those in all the ages who care to remember those who care and sacrifice for others.

CENTENNIAL FOUNDING OF THE ALPHA KAPPA ALPHA SORORITY, INC.

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Texas (Ms. JACKSON-LEE) is recognized for 5 minutes.

Ms. JACKSON-LEE of Texas. Madam Speaker, this evening I rise to commemorate the centennial of the founding of Alpha Kappa Alpha Sorority, Inc., the first Greek-letter organization established by black college women in America. This prestigious organization, founded at Howard University by nine visionary women in 1908, at a period when Jim Crow laws flourished in the law books, knew the rigors of their journey during the early 1900s. The organization, which has grown to 200,000 members in 975 chapters worldwide, includes an extraordinary collection of women, who now encompass diverse ethnicities and nationalities and are united by a bond of sisterhood and a commitment to service.

As a member of the Alpha Kappa Omega Graduate Chapter of Alpha Kappa Alpha Sorority in Houston, Texas, I am proud to honor this historic milestone and welcome my sorors to the birthplace of Alpha Kappa Alpha at Howard University in Washington, DC. This evening, the sorority will conclude a 4-day salute that culminated in a gala week of tributes, salutes, and praise. Today, one hundred years ago, amazing sisterhood, the passion for humanitarian service, and the campaign for education brought nine ardent women together to form Alpha Kappa Alpha Sorority, Inc.

Alpha Kappa Alpha was founded to touch lives, improve the stature of women and serve humankind. Its mission is to develop leaders, expand Alpha Kappa Alpha's economic achievements, and ensure that the Sorority is fully engaged in achieving its possible goals. Sojourner Truth once said, that ''If women want any rights more than [they've] got, why don't they just take them and not be talking about it.'' This quote embodies the spirit that the determined women of Alpha Kappa Alpha Sorority, Inc. exhibit in order to attain the long-awaited goals of freedom and equality.

The sorority is ''home'' to college presidents, deans, directors of Fortune 500 companies, judges, mayors, Members of Congress, state legislatures, city councils, and school boards. This sorority has provided the foundation for intellectuals such as Sharon Pratt Kelly, the first woman to serve as mayor of Washington, DC, Angie Brookes, the first woman President of the United Nations, the long revered Rosa Parks, mother of the Civil Rights Movement, Azie Taylor Morton, the only African-American to hold the position of Treasurer of the United States, and First Lady Eleanor Roosevelt. Alpha Kappa Alpha women have served in the United States Armed Services and devoted their lives to saving ours. I salute those women today who are active or retired military personnel. They and women such as Lt. Col. Anita McMiller, Deputy Legislative Assistant to Chairman of Joint Chiefs of Staff, are the sheroes that should be emulated by the next generation.

AKA's have long referred to founder Ethel Hedgeman Lyle as the ''guiding light,'' a figurative phrase that insists upon one's aptitude, resilience, unwavering service, and valor. President George W. Bush, in his address at the 55th Inauguration, stated that:

> Our nation relies on men and women who look after a neighbor and surround the lost with love. Americans, at our best, value the life we see in one another, and must always remember that even the unwanted have worth.

At a time when our Nation, in fact the world, has experienced unprecedented upheavals, Alpha Kappa Alpha has stayed the course of its mission and provided an anchor for scores of individuals and families by empowering communities through our committed service. A service that has endured 100 years because Barbara A. McKinzie, the Centennial International President, declares that it was built on bedrock of strength.

I am proud to stand on the floor of the House tonight and pay tribute to this extraordinary organization, which has been helping our young women find the support, courage, and passion they need to become leaders in our society.

□ 2045

OVERRIDE THE VETO OF PRESIDENT BUSH

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Texas (Mr. SESTAK) is recognized for 5 minutes.

Mr. SESTAK. Madam Speaker, tomorrow the House will vote on whether to override the veto of President Bush on the Defense authorization bill. He vetoed this bill because, within it, it permitted a servicemember who had been tortured in the first Gulf War to not only successfully sue the Iraqi Government, but having won that case, to be able to be given what the court awarded him or her.

I am concerned and fear that tomorrow this House will vote to recommit to send that bill back to the House Armed Services Committee and to put a waiver in that bill which will permit President Bush to be able to overrule a court that has now awarded, as it has, a servicemember, having been tortured, the judgment that that court gave of Iraqi monies that are held here in the United States.

The reason for that is the Iraqi Government has threatened to pull out of the United States $25 billion that it has invested over here. Every month we put almost $12 billion into Iraq in addition to those that wear the cloth of this Nation.

This is a good bill in many ways, providing a pay raise of 3.5 percent that is needed for the men and women that serve our Nation, but I do not understand how this President nor how this Congress could ever permit a man or a woman who has worn the cloth of this Nation in a war to have sued successfully, having been tortured, as law permits, to now not be permitted to gain the judgment that a court has given him or her merely because the Iraqi Government, obligated under international law for anything that prior governments in Iraq or any country that another successive government has succeeded to be responsible for merely because that government has threatened to take out of this country $25 billion.

We should vote to try to override this veto with the many good things in this bill. Many of us talk about taking care of our men and women. How can those who have not only come close to giving the ultimate sacrifice by torture, and who have continued to serve this Nation as they have come home, not be successful in being given what the court has provided them in their judgment?

