at and they are going to say, listen, I am an Independent, I am going to have to vote for the folks that are about the solution; I am a Republican, I am going to have to vote for the folks that are about the solution. In my house, I am a Democrat, I am going to have to vote for the folks that are willing to move this country in a new direction. And the evidence has spoken over the last 14 to 15 months that the new direction Congress has moved in that direction; and, that through the fact that we have been empowered by the American people to lead this country in a new direction, the President on bills that he said he would not sign had to sign because we kept that pressure on.

So I say all of this, Mr. Speaker, in closing that what we are facing right now are real issues. Our responsibility is great. Historians will write about this time in Congress. And I share with the Members, as a matter of fact I beg the Members to be on the right side of history and making the right decisions right now.

I will close with the information that I received as of April 3 as it reflects in Iraq: 4,011 Americans that have died in the line of duty; total number wounded in action and returned to duty 16,364; total number of wounded in action and have not returned to duty is 13,264.

As we break for the next couple of days and over the weekend, come back hopefully with the heart and the mind to be about the solution.

I yield back the balance of my time.

HEALTH CARE

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

Mr. BURGESS. Mr. Speaker, it has been a long week. We have had a pretty tough legislative day today. It is springtime in Washington. Springtime brings lots of different groups to town; we saw farmers this week, we saw the firefighters, first responders this week, FEMA personnel this week. We also saw some of my friends at the American Medical Association this week, many of my friends from the Texas Medical Association. They came to Capitol Hill to discuss things that are important to them in health care. And, as I frequently do at the end of the day, I thought I would come down here and talk a little bit about health care. I like to call these little visits house calls.

Now, prior to coming to Congress I was a practicing physician. I am still licensed; I am not insured. But in honor of my fellow physicians who are here in town this week, I brought a picture of a famous doctor. No, he is not a medical doctor; he is a physicist. This is Dr. Albert Einstein. But I thought we would have Dr. Einstein accompany me on this house call this afternoon. It is going to be a little talk about the role of healers, the role of physicians, the roles that perhaps they should play in health care reform in America.

Now, Dr. Einstein did a lot of famous things. He did some things that were infamous as well. He is well known for a number of quotes, and one of my favorite quotes from Dr. Albert Einstein is, ''Insanity is doing the same thing over and over again, and expecting a different result this time.'' Of course, Dr. Einstein was right. And I wanted him to be with us today because that quote is a terrific theme for a little talk about how doctors and policymakers can together work on the things that should dictate health care reform in this country. So if you would, let's have a candid conversation about health care, health care at the Federal level, health care at the provider level.

Now, this is an election year in this country, a Presidential election year. It happens every 4 years. There is a lot of big discussions, there is a lot of big debates, and health care will be one of those big debates. There is a broad national recognition that reform is needed in health care. There is not a lot of consensus on how to achieve that.

Now, every one of the Presidential candidates, those who are still active in the race, those who were active in the race and have since dropped out, everyone has or had their own ideas. It won't surprise anyone here to know that Members of Congress also have their own ideas.

□ 1445

Policymakers are focused on change. That is good. That is appropriate. And as we learned this week from visits from doctors of the American Medical Association, physicians are focused on change as well. And they must be because, after all, in this country health care begins and ends with doctors.

Without our doctors, there is no health care. That means our doctor friends, the ones who are in town this week, have to be ones who take an active role in the process of transforming health care in this country. We need them to take a leading role in creating the road map on reasonable reform, to go from where we are now to where we ought to be.

We depend upon our physician leaders because they are leaders and are proactive. They are not reactive. Think about it for a minute. When you are only in a reactive mode, what you end up with are basically band-aid solutions. You think about the term death by a thousand cuts, we can call this death by a thousand scalpels because we were talking to doctors all week.

You know, refusing to do something about liability laws in this country, putting the interest of trial lawyers ahead of patients, that is a cut. Let me give you an example.

My home State of Texas, September 2003, we enacted sweeping liability reform as it affected the health care industry. We got fair medical justice legislation out of our State legislature. It required a constitutional amendment to go into effect, but it did pass under a vote of the people. As a consequence, now some 4 or 5 years later, Texas is seeing the benefits from passing commonsense legislation that limited the amount of payouts for noneconomic damages in medical liability cases.

Because this Texas law has made such a difference in Texas, and let me give you an example, in 2002, the year I first ran for Congress in Texas, the number of medical liability insurers in Texas had dwindled from 17 down to two. You don't get much in the way of competitive bidding when you only have two insurance companies that are willing to write your business. But all the rest had left. The climate in Texas was so hostile that no one wanted to write insurance in Texas.

As a consequence, you had good doctors who were simply unable to get insurance and stopped practicing. I met a young woman during one of the stops I made during my campaign in 2002 who was a radiologist, an interventional radiologist, highly trained, highly specialized, trained by the State of Texas, State-supported schools, so the taxpayers of Texas had paid for a portion of her education. And now 4, 5 years out in practice, she lost her liability insurance and was not able to get another carrier to pick her up. It was too risky. She couldn't practice without it, and she became a full-time mom, no longer practicing interventional radiology at a time I would argue when our health care needs are doing nothing but increasing.

That was wrong, and the State legislature in Texas recognized that was wrong and got busy and changed it. They didn't come up with a new idea, they copied an old idea.

In 1974, the State of California passed a sweeping set of medical liability changes called the Medical Injury Compensation Reform Act of 1974. And with those caps on noneconomic damages, they were able to tamp down the premium increases that doctors had seen over time. And, indeed, when we passed that legislation in Texas, we have seen the same result. It does work and it should be tried in more areas.

