

issues of security, issues of health care, and they are issues that the vast majority of us ought to support.

So I challenge our friends on both sides of the aisle to step forward and support a positive agenda for the American people. It's outlined right here.

I want to commend you for your leadership, and I appreciate the opportunity to join you tonight.

Mr. KIRK. I thank you. And I commend everyone, that if you'd like to learn more about the suburban agenda, you can go on to our website, www.house.gov/Kirk for an outline of the suburban agenda. This is not just an us-only agenda. This is an agenda that we hope will be matched from the other side. But refocusing our work on health care, on education, on environmental protection and on economic growth, so that this Congress can realize it's full potential far better than in the first 5 months of our activity.

HEALTH CARE IN AMERICA

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

Mr. BURGESS. Madam Speaker, I want to also thank and commend my friends for their discussion of the suburban agenda. I am coming to the floor tonight to talk about health care, and of course they've already covered a lot of those issues in their discussion that preceded in the past hour.

I want to talk about some concerns we have in the delivery of health care services throughout the country. The future of medical care in this country is going to be front and center over the next 18 months time. The elections of 2008 will be about a lot of things, but they will also be a lot about health care.

Three bills that I want to focus on this evening as well, H.R. 2583, H.R. 2584 and H.R. 2585. The first, H.R. 2583 deals with residency programs. The second, H.R. 2584 deals with loan forgiveness and tax abatements for medical students and newly minted doctors. And the third, H.R. 2585, deals with physicians in the Medicare program who are adversely affected by reimbursement reductions every year under a formula known as the sustainable growth rate formula.

Well, as we go through these next 18 months and deciding which avenue through which our health care system is going to go, we have two choices on the table. We've got a public sector, the government side, which already has about half of the responsibility for health care in this country. And we've got that which is comprised of the private sector, as well as that care which is just simply delivered without expectation of compensation, what used to be known as charitable care.

Under the option to expand the government's role, the government's side,

the government's sector involvement in the delivery of health care, typically that's known as universal health care. In the 1990s we called that "Hillary Care."

But could we also approach it from a standpoint of encouraging the private sector to stay involved and to improve their products and make them more flexible and user friendly in order to provide more for our health care dollar in this country.

My opinion, having worked in the system for well over 25 years, is the United States does have the best health care system in the world, and it is my obligation, my charge to help it remain the best health care system in the world.

Now, I know there's plenty of people in this body who would contest that statement. And there's plenty of issues around to call it into question.

My predecessor in this office, former Majority Leader Dick Armezy used to be fond of saying, you know, the numbers don't lie; but if you torture them long enough, they'll admit to almost anything.

But let's talk about some of the different principles that are guiding the debate about public versus private and the delivery of health care services. And maybe we ought to spend a little time talking about the background. How did we get into this? How'd we get to where we are today?

You almost have to go back over 60 years to go back to the time coming out of World War II when the United States, of course, was the victor; came out of the war with a flourishing economy.

But during the war, President Roosevelt, in an effort to keep down trouble from inflation, put into effect rather stringent wage and price controls across the country. The employers wanted to keep employees, so a lot of employees, of course, had been drafted and were serving overseas, so those employees that were left the employers wanted to keep them working. But they were constrained. They couldn't offer raises. They couldn't offer the money that would be required; they were worried that someone across town might outbid them.

Well, they went and came upon the idea of providing a health care benefit, and, in fact, the Supreme Court ruled that that was okay; that that did not violate the spirit or the intent of the law that Franklin Roosevelt had passed governing the wage and price controls. So during the war, the concept of employer-based insurance was begun.

The war ended. The United States was blessed with the postwar economic boom that started, and what began as a necessity born out of a wartime economy continued. It was extremely popular. Health care insurance provided by the employer turned out to be one of the most popular employee benefits that has ever been seen in this country. And up until the early 1980s it just worked wonderfully.

Contrast that, of course, with Europe. Even the parts the Europe that were victorious in the Second World War, the battles were fought in their back yard. Their economies were devastated. They needed to quickly stand up a health care system that would take care of a population that had been deprived by 5 years of war or longer. And these countries decided to promote the single payer system that you see that's so prevalent in Western Europe and in England today.

But that was born of necessity also, because, again, the country's economies were devastated or, in fact, they had not been victorious in the war, they had lost the war, but they needed to quickly stand up a system that would take care of their citizens.

We go from 1945 to 1965. Presidency of another Texan, Lyndon Baines Johnson. During that time, President Johnson enacted the Medicare statute, a little over 40 years ago. The Medicare and the Medicaid programs were signed into law during his administration. These were large government-run programs that were created to focus primarily on hospital and physician care for elderly and basic health care services for the people who were this poverty.

Decades later, almost 40 years later, it was evident that the government-run Medicare program, extremely slow to change, very difficult to change a large government program; and anything that that caused any change within the program was going to be incredibly expensive.

Already difficult to operate.

But in 2003, in fact, my first year to serve in this Congress, my first State of the Union message that I heard the President deliver in this House, he talked about how the need for, or the time for a Medicare prescription drug benefit had arrived; and this was too important an issue to be left to another President or another Congress. It was work that we were going to take on that year, 2003, and get that benefit delivered to the American people. And indeed we did.