AMERICAN HEALTH CARE

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

Mr. BURGESS. Madam Speaker, I come to the House floor tonight to talk, like I often do, a little bit about health care. And this is the first day that the Congress is back in session after the December recess. And legitimately, someone might ask is it maybe a little early to begin this type of discussion. But the reality is, since we didn't finish our work in the last year, it is entirely appropriate for us to begin this year talking about some of those same things that were left undone at the end of 2007. Specifically, the reauthorization of the State Children's Health Insurance Program. An 18-month extension was passed at the end of the last Congress. I was grateful for that. I voted in favor of that. But the reality is this Congress should do its work and reauthorize this program for the full 10 years as it was intended when the reauthorization was up last September.

We had a lot of opportunities to do this in my committee, the Committee on Energy and Commerce, but we failed to have a markup in subcommittee. We had a markup in full committee that was little more than a charade. We brought a very bad bill to the House floor in August. It was passed, but was not taken up by the Senate because the bill was so flawed.

Then we had the Senate bill come to the House floor and it was a new bill, not a conference committee report. We had ample opportunity to debate that and take it back to committee and have a subcommittee hearing and subcommittee markup, a full committee hearing and a full committee markup, but we chose not to do that. We brought that same bill to the floor and voted on it. The House passed because they have a majority on the other side, and the President vetoed it and the veto was sustained.

The same bill was brought up a second time in early October. The same result. The bill was passed, and the bill was vetoed and the veto was sustained.

In the interim, many of us worked to try to overcome some of the obstacles to passage for this bill because we felt this was the correct thing to do. But the reality was that politics trumped policy. And at the end of the day, the best we could muster, at the end of December, at the very last minute, was to pass an 18-month extension.

Madam Speaker, perhaps I should be grateful for that, because with an 18-month extension we will be past the next Presidential election before we are forced to look at this bill again. But I hope this Congress does not take that tactic. I hope this Congress takes seriously its obligation to study this problem and find out where the difficulties occurred last time and see if we can't come to the floor with a bill that could be broadly supported by both sides of the aisle. I think that is a possibility. But the reality, again last fall, some people thought the politics were more important than the policy. And the end result, well, we saw what the end result was.

The same thing happened with our Medicare proposals. We have every year this mad scramble at the end of the year. If Congress doesn't do something because of the odd formulas by which we pay physicians in this country, physicians that we have asked to take care of our Medicare patients, but we have a very odd formula by which we reimburse those physicians. And as a consequence, every year at the last minute we are left scrambling, seeing if we can't do something. It is called the physician fix. It is almost like something that will happen on the winter solstice every single year, because if we don't do something by January 1, massive pay cuts are administered to the physician corps in this country. Again, the very physicians whom we have asked to take care of some of our sickest and most complex patients, and these physicians this past year faced a 10 percent pay cut.

Now, at the last minute, we did do something to forestall the pay cut. We passed a rather modest bill to give a one-half percent positive update to physicians who take care of Medicare patients. But we only did it for 6 months' time, which means we literally kicked the can down the field. And the reality is we will have to face this again in June. And guess what? The deeper we go into this year, the more politics will take over, because it is a Presidential election year, and it is a Presidential election year the likes of which this country has not seen since 1952, or perhaps even 1928, when both sides are running for essentially what is an open seat in the United States Presidency.

Well, I did come to the floor tonight because I wanted to have a candid conversation about health care. I think many in this Congress know I had a life before Congress. I was actually a practicing physician for 25 years back in my home State of Texas. So I feel I can approach this problem from both the provider level, on the basis of that 25 years in practice, as well now as the policymaking level, the legislative level, because obviously we do deal with a lot of health care here on the floor of the House of Representatives.

I want to talk in some greater detail about the issues pertaining to Medicare, and I will get to that, but let me step back and talk about where the status of health care is in this country, because when you watch the Presidential debate, it seems everyone is talking about health care. Perhaps that is a good thing. In reality, the conflict in Iraq is not as divisive as it was a year ago. And as a consequence, you hear less talk about this country's involvement in Iraq. And as a consequence, you hear more talk about domestic issues. Health care and the economy have replaced some of the rhetoric that we heard during the 2006 fall election and some of the rhetoric that we heard on the floor of the House a scant year ago regarding this country's foreign policy. In reality, that is a good thing.

It is a strange phenomenon when this country is prevailing in a conflict that we stop talking about it. I can't think of any other time in American history when that was the mindset. Nevertheless, that is what is occurring now. Again, as a consequence, we are talking a good deal more about health care.

When you hear the talk about health care out on the campaign trail, you recognize there are some fairly different ideas that are out there and being talked about. And it is not that one person has any quarter on the best ideas, but it certainly lays the issue at the feet of the American people that there are very different ways of dealing with this problem, very different ways of setting the goal, very different ideas about what the goal should be, and obviously very, very different ideas about how to accomplish that.

In fact, there is a lot of discussion about should we talk in terms of reform of our system of health care or is, in fact, the situation beyond the reform and we need to talk about actually transforming our method of health care in this country. And we will hear that debate play out. We will hear talk about things like mandates and universal coverage. Those are debates we should have at the national level, and those are debates where there should be broad participation.

Madam Speaker, we lost a very good friend in Texas at the end of December. Ric Williamson was the chairman of our Texas Department of Transportation. He died rather suddenly at the end of year, an individual who was younger than I am; so needless to say, it was unexpected. During the memorial service that was held for Mr. Williamson later that week, a lot of discussion of how he had been a State legislator before he took the position with the Texas Department of Transportation, and many of his friends and former colleagues got up to talk about Ric Williamson's life. And almost to a person they talked about how Ric Williamson regarded politics as a full contact sport. That is you went at it with everything you had, but you do it openly. You do it in the committee room. You do it in the light of day. You don't do it behind closed doors in some secret conference in the middle of the night and cut a deal one side with the other.

