fuels the light water reactors that essentially every nation today uses for its electricity production. In France, it is 75 percent of their electricity.

In spite of that, we are still the largest nuclear energy producer in the world. It is only 20 percent of our electricity, while in France it is 75 percent of their electricity. We are so much bigger economy than France, quantity-wise, we are the biggest producer of energy from nuclear today.

Let's look at the finite resources which he talks about. The tar sands, the oil shales, coal. There is more potential energy in the tar sands in Canada than all the oil reserves in the world. So why then aren't we complacent about the future because there is potentially so much energy there? And there may be more energy in the tides. The Moon lifts the whole ocean 2 feet a day. The problem is harnessing the energy, and we have a similar problem harnessing the energy in the tar sands. They are getting about a million barrels a day, a bit over 1 percent of the 84–85 million barrels a day of oil production. They have a shovel which lifts 100 tons. It dumps it into a truck that hauls 400 tons. They haul it to a cooker which I am told uses more energy from natural gas than they get out of the oil. The gas is stranded so it is not worth much in dollars and cents, and they are producing oil at about $18 to $25 a barrel and it is selling for over $60, so it is economically productive to do. But they know this is not sustainable because they will run out of the gas, and now they are thinking of building a nuclear power plant. But if you think of this as a vein, it is largely surface and they can do surface mining. But it will shortly duck under a heavy overlay, and they will have to develop a technology to develop it in situ, and they don't know how doable that is. There has been some experiments in doing that by Shell Oil Company. They believe it will be several years before they know if it is economically feasible for getting energy. So there are potentially huge amounts of oil available in the tar sands and the oil shales, but the big problem is the difficulty in getting them out.

We have a chart that I would like to look at that looks at coal because everybody is going to tell you not to worry about nature because we have got so much coal. Okay, we don't have that chart.

Let me talk about the coal chart. We have 250 years of coal. That is true at current use rates. But if you increase the use of coal only 2 percent, that 250 years drops to 85 years.

□ 2130

Well, a 2 percent increase doubles in 35 years. It's four times bigger in 70 years, and it's eight times bigger in 105 years, and we're talking about 250 years. So now our 250 years of coal shrinks to only 85 years if we are increasing its use only 2 percent, and we will certainly have to increase the use more than that as we find less and less readily available oil and gas.

But for most uses, coal is not very convenient. So we are going to have to convert it to a liquid or a gas, and that will use some of the energy of coal. So now it shrinks to 50 years, but the reality in today's world is that energy is fungible, particularly liquid fuel energy, and we're going to have to share that with the world. There's not much of a way not to share that with the world. If you do that, since we use 25 percent of the world's energy, that now reduces it to 12½ years.

Be very cautious when somebody tells you about a resource that will last so many years at current use rates. It was Albert Einstein I think who said that the most powerful force in the universe was the power of compound interest.

We are running out of time, and I wanted to get to another quote here from Admiral Rickover's speech because he was so prophetic in his speech. ''In the 8,000 years from the beginning of history to the year 2000 A.D. world population will have grown from 10 million to 4 billion.'' He kind of missed that. We are what, over 6 billion today, but that is an enormous growth. ''With 90 percent of that growth taking place during the last 5 percent of that period.'' It would be more than 95 percent because we are now over 6 billion rather than 4 billion. ''It took the first 3,000 years of recorded history to accomplish the first doubling of population, 100 years for the last doubling, but the next doubling will require only 50 years.'' Matter of fact, it occurred in less than 50 years.

And then another chart from Admiral Rickover's talk: ''One final thought I should like to leave with you. High-energy consumption has always been a prerequisite of political power. The tendency is for political power to be concentrated in an ever-smaller number of countries. Ultimately, the Nation which controls the largest energy resources will become dominant. If we give thought to the problem of energy resources, if we act wisely and in time to conserve what we have and prepare well for necessary future changes, we shall insure this dominant position for our own country.''

Mr. Speaker, I wonder if Admiral Rickover would think that we have done that. ''If we give thought to the problem of energy resources, if we act wisely and in time to conserve what we have and prepare well for necessary future changes, we shall insure this dominant position for our own country.'' That's the dominant position where you control a lot of the energy. We have only 2 percent of the world's energy. We use 25 percent of the world's energy. In a chart which shows the 10 largest oil containing countries we're not even near that.

Our oil companies, which pump a fair amount of oil, own very little oil. They are pumping somebody else's oil. The oil resources which we own in this country are very small. The largest, 70 percent, of all the resources of course are in the Middle East and northern Africa.

As I read this talk from Admiral Rickover, I was reminded of how wise and farseeing he was. He says, for instance, ''It will be wise to face up to the possibility of the ultimate disappearance of automobiles, trucks, buses and tractors.''

Let me read that paragraph. That's a pretty interesting paragraph. ''Transportation, the lifeblood of all technically advanced civilizations, seems to be assured, once we have borne the initial high cost of electrifying railroads and replacing buses with streetcars or interurban electric trains.''

He's talking about nuclear energy, which could be huge, compared to the rate at which we are using now which produces electricity. Of course, today we don't have much that runs on electricity. We have torn out all of our streetcar lines. We're now replacing what we call light rail, I think that's what streetcars were, and we are using railroads. Very little for transportation of people.

''But, unless science can perform the miracle of synthesizing automobile fuel from some energy source as yet unknown,'' and I thought here of our corn ethanol and we were going to get so much from that. That article says if we turn all the corn into ethanol, discounted it for fossil fuel input, it would displace 2.4 percent of our gasoline.

Well, I commend this reading of Admiral Hyman Rickover's speech to anyone who's interested in energy. He was really farseeing.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. ARCURI). All Members of the House are reminded to refrain from bringing to the attention of the House occupants of the galleries.

