went back into the district, and they said, Congressman, we're doing fine. Everybody is back to work. We're going to work our way out of this, and we're going to end up being a much stronger company in the long run. That is the magic of the free market, Mr. Speaker, and that is exactly what we are talking about here tonight.

I commend MICHELE BACHMANN for her wisdom in presenting this, and I yield back to the gentlelady.

Mrs. BACHMANN. If the gentleman would yield, what you're talking about with Pilgrim's Pride, the great chicken producer in your district, that could have been done by our car manufacturers here in the United States without one dime of taxpayer money going into the auto industry.

I sit on the Financial Services Committee. We had the Big Three automakers in front of our committee, and I asked that question when the gentlemen were there. I asked, ''Wouldn't bankruptcy protection be your best friend? It would shield your company from further legal liability, and it would allow you the freedom to restructure your contracts and to restructure your organization.'' That would have been a great tool that would not have cost any money.

Unfortunately, our President has made a decision to take the most expensive and the deepest government intervention route that we have ever seen in the history of our country. My fear, Mr. Speaker, is we will never again see a free car manufacturer, an American-made car manufacturer, in the United States. Is there any industry that thinks, once the government gets its fingers at the level where it approves your business plan and then backs up the warranty of your product and decides what your product will be and who the purchasers of your product will be, that the government will ever get out of the car business? At that point, what are we going to have left to buy—pogo sticks?

We are not going to have much of a car industry left once the United States Government gets done with it. It's kind of like free health care. We will never see more expensive health care than when the Federal Government gets involved.

Mr. GINGREY of Georgia. Well, if the gentlelady will yield, she kind of perked my interest a little bit there as she was starting to talk about health care.

Mr. Speaker, you know I am one of the physician Members of this body, and have practiced a long time—delivering babies in Marietta and in surrounding counties—and I am so glad that health care has been brought up tonight because the President just feels like government-run programs work better than the free market. We are on the verge of seeing Hillarycare all over again. I don't want to totally shift gears here on this subject, but it is such an important point, Mr. Speaker.

We don't necessarily try to say that the free market system of health care is perfect or that we don't need to do some things to try to get the 47 million or so who are uninsured in this country health care that is accessible and affordable and portable, that they own, where they can control their own destiny and where we can encourage them to adopt wellness policies regarding their own health.

□ 2200

That is a subject maybe for another hour, and I will yield back to the gentlelady from Minnesota.

But clearly, we Republicans, the minority party, feel that the marketplace is the best place to solve these problems. And I don't want, Representative BACHMANN doesn't want, and nobody in this Chamber should want government motors.

Mrs. BACHMANN. I thank the gentleman and thank you for this time.

We yield back. Thank you.

## REPUBLICAN CONGRESSIONAL HEALTH CAUCUS

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 2009, the gentleman from Texas (Mr. BURGESS) is recognized for 60 minutes.

Mr. BURGESS. Mr. Speaker, I am coming to the floor of the House tonight to talk about health care. We had the occasion this morning over in the Library of Congress to have the first forum from the Republican Health Policy Caucus. This will be the first of several that we will do over the coming months. Obviously, health care is going to be a subject that receives a lot of discussion and a lot of debate, as it should. It's an important topic, and it is going to occupy a great deal of Congressional attention.

Let me just speak a little bit about the Caucus, and then I want to talk about the event that occurred this morning.

The Congressional Health Caucus was founded at the beginning of this Congress, the 111th Congress, and it was formed with several purposes in mind. It is a caucus on the Republican side, it is to educate members and their staff on the issues surrounding health care policy, and certainly, Mr. Speaker, the purpose of the caucus is to equip those same members with the resources for fostering debate and, of course, ultimately serving the American people with the most effective policy. It is designed to help members and their staffs communicate effectively, and we do welcome debate. It is not a closed-end caucus. Certainly we welcome a variety of members.

And perhaps one of the most important things that this caucus can do, this is an inclusive caucus. It does include members, is open to any member on the Republican side—I actually thought about the possibility of a bipartisan caucus but there wasn't much interest in that. But nevertheless, from our side of the aisle—and certainly we've had discussions with members of the other body as to whether they might be interested—but the idea is to have an inclusive discussion on the things surrounding health care reform.

But perhaps one of the most important things that I envision—one of the most important roles that I envision for this caucus is to take the discussion beyond the Capitol, beyond Washington, beyond the Beltway, the Potomac and all of the accoutrements and all things that are Washingtonian and speak to those patients, those doctors, those nurses, those hospital administrators who are actually doing the work in the trenches day in and day out and are actually looking toward Washington and wondering just what it is that we're up to now because, of course, some of them have seen this before. And it caused a great deal of disruption within the medical community some 15 years ago. They didn't see much that changed that was positive. Perhaps we allowed HMOs to get a more greater foothold in many markets across the country after the failure of the plans of health care reform 15 years ago.

So there is a great deal of interest but also a great deal of skepticism as people who work in the field—again, the doctors, the nurses, certainly the patients and their families, certainly the hospital administrators, people who work day in and day out delivering health care to our patients, our seniors, our youth, our families—there is a great deal of skepticism about what they see going on in Washington right now.