We worked on that bill in various committees throughout the year 2003. Right at the end of the year we passed the bill. There was initially a prescription drug discount card that was available, but over the next 2 years the Centers for Medicaid and Medicare Services put together the plan that we now know as the Medicare Part-D plan. And in spite of all of the problems that it had getting started, arguably it is one of the better functioning government-run health care programs ever seen to date.

But the government needed to catch up to a private system that was already focused on prevention, timely treatment of disease and disease management. So finally Congress put the Medicare prescription drug plan, that focused on giving seniors access to needed medications forward, and the program has been successful and provided benefits for seniors. It's come

with, obviously, considerable discussion, and a big push for success, a lot of it delivered by the private sector.

So here we sit at the crossroads today. Again, the government pays for half of the health care administered in the country with a current gross domestic product, the GDP of 11 to \$12 trillion.

The U.S. Department of Health and Human Services, through their Medicare and Medicaid services alone, pay \$600 billion. Add to that the VA system, add to that the Federal prison system, the Indian Health Service, and you have about half of the health care expenditures in this country.

The other half of health care is broken down with the primary weight being carried by private insurance. There is some charitable and there is some self-pay accounting for the rest. I think you'd probably include bad debt in that other 50 percent.

Well, as the numbers increase, the overall cost of health care for the entire country, as that number increases the Federal Government continues to funnel the American taxpayers' dollars into these efforts, and we have to ask ourselves, what is the wisest and best use of taxpayer dollars?

Is the government doing an excellent job of managing your money?

It's not their money. It's your money. Do you think the government is better suited for your health care needs?

Whose going to handle or who is better equipped to handle the growing health care problems crisis, if you will, in this country?

The government only or the universal health care system, to me, almost is unsustainable. And it certainly is likely to hamper innovation, and hamper the delivery of some of the most modern health care services that the world has ever known.

Now, two examples of that, one very close to home, that would support the notion that a private-based system is better equipped and more flexible and less expensive than a government system, look to our north. Look at Canada.

Canada boasts a universal health care system. But what it fails to highlight is the tremendous wait for treatment that its patients must endure. In fact, in either 2004 or 2005, the Canadian Supreme Court ruled that access to a waiting list did not equal access to care because the waiting times were so long in that country. Their access to care is limited by the length of time that one must wait for care.

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Now, in Canada they actually have a pretty good safety valve, and that safety valve is called the United States of America. One of the longest borders in the world is our northern border with our northern neighbor of Canada. And, in fact, if someone has the means to pay outside the system and feels that the wait is deleterious to their health,

they can leave Toronto and go to Henry Ford Hospital in Detroit and have that MRI, have that CAT scan, have the stent placed in a coronary artery if they don't feel the wait is in the best long-term interest of their health.

So you can take your money, cross the southern border of the United States, and receive care almost immediately, waiting for bypass surgery where you go to the hospital that puts you on a waiting list or puts you in a hospital and put you in a cath lab and gets the problem fixed. When it comes down to your health and a serious health problem, who wants to gamble?

Also, look at the National Health Service in Britain. They really have developed within their country a two-tiered system. Indeed, the wait times are a significant problem within the National Health Service. You can go outside the National Health Service, stay in the country of Britain, go outside the National Health Service and go to one of the private physicians. Physicians work in their offices at the time they are required by the government and then operate a private practice on the side. Some of the most expensive health care in the world is available right alongside the free system in the National Health Service. And the fact that it is able to run, the fact that it is able to go, certainly speaks to the fact that it is serving a need that people want filled.

The other thing you have to ask yourself, if you have someone who is going to have to wait 6 or 8 months for a CAT scan or an MRI, if you have someone who is going to wait half a year or a year's time for replacement of an artificial hip and that person is nearing the age of 80, a year's wait is a significant period of time of the number of days that that person has left in their life. It is a sad reality but, nevertheless, true.

Again, I come back to the notion that the private sector is more nimble and more financially responsible and it is the better way to build the future of our health system. It is a complex relationship. And how Congress should do its job to ensure that we have the best health care system possible is going to be the central part of the debate that we have over the next 18 months. In my opinion, Congress has to promote policies that keep the private sector leading the way with some interaction that leads to a well-run government system.

You can hardly talk about health care in this country without coming up against the problem of the uninsured. The Census Bureau right now estimates that some 46 million people in this country are uninsured.

Now, uninsured does not always mean lack of access to health care because we all have heard stories about people who use the emergency room for relatively modest problems. It is one of the more expensive ways to get care. There is also a disadvantage too in that if you wait until a modest health care problem becomes an emergency,

then you are oftentimes not going to get the best health care bargain or the best bargain for your health care dollar. You are also possibly going to jeopardize the health outcome. So no one would argue that just simply relying upon our Nation's overstretched emergency rooms are a method of dealing with the problem of the uninsured. But I think it is important to point out that doctors and nurses in hospitals on the front lines every day see people and take care of their medical needs, fully recognizing that there may not be a reasonable expectation of payment for those services. And we owe those individuals a debt of gratitude for continuing to do that, sometimes in the face of some rather severe Federal regulations and an extremely hostile medical liability climate.

One of the other things that we will talk about, in fact, we are required to do in this Congress is the reauthorization of what is known as SCHIP, the State Children's Health Insurance Program. This is a program that was started some 10 years ago. It had a 10-year authorization and requires that the Congress reauthorize it this year.