HEALTH CARE

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

Mr. BURGESS. Mr. Speaker, I come to the floor tonight to talk a little bit about the Nation's health care system, some of the challenges that face us and some of the successes that have happened in spite of the fact that they aren't generally noticed by the people who report on things.

Mr. Speaker, my career prior to coming to Congress was that of a physician. A lot of people will ask me how did we end up with the situation that we have, how did we end up with the system of health care that we have in this country? After all, Western Europe, we are not that much different from our Western European friends, and yet they have largely single-payer,

double-fund systems, and why is the American system so different?

Mr. Speaker, there are a lot of reasons for that, but at the risk of oversimplification, if we look back to the days when the country was involved in the Second World War, of course President Roosevelt at that time had put in place wage and price controls in order to keep down trouble from inflation. Employers who were anxious to keep their employees working, and there was competition for the workforce that remained behind and was not called off to fight, in order to keep that workforce employed and to keep that workforce interested in working, and not being able to expand wages like an employer might like to do, they offered benefits.

They actually sought an opinion, and the United States Supreme Court ruled that health insurance benefits could be provided and would be outside of the wage and price controls. And in fact, a tax advantage was given for employer-derived health insurance, and it made the program popular, not only during the war years but in the years immediately after the Second World War.

While this country was undergoing a significant economic expansion, this type of insurance policy remained in effect.

Now, contrast that with Europe, and even though some countries in Europe had emerged victorious, others were vanquished. Their backyard was the site where that war was fought. They faced significant humanitarian issues if they did not quickly stand up health care systems and other social systems in order to take care of their citizenry. So, it was an entirely different landscape presented to the people who represented constituents in this Congress during the war years and immediately thereafter.

I reference an article from Health Affairs from December 2006, just a few months ago, an article by Dr. Einthoven who's been a prolific writer. I don't always agree with him but a prolific writer on health issues, and he talked about employer-based health insurance past, present and future.

Talking about the past, the most familiar aspect of employment-based insurance past is its rapid growth in the first three decades after World War II, the relative stability that followed for about a decade.

And then he talks about the declining coverage that has occurred since the late 1980s, the exemption of employer payments for health insurance from employees' taxable income, combined with substantial efficiency advantages of group over individual insurance, fueled a rapid expansion.

And he goes on to cite that by the mid-1950s, 45 percent of the population had hospital insurance. Coverage increased to 77 percent by 1963, and coverage peaked sometime during the early 1980s and, as he points out, declined in the late 1980s.

Lest anyone think that I'm in complete agreement with the article, he does end up his piece that the most likely trajectory in the near term is continued erosion of employer-based health insurance. In the long term, we think that the likely and most desirable income is replacement of job-based insurance with some form of universal health insurance that encompasses choice competition.

Again, we may disagree with his conclusion, and I will go through during the course of this hour some of the reasons why I do disagree with that conclusion, there are a number of things that would need to be taken into account.

But other things that we need to consider with this balance of the hybrid system that we have, the public and private, we do need to talk a little bit about the uninsured in this country, what's happening with the reauthorization of the State Children's Health Insurance Program, what's going to happen with the reauthorization of federally qualified health centers, a bill we took up last year but didn't complete before the end of the 109th Congress and will have to face again this year.

I'd like to talk a little bit about health savings accounts and some about association health plans. Of course, it is hard for me to talk about health care without addressing medical liability reform, and I do want to spend a few minutes on that in the hour that we have ahead of us.

One of the most pressing needs and one of the issues that is brought to my attention with increasing regularity is the whole issue of maintaining our physician workforce. We have a problem in the Medicare system as to how we reimburse physicians. So certainly physicians who are in practice are feeling that burden right now. We also have physicians in graduate education and young people who are perhaps thinking about whether or not they want to go into medicine as a career, and all of those aspects of the physician workforce I think require some of our attention.

Some of the things that the States are doing right now, things that are happening in Massachusetts, California, some recent developments in Illinois, indicate some of the efforts that are going on at the State level, and largely that's because of flexibility we provided to State governors when we passed the Deficit Reduction Act in December of 2005.

Other health care issues, if time permits, I'll try to get into. We talked a little bit about the trauma bill that was recently signed into law by President Bush 2 weeks ago, some aspects of transparency within the health care system, and how we are going to approach coverage for long-term care, particularly as the so-called baby boomers continue to move along in the demographic chain in this country.

Again, we talked about how we got this system that looks the way it does, the hybrid system that is a combination of both public and private systems. I referenced the activity that was going on right after the end of the Second World War.

Fast forward 20 years and a new system into effect in 1965 that was called the Medicare system primarily focused on coverage for hospitalization and some doctor services for elderly Americans.

In 1965, my dad was a doctor when Medicare came into being in 1965, and I used to tease him that in 1965 you only had two medicines, penicillin and cortisone, and you used those interchangeably. So it didn't really matter that you didn't have a prescription drug coverage when Medicare was first passed. I know he didn't think that was very funny either, but that is a discussion we have had on several occasions.

Now, 40 years later, 40 years after the enactment of Medicare, how different the world looks just from the standpoint of the pharmaceutical agents that are available in the physician's armamentarium to not only treat disease when it strikes but to prevent the disease from ever manifesting itself in the first place, for keeping that patient in the state of relatively good health and not coming in, sweeping in at the end stage when the disease has already struck and caused the heart attacks or caused some of the problems that happens with untreated or poorly controlled diabetes over a lifetime.

To be able to reach in and control those medical conditions on a chronic, ongoing basis ahead of time results in a reduction in the overall health expenditure for that particular disease for that particular individual, and you don't have to take my word for it.

The Medicare Trustees Report that came out about a week-and-a-half ago pointed out that in the year 2005 there were about 600,000 hospital beds that were not filled that were expected to be filled, and they were not filled because America's physicians are doing a better job of diagnosing conditions early and treating them early and keeping people out of the hospital when the full-blown effects of the disease might be manifest that in many cases can, in fact, be avoided all together.

