on controversial issues of the day in light of the multiplicity of information sources available to the public, such as television stations, radio stations, daily newspapers, and cable television services. See id. at ¶¶55–56.

In reviewing the Commission's decision to abandon the Fairness Doctrine, the United States Court of Appeals for the District of Columbia Circuit determined that the Commission's findings were supported by the record, and upheld the Commission's determination that the fairness doctrine no longer served the public interest. See Syracuse Peace Council v. FCC, 867 F.2d 654 (D.C. Cir. 1989), cert. denied, 493 U.S. 1019 (1990).

In my judgment, the events of the last two decades have confirmed the wisdom of the Commission's decision to abolish the Fairness Doctrine. Discussion of controversial issues over the airwaves has flourished absent regulatory constraints, and the public now enjoys access to an ever-expanding range of views and opinions. Indeed, with the continued proliferation of additional sources of information and programming, including satellite broadcasting and the Internet, the need for the Fairness Doctrine has lessened ever further since 1987. In short, I see no compelling reason to reinstate the Fairness Doctrine in today's broadcast environment, and believe that such a step would inhibit the robust discussion of issues of public concern over the nation's airwaves.

I appreciate your interest in this important matter. Please do not hesitate to contact me if I can provide further information.

Sincerely,

KEVIN J. MARTIN,
Chairman.

HEALTH CARE IN AMERICA

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

Mr. BURGESS. Mr. Speaker, I come to the floor of the House tonight, as I often do, to talk a little bit about health care, the status of health care here in America.

Tonight, if we could, I would like to talk a little bit about the past, talk some about the present, and maybe just look a little bit into the future.

Mr. Speaker, as I see it, over the last 70 years there have been three transformational times in American medicine: one in the 1940s, one in the 1960s, and I believe we are on the threshold or the beginning of another transformational time here early in the 21st century.

Mr. Speaker, medicine itself, the science of medicine, is pretty highly ordered, highly structured. It's very scientific. The scientific method is always employed in medicine. And when you get to government politics, government policy in regards to health care, in regards to medicine you would expect it to also rest on a firm foundation of science. But I have to tell you, Mr. Speaker, after being here for less than 5 years, you oftentimes see where that intersection of health care policy and health care reality sometimes creates more confusion than shedding light on the subject. And the thing is, Mr. Speaker, when we create these policies in Congress, we affect things not just today, not just for the time the bill-signing occurs, but we affect things for decades into the future. And that is the responsibility that we hold in our hands here in this House of Representatives when we talk about changes in the health care system.

□ 2145

Now, Mr. Speaker, I referred to the 1940s as a transformational time in medicine. Obviously there were a lot of things going on in the world in the 1940s. But just prior to the 1940s, Mr. Alexander Flemming, an Englishman, made a startling discovery. He made a discovery that a mold, the penicillin mold, created a substance that was diffusible across an auger plate that would inhibit the growth of bacteria. He further found that this substance apparently was not harmful to humans. So we have the concept of selective toxicity, something that will attack a microbe and not hurt the host; the first time that science had delivered that type of hope, that type of promise to the world.

Now, Sir Alexander Flemming, receiving all the accolades he did for discovering penicillin, really created, at that point, something that was in such short supply, was so difficult to produce and so expensive that it really had no practical utility. It was almost like a medical trick or parlor game, but it was not something that could be generally used by the public, who was ill and needed access to the medicine. But American scientists, working in this country, created a system whereby they could grow large quantities of this mold, remove the substance from the vats that surrounded it, and purify it in large quantities. This occurred in 1942. We were in the middle of World War II. What a phenomenal discovery. Now this wonder drug that had only recently been discovered but was so rare, so scarce and so expensive that it had no practical utility, now it was cheap, readily available and, in fact, probably made a significant difference in the recovery of some of our soldiers who were wounded in the landing in Normandy. Battlefield infections were notoriously bad for causing loss of life and limb, and now we had an agent that was capable of treating those.

Now, another discovery that occurred in the 1940s, cortisone had been discovered before the 1940s, but again, a laborious process for actually extracting this anti-inflammatory medicine. In fact, Mr. Speaker, they extracted it from the adrenal glands of oxen. So you can imagine how labor intensive that process was. And so only small amounts of this compound were available to treat injured individuals.

But in the 1940s, an individual, Dr. Percy Julian, a Ph.D. biochemist, in fact we honored Percy Julian on the floor of this House as one of the outstanding African American scientists of the last century. I think we did that during the last Congress. And I was very happy to vote for that because Dr. Julian's contribution to American medicine was nothing short of astounding. He was able to use a precursor of a soybean and create cortisone in a laboratory and mass produce it. Once again we had a wonder drug that previously was available only in such small supply as to only be of benefit to a handful of people; now, suddenly, it was readily available, and available to large numbers of people at a reasonable price.

So the 1940s ushered in the era of anti-infective antibiotic agents and anti-inflammatory agents, two true wonder drugs that, again, American medicine had not had available prior to that time.

Now, Mr. Speaker, today we get sick, we go see the doc, he or she writes out a script, tears it off, sends you on the way to the pharmacy, you get it filled and you never give it a second thought. But prior to 1940, that wasn't an option; it didn't happen. Again, our soldiers landing in Normandy who were injured had available for the first time an anti-infective agent that was of such caliber that it provided many of those wounded men to gain back the use of limbs that otherwise would have been placed in peril by battlefield injuries.