The two gentlemen who were here before me talking about the slow pace of things in this Congress could have added the slow pace of the reauthorization of the current SCHIP language to that list of things that they were concerned about. This is legislation that, again, Congress is required to reauthorize prior to September 30 of this year when the authorization expires. There is no continuing resolution. There is no IOU or Band-Aid we can put on this program. We simply must reauthorize the program if we want it to continue. And it has been a good program, and I would argue that virtually everyone within this body wants it to continue.

Not to say there are not some areas for improvement. A bill that I introduced earlier this year, H.R. 1013, the purpose of this legislation was to ensure that the SCHIP funding that Congress has made available be used to cover children and pregnant adults with this coverage. Right now we have four States that are covering more adults than they are children with their SCHIP funding. That stands the whole program on its head. It is cheaper to cover children with health insurance than it is adults. In fact, the ratio is it costs about 60 cents to provide what otherwise would cost a dollar's worth of health care insurance for adults. So we get a lot of mileage for our dollars when we put that coverage into children. If we take that coverage away from children to then cover adults who otherwise would not belong in the system but get in through some type of waiver, we are not doing a good job with the moneys that we intended to put forward to cover children. And the reality is until we have covered all the children who need coverage in this country, we shouldn't be taking those dollars away from the children to cover

adults in the system. Once we have covered all the children in the country, then perhaps it is time to talk about a waiver. If we want to cover other non-pregnant adults, let's find another program to do that. Let's not steal money from the SCHIP program to provide that coverage.

Another thing that we don't really talk about a lot on the House floor, last year in my committee, the Committee on Energy and Commerce, we reauthorized the federally qualified health center statute. We never got that completely finished in the House. We should take it up again this year. It should be taken up by the Senate, and this is a program that fully deserves reauthorization by this Congress.

The federally qualified health center statute provides in federally qualified health centers coverage for about 15 million uninsureds. That is access to medicines, access to a medical home, access to mental health services, access to treatment for substance abuse, a significant set of services that are available to people who otherwise would not have access to medical care. Federally qualified health centers do a good job. Both SCHIP and the federally qualified health center system deserve to be taken up and reauthorized by this Congress. If there are improvements that we can make, then by all means let's have the debate and make those improvements necessary, but let's not let those two programs languish and by default be sunsetted and not continue.

Now, the two gentlemen that were here talking earlier were talking about some of the problems that people get into when they lose their health insurance and wanting to extend COBRA benefits, a noble exercise. One of the things that I have really thought is a forward-looking way to go with health insurance, and it kind of gets at what they were talking about, that is the individual ownership of an insurance policy.

The point made by Mr. KIRK of Illinois, gone are the days where a person gets out of high school or college, works in one job, one factory, one manufacturing plant for the remainder of their work life, then retires and gets a gold watch and goes off to a well-deserved retirement. People change jobs in today's economy. Their health insurance ought to be able to be flexible to change with them, to move with them. One way to ensure that is to allow an individual to own their health insurance policy.

Back in the days when I was practicing medicine in the middle 1990s, this Congress passed a bill called the Health Insurance Portability Act of 1996, the Kennedy-Kassebaum bill. In it, it provided for a demonstration product for what were then called the medical savings accounts. Bill Archer, chairman of the Ways and Means Committee at the time, was a champion of the old MSA. I had an MSA when I was a practicing physician. It allows you to build a tax-deferred savings account

that is dedicated to your medical expenses. You buy an insurance policy that is yours. You do pay for it with after-tax dollars, but the advantage is that since it has such a high deductible, it typically has a lower premium.

Now, there are some problems with the previous MSAs that were first passed by this Congress. This Congress put a lot of regulations on those insurance policies, and as a consequence, in my home State of Texas, we only had two insurers who were willing to take people on with a medical savings account. When we did the Medicare bill that I referenced earlier in the talk, back in 2003, when we did the Medicare Modernization Act, included within that language was language that allowed for a significant expansion of what we now call health savings accounts. The central concept is still there. It is a high deductible insurance policy owned by the individual, not the employer, or the individual can own the policy. Some employers have now begun to offer health savings accounts. A high deductible policy with a lower premium, and you put money into a tax-deferred savings account. Remember Albert Einstein said there is no power in the universe as strong as the miracle of compound interest. Put that as a pretax expense, and that can be something that grows significantly over time. Imagine that. A health-based IRA or a health savings account, an account that is dedicated only to your health care needs. Start that when you are young. It grows over time, and that can be an incredibly powerful tool to combat problems that might occur with health later in life.

But even if someone has a high deductible policy in their younger years and maybe they don't have quite as much stored up in that health savings account that would cover the deductible, still you get into a catastrophic situation, or it doesn't even need to be a catastrophic situation. In today's environment you have a single car accident and the medical costs can just be astronomical after spending an afternoon in the emergency room, a couple of hours in the CAT scanner, maybe a day or 2 in the intensive care unit, 3 or 4 days in the hospital, and by the time you get out, you have got a bill that will literally shock you. And a health savings account would provide that type of catastrophic coverage.

Why is this important? Say a young person just getting out of college decides they want to go off on their own and they want to be the next Bill Gates. They want to be an entrepreneur. They want to develop their own company. They don't want to work for a large company with its attendant benefits and health care insurance. They just want to go out on their own. Ten years ago you went into the private individual market and said, I want to buy some health insurance because I am going to work for myself and start a small business and be my own boss, you couldn't get anybody to talk to

you for any price. There just wasn't a policy available.

