In a recent analysis of Medicaid coverage in all 50 States, the March of Dimes found that each State would significantly restrict coverage for services needed by children with physical and developmental disabilities, States that were exempt from the mandates of the Early, Periodic, Screening, Detection and Treatment program.

Unfortunately, this bill puts the wheels in motion for States to deny necessary health care benefits to disabled children.

Madam Speaker, the light has been shined on this process. This is not a process to reduce the deficit. This is a process to finance additional tax cuts.

There is no way to deny this fact when the same budget that protects $34.7 billion in decreased mandatory spending allows for $70 billion in tax cuts that will decrease revenues used to fund government programs.

It is inconceivable Congress would balance this budget on the backs of low-income Americans, but to finance tax cuts on the backs of America's most vulnerable, that is downright shameful.

The SPEAKER pro tempore (Mrs. DRAKE). Under a previous order of the House, the gentlewoman from Texas (Ms. JACKSON-LEE) is recognized for 5 minutes.

(Ms. JACKSON-LEE of Texas addressed the House. Her remarks will appear hereafter in the Extensions of Remarks.)

ORDER OF BUSINESS

Mr. BURGESS. Madam Speaker, I ask unanimous consent to go out of order and claim the unclaimed time of the gentlewoman from Texas (Ms. JACKSON-LEE).

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

PANDEMIC PLAN—AVIAN INFLUENZA

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

Mr. BURGESS. Madam Speaker, we heard the chairman of the Appropriations Committee come to the floor and speak about his bill that he has introduced to fund preparation for a possible pandemic flu outbreak, and I thought it might be useful to come down to the floor and just review some of the reasons that scientists are concerned about this outbreak of avian flu in the world and some of the reasons why we need to be concerned and some of the reasons why we need to be prepared and some of the good news to share as well.

Madam Speaker, the influenza virus with which we are all familiar undergoes a continuous process of change. It is constantly changing its genetics. It drifts from one genetic makeup to another.

For the past several years, the flu type known as H3N2 has been the type for which we commonly receive inoculations; and because of this genetic drift, a new inoculation is required each and every year.

With the absence of a flu vaccination last year, I did not take a flu shot; but there is still some immunity that carries over from year to year; but about every 30 years, there is a major change in the genetics of the flu virus. These major changes took place during the last century in 1957 when 170,000 people in this country died from an outbreak of what was called Asian flu and in 1968 when 35,000 people in this country died from the Hong Kong flu.

The term pandemic applies when there is a big, big animal reservoir of the virus and no underlying immunity, and those conditions exist today.

The assumptions and the knowledge of prior pandemics certainly have become part of the pandemic plan that was revealed by the Department of Health and Human Services last week; but the important thing is the study of prior pandemics tells us that this virus, if it were to achieve pandemic status, could overwhelm almost all of the available resources that we would have at our disposal in this country, not to mention what would happen in the rest of the world.

The virus that is under consideration for this pandemic, the so-called H5N1 virus, has some similarities with the Spanish flu from the 1918 pandemic. Both of these illnesses cause lower respiratory tract symptoms, high fever, muscle aches and pains, and extreme, extreme fatigue. That fatigue can persist for 6, 8, 10 weeks after recovery. If the patient recovers from the illness, that fatigue may persist for many, many weeks thereafter; and that, of course, could have implications for people returning to the workforce. The virus can cause a primary or a secondary pneumonia. The pulmonary tree is unable to clear itself of secretions and debris. The vast majority do recover, but the potential to kill is certainly related to the virulence of the microbe.

Some of the trouble signs that are on the horizon, things that have gotten the Secretary of Health and Human Services and the chairman of the Committee on Appropriations concerned, some of the trouble signs include the wide geographic setting with involvement of not only birds but now other mammals. Bird-to-human transmission has occurred. It has not been easy for the virus to go from bird to human, but it has happened; and it appears in some instances, although it has not been an easy transmission, there has been transmission from human to human.

If the virus undergoes that last step that allows it to have efficient human-to-human transition, that is what would signify the onset of a worldwide pandemic. It is also entirely possible, and I do need to stress this, that efficient human-to-human transition will never be developed and that the pandemic will never occur.

