Line 22, ''Mining costs (difference between regular tax and AMT).'' They keep switching back and forth.

Line 23, ''Research and experimental costs (difference between regular tax and AMT).''

Line 24, ''Income from certain installment sales before January 1, 1987.'' Glad you are keeping up with that.

Line 25, ''Intangible drilling costs preference.''

Line 26, ''Other adjustments,'' you have always got to have other, ''including income-based related adjustments.''

Line 27, ''Alternative tax net operating loss deduction.''

And finally, line 28, you get to ''Alternative minimum taxable income.'' And there are some instructions, though. ''Combine lines 1 through 27. (If married filing and line 28 is more than $200,100, see page 7 of the instructions).''

That is just Part I. We will save Part II and III for a future date to work you through that.

Mr. SHUSTER. I do not know if I can take it. You have just made the case on why we need to scrap this tax code and start with something new. I do not know.

Mr. CONAWAY. This is the alternative. The regular tax code is much simpler. It is straightforward.

Mr. DAVIS of Kentucky. I think the one thing that gets lost in all this, too, I remember when I was young and I did a little work on the side when I was first in the aerospace industry and I thought it was so great to make a little bit of extra money basically to pay for Christmas, and when I went in to do my taxes the following spring, I found out that at the very low-income level I was at, because it was independent contractor work, that heralded the alternative minimum tax and almost made it not worthwhile to have expended the many hours that I did on the project.

I think what gets lost, what Mike was reading here, I still am marvelling that our tax dollars paid to create such a behemoth, that we were investing in something like that, which gave me a headache just listening to it. Although I could see the goose bumps there.

But other than being a job creation program for accountants, most of whom do not like the complexity of many of these rules because of what it does to their clients, I think we need to look at a more human side of the impact that regressive taxes have. By reducing taxes, by allowing people to keep more of their own money, it created jobs, over 7 million jobs. It has kept our money local.

I think that one of the things I would like to point to for folks here who are watching the Countdown Crew, and you can contact us at countdowncrew@mail.house.gov, we want to create taxpayers, not raise taxes. By creating taxpayers, there will be more revenues that go for all of our communities.

But at the local level, oftentimes the question comes up and I hear it from children a lot in the schools who go around talking with my own kids, Daddy, where do the police come from, where do the school teachers come from, where does the library come from. Ultimately, that comes from our local communities, from taxes. It is property taxes in the vast majority of our taxes that pay for our schools.

My oldest daughter is about to graduate from college soon, and she is going to become a schoolteacher and getting ready to move out into the economy and very excited on the one hand, but also concerned about the tax structure that is going to be facing her and the incentives to advance her education, the burdens that are going to be placed upon her just from what she has seen in the workforce. The quality of our schools is largely funded by local jobs in our communities that pay those property taxes, people who can buy homes, and if you do not have a job, it becomes very difficult to make that investment in a home.

If we do not have small business owners creating jobs, we are not going to have those local taxes to be able to make the investments that are necessary in public safety, in public works, that keeps the water running in our house, that keeps the electricity moving, that keeps our roads paved and being able to expand and ultimately to be able to invest in quality of life in our communities.

□ 2130

This is one of the reasons we have this 1,335-day countdown to the largest tax increase in history, that the American people need to know that when they can keep more of their own money, there are results. I don't want to see the average Kentucky family have an unnecessary tax increase of $2,563. We will find the benefit, not in complex tax documents like that, but simply by allowing people to keep their money to invest in the future to follow their vision and ultimately to build that nest egg for their children.

Mr. SHUSTER. I am getting ready to close. The gentleman from Texas seemed pretty worked up about getting something out. Do you have something else you want to get out here?

Mr. CONAWAY. The IRS on some of the forms gives an estimate of how much time they think it takes taxpayers to comply with a particular form. I was looking through the instructions real quickly to see if they had this made that estimate.

Mr. SHUSTER. I have the time estimate, if you are filling out your own taxes it's anywhere from 8 hours to 27 hours, if you did it yourself, which is a considerable amount of time for an individual.

Mr. DAVIS of Kentucky. I think it was 6.4 billion hours were taken this year.

Mr. SHUSTER. Right, $265 billion.

In closing, I just wanted to point out, as the gentleman mentioned, the importance of keeping your own money, being able to invest it, being able to save it. I think a lot of times Americans feel helpless, hopeless over this tax situation.

You get that paycheck, and as my 18-year-old daughter just got a paycheck, came home, showed it to me and said, why did they take so much out? I said, well the good news for you is they are going to give you most of most of it back, because you're not going to make the minimum.

But as I said, Americans feel helpless or hopeless in a tax situation, but they're not. Americans really have to pay attention to what's going on here in Washington. As we said tonight send us your stories at CountdownCrew@mail.house.gov or send them to your Member of Congress and tell them what you have been able to accomplish with those dollars that you get to keep in your pocket because they are not coming to Washington.

Make sure you are talking to your Member of Congress, communicating with him, telling them that you don't want to see taxes go up. You don't want to see the largest tax increase in American history. You want them to keep their tax rates low. Although many Americans are looking at those tax rates today, think they are high, they are lower than they were 4, 5, 6, 7, 8, 10 years ago.

This Congress has to act. This Congress has to act before all those tax cuts expire by December 31, 2010, and the gentleman is signaling me. We want to make sure that the American people are communicating to their Members of Congress that they want us to stop this tax increase that's going to occur, a tax increase that the Democratic majority is saying, they are not going to increase taxes because they are not going to vote on it, which is just hogwash. The taxes are going to go up for individuals across this country, businesses across this country, if this Congress fails to act in just 1,335 days.

HEALTH CARE IN THE UNITED STATES

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. My colleagues filled the last hour with discussion of what is sublimely intuitive to the most casual of observers of the American scene, the IRS code.

Now we are going to go to something a little more complex and that's health care in the United States.

The question I get asked a lot of times, because I spent my precongressional career as a physician, how did we get into this situation? How did we get the health care system that we have today? More importantly, where are we going within our current system?

