Medicare program, seek early retirement, or restrict those procedures that they offer to their Medicare patients.

It also has the effect of insuring an adequate network of doctors available to older Americans as this country makes the transition to the physician workforce of the future.

In the bill, the SGR formula, this volume-based formula would be repealed in 2010, 2 years from now, but also provide incentive payments based on quality reporting and technology improvements to protect the practicing physician against that 5 percent cut that is likely to happen in 2008 and 2009. That would be voluntary. No one would be required to participate in the quality program or the technology improvement, but it would be available to those doctors or practices who wanted to offset the proposed cuts that will occur in physician reimbursement in the 2 years until the formal repeal of the SGR happens.

Now, why do it that way? Why not just bite the bullet and let's go ahead and get the SGR out of the way and get it repealed? Remember, it costs a tremendous amount of money to do that. Another problem that we have in Congress is we are required to submit all legislation to the Congressional Budget Office to find out how much it costs. If we are going to be spending the taxpayers' money, how much are we going to spend? Over what time will we spend it?

So that is not unreasonable, but because of the constraints of the Congressional Budget Office, we are not allowed to do dynamic scoring. We all knew, for example, when we began the prescription drug benefit 2 years ago, that if you deliver medications in a timely fashion, the timely treatment of disease, you are going to get better patient outcomes. And, in fact, that is what the trustee's report for Medicare that was released yesterday, although it still shows that we have got a big problem in paying for Medicare, the actual outlays for Medicare were down. And the reason they were down, I suspect, is a compendium of things; but part of it is treating disease in a timely fashion, not always catching it at the end stage but treating it at the beginning, you are going to end up with more functional individuals, to be sure, so they are going to continue to be productive in society. But the overall cost of Medicare is going to go down.

Unfortunately, we can't do that look-ahead with the Congressional Budget Office and say, you know, I think if we do this, we are going to save some money. So give me credit for that against that SGR score that you always rate my bill with. They won't and they can't do that.

So by postponing the repeal of the SGR by 2 years' time, taking the savings that occurs during that time and applying it to the SGR formula, actually may give us a number that is doable as far as releasing the SGR and replacing it with the Medicare Economic Index.

One of the main thrusts of this bill is to require the Center for Medicare and Medicare Services to look at their top 10 conditions that drive the highest percentage of payments in Medicare part B, and require CMS to adopt reporting measures relating to these conditions that have already been developed. It is not reinventing the wheel. The AMA Physician Consortium has already developed those reporting measures that drive that spending so high.

You know, the old famous bank robber Willie Sutton when he was asked why do you rob the bank, he said that is because that is where the money is. Let's go to those top 10 things where the greatest amount of money is spent, because that is where the greatest amount of savings can occur. If we can deliver care in a more timely fashion and if we can improve outcomes, we are actually going to spend less. And by focusing on those top 10 programs, at least initially, that will be the greatest return on investment for CMS and ultimately will be the greatest return on investment for retiring the SGR.

The same considerations may apply to the Medicaid program as well, so it will be a very useful exercise to go through that and identify those top 10 conditions. And where cost savings may be most easily gathered, not only will it have an improving effect on Medicare, but I suspect on Medicaid as well. We are going to establish quality measures focusing on these core conditions, and that is where the add-on payment for those 2 years, that is where half of it will come from. A 2½ percent update for those physicians who do voluntarily report quality measures on those top 10 conditions, that is where the protection from the continuation of the SGR for 2 years, that is where that protection will derive from.

We are going to report back to doctors on what their volume and intensity is. This information will not be made generally public, but it will be made available to the individual physician so they can see how they are doing, how they are doing relative to other doctors in their practice, other doctors in their community, other doctors around the country.

But the important point here is these are voluntary measures that will protect the physicians from the cuts that are inevitably going to occur as a result of the SGR program until the SGR can actually be repealed.

□ 2330

But, physicians can opt to take advantage of the bonuses, and it is going to return some value back to their businesses and return value to the taxpayer. Again, there may be an unintended benefit for the parallel Federal program to cover poor Americans under the Medicaid program if some of these programs deliver the benefit back that it is anticipated that they will.