So the chairman is quite right. We need to devote resources to this problem, but we must also recognize that the problem that we are concerned about today may not be the problem that we face. One of the very important aspects of the legislation that has been introduced by Chairman LEWIS and legislation that will be taken up by my committee, the Energy and Commerce Committee, is how do we facilitate the ramp up, the surge capacity, the production of antiviral or the production of antiviral vaccines if an entirely different virus or somewhat different virus from this avian flu is actually the one that causes the outbreak.

There are other antiviral medications available, medications such as Tamiflu and Relenza have activity against the H5N1 virus, and they are going to be one of our first lines of defense.

Again, some good news is that a vaccine has been developed, and it was developed in a relatively short period of time. It was undergoing trials. It appears to be safe. One of the troubles, though, is since we have no underlying immunity to that virus, it takes a lot of that vaccination for us to develop immunity.

Some of the things we are going to have to consider, and the chairman appropriately referred to these, the Federal Government will have to share some of the risks with companies that are manufacturing the vaccines. That means not only some of the liability risks but the risks of guaranteeing purchase of these products if they ramp up production and the pandemic does not materialize. Some guarantee of purchase will have to be there and to allow drug companies to communicate with each other to discuss among themselves what are some of the techniques for producing some of these medications. So perhaps some antitrust reform will have to be included in whatever our preparation and our response is to the flu.

Madam Speaker, I wanted to bring these facts to the floor tonight because I know this is important legislation that this House will be considering in the next couple of weeks, and it is imperative that we all do have accurate and timely information.

HEALTH CARE

The SPEAKER pro tempore. Under the Speaker's announced policy of January 4, 2005, the gentleman from Pennsylvania (Mr. MURPHY) is recognized for 60 minutes as the designee of the majority leader.

Mr. MURPHY. Madam Speaker, tonight, a number of the members of the Republican Conference are going to speak on an issue we know all Americans are concerned about and Members

of the Congress are deeply concerned about and that has to do with health care.

I would like at this point perhaps to step off from the comments just made by the gentleman from Texas (Mr. BURGESS), my co-committee man, who just spoke about influenza, the avian influenza, and use that as a stepping off point to talk about some areas that we need to be working on in Congress and some areas we are working on when it comes to dealing with concerns about infections and infectious diseases. The reason I want to start from this point is to show what we need to do and what we are doing in Congress to deal with a number of potentially large issues.

Everyone will remember just a couple of short years ago we had the concerns about the SARS virus, which quickly spread throughout parts of the world. Luckily, it did not stay around very long; but because people who had the disease treated other folks who then traveled throughout this country and others, we saw that disease spread quickly.

We also remember just a few years ago the Ebola virus and the worries about that. We worry also about mad cow disease, and of course, we are concerned about bioterrorism.

In all of these instances, how Health and Human Services, how county and State health departments, how hospitals, physicians, nearly all health care providers, handle such instances around the world makes a huge difference in containing the diseases and also with regard to saving lives.

Recently, President Bush made some comments in calling for $7 billion in congressional appropriations to help deal with a number of aspects of concerns about avian flu. Buying enough inoculations for that, so the people could have some immunizations against the flu; working on other areas of research; preparing health plans, all these are part of it.

What we are going to be talking about tonight will be some aspects of how we can be better prepared, what our health care system needs to be doing, and how even such things as changes in Medicaid, we are going to be using the clout of the Federal Government to make some changes.

Actually, I would like to, as long as the gentleman from Texas (Mr. BURGESS) is here and the gentleman from Georgia (Mr. GINGREY), my good friend, is here, too, I would like to use a few moments to open up a dialogue with them about some issues about the avian flu, if I may, and ask about a couple of aspects here that have to do with how this really works; and as physicians here, I thought I would perhaps start off with the gentleman from Texas (Mr. BURGESS) and ask a question or two, if I may, if the gentleman would not mind standing for a colloquy on this.

A lot of Americans are very concerned about what happens with the transmission of this disease, in many cases do not understand, well, how can I have a flu one year, but the Spanish flu, the avian flu have something very different.

My understanding of this is that many times people have the flu, those who are at risk for severe problems and death are perhaps the very young, the infirm, those with chronic diseases, the very old, because this flu tends to weaken the system and there could be other bacteriological problems such as pneumonia would take them over.

But there is something really virulent or bad, deadly, about avian flu that is the concern; and you were mentioning a little bit about that. Could you talk about how that is so different that we need to understand it is more of a concern, the deadliness of it.