We currently have a system that is based upon both the aspects of the public-provided system, the government-

provided system and the private system. We have a system that does have a significant number of individuals who lack coverage. They may not always lack medical care, but they do lack coverage for that care. Some of the things we are going to be, of necessity, focusing on this in Congress is the reauthorization of the State Children's Health Insurance Program. We will also be talking about reauthorizing the Federally qualified Federal health center program.

Health savings accounts have actually been around now for 10 years. It's appropriate to look back on where we have been with, first, medical savings accounts and then the expansion that occurred with the Medicare modernization act in 2003 with health savings accounts. Association health plans are not getting as much attention this year as they have in past years, but they are important, and we do need to think about those in the overall picture of where we are going with America's health care.

Medical liability reform, probably one of the more contentious things that we have tackled in Congress since I came here in 2002 he 2003. We still, as far as a Nation, do not have an answer for that question, but several States have done things, including my home State of Texas, and also that is one of the things that I want to touch on tonight.

One thing that does concern me greatly is the physician workforce today and the physician workforce of the future. I will be spending considerable time talking about things that we might do, the things that are within our grasp to do to help ensure that the doctors of today continue to deliver care for our patients, whether they be in the government sector, or the private sector, and ensure that we encourage the best and brightest among our young people to go into, to look at health care as a profession, whether it be as a physician, as a nurse, and one of the ancillary health services, but it is important that we attract our best and our brightest into those professions and perhaps a look at some of the things that are being tried in some of the States.

The States, of course, are the great laboratories in our democracy. There are some interesting occurrences that are going on in some States that are trying to grapple with the problem of coverage for individuals who lack it; and then, finally, some ancillary issues. We recently passed a trauma bill on this House. Last weekend, the President signed that bill into law.

Transparency, how do we make the expenditures in health care. How do we make information about cost, price and quality, how do we make that information available in an understandable format to the average consumer of health care in this country, whether they be in the private or the public sector.

One of the things that we don't really talk about that often, but is going to be a significant issue, as more and more people my age get successively older and older, is how do we deal with the problem of long-term care facing this country? Well, let's go on a journey. Let's talk about the American health care system.

For the purposes of this discussion, we don't have time to go all the way back to the beginning when our country was founded, though it is important to always note that while the forebearers of today's legal profession were drafting documents like the Declaration of Independence and the Constitution, the forebearers of my profession, Dr. Benjamin Rush, was treating people with leeches. We have come a great distance since that time.

But if you look at just the modern era, the time since the end of the Second World War, when truly some of the big differences that developed between European countries and America, some of those differences, in fact, have their roots in the Second World War. In America, of course, in order to prevent problems with an inflationary spiral that threatened to go out of control, President Roosevelt put price controls on wages and said people could only earn so much.

Well, employers wanted to keep employees working, they wanted to keep employees happy. They asked a question, could we provide benefits to our employees. Can we provide, perhaps, health insurance or health care benefits for our employees and not have that as part of the Federal price controls that were in effect, or Federal wage controls that were in effect at that time?

The Supreme Court looked at it and said, that's reasonable. You can do that. You can provide the health care benefit for your employee, and you will not be violating the provisions of the wage control provisions that were enacted in the Second World War.

Well, the system was working, and the war ended, and the system continued. Because, in fact, it was working well, and people liked getting their insurance that way.

It continued for a number of years. If you look at a country in the European theater, the Second World War, whether they were winners or losers at the end of the war, they faced a humanitarian crisis of almost unbelievable proportion. So it is no surprise that even a country that was victorious, like Great Britain, went down the road of national health insurance, because it needed to provide a great deal of care in a very short period of time, and they didn't have the bedrock of the employer-derived health insurance that was available in this country as a result of wage controls that were put on during the war.

We are often compared with Europe and why our health care system looks different from theirs, when both, after all, are modern western nations. Part of the reason does go back to this discrepancy that occurred during the war, and then, of course, the situation, the economic situation, in some cases, a very dire economic situation that occurred on the ground in Europe as the war ended.

It's not the purpose of this discussion tonight to actually provide a compare and contrast with the European system, though that might be interesting to do, but take where we were at the end of the Second World War, the beginning of the great economic expansion that characterized the post-war years in this country, insurance being provided by employers, employees very happy with that, employees having good coverage, doctors being happy with that, because that coverage meant that hospitals and doctors were reimbursed, and the situation was going along, some problems, of course, and some people in this body, 20 years later, said, we need to do better than what we are doing, because after people are no longer employed, and they, perhaps, lose that health insurance, what are we going to do then?

Twenty years after the end of the Second World War, in 1965, we had the rise of a new system, took probably 4 to 5 years for it to actually work its way through Congress. It was, just like today, a situation like this, was by no means easy. In 1965, President Lyndon Johnson signed into law the Medicare bill that primarily focused on hospital care for the elderly in addition to the hospital care. In addition to the part A of Medicare, there was also developed a part B of Medicare that was a reimbursement for physician-necessitated services. But we had the parts A and B of Medicare that came into being in the mid-1960s, another 40 years before Congress made a significant change to the Medicare system by passing the Medicare prescription drug act.

Now, my father was a physician back in 1965, and I used to tease him that in 1965, when the Medicare system was first enacted, there were, after all, only two medicines, penicillin and Cortizone, and they were used interchangeably. I know, he didn't think it was funny either, but the fact is, we didn't have nearly the tools at hand from a pharmaceutical perspective in 1965. Then fast forward to 2005, 2006 and 2007, ones that are just part of our everyday parlance, our everyday armamentarium in medical practice.

We saw this with the trustees' report that was just released last week or the week before, where it was described that 680,000 hospital beds in 2005 were not filled in Medicare, primarily because of the things we are doing better in Medicare, treating that cholesterol at an early stage with a statin and not treating it at the end stage when cardiac surgery or, in fact, sudden death may be the outcome of undiagnosed or untreated heart disease. So we are doing a better job of treating things early at the same time. It does cost more money in the provision of the Medicare prescription drug act.

There was a great deal of discussion during the time that we passed that

prescription plan, but it kind of sets the stage for the debate that we are going to now have, and going to continue today. Is it better to treat things in the preclinical stage, is it better to treat things in the nonacute stage, or is it better to wait and target your therapy toward the end process of a disease, which, characteristically, is how we handled things in Medicare previously.