□ 2145

So when we did the Medicare prescription drug plan back in 2003, it was a fairly lengthy and involved debate. I remember the President of the United States standing in this very Chamber during his State of the Union during 2003. Remarkable for me, because it was the first State of the Union that I got to see here as a new Member of Congress at the time. He said the issues facing Medicare are too important to be left to another President. The issues facing Medicare are too important to be left to another Congress.

So, this Congress, at that time the 108th Congress, was going to tackle the problem of providing prescription drug benefits to America's seniors. Heretofore, prior to that time, they had not been available. Arguably, there were

some ups and downs with that, but the fact is today more American seniors have more access to coverage than at any time in Medicare's history. The coverage that is available to them is certainly vast and extensive.

Generally there are at least two medications in every one of the six major disease categories. I know Administrator McClellan worked on that very diligently in the years between the time the Medicare bill was passed and the actual rollout of the Medicare prescription drug plan. But that was simply setting the stage for the debate that continues today.

Who is better suited, is it the public sector or the private sector? Who is better suited to handle the health care of this Nation? Now, currently, the Federal Government pays for roughly half of health care in this country. I know I am oversimplifying, but the numbers actually back me up on this, the gross domestic product last year was approximately $11 trillion, and we spent $1.4 trillion on health care.

The Health and Human Services budget for Medicare and Medicaid alone was in excess of $600 billion. Add the Federal expenditure for the VA system, for the Indian Health Service, the Federal prison system, and you can see we are quickly going to be at that mark. It is about half of the health care expenditures in this country.

The other half is broken down with a significant amount, the lion's share, being covered by people who have traditional insurance, commercial insurance, HMO coverage and all the things that we generally associate with insurance in the private market, and then smaller amounts would be attributable to individuals who simply pay for their care out of their pocket, and are uninsured, but are available to pay for their care.

There is no question that there is some care rendered in this country, no doubt about it, given by the good graces of either the hospital or the doctor involved, so-called charitable care or uncompensated care, which does account for a significant amount of the care given in this country.

Well, what is the best way, this tension between public and private. Should we expand the public sector? We are going to have that debate in a big way, probably in the months to come regarding the expansion of the public sector, the public side of health care.

Certainly we can look to Canada as an example of a country that has done, essentially done away with the private practice of medicine and put a publicly funded payment plan in place. But even the Canadian Supreme Court a few years ago said that, you know what, access to a waiting list is not the same thing as access to health care. They acknowledge some of the problems that exist in the system, some of the problems that exist within the Canadian system.

The British National Health Service, again, I go back to my comments earlier about the time during World War II and its immediate aftermath, the British National Health Insurance came on the scene earlier in the last century, and has evolved essentially into a two-tier system. You have patients who are taken care of in the National Health Service, to be certain, and everyone has coverage to the National Health Service. But, again, there may be issues with waiting times, there may be an issue to waiting to see the practitioner or the specialist that you wish to see. As a consequence, some of the most expensive health care available today is in the private system that exists, that coexists, with the British National Health Service.

Another aspect to that that is troubling to some people because of the wait. How long is it reasonable to ask someone to wait for an artificial hip replacement, for example? Certainly some of the studies done at the National Institutes of Health have shown that with today's minimally invasive surgery, and the in-joint replacement surgery, the savings to the economy are significant because of the minimization of the lost days of work, the lost productivity by a worker who is having a problem.

But, if you have to wait, as in some systems you do, if you have to wait 1 month, 2 months, 3 months, is that such a big deal; 6 months, going on a year? Well, I would submit that if a patient is in their 70s or 80s, that length of time is a significant electricity of time and, in fact, may increase the morbidity and, in fact, the mortality of people who are suffering from those types of diseases. So those systems are not inherently fair if someone is in their seventh or eighth decade of life, or they may not survive the wait for the care that is involved. So, expanding the private sector, is that the answer? I don't know if it's the entire answer, but it's certainly a big part of what must be the ultimate answer that we come to.

I would reference what has happened with medical savings accounts. They just turned 10 years old last year. The Kennedy-Kassebaum Act was passed in 1996. I was a practicing physician at the time with no thought of ever running for Congress, but I knew I wanted a medical health savings account as soon as I could get one.

In fact, 750,000 policies was the cap placed under the Kennedy-Kassebaum legislation. I was significantly concerned that I would not be able to get signed up for one before the cap was reached and no more were available. Turns out, I needn't have worried, because the cap was never fully prescribed because of some of the restrictions that were placed on the old medical savings accounts that were the original type of policy that was available.

In my home State of Texas, because of the restrictions placed on insurance carriers, only two carriers were really interested in providing what might be regarded as an account, a high deductible account, that could be coupled with a medical IRA or a medical savings account, which would continue to earn interest, be available to pay that high deductible if someone got sick, but in the event that it was not required to be used, would grow over time.

These were pretax dollars that were put away into the savings account, again, much like an IRA, but the only difference being that these dollars would be earmarked, and I realize that's a bad word, but these dollars would be sequestered only for paying for medical care.

Well, that changed in 2003 with the advent of the health savings accounts, as we passed the Medicare Modernization Act. Health savings accounts today are accounting for a significant number of policies, and I don't have the most recent statistics at hand, but 3- to 4 million policies that have now been obtained, and about 40 percent of the people who have a health savings account today previously lacked health insurance coverage.

Now, one of the great things that I tell, particularly younger audiences, when I address them about health insurance, 1994, trying to buy a health insurance policy for someone who was not employed, someone who didn't get their insurance through their employer, just wanted to go out on their own and get a policy that would provide them coverage, if they needed it, and pay for it themselves.