Well, in pursuit of those goals that I outlined, the events and resources provided by the caucus will be designed to prepare members to engage intelligently and effectively during this debate that we're going to see over the next several months and then beyond that. Whatever policies are arrived at or not arrived at, it will be the implementation of those policies, it will be the forward activity that occurs as a result of enactment of sweeping health care reform or the failure thereof.

Remember back in 1993 and 1994 when the bills did not get out of the—the bills did not become law, what was the focus then of the United States Congress on health care going forward? What type of attention was paid? It will be the purpose of this caucus that regardless of what happens, whether reform is enacted or not, that we will not take our eyes off the ball, and we will continue to be vigilant for the sake of the American people.

Now, Mr. Speaker, for reasons that I don't quite understand, I was invited down to the White House a couple of weeks ago to participate in the White House forum on health care reform, the White House Health Care Summit, and the President, in his remarks to us as the afternoon was concluding, was that it was his job to offer guideposts and guidelines, but principally he was there that day to try to find out what works.

And to that end, I applaud the President for having an open mind and having a willingness to listen to a variety of points of view. And I intend to be a resource. I intend to help him find out what works.

Yes, I have some ideas. They may not be mainstream Democratic ideas, but nevertheless, certainly they deserve some consideration. And many Members on both sides of the aisle have ideas, and we saw this very much in evidence in the break-out session that I attended.

One of the concerns I had with going down to the White House that day—was I just another pretty face to be down at the White House? Had this reform bill, in fact, already been written, was it just basking up in the Speaker's office awaiting for the correct time to be visited here upon the House floor and then we would all vote on it—much as the children's health insurance program bill, the reauthorization for that bill, came forward in August of 2007?

Well, is this bill already done? The President assured us it was not, that this would go through regular order, that he would look to the congressional committees and subcommittees to hold hearings to do the work to draft the legislation, to mark up the bills and do so under so-called regular order.

So I take the President at his word that—in fact, we're having a number of hearings in my subcommittee on health in the Energy and Commerce Committee, and I welcome that because I think these are important discussions for us to have.

But the American people also feel that Congress should do its work in the appropriate way and not just simply allow a bill to be crafted out of the public domain and arrive fully formed from the Speaker's office and come to the House floor. But the public expects us to have the debate, to have the discussion, to work on this bill in a bipartisan fashion.

Congress, in undertaking this project, must focus on solutions and not politics, and that's going to be very difficult for some of us to do. And, in fact, the later it gets in the 2-year cycle that the House lives with, the more difficult it is to separate politics from solutions. But still, we need to rise above that and work on those solutions, long overdue solutions, and focus on what is good for the American people.

We need to keep the idea of patients and not payments uppermost in our mind.

Now, the membership in the Republican Health Care Caucus is open to all members of the House Republican conference and their staff. We will host regular briefings and forums for members and staff as well as providing timely resources. This was the first today, the first policy forum that the caucus will host, and we were very fortunate. We were joined by three wonderful panelists whose ideas were not necessarily in concert with mine. Some I agreed with, some I disagreed with, but it was food for thought and very thought provoking; and I certainly learned some things as a result of the conference that we held today.

There will be a follow-up document that will be posted on the caucus Web site. It's actually a tab that can be accessed through my official congressional House Web site that's Burgess.House.Gov, and there is a health care caucus tab that's pretty easy to see when you first go to the page and, in fact, by clicking on that page, there is the opportunity to visit a—we simulcast this on the Web and the archive of that simulcast is now available on the Web site.

In fact, we did—to show that we were well into the 21st century, we took some questions from the audience and we took some that were sent to us over the new media phenomenon known as Twitter. So people outside the Beltway were able to send in questions which could then be posted to the panel. And I think that made for, again, a pretty lively question-and-answer period after the presenters did their formal preparation. We left about half the time for question and answer and again, not all of it came from the audience—or the physical audience—some came from the virtual audience that was watching on the web and sent their comments or questions in through the phenomenon known as Twitter.

So we came together actually in response to President Obama's desire to learn about what works. And with our assurances from the majority party that they are willing to work with Republicans as long as we negotiate in good faith, okay, great, and we wanted to get some ideas on the table, and I think we accomplished that this morning.

We had several questions that we put forth as we started the forum. We wanted to hear about what is being talked about as a so-called public health insurance option, the so-called government-run option, what the President's proposal for a government-run option could mean for health care in the future, what effect would this have on patients, what effect would this have on doctors, what effect would this have on the private market; and indeed, what effect would this have on those already-existing public programs such as Medicare, Medicaid, and SCHIP.

We heard testimony relating to what is called a National Insurance Exchange, a so-called insurance connector that can bring people and insurance policies together, and what are the good things about an insurance connector and perhaps what are some of the drawbacks of an insurance connector.

And we did hear discussion about what has been proposed as a national health board, a Federal-type of Federal Reserve board that would apply to health care and would this board have—how much power would it have, how much ability would it have to direct medical spending and medical decisions. All very important concepts that are all outlined or have been part of the discussion as far as what might be contained within the President's plan.

Just off the subject for a moment. During the fall, I had an opportunity to hear about the President's plan in a variety of cities across the country in a series of debates that were held during the presidential election, and I got fairly familiar with what was being talked about on the other side as far as the concepts embraced by then-presidential candidate Barack Obama as far as what his ideas were for health care reform.

It is interesting, now that we're out of the campaign and into the legislation part, some of the things that we heard a great deal about during the fall, we don't hear about so much any more. And in fact, some of the things that were vilified on the other side are now perhaps being embraced as ideas that are worthy of study and worthy of merit.

