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Now, none of us like to pay taxes. None of us like to pay taxes. Our job, as Members of the United States Congress, House of Representatives, is to make sure that we are good stewards of the taxpayers' money that our good citizens send up here for us to run the country.

Now, a great deal of that money is spent on our national defense, the number one priority of this Nation. None of us on this House floor ever like to vote against defense dollars that are being spent around the world where we ask our men and women to go put on the uniform and defend our values and our freedom and our causes around the world.

Mr. Speaker, over the last 6 years, I think the greatest act of omission that has been perpetrated by this Congress is the lack of oversight that has been exercised by this Congress over the executive branch when it comes to how we spend those tax dollars.

Six years ago, our national defense budget was in the neighborhood of $400 billion; today it is in excess of $650 billion. That's about 5 percent of our gross domestic product. There are not many countries, if any, around the world, that spend that much on their military.

Our American citizens, our people back home, don't mind us doing that. They like for us to do it. But they want to know that when they send that money to Washington, somebody is making sure that it's spent wisely, and we are good stewards of that.

What has happened over the last 6 years, when we had one party come in control of the White House, and the House and the Senate, the oversight role by Congress has been abdicated. It's not the first time it happened. It happened before when the Democrats controlled everything.

But in this case it was the Republican Party that was in the majority. As a result, we have seen systemic deficits built in. We have seen a situation where there has been no oversight exercised by the House of Representatives and the Senate over the administration, and the Congress just got in the mode of rubber-stamping everything that the administration wanted, and ultimately, we had some problems. Some arrogance developed, some corruption developed.

That's basically when the American people stood up in November and said, no more, we don't want that any more. We think a divided government works best.

As Blue Dogs, we want to work with the Members on the other side of the aisle in making sure that the American people's money, when it comes to Washington, is spent wisely and is accounted for.

I wanted to remind our citizens back home that this chart in front of us that shows the $8.8 trillion national debt is for real, and that money has got to be paid back by somebody, or at least interest on it has to be paid back; and we ought to stop increasing that number on a daily basis. That's what the Blue Dogs are all about. Let's make sure that the tax money that we collect from American citizens is spent wisely, and that we exercise good stewardship as we see about the people's business of the United States of America.

I am proud to be a Member of the U.S. House with my good friends on both sides of the aisle. I'm proud to be an American. I want to thank my friend from Arkansas for the time.

Mr. ROSS. I thank the gentleman from Tennessee.

In the hour we have been on the floor this evening talking about the need to restore common sense and fiscal accountability to our Nation's government, we have seen the national debt increase by at least $40 million.

Today, the U.S. national debt is $8,807,559,710,099. And for every man, woman and child in America, their share of the national debt is $29,174. Every Tuesday night, those of us in the fiscally conservative Democratic Blue Dog Coalition take to the floor of the House to demand that we pass commonsense solutions to this problem, because it affects all of us. It's time that we restore common sense and fiscal discipline to our Nation's government.

PERSONAL EXPLANATION

Mr. STUPAK. Mr. Speaker, yesterday, May 21, 2007, I was not present for two votes in order to attend a ceremony awarding the BJ Stupak Memorial Fund scholarships.

Had I been present, I would have voted ''yes'' on H.R. 698, the Industrial Bank Holding Company Act (House rollcall vote 384).

Had I been present, I would have voted ''yes'' on H.R. 1425, the Staff Sergeant Marvin ''Rex'' Young Post Office Building (House rollcall vote 385).

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 am coming to the floor tonight, like I have so often in recent weeks, to talk a little bit about health care in our country. The delivery of health care services is one of the things that may not be the first thing that registers in any poll that's taken in this country, but it's sure third or fourth, and it appears in every poll that is taken in this country.

We are, indeed, on the threshold of what might be called a transformational time as far as how health care services are delivered in this country. Certainly, over the remaining 18 months of the 110th Congress, we are going to have several different issues before us, several different times, where we will be able to talk about and debate various aspects of our health care system.

Of course, just of necessity, as a big part of the Presidential election that will occur in the 18 months time, we will deal with the issues surrounding health care and the delivery of health care services in this country. We will be deciding, what road do we want to go if we have a system in our country now where about half is delivered, half of every health care dollar that is spent originates here in the U.S. Congress, and the other half comes from the private sector, uncompensated care and so-called charity care.

What do we want to see grow? What do we want to see encouraged? What do we want to see improved? Do we want to grow the public sector or do we want to grow the private sector?

Certainly expanding the government sector and its involvement in delivery of services, terms you will hear talked about on the floor of this House, things like universal health care, health care for all—in the early 1990s, we called it ''Hillary care''—or do we want to encourage the private sector?

Do we want to encourage the private sector to stay involved in the delivery of health care services in this country, to be sure, to be certain, whether it's public or private, that the dollars that are spent are spent wisely to expand the coverage that's generally available for our citizens of this country. But these two options, and all of the questions and concerns that surround them, this is what we are going to have to decide in this House, certainly within the 18 months that remain in the 110th Congress, or very quickly after we enter into the 111th Congress.

I am hopeful that by visiting with you on some of these things tonight, providing some explanations and some insights into the directions that we might go, or we could consider going, and at its heart, at its core, I think we need to bear in mind that for all of the criticisms that are out there, and we have heard several of them here in the last hour, but for all the criticisms out there about this country and, in particular, its health care system, we do have a health care system that is indeed the envy of the world.

We have people from all over the world who come to the various medical centers over the United States to receive their care there. I believe, my position is, that we want to be certain that we maintain the excellence in the health care system that we have today, improve those parts that need improving, but don't sacrifice the excellence that exists in many areas of our country.

Some people are going to say, well, that's an overstatement that the United States health care system is a good one. They will look at, cite the numbers of the uninsured, they will start to cite the high cost of prescription drugs. There is no question that these are tough issues that this House is going to have to tackle.