Fast forward to the present time, and with the changes we made with health savings accounts in the Medicare Modernization Act of 2003, you can go on the Internet. You can type in "health savings account" into the search engine of your choice. And in my home State of Texas for a male age 25, just out of college, nonsmoker, you can pick up a high deductible policy in the range of \$65 to \$75 a month. Not an astronomical expense. Sure, there is a high deductible associated with that. So if you want a flu shot next fall, you are probably just paying for that out of pocket. But if you get pneumonia and you end up in the hospital in the ICU for several days, you are going to have coverage for that so-called catastrophic event because, even though it is a high deductible, your medical expenses will quickly exceed that. So that is a good thing to have so that you do have coverage.

For a young family where a husband and wife want to have the coverage, want to do the responsible thing if they have small children, a health savings account may provide the way to do that and have that coverage beginning at an early age. And over time the money will grow in the actual savings account portion of that. It grows tax deferred. It can accumulate quickly. And as a consequence, the specter of having a very high deductible is something that is now not such a big deal because there is easily money within that health savings account to pay for those health care needs. Even the routine care if someone chooses to do that, the dollars are there to be spent for that purpose.

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The popularity has grown a lot. When I first got mine back in 1997, my old Archer medical savings account, I worried because they said we're going to put a cap on this; we're not going to allow more than 750,000 of these to be sold in the United States of America. I thought golly, I better get out there and get one fast or they are going to all be snapped up. It turned out I didn't need to worry because those original insurance policies, probably less than 100,000 were sold.

But the health savings accounts, when the conditions changed in 2003, have been significantly popular. The last year for which I have accurate and verifiable data is 2005. But by December of that year, the end of calendar year 2005, 3.2 million individuals had coverage through a health savings account; 42 percent of those individuals had families with incomes below \$50,000 purchasing an HSA type of insurance. Certainly that is indicative that this is an affordable option. In addition, the number of previously uninsured HSA plan purchasers over the age of 60 nearly doubled, proving that the plans are accessible to people of all ages. And again, out of that number, over 3 million, probably about 40 percent of those

individuals were previously uninsured. So it did have the effect of, at least temporarily, bending the growth curve of the uninsured in this country.

Of those 46 million people that we talked about before that are uninsured, over half, 60 percent, are employed in small businesses. Some of these individuals prefer a more traditional health plan. They would like to have what we talked about earlier, an employer-derived health insurance. But their employers, their small business employers look at those premiums going up every year and they say, you know what, I just cannot do it anymore, and so they drop the benefit because it is simply too expensive.

Now, Congress has had before it, over the last 4 years I think we've had at least three votes on this concept; it has always passed the House of Representatives; it always stalled in the Senate. I don't know if we will take it up this year, but I think we should because I think it is fundamentally a good idea. And maybe at some point we will get some cooperation from the other body.

But to unburden small business owners, Congress has devised the concept of what are called Association Health Plans, essentially allowing a group of small businesses with a small business model to band together to get the purchasing clout of a big corporation. It is really not too hard a concept for most people to understand. It is, again, something that has passed this House at least three times that I am aware of. It is a sensible solution. It allows the spread of the insurance risk amongst a larger group. A small employer, say a realtor in your hometown who has 3 or 4 people working in the office, very difficult, very expensive for them to get insurance, if they can find it. Well, imagine if you let all the realtors in Texas band together and form a single group that was negotiating for the sale of insurance. Now imagine that you couple that with the realtors in Oklahoma, Louisiana and New Mexico. Then you've got a group of people that really is beginning to have some significant financial clout and may be able to get a much better price in the group health insurance market. Well, all of this, from the insurance side, is extremely important. You've got to worry though, are we putting the cart before the horse?

About a year and a half ago, Alan Greenspan, just as he retired as Chairman of the Federal Reserve Board here in Washington, D.C., met with several groups. He met with a group of us one morning, and he was asked the inevitable question, well, Chairman, what about the ability of the Federal Government to pay for Medicare in the future. He alluded to how that was going to be a problem that was going to have to be faced. But at the end of it all, he felt that Congress would be able to come up with an equitable solution to that. And he paused and he said, what concerns me more is will there be anyone there to provide the services that

you want when you get there. That is a pretty profound statement, certainly something that has stuck with me since that time.

No question about it in my mind, our country faces a crisis in health care manpower, a physician shortage, if you will, in the future. We need to ensure that the doctors who are in practice today, those physicians I like to call "mature physicians" at the peak of their clinical abilities, at the peak of their diagnostic abilities, at the peak of their surgical expertise and abilities, we've got to be sure that they stay in the game, that they continue to practice, that they don't retire early, that they don't wander off and do something else. We need to keep them involved.

At the same time, we need to ensure that the younger physicians, the doctors of tomorrow, those that are in residency programs today, those that might be thinking about going to medical school or into nursing, that those individuals stay involved and in fact pursue their career dream of working in health care.