The discovery of cortisone really revolutionized at that time the treatment of illnesses such as Lupus and rheumatoid arthritis. There are other medications that are available now. Cortisone, of course, has some side effects and some problems, but still, cortisone is in widespread use in a number of areas in medicine today. So still, these are concepts that we benefit from.

When you also think of the 1940s, what else was going on? Well, of course, the Second World War. We were in the middle of a two-front war. The American workforce was severely contracted because of the number of men and women who were fighting for our country, so employers back in this country who wanted to produce the material for the war, who wanted to continue to operate their businesses, were pretty hard pressed to find employees to work there.

One of the things that was happening during the war, because of this shortage of workforce, was that compensation for workers started going up pretty fast. President Roosevelt saw that and felt that he needed to put some brakes on the rapid growth of wages; otherwise, the economy would get out of control and inflation would spiral out of control. So he put in place wage and price controls, and he did so because, again, the country was at war and the severe contraction of the workforce caused disruption of the labor market, and the President sought to correct that.

Now, employers said we want to do things for our employees that make them want to work for us and make them not look for other employment in other locations, so if we can't offer

wages, can we offer benefits? Could we, perhaps, offer retirement benefits? Could we, perhaps, offer health benefits? And the United States Supreme Court ruled in 1944 that, indeed, those benefits could be offered and they would not violate the spirit of the wage and price controls. And furthermore, they should be available to the individuals as a pretax expense. And hence, the era of employer-derived health insurance as a pretax expense was born and survives to this day. And many people are very satisfied with that as a method of having insurance for their health care. And it has its roots back in 1940. Again, a truly transformational time in American medicine. We've got new medicines to treat infections and inflammatory conditions, and we've got a new way of paying for health care for Americans in employer-derived health insurance.

The 1960s; what do we see then? We see the introduction of new generations of antibiotics, antibiotics that were more potent. Some bugs had developed resistances to the old antibiotics; we had new antibiotics that were less prone for bacteria developing resistance. We had new antipsychotic medications. We had new antidepressant medications, medications to treat conditions that heretofore had not been treatable. There had not been a rational or a viable treatment available to those patients.

What else did we see in the 1960s? We saw in this House, in 1965, the enactment of a law that we now know as Medicare for protection of United States seniors. For the first time the United States Government was in a position to finance a large portion of health care in this country. In fact, since 1965, over the last 42 years, the portion of health care that is paid for by the Federal Government, about 50 cents out of every health care dollar, begins right here in Washington, D.C. You've got Medicare/Medicaid, the VA System, the Indian Health Service, TRICARE, Department of Defense, as well as the Federal prison system. A lot of health care is paid for and it originates here in the United States Congress.

The other 50 percent, commercial insurance to be sure, some self-pay. And I would actually include the newer health savings accounts in that part that I would designate as self-pay. And then of course there is some care that is just simply not paid for, and some that is given as charity by the hospital or the doctor who provides the care and does not expect compensation.

And now, early in the 21st century, I believe, again, is a transformational time in American medicine. And I think it extends before us really as far as the eye can see. Mr. Speaker, I think this transformation will occur whether we want it to or not. Whether we lead it or not, the transformation will happen. Changes in information technology, concepts like rapid learning, changes in the practice of medicine regarding genomics, protein science. A new era of personalized medicine extends before us. And as we usher in this new era in medicine, how can we facilitate or at least not obstruct the scientific discoveries and allow this important process to go forward? And nowhere will this be more starkly apparent than in our ability to provide this new care at an affordable price to the majority of Americans and ensure that there are the doctors involved who will deliver that care.

Now, as I see it, the problem right now is that most health care is administered through some type of third-party arrangement so the patient and, quite honestly, the physician is generally aware of the cost of care that they receive. This arrangement has created an environment that permits the rapid growth, the rapid escalation of prices in all sectors of health care. So how do we improve the model of this current hybrid system, this public/private partnership that we have right now? How do we improve the current hybrid system that involves both public and private payment for health care but at the same time anesthetizes most of us to the true cost of that care?

Now, Mr. Speaker, we hear it all the time here on the floor of this House that we're just entering into the first retirees of the baby boom, and this is all we can see demographically for years and years to come. There will be more demand for medical services. Medical procedures and techniques and pharmaceuticals will tend to cost more because there is the advancing complexity of what we're able to do. Medicine is going to continue to evolve as it always has.

Now, Mr. Speaker, Alan Greenspan, former Chairman of the Federal Reserve, right around the time that he was retiring spoke to a group of us one morning, and the inevitable question came up to Mr. Greenspan, ''How in the world are we ever going to pay for the liability that we have in Medicare in the future?'' And Mr. Greenspan was quite circumspect about it, but eventually he offered the opinion that, when the time came, the Congress would find the courage and the resources to do what was necessary, and he thought that Medicare would be solvent into the future. He then stopped and went on to add, ''What concerns me more is will there be anyone there to deliver the service at the time you need it?''

Now, Mr. Speaker, I will tell you that those words have stuck with me these last 2 years and caused me to devote a great deal of time and study to the concept of the physician workforce in the United States. Let me just share with you, Mr. Speaker, the Texas Medical Association, back in my home State of Texas, puts out a magazine every month called ''Texas Medicine,'' and this was their March issue of this year, and the title story was, ''Running Out of Doctors.'' My State is far below the national average when it comes to physicians. The national average is 230 per 100,000 residents; Texas' ratio is 186 to 100,000 residents. The American Academy of Family Physicians predicts serious shortages of primary care doctors in five States, including Texas. And further, they go on to say that ''all States will have some level of family physician shortage by the year 2020.'' That's 13 years from now, three Presidential elections from now.