Face it, you can pretty much manipulate statistics and numbers any way that you want to. The old adage is that there are lies, there are darn lies, and there are statistics. We have to be careful about how we ask the question and how we frame the question. We have to also be careful that we don't frame the question just so we get the answer that we want, and that we don't effect any improvement for the American people.

But let's talk a little bit about the history, about the background of how we got the system that we have today, how we got where we are today.

So, actually, if we go back and look at our country during the time of World War II, President Roosevelt felt that he had to do something to prevent wartime inflation from simply overtaking the economy. In an effort to do that, he put in place wage and price controls and told employers that, well, employees' wages would be frozen at certain amounts.

Well, employers were having a tough time keeping employees anyway. Many people were off fighting the war or were otherwise involved in the war effort. So employees that were here in this country and available were at a premium. So the employer wanted to do something to ensure that he kept his workforce on the job. And one of the things that they thought about doing was, what if we offer a health care benefit? Is that something that we can do that we will still not violate the spirit of the wage controls that President Roosevelt has imposed?

Indeed, they got a Supreme Court ruling on this subject, and the Supreme Court said that, no, health care benefits would be outside the scope of the wage and price controls. Health care benefits are something that you can make available to your employees, and in fact, you can make those available to employees, and neither the employee nor the employer will be taxed on those dollars that are so spent.

We came out of the Second World War, of course, victorious; at the same time, we had an economy that was just beginning the postwar boom. That economy that was so robust after the war led to the creation of more jobs, more employment. Indeed, the health care benefit was a benefit that was attractive; it was one that people liked. Indeed, it was one that stuck around and persevered and grew over time.

But we were also right at the beginning of a lot of pent-up demand as far as people starting their families, and we saw families start to have children. Boy, did they have children. This was the initiation of the so-called baby-boom generation.

The United States, like many other allies coming out of the Second World War, the United States was really in a unique position, both economically, and from the standpoint that the war was not fought in our backyard, in contrast to Western Europe, we actually were in pretty good shape coming out of the Second World War.

Contrast that to Western Europe, and even Great Britain, ostensibly a victor in the Great War, but at the same time, their economy was in much tougher shape; and when you get onto the continent of Europe, indeed, a good deal more difficulty with the economic recovery in the time immediately following the Second World War.

So a single-payer health care system of necessity was a requirement that the government needed to stand up and stand up in a hurry in order to prevent a significant humanitarian crisis that might otherwise have existed. In order to uphold the health care of their citizens, these governments were required to set up systems in a fairly short period of time.

Fast forward 20 years from 1945 to 1965, and we have the initiation of Medicare, and, shortly thereafter, of the program now known as Medicaid. These programs were signed into law by another Texas President; agreeably, of note, he was from across the aisle, but another Texas President signed these programs into law.

Today, these large government-run programs are focused. Initially they were created to focus on hospital care for the elderly and basic health care services for individuals who are less well off. Now, decades later—1965, when the Medicare program was started—decades later it was evident that the government-run program was slow to change, in need of reform, and it operated at an expense that was just unthought of at the time of the inception of the program. The expense of running Medicare was truly extraordinary.

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By 2003, Congress certainly recognized the outdated model, and was called upon by the President here in this Chamber. President Bush in the first State of the Union Address that I attended as a Member of Congress stood in this House and said: The problem of providing a prescription drug benefit to our seniors is too important to wait for another Congress; it is too important to wait for another President; and it is work we are going to take up this year with this Congress, and we are going to get this done.

Indeed, the President was correct, and that happened. By the end of 2003, the Medicare Modernization Act, that did provide for a prescription drug benefit we now know as the part D section of Medicare, was signed into law, and 2 years later it began to deliver on that promise and deliver prescription benefits to senior citizens who previously had not had access to a prescription drug program.

But it was clear that the government system needed to catch up to what by comparison was a relatively robust private system that was already doing the things required, focusing on things like disease management and disease prevention.

The good work done by the people at the National Institutes of Health over the previous 40 years had certainly set the stage for what we now recognize as a virtual explosion in preventive care. The premature cardiac deaths prevented by research done and delivered by the National Institutes of Health, probably somewhere between 800,000 and 1 million lives from the mid-1960s to the present time, over that 40-year interval, probably 1 million lives that have been saved or 1 million premature deaths that have been prevented by advances in treatment and prevention of heart disease, which in 1965 was certainly a more serious illness or affected a good number of people. And the problem was that oftentimes the first symptom of cardiac disease in 1965 was sudden death.

We no longer think in terms of cardiac disease as extracting that type of toll from our citizens, and that is largely because of the benefits that are there, benefits provided by the medicines like the statins that lower cholesterol, that are able to prevent and postpone the serious aspects of cardiac disease.

So Congress passed the Medicare prescription drug plan that gives seniors coverage for medication. The program has been successful, providing greater benefits for seniors. It did not come without considerable discussion and considerable argument back and forth. But with a massive push by the Department of Health and Human Services, the success of the Medicare prescription drug program now, I think, is clearly evident. But, at the same time, the private sector also continued to improve and expand, and it kind of brings us to the crossroads where we find ourselves today.

Again, at the present time the government pays for about half of all health care administered in this country. The current gross domestic product is roughly $11 trillion, and the Department of Health and Human Services, with its Medicare and Medicaid services alone, costs this country each year upwards of $600 billion. Add to that the expense for the VA, Indian Health Service, Federal Prison Service, and clearly you can see that we are getting quickly to that number which represents 50 percent out of every health care dollar that is spent in this country originating in this Congress.

Again, the other half is broken down, with the primary weight being carried by private industry, commercial insurance. There is also some charitable and some self-pay accounting for the balance of that number.

As the numbers increase for just the overall expense of health care, and the Federal Government continues to have to put more and more of the American taxpayers' dollars into health care, we have got to ask ourselves, are we using the taxpayer dollar wisely? Is the government providing excellence as far as managing money when it spends dollars for health care? Is the government better suited to make decisions about

health care than families? Who is better suited to handle the growing health care requirements in this country?