But the impetus is, of course, to be more preventive and proactive in taking care of patients. That is the direction in which medicine is going, that is the direction in which science is leading, and that is the direction in which Medicare itself should go.

So I don't think there is any question about which is better, the, the acute-care model, or the long-term model. Furthermore, we will have additional discussion, should this expand the government share of the program, or is there perhaps some room for the private sector, and can they deliver value within the Medicare system as far as providing care for patients?

□ 2145

When I talk about the public and private, let's break it down a little bit. Currently just in rough numbers the government pays about 50 cents out of every health care dollar that is spent in this country. Our gross domestic product is approximately $11 trillion; we spend $1.4 trillion on health care. The Health and Human Service budget alone for Medicare and Medicaid is over $600 billion. Add to that the money that is spent in the Federal prison systems, the VA health system, the Indian health system, all of the other areas where the Federal Government is involved in health care, and it is not difficult to see that you are very close to that number which encompasses 50 percent.

The other 50 percent is certainly not all just simply commercial insurance, though commercial insurance makes up a large portion of that. There is certainly that portion which is self-funded by patients. Believe it or not, there are patients who just simply prefer to pay their bills in cash and continue to do so, and there is a significant number of dollars that are just contributed to the system by doctors and hospitals and nurses and ancillary health care providers because the individuals whom they are taking care of have no health coverage.

In the debate of how to best expand and give people more coverage, you certainly can make the argument for expanding the government system. My personal opinion is that might not be the best way to go about doing things. On the other hand, there are many people within this body who, Mr. Speaker, will be talking at great length, I suspect, over the 18 months leading up to the next election, a great many people in this body who will be talking about just that, expanding the government's role. Again, remember, we are already doing about 50 percent, and they will be looking to expand that.

One of the critical questions we have to ask ourselves in expanding that 50 percent is, are we doing a good job from the government's perspective with the 50 percent that we have now? Are we doing such a superlative job that in fact it is a good thing to push out or crowd out the private sector? Or, are there some areas where the government system perhaps could improve, and some areas that perhaps it is just innately difficult for a large governmental system to improve and where the private sector can in fact do a better job?

One of the things that is frequently asked, and I know I got this the years I was in private practice was, why don't we just do what they did in Canada where they have a national health insurance in Canada and everybody is happy, the doctors are paid and the patients are taken care of? Well, it was probably 2004, 2005 that the Canadian Supreme Court came out with a ruling that access to a waiting list did not equal the same thing as access to care. And I know I will get some criticism about this, Mr. Speaker, but one of the secrets of the Canadian system is the fact that they have on their southern border the United States of America with a significant amount of excess capacity in our health care system; and patients in Canada who can afford to pay, who do not want to wait, simply offload their burden from the Canadian system and come south of the border to have their problems taken care of in a more timely fashion.

In the British National Health Service, of course they have developed within their country a two-tiered system. Some of the most expensive medical care that you can buy today is in the country of Great Britain where they very famously have free care. The reason you can buy private care more expensively is because, again, people want to buy their way out of a waiting list or buy their way out of the public system so that they can get taken care of in a more timely fashion.

One of the problems with a very long waiting list for things like an artificial hip or even coronary angiography for someone who is being worked up for chest pain is you reach a certain point in life, perhaps a person in their 70s or 80s where that 6-month wait, 12-month wait, 14-month wait or longer becomes very detrimental to their overall health because they just simply do not have that many years left from an actuarial perspective.

Well, what about the private sector, and what about Congress' interface with the private sector? Are we doing things that are generally helpful or hurtful to the private sector? And what can we do to promote policies that do keep the private sector engaged in providing health care in this country?

I already alluded to medical savings accounts. Medical savings accounts started with the Kennedy/Castlebaum bill in 1996. The year 1997 was the first year that a medical savings account was available in this country. I know that because I purchased one myself. I was concerned when I heard about the medical savings accounts becoming available because Congress had restricted medical savings accounts such that no more than 750,000 would be sold, no more than 750,000 would be available during those early years of medical savings accounts, and I was very concerned that I would be even able to get one. I thought that they would be so popular that that 750,000 limit would be very quickly subscribed and I might be left out of the process. It turns out I didn't need to worry, because there were so many restrictions placed on those old medical savings accounts that if you didn't have that M.D. degree, perhaps you weren't going to be capable of dealing with all of the things that you would have to deal with. In my home State of Texas, the restrictions were such that there were only two insurers that provided the medical savings account products. Still, I found it to be a very useful type insurance.

First and foremost, it left me completely in charge of any medical decisions to be made for myself and my family. I didn't have to talk to an HMO director, I didn't have to dial 1–800–California and get permission for a particular treatment. I could spend my own money and reimburse myself out of that medical savings account.

The downside was you couldn't put very much money away each year in the medical savings account and the deductibles were significant, and that was seen to be a significant barrier to a lot of people with getting a medical savings account.

In 2003, the compromise that ended up being the Medicare Modernization Act did significantly expand what are now called health savings accounts. The amount of money that can be put away for a family greatly increased from, I believe, $3,200 to up to $5,000 for family coverage. The deductible itself was essentially maintained, though there were several tiered products made available so that that deductible didn't have to be as high as the highest number. You could in fact purchase an HSA product with a deductible that wasn't at the maximum.

One of the most significant things, and the reason I know this is having tried to purchase a health care policy for an adult child back before even medical savings accounts came along in 1994 and 1995, there was almost no one out there willing to sell in the individual market an individual insurance policy. Whether it be a high deductible or a nominal deductible, it just wasn't available for any price.

Fast forward to the time after the health savings account legislation passed in 2003. Come to 2004, 2005, 10 years later, and a young person who needs health insurance just out of college, say, wants to go into business for

themselves, doesn't want to have to work for a big corporation to get that employer-sponsored health insurance but wants to carry their own insurance, they can go to Google or the search engine of their choice, type in ''health savings accounts,'' and with a few clicks and a quick search they can find high deductible PPO policies sold by reputable names that we would all recognize. And of course I won't mention any of those names, but they are sold by reputable companies that we would all recognize as longstanding established insurers in this country, and the premium would be in the range of $60 to $65 a month for a high deductible policy, imminently within reach of that 25-year-old nonsmoking male just out of college in my home State of Texas. Again, that type of policy was absolutely unavailable in 1994 for any price, and now it is available at a price that arguably would be affordable by a lot of people who are just getting out of college and have their earnings at the beginning of their earning cycle.