Number one, they are paying for it with aftertax dollars, so that's a more expensive way to go about getting insurance, but the other thing was, in 1994, you couldn't get it at any price. It just was not available. I know this, because I attempted to buy a policy for a family member who was not working at the time, but I thought needed insurance coverage.

Well, fast forward by 10 years. A young American getting out of college today, 24, 25 years old, now not able to be carried on his parents' insurance any longer, wants to go into business for himself or herself, wants to be a entrepreneur, wants to take part in the American dream but also wants to do the responsible thing and have health insurance. That individual can go to the Internet, go to the search engine of choice and type in ''health savings account.''

Very quickly, they will find a vast array of insurance products that are available to them at a high deductible, PPO product, may cost in the range, in my home State of Texas, for a male, age 25, nonsmoker, those premiums are going to be in the range of about $65 a month. It is eminently affordable for someone just getting out of college who wants to do the right thing and have that insurance coverage. Moreover, if they want to further do the right thing and save some money towards that high deductible, should they ever be called on to make that expenditure, those monies can go into

that account as pretax expense, and they will grow tax deferred over the life of the account.

Now, why is that significant? It's significant in that, correct, it's a high deductible policy. So if that person needs a flu shot, their insurance is not going to cover it. That is going to be contained within the deductible. Yes, they will, in all likelihood, either pay for it out of the money they have held in the health savings account, or they may just choose to pay for it out of pocket.

But, if they have a motorcycle accident some night and wind up with an evening in the emergency room, and 3 or 4 days in the intensive care unit, and face a hospital bill of $15- to $25,000, guess what, that bill is going to be covered. That is a significant difference from what was available in this country in 1994.

I would also reference the expansion of, well, you think, gosh, that high deductible policy, if you need anything more than a flu shot, who is going to want that because the cost of health insurance is so high, or the cost of health care is so high?

In today's Wall Street journal on the back page, the op ed page, there's an article about customer health care. One of the things it talks about is the growth of so-called minute clinics or urgent care centers. Quoting from the article now, written by Grace-Marie Turner, these new retail health clinics are opening in big box stores and local pharmacies around the country to treat common maladies at prices lower than a typical doctor's visit, and much lower than the emergency room, no appointment necessary, open daytime, open evenings, open weekends, most do take insurance.

Prices vary from services like from flu shots from $15- to $30 to care for allergies, poison ivy, pinkeye, $50- to $60 and tests for cholesterol, diabetes, less than $50. Competition is already starting to drive these prices down.

So there we have some good news. We have the health savings accounts, which are now available and sold on the Internet, and that competition has driven those premiums down, and we have the growth of people who are providing care for someone who is willing to pay for it out-of-pocket, whether they be someone who just wants to have the convenience of a walk-in clinic, or someone who perhaps has one of the consumer oriented products, one of the high deductible products, and wants to, is shopping around for that bargain in health care. Now there are other options available that weren't there before.

Other things to talk about within the private sector, association health plans, that's legislation that we have passed before in this House, both in the 108th and 109th Congress. Clearly, we need to take a look at that again in this Congress.

Association health plans allow groups of employers who have a similar business model to band together and buy insurance in the larger group market to take advantage of some of those economies of scale that may be gleaned by a larger employer, make those available to small businesses as well. Again, we have passed that legislation twice in the House of Representatives, in the 108th and 109th Congress, and something that we do need to consider taking up again this year.

When I talk about consumer oriented health care, when I talk about the health savings accounts or the growth in health savings accounts, one of the things that is so important for consumers, if they are going to be educated consumers, if they are going to make informed decisions about when and how they purchase their health care, we are going to have to make more information available to people to rationally make those decisions.

Information about cost, price and quality is going to have to be more generally available, and I recognize that there is a value in opacity, or it wouldn't have developed in the first place, but more information available to the health care consumer. In fact, in my home State of Texas, this recently has happened with hospital charges.

In all except for the smallest of hospital markets, an individual can go to a Web site, txpricepoint.org, and find out information about the hospitals in their area for given classes of hospital care, childbirth, for example, fixing a broken leg, for example, with or without complications, all listed there. Very quickly you can get information about how hospitals in the area compare and how the hospitals compare with other hospitals statewide that are of similar size and have a similar patient mix.

This is just the first step in providing that information. I recognize there is only so much that can be gained from looking at the overall hospital charge for a particular diagnosis, but as more information becomes available, and as more information is placed up and available on these Web sites, consumers are going to be able to make more informed choices about how they spend their health care funds.

One of the biggest problems ahead us and one of the biggest problems we have to tackle is the uninsured.

□ 2200

Currently the United States Census Bureau says that there are over 46 million people who lack health insurance in this country. And I know we can have the arguments about who is represented in that 46 million and that there are some people who lack insurance only during part of the year. But they're still counted toward the total number. But the reality is it is a significant number of Americans who lack health insurance.

As a physician, first, I will be the first to point out that having no insurance does not equate to having no access to health care because every physician can tell you about cases they've had where reimbursement either never arrived or they just simply did the case knowing that the person was uninsured and no reimbursement would be forthcoming.

But I think we also recognize that delivering care in that manner, it is not always delivered in the most timely of fashions, and you don't always get your best health outcome.

Now, one of the solutions that we will have to deal with in Congress is the reauthorization of the Children's Health Insurance Program. Again, that program is 10 years old and had a 10-year reauthorization requirement upon it.

It's not different from Medicaid. It's not an entitlement. It is a block grant to States to provide coverage for uninsured children within that State. It does provide flexibility for the States to determine standards and providing health care funding for those children who are not eligible for Medicare, but whose parents truly cannot afford health insurance.

The bill, when we work on that in committee, there are several things that I think are important that we do need to look at. One the problems of course we have run into with S-CHIP is that some States have found themselves in a shortfall situation. And one of the things that is troubling about the reason some States are in a shortfall situation is that they are covering adults and not just children.