The Council on Graduate Medical Education, a congressionally authorized entity, estimates that after 2010, growth in the physician workforce will slow substantially, and that after 2015, the rate of population growth will exceed the rate of growth in the number of physicians.

Now, what do we do? My opinion, I think there is a three-part approach, a three-part solution to mitigate this shortage in the future.

First and foremost, and it seems so simple that I cannot believe that it doesn't occur to more people, we need to construct a payment system, particularly on the governmental side, that pays doctors fairly to keep them in practice longer. Additionally, improved assistance to medical students, to encourage college students and medical students to go into medicine and practice in high-need specialties in medically underserved areas. And then finally, to increase the number of residency programs, especially in rural or suburban areas, to keep the physician pipeline open.

And the real crux of this article, Mr. Speaker, in ''Running Out of Doctors,'' was the observation that doctors tend to have a lot of inertia. We don't tend to go very far from where we're hatched. And doctors who go through a residency program tend to practice within 50 to 100 miles of the location of that residency. That's why, if we can encourage the development of more residency programs in underserved areas, we will encourage the growth of the physician workforce in that area.

So, before we go completely into the three-point solution aimed at mitigating the possibility of an even greater solution in the future, let's talk about some of the basic principles that I had in mind as I developed this concept of physician workforce reform.

Now, Mr. Speaker, I believe that Congress must develop physician workforce initiatives that ensure future patient access and sustain a robust physician workforce, and this must be both separate, but complimentary, to Medicaid physician payment reform. Why do I say that? Well, Mr. Speaker, as you know and many in Congress know and many across America know, in Medicare we have different payment systems for part B as opposed to part A, part C and part D. In A, part C and part D, there is sort of a cost of living adjustment every year for hospitals, for HMOs, for drug companies. There is a cost of living adjustment that occurs every year so that these institutions, these entities are reimbursed based upon the cost of inputs.

□ 2200

But part B, the physician part, is under an entirely different formula that is coupled to the gross domestic product. Furthermore, it is a finite, a finite, number of dollars that are available to pay physicians who participate in the Medicare program. What happens over time, since that doesn't grow, what happens over time, the individual payments to physicians are scheduled to shrink 5 to 10 percent a year over the next 9- to 10-year budgetary cycle.

This program is so unfair that it causes physicians to retire early, stop seeing Medicare patients and leave the physician workforce. The solution is very, very simple, and it is one that is so simple that, quite frankly, it oftentimes gets lost in all of the other talk and debate. The solution to this problem is stop the cuts, repeal the formula, and then replace it with the Medicare economic index, the cost-of-living formula that hospitals, HMOs and drug companies are paid with.

Now, the current Medicare payment system exacerbates negative physician workforce trends. That is why I feel that the sustainable growth rate formula must be eliminated. Let me just show you a little graph of that. Mr. Speaker, I think this graph accurately represents what I am talking about. Again, we talk about the physician payment as compared to HMOs, hospitals and, in this bar graph, nursing homes. You can see over the years 2002 to 2007 increases in HMOs, hospitals, and nursing homes and very flat increases for a few years for physician payment after an initial decline, and actually this was projected for 2007. We actually held physician payment at a zero percent update, which anywhere else other than in Washington, D.C. let's be honest, that would be a cut but we call it a zero percent update because we like to be euphemistic when we talk to our physician friends. Again, I submit, stop the cuts, repeal the formula.

Now, any new system that we create has to be able to adjust for growth in services, but it has to be agile enough to determine what constitutes appropriate care in service and service volume when growth results in better patient outcomes. Any new coverage decisions by law or regulation must be accompanied by additional financial sources relative to their value for the services.

Now, Mr. Speaker, we spent a lot of time in my committee, Committee on Energy and Commerce, last year having hearings about physician payments. And one of the things that is obvious when you look at recent trends in Medicare outlays is that in fact the trustees report that came out last June talking about the year 2005; 600,000 fewer hospitals beds were filled that year. Why? Because the physician component is doing things better, more timely treatment of disease. I will submit that perhaps some of the new Medicare prescription drug program is playing a role in that as well; doctors are doing more procedures in their offices in ambulatory surgery centers.

The net effect of that, Mr. Speaker, is to keep down the costs for part A, but then that expense occurs in part B. So how could we get the savings that we are managing for part A, how could we get that back for part B? That is really the challenge that is before us.

Now, the Congressional Budget Office and all of the budgetary people who work up here on Capitol Hill will tell you that you can't prospectively go out and say, since you are going to save so much money, you saved so much money last year, and you are going to save so much money next year and the year thereafter, but you can't get credit for that until it actually happens. My belief is that savings will occur. It will accrue.

So what if we pay it forward, so to speak, we don't repeal the SGR in 2008 or 2009, we will repeal it in 2010. But in the meantime, 2008 and 2009 whatever savings occur because the physicians in part B are doing things better, cheaper and safer and saving money for part A, part C and part D, that those savings be sequestered and they be walled off. Remember the famous lockbox for 2000 everybody talked about for Social Security? Let's drag up that lockbox and put the savings in the lockbox, and we will open it up in 2010 and reduce the cost of repealing the SGR formula.