The quality measures are going to be built around these high-cost conditions, and strive to improve the quality of care not only for those conditions and patients, but to drive down the cost of delivering Medicare.

There is also going to be a provision in the bill to help physicians' offices to bring their information technology, their infrastructure, hardware and software, bring it up to a standard where it will begin to derive benefit to not only the patient and the practice but to the Medicare system in general.

The percentage add-on payment is proposed to be 2½ percent, so those two bonus payments in aggregate would be 5 percent. And again, that is designed to be a protection against what are the anticipated reductions in payments that would occur in 2008 and 2009.

The provision will also create a safe harbor that will allow clinics, physicians' offices, and hospitals to share health information technology platforms, and the standards will be established and available to physicians' practices so they will understand how they need to comply with this. The

standards must be established no later than January 1, 2008.

Madam Speaker, I wasn't always a big proponent of things like electronic records. I wasn't sure if it would deliver the payoff that people said it would. But here is a picture of the medical records department in Charity Hospital in New Orleans. This picture was made in January 2006, about 4 or 5 months after Hurricane Katrina and the downtown flooding that occurred. It is the medical records room. These records are ruined. You can see, this is not smoke or soot damage, this is black mold that is growing on the records. You look there and it almost goes on to infinity, tens of thousands, hundred of thousands of records that were active, ongoing charts of people's medical conditions absolutely now unavailable. No one is going to get into that medical records department and risk inhaling the spores from the mold that is covering those charts.

This is the kind of problem that you can get into with a paper medical record. Of course the youngsters of today, the college students of today, the young physicians of today, they understand this very well. They are all connected and wired in. They would no more imagine turning in or doing a paper for one of their classes where they just had a single copy, a single paper copy, the old adage ''the dog ate my homework,'' most students will have a paper on a disk, on a flash drive and readily accessible and retrievable in many forms. We should do no less with our medical records.

But it costs money to do this. It is going to require a push for the private sector. I prefer to think as a bonus payment as being an inducement, an enticement for physician's offices to participate in this type of program. But it is also just good medicine. It is good patient care.

We all heard about the troubles at Walter Reed Hospital a few months ago. I went out to Walter Reed probably the week after the story broke in the Washington Post and talked to this young man who took me around Building 18. Yes, there was some concern. It was a crummy building. But his biggest concern was spending hours and hours with his medical record, his service record, going through the various parts of that and highlighting things. He had a yellow marker, a highlighter, highlighting parts of his medical record because this is how he was going to establish the benefits that he was going to receive in the VA system for his disability.

He said I can spend 20 man-hours putting this medical record together and it ends up on someone's desk and it doesn't get picked up, and then no one can find it and I have to start all over again. That was his main message to me that day.

Now the VA system has been indeed very forward-thinking in its embrace of electronic medical records and its investment in information technology. The problem is the medical records from the Department of Defense and the Department of Veterans Affairs do not possess the interoperability necessary to make this type of activity unnecessary.

So clearly delivering value to the patient, particularly a patient in that situation, is of paramount importance. And it is my contention that if we do make the bonus payment generally available to physicians, this will be something that they will embrace. There is a learning curve, to be sure. It is going to slow people down a little bit initially. But ultimately, the rapidity of the system will be impressive. And even in a smaller physician's office the ability, just think, never having to wait while they find your medical record because somebody didn't put it back in the right place. I know it happened in my medical practice, and I suspect it happens in offices across the country on a regular basis. If nothing else, you will save that time and embarrassment of not being able to locate a patient's record.

One of the problems last year when we dealt with trying to provide the health information technology bill that we passed here in the House and were never able to come to agreement with the Senate, part of the difficulty was being able to have the hospital and the clinic and the physician, there may need to be some relaxation in what are called the star clause to allow safe harbors so that these conditions can be met.

But the reality is that once people become used to this technology will embrace it. The other unintended consequence, the other unintended benefit of this is the rapidity with which the system can learn. When I say the system, the entire health care system because wouldn't it be nice to know which treatments deliver on the promise of getting people better faster at a lower cost. Wouldn't it be great to have that information and know what treatments were effective and what treatments were only marginal? That information can be literally at a physician's fingertips with the right type of computer architecture and technology environment. I believe the time has come that we do need to embrace that.