Now, providing health care insurance or providing health insurance for children is less expensive than providing health insurance for adults because children obviously, are younger, they tend to be healthier, they tend to get better quicker. And although there are some illnesses that are particular to children, in general, the children's population in this country tends to be very healthy. And if you provide a modicum of health insurance and a modicum of prevention on top of that population, they are going to be even healthier still.

So States that cover adults as well as children, if a State is not covering all of the children that it could cover under its S-CHIP program, perhaps it's not a good idea to be covering adults, non-pregnant adults. Pregnancy should rightfully be covered under an S-CHIP program.

And, in fact, Mr. Speaker, there are four States that cover more adults than children. And I do hope we will look at this when we take up our S-CHIP reauthorization in our Energy and Commerce Committee, in the Subcommittee on Health, I certainly hope we will look at that.

One of the ongoing arguments with the Children's Health Insurance Program is, do we tend to drive out the private sector by the State taking on the burden of insurance children whose parents make too much money for Medicaid but not enough money to provide them health insurance.

If an individual has insurance through their employer, but they cannot afford the dependent coverage that the employer offers, and therefore don't take advantage of that dependent coverage that the employer offers, we should allow the flexibility for S-CHIP funds to be used to purchase that, or at least buy down the cost of that dependent coverage. We'll leverage our S-CHIP dollars so that they go so much further if we will do that.

Indeed, we heard testimony in a hearing the other day from an individual who said that as much as 10 percent of a State's S-CHIP funding may be used for so-called premium support. And if that is the case, I think we need to, but most States find that that is a program that is not well subscribed to. So we need to get that information out there. And if we need to make more dollars available for that type of premium support, then, indeed we should do that.

Now, that's not going to take care of all the problems within S-CHIP, but we certainly don't want to crowd the private sector out with a Federal program or a State program because there is value, I believe, in keeping the private sector involved and invested in providing health care for children.

A number of other things we could do during the authorization of that bill, it's a great opportunity to perhaps expand some of the health information technology that everyone talks about but no one ever seems to be able to get done, and the opportunity for providing some demonstration projects in, say, two or three States, a large State, a small State and one somewhere in between might provide us some of the background, some of the tools, some of the data that we need to be able to make rational decisions when it comes to health information technology, and to also get some of the advantages that's going to come from a well-functioning information system that provides almost instantaneous feedback on what things are working, what things aren't, where can we best spend our health care dollars so we maximize the return on the taxpayers' investment.

These are just a few things that I hope we'll take up when we have the opportunity to look at that bill in committee. It will be of necessity. That has to be reauthorized before the end of the fiscal year, and I feel certain that Congress will do that.

Federally qualified health centers I've already referenced. We did do the reauthorization last year, but that did not get completed before the end of the 109th Congress. I trust that we will take that up again this year. That is an important program that does provide a medical home and does provide an insurance equivalent to 15 million Americans. 15 million uninsured individuals actually have a medical home and continuity of care and identified provider through a federally qualified health center.

And one of the things that we talk about, relief of mandates on private insurance, one of the things that always gets my attention is that we seem to have so much difficulty when we sit down and talk. And we saw this last year in our Health Subcommittee. When a bill was put forward to allow insurance companies to sell insurance that didn't have all the mandates that some States will put on an insurance policy, and we had a dreadful fight about that one, it went late into the night. And a lot of hard feelings were expressed during the debate on that bill.

But the fact is, not in this Congress, not in the last Congress, but several years ago, Members of Congress came together and agreed on the types of benefits that should be covered in a basic package, and those benefits are the benefits that are mandated to be covered under a federally qualified health center. Any community that wants to petition for a federally qualified health center will have to show that they are going to provide at least this level of care for an identified number of illnesses or ailments.

And it seems to me, if we could extrapolate that experience from the federally qualified health center legislation that, again, is almost 35 years old, if we could extrapolate that cooperation that had to have been required to get that legislation up and moving over 3 decades ago, perhaps we could come together on the basic package of benefits that should be available in an insurance policy that's going to be sold in the private market.

I have trouble understanding that a private insurance company would not look at 46 million people as potentially market share if they had a product that people could afford to buy. And I do think that's one thing that this Congress does need to take up.

Health savings accounts I've already talked about. There are some additional improvements that we can make to health savings accounts, although they have been improved significantly in 2003 with the Medicare Modernization Act.

The HSA, the so-called flexible spending account or the health reimbursement arrangement that an employer may provide, a flexible spending account of course is money that an employee may sequester, pre-tax, and use that money on health care expenditures, but if they don't use it by the end of the year it goes away. It disappears, the so-called use it or lose it phenomenon.

Similar situation with the health reimbursement arrangement. If an employer is willing to provide additional dollars to take care of an employee's health care, why not allow those dollars, if they're not used at the end of the year, to become a part of that employee's health savings account, to become part of that medical IRA, to be able to grow over time?

We already heard the previous speaker reference Einstein's comment about the miracle of compound interest. And this is exactly the type of power that we could tap into if we were to be able to increase the amount of money that either the employee or the employer could put into that savings account that will be dedicated exclusively for that person's health expenditures.

Some of the other improvements that we could make in health savings accounts would be allow individuals to purchase their health savings account with pre-tax dollars. That would leverage so much more, the purchase of so much more insurance, even for someone in a relatively modest 15 or 20 percent tax bracket. They'd still be buying their insurance with 80-cent dollars, and that means that their insurance, that part of their budget that they allow for insurance, would go a great deal farther.

Perhaps we could allow early retirees to pay some of their continued premiums out of money they've saved in a health savings account. There is lots of flexibility that we could build into the program, and I believe that we've only just started to tap into the power that is available, the power that we can put in the health care consumers hands to be able to provide for themselves and their families with this type of insurance.