And why is this important? Yes, it is a high deductible policy. That means, if you need a flu shot, you are probably not going to be able to show your insurance card and get a flu shot; you are going to go down to the place that gives flu shots and pay the $20 or $25, whatever is required to get the flu shot. If you have money accumulated in your health savings account, yes, you can make a draw on that money to reimburse yourself for that flu shot. But if you are even to the point where you haven't gotten enough of a savings into that account yet to go and tap into that money, you are going to have to pay that money out of pocket, the important thing is, is that after your flu shot you get on your motorcycle and ride home and have an accident and spend a day in the emergency room and 3 or 4 days in the intensive care unit and face a bill that may be as much as $10,000 or $15,000 or $20,000, you do have coverage for those catastrophic amounts. And, let's face it, for young people today, trauma or accidents are going to be one of the principle causes of hospitalization.

Association health plans, again, a concept that we have dealt with in this Congress the last two Congresses. It has not come up this year and the reality is it may not. But this gives small businesses the ability to band together to get that purchasing power of a large corporation. One of the hard things is you go out to buy group coverage for your small business, and they say, you know what, you have got so few employees that it is really not worth our time and the cost for that coverage is, consequently, going to be astronomical. But if you are able to combine with, say, your chamber of commerce and you can combine with a chamber of commerce across in the next county, you can combine with a couple more chambers of commerce in other cities and perhaps even across State lines, suddenly you are accumulating enough covered lives to really get that insurance company's attention and perhaps drive a better bargain, perhaps get a better deal.

Right now, we won't let that happen. But the fact is that Congress should get out of the way and allow those things to occur, because it is not so much that association health plans are going to bring down the number of the uninsured, but it sure will help the rate of rise of the uninsured we see in this country, because that rate of rise is in a large part fueled by the cost of purchasing health care by that small business person; and anything we can do to keep that cost of coverage down is going to ultimately increase the amount of coverage that is available.

Transparency, I mentioned before, is critically important if we are going to have so-called consumer directed health care in this country. We have got to put that information in the consumer's hands so that they can make decisions about cost price and quality in the health care system. And I understand that there is an inherent danger in transparency. Opacity is there for a reason, and that reason is generally it is financially rewarding for whoever is providing the opacity. They don't want everybody to know what goes on behind the curtain.

Again, I will reference my home State of Texas. The very beginning of a transparency project has now gone up on line. Mr. Speaker, if anyone at home were interested, it is tx.pricepoint.org, and someone can go to that, Mr. Speaker, on their Web site and look at that and get information about hospital charges in their area and how they compare with the rest of the State. Granted, there is going to need to be more information available, but it is a good start, and I certainly support the folks at the State level who provided that degree of price transparency for the citizens of Texas.

In talking about the uninsured, one of the things that will come up, and I think we heard the President mention it here in this House during the State of the Union address, is what about the concept of that private ownership of insurance that is paid for with after-tax dollars? The President talked about giving people a tax deduction if they purchased their own insurance, not through their employer, but just went out and purchased it themselves. Certainly a valid argument that can be made about that is, well, there are a lot of people out there who don't pay income tax. So what about the concept of providing a tax credit? Some people would call it a voucher; I prefer the term premium support. If someone is working and their employer is providing the option for having the insurance but they say, you know with what, I still can't afford the $200, $300, or $400 a month I would have to pay individually in order to get that insurance; what if we provided them some help with that premium? And might that not be a better way to approach or to tackle some of the problems of the uninsured rather than just simply ever expanding the Medicaid system or some of the other systems that are out there to cover the uninsured? If someone is earning a living but does not have health insurance available at their place of employment, even providing them that premium support so that they can go out and purchase insurance in the private market. If we would help create and sustain that market, I believe that the private insurers would look at 42 million, 45 million people as a segment of market share that they would compete for, and we ought to give them the tools to do that.

Now, currently the United States Census Bureau says there are 46.6 million uninsured.

□ 2200

I think it's important to stress, once again, that uninsured does not always mean no access to health care. It may mean that the access to health care does not occur at the point where the health care can be rendered for a lower total dollar figure, or you may not receive the best health care outcome because care has been delayed. But having access to coverage will increase access to care.

One of the things that this Congress did 10 years ago, long before I got here, was a program called the State Children's Health Insurance Program. It's 10 years old. It's going to be required to be reauthorized this year. But this did provide States some flexibility and some options for providing coverage for uninsured children that resided within their State.

This was primarily to be directed to children who were not eligible for Medicaid, whose parents earned a little bit too much money to have them covered under the Medicaid system and therefore couldn't, but they, themselves, did not earn enough money to truly afford health insurance. So this was a good thing.

Coverage of children is relatively cheap coverage. You pay $0.60 for what would be $1 of health care for an adult. You can pay $0.60, buy $0.60 worth of health insurance for a child and get the equivalent of $1 worth of insurance for an adult because children, as a general rule, are young and healthy. They tend to recover from their illnesses quicker than do adults, and money invested in the children's program is, indeed, money well spent and money wisely invested.

Some of the things that I think we ought to keep in mind as we reauthorize this bill this year, and we will be doing that through my committee, Health Subcommittee on Energy and Commerce, but some of the things I think we ought to keep in mind is that it is primarily a children's health insurance program.

The decision was made to cover pregnant adults, and I think that that was a good thing, and that should be continued. But covering non pregnant

adults in the Children's Health Insurance Program is perhaps not the best use of those dollars.

If there needs to be a program for providing additional coverage to those adults, then let's look at doing so, but let's not divert those dollars that should be going into coverage for health care for children; let's not divert those to some other purpose. And unfortunately, we have the situation in this country today where four States actually cover more adults than they do children.