So the bill will include a Federal incentive to implement health information technology along with provisions providing safe harbors for the sharing of software, technical assistance and hardware, as well as the creation of consortiums.

Now, it is not just about physicians my age, because we have got to also concentrate on helping the younger doctors with residency programs. The funny thing about doctors is we to have a lot of inertia. A lot of us tend to practice very close to where we did our training. So the idea to get more training programs in areas that are underserved, rural areas, inner city areas, to get more training areas where the doctors themselves are actually needed.

So the second bill or the second prong of this three-pronged approach would be to develop a program that would permit hospitals that do not traditionally operate a residency training program, allow them the opportunity to start a residency training program to build the physician workforce of the future.

This bill would create a loan fund available to hospitals to create residency training programs where none has operated in the past. The programs would require full accreditation and generally be focused in rural, suburban, inner urban or frontier community hospitals.

On average, it costs $100,000 a year to train a resident and that cost for a smaller hospital can be prohibitive. The other issue is in 1997 the Congress passed what was called the balanced budget amendment and within that there is a residency cap that also limits resources to nontraditional residency hospitals such as smaller community hospitals. For the purposes of this bill, the loan amount to any institution would not exceed $1 million, and the loan itself would constitute start-up funding for a new residency program. And the start-up money is essential. Since Medicare graduate medical education funding can be obtained only once a residency program is firmly established, the cost to start a training program for a smaller, more rural or suburban hospital can be cost prohibitive because these hospitals operate on much narrower margins.

The overall bill would authorize a total of $25 million to be available over 10 years. The fund, of course, would be replenished because these are constructed as loans and the Health Resources Service Administration may make the loans available to new loan applicants or extend loans to increase the number of residency slots available at existing programs or a loan to continue newly established residency programs to hospitals that have been approved.

To be eligible, a hospital must demonstrate that they currently do not operate a residency training program, have not operated a residency training program in the past, and that they have secured preliminary accreditation by the American Council on Graduate Medical Education.

Additionally, the petitioning hospital must commit to operating an allopathic or osteopathic residency program in one of five medical specialties, or a combination of these specialties: Family medicine, internal medicine, emergency medicine, obstetrics and gynecology, or general surgery. Again, the hospital may request up to $1 million to assist in the establishment of this new residency program. Funding could be used to offset the cost of the residents' salaries and benefits, faculty salaries and other costs directly attributable to the residency program.

The bill would require the Health Resources Services Administration to

study the efficacy of this program in increasing the number of residents in family medicine, internal medicine, and primary care, and whether the program led to an increase in the number of available practitioners in these specialty areas, particularly in underserved areas. The loans would be made available beginning January 1, 2008, and the program would be sunsetted in 10 years time, January 1, 2018, unless Congress elected to reauthorize the program.

The third prong of the physician workforce for the future would be ensuring the availability for adequate future physicians, and provide medical students with assistance and incentives to practice in shortage specialties and shortage areas.

The third bill would establish a mix of scholarships, loan repayment funds, and tax incentives to entice more students to medical school and create incentives for those students and newly minted doctors to become primary care, family physicians, general surgeons, OB/GYNs and practice in shortage areas such as rural or frontier areas.

This bill would provide additional educational scholarships in exchange for a commitment to serve in a public or private nonprofit health facility determined to have a critical shortage of primary care physicians.

□ 2345

Such scholarships will be treated as equivalent to those made under the National Health Service Corps Scholarship Program and penalties apply for those that take advantage of the scholarships but do not go into one of those practice areas.

This will be a 5-year authorization, authorizing these loans and grants to be $5 million a year. The scholarship amounts will not exceed $30,000 per year. The scholarship amounts may be adjusted based on financial need, geographic difference and educational costs.

Again, this is going to be administered through the Department of Health and Human Services, specifically through the Health Resources Service Administration.