Now, a government-only universal health care system tends to be more inflexible. In America, my concern is that it will hamper our innovation and delivery of some of the most modern health care services available anywhere in the world.

Two specific examples that a private-based system is more flexible and less expensive. Look at what goes on to our northern neighbor in Canada, a government-run system that took over health care shortly after the Second World War. It is a universal system, and the Canadians are very proud of their system, and rightly so. But there are some trade-offs, and one of the trade-offs is there can be a wait for health care services. In fact, the Canadian Supreme Court ruled in 2005 that access to a waiting list was not the same thing as access to care, and that in some instances the waiting list was, in fact, health care denied to Canadian citizens. And the Supreme Court required that the Canadian system remedy that.

But in Canada, if you find yourself with a diagnosis and a treatment, but a long time between that diagnosis and treatment, people who have the cash can certainly travel across the border to the south into the United States and find that they can have whatever it is they have been placed on a waiting list that seems interminable; whether it be a cardiac catheterization, a CAT scan, an MRI, they find they get it much more quickly than if they simply waited it out in Canada.

So, we have to ask ourselves, is our health or the health of someone in our family something with which we are willing to gamble that that length of time, that that delay won't cause problems, won't increase the morbidity for that particular disease process, won't lead to a lower expectation of a cure or salvage with whatever that particular diagnosis is?

The British Isles, where they have a similar type of system, they have a National Health Service. Again, very famous. Britons love the system. But, in fact, they also have a private system that coexists within their country. And if the National Health Service is not able to get to someone in a timely manner, and if that patient or their family has the funds available to expend, then indeed they can be seen in the private system. And for patients who are concerned that they might not survive their wait, or they are living with significant disability, this is a choice that they are willing to make.

But the reality is, again, our population is getting older and older, and if you ask someone who is in their sixth decade, seventh decade, eighth decade of life to wait for 4 months, 6 months, 8 months, 12 months or longer for a procedure or a diagnostic test, we, in fact, are consuming a significant amount of the available time they have left, and this, in fact, is not a fair allocation of health services.

So my premise would be that the private sector, with all of its difficulties, with all of its faults, is more nimble and is a more suitable and stable arena from which we can build our health care system in the future.

This is a complex relationship; and how Congress instructs the medical care in this country be done is largely going to determine if we have the best health care system possible. Certainly, it is incumbent upon Congress to promote policies that help the public sector maintain efficiency and become efficient in areas where it is not efficient, and, at the same time, allow the private sector to lead the way with innovation and development of new therapies, new techniques, and new ways of tackling old problems.

Now, one of the things that immediately comes to mind any time you have a discussion about health care is the issue with the uninsured. The uninsured population in this country is estimated by the United States Census Bureau to be somewhere around 46 million people. Now, within that group, I would argue that access to health care is not frequently the issue; it is the coverage that is the issue, because there always exists an emergency room someplace where care can be delivered urgently. But we all know the problem there is you don't always get your best result if you put off the treatment or the diagnosis until such time as it just no longer will allow itself to be put off, and we can increase the cost of health care by delivering health care under that model. But I would stress that in this country, it is not lack of access to health care, because those access points do exist, but it is lack of access to coverage that drives a lot of this debate.

Now, some of the things that have happened, and two examples that we should talk about, and, in fact, they are issues that we are going to need to take up within this Congress, because both programs require reauthorization, are the State Children's Health Insurance Program, or the SCHIP program, and Federally Qualified Health Centers.

Now, currently the children's health insurance operates as a joint Federal-State partnership. It certainly provides some flexibility for States to determine the standards of providing health care and funding for those children who are not eligible for Medicaid, but whose parents truly cannot afford health insurance. The program has been successful, and it has been successful across the board.

As we look to reauthorize the program this year, I think one of the things we can do and should do is clarify the fact that it is children's health insurance. While the intent of the legislation is clear, some States have opted to spend their funds on individuals other than children or pregnant adults. In an effort to correct this process, I introduced H.R. 1013, making certain that the SCHIP funds are spent exclusively on children and pregnant women, not on other groups. We don't cover every child who should be covered under the SCHIP program; and, until we do, it only makes sense that we restrict the funding, again, for children and for pregnant women, who are obviously going to be having a child in the near future, so that child can be covered during the prenatal period. But to take those dollars that should be spent covering children when not every child is covered in this country and spend that covering nonpregnant adults seems to undo the intent of the legislation.

Now, if our intent is to provide other coverage for other individuals, let's have that debate, let's have that discussion, let's have that vote. But let's keep those dollars that are designated to provide health care for children providing health care for children.

But SCHIP is an example where children and pregnant women can receive additional medical coverage which otherwise would not be available to them through the Medicaid program. And, certainly, there are some people who are now covered by SCHIP who previously would have fallen into the broad category as the uninsured.

Other ways of coverage for those individuals who are not children, who are not pregnant, there is access to care. If a Federally Qualified Health Center is available in the area, certainly health care can be gained through an FQHC. The patient has access to health care without insurance. In fact, 15 million of that number of the uninsured can access their health care through a Federally Qualified Health Center. A medical home, continuity of care, see the same doctor every time, in some instances have dental and other coverage, have some coverage for prescription drugs. This is real care available to real people, and it is care that should not be discounted, because it is available to all persons in the community regardless of ability to pay, and it is a program that has been up and running for 35 years. It is a program that is providing care today.

Both SCHIP and the Federally Qualified Health Center program were designed to help the poorest, the youngest, and those underserved in our communities. What about individuals that can afford to pay some of their health care services? Two programs that would assist individuals and their companies in receiving health care coverage, health savings accounts and association health plans.

Health savings accounts, previously known as medical savings accounts, are a tax-advantaged savings account that is available to taxpayers who are enrolled in a high-deductible insurance plan, an insurance plan with lower premiums and higher deductibles than a traditional health plan. Sometimes that is referred to as a catastrophic health plan, but it is with a difference, because you can put money away up to an amount that is $5,000 for a married

couple. You can put money away in a tax-deferred or tax-free savings account. That money must be used only to pay for health care services in the future, but that money grows over time and can be a significant source of health care funds for an individual or a couple as they go through life.