That has been the obstacle, Mr. Speaker. The Congressional Budget Office estimates the cost of repealing the SGR today right now at $268 billion. Last year when I tried a different approach to this same problem, the cost for repeal was the $218 billion. It goes up every year. One of the reasons it goes up every year is that every year we come swooping in at the last minute with some sort of last-minute fix. But all that money that we used to come in for that last-minute fix gets added on to the budgetary out-years. So we compound the problem. Every year that we don't fix it, we compound it. That is why it is so critical to fix that date that we repeal the formula.

Now, in the bill 2585 that I have introduced, we actually do that. We actually capture and sequester those savings and use that paying it forward to bring the cost of repealing the SGR down.

Now, just a couple of other points in general about physician workforce, preserving the physician workforce. You know, I said the SGR formula, the sustainable growth rate formula, is linked to the growth in the gross domestic product. There is a reason for that. That needs to be delinked. Quality reporting. What about quality reporting? We hear a lot about that. We hear a lot about pay for performance here on the floor of this House. Well, Mr. Speaker, I would submit to you, pay for performance is keeping the mature physician involved in the practice of medicine. If we drive all of our talented and experienced doctors out of the practice of medicine because of what we are doing with the Medicare formulas, it is going to be pretty tough to pay for performance.

Now, I do think some type of performance indicators need to be included in whatever process is going forward. We don't need to reinvent the wheel every time we sit down to talk about this. Many of the specialty organizations have already developed their own criteria. We have the QIOs. The quality improvement organizations have been in existence really I think for 20 years since the latter part of the second Reagan term. So these measures are all available to us.

What I would submit is that if a doctor or a physician group would voluntarily report to one of these quality measures, that there be some positive adjustment, in whatever formula we give them, that there be some positive adjustment for participating in that quality activity.

Similarly, I talked a little bit about this in the beginning. We are in a transformational time. What is one of the things that is going to drive that transformation? It is going to be changes in health information technology, whether we want it to or not. We struggled with the health information technology bill last year. We talked a little bit about one this year. The fact remains, it is happening whether Congress is involved or not. As a consequence, I think we ought to do what we can to encourage physicians' offices and individual physicians to begin to embrace this, to begin to investigate this and an additional positive update would be available to physicians who voluntarily participated in improvements in health information technology and their individual practices.

You know, Mr. Speaker, one of the things that I think would make a lot of sense and I don't know why we haven't done it, we ought to share with our Medicare beneficiaries what did your care cost last year. I get a statement from the Social Security Administration about what my Social Security contributions have been year over year since I first started paying that FICA tax. We could do the same thing with our Medicare patients: What did you contribute over your working lifetime? And now what are expenses attributable to you that are incurred to the system? That information should be confidential. You obviously don't publish that, but give back to the patient that information on what the cost of their care was over the past year because otherwise they have no benchmark. They have no way to know are they, in fact, getting value for their dollar or not.

So there are three bills that I've introduced to help tackle these problems and get at the essentials of what is creating the near havoc situation in the physician workforce. I think these bills are essential to ensuring that America will always have a good supply of

qualified, satisfied doctors to address the growing health care needs of an ever-growing population.

Now, we have already talked a little bit about the sustainable growth rate formula. Getting Medicare payment policy right is the first point to make in any type of reform that is going to affect the physician workforce. Paying physicians fairly will extend the careers of many doctors who otherwise would just simply opt out of Medicare or opt out of the practice of medicine entirely. Paying physicians fairly also has the effect of ensuring an adequate network of doctors. That adequate network of doctors is available to treat some of those complex patients we have in this country, and that is the elderly patient on Medicare and as this country makes a transition to the workforce of the future.

Now, the bill I introduced, 2585, Ensuring the Physician Workforce Act of 2007, modifies the Medicare physician reimbursement policies. It is important because you do have to pay doctors fairly for their services so that they will want to go into medicine, they will want to continue to practice medicine, and maybe even practice medicine to a later point in their life. So we extend the effective practice life of physicians who are already out there practicing.

Now, the fundamentals of 2585 we have covered already a little bit. But I like to think of it as a workforce solution for the mature physician. It provides sustainable Medicare reimbursement now and in the future by getting out of the chasm created by the sustainable growth rate formula and completely eliminating the sustainable growth rate formula by the year 2010. It includes truly transformational incentives to further the development and implementation of quality measures and health information technology in a way that makes sense to the business aspect of the practice of medicine.

Furthermore, in 2008 and 2009, physicians could opt to take advantage of those bonuses, return value back to their practices, and, in fact, return value back to the taxpayer by participating in those measures. Quality measures would be built around high-cost conditions and strive to improve the quality of care for those conditions and ultimately drive down the cost of delivering the care in the Medicare program. The bill would also include a Federal incentive to implement health information technology along with provisions providing safe harbors for the sharing of software, technical assistance and hardware as well as the creation of a health information technology consortium.

That last point is important because there are laws and regulations that Congress has passed in the past that prevent hospitals and doctors working together to develop the type of health information technology network that is really going to be necessary to manage this sea change that we are going to see in medicine in the coming years.

I will confess, Mr. Speaker, let me put another chart up here. Mr. Speaker, I will readily acknowledge that I have not always been a firm believer in things like health information technology and electronic medical records. In fact, right before I left practice, my practice in medicine, we were given a charge to beta test an electronic e-prescribing sort of format and there was certainly no financial outlay on our part. We were simply to use these little hand-held devices and report back as to their utility. There were obviously some plus sides. You knew right away if there was a drug interaction or a patient had an allergy that wasn't apparent on their chart. The computer knew and it would flag that for you. But it slowed you down. It slowed you down in that it took about a minute or 1½ minutes to add this information in for the patient.