That is what this debate should be. It may be hard. We may come at each other again with full body contact in this debate, but it should be done on the floor of the House. It should be done on the floor of the committee rooms and not in a back room where a deal is cut at the last minute.

Many options face us in this country. And again, we will hear a great deal of debate about things like universal coverage and mandates. We will hear a great deal about things like do we in fact craft policies that people actually want, or do we decide what policies people want and then administer them accordingly.

But, Madam Speaker, freedom is the foundation of life. In my home State of Texas, that is very much the case. We thrive on unlimited options. Two years ago when we had the great Medicare part D debates, I remember at first there was a lot of criticism that no one will sign up to deliver these plans. There will be no plans. There will be a default government plan.

So guess what happened? In my home State of Texas, we had 45, 46, 47 companies sign up to provide these drug plans. And then we were told there were too many choices. The reality is Americans thrive on choices. And choices are what this debate, in my opinion, a lot of what this debate should be about. It is what has made this country great. And, in fairness, it is what has made, at least from a scientific basis, the health care in this country the envy of the world.

Well, again, the same kinds of options are going to be out there facing Americans during the debates, and I urge them to pay attention at every level. I know I must direct my remarks to the Chair, Madam Speaker, but if I could speak directly to the American people, I would encourage them to pay a great deal of attention to what is talked about, who is offering what, are they believable, and, in the end, do we think anything will really change no matter how many times they mention the word.

When it comes to innovation, the United States of America is undisputably the world's leader. In the last 25 years, 17 of the past 25 Nobel Prizes in medicine have been awarded to American scientists working in labs. That is a phenomenal record. Four out of the six most important discoveries of the last 25 years have occurred in this country, things like advanced scanning techniques, things like statin drugs to lower cholesterol, things like coronary artery stints and bypasses,

things that have extended life to citizens who 30 years ago, quite frankly, there might not have been any help, there might not have been any hope.

Now, innovations can improve health and life expectancy. It certainly does not mean that can't improve on a good thing, that we step back and rest on the accomplishments that are already there. But it certainly means in the environment that we provide in this country, quite honestly an environment that tolerates uncertainty from time to time, an environment that rewards risk-taking from time to time, that environment is a good thing for the furtherance of the science of medicine and ultimately a good thing for health care in this country.

Madam Speaker, one of the lead articles in this week's New England Journal of Medicine, and I apologize, I have forgotten the author's name. I just read it briefly on my way up here this morning, but it talked about how doctors now need to be prepared for a patient coming into their office and saying, I just had extensive genetic testing done on my own at a low cost, and now I have some information about my own human genome, and I would like you to help me interpret that.

□ 2100

Indeed, that day has arrived. And doctors in this country do need to be aware of these changes and do need to be prepared to answer their patients' questions and provide insight and direction where insight and direction occur, and be able to provide the type of environment that will allow continued learning about this new science that has just arrived on our doorstep.

Two companies now offer genetic testing, genomic testing, more appropriately, simply taking a swab of the inside of a cheek and sending it off to a company and waiting a few weeks and they come back and tell you all kinds of things about what your genomic makeup is.

Madam Speaker, when I think back to when I first entered the doors of Parkland Hospital in July of 1977, I would have never believed, never believed that this type of technology would be available in my lifetime, let alone that this type of technology would be available for a reasonable cost, and such a reasonable cost that people just simply elect to have it done to find out a little bit more about themselves and perhaps underscore some risk factors that they already knew were there and perhaps alleviate some concern about risk factors that may not carry the weight that the patient thought they did.

It's a phenomenal time that we've entered into, truly a transformational time in medicine.

And it has happened before. During the last century, I can think of three times when the scientific advances were so rapid and so solid, and at the same time, there was so much social change brought by bodies that legislate, bodies that govern, that the practice of medicine was forever changed.

Look what happened back around 1910. We were coming from a time where blistering, burning and bleeding were thought to be the peer-reviewed, the evidence-based proper treatments to administer to patients who were in distress. And very abruptly, the world changed. And the world changed because we found out more about the practice of anesthesiology. The world changed because we found out a little bit about blood-banking. The world changed because we found out a great deal more about the science and manufacture of vaccines. And then at the same time when all of that science was consolidating in the practice of medicine, we had the Flexner Commission and subsequently the Flexner Report commissioned by the United States Congress. And those activities now administered more at the State level; but suddenly we had that consolidation of medical school curricula across the country. Medical schools used to be able to teach all manner of things. Suddenly, they were conscripted or somewhat conscribed in what they could teach, but they began to teach evidence-based scientific fact in the medical schools. And it was just at the right time, because the scientific body of information was changing very rapidly.

And if we fast forward to the middle of the 1940s, a country at war, 10 or 12 years before, Sir Alexander Fleming had found an unusual curiosity in his laboratory petri dish: a penicillin mold could inhibit the growth of bacteria. Well, that was an astounding discovery, but it was really little more than a laboratory curiosity until an American company came up with a method of producing large quantities of this substance that inhibited bacterial growth, and thus began the modern pharmaceutical industry in this country. But it was a good thing, because we were a country at war. And, indeed, that infection-fighting antibiotic went from a laboratory curiosity that was intensely labor intensive to produce and intensely expensive to administer, and it went to something that was available to the average person in this country. And, indeed, antibiotics were available to treat our soldiers who were injured during the landing at Normandy, and I dare say many life and limb were spared because of the availability and the inexpensive availability of that antibiotic.