Again, I had a medical savings account when they first became available back in 1996. The reason I did it wasn't because I got to have an additional IRA, though that was a great benefit. But the main reason I did it was because it left me in charge of health care decisions. I didn't have to dial 1–800–California and talk to an HMO director somewhere. I was in charge of the expenditure of those medical dollars, and I made the decisions for myself and my family. And realistically, that is a lot of power that we should put back in the hands of the health care consumer.

Well, a lot of the things that we've talked about so far, about the public and private, the creative tension, if you will, that exists between the public and private aspects of providing for health care in this country. But one of the things that I've referenced before, and I think we do need to spend a few minutes on, is we've got to be careful we don't put the cart before the horse, because if we are not careful, this country could face a significant shortage or a significant crisis in manpower, in physicians, in nurses, in other health care providers, other people that we rely upon to give us the health care that we need when we need it.

We need to ensure that doctors in practice today, those at the peak of their clinical abilities, aren't driven out of the system by decisions that we make here in this Congress. And we need to make certain that the best and brightest that are in training programs now, and those that may be looking at going into medicine or nursing as a career, that we don't, because of our decisions in this Congress, that we don't drive them out of, we don't drive them away from their career goals.

Now, about a year and a half ago, Alan Greenspan, just before he retired as the Chairman of the Federal Reserve Board, was talking to a group of us one morning and talked about, someone asked him a question about the, being able to afford Medicare in the future. And he said, yes, he was concerned about that. But he felt certain that when the correct time came, Congress would deal with how to pay for Medicare.

He said, what concerned him more was, is there going to be anyone there to deliver the services when you want them. And those were words that really stuck with me, because I'm afraid if we don't take some steps to acknowledge and encourage the health care work force in this country, we may find we get to that point where a substantial number of baby boomers have retired and we face manpower shortages, and then it's going to be very difficult to deal with the situation. So I do encourage us in this Congress, just like the President said when he talked about Medicare. It's too important to wait for another Congress. We need to take up those issues in this Congress and deal with them.

Now, perhaps one of the most striking things that we have to deal with every year since I've come to Congress is in the Medicare system we get toward the end of the year, and physicians in part B of Medicare face a 5 percent pay reduction. And every year, they become very concerned about that. And every year, except 2002, we've come in at the last minute and done something to help.

Now, it may be nothing more than just holding off the cuts for that year, but we come in at the 11th hour and do something to help.

Last year, in an effort to prevent that from being an 11th hour decision, I introduced a bill, 5866, to do away with the formula under which physicians are paid. And not to go into too much detail, Mr. Speaker, but when you look at Medicare part A, part C and part D, hospitals, HMOs drug companies, each year get, if you will, a cost of living adjustment, a market basket update that increases the reimbursement for each of those three entities.

□ 2215

Physicians, for whatever reason, are treated differently, and there is a finite number of dollars allocated for the part B expenditure; and the more people who put claims in against that finite number of dollars, the thinner the slices of pie are that are ultimately distributed to the providers.

So Congress's attempt many years ago to control Medicare expenditures by controlling volume and intensity of services has created this system, which every year causes a significant amount of strife not only for Members of Congress, not only for practicing physicians, but just tension in general in the medical profession that, since Congress doesn't value the work that we do, maybe we ought not to work for Congress any longer. And I hear that frequently when addressing groups of physicians. And, of course, this time of year, Mr. Speaker, as you know there are a large number of physician groups through town.

So last year I introduced 5866 that said let's do away with the SGR; let's replace it with the Medicare economic index. That is not some formula that I was smart enough to think up. That is basically a market basket index, a cost-of-living update that would occur for expenditures under part B of Medicare. And this formula was worked out by the MED PAC folks many, many years ago. And a lot of physicians asked why we don't use the Medicare economic index. The main problem with going from the SGR to the Medicare economic index is it scores as an extremely high expense when the Congressional Budget Office looks at the bill and says this is how much it costs to do it. In fact, last year when I introduced 5866, the cost of going from an SGR formula to the Medicare economic index minus 1 percent was about $180 billion, and it was just a bridge too far, a hill too high, and we didn't get that done.

This year, for me, it is not just about looking at the Medicare payment problems but also looking at physicians at the beginning of their time in the workforce as well.

But getting the Medicare payment policy right has to be one of the main pillars, one of the main things that we do to effect reform that stabilizes the physician workforce. So paying doctors fairly will increase the career of many physicians who will either opt out of the Medicare system altogether or perhaps seek early retirement, or you never know. They might run for Congress. But principles of the bill that I am introducing this Congress will eliminate the SGR, but it is going to eliminate it in 2 years' time rather than this year. And I know that is a point of contention for a lot of people, but the reality is we are not allowed to look at dynamic scoring.

The Congressional Budget Office simply looks at a static model and tries to make predictions on the future with that static model, and by law we are not allowed to use dynamic scoring. And yet in the Medicare Trustees Report that I earlier referenced, 600,000 hospital beds were not filled in this country because of the things that doctors are doing in their offices, in their ambulatory surgery centers, in their outpatient imaging centers. These were dollars that were savings to part A; but, actually, the reimbursement for those was drawn from part B. So if we could somehow gather and collect and sequester those savings that are happening every day from part A and offsetting the cost of the ultimate repeal of the SGR formula, perhaps we could get to a number that would be much more workable.

Additionally, there is the audit enforcement that has increased lately. The Inspector General of Health and Human Services came and talked to our Oversight and Investigations Committee earlier this year, and they talked about the dollars that they were recovering in various areas of Medicare. These dollars that are recovered were stolen from part B; so these are not dollars that go to the Department of Justice or the Department of Health and Human Services in some other form. They go to part B to offset the expenditure for repealing the SGR. And I think if we will collect and allocate and sequester those funds and use those against the scoring for repealing the SGR, within 2 years' time we should have a significant dollar amount to be able to use to offset the expense of the SGR repeal.