In fact, I have introduced legislation similar to the Texas legislation in the House of Representatives, H.R. 3509. This bill actually scores as a saving by the Congressional Budget Office. We are in our budget time in the springtime here in Washington. We are scrapping around for every dollar we can find to pay for Federal programs. Here is a gift I will give to Congress. It is a $5 billion gift this bill would save over 5 years as estimated under the Congressional Budget Office, and it does the same things on a national scale as the Texas legislature was able to deliver for their patients back home in Texas.

One of the unintended beneficiaries of this whole process was the small,

community-based hospital. The small, not-for-profit community hospital had to hold many hundreds of thousands, millions of dollars in escrow against a potential bad outcome, a bad event in a liability case. They have been able to back down those holdings and invest that money in just the things you want your community hospital to invest in, like nurses and capital investment. The result has been an expansion of medical care in Texas.

Since that bill was passed, we had gone down to two medical liability insurers. We are now back up in excess of 20, and they have come back into the State without an increase in fees.

My old insurer of record, Texas Medical Liability Trust, has reduced its liability premiums 22 percent in the aggregate since the passage of this law in 2003. Clearly it works.

Remember, our Founding Fathers said that the States should act as great laboratories for the Nation, and things that work in States should be considered for use countrywide. And, indeed, this is one of the concepts that embodies that.

The principles here on the chart are pretty straightforward. It does cap noneconomic damages in a medical liability suit, $250,000 per physician, $250,000 for the hospital, $250,000 for a second hospital or a nursing home if one is involved. It does allow for some periodic payment, and it allows for good Samaritan care. Very sensible, straightforward legislation. It is not a complicated bill, and it behaves as advertised. And that is one of the things in this Congress, we just heard a gentleman talking about solutions. Here is a solution. I offer it as a gift to the United States House of Representatives. It saves $5 billion over the next 5 years. Use that money somewhere else because in a $3 trillion budget, there are plenty of places you can spend money.

Another place where we apply just a band-aid where we really need to do something major is in how we reimburse physicians for taking care of Medicare patients. They are taking care of our Medicare patients. Medicare is one of the largest deliverers of health care in the country, indeed the world. We have asked doctors to take care of our Medicare patients. They are some of our most complex patients. They have multiple conditions, multiple diseases, frequently on multiple medications, and we have asked the medical community since 1965 to provide care for these patients.

What do we do in return? We passed legislation a number a years ago that reduces year over year the amount we reimburse for that care. That doesn't make any sense. Can you imagine a doctor, a small businessman, going to his banker with a business plan. He says I am going to expand my business and I have this business plan, and part of the business plan is I am going to make 10 percent less every year, year over year as far as the eye can see.

Well, even back in the subprime days, no banker is going to make a loan on that type of business plan. How do we expect physicians across the country who are small business owners, how do we expect them to survive? And they certainly cannot thrive in that kind of an environment.

We do this because we have created a condition called the sustainable growth rate formula. I have put it up on this poster, and I am not going to go through this line by line. It is available on the Website of the Center for Medicare and Medicaid Services. But just to demonstrate the complexity of this formula and to point out that going through all of these calculations, the final line in this formula is that you go back to 1996 and capture all of the money that you should have saved and add it on at the end. It is a formula that is destined to fail over time. Until we in Congress recognize that this formula is destined to fail over time, repeal it, reverse it, revise it, get rid of it, stop the cuts, pay the doctors what they are owed, and get on with things.

Currently in this country, we have Medicare divided into four parts. Each part is supposed to be an integrated member of the whole. We have Parts A, B, C and D. Part A deals with hospitalizations; Part B compensates physicians; Part C is Medicare HMOs; and Part D is drugs.

Every part of Medicare with the exception of the physician payment receives a cost-of-living adjustment year over year. Part B is different. It is governed under the sustainable growth rate formula. So a hospital will receive ever-increasing amounts of compensation because the cost of inputs increases, because a drug company or HMO will receive an upgrade every year, year over year because the cost of doing business increases, physician reimbursement will decline over time. Clearly, that is unsustainable.

I have a real problem here in Congress. I show this formula to any Member of the House of Representatives, although they recognize that patient access is a problem, physicians are in peril, although they recognize those features, this is very difficult to understand. This quickly goes into the ''too-hard box'' in someone's mind, and we are just not going to deal with it. But Congress must deal with this.

An example of how we don't deal with it, last December we were right up against a deadline. Cuts were going to go into effect on January 1, so at the last minute we came to this House and we passed a bill that would delay these cuts by 6 months. What an insult to the practicing physicians in America. What an insult that this was all the time we would expend on this very important issue that affects virtually every aspect of their practice life.

I say that because it is not just the Medicare reimbursement that is affected, but literally every private insurance company in this country pegs to Medicare. And so if Medicare does a 5 percent or 10 percent cut, guess what happens to Blue Cross/Blue Shield, United, on down the line. They will follow suit. Can't blame them for doing so, it is the market price. But as a consequence, this House of Representatives, this Congress, exerts wage and price controls over health care in this country that most of us here don't really have an understanding of.

So last December we passed a 6-month delay on phasing in the Medicare cuts. We have to deal with that before the end of June. It is the first of April. Half of that time has been consumed. Half of that time has been squandered, and have we seen any meaningful effort in my committee, the Committee on Energy and Commerce, which has jurisdiction over Part B in Medicare? No, we haven't. We did steroid hearings, for crying out loud, on baseball players. This is the work we should be doing.