Another rather astounding scientific accomplishment that occurred at the same time, cortisone had been discovered several years before but cortisone was not commercially available. The way they got cortisone back then was to extract it from the adrenal gland of an ox. Well, if the ox was not anxious to give up their adrenal gland, you can imagine that was a pretty labor-intensive process.

But an individual that we honored on the floor of this House during the last Congress, Dr. Percy Julian, a Ph.D. biochemist, came up with a way of producing cortisone from a plant precursor, from a soybean precursor. Again, same situation: suddenly you had a medicine that was profoundly useful, but only in limited application because it was so expensive and so hard to obtain in the amounts necessary to treat a patient, and now suddenly it was readily available and it was available at a very low cost because it now could be mass produced.

Well, these two striking phenomena occurred in the 1940s. And what else happened in the 1940s? Again, we're a country at war. The President wanted to prevent an inflationary spiral, or an inflationary cycle; so he enacted wage and price controls. Employers wanted to keep their employees working. They didn't want someone else stealing their employees away, because employees were at a premium. The vast majority of Americans were off involved in fighting the war. So employers came up with the idea of maybe let's offer some fringe benefits, health insurance, retirement benefits. And wait a minute. Don't think we can do that because of the wage and price controls. But a court case ensued, as so oftentimes happened, and the Supreme Court ruled that indeed these benefits could be offered, and not only were they not in violation of the wage and price control statutes, but they also could be administered as pre-tax expenses. So suddenly we had the vast social change of employer-derived health insurance arriving rather suddenly in the 1940s; and at the same time you, doctors, for the first time in the history of medicine had a cheap, inexpensive way of combating infection and treating people with other inflammatory conditions with cortisone.

Again, fast forward to the 1960s. Big changes were on the horizon. In fact, in 1945, President Roosevelt died of malignant hypertension, died of a stroke.

In the mid-1960s we were beginning to develop medicines that treated accelerated hypertension, or malignant hypertension. We were developing medicines that could treat psychoses. We were developing the first medicines that were now known as antidepressants; a lot of changes on the horizon.

And what else changed in the mid-1960s? For the first time, the Federal Government got involved in a big way, in a big way, in paying for health care with the passage of Medicare in 1965 and, subsequently, Medicaid thereafter. And now we're at a time in our country's history, where almost 50 cents out of every health care dollar that's spent originates right here on the floor of the House of Representatives, because of the vast expansions of the expenditures in Medicare, Medicaid, VA system, Federal prison system, Indian Health Service, a lot of different ways where the Federal Government has a participatory role in health care, one that quite frankly was never envisioned 40 years ago.

So the world indeed has changed because of some of the social changes that was brought about by changes in this Congress.

Well, I submit, Madam Speaker, that the world of medicine is on the brink of another such transformational change. I've already alluded to the changes that are going to happen in the realm of genomic medicine, a lot of advances in the types of scanning that are available, the types of imaging that are available. Medical care in this country is going to become a great deal more personalized with the development of genomic medicine. It is of necessity going to be more participatory, but at the same time more preventive. And these are good things. These are reasons to make one excited about a career in health care and in some ways I'm envious of the young people today who look up from their desk in high school or college and say, I want to do that; I want a career in health care. I know it takes a long time. I know the government's interfering at a lot of different levels, but I want a career in health care because it's so exciting. And there's still that basic altruistic feeling inside of a lot of us in health care that we want to do that because it's the right thing to do.

Well, we are on the cusp of a true transformational time in health care in this country. Now, can Congress properly interact with that transformation as it occurs? It's very difficult, and our history is not great in that regard because Congress is inherently a transactional body. We take money from here and we move it over here. We create winners and losers in this system. And all too often the transactional can be the enemy of the transformational. And it is our job, our job, every one of us who sits here in a seat in this House of Representatives, to ensure that our transactional bias does not interfere with the transformation as it's occurring under our very feet.

Congress can't legislation the transformations going on in health care. It's happening anyway. It's happening whether we want it to or not. But Congress can certainly interfere with that transformation if we don't set the proper regulatory tone, if we don't provide the proper liability environment, if we don't provide the proper incentives. Congress can actually be the enemy of transformation.

And, Madam Speaker, there are several more things that I want to cover this evening. But I see I'm joined by one of my colleagues, one of my colleagues in the House of medicine as well as one of my colleagues in the House of Representatives. And I would like to yield to the gentleman from Georgia such time as he may consume to likely address the issue of medical liability, because that is a big aspect of when we talk about health care reform in this country. It's a big part of the equation. So I'll yield to my friend from Georgia.

Mr. GINGREY. Mr. Speaker, I thank the gentleman from Texas, my colleague; and as he pointed out, we're both in our prior life MDs and both in the same specialty, OB/GYN. I practiced a little bit longer than the gentleman from Texas, Dr. BURGESS; but we certainly know of what we speak in regard to the stress and strain of everyday life, a work day in a physician practice across this country, whatever specialty it might be.

I was listening in my office just a few minutes ago, Mr. Speaker, to the gentleman from Texas, Dr. BURGESS, as he talked about some of the things that we failed to do in the first session of this 110th Congress last year, 2007. He started off his discussion talking a little bit about that, the SCHIP program. I think most people, all of our colleagues of course, understand SCHIP is an acronym for State Children's Health Insurance Program, as Representative BURGESS pointed out, enacted 10 years ago. It was a good, a good program. I think 1997, a 10-year authorization for this program, and it would expire. We wanted to see, of course, how it would work, was it going to be a good thing. So when you put sunsets on programs that makes sense, because sometimes ideas don't turn out so good. But this one really did.

