

those funds are spread around like revenue-sharing projects.” We are basically using the opportunity to spend money on homeland security for turkeys, we used to call them in Florida. We call them earmarks here. That means little itty-bitty projects, and every Member knows that there are potential security targets in their own district, but we don’t nitpick homeland security. You don’t spread the money around so thinly so you never make truly one area or region or community truly safe.

They said that until Congress passes a law to allocate funding on the basis of risk and vulnerabilities, scarce dollars will continue to be squandered.

“Second, States and localities need to have emergency response plans and practice them regularly. Hurricane Katrina taught us a lesson that we should have learned from September 11: From the moment disaster strikes, all first responders need to know what to do and who is in charge.”

Do they know that? No.

“Third, we called on Congress to give first responders a slice of the broadcast spectrum ideal for emergency communications.” That won’t happen until 2009. What in God’s name are we waiting for? 2009? What happened to the interoperability in communications that was so essential that was the major problem on 9/11?

I don’t have time to go through all of the recommendations, Mr. MEEK, because homeland security is so woefully lacking and the congressional leadership here has done, I can’t even use that word, congressional leadership has done such a poor job of implementing their recommendations and making us safer that it is laughable. It is ridiculous. It is outrageous for them to suggest that they are the party of national security and safety. I could go on and on.

Mr. RYAN of Ohio. Mr. Speaker, I want to share as we end here from the Newt Gingrich commentary from the Wall Street Journal where he talks about some of this stuff, about trying to figure out what the solutions are by figuring or understanding what the problems are.

Then he talks about, and this is his advice to George Bush, “Then he should announce an honest review of what has not worked in the first 5 years of the war.” That is what we have been saying. Let’s find out what has not been working. Based on the findings, he should initiate a sweeping transformation of the White House national security apparatus. Good idea.

The current hopelessly slow and inefficient interagency system should be replaced by a new metrics-based and ruthlessly disciplined integrated system of accountability. That is what we want to do. Accountability. Let’s sit down and have hearings and figure this out. The House of Representatives has a role to play in this oversight. The President should insist upon creating a new, aggressive, entrepreneurial na-

tional security system. It is time to do this.

Following this initiative, the President should propose a dramatic and deep overhaul of homeland security grounded in metrics-based performance to create a system capable of meeting the seriousness of the threat.

This is about reforming the institution of government. The former Speaker understands it. The Democratic Party understands it, and the only people who seem not to get it are the people who serve in this administration and the high levels of this Congress. I hope it changes. All of the charts that we are using tonight are available on this website, [www.HouseDemocrats.gov/30Something](http://www.HouseDemocrats.gov/30Something). It has been an enjoyable evening once again.

Mr. MEEK of Florida. Mr. RYAN, I want to say that Ms. WASSERMAN SCHULTZ is going to get an opportunity to go through her homeland security piece when we are on the floor again.

I want to encourage members to go on [HouseDemocrats.gov](http://HouseDemocrats.gov) and get a copy of the real security plan that we have here. We even have it in Spanish. Also energizing America is on there, and also an innovation agenda that has a lot of CEOs and leaders in the education field. They say they endorse our plan.

With that, we thank the Democratic leadership for allowing us to have this time. It is an honor to address the House once again.

#### THE ROAD TO AFFORDABLE HEALTH CARE

The SPEAKER pro tempore (Mrs. SCHMIDT). Under the Speaker’s announced policy of January 4, 2005, the gentleman from Texas (Mr. BURGESS) is recognized for 60 minutes.

Mr. BURGESS. Madam Speaker, I too would like to say it is a privilege to come to the floor of the House and be able to address the House on important matters of the day.

In my first term in the House, the 108th Congress, and my background is actually as a physician, and when I came to Congress in 2003, one of the things that you do with a doctor when you put them in Congress is put them on the Transportation Committee. So I had a very good session of Congress on the Transportation Committee. I was fortunate enough after my reelection in 2004 to be placed on the Energy and Commerce Committee on the Subcommittee on Health. So having had experience in Congress on both roads and now health, what I thought I would talk about tonight is the road to affordable health care.

Some of the things that I want to talk about tonight are the overall affordability of health care and where we are in this country and where we are going. I want to talk about the public versus the private systems in this country. We obviously need to talk about the uninsured and some of the programs to help with the uninsured,

federally qualified health centers, association health plans and health savings accounts.

□ 2300

You almost can’t talk about health care in this country without talking about liability reform, and, indeed, we do need to touch on that, and the sustainable growth rate, patient access for Medicare patients, how physicians are reimbursed under the Medicare system, an item that is becoming of critical importance if we want to keep some of our best doctors providing care for some of our most complex and challenging patients.

Information technology has been one of the buzzwords up here ever since I started my time in Congress, and, indeed, we need to talk about that. Preparedness, whether it be from terrorism, whether it be from natural disaster, or whether it be from an outside source like the worldwide flu pandemic that hit this country in 1918, we need to be prepared for that should it happen.

We need to talk a little bit about the number of State mandates that are on insurance policies that tend to drive the cost of health insurance up and thereby reduce the overall affordability of health care.

There are some interesting things that are being done in some of the States as they approach some of the difficulties they had in providing health care to their citizens. I would like to particularly talk about Governor Mitt Romney’s plan up in Massachusetts that provides for personal responsibility in health care.