Specifically, during the fall we heard a great deal about a mandate for children, all children should be covered. I never could get a definition of what is a child. Is that a person who is under the age of 18, 19, 25, or 30? And I heard all four ages mentioned at some point during the debates.

Well, the mandate for children seems to have gotten lost in the translation. We expanded the State Children's Health Insurance Program in January. So I guess the assumption is that that box is checked and we have moved on to other things.

The National Health Board received a lot of attention during the fall. It remains to be seen how big a role that will play in whatever legislation is going to be written, and certainly the concept of a public option was one that was out there and discussed at great length during the presidential debates of last fall.

The public option plan, I can recall several statements that this would be a plan for people who right now lack health insurance, the so-called 40 or 45 million of individuals in this country who lack the benefit of health insurance, and that everyone should be given a plan just as good as a Member of Congress. So that would be the Federal employee health benefit plan option, which is a fairly expensive way to approach that.

Now, faced with the reality of what are some very significant budget deficits stretching ahead of us before we even get to anything beyond the preliminary discussions of health care reform, perhaps that is going to be, of necessity, be scaled back just a little bit and perhaps that public option, that government option, is going to look more like Medicare or perhaps even more like Medicaid going further into the discussion.

□ 2215

But it remains to be seen because that part of the story has not been written, but I bring it up because it's significant and it behooves people to pay attention to what those discussions are because it makes some difference.

We have had multiple hearings, as I mentioned, in our Subcommittee on Health in the Committee on Energy and Commerce. We have multiple panels who will come and discuss various aspects of health care reform. We have Democratic witnesses. We have Republican witnesses. And out of perhaps somewhere between 10 and 15 witnesses that we have had come before our committee, I've only found one witness who would be willing to exchange their health insurance that they have today for a program such as Medicaid if that were to be the government-run option. Almost every other panelist who's come before us, whether it be Republican or Democrat who's presenting to the panel, has no interest in substituting their health insurance for a Medicaid-type program.

Mr. Speaker, in fact, during the debate on the rule in Rules Committee leading up to the State Children's Health Insurance Program expansion, I offered an amendment in Rules Committee to allow Members of Congress the option for signing up for Medicaid as opposed to some of the other insurance products on the Federal Employee Health Benefits plan. Needless to say, that amendment was not adopted and received very little interest when I brought that up to the Rules Committee.

But it brings up the point, if we're not willing as Members of Congress or the people who testify before our committees are not willing to take on a public option program, a government-run program like Medicaid for their health insurance, well, what does that say about what we are making available then to people who currently are covered under Medicaid and people who are currently uninsured who may be offered a government-run program if it is made to look very much like Medicaid looks today?

I think we have a long way to go to fix some of those programs. Certainly, both Medicare and Medicaid have some significant problems. There are significant problems with finding providers. There's a significant problem that the funding for those programs falls far short of what it needs to be, and as a consequence, the private insurance in this country subsidizes or cross-subsidizes the Medicare and Medicaid programs to a significant degree, such that if you lost the option for private health insurance in this country it might be very very difficult indeed to pay for those public, government-run programs that are in place today.

But I have gotten a little far afield. Let me bring it back to the things that we had before us in the forum this morning.

We heard testimony on ways that our current system, public-private hybrid system, of insurance can be improved, and we heard about lessons from the States, lessons that we might look at very closely when we're formulating public policy. After all, in medicine we're always told you need to practice evidence-based medicine. You need to look at randomized clinical controlled, clinical trials before you make a decision about what to do.

Well, if that's good for America's physicians and America's patients, might that not also be good for America's policy-makers? Should we not also ask ourselves what is the evidence for the best policy? In other words, can we practice evidence-based policy here in the House of Representatives, the same as we ask our physicians to practice evidence-based medicine?

So, we are fortunate the States function as laboratories, as the Founding Fathers envisioned, and we did hear some testimony on lessons from the States.

And then finally we heard about proposals for a consumer-driven, market-based approach to reform that really may hold out a great deal of promise as being the most affordable of all of the options that were out there.

Our first presenter this morning was Dr. Karen Davis from the Commonwealth Fund, which is a private foundation that aims to promote a high-performing health care system that achieves better access, improves quality and greater efficiency. Dr. Davis has a Ph.D. from Rice University, the recipient of many accolades, the author of many books, and we were very, very fortunate that she was willing to come down from New York and participate in the forum this morning.

Dr. Davis talked a good deal about some of the problems that we have in our current system, and she spent a good deal of time discussing payment reform as a component of health care reform. Payment reform might reflect a new concept. The Medical Payment Advisory Commission, MedPAC, has talked about a concept called bundling, where we don't actually pay for individual treatments but that we bundle these services, doctor, hospital, laboratory, and there is a payment for an episode of care rather than a doctor billing for the doctor services, the hospital billing for the hospital services, the laboratory billing for the laboratory services. So there's more of a global fee, if you will, but bundling is even perhaps one step more than a global fee.

And one of the concepts embodied therein is that perhaps there would be a payment for an episode of care that would comprise a period for as long as a month, because some of the really difficult payment difficulties we get into, in Medicare in particular, result from patients who have to come back into the hospital after being released, and those rehospitalizations tend to be very expensive. And so this was a way to bring that type of expenditure under control.

