

Mr. BISHOP of New York. Madam Speaker, at least President Bush is consistent. Like the other seven budgets that he has submitted to this Congress, it is no surprise that his eighth and final request continues to reflect spectacularly flawed priorities. There was some debate earlier this week about whether the budget should be printed and distributed to congressional offices. Perhaps the best decision would have been to spare us the books and save the trees.

For the eighth year in a row, the administration has degraded the budget process. This budget barely goes through the motions. Instead of formulating a blueprint to guide this Nation toward what should be our fiscal priorities, the budget continues the flawed policies of the past 7 years.

Without putting forth an honest or straightforward budget, the President has yet to attempt seriously to meet our goals, goals that we should all share of budgetary accountability, enforcement, and fiscal responsibility. This is why so many of our colleagues, Madam Speaker, have already accurately described the President's budget request has a pro forma document with little meaning or relevance, that has also been described as arriving on Capitol Hill "dead on arrival," and that is perhaps a very, very good thing. Perhaps the lack of truth in budgeting represents the best example of why "change" has become the overriding theme of this coming election.

This Congress should refuse to be misled again by a budget that hides the true costs of the devastating fiscal policies of this administration. For example, omitting total war costs gives an artificially deflated notion of what the deficit will be, and we now have the Secretary of Defense estimating that the true cost of the war in fiscal 2009 will be \$170 billion, as opposed to the \$70 billion that is put in the budget as a placeholder. That number alone will drive the deficit up to over half a trillion dollars. The President's budget also omits the cost of extending the tax cuts, the 2001 and 2003 tax cuts, which disproportionately favor those who need those tax cuts the least.

Let me just cite two very troubling aspects of a budget that is shot through with scores of troubling aspects. The first is one that is of particular importance to my home State of New York. We have been fighting, those of us in New York, and this fight has been led primarily by CAROLYN MALONEY and also VITO FOSSELLA and JERRY NADLER, to see to it that the brave Americans who responded to the site of the World Trade Center, first to try to rescue people, then to recover bodies and then to clean up what came to be known as "the pile," some 70 percent of them are suffering from various health ailments relating to the toxins that they were exposed to in the days immediately following those attacks on the Twin Towers.

In the current year, the Congress committed to spend \$150 million to pro-

vide for the ongoing health care needs and monitoring of those very brave first responders and rescue workers. The President's budget cuts that number to \$25 million.

My question for the President is: Have all of these people all of a sudden become well? Have they been miraculously cured? Or, more likely, has the President simply decided that providing health care for these very brave Americans is simply not a Federal responsibility? In either case, I certainly hope that this Congress will do the right thing and restore that funding.

The second has to do with education, particularly access to higher education. In his State of the Union message, the President chided the Congress for not having fully funded his American Competitiveness Initiative. Yet we are now presented with a budget that eliminates two programs for student financial aid that are absolutely crucial for needed students to attend college. One is called Supplemental Educational Opportunity Grants, approximately \$750 million a year, and the other is Perkins loans, approximately \$670 million a year. For those two programs, the President advocates taking approximately \$1.4 billion out of the student loan program, and does so while costs are rising and the ability of students to pay is declining.

How can we have a competitive workforce, how can we have a competitive Nation, if we don't even provide our young men and women with access to college?

Future generations of Americans will pay the price for the President's flawed priorities and more debt as a consequence of his actions. In fact, the debt that will be accrued over the 8 years of the Bush Presidency will amount to some \$3.5 trillion. That is an amount that exceeds the combined debt of all of the Presidents from George Washington through the first President Bush.

Madam Speaker, I encourage my colleagues, I implore my colleagues, to resolve one last time to defeat this budget request from the President and to restore middle-class, mainstream priorities, the very priorities that our new majority has been working on now for the last year.

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HEALTH CARE

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

Mr. BURGESS. Madam Speaker, I come to the floor tonight to talk about health care, which we sometimes do in this hour. It's an important subject, and we are going to hear a lot about this over the coming year. We have got a Presidential election that is now in full throttle across the country.

We just had Super Tuesday, and by a strange turn of events the nominations are not settled and my home State of Texas now next month will, in fact, play a big role in helping select the nominees of the two parties. During this coming month, I expect we will hear a great deal about the plans and visions and the aspirations of the different candidates for health care.

But let's not forget, when we talk about health care, that it is on the floor of this House where about 50 cents out of every health care dollar that is spent in the United States of America today, it is on the floor of this House where that spending originates. I can't help but observe the last speaker who was addressing the House on the subject of the budget was critical of the President's budget, which is his prerogative and his right, but I would remind the previous speaker that it is his party that is in charge, as it was last year, and while it is the President's obligation to present a budget to the Congress every year, it is then the Congress' obligation to work on that budget and pass a budget, which will be voted on later in the year, that either accepts or rejects those proposals put forth by the President.

Indeed, last year, that is exactly what happened. So the budget that went forward last year was not the President's budget, I would point out to the gentleman from New York, but the budget last year was the budget passed by the majority on the House of Representatives floor last year, and the same thing will be true this year. They are in charge. It is their right and prerogative under the rules of the House that they will have absolute authority to create the budget and, as a consequence, those things that are felt to be important are going to be those things that are championed by their side. Those things that are felt to be less important will be those things that are left of the budget. That responsibility lies in the House of Representatives. Under the rules of the House, that responsibility lies with the majority party. Currently, the majority party is the party of the gentleman who just spoke.