Finally, if there is time, we will talk a little bit about the reauthorization of trauma centers in this country. We will talk a little bit about transparency, raise transparency for price cost and quality in our health care system and maybe just a little bit about long-term care, because that is one of the drivers that is going to vastly increase the cost of Medicare and Medicaid as more and more baby boomers retire.

Let me just remove this for a minute so it is not distracting to any other Member of the House who might happen to come by and look at it.

We talk about the current problem facing us. We spend a fair amount of money in this country on health care. We have a gross domestic product of upwards of \$11 trillion, and we spend about 16 percent of that on health care; \$1.4 trillion is spent on health care in this country. In fact, Medicare and Medicaid alone in our HHS appropriations bill, which we have yet to pass, that bill will probably be upwards of \$660 billion just for Medicare and Medicaid.

Of course, we have the Indian health service, the veterans health service, Federal prisons also providing health care, so there is a significant chunk of this Nation’s health care that is already borne by the Federal Government. The other approximately 50 percent is broken down to that care that

is just simply not compensated or not remunerated. You might call it charity care or just simply uncompensated care. Some of it is paid for out of pocket or self-pay, and certainly the lion's share is borne by the private insurance market in this country.

Well, between the public and the private sectors, how is the best way to get more health care coverage into the hands of more people? Should we just simply expand the public sector to the point where it encompasses all or nearly all of the health care expenditures in this country, a so-called Canadian system? I don't think so. Even the Canadian Supreme Court in 2004 and 2005 said that they had a problem with access in their country, and, in fact, access to a waiting list did not equate to access to care.

In the British national health service, some of the most expensive care in the world is in Great Britain. They have a two-tier system. They have their national health service, and then they have private care, and that private care in that country, the cost for that, has gone significantly up. The waiting time for someone who is over 80 years of age, that becomes really problematic. You put someone over 80 years of age on a waiting list for a procedure, a hip replacement, a heart bypass, and the likelihood of them being able to sustain themselves until they receive that service starts to go down. That's unfair as well.

Well, what about the private sector? I believe that we have the best health care system in the world in this country, largely because of contributions of the private sector.

We have more innovation in this country than almost anywhere else in the world. We have the ability to integrate new technologies rapidly into the treatment rooms, the operating rooms, into the health care system in general in this country.

Finally, because we have such a significant component that is borne by the private sector, we have willing sellers and willing buyers. The waiting list is not as big an issue, if an issue at all, in most parts of this country.

Some of the other things that we will talk about, as we talk about expanding the private sector, or at least maintaining the component of the private sector in this country, is the little bit of the history of what we called at one time "medical savings accounts." We now refer to them as health savings accounts as they were expanded significantly under the Medicare Modernization Act of 2003.

But the old medical savings accounts had a lot of restrictions on them. There weren't many companies who stepped up and provided that type of an insurance product, and, as a consequence, you never saw the savings with medical savings accounts that, really, should have been there.

I will contrast that with health savings accounts now. You can go to your search engine, you can type in "health

savings account" into Google, and you are offered a vast array of different companies and plans that sell, market on the Internet. With, in fact, the competitive power of the Internet, many of these plans, these high-deductible health savings account plans are priced well within reach, of, say, a young person just getting out of college.

Contrast that with the mid-1990s when a young person getting out of college who didn't have an employer-based health insurance, who just wanted to go buy an individual policy, I know, because I had experience with that in my own family, you just almost could not buy an individual health insurance policy for a single individual in the marketplace. No one was interested in selling that to you at any price. But now you can go on the Internet, and you can find a lot of products that are available.

The last time I looked, which, albeit it was a couple of months ago, but for a young person, 25 years, male, in the State of Texas, for a high-deductible plan, would range between \$50 and \$60. There were some that were even cheaper, but they were companies that I didn't recognize the name of, and I certainly wouldn't recommend that someone buy from someone they have never heard of before. But there were some reputable names, named insurance companies that had providers, provider lists that were more than adequate, that were for sale at a price that I would consider affordable for a young entrepreneur just perhaps starting their own business or leaving the protective fold of a group health plan from their employer.

How we keep the private sector involved and keep health care affordable is truly one of the challenges that we in this Congress, not just Republicans and not just Democrats, but both sides of the aisle, need to take on and meet head on.

Some of the downsides of going to a completely nationalized system is I am afraid we will lose a lot of the energy toward innovation. When you stop and think about it, we have had three Presidents in my lifetime who have espoused programs of a nationalized health insurance, President Truman, President Nixon and President Clinton most recently.

Under Truman, if they had gotten their way and nationalized health care, what if, what if we had stifled innovation with that type of maneuver? The antibiotics that we used today would be penicillin and tetracycline, those that were most commonly in use in the late 1940s and early 1950s.

Under the Nixon administration, what if they had gotten their way with the nationalized health insurance with, again, a chilling effect on innovation? We might be looking at treating psychiatric illness still with Thorazine rather than having the availability of the very potent antipsychotics and the selective serotonin reuptake inhibitors that we have now today. During the

Clinton administration in the 1990s, there are just untold innovations that have happened.

Even in the last 15 years, there are innovations in the treatment of arthritis, innovations in the treatment of osteoporosis. In fact, if innovation had been stifled in 1992, osteoporosis would be treated today with estrogen replacement and pain medicines, as opposed to having the newer phosphonates or medicines like Fosamax and Actonel and Boniva that are available to us today.

When we look at the uninsured in this country, it is an election year, so we can certainly expect the number to go up. The most recent U.S. Census Bureau was 46 million people uninsured.