Mr. Speaker, when I first went into private practice after I completed my residency at Parkland Hospital, went into private practice in 1981, reimbursement rates were such that if you saw 15 to 17 patients a day, you pay your overhead and have a nice amount to take home at the end of the month. With everything that has happened with HMO declining reimbursement rates, from private insurance declining reimbursement rates from the government-funded sector of health care to be sure and a growing government sector of health care that historically underfunds their component and undercompensates their component, what has happened over time in order to maintain that similar amount of money that is needed to pay for overhead and have something to take home at the end of the month, physicians are now finding that instead of seeing three patients an hour, they have to see five. Instead of working 7 hours in the office, they now need to work 8 or 9.

So if you are not seeing 35 or 40 patients a day, you may not be measuring up as far as covering that overhead and having something to take back to your family. After all, they put up with the sacrifice and aggravation of having you, their husband or father as a physician, meaning you are frequently gone from home, you go and leave in the middle of the night to attend to problems. And we always do that willingly and lovingly; but at the same time, it does create wear and tear on families, and certainly any doctor's family can tell you that. Doctors, over time, have tended to be fairly well compensated. As a consequence, families have been ready and willing to accept that. But in order to maintain that same level, we have gone from a time where we were seeing 15 to 17 patients in a day to 35 to 40 patients in a day.

Let me go back to the e-prescribing. If it is taking you 1½ minutes to enter in the patient data and hit the send key to send the e-mail to the pharmacy to provide that prescription for that patient, that is another hour you have added on to that physician's day.

□ 2215

How are you going to pay the doctor for that? None of this has ever been worked out. If you go even further and say we're going to go with a full-on electronic record, there's a learning curve there. It's going to take some time, and it's going to slow that doctor down. Not only will it slow him down so he is able to see fewer patients, it slows him down so that there's less face time, if you will, with the patient, less time to listen to what the patient is saying, to look the patient in the eye and make sure you're getting the straight story so that you come to the correct diagnosis.

Mr. Speaker, I was late to come to the table as far as electronic medical records. I will tell you the sentinel moment that changed my mind, that shifted me on this issue, and said, you know, it is going to take more time; there has to be a way to compensate doctors for the time involved in doing that e-prescribing and creating those electronic medical records.

Well, 2 years ago, of course, we were suffering in the aftermath of Hurricane Katrina. Two years ago next January our Committee on Energy and Commerce had a field hearing down in New Orleans, and one of the places we went on that field hearing was to Charity Hospital, one of the venerable old teaching institutions in this country. Many of my professors at Parkland Hospital had been trained by professors at Charity Hospital. It was truly an icon in American medicine. It was absolutely devastated in the flooding that followed Hurricane Katrina in New Orleans.

Mr. Speaker, we went into Charity Hospital. We went down to the basement where the records room typically is in a hospital. And here, Mr. Speaker, is the medical records department of Charity Hospital. Now, this isn't fire or smoke damage on these charts. It's black mold. You really can't send someone down there to retrieve medical data without putting the medical records transcriptionist at risk.

These records are essentially lost forever, if the ink hasn't washed off all the pages. Remember, this was all completely underwater, because this was in the basement. You remember how much water was standing in the streets of New Orleans. So completely underwater. We don't even know if these are readable. But who is going to get in there and risk disturbing all the black mold and getting the health consequences that would result from it?

So all of this medical data is lost. Who's to know? Maybe there is a kidney transplant there, some important data. Maybe someone being treated for non-Hodgkin's lymphoma here, and important clinical data lost. Maybe there was a child with a rare illness that,

again, no one would be able to retrieve those medical records. This is the reason why I have now become a believer in the electronic medical records system.

Furthermore, when a large number of persons who were evacuated from New Orleans and brought to the Metroplex in the north Texas area, north Texas physicians turned out in great numbers to receive people who had been in the domed stadium in New Orleans, the Superdome I guess it's called, as well as other individuals who were evacuated from the Convention Center, and they were brought in buses to downtown Dallas and doctors met them as they were coming off the bus.

One of the large pharmaceutical chains set up there with their computer system, and if that patient had gotten their prescription at that chain drug store, they were able to recreate not their entire medical record, but at least their prescription history, which a lot of times will give you a great deal of insight into what a patient's conditions are and what they are being treated for.

So the availability of that, albeit very limited pharmaceutical data, provided a great deal of service to the doctors who were on the ground receiving these individuals who had to be evacuated out of the city of New Orleans. Again, it really made a believer out of me that that data needs to be retrievable wherever you are, wherever you go.

Mr. Speaker, all too often we run into in medicine the fact that, yes, the patient went down somewhere and had a CT scan, and now they're seeing a different doctor and that CT is not available because it's only a written, typed report and it's locked up in some other office and they are now closed. So we either go on a hunch without the information, or you repeat the test and spend another $1,000. It is so critical to have that information where it is readily retrievable by any doctor involved in taking care of the patients.

Mr. Speaker, I have digressed just a little bit from the physician workforce issues, but I do think this is such an important issue, and that is why I included in H.R. 2585 bonus payments for doctors who are willing to begin to make that change into improved health information technology and perhaps consider electronic medical records, perhaps consider e-prescribing.

There is no question that our handwriting as physicians is generally abominable. I will tell you, Mr. Speaker, it doesn't improve with age. Medication errors that are because of poor handwriting or illegible handwriting on the prescription pad, we have all encountered it during our practices.