The first issue that always comes to my mind when I think of what are some of the things that drive doctors out of practice or keep people from going into the practice of medicine, and that is, of course, the conundrum of medical liability. Again, we faced it in this House of Representatives probably four times in the time that I have been in Congress. It is an issue that has never gotten through the other body. Again, I believe we need to continue to push that as an issue because in so many ways we just need some common-sense medical liability reform to protect patients, stop the escalating costs associated with lawsuits that are not well-grounded, and to make health care more affordable, ensure that health care is in fact even available to Americans all across from coast to coast in Alaska and Hawaii, and make sure that those physicians stay in the game and continue to provide the needed services.

I believe we do need a national solution. State to State coverage is always going to be tenuous. My home State of Texas did a great thing as far as medical liability reform is concerned back in September of 2003, but you worry every time the State legislature comes into session every 2 years, is something going to happen that undoes those great steps forward that were taken back in 2003.

I do think that modelling after the concept that was developed, actually originally in the State of California back in 1975, the Medical Injury Compensation Reform Act of 1975, signed into law by Governor Jerry Brown, a great step forward that put a cap on noneconomic damages in medical liability suits.

Fast forward to 2003, and the Texas plan came forward. Indeed, the basis of the program or the basis of the reform does lie in a cap on noneconomic damages, but I like to say it's got a 21st

century angle to it. There is a \$250,000 cap on noneconomic damages for the doctor, a \$250,000 on noneconomic damages for the hospital, and a third cap of \$250,000 for noneconomic damages from a second hospital or nursing home, if one is involved. In fact, the original cap legislation that worked so well in California, in Texas it has been trifurcated. It is in the aggregate of a \$750,000 cap.

Well, how does that work? Did that fix the problem that the State of Texas faced the year I ran for Congress 2003? Well, in Texas, we've gone from 17 medical liability insurers down to two. My personal situation, running my own practice, really having not had a problem that would take me into the courts, but my rates were increasing by 25, 30, 40 percent a year. Well, in 2003, the Texas legislature passed medical liability reform based off that California law, again, updated for the 21st century, for an aggregate cap of \$750,000. What has happened since then? Well, remember I just said, we dropped from 17 liability insurers down to two because of the medical liability crisis. We are back up to 14 or 15 carriers. And most importantly, those carriers have returned to the State of Texas without an increase in their rates. They have held their rates down.

My old insurer of record, Texas Medical Liability Trust, between rate reductions, rebates and dividend payments to physicians over the 3½ years since this law was passed, the actual net effect is a 22 percent reduction in premiums for physicians across the board in the State of Texas. Again, remember premiums were going up by 20, 25, 30 percent or more a year, now they are coming down, and over the last few years they have come down 22 percent.

One of the most significant, unintended benefits of this was what happened with the small not-for-profit, community-based hospitals, those hospitals that were essentially self-insured for medical liability. They have been able to take money that was in those escrow accounts against the uncertainty of the medical liability climate that they faced in 2001, 2002 and early 2003, now that money has been able to go to hiring nurses, capital improvements, just the very things you would want your smaller not-for-profit, community-based hospital to be able to do. This is certainly one of the good news stories. And again, the smaller hospitals were not the intended beneficiary of this legislation when it passed in the State of Texas.

I took the language of the Texas-passed medical liability reform, worked it into the type of language that we have to have here in the House of Representatives, ran it through legislative counsel and offered it to Mr. RYAN, Paul Ryan, the ranking member of the Budget Committee on the Republican side, when we were doing our budgetary work in March. He had that bill scored by the Congressional Budget Office. And the Texas plan, as applied

through the House of Representatives language, applied to the entire 50 States, would yield a savings of \$3.8 billion over 5 years. Now, not a mammoth amount of money, but when you are talking about a \$2.999 trillion budget, savings is savings. And these are monies that we are in a sense just going to leave on the table in this budgetary cycle that could have gone to some of the other spending priorities, some of which I have already alluded to in the SCHIP and the Federally Qualified Health Center statutes. But anything, even those things not dealing with health, \$3.8 billion, as the old saying goes, you keep leaving that amount of money on the table and pretty soon you're going to be talking about some real dollars.

And also consider this: A study done in 1996, that's over 10 years ago, out of Stanford University, revealed that in the Medicare system alone, the cost of defensive medicine was approximately \$28 to \$30 billion a year. The cost of Medicare, not the entire cost of the health care infrastructure of the United States of America, the cost to Medicare was \$28 to \$30 billion a year 10 years ago. I submit that that number has likely increased today. We can scarcely afford to continue this trajectory that we are on with regards to medical liability in this country.

And again, remember when I started this part of the discussion talking about are we going to have anyone there to provide the services when we want them. And another consideration is that young people today entering college, in college, just getting out of college, who wanted to consider a career in health care, are looking at the crisis that we face in medical liability in this country, and it's keeping them out of the game, and that's not right. One of the obstetrics residency directors from a big New York program was down here actually a couple of years ago now, and I asked her, is the medical liability crisis, is it having an effect on your residency classes that you're recruiting? And she told me that right now we are taking people into our residency program that we wouldn't have interviewed 5 years ago. In other words, we are lowering the class and the capabilities of those people who are willing to go into obstetrics as a specialty. Well, these are our children's doctors, these are our children's children's doctors that are being trained in the residency programs today. I fail to see how it advances the case for patient safety and the well-being of Americans to continue to allow this condition to exist without addressing it.