We heard the other gentleman talk about solutions. Here is a solution we could wrap up and give to patients in America, and they would be the better for it.

Now, one of the other things that happened in December which we didn't get done, and sometimes in a way it is a good thing that we don't get things done. We talk a lot about trying to bring the architecture and information technology in health care, to bring it on up into the 21st century. It is a difficult concept for a lot of people to understand. It is difficult for some people to understand why we don't just flip a switch and turn on a computer and make it happen.

One of the bills that we saw come to Congress last December which didn't get passed was a bill that was going to mandate that physicians in the Medicare program use electronic prescribing.

Conceptually, it is a good idea. I am a physician. I am left-handed and have bad handwriting. Every year older I get, my handwriting doesn't get any clearer. So e-prescribing will remove some of those problems. And yes, it could reduce error rates. And yes, it will immediately flag things like medicines that are in conflict with each other and allergies that a patient has.

So it is a good concept, but what do we do with it here in Congress? We make it punitive. We come to the medical community and say here is our grand plan for e-prescribing. First of all, we give you $2,000 to invest in the infrastructure. Two thousand dollars; $2,000, do you have any idea how much these programs cost and how much it costs to buy the infrastructure and do the training? It is far in excess of $2,000. In addition to that, if you do this e-prescribing program, we are going to give you a 1 percent bonus over time for doing this program. But if you haven't done it in 4 years' time, we are going to come back with a $10 penalty for every patient that you see.

Well, a 1 percent bonus, that is better than nothing, but think about it for a

moment. In my practice if I saw a Medicare patient, return visit, moderately complex, on a good day, if that was a $50 visit, they reimbursed $50, that would be a miracle in itself. But let's do it that way because it makes the math easy and I'm not good at math. So a $50 patient visit. And if I am really moving and if I am really on my game, I can see four of those patients in an hour. So that is a $200 hour that I have put in in the clinic that morning. And we are going to get a 1 percent bonus for that. So for each of those four patients I saw in that hour, I am going to get an extra 50 cents. That is a $2 an hour increase. Well, that is not a lot when you think about all of the extra work that goes into maintaining and training for these e-prescribing programs.

□ 1500

But what if I don't do it, what's going to happen then? In 4 years' time, we're going to come back with a 10 percent reduction. What does that 10 percent reduction mean to that same hour of intensity, that same hour of work applied 4 years later? Well, a 10 percent reduction, instead of now a $2 increase, I get a $20 penalty for seeing those four patients but not using e-prescribing.

If you couple that on top of the program, 10 percent cuts that are supposed to go in year after year, is it any wonder that when you pick up a phone and try to make a new patient appointment in a doctor's office, they say, I'm sorry, we're full, I'm sorry, we're not taking any new Medicare patients. And this is becoming a crisis for our seniors all because Congress will not do the work for our physician community and for our patients. And it's work we've asked our physicians to do. Since 1965, we have asked them to participate in this program.

But let's stay on the concept of information technology for just a moment. And I will tell you, Mr. Speaker, I haven't always been a big fan of some of the advanced and higher information technology, electronic medical records. Yeah, those were good for someone else, maybe not for me. E-prescribing, I did it with a couple different vendors in my private practice. It never was all that it was cracked up to be. But in August of 2005, late August of 2005, I changed my mind on this subject. And I changed my mind on this subject because of a very harsh event that happened in America, and that was the passage of Hurricane Katrina over the City of New Orleans.

And we all know the story there, the multiple breaches in the levees and the city flooded. And one of the consequences of that city flooding was the flooding of one of the venerable old health care institutions in this country, Charity Hospital in New Orleans. The basement was flooded for weeks. Guess what we have in our basements of our hospitals around the country? That's where we put our records. That's where we store these paper records.

So, here is a visit. In January of 2006, we did a field hearing on one of my subcommittees on Energy and Commerce. We went down into the basement of Charity Hospital in New Orleans. The room had been dewatered. Prior to that visit, I didn't even know ''dewatered'' was a verb. The room had been dewatered, and here is the medical records department.

Now, this black stuff that you see smudged on the charts, and these are rows and rows of medical charts, you can see the identifying patient numbers on the end, this black material smudged on the charts is not soot from a fire, it's black mold. That means that anyone who comes in here and pulls a record off the shelf is going to get a lung full of mold spores. And clearly, because of that hazardous condition, these records will never be accessed again. And of course you can imagine, this room was under water for weeks and weeks and weeks. The effect of salt water, brackish water on the ink that went to record these medical events, these records were likely unreadable even if someone had been willing to hazard the mold spores to pull one off the shelf. So, all of this data is lost forever.

And we don't know what's in there. Perhaps a kidney transplant, perhaps a premature birth, perhaps just a well-baby check. Absolutely impossible to tell. This was so critical because when many of the people who left New Orleans after that storm, after the difficulties that were encountered in the aftermath, a lot of those individuals came to Dallas, Texas and they arrived on the parking lot at Reunion Arena, where they were to be triaged to receive health care if they needed, housing, start to get their lives back on track. There were many people who arrived there who actually had significant medical conditions. And it was very, very difficult to obviously go back and access these records that were, in effect, under water in the City of New Orleans.