And the basic concept, Mr. Speaker, as we all know, was to try to help parents have health insurance for their children when they were in a situation where their income was too much to qualify for safety-net programs, in particular the Medicaid program; they were making more than that minimum amount. But, yet, in no way were they coming close to having enough income, discretionary income to pay even their portion of a health insurance premium for their children if their employer happened to cover part of it. And, of course, many didn't.

So this program was a wildly successful program covering about 6 million children a year, Mr. Speaker, and spending about $5 billion a year in the process. And it was a Federal/State matching program, more generous on the part of the Federal Government, the taxpayers across this country, than the Medicaid program, which was more a 55/45 sharing. The SCHIP program was a better deal, if you will, for State governments. And it worked so well, of course, that there were 6 million children covered, I stated, and it was estimated that in some States that there were children that were falling through the safety net and not getting the coverage because States like my own of Georgia, and my own district, the 11th of Georgia, we were running out of money.

So I think clearly, as this program came to its expiration date this past year, everybody in this body, in this House and in the other body, in the Senate, I think all 435 Members realized we wanted to reauthorize this program and we needed to spend a little bit more money to make sure that those children that were eligible, needed the coverage, there would be enough money available for them.

□ 2115

Most people estimated that about 1 million additional children, 750,000 to 1 million children, we have some of them in the State of Georgia, needed that coverage. So President Bush in his wisdom said let's reauthorize this program and let's increase the spending by 20 percent, and I thought that was a pretty generous thing; that would cover these additional children.

But as Dr. BURGESS pointed out, Mr. Speaker, the Democratic majority came to the floor with a bill that was not even vetted in committee, certainly no Member of the minority party had much chance at all to see this bill, that wanted to increase coverage to up to 10 million children. Now, we were covering 6 million, and they arbitrarily wanted to increase that coverage to 10 million. So that's an additional 4 million children, Mr. Speaker, when by anybody's estimate there were no more than 1 million that were in this range that warrant getting coverage.

So I honestly believe that the Democratic majority wanted to bring forward a piece of legislation that in no way could any fiscally responsible Member of this body vote in favor of. And it's hard to stand up here and say what people's motives are, but I think the gentleman from Texas alluded to it earlier. There are a lot of politics involved in this one, Mr. Speaker, and of course, here we are now, we ultimately we have an 18-month extension. But we need to come together. This is just a perfect example, in the health care arena in particular, where we can and should come together in a bipartisan way to do things for the benefit of the American people to provide better health care.

We like to tout that we have the greatest health care system in the world. Maybe we do. But sometimes I wonder, and clearly, I think there are things that we could do in a bipartisan way to improve it, and Dr. BURGESS has mentioned it. He's talked about the payment formula, that flawed formula, in regard to paying our physicians, and so it's no surprise that not only are more and more of them unwilling to accept Medicare patients because they're not even being reimbursed enough to cover their expenses, there's no surprise to me when I picked up the Sunday newspaper, the Atlanta newspaper in my hometown of Marietta this past weekend, and there's this big full page ad where one of the chain drugstores is now opening up these clinics, manned and ''womanned'' by men and women who are not MD's, but they're nurse practitioners. They're very skilled. They're trained. They certainly are dedicated, and the fees for seeing them are anywhere from $60 to $75 for a 15- or 20-minute visit.

So what you're seeing is so much of medicine is not an MD providing the care. It's these situations like these drop-in clinics in chain drugstores. I don't think this is the way it should be,

and I think we can do things like enact tort reform to take some of the pressure off of the physicians so that there's not so much defensive medicine. And of course, that runs up the costs tremendously.

Tort reform is hugely important. Dr. BURGESS and I, Mr. Speaker, have worked very hard in the 5 years into our 6 years as Members of this body trying to get that passed. We have been trying to get association health plans where people can come together in an industry and purchase health insurance across State lines, free of all these mandates of the individual States. Fifty different States have all these mandates on health insurance policies that drive up the premiums.

I thank Dr. BURGESS for taking the time tonight on our first day back in this second session of the 110th to continue to talk about health care. This is clearly a passion of his. It's certainly a passion of mine, not just physician Members of this body, but a lot of very, very good, experienced Members who are concerned with this.

Before I yield the time back to my colleague and I continue hopefully during the remaining time tonight to engage in a colloquy with him on these issues, I think one of the most important things we could do and we could do it now is to enact electronic medical records, say a complete fully integrated system and incentivize doctors. We can do it through the tax code to give them an opportunity, particularly the small group practices, the primary care physicians so they can get electronic medical records. This would clearly save a lot of the money that Dr. BURGESS was talking about. My friend has done some good work on that in his committee assignment on Energy and Commerce, Health Subcommittee, as well as the ranking member there, my colleague from Georgia, Representative NATHAN DEAL. We'll continue the discussion.

Mr. BURGESS. I appreciate my friend coming to the floor tonight. In fact, let's stay on the concept of electronic health records, electronic medical records for just a moment.

I have a confession to make to my friend from Georgia. I haven't always been a big proponent of electronic medical records. There has been some debate from time to time in our literature as to whether the savings is actually as great as what is anticipated. I've used the two separate prescribing platforms in my private practice back in Lewisville, Texas, with sort of marginal success, but became a believer in the availability of an electronic medical record sometime after Labor Day in 2005.

And the reason I became a believer was because after Hurricane Katrina ravaged the Louisiana and Mississippi gulf coasts, I had an opportunity on several occasions to travel to the city of New Orleans. In January of 2006, in fact, we had a field hearing in New Orleans. As part of that field hearing, we visited Charity Hospital, Charity Hospital one of the venerable old hospitals in this country, one of the hospitals that is responsible for training some of our medical pioneers. In fact, through good fortune, I had a chance to sit down with Dr. DeBakey late last fall, and he talked a little bit about his time of training in the city of New Orleans.