So while I appreciate his passion, I appreciate his fervor in talking about the President's budget, I think he would be better served to actually spend some time talking to his leadership about the priorities as they come forward over this next year, because there are some significant problems that faced this House last year that were simply kicked down the road at the end of the year.

In fact, we saw a repeat of that last week. We were obliged to reauthorize the Foreign Intelligence Surveillance Act so that we have the tools necessary, our intelligence community has the tools necessary to prevent terrorist attacks on our homeland security and to help protect our soldiers who are serving in Iraq and Afghanistan. We couldn't do it, so we kicked the can

down the road a couple of weeks right at the end of the year, December.

We were supposed to do something about Medicare because physicians across the country were facing a 10.1 percent reduction in their reimbursement, a 10.1 percent pay cut if Congress didn't act. Well, we did act. We prevented that, but we prevented it for 6 months. Six months. What an insult. What an insult to the physicians of this country who are taking care of our Medicare patients, the patients we have asked them to care for. We couldn't even do our work to give them the certainty of what they would be reimbursed for the next year? No, it's 6 months is all you get, Doc, and then we're going to come back and visit it again. And, oh, by the way, we'll be in the middle of that Presidential campaign by then, so don't expect us to devote much more attention to it in June than we were able to muster in December.

But I digress. My purpose in being here tonight is to speak a little bit about what is going on in the practice of medicine, and, in spite of the fact that I may sound a little bit despondent, I will tell you that I am so optimistic about the world ahead, what the future holds for the young people today who are contemplating a career in health care.

When I was a young medical student in the mid 1970s in Houston, Texas, I could never have imagined that the day would come in my lifetime when a person could, of their own volition, go to the Internet and, with a couple of mouse clicks, find a place that would analyze their DNA and for less than \$1,000 provide them vital insights into their genomic makeup so that they might be forewarned about some diseases, so that they might be forewarned about some conditions and use those tools to help manage their health well into the future.

Now, we hardly know what the results of this type of investigation are going to be. It has only been in the last couple of months, in fact, I think it was Thanksgiving that I read the New York Times article that talked about one of these labs that would provide this service. But who would have thought when I was in medical school in the mid-1970s that this day would have dawned where that information is available not just to the physician, it's available to the patient, to anyone who wishes to go on the Internet and seek out that information, seek out that lab and have that type of analysis done.

Think back on 20 or 30 years ago, a patient went to the doctor, the doctor gave a diagnosis, recommended a treatment plan to the patient, who pretty much had to accept what was given or go get a second opinion. Then, of course, in the late 1990s, and I know this very well because I was practicing actively at that time, render a diagnosis, write out a treatment plan, the patient would go to the Internet and check it out and then they come back

and say, Doctor, this is what you're supposed to be doing. I went to the Internet and read about this.

Now in the 21st century a patient will be coming to their physician and providing genomic information and saying, Doctor, here's what I'm at risk for developing. How are you going to help me keep that from occurring? You know, Dr. Elias Zerhouni, the head of the National Institutes of Health, talks about a world where medicine becomes a great deal more personalized. It's no longer one size fits all, it's no longer just one antidepressant is out there for everyone. It's a much more personalized endeavor.

Because of the ability to know this information about the human genome, it's going to be a great deal more predictive. As a consequence, because of that predictive value, preventive medicine is going to take on new meaning, a meaning that, again, I would have never thought possible early in my training.

Finally, medicine is, of necessity, going to become more participatory. A patient will no longer be just a passive passenger along for the ride on their medical journey. No, they will have to be an active participant in managing their health care from times of health and times of disease.

Medicine is right on the verge of a truly transformational time. You add what we know, what we are beginning to understand and learn about the human genome and look how fast information comes at us nowadays. It is, again, just hard to think that back in the mid-1970s when I was in medical school, Internet, never heard of an e-mail, what's that? And now these are things that we take for granted. To our children, these modalities are simply second nature. They cannot imagine existing for even a day in a world where a cell phone and e-mail are not readily at their fingertips.

The speed at which information comes to us is truly phenomenal and, as a consequence, in professions such as the health care professions, a dramatic effect is going to be felt because of the ability to sort through large amounts of information over a short period of time and to extract data from those large amounts of information.

On the floor of this House, in September of this year, we reauthorized legislation pertaining to the Food and Drug Administration. It was truly landmark legislation. I don't know if my friends on either side of the aisle really recognized how significant that legislation was, because, for the first time, for the first time the Food and Drug Administration is provided with the tools for collecting that type of information and proactively researching that database.

The day may well dawn when a problem like Vioxx is discovered early, early in its release into general use and the types of difficulties that were encountered with that medication several years ago will, in fact, be a thing of the

past. The red flags will be up. The warnings will be there. They will come immediately to someone's attention because of the type of database management that will be available. Truly, we will have a system that is totally interactive. The resultant effect on public health will be profound, because it's not just the side effects and the untoward effects that we are talking about, what if there was an unexpected beneficial effect where, perhaps, more people ought to be offered the benefits of this therapy or this medication.

Certainly, the story that we have learned with the type of medicine, the class of medicine called statins that lower cholesterol, that story has evolved significantly over the last several years. In the early 1990s, a LDL cholesterol of less than 130, you're in good shape. Then a couple of years later, it was less than 100, and now it's well under 100. The numbers to shoot for have gone down because the experience with that medicine, the information and data that has been gathered has pointed the way for physicians to understand that a subsequent lowering of that value will, indeed, protect a person's health in ways that they wouldn't have imagined when those medicines were first released.