I yield to the gentleman from Texas (Mr. BURGESS), my friend.

Mr. BURGESS. Madam Speaker, I thank the gentleman for bringing this topic to the floor tonight and for including me in the discussion.

In the Spanish flu outbreak in 1918, one of the observations was, instead of the very young, the very old and the infirm who were the victims of this illness. It was, in fact, young people age 28 to 45 who appeared to be the primary victims of this illness.

Undoubtedly, part of that is related to the fact that we do not have any underlying immunity to this disease and people who are, as a general rule, exposed to a lot of other people, that is, people in school, people in the workplace, in other words, your 20- to 45-year-old age group, would have a greater chance to come down to exposure to this virus, which was very virulent, had a high ineffectivity rate, and simply a cough in the room was enough to expose someone to the virus; and, again, with no native immunity, it could overwhelm their system fairly quickly.

There is no question it is still a deadly virus to the very young. It is still a deadly virus to the very old, but I think one of the striking epidemiological features of the 1918 flu was that people who were generally regarded as being in good health also seemed to fall victim to this illness.

Also bear in mind, we were in the last months of the First World War so there were a lot of recruits who were stationed together in barracks and tents, and the virus seemed to be particularly virulent in its outbreaks in those types of situations.

So some differences from 1918 to now and certainly our ability to know about an outbreak. Syndromic surveillance will be an important part of the pandemic plan that the Secretary has unveiled.

□ 2030

The other important concept, since this disease is so widespread, about a quarter of the globe right now is affected with the bird flu. Because the geographic footprint is so large and because birds can fly from place to place and people travel from place to place so easily, an outbreak anywhere has to be regarded as an outbreak everywhere. So if the disease appears to travel easily from person to person in Vietnam, in Indonesia, that means that our full pandemic plan has to come into play in this country.

The gentleman mentioned the experience with SARS, when we first came to Congress in 2003, a deadly, deadly illness that previously was only known in an animal host in China. The transmissibility of SARS was with a little more difficulty than with influenza; that is, you had to get a little closer to the infected person with SARS than with the flu, which meant that health care workers and close household contacts were the types of people who were most at risk.

But bear in mind, we conquered SARS, we beat back SARS without developing a vaccine for the virus and without any specific treatment for the virus. This was accomplished through studies of epidemiology, knowing where the outbreaks were, what travel patterns were and then very careful quarantine of those individuals in whom the disease was suspected and very careful isolation techniques for health care providers when it was suspected they were dealing with a case of that disease. The few times we forgot those principles in dealing with SARS is when the outbreak was allowed to, in fact, reignite or reengage.

Quite different from our current situation. No vaccine for the virus, although the virus was identified by the use of genomics. The virus was identified very quickly, but no vaccine was developed and no effective treatment. With the avian flu, there is a vaccine that is already now available; it has been developed, it is in testing. And, of course, there are antiviral medications that are effective in treating the H5N1 virus. So some differences there between those two.

If I could make one last point, and I did not make it during my previous remarks, and I should have: Although the regular flu shot will provide no protection against the bird flu, we should all still get our regular flu shots and keep the appearance of regular flu to a minimum this year, this flu season, because the fewer people who are sick and the fewer people are who are debilitated by the regular flu virus, I think that will improve our overall odds in keeping the pandemic flu at bay.

I yield back to the gentleman and thank him for his time.

Mr. MURPHY. Madam Speaker, I thank the learned gentleman on these issues, so important to understanding infectious disease. I know one of the aspects of this, too, and I will ask my friend and colleague, Dr. Gingrey of Georgia, to comment on this, and that is helping us in Congress put this in perspective.

Back in 1976, an 18-year-old Private David Lewis came into his base at Fort Dix, staggering in, was given some resuscitation, and soon afterwards they

determined that he had something called swine flu. Soon after that there was a declaration that this would be a deadly virus, perhaps reaching the level of the Spanish flu of 1918. Even at that time, President Ford went on television saying, ''I have just concluded a meeting on a subject of vast importance to all Americans. I have been advised there is a very real possibility that unless we take effective counteractions, there could be an epidemic of this dangerous disease next fall and winter here in the United States.'' At that time President Ford asked Congress to appropriate $135 million to fight it; and of course, huge problems did not develop with swine flu.