Now, there were some big chain pharmacies who arrived on the scene with a mobile truck. And using the information that they could download off their central computer system, from a patient's name and birth date they were able to recreate medicine lists. And I will just tell you, if you can get an accurate medicine list on a patient, a lot of times you can know a great deal about their medical history given the types of medications they were on. Or, if nothing else, here was verification that this was the anti-hypertensive that this patient needed, this was the type of diabetes medication that this patient was on. It accelerated care for these patients in an unbelievable fashion.

And these two series of events made me a believer in electronic medical records. If you have an electronic medical record that stays with the patient, that follows the patient throughout life, that can be accessed by the patient, be accessed by that patient's physician if the patient gives permission. If you have that capability, that would have gone a long way towards the rapid reinstitution of medical care. For some patients who are, frankly, quite ill, not just because their underlying medical condition made them ill, but they were ill from spending several days in water up to their waists, or in the Superdome where they lacked air conditioning or lacked access to some of the most basic facilities for hygiene, these were patients in distress because of their medical condition and because of the conditions in which they had existed after the storm.

So, how much better was it to be able to resume their care because there was the availability of at least a small amount of data that could be retrieved electronically. If a patient had their own medical record over which they had control, much, much more facile to be able to treat those patients in that type of situation.

Now, we do hear a lot, here in Congress there are various bills and ideas out there, as far as how to get the health care community up to speed on electronic medical records or health information technology, as you frequently hear it referred to here in Congress. There was a big study done a few years ago by the RAND people. And in this study they talk about the billions of dollars, $77 billion, that can be saved over 15 years if we go to an electronic medical record model. Now, that's a significant amount of money. And the study is a very meaningful one, very well thought out, very well constructed. Most people don't go much more deeply into it than that, but if you actually take the trouble to read the RAND study, if you look into it, most of those savings actually occur on up towards that 15th year of that study.

Most of the investment in information architecture is going to be done on an individual basis and wasn't included in the cost or the benefit of the RAND study, so it skews the figure a little bit on the plus side because of that; no allowance for training, no allowance for maintenance. But, nevertheless, still they do show a significant savings available by going to electronic medical records.

Their sum-up paragraph, the very last paragraph of the study, they say for this world to go away and the electronic world to occur, it is going to take incentives. And they talk about incentives that they must begin early, that is, you want to be sure and make that incentive available so that you don't penalize someone for getting in early, or more importantly, you don't reward a late adopter. So, the incentives have to be available early. And the time limit that the incentives are available, the time frames that the incentives are available have to be limited.

But the final point, and the one that is always missed on the floor of this

Congress, is the incentives must be substantial. I would submit to you that a 1 percent increase in a Medicare patient's compensation for an office visit for using e-prescribing does not fall into the category of a substantial benefit. And then, as we so often do here in Congress, we go on to add insult to injury by saying, if you don't do it, we're going to punish you. Here's a little carrot, but a big stick if you don't do what we've asked you to do.

So, I do think that the day will come when we will see a great deal more adoption of electronic medical records. Some of the things I think we could do are: encourage the private sector, that is really light-years ahead of the Federal Government on this, perhaps with a little relaxation of some regulatory regimens called the Stark provisions, perhaps with at least some definition of what privacy is and what privacy means so people have some certainty about the systems that they're developing. Maybe a little bit on the liability side. And true enough, ask something from the private sector in return. If it's an insurance company that's developing this model, make certain that the information itself is owned by the patient and may travel with the patient if they transition from one company to another, or if they transition from one employer and they go to individually owned insurance, make certain that that information is not lost in that transaction and the patient can control the information.

But I do believe if we put some of our partisan differences aside, we could devise a scenario that would be conducive to the development of this type of technology. And again, as the gentleman who was talking before me kept talking about solutions, these are the types of solutions that the American people want to see us working on. Again, they're not really interested if we hold another hearing about steroids in baseball. They are interested if we can provide them this type of value in their doctor/patient interactions.

Now, one of the other concerns that I have when you hear people talk about health care, and certainly when you hear people talk about it at the national scale, is, well, why don't we expand the Medicare program. Please be advised, in my opinion, the Medicare program, for all the good things that it does do, has enough areas of uncertainty around it that, number one, I don't think it is the type of program in which we want to be placing everyone.

But going back to the SGR formula, I spent probably 40 to 60 percent of my week dealing with problems that are brought about by difficulties administered through Medicare, Medicaid, SCHIP, all of the Federal systems that we have to provide health care in this country. We are not doing a great job.

So, at this point, I don't see the value in rewarding the Federal Government by giving it a greater and greater share of health care in this country. And I would simply ask the question, does the private sector have a role to play in the delivery of health care in the United States of America? My answer to the question is yes. And, in fact, a long hearing that we had today dealing with Medicaid funding, if you do not have the private sector, you have no way to pay for Medicare and Medicaid because, let's be honest, Medicare and Medicaid do not pay the full cost of the care that's rendered. Hospitals, physicians and clinics across the country have to cross-subsidize their Medicare and Medicaid populations with money from their private practices, with money that they receive from the private sector.

So, I would submit that the private sector does have a role to play in the delivery of health care in this country because, at the very least, right now we depend upon the excess payment from the private sector to fund the cross-subsidization for Medicare and Medicaid.

One last thing about the physician's compensation let me talk about, because I've been very critical of the way the current majority, the current leadership handled the Medicare reimbursement at the end of 2007, but I must say at the end of 2006, when my side was in charge, we didn't do a great deal better.