Again, we need to get back to the original principle that this program was enacted, and make sure, once we're covering all the children, once we're covering all the uninsured children in this country, then perhaps we can talk about expanding it to include adults. But until that time, we do need to focus and make certain that we are covering the uninsured children.

You know, a letter to the editor back home in Dallas this weekend I was reading made the comment that, of course, SCHIP, and they were talking about it primarily at the State level. And the State, my State Legislature is in session right now, and they are grappling with the questions of funding for SCHIP.

But the comment was made in the letter that the SCHIP program was there for some parents who cannot afford insurance; and sure enough, that's what it's there for.

And the second line went on to say that also there are some parents who are working and covered under their parents' insurance, but they can't afford that additional premium for the dependent coverage on their insurance.

This is some of the cheapest coverage out there that we should take advantage of. And certainly, it is available within the SCHIP program currently for some degree of premium support. But I certainly think we need to expand that, certainly, make states aware that this is available for them to use, that they can leverage those children's health insurance dollars to buy more health insurance.

And the other thing that we do that's extremely important, if the Federal Government simply takes over the function of providing all of the insurance for all of the children, the private sector is completely crowded out. And is that fundamentally a good thing or a bad thing?

I would argue that it is not in the best interest of our country to let that happen, that the private sector does belong in the children's health insurance market. And we should, while we may not be required to do anything to particularly subsidize that, we certainly should not do anything that makes that an untenable business model because, ultimately, I think we are going to be less satisfied with the result.

Federally qualified health centers. We are going to have to, we didn't finish the work on reauthorization of the federally qualified health center statute last session of Congress. It is going to be important to try to do that again. Once again, that's an issue that will come through my committee on Energy and Commerce. We had some very good hearings on that last year, leading up to the introduction of the bill by Mr. BILIRAKIS, who is no longer with us. And that bill will come up again this year.

I think that when you look at the federally qualified health center, one of the things that is really encouraging to me is that a Congress, and I grant you it was 35 or 40 years ago, sat down and agreed amongst themselves, the Members on both sides of the aisle, agreed what procedures, what items would be covered under that federally qualified health center statute.

And to me, that's a beacon of hope, that perhaps we can work, this body can work together and decide on what are the things that should be covered; if we wanted to have an insurance policy, for example, that was generally available for individuals who were currently uninsured.

What are the parameters that should be covered? What should we encourage?

If we are going to go talk to the private sector about insurance policies that may be affordable by the Nation's working poor, what should those things cover, and can we ever come to an agreement that will allow those types of policies to be sold in one State or another, and what could we do about getting those policies up and on the Internet to take advantage of the competitive influences that are present on the Internet?

You know, one of the things, again, I reference Texas a lot because I spend a lot of time there. But one of the Nation's largest automobile insurers has really made a big push in the Texas market. They're famous because they have a little green lizard who's kind of their spokesman, the little green lizard with an English accent, in fact, who's kind of their spokesman.

But the message is that if you can go online and spend 15 minutes with them, they can save you some money. Wouldn't it be great to provide that same tool, that same device in the health insurance market as well and get the advantage of that, that very strong competitive market out there that has been provided by the new technology of the information superhighway?

It's certainly had a very significant beneficial effect on bringing down the costs of term life insurance. And we saw this back in the late 1990s, the early part of this century. Why not take that same competitive power and unleash it for health insurance and allow more people to be covered?

I referenced health savings accounts before. Again, you can go on the Internet and buy a health savings account now that's available because some of the state-by-state restrictions do not apply because of the way that legislation was written. And this is an extremely powerful tool to put into people's hands.

One of the disadvantages, one of the ways we disadvantage our citizens when it comes to purchasing a policy like a health savings account is that it is paid for with after tax dollars. You don't get that pre-tax expenditure.

We could, in fact, further leverage the health insurance, how far a health insurance dollar could go in a family's budget by tapping into that concept of a pre-tax expense.

But some of the things we have done with health savings accounts, and again, I would stress that since we passed the Medicare Modernization Act a scant 4 years ago, between 4 and 7 million people have now purchased health savings accounts.

I referenced early on that first off, back in the early 1990s or, I'm sorry, the middle 1990s, it was going to be capped at 750,000 total policies. That cap was removed with the Medicare Modernization Act, and as a consequence now, at least 4 million people have purchased health savings accounts. Forty percent of those people were previously uninsured. That means that number of the uninsured would be higher by a factor of a million or a million and a half had we not passed that legislation that expanded health savings accounts.

Making those premiums tax deductible, that is something that, an idea whose time has come, has long since come. We weren't able to do it during the last Congress. I know there are a number of competing influences out there, and we heard references to things like PAYGO before, so it is going to be a tough battle. But I do believe that we need to do that.

The low income tax credit, or the premium support for an HSA like product for someone whose low income, again, an idea, certainly whose time has come.

Maybe we should allow employers to make larger contributions to an HSA for a chronically ill employee, an employee who has diabetes or rheumatoid arthritis or any of other of a number of chronic diseases where, yeah, their health expenditures are going to be higher because they were unlucky enough to have this chronic disease, so their health insurance may cost a little bit more. But let's allow the employer the flexibility of perhaps contributing a little bit more to that plan.

What about allowing the flexibility for health savings accounts to coordinate with other type of things that employers do to make the health care insurance burden for their employees easier to bear?

□ 2210

Things like flexible spending accounts. A flexible spending account where an employer contributes a certain amount of money each year so that their employee can go out and have some of the first dollar coverage that they otherwise might not have,

because even if they don't have a health savings account, just the regular deductible on regular commercial insurance, anyone who works and has employer-derived insurance will tell you that number has increased over the past 5 or 10 years. So flexible spending accounts are moneys that the employer puts away for the employee to help to use to offset some of these expenses that may be incurred.

If we allowed someone with a health savings account to participate in a flexible spending account and even went further; for a flexible spending account, at the end of the calendar year, it is a use it or lose it phenomenon. If the employer has contributed that money or the employee has said, I want to put away a tax-deferred amount of money into this account so that I can spend it for health care needs and try to capture a little bit of that pretax leveragability there, they lose that money at the end of the year if they haven't spent it on their health care.