Medicine is in a transformational time. Congress is going to have a lot to do with how medicine is practiced and paid for and regulated, not just in the next couple of years, but in the next 20 years, 30 years, 40 years, 50 years. The decisions that we make on the floor of this House today are going to extend far into the future, probably far beyond the lifetimes of many of us who serve in this House today.

But Congress really is not in the business of being transformational. Congress is transactional. We heard that just a few moments ago with the discussions on the budget. What does Congress do? We take money from this group and we give it to this group, and it defines who we are morally if we listen to the rhetoric of the last speaker. But that's what Congress does. We transact, we take money from this group, and we give it to this group. If you will watch the discussion that unfolds on the budget over the next several weeks, that will become intuitively obvious to the most casual of observers.

However, in a body that is so focused on the transactional, is it possible to keep an eye on the transformational and be certain that we don't derail the transformation that is likely to be occurring in medicine today? That's one of the tasks, that's one of the challenges, that's one of the obligations that we have serving in this body.

Now, I would submit if Congress wants to participate in the transformation, if they want to participate in improving health care, they are, in fact, capable of doing so. In fact, Congress could be a partner in the transformation if we can step back from the transactional long enough to focus on

the transformational. This is not just theoretical.

I had an opportunity to speak to Dr. Michael DeBakey, pioneer in heart surgery, a gentleman of great renown. We honored him on the floor of this House with a Congressional Gold Medal earlier this year. I had an opportunity to sit down with Dr. DeBakey. He talked about some of the changes that he has seen in his lifetime. He related how when he was a young man and graduated from medical school and then did his residency at Tulane Charity Hospital in New Orleans, he wanted to go into research. But he knew that in order to have the credentials to go into research he would have to go to Europe in order to obtain those credentials. This was back in the 1930s. Well, nowadays, someone who graduates from medical school and finishes their training and wants to devote a lifetime to research gets those credentials in the United States of America. In fact, other physicians travel to this country, to our hospitals, to our Texas Medical Center in Houston, to our Southwestern Medical Center in Dallas, to our M.D. Anderson Hospital in Houston. They travel to our country to get those credentials because that's where the best science is being done.

Dr. DeBakey reflected what caused the change between the time he graduated in the mid-1930s and what we see now at the end of the 20th century and the beginning of the 21st century. He maintained the cause of that change was the focus and attention, and, yes, the funding that Congress provided to medical research right after the Second World War. Indeed, the funding and the vision of the entire National Institutes of Health was a product of that type of visionary thinking.

So as Dr. DeBakey presented that thought to me, it was with the underscored emphasis that Congress can do this because Congress has done this before. So if we stay focused on helping and protecting and promoting that transformation in medicine, then it is possible for Congress to be, again, a participant in that transformation and not an enemy of that transformation.

Now, I am fortunate, because I did spend a number of years practicing medicine, working one time in a multi-specialty practice, part of my time in a solo practice, part of my time in a single specialty practice, having practiced medicine in several different modalities during my lifetime, it gives me the ability to see things from the provider's side and now to see things from the policy side.

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It is so important that we spend the effort understanding those things that will work and understanding those things that will not work.

I alluded earlier when I first started speaking about the problems that we face because we couldn't do our work in December and we postponed any real reform on the reductions in physicians'

payments that we see year after year. You have seen me put up the posters that detail how hospitals, drug companies, HMOs are paid on a cost-of-living adjusted basis year over year, but physician reimbursement is paid on a crazy formula that reduces and ratchets down reimbursements year over year. That just simply won't work.

When I talk about Congress being a transactional body and that transactional activity being the enemy of the transformational, that is precisely the type of transactional activity to which I am referring.

Think of it. We always talked about the laws of supply and demand. What are we doing to the supply side of that equation if we are actually telling our doctors we don't value what you do, and we don't care about the fact that you take care of our sickest patients, our Medicare patients? That is just not important to us in Congress, and then we underline that by postponing dealing with it for 6 months. Again, an assaulting concept to the doctor who is toiling day after day to take care of the patients that we have asked them to take care of for us.

Another aspect of that activity, as the year wound down last year, was the attempt to attach a rather inflexible program of e-prescribing to whatever fix we managed to achieve for the Medicare payment. Now, e-prescribing is not inherently a bad concept.

Madam Speaker, you think about it, I am left-handed so my handwriting has never been good. And then I went to medical school and had to take notes fast, and my handwriting got worse. And then I got old, and my handwriting got even worse. And so it is very difficult to read those handwritten prescriptions that we scribble out quickly at the end of a patient visit. What a benefit it would be to the patient, to the pharmacist, and to the physician to have a method whereby that prescription was shot to the pharmacist via e-mail at the time of the patient encounter. It would save waiting time, no problems with legibility, and there could be computer algorithms that were developed that would prevent a patient receiving a medicine to which they were allergic or which would counteract or interfere with another medicine they were taking. So a good concept. And then like so many things, Congress deals with it in a way that makes it untenable.

The e-prescribing bill introduced by a Senator on the other side of the Capitol, said, Doctor, if you do this, we will provide you a carrot and a stick. The carrot is a 1 percent increase in your reimbursement for taking care of that patient and providing an electronically written prescription at the end of that patient visit. Just 1 percent.