Interestingly enough, between the years 2004 and 2005, there were 1 million more people who had health insurance in 2005 than had it in 2004, and I suspect the reason for that was because of the expansion of health savings accounts.

But when someone is labeled uninsured, it means that for any portion of a year they lacked health insurance. It doesn't always mean, though, that they have no access to health care. Access to health care, I will tell you as someone who made a career of being a physician, access to health care is uniformly available. It may be expensive care, it may be care that is accessed far later in the course of the disease than anyone would recommend, but access to health care does not, or not having health insurance, does not equate to not having access to health care.

In fact, this Congress in the 1980s mandated that anyone arriving in an emergency room would have access to health care, whether or not they had the ability to pay for it. In fact, as a physician, I was required to respond to that patient within 30 minutes or a reasonable timeframe or face some rather significant civil money penalties. So lack of insurance does not equate to lacking access to health care.

We also have a system in this country, under the Federally qualified health center system, that provides health care and continuation of care in a medical home to between 15 and 17 million recipients. That is a significant number of people who lack health insurance but have access to a medical home and have access to care when they need it and, in fact, have continuity of care that in a lot of cases rivals that of any HMO out there.

There are some things we could do, I think, to strengthen the ability of federally qualified health centers to provide care when it is needed. I represent an area of north Texas, Denton County, Tarrant County. Fort Worth is the largest city in my district.

Last year when Hurricane Katrina hit the gulf coast, we had a number of persons who were displaced by Hurricane Katrina, who came to the Dallas-Fort Worth area, individuals who came needing medical services and not being able to wait the 6 to 8 years that is now

required to set up a federally qualified health center.

Indeed, last year, the Deficit Reduction Act, I tried to introduce amendments that would streamline the process of setting up a federally qualified health care that would make more of those facilities available to more patients so that they could have more services available to them.

Unfortunately, those amendments did not stand during the conference report. But there is still an opportunity to work on streamlining the startup procedures for federally qualified health centers. Indeed, in my district I am working on a couple of those even as we speak.

Another issue is having affordable products for companies to sell. You got 46 million uninsured. Don't think that Aetna Life and Casualty wouldn't look at that as potential market share if we would provide them the tools that they need to have an affordable policy available to individuals.

We will talk about this a little bit more in just a moment, but to give some relief for some of the mandates that are put on insurance companies, where they have to offer brow lifts and involved infertility treatments to every person who purchases their insurance when it may not be necessary, and, indeed, the cost of adding those benefits may be keeping insurance benefits from a greater segment of the population.

On the concept of health savings accounts, we did expand them significantly during the Medicare Modernization Act. There, in fact, is legislation out there this year. ERIC CANTOR, from Virginia, and myself have introduced legislation to expand and make a little bit more flexible the health savings account.

□ 2315

One of the things, in the interest of full disclosure, some employers will provide employees an amount of money to have each year to perhaps pay incidentals or eyeglasses or maybe even help pay for a higher deductible that is selected to offset some of the cost of the insurance premiums, these so-called use-it-or-lose-it funds that a company might provide a patient every year. But when you get toward the end of the year, and gosh, nobody wants to lose that money, they want to get the use of that money, it may be as much as \$1,800 or \$2,000, so we actually incent people to go out and spend more money on health care that perhaps they might not even need.

There was a big, full-page ad in the Dallas Morning News right before I left to come back up here about a doctor who provides refractive surgery, or LASIK, for someone's eyes, and if you have a use-it-or-lose-it policy at your work, look into buying yourself LASIK for Christmas this year, because you will lose that money if you don't spend it. Again, a kind of the wrong incentive and the wrong message to send to em-

ployees that yes, you have to spend at least \$2,000 on health care every year or you are going to be penalized.

For people who are young and healthy who feel that they are bullet-proof and they don't even need to buy insurance, making these HSA premiums payable with pre-tax dollars would be a powerful incentive to get these individuals to buy into the concept that they do need to insure themselves.

For low-income individuals, people who don't make enough money to even cover the relatively low cost of a Health Savings Account insurance premium, provide them with a pre-fundable tax credit or a voucher, if you will, to be able to buy that insurance, or perhaps at least buy down the cost of the insurance premium for someone who is not unemployed but doesn't make enough money to pay for health insurance.

What about someone who has got a chronic disease? A Health Savings Account may not be the best option for them. It might be, if we allowed employers to make a larger contribution, a larger or greater HSA contribution for someone with a chronic illness, say someone with diabetes, someone who is in remission from leukemia, a valuable employee that an employer wants to be able to keep on the payroll and keep on providing their insurance benefit and would welcome the opportunity to be able to buy one of these lower cost Health Savings Accounts and yet contribute a greater amount to that person's deductible.

Allowing flexibility to coordinate Health Savings Accounts with existing health coverage, like a flexible spending account or a health reimbursement account, and allowing early retirees to use HSA savings to pay for insurance coverage premiums until they are of an age that they can be covered on Medicare.

But probably the most powerful tool that we could employ is providing a pre-tax treatment of health care expenses incurred under HSA compatible plans. That has been something that has met with some resistance, but truly I think it is time to investigate that and take that up.