Why don't we let that roll over into their health savings account and let that health care nest egg accumulate at a little bit faster rate so that those citizens who do wish to utilize the power of a health savings account can perhaps make it work even more to their advantage?

And what if someone wants to retire early and they have got that health care nest egg built up in their health savings account but now they are going into early retirement, and doggone it, that insurance premium is going to be an additional burden to bear? What about allowing them to draw on the health savings account to pay their premium to continue their health savings account in those years from their early retirement prior to the time that they are covered by Medicare? It is an interesting concept and one I think this Congress would do well to spend some time thinking about doing.

I will come back again to the pretax treatment of health care expenditures incurred under an HSA. Again, we can leverage a citizen's dollars so much more by allowing that type of treatment of those dollars.

Again, association health plans for employers who want to provide their employees insurance but find they are being increasingly priced out of the market. Give them the flexibility to go out there and group together and say, We are a group of realtors and we want to be able to go out and buy health insurance in the market like we had a whole bunch of employees rather than an office that employs five or six people because we are not getting a good deal when we just go out and try to buy insurance in the market to cover five or six employees at a time.

All of these things are critical for us to think about. All of these things are ways that we can improve the system that we have before us today. But we do have to ask ourselves if we are perhaps putting the cart before the horse.

Alan Greenspan, the gentleman's name who is not unknown in this town, the prior Chairman of the Federal Reserve Board, about 1½ years ago came and talked to a group of us one morning, talking about just things in general, and the question inevitably came up about Medicare: How in the world are we ever going to pay for Medicare? How in the world are we ever going to tackle this unfunded obligation that we have?

And Chairman Greenspan felt confident that at some point some Congress would be able to deal with this problem in a satisfactory way. And he paused and he got quite reflective, and he said, You know, what concerns me more is, is there going to be anyone there to provide the services when you need them? Of course he was talking about our physicians. Of course he was talking about our nurses.

Those are words that certainly I have taken to heart. And I think we do need to spend considerable effort on thinking about this problem and considerable effort towards rectifying some of the difficulties that are out there so that we do, indeed, preserve the health care workforce that is present today and the health care workforce that we are going to want for the future.

Last year, in order to deal with this problem, I introduced a bill, H.R. 5866, the Medicare Physician Payment Reform and Quality Improvement Act of 2006. I introduced that bill in July. Of course, with the August recess and then the recess before the election, there wasn't a lot of time left in the year to work on it. The reason it was so important is because the system we have developed in our Medicare system, parts A, B, C, and D are not paid for equally. The fact is that part B, the part that is handled by physicians, is dealt with in a different fashion. Part A, the hospital; part C, the HMO; part D, the prescription drug benefit, all of those each year receive essentially a cost-of-living adjustment, an update, because the cost of inputs is going to go up.

The physician payment, this is an important concept. I realize it may sound arcane, but the physician payment is handled differently. There Congress, in its wisdom many, many years ago, said if we can control the volume and intensity of these payments, we are going to be able to save money over the long term. So a system was put in place called the Sustainable Growth Rate formula. You will hear it referred to as the SGR. The problem with the SGR is that every year physicians, instead of getting a cost-of-living update based on the fact that their electricity costs more, it costs more to put gas in their car to drive to work, it costs more to pay their help, all of those things go up, but the physician reimbursements go down. An estimated 5 percent a year, and this is projected to go up for years in the future so that the accumulative effect will be a 30 to 35 percent reduction in physician reimbursement in the Medicare system. And anyone just looking at this understands that that is untenable. You can't keep doing that. Every year Congress has to come in at the last minute and do something to keep that from happening for that year. Sometimes we get it done; sometimes we don't. But the problem is every year that we put that fix in place, we increase the price tag for eventually getting out of that system.

A case in point: I first came to Congress in 2003. In fact, the Congress before my first term here had not passed any appropriations bills. So the first thing we were faced with was a huge omnibus bill, spending hundreds of billions of dollars. That omnibus bill contained within it a fix for the doctors. And I remember the then chairman of the Ways and Means Committee coming to our conference and saying, I have put a fix in there so that the doctors won't see that pay cut that they got last year, and it is going to cost $52 billion to do that. At that time the cost of buying our way out of the SGR formula and switching over to a cost-of-living formula, a cost-of-living adjustment formula, known as the Medicare economic index, was pegged at about $118 billion, a significant sum of money. But $52 billion as a down payment on a $118 billion problem, that seemed reasonable. It seemed like we were going in the right direction.

But fast forward 4 years, and every year, of course, we have done something similar, never quite as much as the $52 billion that was passed that first month that I was in Congress, but every year that at the end of the year where we have had to add that money to keep physicians from seeing a pay reduction, we have increased the cost of eventually repealing the SGR so that it now totals $280 billion.

But wait. There is more. If you do not protect seniors, because by law in part B of Medicare, seniors pay 25 percent of the cost of the part B program, which 75 percent is borne by the Federal Treasury; 25 percent is recovered in premiums, and every time we increase that amount, the premiums necessarily increase. No one likes to do that because those premium increases by law hit in the month of October and that is very close to an every 2-year election that occurs in the month of November. So everyone wants to deal with that problem of the premiums going up every year. If you were to deal with the entire problem, the SGR and premium protection for senior citizens, the costs suddenly goes up to $340 billion. It is clear to see in a PAYGO environment that that is almost an impossible hill to climb.

Last year in the Physician Payment Reform and Quality Improvement Act of 2006, in attempting to deal with that, I looked for help within the health care community, people to find places where there could be efficiencies to help offset that SGR price tag that at that time was $218 billion.

□ 2220

Suffice it to say that those cost savings were never identified. People were reluctant to come forth with areas in their particular part of Medicare where they might save money. And as a consequence, the pay-fors did not materialize, and the bill was something we didn't take up.