This program will have an established repayment program for students who agree to go into family practice, internal medicine, emergency medicine, general surgery, or OB/GYN, and practice in underserved areas. Again, HRSA will administer and promulgate the requirements. Recipients must practice in the prescribed specialty and prescribed area, which is designated as an underserved area, and the practices may include solo or group practices, clinics, public or private nonprofit hospitals. Again, a 5-year authorization at $5 million per year.

This will establish the Primary Care Physician Retention and Medical Home Enhancement grants to help ensure that primary care physicians continue to provide coordinated medical care to patients in underserved areas or high-risk populations. Now, I know we can all think of areas like that in our home districts and home States.

Also, in an area such as the gulf coast area where so many physicians left after the devastating twin hurricanes of Katrina and Rita a year and a half ago, it has been very hard on doctors in those areas. Many doctors have left. It is going to be difficult to attract doctors back to that area, and this will be yet one more tool, one more way, to get doctors to consider practicing in an area where the need is great.

This encourages States to establish Physician Workforce Commissions, especially in rural areas and in certain practice specialties such as family medicine, again basically primary care, by exempting from income tax any amount paid by the Physician Workforce Commission in the form of salary to a physician who has signed a contract with the political subdivision to practice in that area for any amount of time, no fewer than 4 years.

Every year there would be a report back to Congress about the effectiveness of this program, that is, once again, are we spending our dollars wisely, are we getting what we thought we would get when we initiated that program.

So, Madam Speaker, those are three bills that, again, I will be introducing during the week next week after we get back. I think these, while they may not be the answer to all the problems, certainly focus on where the problem areas exist, that is, physicians who are my age, 50 years plus or minus a little bit, who are in the Medicare program but looking to drop out or opt out because they can no longer continue their practices because we in Congress are cutting reimbursements to the point where we are no longer paying our fair share. We are no longer paying the freight on taking care of Medicare patients, but in addition to that, looking over the horizon to the future, being sure that we have the physician workforce of the future, to provide care for the baby boomers who are getting older, but just being able to provide that care in general.

In fact, we are not even talking about just the Medicare population here. We are talking about doctors who are going to work in primary care in a medically underserved area in a specialty which is in short supply in that area. That dual approach of increasing the number of residency slots, again, doctors tend to go into practice and stay in practice where they trained, and the other, a loan forgiveness program and a tax incentive program to young physicians getting out of school, may have several hundred thousand dollars in debt from their undergraduate and then their medical school training, this is a way for them to begin their careers without having that incredible debt load to carry with them, a loan forgiveness, a tax incentive program, provided they are willing to give back some time in a medically underserved area in a specialty that is in high medical need.

I believe that by taking these three steps, Madam Speaker, we really will go a long way towards alleviating the physician shortage. There is no question that we are going to need to devote a lot more time and energy to how we approach the problem dealing with health care in this country and dealing with the uninsured. I expect to have many more hours on subsequent evenings in the coming weeks to talk about just this problem and just what are some of the approaches that may be taken.

We had a fairly long hearing in committee this morning, in my committee, the Health Subcommittee of Energy and Commerce, hearing from a variety of people about how to provide additional care for the uninsured. Again, it is going to be a lively debate, what happens in the private sector or do we just simply give it over to a government program, perhaps bring the age for eligibility for Medicare down lower and lower, expanding the SCHIP program higher and higher, and then the two programs will meet in the middle and provide coverage for everyone in the country. I do not think that is necessarily a good way to go.

I think there are some reasons that the private practice of medicine does bring value to the entire American medical system. There is no question we have no shortage of critics in this country and around the world about the system of health care in this country, but my opinion, it is the American system that stands at the forefront of innovation in new technology, precisely the types of system-wide changes that are going to be necessary to efficiently and effectively provide care for Americans in the future.

There was an article in the New York Times published October 5, 2006, by Tyler Cowan. He writes, ''When it comes to medical innovation, the United States is the world leader. In the past 10 years, for instance, 12 Nobel prizes in medicine have gone to American-born scientists working in the United States, three have gone to foreign-born scientists working in the United States, and just seven have gone to researchers outside of the country.''

But he does go on to point out that five of the six most important medical innovations of the past 25 years have been developed within and because of the American system.