Now, in the meantime, yes, it is necessary to protect physicians who are practicing against the cuts that are already programmed to happen in the SGR formula for 2008 and 2009, and I would propose voluntary reporting, voluntary health information technology upgrades, and if a doctor or medical group is willing to do that, they could achieve as much as a 6 percent bonus payment for those 2 years to offset the reduction in payment that would come about as a result of the SGR formula. But the reality is that if we don't put a premium on prevention, if we don't put a premium on timely treatment of disease, and if we continue to drive mature physicians out of the workforce, we are probably not going to get our best fiscal results with the Medicare program, not to mention our best medical results.

Well, what about the other aspects of the physician workforce? What about graduate medical education? And currently we know we are going to need more physicians in primary care, OB/GYN, pediatrics, those specialties that are devoted to treatment of aging individuals. And it only makes sense to increase the number of residencies, particularly in or near communities where the need is the highest. So high-need areas with high-need physician specialties is something that we could bring together and allow hospitals that haven't previously offered a residency program the ability to do that.

We know, for example, in Texas that a physician who trains is likely to practice within 100 miles of where that training occurred. We are losing Texas-educated medical students who are going to other parts of the country for their training and they are not coming back to Texas, and the same thing is happening in other States as well. In an effort to deal with that, if we were to allow medium-size hospitals to start up residency programs, provide some Federal grants and loans for these residency programs to start up, it would encourage physicians to be in practice in high-need specialties in medically underserved areas for those high-need specialties.

Now, further expanding that to the younger individual who is perhaps

thinking about a career in medicine, if we expanded the old health profession scholarship loan concept and provided loan forgiveness, provided tax forgiveness for individuals in medical school, in training, who are willing to go and serve after their training is complete in a medically underserved area in a high-needs specialty, and again, family practice, pediatrics, OB/GYN, and gerontology would be the specialties that immediately come to mind; so all three aspects, keeping the physician workforce of today involved and providing care to arguably that group of the population that is our most challenging, our senior citizens, providing help to physicians who are in training today, and providing some additional help for young people who are looking at medicine as a career but might be concerned about their ability to deal with the large number of dollars that they would owe at the end of that training, to provide some loan forgiveness and some tax incentives for these individuals to, indeed, practice in medically underserved areas in high-need specialties.

Well, I almost can't talk about reform in the Nation's health care system without at least talking briefly about medical liability reform. We have passed medical liability reform in both the 108th and 109th Congresses. We passed it, in fact, a couple of times in each Congress. And this medical liability reform, H.R. 5, that we passed in this Congress in my first months here, in March of 2003, was legislation that put a cap on noneconomic damages in medical liability lawsuits. Modeled after the 1975 Medical Injury Compensation Reform Act from California, this legislation was scored by the Congressional Budget Office as a savings of $15 billion over 5 years back in 2003 when this was first proposed by Congressman Greenwood of Pennsylvania. A savings, Mr. Speaker, and we held many hours to spend looking for savings that the Congressional Budget Office would allow us to credit against additional spending. Well, here was savings that we essentially just walked away from.

Now, in my home State of Texas, we passed a medical liability reform in 2003 for the State of Texas that has been enormously effective in keeping physicians in the State. Previously, physicians were leaving the State. Keeping insurance companies providing the coverage in state. We had gone from 17 insurers down to two the year I first ran for Congress in 2002. And now we are back up to 13 and 14. And, most importantly, those insurance companies that stayed and those that have come back to the State have done so without increasing their rates. And over all, Texas Medical Liability Trust, my last insurer of record before I left my practice at the end of 2002, has dropped their premiums for their medical liability insurance by 22 percent since this law was passed in September of 2003. And mind you Texas Medical Liability Trust in the State of Texas was increasing my premiums by 20 to 50 percent each year for the 3 years preceding 2003. So a real victory as far as providing some relief in medical liability premiums.

The real beneficiary of this law when it passed has been the smaller or the midsize community not-for-profit hospital, and these hospitals, largely self-insured, have now found millions of dollars that have come back to their bottom line that they are able to use to reinvest in capital expansion, to pay nurses' salaries, exactly the type of thing that you want your smaller community not-for-profit hospital to be doing.

So this is important legislation that passed in Texas. I have drafted legislation that essentially copies the Texas law. The Texas law was a little different from what we passed in this House that never got through the other body. The cap on noneconomic damages in the House-passed bill, H.R. 5 in 2003, was a $250,000 cap on noneconomic damages. The Texas plan actually trifurcates the cap. There is a $250,000 cap on noneconomic damages in regards to the physician, a $250,000 cap for noneconomic damages for the hospital, and an additional $250,000 cap for a second hospital or a nursing home if one is involved. So basing off the Texas plan, I think, could give us at least room for discussion about how we might provide some stability, some fairness in our medical justice system in this country.

□ 2230

Other things that we have talked about in our committee, we have had hearings on concepts like arbitration and mediation, the concept of an early offer, where a medical entity, be it a doctor or hospital, could make an early offer to an injured party or a family that would put the reimbursement or the cash in the hands of the person who is injured much more quickly. The current system that we have doesn't do a good job of delivering dollars to people who are injured. And the time it takes, average 8 years time, between the injury and the time of any payment or any settlement is further injury to the person who has already suffered something.

Now, we do need to look at how we structure reporting to the National Practitioner Data Bank if we were to have the concept of an early offer. But again, it's something we talked about and had testimony about in our Subcommittee on Health and I think is something that is worthwhile for us to consider.