This year, it's not even just about fixing that part of the formula. It is important to do that because one of the pernicious effects of that formula is you have doctors who are looking toward their retirement and perhaps thinking about accelerating it for a few years. So we have physicians in the workforce who may be leaving early because they look down the road and say, 5 percent reduction in the rate of Medicare reimbursement every year for the next 10 years for a cumulative total of 30 or 35 percent, I don't think so. Maybe I do need to get on with my retirement plans. And then on the other end of the spectrum you have the young physician who is just getting out of medical school, who is meeting the residency in those primary care high need specialties, they may need some additional help. And finally, the student who's finishing college and looking to go to medical school; how am I going to deal with those significant loans I'm going to face when I get out of school?

All three areas are going to require this Congress to think very carefully and work very hard on trying to craft solutions. And I would just stress that it is important not to craft a solution that is only going to fix the short term. We've really had this kicking-the-can phenomenon or postponing-the-pain phenomenon has worked only up to a point. And you have to believe that this type of trajectory does have a shelf life, and ultimately we're going to reach a point where we are in fact no longer able to afford even those relatively modest, and I use the term modest advisedly because we are talking about a Washington expenditure here, will be unable to afford even those modest payments that are required to offset the reductions that happen year over year.

And you might say, well, that's not so bad, it's just the Medicare system. That's just half of health care, how could that be that big a problem? The unstated aspect of this is that every private health insurance company out there who writes insurance policies, I shouldn't say every, but a lot, will peg their reimbursement rates to what Medicare pays. They pay 80 percent of Medicare, they pay 120 percent of Medicare, but they pay some percentage of what Medicare pays. And when we as a Congress say to the physicians of America, guess what? You get a 5.4 reduction this year. Those companies that peg their reimbursement rates to the Medicare 2007 reimbursement schedule are in fact also given a bit of a break. And they were never intended to be the recipients of the largess of the Federal Government, but that's what happens when you have Federal price controls on a system like health care.

Well, improvements in the bill from last year I think are in progress. And the fact that the entire concept is split into three parts to deal with the overall affordability of educating and providing the incentives for people to go into medicine in the first place, providing the tools for their educational process, providing some flexibility with loan forgiveness, tax credits for the young physician, and then finally, providing some stability for the physician who is mature and in practice, that they are going to face a stable pricing environment going forward, not a continuously shrinking price environment going forward.

It is going to be difficult. There again, I will reference the Medicare Trustees Report. Again, 680,000 hospital beds that were not filled in 2005 because of improvements in the practice of medicine. We've come a long way from the days of Benjamin Rush, when they used leeches to treat their patients. Those 680,000 hospital beds that weren't filled in the Medicare system, that is money that is saved in the part A part of Medicare, but the savings actually occur because of the work being done in the part B part of Medicare. And there has got to be somewhere, some way within the Federal statutes that the savings that occur in part A or part C or part D because of continued work and vigilance by the folks who are practicing in part B, there has got to be a way that those savings will accrue to part B, and use those savings as the offset for lowering that total price tag on the SGR formula.

Further, there are some places, unfortunately, where people do attempt to abuse the system and take money that perhaps they are not entirely entitled to. The Inspector General's Office at HHS and the Department of Justice held a lengthy hearing with our Energy and Commerce Subcommittee a few weeks ago; it was a terribly enlightening process. But the money that's recovered in those audits is not money that should go to the Department of Justice, though don't tell them I said that, but it's money that should go back to the part B of Medicare to offset the eventual repeal and replacement of the SGR formula with the Medicare Economic Index. And I quite simply don't know any other way how to say that.

If we are not able to get that done this year or next year or the year after, we do need to put some programs in place that will protect physicians from those cuts that are programmed to occur in 2008 and 2009. And again, that is part of the legislation that I will be working on to not only capture those monies that rightfully belong to part B to offset the eventual cost of repealing the SGR, but additional things in place to protect the earnings of the physicians who care for our Medicare patients during those years before the SGR can be repealed.

Well, I mentioned earlier that some of the States have done some things within their health plans that have been innovative and really quite exciting; Massachusetts is probably the leader in that regard. It's significant because the Governor of Massachusetts is offering himself as a Presidential candidate and is certainly one of the individuals who can say ''check the box, I've done that.'' And working with a legislature and a State senate who was of the opposite party and not always aligned with his vision of where things were and where they ought to be, was able to craft a plan. Just like so many things, we can always say it's God's plans, but the devil is in the details, and sure enough in this situation the devil is in the details. The months starting in July of this year will tell the tale as to whether or not that plan will actually work. But some very clever ideas were incorporated.

Now I will be the first to admit that as a Texan there are a lot of things that you can apply to Massachusetts that you could never apply in Texas. But one of the concepts that I thought was, you have heard me reference several occasions that wouldn't it be great to get the leverage of getting a pretax expense for someone who wanted to buy their health insurance? Well, they found a way to do that in Massachusetts, it's called the Massachusetts Connecter. And indeed, even back in my home State of Texas I know they are looking at this concept. There is apparently a chapter in the IRS code, we heard the last speaker say how complicated the IRS code can be, but buried within the IRS code is section 125, which will allow for Federal tax deductibility of insurance premiums where the State acts not so much as the broker, but the middle man, if the State acts as the person who is going to bring the buyer and seller in the insurance market together, there is apparently a way in the IRS code where there is a tax deductible treatment then of that expenditure. And think about that for persons who are in the 20 or 25 percent tax bracket. If they can buy their health insurance premiums with 80 cent dollars, suddenly we've gone a long way towards allowing them some additional flexibility within the plan.

The thing I like the best about the Massachusetts plan is it does stress the concept of personal responsibility. That is to say that if you are a resident in the State of Massachusetts and you can afford health insurance, then you've got no good reason not to have health insurance and we are going to require you to have it. Again, a concept that may not work in other States. And Governor Schwarzenegger is looking at doing something in California. I know in my home State of Texas, Governor Perry is looking at some options. Governor Jeb Bush in Florida and now Governor Crist, who

replaced him, all have the ability to look at the State programs because of flexibility that was put in the system when the Deficit Reduction Act passed in December of 2005. Again, the much maligned Deficit Reduction Act gave the tools to these State leaders so that they can look at doing these innovative plans in their States to provide coverage for their populations who are uninsured. And after all, again, one of the great things about the United States is the States can serve as laboratories. We don't necessarily have to change everything for the whole country, we can see how it works in a given State, and to the extent that it is helpful, we can expand the program.