For the health savings accounts, the funds are contributed to the account, they are not subject to income tax, and they can only be used to pay for qualified medical expenses. But the best part of having a health savings account is that all deposits to an HSA become the property of the policyholder regardless of the source of the deposit. So that means whether it is the individual themselves or their employer who deposits that money into the health savings account, the actual policyholder is the owner of those dollars designated for health care.

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And patients have a say in how and when they spend their health care dollars; any funds deposited but not withdrawn each year carry over to the next year. And the popularity of HSAs has grown considerably since their inception.

Now remember, medical savings accounts were started a little over 10 years ago in the Kennedy-Kassebaum bill that was passed in 1996. With the Medicare Modernization Act in 2003, the health savings accounts became the follow-on from the medical savings account. These were expanded. The number of companies offering insurance greatly expanded, a lot of the restrictions were removed, and health savings accounts really represent the full measure of what the old medical savings account attempted to achieve, but it just simply had too many regulations in its way to allow itself to come to fruition.

But numbers from 2005, by December of 2005, some 3.2 million individuals had coverage from a HSA. Of that number, 42 percent of those individuals or families had incomes below $50,000 and were purchasing health savings account-type insurance. The HSAs are an affordable option.

In addition, the number of previously uninsured HSA plan purchasers over the age of 60 nearly doubled, proving that plans are accessible to people of all ages. And really, the proof of that, for a young person in the mid-1990s, getting out of college, perhaps going to go into business for themselves, didn't want to go to work for a big company, no longer can be carried on their parents' health insurance, almost impossible to buy health insurance coverage at any price. I know, because I tried in the mid-1990s to do just that for one of my children.

Fast forward to the present time. Go on the Internet, your search engine of choice, type in health savings accounts, and very quickly, with a few clicks, you'll be with a menu that has a number of options available as far as health savings accounts are concerned. And a high deductible, reputable company, PPO plan in the State of Texas for a male, 25 years of age, nonsmoker, these premiums run about $65 a month.

Yes, you do have a high deductible. Yes, until that high deductible is funded with tax-deferred, pretax dollars that are going to go into that health savings account to grow over time and provide the offset for that high deductible, sure, during the first year or early years of having a health savings account, things like preventive care are not necessarily going to be covered. Those are expenses that will have to be paid for out of pocket because most people, fortunately, will not get to the limit of their deductible.

A young person needs a flu shot. They're probably going to have to write a check for that out of personal funds. But over time, that so-called medical IRA will grow and, again, it grows tax deferred and so it can begin to grow quite quickly.

Albert Einstein one time said the most powerful force for good known to man was the miracle of compound interest. That money will grow over time. So for a young person especially, starting that type of account, again, that that can be very powerful.

Now, of the 46 million Americans who are uninsured, nearly 60 percent of them are employed, and they're employed within a small business. Some of these individuals prefer a more traditional health plan than a HSA, but their employer, the small business for whom they work, find offering a health benefit is either nonexistent or just quite simply too expensive for them to provide.

To take some of the burden off of the small employer who wants to provide insurance for their employee, Congress has devised the concept of what is known as association health plans. This allows small businesses a similar business model, or business plan, to band together to get the purchasing power of a much larger corporation in order to provide more cost-effective insurance coverage to their employees.

A group of realtors, for example, or a group of Chambers of Commerce, or medical offices or dental offices or insurance offices, these groups would be able to form a purchasing unit that would be able to purchase health care, again, get the purchasing clout of a much larger group than a small office could ever provide by itself.

This legislation has passed the House of Representatives twice in the 108th Congress, twice in the 109th Congress. It never could get through the Senate, and I believe it is still an important concept and one which we need to come together and work on.

We heard the group before me talking about how important it was to have a bipartisan effort on these issues, and I certainly welcome that spirit, and would suggest we do need to have a bipartisan effort on working out these types of problems for the American people, because association health plans might not bring down the number of uninsured acutely, right away, but it will certainly help stem the number of small employers who are finding it increasingly difficult to provide insurance for their employees.

So it will bend that growth curve of the uninsured that has gone inexorably upward. It will bend that growth curve of the uninsured in a much more favorable direction.

But I think we also heard from the President this year when he talked in the State of the Union address, he talked a little bit about perhaps providing some tax relief to individuals who are self-employed, who would purchase insurance but, gosh, I've got to buy it with after-tax dollars, and that just adds to the expense. So the President was talking about providing some measure of tax relief for individuals who wish to have their own insurance policy.

He also talked about putting a cap on the upper limit of insurance benefits that would be able to be offered by a company to an employee and come to that employee as an untaxed benefit.

One of the things in addition to the issues that the President brought up and one of the things that I think this Congress should look at as perhaps a follow-on or extension to what the President was talking about, would be to provide, whether you call it vouchers, whether you call it tax credits for people who lack insurance, whether you call it premium support, to buy down the cost of the premiums so that a person who is employed, but says those health insurance premiums are just too expensive for me to afford. If we can help that individual pay that premium cost, that keeps the individual off of the Medicaid rolls. So it keeps them from being a governmental expense and allows them to participate in their employer's insurance plan, which has an advantage of keeping the insurance plan that the employer offers a viable one because more employees will be participating; and over time, perhaps that employer will find that they can indeed reach a stage in their employment where they are, in fact, able to carry the cost of the premium expense themselves.

But the concept of premium support not mentioned by the President during his State of the Union address, but one which I feel very strongly is an issue that should be explored by this Congress, it is a concept that we should study, and I think come up with a solution that would be a benefit for the American people.

Well, one of the other things that I do want to talk about in the context of all of these things that I've discussed with health care is, we've got to be careful we're not putting the cart before the horse. A conversation with Alan Greenspan about a year and a half ago, just as he was leaving the Federal Reserve Board, the obvious question came up, how in the world is Congress

ever going to pay for Medicare in the future?