We decided to provide a 1–1.5 percent increase in physician compensation if doctors were willing to undergo some quality reporting. Now, quality reporting generally would be thought of as a good thing, but again, the incentive was so low as to not cover the cost of collecting the data. And now, after the first year and a half of this initiative called the Physician Quality Reporting Initiative, started out life as PVRP, and then became PQRI, the results are pretty disappointing. Not that quality wasn't there, the results are disappointing because it wasn't worth the time of the doctors and clinics around the country to participate in the program. Almost 90,000 physicians across the country could have participated in a reporting program for asthma patients, but, in fact, less than 100 did.

Again, if incentives are going to work, if incentives are going to be worthwhile, they have to be meaningful. If you provide a meaningless incentive, then the person who is to receive the incentive says, this is information you really don't value, so I'll tell you what, I'm not going to bother with it, it's not worth it to me.

Incentives will work; they will work if they're meaningful, they will work if they start early, they will work if they're time limited, but they must, above all else, they must be substantial.

Now, again, I referenced earlier that a physician's office is nothing more than a small business. They need the resources to pay the overhead. We heard a very moving story today in committee of a pediatrician who practiced in Alabama. Her patient population was 70 percent Medicaid, and she had reached the point in her practice where she wasn't covering overhead any longer; she had to borrow from her savings in order to keep her practice open. And from what she described to us, it sounded as if she had done all the things she could do to hold costs down in her practice, extended hours, hired physician extenders, she had a physician's assistant working with her. But the reality is, because the payment for Medicaid patients is so low for physicians, the result is, if they don't have a sufficient private population, again, to bring those earnings up, they're not going to make it. So, a practice that is 70 percent Medicaid in rural Alabama apparently can't make it paying the overhead and trying to keep the doors open for, again, the very critically ill patients, the disadvantaged patients, the patients that we in Congress have asked this doctor to take care of.

It is disappointing, to say the least, it's a travesty, it's a tragedy, that a doctor in that situation will only be able to keep that up so long. There are only so many nights you can go home and explain to your family that, once again, you had to raid the retirement savings or raid the children's college fund simply to pay for operational expenses to keep the office open, because if you were doing that, bear in mind, that physician is not drawing a paycheck for those months either.

So, it's difficult for doctors to build their businesses. It's difficult for doctors to pay their bills when the very policies developed on the floor of this House are so detrimental to the practice of medicine.

□ 1515

And if we can continue to accept these types of Band-Aid solutions in liability, in Medicare, in Medicaid, if we continue to accept those Band-Aid solutions, just like Dr. Einstein said, we're going to get the same results, or worse.

Doctors are leaving Medicare as a result of some of the activities taken on by this country. It is time, it is time for this Congress to step up and do something new, try something new. I mean, 435 leaders, elected by their respective constituents across the country; 435 leaders, we need to lead.

We need to do the hard work, take a short-term, a mid-term and a long-term approach to these problems. And they're not insoluble. They're hard, to be sure. They're complex. They may require hours of work. They may require some hard bargaining and, at the end, they may require some compromise. But solutions are within our grasp.

But when we do stuff like a 6-month Medicare payment fix, we do more than harm the physicians who we've asked to take care of our Medicare patients. We do more than harm our seniors who now pick up the phone and can't find a doctor who will accept their Medicare. We actually harm the very credibility of this institution, and we undermine the credibility of this institution when

we take such short-sighted approaches to very significant national problems. And the American people, correctly, stand back and say, what's going on?

And so is it any wonder that approval ratings of Congress are at historic all time lows?

Well, to be certain, there are health care policy reform questions and goals that, over time, and with some thoughtful deliberation, can result in successes. But we're going to have some big questions we have to answer.

And that's one of the fortunate things about being in the middle of an election year because these things now get elevated to a national forum; there's a national referendum, if you will, about the future of health care.

We'll have really, I expect, some fairly different choices out there to make. We'll have to ask ourselves, how are we going to go through these changes and continue to value that interaction that takes place between the doctor and the patient in the treatment room? After all, that's the fundamental unit of production that occurs in this big, vast machine that we call American medicine.

So how do we keep that relationship sacred? And what do we do that delivers value to that relationship?

We're going to hear a lot of talk about mandates. We already have. We hear people talk about individual mandates, where every individual is required to buy health insurance. We hear things about employer mandates, where every employer is required to have health insurance.

Do mandates work? Are they a good thing? Will they work in a free society? How do you force everyone to do what you think is a good idea and ought to be done?

Well, it turns out it can be terribly difficult to do that, and the history of mandates is sketchy, to say the least.

A very good article in Health Affairs, a magazine or periodical called Health Affairs last November, the title was Consider It Done, talking about mandates. We're there; we've reached the promised land and we're going to have mandates to require health insurance.

But even in that article, as they go through the history of mandates in this country, certainly raises some valuable questions about whether or not mandates will ultimately work.

And going back into the 1960s, there was the helmet law brought to motorcycle riders by this United States Congress. And the outcry was so severe when Members of Congress went home from their constituents who were part of the motorcycle riding community that they very quickly came back and said, well, that's a State's issue. We're going to repeal that at the national level and, Mr. State Legislator, you're going to have to deal with that; Governor, you'll have to deal with that as a problem, and States have over the intervening 40 years. Some States, my home State of Texas does not require a helmet. Some States do. But Congress very quickly found out that mandates can have some negative consequences.

Well, can you get 100 percent compliance with a mandate? Some people argued that if the penalty for not complying is severe enough and well-known enough, that you will, indeed, get near that 100 percent compliance. But think about it for a minute.