Charity Hospital, again, one of the venerable old institutions, now likely lost to us forever. And down in the basement of Charity Hospital was a room that had been underwater for weeks. In fact, there was still water on the floor. This photograph doesn't really do that justice. There was still water on the floor after the city had been dewatered. I didn't know ''dewatered'' was a verb. But after the Corps of Engineers had dewatered the city and they were able to go back down to the records room of Charity Hospital, this is what they encountered. These are records that had been submerged for weeks in brackish water, water contaminated with goodness knows what, and what we see here is now smoke or soot damage on these medical records. This is, in fact, black mold that is growing on the medical records. And the reality is you could not send anyone in there to retrieve this information because it would simply be too hazardous, but also, the records themselves had been submerged for weeks at a time in seawater, brackish water, and the ink itself, many of these records were written in ballpoint pen by people over decades. And that ink washed off the pages so those that aren't ruined by the black mold are rendered illegible. Doctors' handwriting is hard to read anyway, but you submerge it for several weeks in brackish waters, and it truly becomes something you cannot read.

Mr. GINGREY. I also had an opportunity over that Labor Day weekend to go down on an angel flight to Baton Rouge and to try to help man, staff an emergency Red Cross clinic there. I think it was called the River Center, a huge clinic that had been set up. And as we began to see patients, I realized the enormity of this situation, as Dr. BURGESS points out with his poster. One patient in particular was HIV positive and seven months pregnant and had not received any medication, retrovirus medication in 2 weeks, and this is the kind of thing that is life or death.

This situation in New Orleans really pointed it out. But suppose someone from this country is traveling in another country where they don't speak the language, and all of a sudden some catastrophic event occurs, a stroke, where the person cannot communicate. There's no way that the physicians, no matter how skilled they might be in the emergency room, and in the Ukraine they're not going to be able to take care of somebody from the United States that cannot communicate.

But with electronic medical records, it's just a matter of a swipe of a card, just like you do your American Express card where the radio frequency, identification system, secure, absolutely secure, privacy maintained, guaranteed, a system set up by our Federal Government where the standards are the same across the board. It, without question, would save a tremendous amount of money. The Rand Corporation estimates something like $175 to $200 billion a year out of that $1.6 trillion medical expenditures each year, $200 billion savings. But more important than the cost saving, of course, is the life savings aspect of it.

So I'm so glad the gentleman from Texas (Dr. BURGESS) brought that up and showed that very, very telling poster.

Mr. BURGESS. Let me just point out, though, one aspect of the Federal Government's involvement in electronic medical records and one of the reasons we have to be so careful.

When I said earlier that the Congress, being a transactional body, can sometimes be the enemy of transformation, a year ago a lot of us heard stories about some difficulties out of Walter Reed Hospital here in the city of Washington, DC.

And I traveled out to Walter Reed and visited that Building 18, and indeed, there were some significant problems. But the young man who showed me around Building 18, Master Sergeant Blades, said, You know what's really, really at the heart of a lot of this frustration is that my guys here on medical hold have to go through their medical records. They will go through this long arduous process of compiling their record, yellow highlighting the important features, all done on paper, and that will be delivered to someone's desk where it sits for 2 weeks and then gets lost, and they've got to start all over again, which increased the frustration to be sure, but also increased the time that these young men who were at Walter Reed on medical hold trying to decide whether they went back with their unit or whether they were going to be discharged and cared for in the VA system, while all of that was sorted out, the paper record did indeed seem to be an impediment to that process.

But we do have an electronic medical record system at the VA, and one I've never used it myself, the Vista system, multisource software. I understand it works very well. And we also have an electronic medical record at the Department of Defense, but the problem is that the two won't talk to each other, and as a consequence, our soldiers are caught in between. And the result, at least a year ago at Walter Reed Hospital, was concerning to many of us here, and it has taken a good deal more time than I would have thought necessary to get this problem solved to bridge that gap between one set of electronic medical records and another.

□ 2130

So we do have to be careful at the Federal level. We don't always have the best solutions.

So sometimes what our approach needs to be is to provide the right regulatory environment, to provide the right liability environment, to provide the right incentives, perhaps establish some standards, as Dr. GINGREY said, and then get out of the way and let the people who know how to develop these things actually be in charge and not have Members of Congress responsible for writing software.

The gentleman also brought up some very good points about the formula by which we reimburse physicians under the Medicare system. I thought the gentleman would enjoy seeing, and I know I'm not supposed to go through this because I'm accused of being too much into the process, but this is the formula by which we pay physicians, by which we reimburse physicians under Medicare. It's called the Sustainable Growth Rate Formula. It's been around for a while. It looks a little daunting, but it's, perhaps, understandable when you look at it. We have a relative value unit for work, plus a geographic modifier, another relative value unit for practice expenses and another geographic modifier, and a relative value unit for liability insurance, and a geographic multiplier.

And then we see all these terms defined here. There is actually a misprint on this page, and it's the fault of the Congressional Research Service, not the person who made this poster for me. But it's almost applied at the end by CF, which is a conversion factor, referred to here as CV, the conversion factor. Well, that's an interesting thing. How do we get the conversion factor? Well, we've got to go to another formula. And here we're going to be able to calculate the conversion factor. And I won't go through all of this because I'm told I shouldn't, but at the very bottom of the page you see we need to know the UAF before we can calculate the conversion factor, the update adjustment factor. And how do we get the update adjustment factor? I'm glad you asked. The update adjustment factor is here, yet another formula.