I always have the concern that when we are engaged with a public health activity, we have two possible dangers. One is that the disease really does have an outbreak and there is great deal of harm; and two is that if it does not occur, it will leave the public feeling much like the boy who cried ''wolf,'' and then saying there is no concern, we do not really need to do anything.

And from your perspective, Dr. Gingrey, I wonder if you could comment on how the public best needs to put this in the perspective of what we need to be thinking of here, and comment on how Congress can best handle that. And I yield to the gentleman.

Mr. GINGREY. I thank the gentleman for yielding, Madam Speaker, and am happy to be with him during this time and conducting this special order. My colleague, Dr. Burgess, of course, just did a 5-minute on this issue of avian flu, and also engaged in a colloquy with the gentleman from Pennsylvania just moments ago.

We are in a situation, Madam Speaker, where you are darned if you do and you are darned if you don't in regard to what is the proper level of response to this avian flu outbreak in the Far East. I was interviewed recently on television, and the very first thing the reporter asked was, Congressman, do you think that what the President is recommending in regard to this potential, in combating this potential pandemic of flu is just a make-up call for his slow inadequate response to Hurricane Katrina? I immediately challenged him in regard to what he was suggesting.

But it is important, I think, that the media get it right. I do not think, quite honestly, they got it right in regard to Katrina. There was terrible, terrible loss, and the loss of any lives is tragic, but at one point they were predicting 10,000 lost lives along the gulf coast; and it was closer to 1,000. They missed it pretty badly. It is important they understand their need to get it right, Madam Speaker. Because while we want to be prepared, and I commend the President and Secretary Leavitt for bringing this plan to us, we do not want to create a pandemic of panic.

The gentleman from Pennsylvania, Dr. Murphy, was talking about 1976–77 and the so-called swine flu. Well, at that time, as Dr. Murphy pointed out, the government actually purchased something like $150 million worth of vaccine, subsidized that, and began to administer vaccine for swine flu. Lo and behold, what happened shortly after that was people started getting some side effects, which may or may not have been related to the vaccine, but there were some cases of a neurologic condition called Gillian Barre syndrome where all of a sudden you became paralyzed. Fortunately, it is usually a temporary condition, but the Federal Government, assuming all liability for this vaccination against swine flu, not only had the $150 million cost, but ended up spending about $90 million more settling hundreds of claims of liability.

So we really need to be very careful, particularly, I would say, in regard to a mass immunization against avian flu, bird flu, H5N1, as Dr. Burgess described it, that type of flu.

Now, we have, and there has been some money suggested and appropriated for the NIH to develop something like 20 million doses of this vaccine to the bird flu, when as yet there have been no, and I repeat no incidents of human-to-human transmission. There have been a total of about 125 cases in the Far East where humans have contracted this so-called bird flu. But in every instance it was people working very closely with poultry, maybe in their back yard slaughtering chickens with unsanitary conditions. But absolutely no incidents of human-to-human transmission.

So while I commend the President and the Secretary of Health and Human Services for the plan and do not necessarily say that they are asking for too much money, I think we need to look very closely at how this money is spent. I think it is appropriate, I say to my colleague from Pennsylvania, to spend money to develop a technique where we can go from egg-based vaccine production to a cell culture technique, which is much more efficient. But it is going to cost some money, and I think in the $7.1 billion it calls for about $2 billion to develop that technique.

Also, as Dr. Burgess said, it is very important that we are better able to vaccinate against the routine, I think he described it as H3N2-type virus, against the typical garden variety flu and not just vaccinate children under 2 and seniors over age 65 or first responders. We need to be able to do better than that. We are losing 36,000 people every year dying from influenza in this country, and I think we can do better than that.

So, again, I think the President does find himself in a Catch 22 situation. This is the worst possible time for us to have to deal with this, but we do have to deal with it. And whether it is $7 billion or something less than that, hopefully not more, I think we, the Congress, are going to have to step up to the plate and realize there is something that has to be done.

Mr. MURPHY. Madam Speaker, I thank the gentleman. One of the ways that our Nation needs to be dealing with this potential and other issues is to have a better health care system overall. The gentleman mentioned Hurricane Katrina, and I would like to use that as a stepping-off point to talk about some of the work this Nation needs to be doing in some of the things we are doing.