It is so critical to be able to have that information in a legible, reproducible form and have it available when a patient goes from city to city, as these individuals were because of a crisis in their hometown, where they had to leave and go to another town. But even just for someone on vacation who develops a problem, if you have the availability of accessing their medical records online or through some service, that is going to make a tremendous difference.

Now, Mr. Speaker, one of the things we talked about, too, when I first began this discussion on the workforce issue is how do we help the physician who's through with medical school and pondering a residency, or in fact in a residency. Could we develop a program that would permit hospitals that do not now currently have a residency program to begin a training program where none has existed previously.

So the second bill, H.R. 2583, would create a loan fund available to hospitals to create a residency training program where none has operated in the past. These programs, of course, would require full accreditation by the appropriate agencies and would be focused in typically medically-underserved areas, rural, suburban, frontier community hospitals.

Mr. Speaker, on average it costs about $100,000 a year to train a resident. For a lot of small hospitals, that is a barrier to entry that they just cannot meet.

Two, the Balanced Budget Act passed by this Congress long before my service here, back in 1997, 10 years ago, placed the cap on residency slots Medicare would fund, making it very difficult for some programs to expand and hospitals to create residency programs. So, especially for smaller hospitals that are interested in creating a residency training program, federal regulations, federal regulations stop them cold, dead in their tracks, from creating that residency program.

Again, these are some of the things that were done in the Balanced Budget Act, but these regulations need to be streamlined. We need to have a second pathway for these hospitals to follow to establish a residency training program. It is a major financial investment for small hospitals to undertake, and frequently they just simply have to forego, because they can't afford it, even though their community might very well benefit from having such a training program.

Now, in the bill before the Congress, H.R. 2583, loan amounts would not exceed $1 million and the loan would constitute startup funding for new residency programs. The start-up money is critical here. Since Medicare graduate medical education funding can be obtained only once a residency program is firmly established, the cost to start a training program for a smaller, more rural or suburban hospital is cost prohibitive. The barrier to entry is just too high, because these hospitals operate on much narrower cost margins.

H.R. 2583 is a bill that has been introduced as part of the physician workforce package of bills. It will allow smaller hospitals to establish residency training programs.

As I said earlier, Mr. Speaker, doctors tend to have a lot of inertia. We don't fall far from the tree when it comes time to start up practice. We tend to go into practice within 100 miles of where we did our residency. That would be the reason to move the residency programs into the areas of States, into the areas of the communities where doctors are most needed.

Two, this program could be a recruiting tool for small communities to recruit essential professionals to consider a residency program in their town and then hopefully stay around once the training program is finished, because, after all, you know all the referring doctors, you know the personnel in the hospital, and that arduous task of setting up a practice becomes perhaps just a little less daunting because you are working with known entities.

The third point of assuring availability of an adequate future workforce is providing medical students or college students who are considering a career in health professions, to provide them with assistance and incentives to practice in shortage areas in shortage specialties.

The third bill, H.R. 2584, would establish a mix of scholarships, loan repayments and tax incentives to encourage more students into medical school and beyond. It also creates incentives for those students and newly-minted doctors to become family docs, general surgeons, geriatric doctors, OB–GYNs, and practice in shortage areas such as rural and frontier areas.

H.R. 2584, the High Need Physician Workforce Initiative Act of 2007, amends the Public Health Service Act to alleviate critical shortages of physicians in the fields of family practice, internal medicine, pediatrics, emergency medicine, general surgery and OB–GYN. H.R. 2584 would establish additional loan and scholarship programs and would assist underserved communities to build a pipeline for the medical professionals of tomorrow.

Mr. Speaker, I spoke already about the medical records situation in New Orleans. Also as an outgrowth of actually several trips I made to the New Orleans area in the fall of 2005 and the early part of 2006, you really began to see the attenuation of the physician workforce in that area and you really saw the arduous task of rebuilding the physician workforce in that area.

Mr. Speaker, it is almost as if a physician or his spouse, if they weren't from the area, they likely weren't staying. They had to have significant family ties to make them consider staying in the area. That is so unfortunate, Mr. Speaker. But not only do we have the unspeakable horror of the hurricane itself, but then we had the slow response in getting aid through State and Federal and local agencies to physicians in private practice and they were left to fend for themselves. They ended up spending their own savings to keep their practice open and they reached a point where they simply could not sustain that any longer. It will be hard to entice people back.

So the reality is the physician workforce of tomorrow, especially in an underserved area like the City of New Orleans, is going to require growing your own. And part of growing your own is this mix of scholarships, loan forgiveness and tax incentives to encourage physicians to go into the health professions, and as part of the loan payback, they agree to serve in a medically underserved area in a high-need specialty. This bill provides targeted incentives to develop medical students and encourages the growth of specialties that will be in high demand in underserved or emerging communities.

So, Mr. Speaker, those are the three bills, H.R. 2583, H.R. 2584 and H.R. 2585, that deal with the problems that I see as emerging with the physician workforce. Remember, we are in a transformational time. We are in a time that is just as transformational as 1940, 1965, or even some of the earlier transitional times that we didn't have time to talk about tonight. We are in a transitional time that is going to require us, require us as legislators, to be at the top of our game so we don't obstruct this process and, dare I say, we enhance this process, we further this transformation, we make the transformation proceed in an orderly fashion, in a fashion that is beneficial.

But, Mr. Speaker, I can hardly, hardly, talk about physician workforce issues and not address the number one issue that is so pernicious to physician practice and drives more doctors into early retirement, and that is the state of the medical justice system in this country.