The fact is the United States is not Europe. American patients are accustomed to wide choices when it comes to hospitals, physicians, and pharmaceuticals. Because our experience is unique in this country, because Americans indeed are exceptional and we are different from the types of programs that are in other countries, this difference should be acknowledged and embraced, whether we are talking

about public or private health insurance programs.

Madam Speaker, it has been a long day and we have gone fairly late into the evening. I appreciate the time.

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

Mr. CUMMINGS, for 5 minutes, today.

Mr. MCDERMOTT, for 5 minutes, today.

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

Mr. DEFAZIO, for 5 minutes, today.

Mr. WATSON, for 5 minutes, today.

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

Mr. WYNN, for 5 minutes, today.

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

Mr. POE, for 5 minutes, on May 2.

Mr. BOOZMAN, for 5 minutes, today.

Mr. DUNCAN, for 5 minutes, today.

Mr. MURPHY of Pennsylvania, for 5 minutes, today.

Mr. CONAWAY, for 5 minutes, today.

Mr. JONES of North Carolina, for 5 minutes, May 1, 2, and 3.

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

SENATE ENROLLED BILL SIGNED

The SPEAKER announced her signature to an enrolled bill of the Senate of the following title:

S. 521. An act to designate the Federal building and United States courthouse and customhouse located at 515 West First Street in Duluth, Minnesota, as the ''Gerald W. Heaney Federal Building and United States Courthouse and Customhouse''.

BILLS PRESENTED TO THE PRESIDENT

Lorraine C. Miller, Clerk of the House, reports that on April 24, 2007, she presented to the President of the United States, for his approval, the following bills.

H.R. 137. To amend title 18, United States Code, to strengthen prohibitions against animal fighting, and for other purposes.

H.R. 727. To amend the Public Health Service Act to add requirements regarding trauma care, and for other purposes.

H.R. 753. To redesignate the Federal building located at 167 North Main Street in Memphis, Tennessee, as the ''Clifford Davis and Odell Horton Federal Building''.

H.R. 1003. To amend the Foreign Affairs Reform and Restructuring Act of 1998 to reauthorize the United States Advisory Commission on Public Diplomacy.

H.R. 1130. To amend the Ethics in Government Act of 1978 to extend the authority to withhold from public availability a financial disclosure report filed by an individual who is a judicial officer or judicial employee, to the extent necessary to protect the safety of that individual or a family member of that individual, and for other purposes.

ADJOURNMENT

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

The motion was agreed to; accordingly (at 11 o'clock and 53 minutes p.m.), the House adjourned until tomorrow, Thursday, April 26, 2007, at 10 a.m.

EXECUTIVE COMMUNICATIONS, ETC.

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

1269. A letter from the Deputy Director, Defense Security Cooperation Agency, transmitting Pursuant to the reporting requirements of Section 36(b)(1) of the Arms Export Control Act, as amended, Transmittal No. 07-16, concerning the Department of the Air Force's proposed Letter(s) of Offer and Acceptance to Norway for defense articles and services, pursuant to 22 U.S.C. 2776(a); to the Committee on Foreign Affairs.

1270. A letter from the Deputy Director, Defense Security Cooperation Agency, transmitting Pursuant to the reporting requirements of Section 36(b)(1) of the Arms Export Control Act, as amended, Transmittal No. 07-12, concerning the Department of the Navy's proposed Letter(s) of Offer and Acceptance to Korea for defense articles and services, pursuant to 22 U.S.C. 2776(a); to the Committee on Foreign Affairs.

1271. A letter from the Deputy Director, Defense Security Cooperation Agency, transmitting Pursuant to the reporting requirements of Section 36(b)(1) of the Arms Export Control Act, as amended, Transmittal No. 07-21, concerning the Department of the Air Force's proposed Letter(s) of Offer and Acceptance to Israel for defense articles and services, pursuant to 22 U.S.C. 2776(a); to the Committee on Foreign Affairs.