We're just a few weeks away from April 15. We've all got to pay our income taxes. There's a mandate. Everyone is aware of the income tax law in this country. Everyone is aware of the Internal Revenue Service. Everyone is aware, they may not be aware of the specific penalties, but if they know that they don't do what they're supposed to do there is a very swift and sure penalty out there awaiting them from the Internal Revenue Service. And all of us know the story of Al Capone, who was arrested not for being a bootlegger and doing bad things to people, but arrested because he did not pay his income taxes.

So you would think, with the mandate for paying Federal income taxes, that there would be near 100 percent compliance. But the reality is you get about 85 percent compliance. You get about 15 percent of people who decide not to follow the rules with the Internal Revenue Service.

In fact, you'll hear us talk about it on the House floor, especially this time of year when taxes are due and we're talking about budgets and we're looking for more money. People on the floor of the House will talk about the tax gap, that is $300 billion, and if we had that $300 billion we could do good and great things for the country. We have the tax gap because we have 15 percent of the people in this country who are willing to look at the penalties for not filing their income tax and say, you know what? I'm not going to file my income tax.

How many people do we have this it country without health insurance? A lot. It's about 15 percent of the population. We have 300 million people in this country, give or take, probably more than that now. That figure's a couple of years old. And how many people do we have without health insurance? People argue about the number, but around 45 million, and that's about 15 percent of what our population is in this country.

We already have that compliance, even without mandates. So are mandates going to take us to a higher level of compliance?

And what do we give up in terms of freedom if we go down the road of mandates?

But to me, more importantly, what's the flip side to mandates? If you're not going to have mandates, okay, well how are you going to get people to recognize that they should have health insurance?

Well, one thing you can do is work on the affordability side because it's no question, if the bills get too high the employer's going to say I'm not going to provide insurance for my employees any longer because it becomes cost prohibitive. And if an individual looks at the individual market and says the cost is so high I'm not going to comply with it. So certainly the affordability side is a big part of the equation.

But more importantly, it's creating problems that people want. It's creating programs that people recognize as delivering value back to their lives.

And we do have a little experience with this over the past 5 years. We did, in a number of Medicare reforms in 2003, provide Medicare Part D, a Medicare prescription drug benefit. And there were those in this House who argued that this should be something that is mandated by the Federal Government and completely controlled by the Federal Government.

There were others who argued that maybe it would be better to let companies compete with seniors for that business. And that was the argument that eventually prevailed. And as a consequence, we had, at the roll out of Medicare part D, we had complaints because there's too many choices; there's too many companies out there that are offering this, and I can't make up my mind. The cost ranges from $10 a month to $50 a month, and how in the world am I ever going to know what I'm supposed to do?

But after some of the louder rhetoric died down and people began to look at these programs, indeed, these were programs that delivered value to a segment of the population who had never had an affordable prescription drug benefit available to them before and, as a consequence, the penetration with this benefit is extremely high in the Medicare population. And the overall satisfaction rate is also extremely high.

So that's perhaps a model for us to consider when we talk about things about how do we provide insurance. We tell everybody you've got to have it, but there are going to be some people who just won't do it. We make programs that are affordable and that appeal to people, that people want. People want to be able to provide protection for their families. They want to be able to provide additional help if health care is needed in their families. So that would be another way to approach.

One of the great privileges of serving in the United States House of Representatives, you occasionally get to go places or meet people that you otherwise may not have gotten to meet. And for me that hour came last fall when I had the opportunity to spend an hour with one of my heroes, Dr. Michael DeBakey down in Houston. Many people know Dr. DeBakey as a famous heart surgeon. He was also the individual who developed the Mobile Army Surgical Hospital that has been responsible for the saving of so many lives in our Nation's conflicts over the last 50 years. Dr. DeBakey himself is going to turn 100 years old this year, so it was a

phenomenal ability to talk with an individual who has witnessed and lived through and directed the last century of medicine.

And many of the comments Dr. DeBakey made to me were similar to the same things that I wrestle with; how do you provide mandates? How do you require mandates in a free society? Wouldn't it be better to give people things, make available to people things that they would want and would willingly sign up for, rather than forcing them into individual programs that really might not appeal to them?

One of the other things that Dr. DeBakey said to me that gives me, really gives me a lot of hope, really gives me a lot of optimism in looking forward to the future, because he said, Congress can do this. Congress is up to this task. And he said he knew that because when he was a young man, having just graduated from LSU, I'm sorry, graduated from Tulane down in New Orleans, Louisiana, as a young man, after graduating from medical school he had to go to Europe in order to get the credentials in order to be a research physician. Those credentials were not available to him at American institutions, so he went to France and Germany and did his study there in order to get the credentials to be seen as a credible researcher.

But that changed in the 1940s, and it changed because of the efforts of Congress in funding research at the National Institutes of Health, and developing the types of programs that now allow America to be at the forefront of research across the globe. And scientists come here to train, come here to get those credentials, those same credentials that Dr. DeBakey had to cross the ocean to receive a half century ago.

So he told me, Congress can do this and I know Congress can do this because they've done it in the past. They've tackled big things and they've come to the right conclusion.

Well, I pray that he's right. I wouldn't be here if I didn't believe that he was right. But it is going to be difficult to do that.

Now, I can't make all of these things happen by myself. And one of the reasons you're in Congress is because you want to work with others. Well, maybe that's not the reason you're in Congress. But nevertheless, Mr. Speaker, you're in Congress and you do work with others, as is the nature of this body. There's 434 other individuals who have to be consulted, whose vote has to be one before you're going to be able to see your policies become law.

So I will just tell you one of the things I've learned. You can have the best ideas in the world, and you can have all of the enthusiasm and all of the energy required to get those things over the line, but if you don't have people working with you, if you don't have people helping you, it's going to be very difficult to get those things done.

So I am very grateful, with the legislation that I have, to help reform the Medicare payment formula, the bill Number 5545, I do have help. I've got help now over in the Senate. I've got help from the doctors in the American Medical Association. And very important to me, I've got help from my doctors with the Texas Medical Association. And I think together we can get this work done.

There's not a Member of Congress that I've talked to when I've asked them how things are going with their doctors back home who doesn't bring up the problems that their doctors bring in to them about the Medicare payment formula. So the groundwork has been done, and now it's up to us in this Congress to get that accomplished.

And a little preventive medicine will go a long way, will go a long way in fixing some of these problems.

And if you know that two trains are coming at each other down the track and it looks like tragedy's inevitable, what do you do? What does this responsible person do? Do they run down to the track and see if they can find the appropriate switch, or warn somebody off to avert the disaster? Or do you run home and get your video camera so you'll be the first one to get it up on YouTube? I would submit the responsible thing to do is to try to avert the disaster, and not simply document its destructive events.

Mr. Speaker, as our time draws short and this week is going to draw to a close, let me just reflect on a couple of things from the last century of medicine. The last century of medicine I do feel I have some interest in, some ability to talk about that. My father was a physician. His father before him was a physician, so between the three of us, we pretty much occupied the last century in the delivery of health care.

And over the last century, we saw some incredibly transformative things occur within the science of medicine, and we saw some incredibly transformative things occur at the social level, at the legislative level.

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And you think back to what the state of medicine was coming into at the end of the first decade of the last century, what things were like coming up to 1910, medical schools across the country where the curricula was so varied. There was no standardization. The graduate of one medical school could be well-trained and the graduate of another medical school could be woefully inadequate.

We were right upon the time of intense scientific discovery: Anesthesia was coming into its own, the ability to administer a blood transfusion, the knowledge about blood blanking was coming into its own. Immunizations, the whole science of immunology was just coming upon the scene. And at the same time, from Congress, a group of individuals were convened called the Flexner Commission. They came up with a report called the Flexner Report which called for the standardization of medical school curricula across the country, and that stabilization of medical school curricula allowed for the stable platform on which those scientific discoveries could be based and set the stage for some of the great scientific breakthroughs that were yet to come.

And right around the corner, some 30 years later, we were engaged in the activities of the second world war. A scientist in great Britain had found an odd thing had happened when he grew a mold in a petri dish and it inhibited the growth of bacteria. And he had discovered Penicillin. That was 1928. But that was a little more than a laboratory curiosity. There wasn't really anything you could do with it on a commercial basis. There certainly wasn't any patient application for this until American scientists discovered in the 1940s how to produce this on a mass scale, the cost came way down, and the first antibiotic became commercially available, and relatively cheaply, to large numbers of people.

It changed the course of things in the second world war. This happened right before D–Day. And think of the life and limb that was saved by the ability to fight inspection reliably for the first time with a chemotherapeutic agent.

Also, around the same time, cortisone had been discovered earlier, but cortisone was one of those things that was very rare, very difficult to get. You obtained it at the slaughter house. Very, very labor intensive. A Ph.D. chemist, a gentleman that we honored in this House last Congress, Percy Julian, an African American scientist, found a way to extract cortisone from soy beans. Well, that changed the course. Suddenly this very potent anti-inflammatory agent became readily available in large quantities at a relatively low cost.

On the social side in the 1940s, we saw some big changes in the practice of medicine because we were in the middle of the Second World War. President Roosevelt wanted to keep down trouble from inflation so he put wage and price controls in place across the land. Employers wanted to keep the few employees who were still able to work for them. They wanted to keep them coming to work. So they said, can we provide benefits to our employees since we can't raise their wages? Can we provide them benefits?

The Supreme Court ruled that, indeed, did not violate the spirit of the wage and price controls. Those benefits could be given to individuals and, oh, by the way, they could be given with pre-tax dollars. And that set the stage for employer-derived insurance, and some people would argue it has given us some of the difficulties that we now encounter 60 or 70 years later.

But nevertheless, in the 1940s we saw for the first time commercially available, large-scale quantities of antibiotics, anti-inflammatory and health insurance. And think about how the next several decades were changed.

In the 1960s, we saw similar changes. For the first time we saw reliable drugs to fight hypertension become available. Anti-psychotics became available. Antidepressants became available. And in the midst of all of that scientific change, there also occurred a big change in that this Congress, or this House of Representatives, passed a bill that we now know as the Medicare bill.

In 1965 when Medicare was enacted, for the first time the Federal Government had a large footprint in health care in this country, and, of course, it has grown significantly since that time in ways that probably most of the people who are on the floor of this House voted for that bill would never have imagined that it would spend in excess of $300 billion a year, but that's where we find ourselves now.

Think of where we are now on just the beginning of the dawn of the 21st century. The human genome has been sequenced. You can go on line and find a place that, for a little less than a thousand dollars, will investigate your human genome, will tell you your risk factors for diseases like multiple sclerosis, heart disease, diabetes, even being overweight. It's phenomenal to have that information literally at our fingertips. When I was a resident at Parkland Hospital in the 1970s, I never would have imagined that that type of information would be available to people so cheaply and so easily. I never would have imagined that there was anything called the Internet, but nevertheless, that information that could be so easily accessed.