Now, I don't show these to impress people with my ability to go through the mathematical formula, but I do use this to point out that the system by which we reimburse physicians, it needs some attention.

Mr. GINGREY. If the gentleman will yield, I will point out that my 2 years of calculus at Georgia Tech, when I was getting that degree in chemistry, has not helped me one bit with figuring out this formula. So I appreciate the fact that the gentleman agrees it is an absolutely impossible, arcane system to ever figure out. And how they came up with it is Greek to me.

I yield back to the gentleman.

Mr. BURGESS. I thank the gentleman for yielding.

And here's the deal with this formula: what it results in is a vastly different universe for physicians who are providing care to our Medicare patients when you compare them with hospitals, nursing homes, HMOs, drug companies. Each one of those entities receives a positive update every year based on, guess what? It's kind of like a cost-of-living adjustment; it's called a market basket update. The physicians formula, though, unless Congress intervenes, which it did on every one of these years, unless Congress intervenes, this adjustment factor is going to go down, and it's projected to go down year over year for the next 10 years' time to the tune of approximately 35 to 37 percent, clearly an untenable factor.

You know, if a doctor goes into his banker's office and says, here is my business plan, Mr. Banker, and I want you to help me get my business established, I've got this business plan where I'm going to earn about 10 percent less each year over the next 10 years' time, do you think you will be able to fund me some money? No, sir, I don't think that would happen. In no business would we ask someone to stay in business where the cost of reimbursement is going to go down year over year. And we all know, is it going to cost any less for energy to heat and cool that physician's office over those years? No. The answer is, of course not. Is it going to cost any less to have the employees in the office? Is it going to cost any less for the liability insurance? And the answer is ''no'' to all of those questions.

Mr. Speaker, I know we're running a little short on time, but I wanted to give the gentleman from Georgia a chance just to talk a little bit about what is happening in the arena of liability reform in the House of Representatives, because I know that is an issue that's been important to both of us.

We have done some things in Texas over the last 4 years' time which I think, from my perspective, have been very positive. There are other concepts out there that are talked about, concepts such as medical courts, concept such as earlier offer. We had a bill similar to the Texas bill that came through the House of Representatives, as the gentleman pointed out, for the 108th and 109th Congress; but I would like to yield to the gentleman just for a moment to talk a little bit about liability reform.

Mr. GINGREY. I thank Dr. BURGESS for yielding.

Mr. Speaker, the issue of medical liability reform is something that we've been talking about for a long time in this House of Representatives and in the other body, and it's time that we do something about it. I remember back in 2004, during the Presidential debate between our current President Bush and the Democratic nominee, Senator KERRY, and on one particular debate they were talking about the cost of medical malpractice insurance. And Senator KERRY made the statement that, well, you know, if a doctor has to pay $40,000, $50,000 a year, some can afford it; that's just a very small amount in the big scheme of things. And I thought President Bush did such a great job of responding to that and he said, you know, Senator, I believe you missed the point. Yeah, some doctors can afford to pay $50,000, some can afford to pay $75,000 a year, depending on their specialty, for medical malpractice coverage; other doctors can't. But that is really not the point.

The point that causes the cost of medicine to go up so much is that all of these physicians practice in a defensive mode, and they order tests in many instances that are absolutely unnecessary, way too expensive, and, indeed, can be harmful to the patient.

You know, I would imagine today, Mr. Speaker, if you went to any emergency room in this country with a headache, you are not going to get out of there without a CT scan being performed. And that particular procedure, by the time it is done and the radiologist reads the film, you're talking about $500, $600, when it would be obvious to a clinician, a skilled clinician in physical diagnosis that this patient is suffering from a tension headache or maybe a migraine headache. So this is where that cost goes up so much.

I appreciate the gentleman giving me an opportunity to talk about it because the model for tort reform is what the State of California did back in 1978; the acronym is MICRA. But basically what we're talking about is to say that no patient who is injured by a physician practicing below the standard of care or a health care facility practicing below the standard of care that results in direct harm to the patient, they should have every opportunity for their day in court.

Dr. BURGESS and I probably have seen situations where we are pulling for the plaintiff because we know what happened in the particular setting and maybe in our community. But the judgments for so-called pain and suffering that can be up into the millions of dollars, which are totally unrelated to the degree of injury, is inappropriate. And that's basically what was passed in California and it has worked. The State of Texas, my State of Georgia, the State of Florida, several States have done this; but the vast majority of States are in situations where you don't see any neurosurgeons covering the emergency room. You see very few OB/GYN doctors staying in practice beyond the age of 50. They're all either getting out of the practice completely or they're going over to just a GYN practice. So I thank my colleague for bringing this issue up.

And as I finish my remarks and yield back to the gentleman from Texas, I want to say, Mr. Speaker, that what happens so many times in what we do, we're constrained because of the cost. And we base cost on programs like Medicare part D, by this so-called static scoring that it cost too much money

when so often programs like that have the potential to, in the long run, save money, but would get no credit for it. So we don't do things that we should be doing. Just like, as we were talking about earlier in the evening on electronic medical records, yes, it would cost some money, Mr. Speaker; the Federal Government would have to spend some money. I think that the new Democratic leadership has made a mistake in enacting these PAYGO rules which make it impossible in some instances to do things like the physician payment fix that Dr. BURGESS is talking about, the repeal of the alternative minimum tax, which clearly was a mistake, an oversight 35 years ago when it wasn't indexed for inflation.