Again, we voted on the bill several times in this House over the past several years. My understanding is the bill was just recently reintroduced last week. I hope we will have a chance to address it in this House. And I hope we can get some activity from the other body. I am not optimistic, but I believe this is so important that we have got to continue to try to get this done.

This brings me to one of the things I initially spoke about, one of three health care bills, H.R. 2583, the so-called Physician Workforce and Graduate Medical Education Enhancement Act of 2007. There is a Washington-type title that everyone can love. Well, part of ensuring the future health care workforce in this country is going to be to make certain that there are the types of residency programs in the types of communities in which we want doctors to consider going into practice. You know, the funny thing about physicians is they do have a lot of inertia. They tend to stay where they're dropped; that is, they tend to work and have their practice in communities where they trained or close to where they trained.

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A lot of us have followed that trajectory, and I suspect there is nothing unique about that. It will continue to be the way physicians behave for probably well into the future. So the bill introduced just last week was designed to get more training programs in areas that are underserved, like rural areas, inner-city areas, to get young doctors-in-training in locations where they are actually needed.

The Physician Workforce and Graduate Medical Education Enhancement Act of 2007 would develop a program that would permit hospitals that do not traditionally operate a residency training program that will allow them the opportunity to start a residency training program and in fact build that physician workforce of the future on site in those communities where they are in fact needed.

On average, it costs \$100,000 a year to train a resident, and that cost for a smaller hospital is clearly prohibitive. Because of the cost consideration, the bill would create a loan fund available to hospitals to make residency training programs where none has operated in the past. The programs would require full accreditation and be focused obviously in rural and suburban inner-urban or other smaller community-type hospitals. I can think of several communities in the congressional district that I represent that might benefit from such a program.

Clearly, it is one thing to say we are just going to educate more doctors, but to get them to practice in the areas where they are needed, and, boy, an area that comes to mind is the area around New Orleans, Louisiana. They have lost doctors. The wholesale loss of doctors since the twin hurricanes of August of 2005, it is going to be very difficult to encourage people to come back to that area. But the reality is if someone trains in that area, the likelihood of them staying in that area is increased.

It is all well and good to create new residency programs, but if you don't have anyone interested in filling that residency slot, it is not going to be really something that does all that

much good. So the second bill, H.R. 2584, the High Need Physician Specialty Workforce Incentive Act of 2007, would help locate young doctors where they are needed to solve part of the impending physician shortage crisis that likely could affect the entire country.

We have got to consider training doctors for high need specialties. This act will establish a mix of scholarships, loan repayment funds and tax incentives to entice more students to medical school and create incentives for those students and newly-minted doctors to help them go into healthcare. The program will have a established repayment program for students who agree to go into family practice, internal medicine, emergency medicine, general surgery or OB/GYN, and practice in underserved areas. It will be a 5-year authorization at \$5 million a year and it will provide additional educational scholarships in exchange for a commitment to serve in a public or private nonprofit health facility determined to have a critical shortage of primary care physicians.

Again, the Gulf Coast area comes to mind, but there are plenty of areas in my home State of Texas, West Texas and in fact East Texas, that would fit the bill for something like that. It is very similar to what used to be called the Berry Plan. The armed services used to offer a scholarship and some loan forgiveness to encourage physicians to go into one of the branches of service. This is modeled after those plans that were so popular in the early 1970s. Again, it is an important step in getting doctors into the communities where they are actually needed.

The third bill of the three that I introduced last week, H.R. 2585, really deals with the heart of the problem, which is stabilization of the current physician workforce.

When we talk about the current physician workforce, discussing things like medical liability, placement of doctors in locations of greatest need and financial concerns, encouraging doctors to remain in those high-need specialties, the next step is to fix on that largest group of doctors in the country and certainly the largest and still growing group of patients, those baby-boomers that you heard MARK KIRK talk about in the last hour.

Baby-boomers are going to continue to age. They are going to retire, and the demand for services has no where to go but up. If the physician workforce trends continues as they are today, we may no longer be talking about trying to fund the Medicare program. We may be talking about trying to find the Medicare physician. We may be talking about the fact that there is no one there to take care of America's seniors.

Year after year, there is a reduction in reimbursement payments from the Center for Medicare and Medicaid Services to doctors for services that they provide their Medicare patients. This is not a question of doctors just simply

wanting to make more money. It is about a stabilized repayment for services that are already rendered. It is about a question of fundamental fairness. And it is not just affecting doctors. It is affecting patients, and it becomes a real crisis of access.

Not a week goes by that I don't get a letter or fax from a physician back in Texas who says, you know what? I have just had enough of this, 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 Medicare patients.

In fact it happened to me while we were home on the Memorial Day recess. A woman came up to me, someone I had trained with, and said, look, I just can no longer do these long, involved operations and be paid literally a pittance for the service, when I could spend my time doing other things that would actually pay for the cost of running my practice.

I certainly understand that. I certainly sympathize with that. It is a difficult situation for doctors to find themselves in, because they want to do right. These are difficult operations that they trained for years to be able to provide for people. Now, the fact that they are so poorly compensated by Medicare, they are simply having to turn their back on these challenging, technically difficult procedures, and say I will just see the well patient in the office and stay out of the operating room. I saw it happen in the hospital environment before I left the practice of medicine to come to Congress.