□ 2230

If we find it wasn't helpful, we won't expand the program. But it is one of those great things that our Founding Fathers envisioned, that the States would be great laboratories for needed social change to occur in this country.

One of the other things that I didn't cover earlier because I wasn't sure if time would permit it, I do obviously need to say a word about the medical liability system in this country.

My home State of Texas, again, did tackle this issue in 2003 and did pass a State law that capped non-economic damages, much along the lines of the Medical Injury Compensation Reform Act of 1975 that was passed in California. Our State of Texas picked up that concept, modernized it for the 21st century, and those caps on non-economic damages, instead of just being one realm of non-economic damages, the cap is trifurcated, $250,000 thousand cap on the doctor, $250,000 thousand cap on the hospital, $250,000 thousand cap on the on a nursing home or second hospital, if one is involved.

The critical thing about this is it has brought insurance costs for medical liability insurance down by 20 percent in my home State of Texas, and, remember, medical liability costs were going up by 25 to 30 percent a year prior to the passage of that law.

So it has had an immediate and beneficial effect on physicians in Texas. And one of the unintended beneficiaries was the mid-sized, community-based, not-for-profit hospital who self-insured. Those hospitals have seen a significant reduction in the amount of moneys that they had to put toward medical liability, and, as a consequence, those are dollars that they are investing in capital improvements, nurses' salaries, the very things you would want your medium-sized, not-for-profit community hospital to do if they had the flexibility to do so.

I have legislation that I have drafted that bases off the Texas plan. I think it is reasonable legislation. In our budget resolution that the Republicans had, the savings, and this was scored by CBO as a savings, at a time we are looking for ways to save money in the healthcare system to pay for other things, it is almost unconscionable to walk away from that $8 to $10 billion in savings that CBO scored this particular legislation.

Mr. Speaker, I see that the hour, it goes so quickly when you get down here to talk about these things. I will wrap up.

I do want to point out that Americans, for all of the criticism that we have, there was an article in The New York Times published October 2006, Tyler Cowan, who writes, ''When it comes to medical innovation, the United States is the world leader. In the past 10 years, 12 Nobel Prizes in medicine have gone to American-born scientists working in the United States, three to foreign-born scientists working in the United States, and just seven have gone to researchers outside of the country.''

That is what we need to preserve, protect and defend. That is why these issues are so important for us to face in this Congress.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. CUMMINGS (at the request of Mr. HOYER) for today.

Mr. ISRAEL (at the request of Mr. HOYER) for today.

Ms. KILPATRICK (at the request of Mr. HOYER) for today on account of official business in the district.

Mr. MORAN of Kansas (at the request of Mr. BOEHNER) for today on account of inspecting tornado damage.

Mr. TIAHRT (at the request of Mr. BOEHNER) for today and May 8 and 9 on account of inspecting tornado damage.

Mr. HULSHOF (at the request of Mr. BOEHNER) for today and May 8 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. PALLONE) to revise and extend their remarks and include extraneous material:)

Mr. PALLONE, for 5 minutes, today.

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

Ms. WOOLSEY, for 5 minutes, today.

Ms. SOLIS, for 5 minutes, today.

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

Mr. ELLISON, for 5 minutes, today.

Ms. LORETTA SANCHEZ of California, 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. SHAYS, for 5 minutes, today.

Mr. POE, for 5 minutes, May 14.

Mr. MORAN of Kansas, for 5 minutes, May 8.

Mr. BURTON of Indiana, for 5 minutes, today and May 8, 9, 10, and 11.

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

Ms. LEE, for 5 minutes, today.

ADJOURNMENT

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

The motion was agreed to; accordingly (at 10 o'clock and 34 minutes p.m.), under its previous order, the House adjourned until tomorrow, Tuesday, May 8, 2007, at 10:30 a.m., for morning hour debate.

EXECUTIVE COMMUNICATIONS, ETC.

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

1511. A letter from the Comptroller, Department of Defense, transmitting a report of a violation of the Antideficiency Act by the Department of the Army, Case Number 04-12, pursuant to 31 U.S.C. 1351; to the Committee on Appropriations.

1512. A letter from the Comptroller, Department of Defense, transmitting a report of a violation of the Antideficiency Act by the Department of the Army, Case Number 06-01, pursuant to 31 U.S.C. 1351; to the Committee on Appropriations.

1513. A letter from the Under Secretary for Acquisitions, Technology and Logistics, Department of Defense, transmitting a review of the Guided Multiple Launch Rocket System (GMLRS) program, pursuant to 10 U.S.C. 2433; to the Committee on Armed Services.

1514. A letter from the Secretary, Department of Defense, transmitting a letter on the approved retirement of Lieutenant General Dell L. Dailey, United States Army, and his advancement to the grade of lieutenant general on the retired list; to the Committee on Armed Services.

1515. A letter from the Secretary, Department of Defense, transmitting a letter on the approved retirement of Lieutenant General William G. Boykin, United States Army, and his advancement to the grade of lieutenant general on the retired list; to the Committee on Armed Services.

1516. A letter from the Under Secretary for Personnel and Readiness, Department of Defense, transmitting a letter on the approved retirement of General Bryan D. Brown, United States Army, and his advancement to the grade of general on the retired list; to the Committee on Armed Services.

1517. A letter from the Under Secretary for Personnel and Readiness, Department of Defense, transmitting a letter on the approved retirement Vice Admiral Stanley R. Szemborski, United States Navy, and his advancement to the grade of vice admiral on the retired list; to the Committee on Armed Services.

1518. A letter from the Under Secretary for Personnel and Readiness, Department of Defense, transmitting authorization of the enclosed list of officers to wear the insignia of the grade of brigadier general accordance with title 10, United States Code, section 777; to the Committee on Armed Services.

1519. A letter from the Director of Defense Research and Engineering, Department of Defense, transmitting the Department's report on the management and adequacy of biometrics programs pursuant to Conference Report 109-702, that accompanies the John Warner National Defense Authorization Act for Fiscal Year 2007; to the Committee on Armed Services.