And so now the Democratic leadership has put themselves in a position where we can't get things done because of those PAYGO rules when in the long run the program that we would enact would save money; it wouldn't cost money. So you would be paying for it doubly by cutting another program and raising taxes to pay for something that will eventually pay for itself. And, certainly, I think that's true with Medicare part D, and I absolutely believe it is true with the electronic medical records system that we need in this country, and I think it's true in regard to medical liability reform that Dr. BURGESS is talking about. So I thank the gentleman for bringing that up, and I yield back.

Mr. BURGESS. I thank the gentleman for his participation this evening. I actually thank you for bringing up the issue about Congressional Budget Office scoring. We're about to the time in this Congress where you hear us talk a lot about the budget, and we will be developing the parameters of the congressional budget shortly after the President gives his State of the Union message here in a few weeks. The President delivers his budget, and then we come up with a congressional version of the budget.

The last year when we were working on the budget, I brought essentially what was the Texas medical liability reform model to the Budget Committee, had it scored by the Congressional Budget Office, and it scored in a savings just under $4 billion over the 5-year budgetary window, not an enormous amount of money; but for a body that spends $3 trillion a year, it was savings worth looking at. And the Texas legislation, as the gentleman from Georgia pointed out, the law passed in California back in 1975 seems like forever ago. The Medical Injury Compensation Reform Act of 1975 passed in the State of California, signed by the Governor, who at the time was Jerry Brown. This same concept in Texas was developed. And the Medical Injury Compensation Reform Act of 1975 in California capped noneconomic damages at $250,000. The Texas bill was a little more flexible than that: it allowed for a trifurcated cap of $250,000 on the physician and $250,000 on the hospital, and $250,000 on a second hospital or nursing home if one was involved.

But that trifurcated cap allowed for a little more flexibility in trying to establish just compensation for a patient who, indeed, had been injured; but it also acknowledged the reality of our system in that you cannot have an open-ended amount of compensation for noneconomic damages because it throws so much indecision into the system that people can't make rational decisions.

So by trifurcating the cap, and interestingly enough, in the State of Texas punitive damages were still allowed to stand, we also had periodic payments for large settlements, and we also had a Good Samaritan rule. This bill passed in 2003. It was upheld under a constitutional amendment election in September of 2003 and has now been the law of the land since that time. And we have seen phenomenal success in Texas, not only with holding down the cost of medical liability premiums, which were going up year after year after year, but we also saw medical liability insurers leaving the State in vast numbers. In fact, we've gone from 17 down to two. And you just don't get very good competition between insurance companies when you only have two of them.

So we now have brought more insurers back into the State. They've come back into the State without an increase in premiums. In fact, Texas Medical Liability Trust, my last insurer of record, has reduced premiums by 22 percent over the last 4 years compared to double-digit increases for each of the last 5 years prior to 2003.

So it really is a phenomenal success story. Smaller, mid-sized not-for-profit community hospitals have had to put less money into their contingency funds to cover possible liability payouts, and as a consequence they've been able to return more money to capital investment, hiring nurses, just the kinds of things you want your smaller community not-for-profit hospital to be able to do when released from some of the constraints of the liability system.

I'm not saying that this is perfect; I'm not saying that this is what we should all aspire to. Certainly there are reasons to consider concepts like medical courts. Certainly there are reasons to consider concepts like early offer. But the fact of the matter is we can do a lot better than what we're doing today because the system that we have today only compensates a small number of the patients who are actually injured. And, moreover, the time it takes for a patient to recover money under the current system is far too long.

□ 2145

And if you will, the administrative costs, that is, costs of the medical experts and the legal system and the lawyers' costs, consume about 55 to 58 percent of every dollar that's awarded in a settlement. Well, we wouldn't tolerate a health insurance company that had an administrative cost of 58 percent. We'd call them profiteers and we'd bring them up before hearings, but yet we tolerate it in our medical justice system every day of the week. And it's not right.

I want to so much thank my friend from Georgia for joining me here tonight. This is an issue that we will get to talk about a lot over this next year. Obviously, we have got a 6-month window of opportunity on getting the physician payment formula right. I believe that means taking a short-term, mid-term, and long-term approach to the problem, which I have tried to do in the past. And we will be working with other people here in the House of Representatives, I hope on both sides of the aisle, to try to craft a solution to this problem, which has vexed this Congress for a number of years. But suffice it to say, we will be able to be back here on several more occasions talking about this and other issues as they relate to health care in this country.

GENERAL LEAVE

Mr. COHEN. Mr. Speaker, I would ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and include extraneous material on the subject of my Special Order.

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

There was no objection.

DR. MARTIN LUTHER KING, JR.

The SPEAKER pro tempore (Mr. ALTMIRE). Under the Speaker's announced policy of January 18, 2007, the gentleman from Tennessee (Mr. COHEN) is recognized for 60 minutes as the designee of the majority leader.

Mr. COHEN. Mr. Speaker, the subject of my Special Order today is the birthday of one of America's greatest citizens, Dr. Martin Luther King, Jr.

Dr. King's birthday will be celebrated next week with the national holiday on Monday, one of the only men or women to have a holiday named for them in this country. At one time, of course, we celebrated the birthdays of George Washington and Abraham Lincoln, and now we celebrate Presidents Day. But we celebrate Dr. King's Day, a great American and an individual who changed this country for the better and whose life is a testament to fortitude and courage, faith, and a desire to make America better.

On April 4, 1968, 40 years ago this year, Dr. Martin Luther King, Jr. was assassinated in my hometown of Memphis, Tennessee. That was a defining moment in the history of America, indeed, in the history of the world. While Dr. King's death should not and will not ever be forgotten, I think that today on what would have been his 79th