But I hear it in virtually every town hall that I do back in my district. Someone will raise their hand and come up to me afterwards and say, how come on Medicare, you turn 65 and you have to change doctors? The answer is because their doctor found it no longer economically viable to continue to see Medicare patients because they weren't able to cover the cost of delivering the care rendered. They weren't able to cover the cost of providing the care.

Medicare payments to physicians are modified annually. They use something called the sustainable growth rate formula. A lot of the people around here call it the SGR rate. Because of flaws in the process, the sustainable growth rate formula, mandated physician fee cuts in recent years have only been moderately averted by last-minute machinations and fixes that the Congress has provided. In fact, if no long-term congressional action is implemented, the SGR will continue to mandate cuts for physician reimbursement as far as the eye can see, cuts in aggregate between 35 and 40 percent over the next 10 years.

Now, unlike hospitals, who are reimbursed under essentially a cost of living adjustment every year known as the Medicare Economic Index, physicians are reimbursed under the SGR, which says there is a fixed amount of money to pay for all of the doctor-derived healthcare in this country, and

there is more demands on that volume, then the slices of that pie are just going to get successively thinner year after year.

Medicare payments to physicians cover only about 65 percent of the cost of providing the patient services. That doesn't figure in anything for the doctor's take-home pay. That is the cost of providing the services. That is the office rent. That is the nurse's salary. That is keeping the lights on. That is paying for the medical equipment. That is buying the syringes and the medicines that might be administered in that office.

Can you imagine any industry, any business, any company that would continue in business if they received only two-thirds of the cost of what it costs them to provide the services? Currently the sustainable growth rate formula links physician payment updates to the Gross Domestic Product, which actually has no relationship whatsoever to the cost of providing those services.

But simply the repeal of the SGR, one of the big stumbling blocks for that is it is very, very costly when figured in the overall Federal budget. But the reality is we have to do it. Maybe if we do it over time, perhaps we can bring that down to a level that is in fact manageable.

Paying physicians fairly will extend their careers for many of those doctors now in practice and those who would otherwise opt out of the Medicare program or seek early retirement or restrict those procedures that they offer to their Medicare patients. It also has the effect of ensuring an adequate network of doctors available to older Americans as this country makes the transition to the physician workforce of the future.

In the physician payment stabilization bill, the SGR formula would be repealed 2 years from now, in 2010. There would be some incentive payments based on quality reporting and technology improvements installed to protect the practicing of physicians against the 5 percent cut that will likely occur each in the years 2008 and 2009. Those things would be voluntary. No one would have to do them. No one would be required to participate in the quality program or the technology improvement, but it would be available to those doctors and those practices who wanted to offset the proposed cuts that would occur in physician reimbursement over the 2 years until a formal repeal of the SGR would be allowed to happen.

Now, for most doctors, that is unacceptable. They say, well, I want the SGR repealed now, not 2 years from now, and I want it repealed this year and I want a positive update or I am going to stop seeing Medicare patients.

The reality is that possibly if we do this over time, we will be able to get it done. The other reality is I wish we had started this when I first got to Congress 4 years ago, and we might be well

on our way or well past the where we would have in fact solved this problem. So, it is time to begin that journey of 1,000 miles with the very first steps, and we do have to focus on the fact that this is a long-term solution.

A lot of people say why do it that way? Why not just bite the bullet and get the SGR out of the way and get it repealed? It costs a tremendous amount of money. The other unfortunate aspect of that costing a tremendous amount of money is it may make the premium for the Part B recipient, it may make that premium go up significantly.

In Congress, we are all required to submit legislation to the Congressional Budget Office to find out how much it costs. If we are going to spend the taxpayers' money, how much are we going to spend, over what time will we spend it?

Because of constraints at the Congressional Budget Office, we are not allowed to do what is called dynamic scoring. We are not able to look at changing a program or a new program and say if we did things this way, we would save money in the future. That is well and good, but we can't claim those future savings to offset the cost of doing it a new way. And that is what static scoring tells us, and that is why dynamic scoring would be so beneficial in a situation like this. But we are not able to use that.

If we look at some of the things we have done already in the Medicare system we can say, you know, if we do it this way, we are actually going to save some money. We are not allowed to capture those savings.

The Trustees Report that came out just a few weeks ago, there were 600,000 hospital beds in the year 2005 that weren't filled because of things that doctors and hospitals are doing better, improvements that have been made in the healthcare system. 600,000 hospital beds that weren't filled. Do we get the financial credit for those 600,000 hospital beds that weren't filled? No, we can't claim that. That is just something that is absorbed by the system, and we go on and reset things for the next year and continue on our merry way with the SGR.

But the reality is if we could capture those savings, if we could aggregate those savings, it is not just in hospital beds, there are other areas where savings are occurring at the same time, if we could capture those savings, aggregate those savings, and use those savings to offset the cost of the SGR repeal, we might very well come down to a much more manageable number.

The old bank robber, Willie Sutton, was famous for saying he robbed banks because that is where the money is. Well, let's go after the procedures where most of the money is spent in CMS, identify where the savings are in delivering the care for people who are in those diagnostic groups, and let's keep that money, capture that money, and use it to offset the cost of the SGR.

I think that is the greatest return on investment that we could expect from those savings that we are likely going to see from Medicare in the future.