Another concept that was discussed was a concept called gain-sharing; that is, if a medical group, hospital and doctor group could devise a method of delivering care in a more economic way, that part of the savings that that doctor group and hospital was able to demonstrate, part of that savings then could be shared with the medical group, the hospital that was involved in that episode of care.

These are concepts that are—they have been tried in some demonstration projects. To be sure, there's some difficulties. Emotionally, I have some difficulties when we talk about bundling a doctor's payment with a hospital payment. Quite honestly, doctors don't trust hospitals and hospitals don't trust doctors, so there are some barriers to overcome there.

The concept of gain-sharing, certainly if we're going to ask physician friends to do things smarter, cheaper, faster, perhaps we can include them in whatever benefit accrues to the government, i.e., the Medicare system. Perhaps we can include them in the distributional aspects of that.

Dr. Davis did talk some about the concept of a health care connector or an insurance exchange, the advantages there that you bring together the patient and the insurance policy. Particularly for someone who doesn't have employer-sponsored insurance, it can be a confusing array of products that are out there, particularly now if we're going to have a government-run option out there. A public plan, a public government-run plan out there, perhaps an insurance exchange may be a way to bring together the patient and the insurance company.

So, to be sure, there's some people are skeptical of exchanges. The current experiment going on in the State of Massachusetts points out some of the benefits but also some of the pitfalls for insurance connectors and insurance exchanges.

Part of the difficulty that has been discussed about is, is there an inherent conflict of interest having an umpire also play for the home team, and therein is the problem with the combination of a public, government-run plan and an insurance connector. The insurance exchange is going to set the rules by which coverage must be sold. It's going to set the rules as far as pricing is concerned, and oh, yes, it's also a competitor because the government-run option is going to also be part of that exchange.

But nevertheless, all of these are ideas that are worthy of discussion because the concepts going forward, we need to have the discussion on these. We can't just accept them as good ideas because someone else thought of them, and it's a way out of our conundrum with the uninsured and it's a way perhaps to control costs, but certainly, these philosophies need to be fully vetted.

We were then very fortunate to be joined by Dr. Merrill Matthews, who's the director for the Council of Affordable Health Insurance, and this is a Washington, DC-based research and advocacy organization promoting free market health insurance reform. Dr. Matthews earned his Ph.D. in philosophy and humanities from the University of Texas at Dallas.

Now, Dr. Matthews had a very interesting discussion for us. He focused more on what was happening with the role of the States and brought to us current examples of six States that are doing things. Some are working well, some not so much, but nevertheless, the President did, in his charge to us as he finished up that day at the White House, he said, I want to learn from what works. And Dr. Matthews brought to our policy discussion this morning six examples of things that are going on in States around the country and how those might deliver to us ideas that may be worthy of study or ideas that perhaps deserve a great deal of scrutiny because they've already been tried somewhere and they're not working so well.

The first State that Dr. Matthews mentioned was the State of Georgia. Georgia, of course, has a State income tax, and he highlighted the role of the tax system in providing for health care for the citizens of Georgia. A State tax credit for qualifying employers that offered health savings accounts and high deductible health plans was available. So an employer could get a tax credit off of their State income tax for offering a high deductible health plan or a health savings account, and for individuals, also, there was a State tax deductible for individuals purchasing health insurance, which begins to remove a little bit of the discrimination against an individual holding an insurance policy. But apparently, the preliminary results of Georgia are encouraging, and certainly that points the way to some discussion of some changes within our Federal tax code that may be more applicable to the national stage.

The State of North Carolina really highlights the need and the benefits of having a robust safety net for patients who have a preexisting medical condition. This is always a great fear that people have, what if I lose my employer-sponsored health insurance, I can't keep up with the COBRA payments, I'm diagnosed with some serious illness in the meantime, and then I am thereafter uninsurable and will remain uninsured until I can get taken on a Federal program such as Medicaid or Medicare. North Carolina has now a program to deal with those individuals who, because of the condition of medical fragility, are uninsurable by really fine-tuning the State high-risk pools.

This requires an assessment from the health plans that sell in the State. So each of the private entities are asked to contribute to the overall maintenance of this high-risk pool. To be sure, there is a sliding scale, Federal subsidy, State subsidy that can be made available, but it certainly shows with a little bit of planning and a little bit of willingness to work between the public and private sector that individuals with preexisting conditions do not need to be shut out of the health insurance system. There is a way, indeed, to provide insurance and bring people back into the fold.

Dr. Matthews talked about the State of New Jersey and how New Jersey has some of the highest health insurance premiums because of various requirements on policies in New Jersey and how just across the State line in Pennsylvania the health insurance premiums are significantly lower. So, within the State of New Jersey, legislation has been introduced to allow individuals to purchase insurance in adjoining States, insurance that is under the control of the insurance commissioner in those States, that has been fully evaluated and vetted, but at the same time has relief from some of the mandates that drive the cost up so very high within that individual's home State.

□ 2230

Certainly, this is a concept that is worth exploring. And it will be interesting to see if this legislation is indeed enacted in New Jersey and, if it is, how does it fare for allowing more people to use their own money to purchase insurance when the cost is not set arbitrarily so high that it is beyond their ability to pay.