He thought about it. He said, at some point, when the time comes, the Congress will do the right thing and figure out a way to pay for Medicare. He paused and then said, what concerns me more is, will there be anyone left to provide the services that you desire when you get to that point? And that is a very valid observation, and certainly one that drives a lot of my thinking when I study the issues surrounding health care and health care delivery in this country. Because the question legitimately can be asked, is our country heading into what might be described as a crisis in physician staffing, a crisis brought on by a physician shortage in the country?

And I reference back in my home State of Texas. The Texas Medical Association puts out a magazine every month, a periodical every month, called Texas Medicine. I stole the cover of their March issue because it really says what Mr. Greenspan was telling us that day. The title of the lead article in the periodical last March was, Running Out of Doctors. And that is a concept that I think this Congress, we need to pay some attention to that. And if we don't, I think we put the system in this country in greater peril than it needs to be.

And we need to ensure that the doctors who are in practice today stay in practice, that they stay engaged, they stay there providing care to their patients. These are doctors who are at the peak of their clinical abilities, they're at the peak of their diagnostic abilities. We want them to remain active in their practices and providing services and, honestly, services to the patient who have, who provide them with their most complex medical challenges, our senior citizens.

So what steps do we need to take to ensure we have an adequate physician workforce going forward into the future and ensure that the doctors of today stay engaged in the practice of medicine, and that the young people of tomorrow come to realize that a career in health care is one that is not only viable but one that is going to be rewarding for them as well?

Well, tackling a problem that has plagued the medical community for years and years revolves around the issues of medical liability. My belief is that we need a commonsense medical liability reform to protect patients, to stop the escalation of costs associated with lawsuits, and to make health care, to keep health care more affordable and thereby more accessible for more Americans, and to keep the necessary services in the communities that need them the most.

My belief is that we do need a national solution. The State-to-State solutions that have grown out of necessity do leave vast populations in jeopardy, and have the undesirable effect of actually increasing health care expenditures in this country all of the time that we leave that condition unsolved.

I like the system that was developed by my home State of Texas that placed caps on noneconomic damages in medical liability suits. I think it is one that certainly is worthy of study by this body, and perhaps worthy of consideration by this body. Texas brought together all the major stakeholders in the discussion, doctors, hospitals, nursing homes and patients. The State was able to have these discussions and bring the stakeholders to the table and come up and craft legislation that really put the brakes on the escalation that was going on in medical premiums; and just as importantly, to keep medical liability insurers involved in writing policies in the State of Texas.

We'd lost most of our medical liability insurers from the State. They had simply closed up shop and left because they could not see a future in providing medical liability insurance in Texas. We went from 17 insurers in 2000 down to two in 2002. Rates were increasing year over year. In my personal situation, before I left medical practice, my rates were increasing by 30 percent to 50 percent each year.

So, in 2003, the Texas State Legislature passed a medical liability reform based on a much older reform passed in the State of California. California, in 1975, passed the Medical Injury Compensation Reform Act of 1975, which essentially put a cap on noneconomic damages in medical liability suits, and it has worked extraordinarily well in the State of California.

The Texas law was modified a little bit, I'd say made ready for the 21st century. Instead of a single $250,000 cap, there is a $250,000 cap on noneconomic damages as it pertains to a physician, a $250,000 cap on noneconomic damages as it pertains to a hospital, and an additional $250,000 cap as it pertains to a nursing home or a second hospital, if one is involved, for an aggregate cap of $750,000.

So the question is, how has the Texas plan fared? It actually came into law September 12th of 2003, and remember, I said the State had dropped from 17 medical liability carriers down to two because of the medical liability crisis in the State. Now we're back up to 14 or 15 carriers. And most importantly, they came back to write business in the State of Texas without an increase in their premiums. This is, indeed, a significant reversal.

More options mean better prices and a more secure setting for medical professionals to remain in practice and certainly provides physicians the certainty that they need to keep their practices open in Texas. And one of the most astounding and unintended beneficiaries of this was that of the small, community, not-for-profit hospital that was self-insured for medical liability. These small community hospitals have been able to take money out of those escrow accounts that they were having to hold in abeyance in case they found themselves involved in a liability suit, and have been able to put more money back into their community hospitals, been able to spend money on capital expenses, been able to spend money on nurses' salaries, precisely the types of things you want your small, community, not-for-profit hospital to be doing, rather than just holding money against a day where they might be involved in a large damage suit.

So I took the language of the Texas plan and worked so it would fit within our legislative structure here in the House of Representatives, and actually gave this legislation to the ranking member of our Budget Committee, and he had that bill scored by the Congressional Budget Office. So the Texas plan, as applied to the Texas house of representatives, to the entire 50 States, would yield an average savings of $3.8 billion over 5 years.

□ 1945

Not a mammoth amount of money, but when you are talking about a $2.99999 trillion budget, this savings would amount to moneys that we could use on any of the other number of spending priorities that we hear so much about in this Congress.

And consider this: A study done in 1996 by Stanford University revealed that in the Medicare system alone, the cost of defensive medicine was approximately $28 to $30 billion a year, 10 years ago, Mr. Speaker. I suspect that that number is significantly higher today. Defensive medicine, those additional tests and procedures that are ordered by doctors in order to help them provide a good defense should they have a bad outcome and should the case go to litigation in the courts, again, moneys expended on medical care not for the care of the patient, but to provide the best possible defense for a physician if a case is taken into court.

Another consideration is young people getting out of college who are considering a career in the health professions, whether it be medical school, nursing school, dental school, or one of the allied professionals, the current system keeps young people out of the practice of health care for their livelihood because of the burden that we put on them. One thing we have to consider: They are graduating from school with massive amounts of debt, and then immediately upon getting out and emerging on the world and starting into practice, they have to come up with another $100,000 for their liability insurance. It is an untenable position, and it drives young people away from considering a career in health care.