Now I am going to make some numbers up because it makes the math work. In fact, the numbers are probably much lower than what I am going to make up. But assume a physician

working in an average practice in a city like mine sees a Medicare patient, return visit, moderate complexity. Assume they are paid \$50 for that visit. That is actually pretty generous if you look at most of the Medicare fee schedule reimbursement rates. But because it makes the math easy, let's say \$50.

So if that doctor participates in an e-prescribing regimen, what does that mean? It means they get an extra 1 percent. That is 50 cents for those of you slow at math. So that visit is going to take about 15 minutes if you do it correctly. Again, remember it is a moderately complex Medicare patient, a senior citizen. So you get an extra 50 cents if you, instead of writing that prescription by hand, you put it into a laptop or BlackBerry and send it off to the pharmacist electronically.

You can see four of those patients in an hour. If you are really pushing yourself and you have everything firing on all eight cylinders in the office and the front desk and nurses are moving along, you can see four patients in an hour. So four \$50 visits. So that is \$200 reimbursed for that hour's work. That is not the doctor's pay. Don't misunderstand me. He has to pay all of the overhead as well. Nevertheless, during that hour, that physician will generate \$200 in revenue. For that, if they do e-prescribing, we will reward them and give them an additional \$2 for that hour's work.

That is not a great incentive, but let's think about it also from the fact that it is not just one prescription that doctor writes for that Medicare patient, no. The average Medicare patient has three or four prescriptions. So when you figure it on a per prescription basis, the actual benefit to the physician is somewhat less than 10 cents for every prescription that is handled electronically. And it is a little bit more involved to do that. A doctor who is used to writing out a prescription quickly can do so quickly. Typing it into a laptop or BlackBerry is going to take longer, maybe a minute or two minutes. But if you are seeing 30 patients a day, 2 minutes per patient, that adds up to an extra hour, and that extra hour is an hour away from hospital activities, seeing other patients, an hour away from family. It comes from somewhere, because we all know that the hours in the day is a zero sum game. If you take an extra hour, it comes from somewhere else.

So we are going to compensate for that. We are going to pay a little less than 10 cents per prescription as it is written.

What if you don't do it? You say it isn't worth it. You cut my reimbursement every year in Medicare, I have to take on this big expense, I have to learn a new technology, pay the expense of the software maintenance, I am not going to participate.

Well, the bill that was introduced last December, after 4 years' time, would have applied the stick to encourage, again, our physician community

to utilize this technology. And the stick was a 10 percent penalty.

Wait a minute, a 1 percent up tick and a 10 percent penalty. That is imbalanced. Let's go back to our hypothetical return visit, moderately complex Medicare patient, a \$50 reimbursement, 10 percent penalty, that is a \$5 penalty for that visit. And if you are seeing four patients an hour, that is a \$20 penalty for that hour's work. You see the balance. If you do it, we will pay you \$2 because we think it is worth that. If you don't do it, it will cost you \$20.

And we wonder why our senior citizens call up to get an appointment with a physician when they get covered on Medicare and no one wants to see them? This is the way we behave. We cut their pay. We can't agree amongst ourselves to do something rational to protect physician reimbursement rates at the end of the year. And by the way, we want to add this thing on top, this secondary insult on top of the others.

I urge Congress to not focus on the transactional; focus on the transformational. What do you need? If you are going to move from a system we have today, which is based on a written prescription, to a true electronic prescription environment, who do you need on your side on that? I am telling you, if you don't have the doctor on your side, it is not going to happen. Yes, you can frighten and cajole and preach all you want, but it is important for Congress to remember that this transformation will take place faster, with much more expediency, if we will take the time and trouble to instruct, educate, provide for, provide the proper support and proper compensation for our physician community if they undertake it, embracing this type of technology.

One of the things we are going to hear a lot of as we go through this Presidential election year, terms like "universal coverage," "universal access," and they don't mean the same thing, so it is important to spend a few minutes differentiating between the two. We will hear talk about mandates and whether they are a good thing or a bad thing. We will hear "individual mandates," "State mandates," "employer mandates," and it is important to spend a few minutes discussing the differences between those terms as well.

Let's deal with the concept of universality of medical care. That is one that many people in this body and many people on the Presidential trail today say they want to see.

Now, universal coverage, universal access. Universal access, everyone has insurance whether they want to do it or not. It is a little tough to do that in a free society, but yes, we can write laws that can make that happen. See the discussion on mandates in a few minutes. But universal coverage is one of the options available to us.

Universal access would say that everyone has access, everyone has the

ability to go out and purchase an affordable policy. And if they can't afford it, they have the ability to access a funding mechanism that will provide the type of premium support, the type of premium assistance to get them that coverage. And that debate will occur over this next year.

Universal coverage, universal access.

On the whole issue of mandates, and this is an important concept for people to understand, is it better to say this is law, this is something you have to have, or is it better to create the types of programs that people will actually want to have? Let's think about that for just a minute.

What does the term "individual mandates" mean? It means a law is passed by a legislative body, in this case the Federal Government, although it has been tried at the State level. An individual mandate means that everyone has to go out and buy insurance. In my home State of Texas, we have that with our automobile policies now. Everyone has to buy an automobile policy. With an individual mandate, that is how we would achieve universal coverage. You have to buy insurance, and if you don't, there is a penalty to be paid of some sort.

In the State of Massachusetts, in really what I consider a very bold attempt to provide coverage for everyone, an individual mandate was instituted. It hasn't worked out exactly as planned, and some of the difficulties encountered in Massachusetts were cited in California as a reason why that State's plan for universal coverage was recently defeated in the California State Senate. Many people looked at the option, or the requirement, I should say, of buying insurance and said, I don't know. And then remember the law of supply and demand. We increase the demand because we mandate it, you have to do it. What happens? The price goes up, and as a consequence some people looked at that and said, I really can't afford that. I will pay the fine rather than buying the insurance. Truly a perverse incentive.

So some of the support for the concept being talked about in California found itself lacking when faced with that equation in another part of the country. How can you consider putting an individual mandate on when it drives costs up and people find themselves in a position that they would rather pay the fine for not having the insurance than they would to purchase the insurance itself?

When we talk of mandates, and there have been several studies done on this, think back to the 1960s. The United States Congress put a mandate out there that every motorcycle rider in the country would have to wear a helmet. They reversed that mandate and put that obligation, correctly, in the court of the States to make that decision. And the reason Congress reversed that decision was the hue and cry and outcry from across the land from mo-

torcycle riders saying that you can't make me wear a helmet in a free society, and Congress eventually backed down. And so that was kind of an unpleasant experience with mandates.

Most States do have an individual mandate for automobile insurance, and they get good compliance with that. But it is interesting, one of the States with the best compliance has no individual mandate. So mandates don't always equal better compliance, and nowhere is that more evident than our current tax structure.

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The Internal Revenue Service, which collects our taxes, there's a mandate, an individual mandate on every person who earns above a certain income level that you will pay taxes. You will pay a percentage of that in taxes and, in fact, everyone knows, it's no secret that if you don't pay that tax the punishment is going to be sure, it's going to be swift, and it's going to be extremely unpleasant.

We've got 15 percent of the country right now that lacks health insurance. Can we get improvement on that number by putting an individual mandate on?

Look at the case with the Internal Revenue Service. A severe mandate, severe penalties for noncompliance, and what is our compliance rate with the Federal income tax? It's about 85 percent. In other words, 15 percent don't comply. So this requires a good deal more study and a good deal more attention than just simply making that leap of faith and saying everyone needs insurance, therefore, there will be an individual mandate that everyone will have insurance.

Again, there were some problems with the cost structure when that was tried in Massachusetts to the point that the people in California, the State Senators in California, when they looked at that, said, maybe that's not the best idea for us.

Well, once we determine what the overall goal is, then perhaps our path will be a little bit easier. Certainly we want to democratize our health care in a way that preserves choice, makes certain that patient focus is the central theme, and we want to continue to promote innovation, because, remember, America is the country that is known for medical and scientific innovation.

Well, what about the concept of creating products that people actually want? Do we have a model? Do we have a template that we can look at to perhaps discuss that a little further?

And, in fact, we do. We passed a bill on the floor of this House, late in the night of November 22, 2003, called the Medicare Modernization Act which provided for a prescription drug benefit for citizens on Medicare who had not had one previously. It was called Medicare part D.

What's been the experience with Medicare part D? And I will stipulate

that there were people on both sides of the aisle in this House, there were people on the right who were critical of the Medicare part D program, and there was certainly no shortage of critics on the left who were critical of the Medicare part D program.

But as that program was instituted and has now been up and running for over 2 years, what lessons have we learned from Medicare part D? Well, we've learned that more than 90 percent of the persons who were eligible for that coverage have, in fact, enrolled.

Wait a minute. With the IRS, with severe and certain and sure penalties, we only get 85 percent compliance. With Medicare part D, by creating programs that had value to patients we've got 90 percent compliance, and 80 percent are happy with the program. If we go back to our friends at the IRS and say, what's the percentage of people that are happy with the way our tax system is administered, I don't think the number is 80 percent.

Consider that when we passed that bill on the floor of this House in the early morning hours of November 22, or actually I guess it started on the night of November 22. It was in the early morning of November 23 that the bill actually passed. Consider at that time we were told by the best actuaries at the Office of Management and Budget and the Center for Medicare and Medicaid Services that it was going to cost about \$37 a month for that coverage. What has the experience been? The average plan costs less than \$24 a month now, over 2 years into the program.

So this is a Federal program that relies on some competitive forces and relies on some participation of the private sector, and, in fact, has reined in some of the increase in spending that was feared to accompany this program by restoring the savings and incentives and leveraging competition and getting the buy-in from the patients themselves. What would be the more favorable trajectory? Force people into a program, difficult to do in a free society, and your compliance rate may not be exactly what you want it. Or would it be better to create a program of value that also relied a little bit on some competitive forces to keep that cost down.

Now, one of the great debates that was had on the floor of this House a year ago when the current majority party took over was the whole concept of reforming the part D benefit. And we don't hear much about that anymore. They weren't successful. One of the big proponents, or one of the big themes that was proposed was to cause or ask or demand that the Secretary of Health and Human Services negotiate drug prices with drug companies. I will just tell you from a lifetime in health care that HHS or CMS, they don't negotiate prices, they set prices. That's what they do. And many of us on my side of the aisle felt that that would be counterintuitive to the way this pro-

gram was working, and in fact, it was working.

And, you know, Madam Speaker, and this is only partly in jest, but if we wanted to create a program where the head of a Cabinet agency, an agency secretary was to negotiate, maybe we ought to look to the Department of Education and ask the Secretary of Education to negotiate prices with college deans for the cost of higher education. That might be a better trajectory. I'm waiting to see that legislation come forward from the majority.

But, nevertheless, part D was left untouched last January. I'm grateful that it was, and I think again the numbers speak for themselves. This is a template. This is a model, this is a program that we perhaps should seek to duplicate because it created a condition of value, that consumers, that patients, that individuals wanted, and the compliance rates are high. The satisfaction rates are high. And, most importantly, seniors now are getting the medicines they need to keep them out of the hospitals and out of the doctors offices, and the overall cost for delivering Medicare, while it is still extremely high and still likely unsustainable over time, it has at least moderated or ameliorated over the last couple of years. In fact, the trustees' report from June of last year that came out said the bad news is Medicare is still going to be broke. The good news is it's going to go broke a year later than what we told you before. So seeing the beginnings of that cost savings and how that can change the practice of medicine and the delivery of health care in this country, that's a powerful anecdote for people to consider.

One of the things that we talked about is the speed at which information will come to us in the future. And there's no question that it's increasing every day. Most of us wear a BlackBerry on our belt that has more computing power than the big computers on Apollo 13. It's astounding what's happened with computer power over the last two or three decades. And we hear a lot about the improvements of health information technology, the improvements in the platforms and what that improvement can mean to patient care, what it can mean to the practice of medicine, what it can mean to bringing down the cost of medicine. And, indeed, these are powerful influences.

Madam Speaker, I will tell you I haven't always been a big proponent of things like electronic health records. But as my experience on the ground in Louisiana in 2005 and early 2006 taught, getting to visit the medical records room at Charity Hospital shortly after it had been dewatered, I didn't know that dewatered was a verb, but, nevertheless, that's what the Corps of Engineers told us they did, and indeed, these flooded basements were now available for people to go into, the scene in the medical records room, the medical records that were damaged by

the high water, damaged by the chemicals that circulated in that water, the black mold that was going on these paper records made it abundantly clear that these were records that could never provide useful information to a physician or a patient again. And how much more powerful would it have been to have that information available electronically, available to be transmitted from New Orleans to Dallas or Houston or wherever the person had had to travel to after that terrible storm and in the ensuing aftermath. It changed my thinking on electronic health records and electronic medical records.

But I will also tell you, I'm concerned about the Federal Government's ability to create the structure that people feel is necessary for that day to dawn where electronic health records are, indeed, the standard. And I say that because when I came here 5 years ago, the discussion was, the Federal Government is going to create those platforms. It is going to create the software. It is going to create the type of information technology that private industry will then follow the leadership of the Federal Government. And, Madam Speaker, it's 5 years later and we still don't have it.

I did have the opportunity to speak to a CEO of one of the larger insurance companies in this country a few months ago. In fact, he talked at a symposium that was put on by Health Affairs downtown the first of November. He talked about within his company he has 45,000 employees, and fully 15 percent were employed in the development of software. Fifteen percent were employed in the development of that information technology architecture that we all talk about here on the floor of this House. In fact, he said if his software development portion was a stand-alone company, it would be one of the largest software development companies in the United States of America. And yet it is a single branch of a single private insurance company. And more to the point, they had developed algorithms, mostly from financial data, but they had tens of thousands of conditions, medical conditions that they had studied, again using purely financially data, and they had found some things that actually seemed clinically very relevant and certainly important for a company that might be interested in holding down the costs of administering health care. They found that if they paid for A and B, C was very likely to follow, and guess what? They were very likely to have to pay for D, and D cost a lot of money. The example given to me was of treating an individual with a heart attack. If that individual with a heart attack, if they did not anticipate an episode of depression following that individual's illness, it would very likely interfere with their rehabilitative efforts after they got out of the hospital, and so their likelihood of a long term return to health and productivity was curtailed.

And again, they found this by analyzing financial data, that if they put someone in the hospital for a heart attack, successfully treated them, discharged them, but did not anticipate depression, they were very likely at some point to pay for a hospitalization for depression, pay for treatment of another heart attack because they didn't comply with the regimen after they got out of the hospital. Very powerful information. And as someone who spent 25 years in clinical medicine, I will tell you, that's just exactly the type of information that would be extremely valuable to the clinician.

Well, what's the problem? The Federal Government said 5 years ago that it was going to develop the platforms that private industry would then take up and follow, and we haven't done it. And yet here's an individual from the private sector excitedly telling me about what his company is doing and the benefits that they've found. And you have to ask yourself, would it not perhaps be better for the Federal Government to allow that to happen, allow a company to develop that type of software, to develop those types of programs, to perhaps bring the clinicians now and begin to populate some of those fields with clinical data so that they could get even better and more accurate information.

And I asked that individual, well, what would it take? What would you need to see from us to allow this to work better for you? And, no great surprise, he talked about the things that we talk about on the floor of this House all the time. He said, it wouldn't hurt to have some regulatory reform. It wouldn't hurt to have some reform in what are known as the Stark laws that prevent hospitals and physicians from doing too much together for fear of some type of unjust enrichment. We would need some modifications to some of the privacy laws. And at the end of the day, too, we're going to need some safe harbors with liability. But if you provided us that, we could really take this to the next level. And we won't. And yet they're ready to make the investment and they're already making the investment, even without any Congressional activity, because they find it delivers value to their patients, to their physicians and, yes, to their bottom line because they're a profit-oriented company.

What is the difficulty with this body recognizing that that type of activity is going on all around us, and maybe we don't need to reinvent the wheel here on the floor of this House. Maybe we just need to wake up and look around at what is happening literally just across the street.

□ 2030

Now, some of the other things I want to talk about this evening before I run out of time, I have already alluded to the problem with supply and demand in our physician workforce.

Just a little over 2 years ago when he was finishing up his term as Chairman

of the Federal Reserve Bank, Alan Greenspan came and talked to a group of us one morning and the inevitable question about Medicare came up: How are we going to pay for it in the future? What is it going to cost? And the Chairman was concerned as well, but he did say, When the time comes, I think Congress will make the hard decisions that Congress is required to make so that the program will continue. He stopped, and then he went on to say, What concerns me more is will there be anyone there to deliver the care when you need it?

And we've already talked about some of the problems that are inherent in the formula by which Medicare reimburses physicians.

And one of the things I don't think I can stress enough on the floor of this House, because I don't think Members understand this, they think, well, that's just Medicare; that's just a part of the practice of medicine. That's not the whole story. Well, it is about half the story. Actually, the Federal Government does pay for about half of the health care expenditure in this country, if you go back to the first moments of this discussion.

But the other thing is that the rates by which Medicare reimburses for health care informed the rates that are set by the private insurance companies in this country.

So indirectly, we have a system of Federal price controls on medicine in this country today. And that's why, when we ratchet down the reimbursement rate for physicians on Medicare, and everyone in the body is quick to say, Oh, well, doctors make plenty of money. There's no need to worry about that. Remember, also, we are affecting not just Medicare, over which we have jurisdiction, but we are also affecting those reimbursements in the private sector as well because there is not a level playing field between provider and third-party payer. That's one of the problems inherent in our system now. People that go to the physician don't actually pay the physician; they pay the insurance companies. Same with the employers. They don't actually pay the physician; they pay the insurance company.

So that interposition of a third-party intermediary has created a good deal of the tensions and a good deal of the problems that we see today.

But we must not forget, that is a system that is there, that is a system that is in place, and when we make a decision about Medicare reimbursement rates, the ripple effect throughout the health care world in the reimbursement is significant, it's profound, and it is immediate.

One of the things that I feel very strongly about is that we do need to help people know what they're buying and what they're getting in health care. And one of the bills that I introduced early in the first session, the last year of this Congress, was H.R. 1666, which does deal with health care transparency.

It sets a floor of a level of transparency that should be available in every State. Many States have already undertaken this work. My home State of Texas has, and, in fact, patients can go to the Internet to a Web site. It's texaspricepoint.org, abbreviation txpricepoint.org, and they can get information about the hospitals in their county. Most of it is pricing information. Other information, other useful clinical information such as length of stay is also available.

At some point I expect there will also be the transparency about things like complication rates and infection rates, but it's still a work in progress. Other States have done similar activities. The State of Florida with its RxCompare. People can compare prices for different prescriptions, which has been useful for the people of Florida.

What the intent of H.R. 1666 was to not provide a Federal standard but at least to provide a level of transparency below which States should not go. And I would like to see this House of Representatives at some time take on this problem, because I think it is one that is extremely important.

And it does lead in to the other issue of how States and hospitals report complications, such as infections. And, again, I do think there is a role for Congress, I do think there is a role for the Federal Government, not so much in writing that legislation State-by-State, but providing the framework by which the reporting can occur to allow a Federal agency such as the Centers for Disease Control the ability then to aggregate that data and provide useful information back in real-time to the States and to the hospitals and to the physicians about infection rates in their particular areas.

Most epidemiologists will tell you the chance to measure is the chance to cure, or the chance to prevent, in the case of infections. And the metrics, just the activity of undergoing the metrics in those conditions, will often-times lead to improvements that were unanticipated at the beginning of that program of metrics.

Other legislation that's out there that deals with our physician workforce, H.R. 2583, H.R. 2584, both bills designed to affect individuals earlier in their career, in the health care workforce even prior to the entrance into medical school, the ability to provide a little bit more flexibility and a little bit more balance in the health profession scholarship, a little bit more flexibility in loan forgiveness and tax incentives for individuals who are going to medical school and will agree to practice in medically underserved areas in high-need specialties, and that is essentially primary care, also fields like OB/GYN and general surgery, to provide a little bit more flexibility to help incent people who are willing to make those types of decisions. And there is significant lifestyle decisions that they are making to undertake those type of careers.

And then there's another program to increase the number of primary care residencies that are available, again, in high-need areas, medically underserved areas for specialties that are in high demand, and, again, we are principally talking about the primary care specialties.

The barriers for entry for a medium-sized to moderate-sized hospital to start up a residency program are essentially costs. And some of those start-up costs in this legislation can be provided for in a loan. And there will be a loan that is paid back so that money will recycle, and the overall return to the taxpayer is increased that way. It will allow those hospitals the ability to set up a residency program where none has existed in the past. And I can think of many, many hospitals in my home State of Texas that could benefit from that type of activity.

And one of the things when people study how physician manpower is distributed, you can say a lot of things about doctors, but sometimes we are not very imaginative and we don't tend to go very far from where we trained, and there are some valid reasons for that. You get comfortable with referral patterns. People know you from your training program, so they're apt to refer to you. There's a degree of comfort there. And myself, for example, I went into practice less than 25 miles from where I did my training. A lot of doctors do follow that same sort of trajectory.

So if we can move the training programs into the areas that need the physicians, it may then follow that those physicians who train in those programs will end up staying in those medically underserved areas.

It's difficult for me to come to the floor of the House and talk about things related to health care and at least not mention some of the problems that we face with our medical justice system in this country. And I know there are lots of people out there with a lot of different ideas, caps on non-economic damages, medical courts, early offer arbitration. The time has come for us to have a serious discussion to put some of the partisan differences aside, to put some of the special interests aside and have a rational discussion about how we can meaningfully impact that problem in this country.

My home State of Texas passed rather significant legislation 4 years ago dealing with the issue of caps on non-economic damages. It was patterned after an earlier California law, the Medical Injury Reform Act of 1975. It was passed out in California, which put a \$250,000 cap on noneconomic damages. The Texas legislation was a little bit different. Instead of a single cap, there were three different caps, each capped at \$250,000, but the aggregate was \$750,000 compensation available for noneconomic damages. It has worked very well in my home State of Texas.

The year that I left practice to come to Congress, we were in crisis. We had

gone from 17 medical liability insurers down to two. You certainly don't get much in the way of competition when you only have two insurers, and as a consequence, the price for those premiums was ever escalating. Now we have had many insurers come back to the State. They've come back to the State without an increase in premiums. And, in fact, Texas Medical Liability Trust, my last insurer of record, has returned, the last time I checked, 22 percent reductions and dividends back to their physicians that they cover. And that's significant because, remember, these premiums were going up by 10, 15, 20 or 25 percent year over year, and then on the past 4 years, they've not only stabilized, but they've come down 22 percent.

Small and medium-sized hospitals that self-insure for medical liability have had to put less in reserve against a bad judgment, and as a consequence, there has been more money to spend on just exactly the kinds of things you want your community hospital to be spending its money on; things like nurses' salaries, capital improvement, investing in their capital infrastructure.

So it is a good news story from the State of Texas in terms of what we've been able to do with liability in my home State, and I'm not going to say that's the only answer, but I think it is a very good answer. I introduced legislation, H.R. 3509, to essentially provide the Texas legislation on a national scale.

In fact, we had a lot of talk about the budget earlier tonight. Last year, I offered that bill to the Budget Committee because the Congressional Budget Office scored it as nearly a \$4 billion savings over 5 years. I realize that's not much when you are talking about a \$3 trillion budget, but that's \$4 billion. That's a significant savings, and I was willing to donate that to the Congress.

Take up that concept, write it into law in your budget resolution, and let's get something done to stabilize medical liability prices in this country, not so much for my home State of Texas, as we've already done it. But what about Pennsylvania? What about New Jersey? What about Maryland? What about New York? Maybe those areas could benefit from some of that same type of thinking as well.

Well, suffice it to say that that concept was not accepted, but I will extend the offer to members of the Budget Committee on both sides of the aisle that \$4 billion in savings is still available to you. H.R. 3509 is the bill, and I will be happy to relinquish all ownership rights and donate that to the greater good of the United States Congress and the people of the United States.

One last piece of legislation that I want to mention, and it was introduced right at the end of the year, H.R. 4190. We talk on the floor of this House a lot about the problem of the uninsured. In

fact, I've spent some time talking about it this evening.

H.R. 4190 isn't a new insurance program. It isn't a new expansion of Medicare or Medicaid or SCHIP. What H.R. 4190 does is take the concept of being uninsured and extend that privilege to everyone who serves in the United States Congress. H.R. 4190 would remove us, as Members of Congress, from the Federal Employee Health Benefits plan, provide us a voucher, if you will, to go out and purchase insurance on the open market. And I can't help but think, if we were put in the position of many Americans who are faced with those decisions about having to buy health care coverage on their own out in the open market, perhaps we would get a little more creative about the unequal treatment from the Tax Code for employer-derived insurance versus an individually owned policy. Perhaps we would get a little bit more creative about providing a little more flexibility in a health savings account.

Perhaps we would get a little bit more flexible even if we are of the mindset that said, Well, we are going to extend our single-payer health care to more and more people. Well, what if Members of Congress had the same problem finding a doctor that your senior citizens at home tonight are having when they call up the doctor they've seen all of their lives and are told, Sorry, we can't take any more Medicare patients?

Well, H.R. 4190 is an intriguing concept. I haven't had much interest as far as cosponsorship is concerned, but it's still out there. It's still available, and I welcome Members from both sides of the aisle to think about that, to look at that, and see if we couldn't forge a common bond and a good-faith effort to really do something for the people who lack insurance coverage in this country or the people who are fearful that they will lose their insurance company if their job changes or their financial situation changes.

There's a lot of things out there on the horizon, Madam Speaker. There is a lot of good that this Congress can do. I think it is important for me to make the point one last time that medicine is evolving in a big way. It's going to change significantly in our lifetime.

□ 2045

Congress can participate in that evolution, and actually participate and be a force for good if we're only willing to pick up and take on the work that the American people have sent us here to do.

Thank you, Madam Speaker, for your indulgence.

30-SOMETHING WORKING GROUP

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