One of the other things that I just want to bring up because it is so important, we passed the Deficit Reduction Act in December of 2005. A lot of stuff has been written about the Deficit Reduction Act, but one of the little noticed things about the Deficit Reduction Act was it did allow of State Governors a good deal more flexibility to do things within their State if they thought they had a plan that would provide more people with insurance coverage. And of course the prototype is the Massachusetts plan that has been talked about so much. And I recognize that there are plenty of things that you can talk about in Massachusetts that would not extrapolate to my home State of Texas, but still it is a significant feat where a Republican Governor working with a Democratic legislature and State senate could get this legislation through. Now, the proof is going to be in July, when the program actually takes effect and we will see how well it works. But you have also seen California and Governor Schwarzenegger talk about providing a similar sort of plan in his State. Jeb Bush, before he left office in the State of Florida, had additionally a plan for covering more people and providing people more coverage with the dollars that were being spent under the State's Medicare program; again, all because of the flexibility that was brought by the Deficit Reduction Act.

We recently saw in Illinois where a bold attempt at universal coverage did not pass the State legislature. And there I think the issue was largely because of the gross receipts tax and not so much the health care aspects. But nevertheless, many States are tentatively trying to see if there may be some system that works better in their State. Again, the one-size-fits-all philosophy may not be in the best interest of every citizen in every State.

The States taking the lead in crafting new approaches I think are reasonable attempts, and I think these are attempts that should be encouraged by this Congress and not discouraged by this Congress.

Mr. Speaker, I realize that the information that I've been talking about tonight, some of it is technical and complex, some of it is confusing, there are some topics that some people do not even want to think about, but we are in a debate this year, next year, the year after that will forever change how health care is delivered in this country. The decisions we make in this body over the next 12 months, 36 months time are going to affect the health care of our children, of our children's children. And it is important to talk about it, it is important to debate it and it is important to get it right. We must understand the things that are working in our system and the things that are not. Fix the things that are not, and encourage the things that are working.

The only way, I believe, is to keep the public private partnership that has developed in this country since the end of the Second World War, to keep that working for providing health care for the American people; plenty of places where it can be improved, and we are obligated to work on those improvements. But to simply scuttle the system because someone thinks they have a different idea, well, we saw what happened back in 1993, the enormous upheaval that happened in this country

where people really got concerned about whether or not their doctor would be there and able to see them if they got sick. We want to reassure the American people that, indeed, their doctor will be there, their hospital will be there. And keep the thriving private sector, keep the growing public sector and allow that creative tension that exists between the two to expand coverage for more Americans, and most importantly, so that we keep it affordable for our children, our children's children and into the future.

Mr. Speaker, it has been a long day. Many of us traveled today. And I appreciate your indulgence. I am going to yield back whatever time is remaining.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

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

Mr. ENGEL (at the request of Mr. HOYER) for today and the balance of the week on account of a family medical emergency.

Mr. GUTIERREZ (at the request of Mr. HOYER) for today and until 3:00 p.m. May 15.

Mr. CULBERSON (at the request of Mr. BOEHNER) for today on account of personal business.

Mr. WHITFIELD (at the request of Mr. BOEHNER) for today on account of attending a funeral.

Mr. CRENSHAW (at the request of Mr. BOEHNER) for today on account of business in his district.

Mr. WAMP (at the request of Mr. BOEHNER) for today on account of family health reasons.

Mr. EVERETT (at the request of Mr. BOEHNER) for today on account of business in his district.

Mr. PITTS (at the request of Mr. BOEHNER) for today and May 15 on account of attending a funeral.

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

Mr. EMANUEL, for 5 minutes, today.

Ms. WOOLSEY, for 5 minutes, today.

Mr. WELCH of Vermont, for 5 minutes, today.

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

Mr. DEFAZIO, for 5 minutes, today.

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

Ms. SOLIS, for 5 minutes, today.

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

Mr. MCCAUL of Texas, for 5 minutes, today.

Mr. FORTENBERRY, for 5 minutes, May 15.

Mr. POE, for 5 minutes, May 21.

Mr. BURTON of Indiana, for 5 minutes, today and May 15, 16, 17, and 18.

Mr. DAVIS of Kentucky, for 5 minutes, today.

Mrs. BLACKBURN, 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 15, 2007, at 9 a.m., for morning-hour debate.

EXPENDITURE REPORTS CONCERNING OFFICIAL FOREIGN TRAVEL

Reports concerning the foreign currencies and U.S. dollars utilized for speaker-authorized official travel during the fourth quarter of 2006 and the first quarter of 2007, pursuant to Public Law 95–384 are as follows:

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, CINDY M. BUHL, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN MAR. 2 AND MAR. 5, 2007

Name of Member or employee	Date		Country	Per diem [1]		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]
Hon. James P. McGovern (MA–3)	3/2	3/5	Colombia	1,845,600	828.00		1,590.00			1,845,600	$2,418.00
Committee total											

[1] Per diem constitutes lodging and meals.
[2] If foreign currency is used, enter U.S. dollar equivalent; if U.S. currency is used, enter amount expended.

CINDY M. BUHL, Mar. 22, 2007.

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, HON. FRANK R. WOLF, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN MAR. 29 AND APR. 4, 2007

Name of Member or employee	Date		Country	Per diem [1]		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]
Hon. Frank Wolf		3/29	USA				9,176				
	3/30	4/1	Syria		500						
	4/1	4/1	Jordan [3]								
	4/1	4/3	Israel		794						
	4/4		USA								
Committee total					1,294		9,176				10,470

[1] Per diem constitutes lodging and meals.
[2] If foreign currency is used, enter U.S. dollar equivalent; if U.S. currency is used, enter amount expended.
[3] Pass through.
NOTE: Airline ticket price includes flight from Syria to Istanbul that was changed and then Istanbul to Israel.

FRANK R. WOLF.