1272. A letter from the Deputy Director, Defense Security Cooperation Agency, transmitting Pursuant to the reporting requirements of Section 36(b)(1) of the Arms Export Control Act, as amended, Transmittal No. 07-17, concerning the Department of the Navy's proposed Letter(s) of Offer and Acceptance to Turkey for defense articles and services, pursuant to 22 U.S.C. 2776(a); to the Committee on Foreign Affairs.

1273. A letter from the Deputy Director, Defense Security Cooperation Agency, transmitting Pursuant to the reporting requirements of Section 36(b)(1) of the Arms Export Control Act, as amended, Transmittal No. 07-11, concerning the Department of the Navy's proposed Letter(s) of Offer and Acceptance to Korea for defense articles and services, pursuant to 22 U.S.C. 2776(a); to the Committee on Foreign Affairs.

1274. A letter from the Assistant Legal Adviser for Treaty Affairs, Department of State, transmitting Copies of international agreements, other than treaties, entered into by the United States, pursuant to 1 U.S.C. 112b(a); to the Committee on Foreign Affairs.

1275. A letter from the U.S. Global AIDS Coordinator, Department of State, transmitting a certification related to the Global Fund to Fight AIDS, Tuberculosis and Malaria, pursuant to Public Law 109-102, section 525; to the Committee on Foreign Affairs.

1276. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting a Report on Denial of Visas to Confiscators of American Property for the period of April 1, 2006 through March 31, 2007, pursuant to 8 U.S.C. 1182d; to the Committee on Foreign Affairs.

1277. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting a copy of Presidential Determination No. 2007-16, pursuant to Section 534(d) of the Foreign Operations, Export Financing and Related Program Apporpriations Act of 2006, Pub. L. 109-102; to the Committee on Foreign Affairs.

1278. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting a proposed removal from the United States Munitions List of the Commercial Primary Instrument Systems, pursuant to Section 38(f) of the Arms Export Control Act; to the Committee on Foreign Affairs.

1279. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting a report pursuant to the Cooperative Threat Reduction Act of 1993 and the FREEDOM Support Act; to the Committee on Foreign Affairs.

1280. A letter from the Chairman, Federal Communications Commission, transmitting the Commission's FY 2006 Annual Report required by Section 203 of the Notification and Federal Antidiscrimination and Retaliation Act of 2002, Pub. L. 107-174; to the Committee on Oversight and Government Reform.

1281. A letter from the Secretary, Federal Maritime Commission, transmitting the Commission's report on the amount of acquisitions made by the commission from entities that manufacture articles, materials or supplies outside the United States, pursuant to Section 641 of the Consolidated Appropriations Act of 2005; to the Committee on Oversight and Government Reform.

1282. A letter from the Director, National Science Foundation, transmitting the Foundation's annual report for FY 2006 prepared in accordance with Title II of the Notification and Federal Employee Antidiscrimination and Retaliation Act of 2002 (No FEAR Act), Public Law 107-174; to the Committee on Oversight and Government Reform.

1283. A letter from the Director, Office of Personnel Management, transmitting the Office's ''Major'' final rule — Examining System and Programs for Specific Positions and Examinations (Miscellaneous) (RIN: 3206-AK86) received March 22, 2007, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Oversight and Government Reform.

1284. A letter from the District of Columbia Auditor, Office of the District of Columbia Auditor, transmitting a report entitled, ''Letter Report: Sufficiency Review of the Water and Sewer Authority's Fiscal Year 2007 Revenue Estimate in Support of $50,000,000 in Commercial Paper Notes''; to the Committee on Oversight and Government Reform.

1285. A letter from the President & CEO, Overseas Private Investment Corporation, transmitting the Corporation's FY 2006 Annual Report required by Section 203 of the Notification and Federal Antidiscrimination and Retaliation Act of 2002, Pub. L. 107-174; to the Committee on Oversight and Government Reform.

1286. A letter from the Program Analyst, Department of Transportation, transmitting the Department's final rule — Standard Instrument Approach Procedures; Miscellaneous Amendments [Docket No. 30533 ; Amdt. No. 3203] received March 15, 2007, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

1287. A letter from the Program Analyst, Department of Transportation, transmitting the Department's final rule — Standard Instrument Approach Procedures; Miscellaneous Amendments [Docket No. 30531 ;