The same considerations apply to the Medicaid program as well. Again, it could be a useful exercise to go through and identify the top 10 conditions and see where the easy savings are in taking care of patients with those conditions. How can their care be better managed? How can things be prospectively managed? What types of intervention might keep a patient out of an expensive hospitalization or away from an expensive dialysis unit? These are the times of savings we need to gather.

I see that I am going to run up against some time constraints. I just want to mention health information technology is something that we do have to pay some attention to.

In the SGR reform bill that I introduced, there is some language about moving us down the road on information technology, embracing information technology. I haven't always been a big proponent of that. When I was practicing medicine, if someone had come to me with proposals like that, I would say, you know, that is going to increase the number of hours I spend every day, not increase my payments to any great degree, and I just don't see how it is going to be economically useful to me as a physician.

That was before I traveled to the City of New Orleans for the second time in January of 2006 and was taken into the records room at Charity Hospital shortly after they had gotten all of the water out of the records room at Charity Hospital.

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It looked like the records room of any big city hospital. There were rows and rows, perhaps hundreds of thousands of records in this large room, tens of thousand of square feet devoted to the storage of medical records. They were ruined. They had been ruined by the water and by the black mold growing on the manilla folders. There was not enough protective gear to protect someone to go in and pull the charts out of the racks and begin to go through them to get the patient's medical history.

Clearly, the time has come where we need to have the concept of computerized access to medical records. It is something this country needs to embrace.

The old adage when I was in college, you could say, the dog ate my homework. No student today would do a report, a term paper and keep one single paper copy. They have it on a flash drive, on a hard drive, on a floppy disk. They have printed it out several times. They live in the electronic age. It would make no sense to the medical student of today to have a single paper copy of a term paper or lab report that they would have to turn in for a grade. It would never cross their mind.

Some of the other things, the interoperability of our systems is key.

Right after the Walter Reed story broke, I was there visiting. Yes, the physical conditions were one thing; but one soldier told me the biggest concern he has is as he prepares his records, he is on medical hold and as he is looking to go back to join his unit or be discharged, he has to put in order his medical records to make the case for staying in the service or get the disability to which he is entitled if he is discharged from the service.

The biggest fear they have is they will spend hour after hour putting records together and highlighting critical areas, have them sit on someone's desk until they are lost, and then have to start over again. Their biggest concern was the inability of the Department of Defense and the Veterans Administration to interact with each other on the transfer of medical records. Clearly, that is a concept whose time has come.

Price transparency. I have talked about HSAs. If we are going to have health savings accounts work for Americans, we are going to have to be able to allow them to access information about price, cost and quality of medical care and procedures. I introduced legislation dealing with price transparency earlier.

My home State of Texas has gone a long way in this regard, providing information up on the Internet about the costs at various hospitals throughout the State and how they compare to other hospitals in the State. There is a lot of information. It is technically complex. It may even be boring to listen to, but nonetheless it is part of an incredibly important story. The story of how the most advanced, most innovative health care system in the world itself is in need of a little attention.

The last chapter should read happily ever after. How do we get there? The last chapter may read private industry leads to a healthy ending. We are in a debate that will forever change the way health care is delivered in our country. The next 18 months will spell that out for us. We have to understand what is working in our system. How do we make it work better, and how do we extend that to areas where we don't find excellence in our system, whether those areas be public or private. We can't delay making changes to bring our health care system into the 21st century.

I believe the only way this can work is to allow the private sector to lay the foundation for further improvements. The pillars of the system we have have to be rooted in the bedrock of a thriving public sector, and a thriving private sector, not in the shaky ground of a public and private system always at war with each other, and many times are inefficient.

We need to devote our work in Congress to building a stronger private sector in health care. History has proven this to be a tried and true measure. We can bring down the number of uninsured, increase patient access, stabilize

physician workforce and modernize technology if we simply have the political and institutional courage to take the steps necessary.

OMISSION FROM THE CONGRESSIONAL RECORD OF THURSDAY, MAY 17, 2007 AT PAGE H5467

Mr. FRANK of Massachusetts. Mr. Chairman, I move that the Committee do now rise.

The motion was agreed to.

Accordingly, the Committee rose; and the Speaker pro tempore (Ms. JACKSON-LEE of Texas) having assumed the chair, Mr. ALTMIRE, Acting Chairman of the Committee of the Whole House on the state of the Union, reported that that Committee, having had under consideration the bill (H.R. 1427) to reform the regulation of certain housing-related Government-sponsored enterprises, and for other purposes, had come to no resolution thereon.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair desires to announce that pursuant to rule XXVII, as a result of the adoption by the House and the Senate of the conference report on Senate Concurrent Resolution 21, the joint resolution (H.J. Res. 43), increasing the statutory limit on the public debt, has been engrossed and is deemed to have passed the House on May 17, 2007.

DISPENSING WITH CALENDAR WEDNESDAY BUSINESS ON WEDNESDAY NEXT

Mr. FRANK of Massachusetts. Madam Speaker, I ask unanimous consent that the business in order under the Calendar Wednesday rule be dispensed with on Wednesday next.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Massachusetts?

There was no objection.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. DAVIS of Illinois (at the request of Mr. HOYER) for today.

Mr. GUTIERREZ (at the request of Mr. HOYER) for today and June 12.

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

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

Mr. SESSIONS (at the request of Mr. BOEHNER) for today and the balance of the week on account of taking his son to scout camp.