Dr. Matthews also talked a little bit about what's going on in the State of Florida. Florida also highlights the issue of cost. They have required from the insurance companies within the States to sell insurance to anyone—the so-called guarantee issue—but it does focus on catastrophic coverage that is the high-deductible, low-premium type of insurance.

Again, it will be interesting to see if this does indeed bring more people into a condition of coverage and remove those individuals from the ranks of the uninsured.

Tennessee had an example with TennCare where virtually everything was offered to everybody for almost nothing. It really put severe financial constraint upon the State. So the Governor has now outlined a new plan—it's called Cover Tenn, which is a much more limited benefits plan. The premium is $150, which is split three ways—the individual, the employer, and the State all paying a share. There is a significant focus on preventive care and routine screenings.

Somewhat controversial, there is a benefit cap. Benefits are capped at $25,000 dollars, which may seem like this is not providing enough care but, in actuality, only four out of several thousand people covered under this program have actually hit that ceiling.

Clearly, this is a work in progress and this will have to be monitored. But it certainly shows we always talk about we need more preventive care, we need more disease management, we need medical homes so those so-called low dollar-expenditures you can make in health care perhaps, perhaps can deliver a significant benefit and prevent some of the high expenditure situations that people encounter.

Finally, Dr. Matthews talked about what's going on in the State of Arizona where a State initiative has been in place that sort of deals with the issue of personal freedom. You can choose to have insurance or you can choose not to. It is important. It is not forcing someone to pay something that they don't want or feel they don't need.

Now that initiative was put forward in the Arizona legislature. The initiative failed. But it's likely to see some additional activity in the coming legislative session.

So those were the ideas brought to us by Dr. Merrill Matthews, who is, again, from the Council for Affordable Health Insurance, and certainly showed how the States can function as laboratories in the concept of creating new ideas in the arena of health reform.

Finally, we heard from Dr. Grace-Marie Turner, the president of the Galen Institute, a public policy organization that promotes an informed debate over free-market ideas for health reform. Perhaps one of the most impressive statistics that Grace-Marie Turner has brought to the discussion is the percentage increase—the cost increase for regular indemnity insurance, the cost increase for PPOs, the cost increase for Medicare and Medicaid has all been 6 to 7 percent a year, well ahead of inflation, and it is that cost driver that is pushing the affordability of insurance past the reach of many patients.

With so-called consumer-directed health plans or consumer-directed options, high-deductible health plans, the actual rate of increase is 2¼ percent. So about one-third of what it is for the public plans and the indemnity plans and the PPO plans.

If indeed we want to find out what works and if indeed affordability is an issue, and I believe that it is because affordability is what is preventing many people from actually being able to afford or buy insurance, then why wouldn't we look at this type of data and why wouldn't we look at expanding, as Florida has done, as Arizona discussed doing, why wouldn't we look at expanding these so-called consumer-directed options that clearly the price goes up at a level much more in line with inflation and the consumer price index and not two to three times that level.

So certainly Grace-Marie Turner brought some good ideas to the forefront. She did talk about there being a climate for innovation that is pervasive and the fact that everyone is talking about health care, everyone is talking about how do we reform and improve the system. So that climate for

innovation is one that we should embrace and capture and utilize, not for political advantage, but for the advantage of, after all, the person who should be at the center of all of this is not an insurance executive, it's not the Secretary of Health and Human Services. The person at the center of all of this, ultimately, is the patient and their family.

Now, Mr. Speaker, just to depart for a moment, I've spent a lifetime in health care and I know very well that you look at this vast machine that we call the American health care system and what is it that we produce, what is the widget that the American health care machine churns out at the other end?

Well, the widget is the interaction that takes place between the doctor and the patient in the treatment room. It may very well be the operating room or the emergency room or the delivery room. But it is that fundamental action that occurs between doctor and patient.

So when I think of things that deal with changing health care and how it's delivered in this country and how doctors are paid and how patients are cared for and how insurance companies are structured, you have to look at that fundamental interaction between the doctor and patient in the treatment room and does this change that we're talking about, does it bring value to that interaction or is it perhaps somehow injurious to that interaction.

If it brings value then it really doesn't matter to me which side of the aisle the idea came from; it is one that is worthy of merit, it's worthy of study, it's one that perhaps is worthy of inclusion in whatever we eventually do in health care reform.

On the contrary, if what we are proposing to do detracts from the level of value of that fundamental interaction between doctor and patient in the treatment room, then we have got to be very, very critical, very, very serious about how we look at that because, after all, if we devalue the interaction between the doctor and patient in the treatment room, ultimately we devalue the experience for the patient and ultimately we are causing more stress and more harm to the system.

As we've talked about a number of things this evening and when Dr. Matthews was talking about his experience with the several States, I couldn't help but think of what has gone on in my own home State of Texas in the past 5 years since September of 2003, when the State passed what was then a very innovative, very forward leaning, extensive medical liability reform that really has been a game changer back home in Texas.

When I ran for Congress in 2002, Texas was in the middle of a very serious medical liability crisis. We were losing medical liability insurers. They were leaving the State because the State's environment was so hostile. They were losing money so they left the State. We went from 17 insurers down to two in a very short period of time. I promise you—you don't get many competitive influences when you have only got two insurers out there writing medical liability insurance.

Medical liability insurance was going up and up and up. Even for physicians who didn't have a claims history, just because you were practicing medicine in Texas, you were a significant risk to that insurance company. As a consequence, doctors all across the State saw their premiums go up, and some doctors simply could not find insurance at all, at any price.

I talked to a number of doctors that year I was running in 2002 who had just simply left practice or never were able to start their practice and were just out of school and unable to set up their practice in their home State of Texas because the medical liability climate was so severe that insurers were not willing to write them insurance policies at any price.

The whole trauma network in the Dallas-Fort Worth area was brought down by the fact that one of the neurosurgeons got his premium bill to re-up his medical liability premium, looked at the six-digit figure and said, That's it. I can't do it any more. I can't earn enough money to pay this bill, and I will have to leave the State.

When that happened, about 50 percent of the neurosurgeons then were gone from the trauma system, the trauma network in north Texas, putting that trauma network in serious jeopardy. How were they going to provide neurosurgical services 7 days a week, 24 hours a day, when they had but one physician remaining to provide those services?

So we were under extreme stress in the State of Texas in the fall of 2003. Then the State legislature passed a very forward leaning medical liability reform. It was a cap on noneconomic damages. It was a cap similar to the Medical Injury Compensation Reform Act of 1974, which has done such a good job in California, but perhaps modernized a little bit for the 21st century.

The cap was trifurcated; that is, there was a $250,000 cap on the physician, a $250,000 cap on the hospital; and a second $250,000 cap on a secondary hospital or nursing home if one was involved.

So an aggregate cap of $750,000 for pain and suffering. Actual damages, medical damages were not capped in any way. In fact, punitive damages, if gross negligence could be demonstrated, punitive damages were not capped.

What this has done in the State of Texas has been nothing short of phenomenal. We have doctors coming to the State, a State that was losing doctors in 2002, is now seeing more and more doctors coming to the State. In fact, one of the bigger problems we have today is not the inability to find medical liability insurance; one of the bigger problems today is the State Board of Medical Examiners finds itself short-staffed and is having difficulty keeping up with the volume of applications for State licenses that are coming in from other States.

As a consequence, Texas has gone from a situation where we were in fact getting into difficulty. We were in quite a fragile condition from the standpoint of providers. And now we find that that situation has been reversed.

This is such a commonsense application of previous legislation, again, that was enacted out in California over 25 to 30 years ago, that now is working today in its modern iteration in the State of Texas. I've introduced a similar bill in Congress because I feel this is so important to be able to offer this same type of protection to other doctors in the country.

There's no question that the concept of defensive medicine is a real one. When people look at the cost, escalating cost of medical care, one of the problems is that as a doctor you feel like you have got to do every test and every study so that if something goes wrong and you're called into court and that chart is put on the stand with you, that chart is going to be an A-plus and you've done every possible test right down the line and there can be no second-guessing. That's the onus, that's the burden that doctors practice with today in this medical liability climate.

So the idea of being able to relieve some of that pressure from defensive medicine, it won't happen overnight. This will take a significant amount of time to reverse some of these work patterns and thought processes. But, as they say, the journey of a thousand miles starts with the first step. And this Texas legislation is a very, very good place to start.

The legislation in fact saves money. As estimated by the Congressional Budget Office, it saves $3.8 billion, almost $4 billion over 5 years. I know that's not an enormous sum of money when you've got Congress writing a blank check for $787 billion in one weekend. I know a paltry little $5 billion doesn't look like much. But we are up in budget time and every little billion dollars adds up.

So I have, with no thought to any personal aggrandizement, I have offered this concept to both sides in their budgetary process. I'm willing to give up my $5 billion to the cause. And I would like to see us seriously take on some type of meaningful medical liability reform.

That brings up another issue. We've got 47 million people who are uninsured and we have got various proposals to bring more and more of those individuals into the ranks of the insured. You look at some of the graphs and people will talk about, ''well, we've got this plan, we've got that plan.''

And look how the number of the uninsured just drops precipitously. But, unfortunately, the other line on that

graph that no one ever pays any attention to is the number of doctors out there who are capable and willing and able to see patients. That's a relatively stable number.

So what is the essential effect of bringing many, many more people into the ranks of the insured if we haven't impacted the physician workforce at the same time. No question we are going to put additional stress on the system.

Now I do work on issues dealing with the physician workforce because I think that is so important. In the Health Care Caucus that will be the subject of one of our future forums because I do feel this is so important.

Certainly, at the end of the scale that deals with the young person getting out of college and contemplating a career in health care, cost—the barrier to entry right now—is a huge barrier to entry. No one wants to end up with 8 or 12 years of professional education with a loan repayment plan that is structured such that it's almost impossible to repay.

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We have got to pay attention to that. We have got to make more help available to those, the best and brightest of our young people who may be contemplating a career in health care.

We passed a bill on the floor of this House just a couple of weeks ago that came through our Energy and Commerce Subcommittee on Health that dealt with the number of residencies out there for primary care physicians, pediatricians, OB/GYNs, family practice, internal medicine, general surgeons, the type of doctors that are going to be needed on the front lines of delivering care for generations to come. We are not making enough of them, and many communities just simply cannot attract a doctor.

One of the things that we found in Texas, a study done by the Texas Medical Association, is that a lot of doctors, maybe it is because they don't have much imagination, but they tend to practice close to where they train. I am a very good example of that; I trained in Dallas and I practiced in Louisville, Texas, about 15 miles away. We tend not to go very far away from where it was that we took our training.

As a consequence, if you can develop residencies in more communities where the actual need is high, those medically underserved areas, and you can develop residencies in those programs, pediatrics, general surgery, OB/GYN, family practice, internal medicine, if you can develop those residencies in hospitals or in those communities, you might be able to keep some of those physicians in the area, and that would be an innovative or a different way of trying to bring doctors or keep doctors in those communities.

Now, there was a bill very similar to that that passed out of Energy and Commerce. It passed on the floor of the House here a couple of weeks ago. It is now over in the other body. We in fact passed it last year as well, and it made it over to the other body, but it didn't quite make it out of the other body. And it was late in the year and I understand that. It is certainly no criticism to our good friends in the other body. But this year we passed it relatively early in the 111th Congress. We want to give them plenty of time to scrutinize it, plenty of time for the guys down at Office of Management and Budget and the White House to scrutinize it. But ultimately I think they will see that this is a good program, and it is not an enormous program.

The money that is going to be used for this will be a self-replenishing loan program, so that as the program matures the money will constantly be repaid. But it removes some of the barriers to entry for a hospital that right now is not offering a residency program in a medium-sized community, in a smaller community, perhaps a rural community that has got a hospital with sufficient clinical material that can be accredited by the American Council of Graduate Medical Education but at the same time right now does not have a residency. This can help eliminate one of the barriers to entry for that hospital being able to set up a residency program and, ultimately, can bring more physicians to those communities that right now are medically underserved, particularly in the primary care specialties.

Then, finally, and I talk about this frequently, we are going to talk about it I suspect many times this week because of the ongoing budget debate. But a formula that is used to calculate physician reimbursement for patient services in the Medicare program, the so-called sustainable growth rate formula which has programmed into it payment cuts for physicians, reimbursement reductions for physicians for years to come is a significant onerous burden on our physician community, and we do need to correct that problem.

We did a temporary fix in July of last year, about 9 months ago; it was an 18-month fix. It expires December 31 of this year. And Members of Congress who are not paying attention to this may find themselves very unpleasantly surprised when they go home sometime after the August recess and their physician community is up in arms because Congress hasn't done anything about this 20 percent reimbursement reduction that they are facing New Year's eve of this year. This is a problem that is barreling down the pike at us, and so far this year we haven't spent a great deal of time or energy dealing with that.

Now, to the President's credit he talked about dealing with that in some way in the budget, and indeed there was a line item in the budget that the President put forward, but it didn't really solve the problem. It extended this cliff that we fall off of every 6 months, 12 months, or 18 months. It extended it out for 10 years, but the cliff will be every bit very in evidence and in fact all that steeper because it is a 10-year cliff as opposed to a 2-year cliff. We really need to fundamentally change that formula, pay doctors under what the Medicare Payment Advisory Commission has called the Medicare Economic Index. That is a cost of living adjustment for paying Medicare physicians that basically says if the cost of doing business increases, we are going to increase the amount of reimbursement. It is the same thing we do for hospitals, it is the same thing we do for drug companies, it is the same thing we do for HMOs. We ought to do the same thing for America's physicians; because if we don't, we are going to wake up some morning and find ourselves with an absolute lack of physicians that is going to be almost impossible to overcome, and then Congress will be left scrambling on how to fill that gap. Do we just simply ordain people as doctors and tell them to go to work? Do we open the borders and bring people and steal doctors from some other country? Who knows what the position of a future Congress might be.

It is incumbent upon us to face that problem this year. It is important enough that we take care of it, that we not leave it for a future Congress, that we not postpone it 10 years, as was outlined in the President's budget. We just simply need to change this formula, and do it now. This is something that doctors are looking at the Congress and saying, well, you are talking about a public option government-run plan, you are talking about expanding Medicare, you are talking about all these things that you are going to do. But, Mister Member of Congress, when the only lever you have to pull to reduce cost is to restrain provider payments, that is going to make it pretty painful for those of us out here who are trying to earn a living taking care of your patients, the patients you asked us to take care of, the country's Medicare patients, arguably some of the most fragile and difficult patients to manage, and you are telling us you are going to cut our pay every year as far as the eye can see by 4 percent, 5 percent, 6 percent per year. This year, in fact, the aggregate will be a 20 percent reduction if we don't do something.

Well, we have got to maintain our physician workforce, and those three areas, paying attention to the health profession scholarships, loans, and bringing that up into the 21st century, perhaps we can talk about additional tax benefits for people who are willing to go into the health professions, certainly looking at residency programs in areas that are currently in medically underserved areas with high-need specialties; and then finally fix, once and for all, this cockamamy idea of a sustainable growth rate formula which pays physicians under a formula that is clearly, clear unsustainable and it is unjust.

Here is the secret about the sustainable growth rate formula. We talk about the fact, oh, it is so difficult to repeal because it costs so much. Guess what. That money that it supposedly costs is money that we have already spent. That is not money that is sitting in an earning account in some Federal T-bond somewhere. It is money we have already spent. It went out the door in 2001. We paid it out in 2005. Doctors were reimbursed that money in 2007. We just never accounted for it on the books. We sound like AIG.

This is nuts. We have got to stop this. End the SGR formula. Be up front about it. If the Congressional Budget Office needs to be instructed through legislation to do directed scoring to wipe that debt off the books, and then going forward we play this game straight with our country's physicians, then that is what we have to do. I intend to be introducing a bill; I have done so every Congress that I have been here, and I intend to introduce a bill that will do just that, and I will be back on the floor to talk more about that when that time comes.

We will hear some talk about mandates. When you hear the talk about the public option and mandates, you have got to ask yourself, what are we trying to do here?

Now, with mandates you tell everyone that you have got to buy insurance. We either do it as an individual mandate or an employer mandate. Well, employers look at that as a tax that you are going to put on jobs for health insurance. And if we put a tax on jobs while we are trying to recover from a recession and we want jobs to be created and we are going to tax them, so the small business community will come to us and tell us: Don't put a tax on jobs with an employer mandate in health insurance.

Now, an individual mandate says that everyone out there has the responsibility to have an insurance policy. The trouble with individual mandates is people don't always take them seriously. Look at the IRS, a pretty serious mandate, a pretty serious penalty if you don't comply. And what is our compliance rate with the IRS? About 85 percent. What is our compliance rate with voluntary health insurance right now? It is about 85 percent. So you don't get a lot of bang for your buck by putting in mandates.

Now, mandates are great for insurance companies, because everyone has to have insurance so they like that. Everyone is going to buy their product. Yea, we all make money. Put a public option plan on the table, and then the insurance companies are not so happy because now that mandate may be satisfied by a public option. But now we are forcing our insurance companies to compete with insurance that we are putting on the table at the Federal Government. It is hard to compete with the Federal Government. We can write a check for any amount of money. We never go broke, we never run out of money, we just simply print more money when we need it. Well, the large health insurers in this country don't have that option. It is very, very difficult for them to compete with a government option or a government-run plan because they don't have the option of just simply printing more money when the time requires it.

So we do have to be careful with how we institute, if that is the direction we are going to go. And certainly all through the campaign I heard President Candidate Obama say that, surely if you like what you have got, you are going to be able to keep it. Well, that is true, unless we run them all out of business, in which case it will be hard for you to keep what you have got in your employer-sponsored insurance, and the only option will be a public.

Now, there are lots of moving parts to this debate. We are going to be back here frequently over the next several months. We are in the budgetary cycle now. As I understand, late in the night in the Budget Committee, the House Budget Committee, the House-passed budget did contain so-called language for reconciliation, which means that over on the Senate side they will only need 50 votes to pass whatever they want to pass.

The way forward is set for almost any change the Democratic majority and the Democratic President want to make in health insurance. I hope they are going to make the right decisions. I take the President at his word that he wants to learn from what works. I think we have talked about some of those things this evening, what we have seen working as far as State plans are concerned, what we have seen working as far as the affordability concept in the consumer directed plans. Certainly we need to learn from what works as far as connectors, because we have a State, Massachusetts, that is currently using a connector, and we need to see what the effect has been on the cost and availability of insurance; and, are people in fact conforming with the individual mandate that the State of Massachusetts has imposed?

If we look at all of these things in aggregate, we may not always make the right decision, but we will come closer to making that right decision than if we all just sit in a windowless room, as we all want to do here in the United States Congress. We love to do that down. We sit in a little windowless room down in the basement of the Capitol, we all talk about the things that matter to us. We never listen to anyone else's ideas. And is it any wonder that everything always looks the same when it comes out of the United States Congress?

Let's do things differently this time. Let's listen to each other. Let's take the President at his word. Let's practice evidence-based policy, let's figure out what works, and then let's get on with it.

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

## LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Ms. BERKLEY (at the request of Mr. HOYER) for today.

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

Mr. WESTMORELAND (at the request of Mr. BOEHNER) for today, March 31 and April 1 on account of illness.

Mr. GARY G. MILLER of California (at the request of Mr. BOEHNER) for today and the balance of the week on account of medical reasons.

## SPECIAL ORDERS GRANTED

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

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

Ms. WOOLSEY, for 5 minutes, today.

Mr. DEFAZIO, for 5 minutes, today.

Mr. SHERMAN, for 5 minutes, today.

Ms. LEE of California, for 5 minutes, today.

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

Mr. BURTON of Indiana, for 5 minutes, April 3.

Mr. POE of Texas, for 5 minutes, April 3.

Mr. JONES, for 5 minutes, April 3.

Ms. ROS-LEHTINEN, for 5 minutes, today and March 31.

Mr. FLAKE, for 5 minutes, April 1, 2 and 3.

Mr. MORAN of Kansas, for 5 minutes, March 31, April 1 and 2.

## ENROLLED BILL SIGNED

Lorraine C. Miller, Clerk of the House, reported and found truly enrolled a bill of the House of the following title, which was thereupon signed by the Speaker.

H.R. 146. An act to designate certain land as components of the National Wilderness Preservation System, to authorize certain programs and activities in the Department of the Interior and the Department of Agriculture, and for other purposes.

## BILL PRESENTED TO THE PRESIDENT

Lorraine C. Miller, Clerk of the House reports that on March 24, 2009 she presented to the President of the United States, for his approval, the following bill:

H.R. 1512. To amend the Internal Revenue Code of 1986 to extend the funding and expenditure authority of the Airport and Airway Trust Fund, to amend title 49, United States Code, to extend authorizations for the airport improvement program, and for other purposes.

## ADJOURNMENT

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