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Texas in 2003, September of 2003, a little over 4 years ago, passed what I considered a very reasonable bill to put some caps on noneconomic damages in medical liability cases.

Texas was in crisis. When I was running for Congress in 2002, we had really hit rock bottom as far as medical liability issues were concerned. We had gone from 17 medical liability insurance companies down to two. They were leaving the State in droves. If you only have two companies, it is difficult to have competition. Premiums were going through the roof. Every year I was seeing premium increases of 20, 25 or 30 percent. And the reality was that reimbursement rates were not keeping up and doctors couldn't keep up.

I remember when I was campaigning in 2002 at an event I ran into a young woman who was a radiologist. I say young woman, she had been through medical school and residency. She said, I hope you can get something done about the liability situation because as a radiologist, I lost my insurance because my company left the State and I can't get insurance with the two remaining companies. As a consequence, I cannot practice interventional radiology without liability insurance. I can't accept that kind of risk, taking care of high-risk patients without some type of liability coverage.

So the State of Texas paid to educate this woman. The woman went to a State-supported school, so taxpayers partially paid for her education because she went to a residency program at one of the State universities, and she was lost as a provider to the State of Texas because of the liability situation.

Texas, fortunately, stepped up to the plate and recognized they had a serious problem. Across the board in Texas, everyone was talking about the crisis in medical liability. So they passed a bill in 2003 that put a limit on noneconomic damages in medical liability suits. It was patterned after the Medical Injury Compensation Reform Act of 1975 which affects the State of California and has done a good job in California as far as keeping doctors involved in practice and keeping medical liability rates low.

Well, in California, the Medical Injury Compensation Reform Act of 1975 put a cap on noneconomic damages at $250,000. That was a tall order in Texas. They were not able to achieve the same level of cap on noneconomic damages, but they went about in a way so that a $250,000 cap on noneconomic damages exists for the doctor, for the hospital or nursing home or a second hospital. So each provider named is going to be capped at $250,000, and a maximum of $750,000 that could be awarded to a plaintiff in noneconomic damages. Actual damages, punitive damages, are not affected by this law. So average compensation for patients is still going to be very, very high, but it removes a lot of the uncertainty that was present in the medical liability market. And as a consequence, it provides fair compensation for injured patients and their families. It has been a success in Texas. Liability premiums have dropped. Competition has invigorated the insurance market, and patients once again have access to the doctors they need. Remember, we dropped from 17 down to two insurers. The next year we were back up to 15, and I believe the number is substantially higher today.

The best news is they came back to the State without asking for an increase of premiums. Texas Medical Liability Trust, my old insurer, has provided a 22 percent reduction in premium expenses for physicians since 2003. Remember, we were going up by 20, 25, 30 percent a year every year prior to 2003, so this has been a dramatic turnaround in Texas.

Remember, I talked about Texas as being one of the States that is medically underserved. Remember that figure of 186 doctors per 100,000 population. But since this law took effect, things are on the upswing as far as physician workforce in Texas. Over 10,000 new physicians have been licensed, including a record 3,300 doctors licensed in fiscal year 2007. The Texas State Board of Medical Examiners can scarcely keep up with the demand. Several have asked what is taking the Texas State Board of Medical Examiners so long, and there is a lot of demand. When you have to ask how big are you winning, that is a good thing, and Texas is winning big with this legislation.

Doctors are moving back to areas that were underserved and critical specialties are moving back into the State. Doctors who practice a specialty called perinatal medicine where you take care of the most complicated pregnancies and the sickest babies, these doctors could not get insurance at any price in 2002. And I remember talking to a young doctor at a hospital who said, I am going to have to stop practicing. I have all of these loans to pay back, and I can't practice because I can't afford the liability premiums.

Our whole trauma network in north Texas was put at risk because 50 percent of the neurosurgeons, that is one out of two who were available, said he got his six-figure premium notice, and he said, That's it, I can't do this any more. With him leaving, leaving only one neurosurgeon in the trauma network, it put north Texas in a serious position for how they were going to be able to handle trauma cases in north Texas.

Since the passage of this law in Texas, that perinatologist has gone back into practice. He went to work for a computer firm, believe it or not, and now he is back in practice and probably saving babies today that wouldn't have been saved without his care and expertise. I am sure he did a good job taking care of computers, but babies are more important than computers.

New neurosurgeons are attracted to the north Texas area, preserving the trauma network we have in the north Texas area. It was very much put at risk by the crisis in medical liability.

One of the unexpected beneficiaries of this law in Texas has been the smaller, not-for-profit hospital that is self-insured. They were having to put so much money away to protect against future losses because the upper limit was unknown. Now they are able to take some of that capital and reinvest it in capital equipment, nurses' salaries and outreach and education, the very things you want your hospital to be doing. They are able to do those things because of sensible reform that happened in the State of Texas.

Claims and lawsuits have declined, and the current situation that exists in some States only drives up the cost of health care and forces doctors to treat every patient as a potential lawsuit.

Mr. Speaker, the Founding Fathers suggested that the States could function as laboratories for the rest of the country, and I think this is one of those instances where we have seen the function of the laboratory, that is Texas in medical liability, function in every way as we would want it to. In fact, when we were going through the budget process last March, I provided the ranking member, our ranking member of the Budget Committee, the legislative language that would be the

Texas law if it were written by legislative counsel here in the House of Representatives.

And they took the bill and did a back-of-the-envelope score and came up with a $3.8 billion savings over 5 years that would be available to the budgeteers had they chosen to accept that. In other words, do medical liability reform like we did in Texas across the country, and you are going to save some money.