One of the things that I think we really need to focus on, getting back to the cover of Texas Medical Association and running out of doctors, part of ensuring that the workforce for the future includes helping younger doctors and younger students with residency programs, one of the strange things about doctors is we do tend to have a

lot of inertia. A lot of us tend to practice very close to where we did our training. Studies have shown that many doctors will stay within 100 miles of where they trained. They like to practice in communities similar to the communities in which they did their training. So it would be a great asset to look at areas in this country where there is high need for certain types of physician specialties, areas that are currently medically underserved, and encourage young doctors to get their training in these locations where they are actually needed.

Now, a bill that I am going to introduce, called the Physician Workforce and Graduate Medical Education Enhancement Act, would develop a program that would permit hospitals that do not traditionally operate a residency training program the opportunity to start a residency training program to build a physician workforce of the future. This bill would create a loan fund available to hospitals to create residency training programs where none has operated in the past. The programs would require full accreditation and be generally focused in rural, suburban, inner-urban community hospital locations.

On average it costs a hospital $100,000 a year to train a resident, and the cost for smaller hospitals can be prohibitive. Another concern stems from the 1997 congressionally passed balanced budget amendment that set a residency cap that also limits resources to nontraditional residency hospitals such as smaller community hospitals. In my bill the loan amount to any institution would not exceed $1 million, and the loan itself would constitute start-up funding for a new residency program.

As we all know, the start-up money is essential. Since Medicare graduate medical education funding can be obtained only when a residency program is firmly established, the cost to start a training program for a smaller, more rural, or suburban hospital can be cost-prohibitive because these hospitals operate on much narrower operating margins.

The overall bill would authorize a total of $25 million to be available over 10 years. The fund, of course, would be replenished because these are constructed as loans, and the Health Resources Service Administration may make the loans available to new applicants. These moneys would be repaid, and the residency slots in existing programs would continually work to bring new residents into the program and keep the program self-perpetuating.

To be eligible, a hospital must demonstrate that they currently do not operate a residency program, have not operated a residency training program in the past, and that they have secured preliminary accreditation by the American Council on Graduate Medical Education. Additionally, the petitioning hospital must commit to operating a residency program in one of five medical specialties or a combination of specialties: family medicine, internal medicine, emergency medicine, OB–GYN, or general surgery. Again, the hospital may request up to $1 million to assist the establishment of this new residency program, and funding could be used to offset the cost of residents' salaries and benefits.

The bill would require that the Health Resources Services Administration study the efficacy of the program in increasing the number of residents in family medicine. The loans would be made available beginning January 1, 2008, and the program would be sunsetted in 10 years' time, in January 2018, unless Congress voted to reauthorize the program.

Now, locating young doctors where they are needed is just part of solving the impending physician shortage crisis that will affect the entire health care system. Another aspect that must be considered is training doctors for high-need specialties.

My High-Need Physician Specialty Workforce Incentive Act of 2007 will establish a mix of scholarships, loan repayment funds, tax incentives to entice more students to medical school, and create incentives for those students and those newly minted doctors. This program will have an established repayment program for students who agree to go into, again, family medicine, internal medicine, emergency medicine, general surgery, or OB–GYN, and practice in an underserved area. The Health and Human Services Department will administer and promulgate the requirements. The recipients must practice in the prescribed specialty and the prescribed area, which is designated as a medically underserved area, and the practices may include solo or group practices, clinics, public or private nonprofit hospitals. And it will be a 5-year authorization at $5 million a year.

The bill would provide additional educational scholarships in exchange for a commitment to serve a public or private nonprofit health facility determined to have a critical shortage of primary care physicians. Such scholarships will be treated as equivalent to those under the National Health Service Corps, and penalties apply for those that take advantage but do not go into one of those practice areas.

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

In other areas such as the Louisiana gulf coast, where so many doctors left after the devastating hurricanes of Katrina and Rita 1½ years ago, it has been very hard on the doctors in this area, very hard to keep doctors in this area, very hard to encourage and entice new doctors to come to the area; and this would be one more tool, one more way, to keep the rather fraying social safety net from becoming completely undone in that area.

Every year there would be a report back to Congress about the effectiveness of the program. This would allow us to assess if we are spending our dollars wisely and getting what we thought we would get when we initiated the program. Again, oversight is going to be key to this process.

Well, so far in addressing the physician workforce crisis, we have discussed the medical liability, the placement of doctors in locations of greatest need, and the financial concerns of encouraging young people to go into medical school in the first place and to remain in high-need areas in high-need specialties.

The next portion of this has to deal with perhaps the largest group of practitioners affected in this country and certainly the still-growing group of patients, our baby-boom generation, within the Medicare program.

The baby boomers, and we have already talked about it, as they age and retire, the demand for services has nowhere to go but up. And if the physician workforce trends continue as they are today, which is downward, we may not be talking about funding a Medicare program. We may be talking about what are we going to do to take care of our senior citizens when there is no one there to take care of them? I often tell people if you see a train wreck coming, you have two options. One is to stop the wreck and avert the wreck from happening in the first place; and the other is to run home and get your video camera and be the first to get it up on YouTube. I believe the responsible approach is to avert the crisis in the first place.

Year after year there is a reduction in reimbursement payments from the Center for Medicare and Medicaid Services to doctors for the services they provide to their Medicare patients. This is not a question of doctors wanting to make more money; it is about a stabilized payment system for the services that are already rendered. And it isn't just affecting doctors. It affects patients. It becomes a real crisis of access.

Not a week goes by that I don't get a letter or fax from some physician who says, you know what, I have just had enough, and I am going to retire early. I am no longer going to see Medicare patients in my practice, or I am going to restrict the procedures that I offer to my Medicare patients. Unfortunately, I know this is happening because I saw it in the hospital environment before I left the practice of medicine to come to Congress, but I also hear it in virtually every town hall that I do back in my district. Someone will raise their hand or come up to me after the town hall is over and say, how come on Medicare, when you turn 65, you have to change doctors? And the answer is because their doctor found it

no longer economically viable to continue to see Medicare patients because they weren't able to keep up with the cost of delivering the care. They weren't able to cover the cost of providing the care because of the cuts that are happening year over year in the Medicare reimbursement formula.

Now, Medicare payments to physicians are modified annually using a formula called the sustainable growth rate. Because of flaws in the process, the sustainable growth rate formula has mandated physician fee cuts in recent years that have only been moderately averted by last-minute activity by Congress. If no congressional action is implemented, a cut goes through. And if no long-term action is taken, the SGR will continue to mandate fee cuts for physicians. And unlike hospital reimbursement rates, which closely follow the Medicare Economic Index, a cost of living index, if you will, which measures the increasing cost of providing care, physician reimbursements don't do that. In fact, Medicare payments to physicians cover only about 65 percent of the actual cost of providing patient services. Can you imagine any other industry or service or company that would continue in business if they received only 65 percent of what they spent to deliver the service? Not 65 percent of what they needed to make a profit; 65 percent of what they need to simply keep the doors open in the first place. Currently, the sustainable growth rate formula links physician payment updates to the gross domestic product, which has no relationship to the cost of providing patient services.

But the simple repeal of the sustainable growth rate formula can't happen, or we are told it can't happen, because it is too cost-prohibitive. Two hundred and eighty billion dollars is what it would cost this year to repeal the sustainable growth rate formula.

But perhaps if we approached it as something we could do over time, we could bring that cost level down to an area that is manageable. And paying physicians fairly will extend the careers of many physicians who are now in practice who would either opt out of the Medicare program, seek early retirement, or restrict those procedures that they offer to their Medicare patients. It also has an effect on ensuring an adequate network of doctors available to older Americans in this country that make the transition to the physician workforce in the future.

In the physician payment stabilization bill that I will introduce, the SGR formula would be repealed in 2010, 2 years from now, and provide incentive payments based on quality reporting and technology improvements. These incentive payments would be installed to protect practicing physicians against the program cuts that are likely to occur in 2008 and 2009. The incentive payments would be voluntary. No one would be required to participate in a quality program or the technology improvement, but it would be available to those doctors or practices who wanted to offset the proposed cuts that will occur in physician reimbursement in the 2 years until a formal repeal of the SGR happens.

Now, I do know from talking to my friends who are physicians and my friends in organized medicine that it is an alarming thought that we would have to wait for any period of time before repeal of the SGR.

□ 2000

If we step back and look, in terms of a long-term solution, the only practical approach is, in fact, to deal with it on a long-term basis. The reason we are in the deep depression we find ourselves in is because year over year we've only provided these last-minute fixes, which have only served to exacerbate the problem, not solve the problem.

Well, why not just do away with the SGR once and for all and get it done? Remember, the cost for doing that is going to be about $280 billion. One of the problems that we have in Congress is the Congressional Budget Office is the group to which we must petition and the group to which we must look for advice about how much things are going to cost. If we are going to be spending the taxpayers' money, how much are we going to spend, over what time will we spend it? Because of some of the constraints of the Congressional Budget Office, we are not allowed to say, look, we are doing things so much better now within the system that give us credit for that going forward so we can, in fact, reduce that number from $280 billion down to something that is more reasonable.

We all saw the Medicare Trustees Report from about 2 weeks ago. It said that in the year 2005, there were 600,000 hospital beds that were not filled as a result of improvements that have occurred because of disease management, because of doctors doing things more efficiently. These are dollars that have been saved out of the part A portion of Medicare, but it's because of work done in the part B part of Medicare, and that is, after all, where we are all focused within the part B world.

By postponing the repeal of the SGR by 2 years' time and taking the savings that occur during those next 2 years and applying it back to the SGR formula, we may actually get a number that is doable as far as releasing the SGR and replacing it with the full Medicare economic index so we can pay doctors the same way hospitals, HMOs and drug companies are reimbursed.

One of the main thrusts of this bill is to require the Center for Medicare and Medicaid Services to look to their top 10 conditions that drive the highest percentage of payment. It's the old Willie Sutton argument: He robbed banks because that's where the money is. Let's look at the top 10 drivers of health care expenditures in this country, and look at ways where we can improve the care that is delivered in those 10 areas, and look to those areas to give us the savings that will, in fact, deliver the benefit towards the ultimate repeal or retirement of the SGR.

The same conditions actually apply to the Medicaid program as well. It will be a useful exercise. It helps not only Medicare, but would also help CMS with the Medicaid expenditures as well, and will just help physicians in general provide better care for their patients.

It will include some reporting back to doctors and back to patients as to their utilization amounts; these numbers will not be made public generally, but will allow doctors to individually modify their own practices if they see there are ways where they may improve.

Health information technology, it is something which, I will admit, I have been slow to come to the table with as far as looking for improvements in health information technology to provide substantial savings. And I will tell you what changed my mind on that.

In January of 2006, with our Oversight and Investigations Committee down in New Orleans, Louisiana, to look at the recovery from the hurricane as it impacted the health care system in that part of the world, this is the medical records department at Charity Hospital, one of the venerable teaching institutions in our country. When the city of New Orleans was flooded, these records were completely under water.

Now the basement has been all but completely emptied of water. There is probably about a foot of standing water that doesn't show up in the photographs. But look at the records. This is not smoke or soot damage, this is black mold growing on these records. So how do we know that there is a patient in there that is on dialysis waiting for a kidney transplant? We will never know.

We couldn't ask anyone to go in there and go through those records, it would be hazardous to their own health. How do we know about where a person was in their cancer treatment? We will never know that information; that information has been lost to the ages. This is the kind of problem that you can get into with paper records.

You know, the youngsters of today, the college students of today, indeed, the young physicians of today, they understand this very well. They are connected, they are wired in, they all have flash drives and zip drives. They would no more imagine preparing a term paper for one of their classes and then only keeping one paper copy. No. They've got it on their hard disk. They've got it on a floppy disk. They've got it on a flash drive. They have probably e-mailed it to someone back home. The old adage of ''The dog ate my homework'' just won't wash anymore. We need to evolve into the 21st century when it comes to medical record keeping.