Association Health Plans. You hear it talked about. I have heard it talked about every year since I have been in Congress. Over 60 percent of all uninsured workers are employed by small businesses with fewer than 100 employees. But what if we were to give small business, give those small employers the ability to pool together, and if they are of a similar business model, say they are chambers of commerce, or say they are realtors, or say they are physicians or dentists offices, if they could pool together to be able to get the purchasing power of a larger entity, then they would be able to command more control in the insurance market and command a more cost-effective premium.

What if we allowed them to do this across State lines? That has been the

difficulty in allowing, or for the Senate or the other body to allow the institution of Health Savings Accounts. They came very close this past year. I know they worked very hard on that over there.

Association Health Plans may not immediately bring down the number of uninsured like expanding Health Savings Accounts will, but allowing Association Health Plans would provide some measure of stability and affordability in insurance premiums that would allow small businesses more certainty in that market and would keep them from leaving the health insurance market for their employees.

Well, as promised, it is almost impossible to talk about the affordability of health care and not bring up the question of liability, medical liability reform. We have done that I don't know how many times on the House side.

Some states, my home State of Texas, has made great strides in improving the liability picture back home in the State of Texas. But these State-by-State solutions are in constant jeopardy by special interests who will reappear every legislative session to try to undo, for example, the good that they did in my home State of Texas.

When we passed H.R. 5, which was the Medical Liability Reform Act in this body in 2003, the Congressional Budget Office scored that as a savings of \$15 billion over 5 years. I believe the amount really will turn out to be much greater than that because of the pernicious effect from a spending standpoint of defensive medicine. In fact, a study done out of Stanford, California, in 1996, in the Medicare population alone showed that the practice of defensive medicine cost about \$30 billion a year in 1996 dollars to the Medicare system. So there would be a significant cost savings across the board in this country if we would be able to pass some type of meaningful liability reform. We are wasting money by not pushing for this on a national level.

What happens if we don't change? Well, several years ago when I was on the transportation committee we had a field hearing up in ANWR. On the way back we stopped in Nome, Alaska, for lunch and kind of had a Chamber of Commerce type lunch there in Nome, Alaska.

Because it is unusual to have a congressional delegation come through Nome, Alaska, all of the people turned out for that, including all 19 members of the medical staff of the hospital there at Nome. They spoke to me with great concern saying, I hope you will be able to get that medical liability bill passed, because we can't afford the insurance premiums for an anesthesiologist at our hospital.

I said to the person sitting next to me, what kind of medicine do you practice, sir? He said I am an OB-GYN, just like you.

How do you practice OB-GYN without an anesthesiologist in your hospital? Forget an epidural for pain relief during labor. What do you do if the patient requires a C-section?

He said, we get an airplane and take the patient to Anchorage.

Anchorage is an hour-and-a-half away, and that is if the weather is good. Nome, Alaska, as I understand it, has episodes of bad weather where aircraft can't take off. I fail to see, Madam Speaker, how we are furthering the cause of medical safety, patient safety, by allowing this system to continue.

In addition, the head of one of the residency programs in New York was speaking with me one night. I asked if the medical liability climate was affecting their ability to get OB-GYN residents into their program. It was related to me that evening that, well, Congressman, we are taking people into our program that we wouldn't have interviewed 5 years ago.

Wait a minute. These are our children's doctors they are educating today. How are we furthering the cause of patient safety, how are we enhancing patient safety by allowing that system to continue? The best and the brightest are not going to go into fields like OB-GYN or neurosurgery, so-called high-risk specialties that might expose them to a greater degree of liability peril.

Well, in Texas, we did do what I consider a very good thing as far as medical liability was concerned, and we did pass a so-called cap in Texas, a cap on non-economic damages.

It was a little different from the House-passed bill. The House-passed bill was a \$250,000 cap on non-economic damages. In Texas we passed a bill that would cap \$250,000 of non-economic damages for the doctor, another \$250,000 for the hospital, and another \$250,000 for a second hospital or nursing home, if one was involved. This bill required the passage of a constitutional amendment in Texas in 2003, and it did indeed pass, and now Texas is well into its third year of this medical liability reform.

What have been the results? Texas Medical Liability Trust, my old insurer of record when I left the practice of medicine in early 2003, the cost for premiums from Texas Medical Liability Trust, coupled with the rebates that had been given to doctors who were their customers over the last 3 years, have now totaled to over 20 percent. That is significant, because in the 2 years before I left the practice of medicine, my rates went up by 20 percent and 30 percent for those 2 years before I left the active clinical practice of medicine. So it is a significant change that has happened in Texas.

One of the major advantages has been what has happened with mid-sized, not-for-profit hospitals who were self-insuring for medical liability before. Many of these smaller hospitals have found millions of dollars that are now re-

turned to them in medical liability premiums that are available for capital expansion, to hire more nurses, the kinds of things you want your mid-size, not-for-profit community hospital to be able to do.

We have some other options in our Committee on Energy and Commerce on our Health Subcommittee. We have talked about some of the other options. Arbitration, mediation, certainly if there could be an expansion of those to allow for an earlier settlement or even the concept of an early offer for someone who actually has been harmed.

One of the really unspoken but one of the significant downsides of our medical liability system is it takes on the average of almost 8 years for a patient who is truly harmed to receive any type of compensation. Then the amount of compensation they receive is strikingly reduced by legal fees and court costs and preparation costs and all of the things that go into that. So there is a very lengthy process that doesn't really help anyone as far as getting money to someone who is truly injured.

The concept of an early offer or even arbitration or mediation, we will have to make some adjustments to what is referred to as the National Practitioner Data Bank, and hopefully my committee will be able to take that up in the near future.

Let's shift gears for just a minute and talk a little bit about something that significantly affects patient access to physicians, and that is the proposed reductions in physician payment that are going to occur under the Medicare system, the so-called reductions because of the sustainable growth rate formula, something that I believe needs to be fixed and it needs to be fixed this year.

Under the sustainable growth rate formula, physicians' compensation is basically set. It is an attempt to limit the amount of expenditures of medical care under the Medicare system by controlling volume and intensity of services.

Other parts of medical care delivered under the Medicare system, the year-over-year rate is calculated based on the cost of input, a market basket type of update that is based on medical inflation. This rather graphically shows the results of the two different types of formulas.

Compare the reimbursement for the Medicare Advantage Plans, compare the reimbursement rates for hospitals or nursing homes with the reimbursement rate of physicians. This blue line here represents the year 2002. That was the first year that a cut was allowed to proceed under the sustainable growth rate formula. It was about 4.4 percent, what is euphemistically referred to as a "negative update."

The next 3 years, Congress came in at the last minute and said, we will give you a little bit of a bump up. As you can see, a little bit less than 2 percent for each of those years.

Last year, we held the SGR rate at a zero percent update. It didn't go up or down. Almost anywhere else in Washington, if you hold spending level for a year, you are accused of having cut benefits. But that is what we did for our physicians last year. And really part of that story is we didn't do it by January 1, we had to come back after the first of the year to provide that zero percent update. In reality, January 1 physicians got again a 4.4 percent negative update.

□ 2330

Yes, the administrator of the Center for Medicare and Medicaid Services did come in and say that as long as Congress does what it is supposed to do at the end of January, which we did, that CMS would come back and reimburse physicians for that amount of money to bring them up to that zero percent. Unfortunately, there are many private insurance companies out there that pay into Medicare; so doctors took a pay cut for other private insurance, which was never the intent of this Congress. It was never the intent of the administration of the Senate, but nevertheless, that is what we did.

The purple line here represents the proposed 5.1 percent negative update that is to go into effect if we do not affirmatively do something before January 1, and that is why I say it is incumbent upon us to do something, in fact, this month before we wrap things up on the 30th of September.

I would just like to make a couple more points about this graph. Cutting Medicare rates hurts all physicians and patients. Private health plans and other government programs follow Medicare's reimbursement trends. They look at Medicare's reimbursement rates, and they structure their plans to pay physicians the same, regardless of how much it costs the physician to provide the care. TRICARE, for example, reimburses at a rate that is 85 percent of Medicare. Many of the private plans will reimburse at rates that vary between 85 percent and 120 percent of Medicare. But, again, it was never the intention of this Congress to provide a break for private insurance with the SGR formula.

Setting up the silos for Medicare reimbursement is itself flawed. We have a silo for the Medicare Advantage programs, a funding silo for hospitals, for nursing homes, and physicians. With more procedures and more services being delivered outside of hospitals, the payments should be based on the highest quality and most cost-effective treatment setting. Elements of the sustainable growth rate formula originally were designed to control utilization by reducing physician fees. The primary drivers of utilization, however, are new, improved technologies, patients' increased awareness of treatment options, and the general shift from inpatient to outpatient care. Physicians control none of these factors.

And there is even one more factor over which physicians have no control,

and those are the mandates that this Congress puts on Medicare for types of medical care that have to be included. The Welcome to Medicare Physical, I personally think that is a good idea. I think you are going to pick up problems where you can more timely diagnose and treat those problems. But it costs money and that money comes out of the physicians' position of the SGR formula.

Again, in the Deficit Reduction Act, we passed a measure that would require every person on Medicare to have an EKG at age 65. That money comes from somewhere. It does not come out of the hospitals. It does not come out of the Medicare Advantage plans. It comes out of the physicians' part of the sustainable growth rate.

We also decided that everyone should have a screening for an abdominal aortic aneurism. It may or may not be worthwhile, but that money is going to be taken out of the physicians' portion of the SGR formula. And, again, physicians have no control over that utilization.

The legislation introduced right at the end of July, H.R. 5866, would put the focus to ensure that elderly patients have better access to the health care they need.

Four goals of this legislation: ensure that physicians receive a full and fair payment for services rendered; create quality performance measures that keep consumers informed; improve the quality improvement organizations' overall accountability and flexibility; and, finally, find reasonable methods, reasonable offsets for paying for these benefits.

For fixing the SGR, for title I of that bill, it ends the application of the sustainable growth rate formula January 1. So January 1, instead of a pay cut, SGR would go away. It substitutes for the sustainable growth rate formula a different formula. One that was derived by a group called MedPAC, the Medicare Payment Physicians Advisory Commission, called the Medicare economic index. And this shifts physician compensation so it will more closely mirror hospitals and Medicare Advantage plans. It bases updates and physicians' compensation on the market basket.

What does it cost to deliver the care and how much did that cost increase over the past year based on medical inflation? That is the Medicare economic index. We will use the Medicare economic index minus 1 percent, which will be an increase of about 2 percent for physicians for the year 2007. And it basically puts us back on a more market-sensitive system. What is health care inflation? What is it costing the hospitals, the Medicare Advantage plans, and the doctors to deliver the care and compensate them accordingly? Under the quality measures, in conjunction with physician specialty organizations, it creates a voluntary system of evidenced-based quality measures. It gives doctors feedback on

their performance. As a physician, you are always wondering how you are doing; how do you compare to your peers; how do patients rate you. This is information that we are always seeking. It also allows patients to be selective. If a doctor elects not to voluntarily report, that information could be available to patients when they make their selection as to what physician they see.

There will be offsets in the bill. Currently, the offsets that are made are looking at the Medicare Stabilization Fund from the Medicare Modernization Act and eliminating the double payment for medical education costs in the Medicare Advantage plans.

The important thing here is it keeps the power in the health care community. It does not devolve that power to the Federal Government. And it is just a start. It is a start on the path of developing a product that will ultimately be satisfactory to all of the stakeholders.

A quote from the AMA news: "We are encouraged by the introduction of this legislation that would replace the current flawed Medicare formula," from the AMA Chair, Dr. Cecil B. Wilson.

One of the things that is talked about a lot here on the House floor, and, in fact, we passed H.R. 4157 in July, which is the Health Information Technology Promotion Act, there is no question that health information technology holds a great deal of promise for being able to streamline the delivery of medical care to provide a method of continuity of care if something happens. With electronic medical records, those are then available online. And if something happens to a patient's original medical record, all is not lost. You can go to a safe, secure, sequestered Web site in order to retrieve that patient's medical data.

I will admit I came late to the table on health information technology and its promise to improve medical care in this country. My own attempts at electronic medical records, electronic prescribing seemed to increase the time involved with every patient interaction. And, of course, there is no additional compensation for that increased time with every patient interaction.

But last January, my committee, the Oversight and Investigations Subcommittee of Energy and Commerce, went to New Orleans and had an opportunity to visit Charity Hospital. And there in the basement in Charity Hospital we were still walking through water that was still in some places ankle deep, looking in the medical records room there in the basement of Charity Hospital. Here were rows and rows and rows of medical records that were absolutely ruined when the basement flooded and the water came in and now had black mold growing up and down the sides to some places where you couldn't even read those bright pastel numbers that were on the sides of medical records.

Clearly, Katrina showed us how vulnerable our medical data can be even

in a venerable institution like Charity Hospital in New Orleans that you just assume is always going to be there and those records are always going to be there. Well, this time they weren't. And when some of those individuals came to Texas and came to north Texas, it made delivery of their medical care much more difficult.

The bill that we passed does provide for updating some standards, reporting on the American health information community, with a strategic plan for coordinating the implementation of health information technology.

Well, talking about Charity Hospital, talking about New Orleans, I mentioned that we were going to discuss preparedness. And we are just beyond the 1-year anniversary of Hurricane Katrina. We have to step back and ask what we have learned. While we watched that hurricane, my wife and I, coming up the Gulf of Mexico, it was almost like watching a train wreck in process. We were transfixed by the hourly reports of the progress of the hurricane. It looked like it was just going to hit the central city of New Orleans and just at the last minute took a little bit of a turn back to the east, and the central city of New Orleans was spared. And I think the headline in my paper was "Bullet Dodged," or something to that effect. It was only later, not even that day but the next day, on Tuesday, when we realized how serious the situation had become because of the flooding caused by the breaches in the levees.

Back in my district, my home district in north Texas, we watched, of course, as people were taken into the Astrodome and then, of course, as the waters rose. And people who had not left the city of New Orleans had to be evacuated. Many of them were evacuated to Dallas, Texas, to Fort Worth, Texas, where my district office is in southern Fort Worth. A gymnasium on the same campus where my district office is was converted to a shelter for individuals who had been displaced. We set up 250 pallets that night. We had chicken dinners that were donated by a restaurant, waiting for displaced persons from Katrina when they arrived. Some very tragic stories from some of the individuals who arrived there over the next couple of days.

I got a call from my staff, and they asked me how soon can a woman who has had a C-section sleep on the floor? I said, why do you want to know this information? They said, well, we have three women here who just had C-sections, and we want to know if we can put them on pallets or if we have to find cots for them.

I said, I will be right there.

One of these individuals, her baby had been in intensive care. They were separated in the process of the evacuation. And it was only after several days with my staff spending every hour on the phone that we were finally able to reunite mother and baby. And just

this past week they had a 1-year anniversary there in Mississippi with mother and baby, celebrating the anniversary of not the child's birth, but the mother and baby getting back together after the hurricane was over.

The Dallas County Medical Society, on a holiday weekend, Labor Day weekend, the blast fax went out to probably 800 members of the Dallas County Medical Society. A quarter of them showed up in the parking lot of Reunion Arena to help with the medical care for people who had been evacuated from the Louisiana Gulf Coast. What a tremendous story of all of the individuals getting off the buses that evening. They had a triage desk set up. If someone had been off their meds and simply needed meds, there was a mobile pharmacy set up where they could be administered those medications.

And of all of the people who got off the buses that night, in the thousands, only about 200 required hospitalization as a result of having been in a shelter and off their medications for several days. The doctors that were there did a tremendous job of identifying who was sick and who was simply in need of a hot shower and a warm place to sleep and getting back on their medications.

One of the other great stories was there was a lot of fear with this many people crowded into a shelter, would there be an outbreak of transmissible illnesses like gastrointestinal illnesses, infectious diarrhea? They had hand sanitizers. You could not walk 10 feet without someone putting a bottle of hand sanitizer in your hand. People used them repeatedly throughout the day and night, and as a consequence, only a very limited number of people actually had any type of gastrointestinal illness. They were quickly sequestered in another facility, and as a consequence, a public health crisis was averted.

In follow-up, I have traveled to New Orleans twice in the past year, once in October at the request of one of the hospitals down there to try to get some help for their medical providers. And then in January, as I mentioned, our Oversight and Investigation Subcommittee went to New Orleans, and we had a hearing down there. It really was remarkable to see what the difference in preparedness between the Charity Hospital and the private hospitals, Tulane University Medical Center.

HCA hadn't planned necessarily for a hurricane, but they had some disaster plans in place. They had been rehearsed. They had been practiced. And as a consequence, when we were there in January, they were about ready to open their emergency room again. Charity Hospital still appeared to be light years away from being able to reopen.

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So some of the lessons that came out of that trip down there were when you have disaster plans, when you have pre-

paredness plans, it is not good enough to just have them and have them on the shelf. And I heard this from nursing homes, and I heard this from hospitals that, unfortunately, there were places that had purchased disaster plans but no one had looked at them. You have got to take them off the shelf, you have got to break the seal, you have got to break the shrink wrap that surrounds them, and you have got to practice them.

Our chairman of the House Government Reform Committee held a series of hearings on what happened in the aftermath of Hurricane Katrina. And for any House Member who hasn't read or at least looked at that publication that they put out as a result of those hearings, the title was "Failure of Initiative." That is truly an outstanding work that Chairman DAVIS did, and I know every House Member got a copy of that and I would recommend that they look at that. Remember, this was a committee, a special select committee. It was bipartisan, though many people on the other side of the aisle chose not to participate. It wasn't an unelected, unaccountable commission like the 9/11 Commission. These were our House Members who were truly interested in what happened in the aftermath of Katrina and were very interested in getting it right.

As you think about Hurricane Katrina, as you think about 9/11 and some of the disasters that have befallen not just this country but the world, with the tsunami right after Christmas in 2004, the fact of the matter is we just can't afford to fail next time, whether it is a hurricane, whether it is a terrorist, or whether in fact it is a problem with a worldwide pandemic.

And I won't spend a lot of time on this, because I can talk about the avian flu for an hour in and of its own right, but just a couple of points. As of September 8, 2006, just last week, the World Health Organization had confirmed 244 human cases of avian flu with 143 deaths.

What is so remarkable about this illness is that it seems to be so lethal. That is an over-50 percent mortality rate for influenza. That is unbelievable to have that type of mortality rate.

During the summer months on a trip over to Iraq and Afghanistan, I was actually able to stop in Geneva for a few hours and talk to some of the folks at the World Health Organization. At that time, when I was there, there were coordinating efforts between 192 different countries. Dr. Michael Ryan, who is the director of the Strategic Health Operations Center, provides strategic support and global coordination to the World Health Organization, the Center for Disease Control, and our own Health and Human Services Administration. Dr. Ryan, I should point out, is on loan to the World Health Organization from the Centers for Disease Control. And the idea is that we won't reinvent a global CDC over there, but we

will take the expertise of the CDC, apply it to the World Health Organization, and allow them a greater reach as far as monitoring and notifying.

The concept is to control the disease at its source, culling of infected avian populations, isolation of infected avian populations, or humans should they become infected, vaccination and antivirals for people who are exposed or infected. We need intelligence, we need verification, and we need assessment, and we need a response, all of which can act globally, because as this map shows, it is indeed a global issue.

This shows eight areas where the avian flu has occurred and areas where human cases have occurred. If you notice the time line, the arrows are pointing from east to west. And with the migratory flyways, it is possible that in wild birds and wild water fowl, the carriage of this disease could occur from the eastern hemisphere to the western hemisphere perhaps as early as this fall or winter. To date, it has not been detected in the western hemisphere. To date, there has not been an easy or facile transmission from human-to-human. Human-to-human transmission only occurs with great difficulty. The virus hasn't undergone that mutation that would allow for facile transmission from human to human.

But clearly, with a disease that is so widespread in the avian population and with a disease that has shown such a striking lethality rate, it is critical to keep the surveillance up and to make certain that other countries do what they are supposed to do in this regard. International transparency is absolutely key. A country keeping silent on a problem it is having with this illness is not only not acceptable, but it may be lethal to other areas in the world as well.

It is already a pandemic in birds but not in humans. The best way to prevent a pandemic is to control it in animals before effective human-to-human transmission occurs, meaning to minimize cross-species contact and make certain that in countries where avian populations are infected that there is the proper culling of avian populations, and that it is done safely without unduly exposing those people who are handling the infected birds.

Protecting North and South America from this global health threat, all of the outbreaks have been contained so far. Indonesia was a point of particular concern a few months ago where many people appeared to be infected in a cluster, but it does appear that those were all a direct result of either living with infected birds or close human-to-human proximity that allowed for that human-to-human transmission.

Clearly, we have got to prevent the spread to the United States and Central and South America. The disease at this point may know no boundaries because of its distribution in the avian population. And other countries, it is critical we have got to monitor the disease at the border.

I did also take a trip just up the street to Bethesda, Maryland to meet with Dr. Anthony Fauci to talk with him about a vaccine development. There are some remarkable things that are going on as far as vaccine development.

I guess one of the important aspects of bird flu is we are going to develop more capacity for delivering more vaccine for just the regular flu as a consequence for the preparedness that is happening with getting ready for the possibility of a worldwide pandemic.

This may not be the one. Avian flu may sputter out and never be the pandemic that everyone fears. But the fact remains that almost for every century that anyone has kept track, about three pandemics per hundred years do occur. We did indeed have three during the last century, and even a relatively mild pandemic of the Hong Kong flu still claimed 50,000 lives in this country. So it is a matter of no small importance.

Additionally, we have got to be certain that, just like the nursing home in Louisiana that left their disaster preparedness plan on the shelf with the shrink wrap still on it, we have got to be certain that we take those plans down and we talk to our local first responders, our local health departments. And I had such a roundtable just last week in my district, very well received by the folks at the health department, by the administrators in all three hospitals in one of my counties. I wish we had a little more participation of the medical staff, but we did have some and I did at least receive an invitation to talk at one of their medical staff meetings.

But the key for us here in Congress is when faced with whether it be the avian flu, terrorist attack, another hurricane, we have got to be honest. No spin, no sugar-coating, no BS. And, above all, we have to communicate with our constituents and with our first responders back at home.

One other thing that I want to talk about as time runs short here is, and I mentioned this earlier, about a bill that is out there to reduce or restructure the number of mandates that are on health insurance. Again, Aetna Life and Casualty might look at 46 million uninsured individuals as potential market share if they only had a product that they could sell.

Now, in our Committee on Energy and Commerce we had a debate on a bill that would reduce significantly the number of State mandates on insurance policies in the individual market. This wasn't even discussed in the group health insurance market, but just the individual market. It was a pretty contentious debate and there wasn't a lot of agreement across both sides of the aisle, and that is unfortunate, because when the American people watch what this body does, they are really not interested in the tennis match or volleyball match that goes on from one side or the other. They want results.

They want more affordable health care, health insurance. They want Aetna Life and Casualty to be able to look at that 46 million uninsured as a potential market share.

Well, what if we could get together across the aisle and discuss what is that basic package of benefits that we would like to see available in a health insurance policy, one that could be sold on the Internet from State to State. It seems like an almost impossible task, or at least it seemed almost impossible that night when we were debating this bill in the Energy and Commerce Committee. But the fact is we have already done that work. I say "we." I wasn't here 30 or 40 years ago when the federally qualified health center statutes were first written. But in fact, in that statute in law is identified a basic package of benefits that has to be offered at every federally qualified health center.

Well, we have already agreed then in principle what that basic package of information is. Now, the information may be 30 or 40 years old, but perhaps we could sit down and decide which of those things we could eliminate because they are no longer necessary, which of those things we would have to add because we have learned some stuff since then, and then go to our private insurers and say, here is a basic package of benefits that, if you will abide by these rules and make certain people know what they are buying, that there is full disclosure about what is covered and what is not covered in these insurance policies, that you can then market this to the uninsured. And then give individuals who are unemployed a voucher or a pre-fundable tax credit to purchase that insurance. Or give that family that is of a low-wage earner, give them some additional health, buy down that premium.

These are the types of concepts that, really, the American people are anxious to see us work on, and I for one would really welcome the day that we could do that.

Just one last brief thing about the Medicare part D, the Medicare prescription drug program that actually started the first of this year. At the end of the enrollment period, well over 38 million people had prescription drug coverage under Medicare. This was the population, the Medicare population that was the largest population that didn't have access to a prescription drug plan if their employer or retiree insurance did not offer it.

This is a tremendous benefit. We will and do hear a lot of discussion about people who are caught in the so-called gap coverage. But remember, there are plans out there that if a person is willing to consider a generic compound, there are plenty of plans that cover in the gap; and in my home State of Texas, there was at least one insurance company that would cover both brand and generic in the gap.

So I would encourage people who have looked at the difficulty they are

having with the so-called donut hole, when they re-up on their insurance plan, their prescription drug plan in November in that open enrollment period, look at one of those plans that will provide for coverage in the gap.

Madam Speaker, I yield back the balance of my time.

#### LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. CULBERSON (at the request of Mr. BOEHNER) for today after 2:30 p.m. on account of illness.

Mr. KELLER (at the request of Mr. BOEHNER) for today on account of personal reasons.

#### 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 Mr. BUTTERFIELD) to revise and extend their remarks and include extraneous material:)

Mr. MCDERMOTT, for 5 minutes, today.

Mr. EMANUEL, for 5 minutes, today.

Mr. KIND, for 5 minutes, today.

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

Mr. SHERMAN, for 5 minutes, today.

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

Mr. POE, for 5 minutes, September 19 and 20.

Mr. WAMP, for 5 minutes, today.

Mr. BURTON of Indiana, for 5 minutes, today and September 14.

#### ADJOURNMENT

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

The motion was agreed to; accordingly (at 11 o'clock and 58 minutes p.m.), under its previous order, the House adjourned until tomorrow, Thursday, September 14, 2006, at 9 a.m.

#### EXECUTIVE COMMUNICATIONS, ETC.

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

9321. A letter from the Executive Director, Commodity Futures Trading Commission, transmitting the Commission's final rule — Joint Final Rules: Application of the Definition of Narrow-Based Security Index to Debt Securities Indexes and Security Futures on Debt Securities [Release No. 34-54106; File No. S7-07-06] (RIN: 3235-AJ54) received August 9, 2006, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

9322. A letter from the Executive Director, Commodity Futures Trading Commission, transmitting the Commission's final rule — Foreign Futures and Options Transactions — received August 14, 2006, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.