It is not a huge amount of money. I know in Washington-speak $3.8 billion doesn't resonate like some other figures, but it is real money and it is available to us. All we have to do is enact some type of sensible medical liability reform across the country like we did in my home State of Texas.

So I took that language that ran through legislative counsel on the Texas liability law and actually introduced the Texas medical liability law. It is H.R. 3509, the Medical Justice Act of 2007. It is now available. Members may cosponsor it. I recognize in the current climate in the United States House of Representatives it is going to be very difficult to get any type of medical liability reform passed, but at the same time, this is important work and we shouldn't shy away from it. We should at least have the discussion and the debate. Let's clash in the marketplace of ideas here. Here is a system in Texas that is delivering real value to the patients of Texas and to the doctors of Texas.

Mr. Speaker, we can't rise to the transformational challenge that stretches before us without keeping the best doctors involved and recruiting and training the best and brightest doctors who are coming behind them, recruiting and training those doctors for tomorrow. This is going to require a near-term, a mid-term and a long-term strategy. Mr. Speaker, we have to work together, both sides of the aisle. This is not a partisan issue. This is going to face every single one of us in our district as we go through this next several years. And we are not going to be able to master the transformational challenge that extends ahead of us without America's best and brightest staying involved and providing care for patients in this country. The best and brightest men and women of medicine, we need to keep them on the front lines. I stress, this is a true bipartisan issue. There is not a single party label attached to this concept.

So let's sit down, both sides of the aisle, and work together to insure a healthy future for all Americans. The bottom line is we have to make certain that doctors are continuing to practice, they are satisfied with their compensation and satisfied with their ability to deliver services to the patients.

You hear the phrase in Washington, ''well, we will cross that bridge when we come to it''; in other words, we won't act until we absolutely have to act.

Mr. Speaker, this is a transformational time. I think this calls for a different type of thinking. We are going to have to build a bridge while we are crossing it, not wait until we get there. We are going to have to build that bridge ahead of time, and I think we can.

I visited a group of scientists at the National Institutes of Health and they talked about the challenge of working through the genetic sequence of the human genome and sequencing the base pairs in the human genome. And they started this project in the 1990s, a very labor-intensive project, and they didn't have the Internet. They didn't know that they needed the Internet. Fortunately, the Internet came along while they were in the process of cracking the genetic code. But if it hadn't been the Internet, they wouldn't have been able to share information with other scientists around the world on a real-time basis. And I don't know if by today we would have cracked the genetic code, so an example of building the bridge while you are crossing, and certainly those scientists at the National Institutes of Health really did take that to health.

Why wait any longer? Why should we keep doctors and patients waiting? Sensible legislation is before us now. Again, I repeat, I urge my colleagues to look at this, talk to me if you have questions about it. It is extremely important for those students who are looking to go into health care as a profession, those in medical school now, those doctors in residency, and again, what I would refer to as the mature physician. It is important to the whole continuum of the timeline of the physician workforce.

We don't want to end up in that day that Alan Greenspan looked into the future and saw a couple of years ago. We don't want to arrive at that day where there is no one there to take care of America's seniors because we didn't pay attention, we took our eye off the ball back here in the year 2007.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. DAVIS of Illinois (at the request of Mr. HOYER) for today on account of official business in the district.

Ms. EDDIE BERNICE JOHNSON of Texas (at the request of Mr. HOYER) for today and October 23 on account of a death in the family.

Mr. KIND (at the request of Mr. HOYER) for today.

Mr. WILSON of Ohio (at the request of Mr. HOYER) for today and the balance of the week on account of medical reasons.

Mr. YARMUTH (at the request of Mr. HOYER) for today.

Mr. GINGREY (at the request of Mr. BOEHNER) for today on account of flight delays.

Mr. YOUNG of Florida (at the request of Mr. BOEHNER) for today on account of illness in the family.

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:)

Mr. CUMMINGS, for 5 minutes, today.

Ms. WOOLSEY, for 5 minutes, today.

Mr. DEFAZIO, for 5 minutes, today.

Ms. WATERS, for 5 minutes, today.

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

Mr. BURTON of Indiana, for 5 minutes, today and October 23, 24, and 25.

Mr. POE, for 5 minutes, October 29.

Mr. ENGLISH of Pennsylvania, for 5 minutes, October 24.

Mr. JONES of North Carolina, for 5 minutes, October 29.

SENATE BILLS REFERRED

Bills of the Senate of the following titles were taken from the Speaker's table and, under the rule, referred as follows:

S. 2206. An act to provide technical corrections to Public Law 109–116 (2 U.S.C. 2131a note) to extend the time period for the Joint Committee on the Library to enter into an agreement to obtain a statue of Rosa Parks, and for other purposes; to the Committee on House Administration.

S. Con. Res. 51. Concurrent resolution supporting ''Lights On Afterschool!'', a national celebration of after school programs; to the Committee on Education and Labor.

ADJOURNMENT

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

The motion was agreed to; accordingly (at 10 o'clock and 43 minutes p.m.), under its previous order, the House adjourned until tomorrow, Tuesday, October 23, 2007, at 9 a.m., for morning-hour debate.

EXPENDITURE REPORTS CONCERNING OFFICIAL FOREIGN TRAVEL

Reports concerning the foreign currencies and U.S. dollars utilized for speaker-authorized official travel during the second and third quarters of 2007, pursuant to Public Law 95–384 are as follows: