Dr. Walter Rosin (Secretary Emeritus, The Lutheran Church-Missouri Synod).

Representative John Shimkus (United States Congressman, Illinois).

Dr. Uwe Siemon-Netto (Former Religion Editor, United Press International).

The Rev. Jonathan P. Stein (Regular Pastor on FKUO-FM for more than 20 years).

Dr. Richard L. Thompson (Former Chair, Board of Directors, Lutheran Church-Missouri Synod).

Edwin A. Trapp, Jr. (Former member Board of Directors, Lutheran Church-Missouri Synod).

Dr. James Voelz (Dean of the Faculty, Concordia Seminary, St. Louis).

Phyllis Wallace (''Woman to Woman,'' Lutheran Hour Ministries).

John D. Wittenmyer (Vice-Chair, Board of Regents, Concordia Seminary, St. Louis).

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Oregon (Mr. DEFAZIO) is recognized for 5 minutes.

(Mr. DEFAZIO addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Texas (Mr. POE) is recognized for 5 minutes.

(Mr. POE of Texas addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

HEALTH CARE BILL NEEDS EXPERT OPINION

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Pennsylvania (Mr. TIM MURPHY) is recognized for 5 minutes.

Mr. TIM MURPHY of Pennsylvania. Mr. Speaker, when the White House summit occurs at Blair House to talk about health care, I am disappointed that not a single Member of the House of Representatives who has a background in health care has been invited, despite the fact that Medicare and Medicaid alone spend several hundred billion dollars. It would be nice if someone who has actually diagnosed a patient, prescribed medication, or treated a patient would be there, but so be it, it's not.

But also, as the discussions are coming forth, there are great differences between what one is looking at and the other party may be looking at for interventions here. We cannot have a system that simply is based upon raising taxes to pay for a broken system. There are 31-some taxes that my friends on the other side of the aisle have proposed, such as taxing employers for providing health insurance, taxing them if they don't provide it, tax you if you own insurance, tax you if you don't. If you spend money on health care, charitable contributions, alcohol, mortgage interest, pollution, oil, prescription drugs, payroll, capital gains, smoking, health care, and now a tanning bed tax. This does not change the system. In fact, it is something that is akin to just saying ''take two taxes and call me in the morning.'' That is not real health care.

Now, Republicans have talked about a number of things, such as allowing people to choose plans across the country, to join groups. I also believe people should be allowed to choose a basic plan, that is, choose a plan that is what you need instead of the government telling you what you need. But most important of all is the number of quality reforms which are not being addressed yet. In a $2.5 trillion system, we waste from inefficiency, we waste from changes, perhaps between $800 billion and $1 trillion.

An article published by Wennberg, et al., in Health Affairs a couple of years ago described it well. Wennberg, Fisher, Skinner, and Bronner, all from Dartmouth University and Medical School, they said that part of the nature of the problem is the present value of projected lifetime Medicare costs for a 65-year-old in Los Angeles is $84,000 greater than for a 65-year-old in Seattle. The difference between Portland and Miami is $125,000 in a lifetime.

''Much of the health policy is based on the assumption that geographic variation and utilization is driven primarily by the local prevalence and severity of illness. In reality, prevalence of illness doesn't drive spending; only about 4 percent of the variation in Medicare spending among groups is associated with the regional variation in the prevalence of severe chronic illness.

''When we look at utilization,'' they go on to say, ''among academic medical centers which care for the sickest of the sick, we see the same pattern; equally sick patients receive different care depending upon which academic medical center they routinely use for care.''

I read on here: ''Higher spending might be justified if more intensive use of in-patient care resulted in better quality of care or better health outcomes, but it does not appear to do so. At the population level, research has shown that patients with severe chronic illness who live in communities where more intensive use of in-patient care is the norm do not have improved survival, quality of life, or access to life. Indeed, outcomes appear to be worse.''

They go on to propose a few changes here which are the things I have talked about at some length over time—that we need to make sure we are doing disease management. They say such things as, ''We recommend that the Federal Government fund a program of clinical research designed to transform the management of chronic illness to a system where care is based primarily on illness level, valid science, and patient preference.''

Detailed specification of the clinical pathways for caring for the chronically ill—for instance, when hospitalizing a patient with congestive heart failure, which patients with chronic obstructive pulmonary disease will benefit from steroids, when to schedule patients for a revisit, or when to refer to a specialist for additional diagnostic testing are all important. Unfortunately, in the bills proposed by the House and Senate, they cut the funding for the very things that could do that, Medicare Advantage, cutting out $500 billion from Medicare from the very programs that invest money in disease management where we can save money.

They go on to say as another strategy that the transition for Pay for Performance should be based upon cost-effective care. The endgame is the establishment of prospectively managed, cost-effective and coordinated care. The enrollment of patients and the cohorts for prospective care management requires risk adjustment methods that account not only for illness level, but also socioeconomic status, adherence patterns, and social supports. This care would be supported by adequate infrastructure, information technology systems, electronic medical records to provide clinical guidance through care coordination, and a program for monitoring quality and efficiency.

□ 2130

Mr. Speaker and my friends, we cannot continue to pay for a broken system. There is a lot of great health care in this country, but as long as we have a system that continues to say we will pay doctors for procedures, whatever that might be, as opposed to paying doctors or hospitals, which are helping to treat patients to get better, then we will continue to see costs spiral.

I hope that the House and Senate work on really reforming health care, on really reforming health care and pushing for coordinated care. That, my friends, is the answer of how we lower health care costs.

THE PRESIDENT'S EXTREME AGENDA

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Texas (Mr. BRADY) is recognized for 5 minutes.

Mr. BRADY of Texas. Mr. Speaker, this past week was the 1-year anniversary of the so-called ''stimulus bill''—$862 billion—every dime of it borrowed from the future and from our grandchildren.

When that bill was rushed through the House with almost no time to study it, we were promised as a country that it would jump-start the economy, that it would stabilize unemployment and that it would restore consumer confidence.

The fact of the matter is that we have lost 4 million jobs since the stimulus was passed. Unemployment has risen dramatically. It continues to hover around 10 percent. Only 6 percent of Americans in the latest poll believe that the stimulus actually created jobs in America. Most of them feel that that extra debt has actually hampered the economy. Six percent. By comparison, I should say 7 percent of Americans still believe Elvis is alive, so you