We are indeed at a transformative time in medicine in this country. I referenced information technology. Think of the speed of change of information technology, how things are progressing and evolving so rapidly that it really isn't reasonable to ask the Federal Government to keep up and moderate those changes. We need to depend on the private sector to do that because it's happening so fast.

But as medicine is transformative, Congress, by its very nature, can't be transformative. We are transactional. We take money from one group and we give it to the next. That's what we do. We collect the taxes, we spend the money. Congress is inherently a transactional body. But Dr. DeBakey said Congress can do this; Congress can participate in the transformation of delivering health care in this country.

Well, I thank Dr. DeBakey for his wise counsel. I thank the American Medical Association for being up here this week. It is not easy taking time away from their families and their practices and their practices to come here and interact with legislators such as myself and other Members on both sides of the aisle to help explain and help us understand some of the very complex issues that they face on a day-to-day basis, yes, dealing with sick people but also dealing with this vast morass of regulations and rules that we lay at their feet every year.

And most of all, I want the American people over this next year's time to focus on this grand debate that we are going to have at the national level. Your future is dependent upon it. Certainly your children's future and your children's children's future is dependent upon it.

Think of the Congress back in 1965. It enacted Medicare and had no idea what it would be like 40 years hence. The same things apply today. The decisions we make on the floor of this body today, 30 and 40 years from now are going to look decidedly different. And I would say help us to make the right kinds of decisions so that the American citizens, 30 and 40 years' time from now, will look back and say the 110th Congress stepped up and did the right thing.

Mr. Speaker, it has been a long week, and with that, I am going to yield back the balance of my time.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

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

Ms. WOOLSEY, for 5 minutes, today.

Mr. DEFAZIO, for 5 minutes, today.

Ms. KAPTUR, for 5 minutes, today.

Mr. GEORGE MILLER of California, for 5 minutes, today.

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

Ms. WATSON, for 5 minutes, today.

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

Mr. POE, for 5 minutes, April 10.

Mr. JONES of North Carolina, for 5 minutes, April 10.

Mr. PENCE, for 5 minutes, today.

Mr. WELLER of Illinois, for 5 minutes, April 8 and 9.

Mr. PRICE of Georgia, for 5 minutes, today.

Mr. CONAWAY, for 5 minutes, today.

ADJOURNMENT

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

The motion was agreed to; accordingly (at 3 o'clock and 36 minutes p.m.), the House adjourned until tomorrow, Friday, April 4, 2008, at 10 a.m.

EXECUTIVE COMMUNICATIONS, ETC.

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

5841. A letter from the Chief Counsel, FEMA, Department of Homeland Security, transmitting the Department's final rule — Final Flood Elevation Determinations — received March 10, 2008, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Financial Services.

5842. A letter from the Director, Department of Labor, transmitting the Department's final rule — Mine Rescue Teams (RIN: 1219-AB53) received March 3, 2008, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Education and Labor.

5843. A letter from the Deputy Director Office of Health Plan Standards and Compliance Assistance EBSA/USDOL, Department of Labor, transmitting the Department's final rule — Mental Health Parity (RIN: 1210-AA62) received March 18, 2008, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Education and Labor.

5844. A letter from the Deputy Director, Pension Benefit Guaranty Corporation, transmitting the Corporation's final rule — Benefits Payable in Terminated Single-Employer Plans; Allocation of Assets in Single-Employer Plans; Interest Assumptions for Valuing and Paying Benefits — received March 3, 2008, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Education and Labor.

5845. A letter from the General Counsel, Consumer Product Safety Commission, transmitting the Commission's final rule — Final Rule: Standard for the Flammability (Open Flame) of Mattress Sets; Correction — received March 18, 2008, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

5846. A letter from the Director, Office of Congressional Affairs, Nuclear Regulatory Commission, transmitting the Commission's final rule — Fitness For Duty Programs (RIN: 3150-AF12) received March 13, 2008, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

5847. A letter from the Assistant Secretary Legislative Affairs, Department of State, transmitting the Department's final rule — Amendment to the International Arms Traffic in Arms Regulations: Sri Lanka [Public Notice:] received March 18, 2008, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Foreign Affairs.

5848. A letter from the Deputy Assistant Administrator For Regulatory Programs, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries of the Exclusive Economic Zone Off Alaska; Gulf of Alaska; 2008 and 2009 Final Harvest Specifications for Groundish [Docket No. 071106671-8010-02] (RIN: 0648-XD67) received March 13, 2008, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

5849. A letter from the Deputy Assistant Administrator for Operations, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries of the Caribbean, Gulf of Mexico, and South Atlantic; Reef Fish Fishery and Shrimp Fishery of the Gulf of Mexico; Amendment 27/14; Correction [Docket No. 0612243157-7799-07] (RIN: 0648-AT87) received March 13, 2008, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

5850. A letter from the Deputy Assistant Administrator For Regulatory Programs, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries of the Exclusive Economic Zone Off Alaska; Groundfish, Crab, Scallop, and Salmon Fisheries of the Bering Sea and Aleutian Islands Management Area [Docket No. 070711313-8014-02] (RIN: 0648-AV62) received March 5, 2008, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

5851. A letter from the Under Secretary and Director, Department of Commerce, transmitting the Department's final rule — Changes in the Requirement for a Description of the Mark in Trademark Applications [Docket No. PTO-T-2007-0035] (RIN: 0651-