It costs money to do this. It is going to require a big push from both the

public and the private sectors. I prefer to think of the bonus payment as being an inducement and enticement for physicians offices to participate in this program. But on the face of it, it's just good medicine, it's just good patient care.

Now, we all heard about the troubles at Walter Reed Hospital a few months ago. I went out to Walter Reed shortly after the story broke in the Washington Post, and here is Master Sergeant Blades. And he took me around building 18, and yeah, it was a crummy building. We could certainly have done a lot better than we were doing for our soldiers on medical hold in building 18.

But the real thing that bothered Master Sergeant Blades was the fact that they had to wait so long to get in to see someone. And when they did, oftentimes their records that they had worked on and they had prepared and they had organized, sometimes those records, after they delivered them to the appropriate clinic, their records would get lost. His specific complaint to me was, I can spend 20 man-hours putting together my medical record and highlighting the areas that are of significance and importance to me. This goes over to one of the clinics. It sits on someone's desk until it is no longer retrievable, and I have to start all over again.

Now, the VA has been very forward thinking in its embrace of electronic medical records and its investment in medical technology. The problem is the Department of Defense medical records do not interface with the VistA system at the Department of Veterans Affairs. So if delivering value to the patient is of paramount importance, it is critical that we make this type of service generally available to our patients.

Mr. Speaker, I was also going to address some of the issues on health care transparency; I probably don't have time to do that. I will simply mention that I have introduced a bill dealing with health care transparency that provides for keying off what is happening in the States, and making certain that every State would have at least some level of transparency in health care pricing.

In Texas, up on the Web right now, and I realize it is going to go through several different iterations and it will evolve considerably over time, but TXpricepoint.org, available on the Internet, allows patients to compare prices on hospitals in their area.

Again, a lot of things we have to consider when we work on the transformation of the health care system in this country. There are good things as far as the public system, there are good things as far as the private system. We have got to be certain that we build on the good things present in both systems, and that we stop doing the things that no longer deliver value to our patients.

U.S. TRADE AGREEMENTS

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

Mr. CROWLEY. I thank the Speaker for affording me this opportunity. And to the new Democratic coalition, to have an opportunity to speak a few moments on the new template that has been created as we move forward on trade here in the House of Representatives.

I want to take this opportunity again to applaud the Chair of the Ways and Means Committee, my chairman, Mr. RANGEL, as well as chair of the Subcommittee on Trade, Mr. LEVIN, as well as the Speaker of the House, NANCY PELOSI, and the entire Democratic leadership for what I believe was forcing the Bush administration to agree to a framework that will encompass all future trade agreements, a framework that will ensure that our trade pacts with other nations respect labor, both here in the United States and abroad; that respect the environment both here and abroad; and respect our Nation's future economic success. And specifically, the new Democratic majority achieved a long sought-after goal that our trade agreements will include enforceable labor and environmental standards.

I think it is incredible that our caucus, that charged our leadership and Mr. RANGEL with the authority to negotiate on behalf of our caucus with the administration, with the USTR, the principles that we laid out for him and for our leadership. And what is remarkable is the success that Mr. RANGEL and our other leaders met in those negotiations.

This new framework, this new template, as I said before, illustrates how Democrats, in response to public demands to work in a bipartisan way, how we were able to achieve our goals by working cooperatively with Republicans without compromising what we stand for as Democrats—and that, in large contrast to the stalemates that we saw in recent past Congresses.

I think it is a new day in many respects for the Ways and Means Committee and for the House of Representatives. I hope it goes beyond this new template for fair and free trade agreements: that this can be used as an example in other areas; that we can hopefully work in a more bipartisan spirit, not always agreeing, not always getting along, but working in the spirit of cooperation on behalf of all our constituents, be that Democrat, Republican or Independent.

This new trade policy achieves the core Democratic principles and goes far beyond the provisions in any previous free trade agreement. All pending free trade agreements will be amended to incorporate key Democratic priorities and will be fully enforceable. Key demands that were met are fundamental labor and environmental protections included in trade agreements that are fully enforceable.

I think it is important to note here, after years of opposition, this administration and the former Republican-controlled Congress agreed to include in the text of the agreement the five ILO worker rights: first, the right to association. Secondly, the right to collectively bargain. It also prohibits child labor. It prohibits slave labor. It prohibits discrimination. For the first time, environmental standards cannot be lowered, and will be fully enforceable in free trade agreements going forward.

The agreement upon framework expands access to life-saving medicines in developing countries as well. Trade agreements with South Korea and Colombia present additional and distinct obstacles that need to be addressed. This is a framework; it is not carte blanche for every free trade agreement moving forward.

The framework is about leveling the playing field for America's workers, for our farmers and businesses, and promoting a trade policy that advances U.S. economic interests around the world, but also advances what we stand for as Americans.

Democrats will continue to work across the aisle to make sure our country stays in the forefront of this globalizing economy and this globalizing world. Working across the aisle, Democrats will educate our youth and upgrade worker skills on the job, and stimulate science, education and research as we move forward.

Democrats are committed to moving beyond the current trade adjustment assistance, TAA system, to provide meaningful support, training and revitalization programs for entire communities which have been hurt by the effects of trade and technology. This bipartisan framework will keep America as a global economic leader and a champion for the principles Americans all believe in.

I am so happy to be joined this evening by a fellow member of the New Democratic Coalition, ALLYSON SCHWARTZ from Philadelphia, who would also like to share her thoughts about this new template that we have been able to create here in the House of Representatives.

Ms. SCHWARTZ. I thank Congressman JOE CROWLEY from New York, who has been a leader in the New Democratic Coalition. He has really been, as a member of both the coalition and of the Ways and Means Committee, as I am, really out front and really working to make sure that we are as economically competitive as we need to be in this country. And that means all American workers being given new opportunities. And that really does involve making sure that we get these trade agreements right.

So I want to thank the Congressman, and thank him for asking me to join him this evening.

What I want to do is to add my words, some of them will be similar, I