When Hurricane Katrina hit and, subsequently, Hurricane Rita, we saw something we had not really been prepared for, not only the huge devastation of 90,000 square miles, almost double the size of Pennsylvania, but we also saw hospitals were closed, records were destroyed, physician offices were inaccessible and patients were inaccessible. Patients by the hundreds of thousands traveled around the country, many without their medications, without their medical records, and in some cases not even knowing what their medications were. We had to essentially reinvent for many of them a system of health care.

Now, let me take this on another smaller role here too with regard to individuals. When a person goes to their own physician, many times you have what I refer to as 21st century medical technology kept track of in a 19th century system, and that is paper and pen records. Now I have seen these myself through many years of working in hospitals and in my own practice settings where you write your notes down, and when lab results come, you stick them in the chart, and it could be for a typical patient perhaps the pile of papers could be much thicker than this.

Yet, when a person goes to the hospital, it is not unheard of, for example, I was talking to someone at one hospital; and I would be interested to hear if my colleague's experiences are the same. But say a woman showed up in an emergency department in labor. Some notes may be made there. She then may go up to the delivery area to deliver. After that, she goes to recovery and her baby goes to pediatrics. And each time separate mounds of medical records are made, which may not really be collated together for hours, sometimes days afterwards simply because of what is happening there, not to mention her own medical records from her own obstetrician back home. That is the way the system operates every day.

Let us take another scenario. Take a single mom who has a son who has asthma. And perhaps because of whatever housing, perhaps she is on Medicaid, low income, and she finds a situation where she has to move to a different part of town and it becomes difficult for her to get across town to see her other doctors, so she goes to a new doctor. And they have to essentially reinvent what has been done for this child or call for those records and have them shipped over.

Now, if one has the luxury of days, sometimes that can be done, with the

situation of establishing new relationships with new physicians and new nurses. But you also have the situation, if the child goes into acute distress with something like asthma, of showing up in an emergency department and having to have all the medical staff there trying to track down what is the child's medical history, what prescription drugs is he on, are there any particular allergies he has, if he is on other medications will there be drug interactions, what is his blood type. Even the most basic information is important to have, but they do not have it.

Now, in some hospitals around the country we see some changes being made. University of Pittsburgh Medical Center, where I am from, is one that is doing this, but there are other centers, at Northwestern, and other States have this, where they are emerging towards the technology of electronic medical records and electronic prescribing. I want to talk a little about how that is done and show some things that are being done on Medicaid.

Imagine going to a medical office and filling out a clipboard with your name, address, phone number, your medical history, and allergies, if you can remember it all. Very often, it is tough. Certainly my colleagues in Congress, I think we would all be hard-pressed to remember every doctor we ever saw, every medication we ever took, or every diagnosis that was ever placed in our chart, but it is important information. Add to that every x-ray we have ever taken, every lab test that has ever been done. Those are oftentimes lost to the ether.

Some studies have indicated that perhaps as much as 14 percent of medical records are missing, some important information, important enough that it would change the direction of what the provider would diagnose or call for treatment in those cases, and in some cases, physicians say major changes in how they would diagnose.

Perhaps a patient was set up for a blood test and they never showed up for the blood test. Or perhaps they did show up, and the information was never forwarded to the physician's office. Or if it was forwarded, maybe it was misfiled or placed somewhere else. A whole host of things can go wrong when you are dealing with reams and reams of paper filings.

□ 2045

Then the moment of truth comes when the doctor needs it, where is the information. If it is missing, they may have to call for repeat tests or write a prescription and then find out that it causes problems with the patient, which can cost lives as well as money. It is estimated that 150 million times a year pharmacists call physicians to double-check medications. Perhaps they cannot read their handwriting, or double-check the decimal point on the medication dosage level, or perhaps to say Mr. Smith is on another medication from another doctor which is identical, or it is one that would have a bad drug interaction with this other medication. That is a grave concern, how do we fix this.

Well, by using electronic medical records, the medical record could actually be placed on a computer, perhaps in the physician's office. In some cases, individuals can carry their own. I brought a sample, smaller than a stick of gum. This is a 64-bit memory chip. It happens to be on a key ring. It is quite possible in the near future we may be seeing individuals who carry their own extensive medical records that can fit into their wallet or on a key ring. If an emergency came up and if something came up, they could, at a moment's notice, hand it to a doctor. They plug it in and pull up the records right away.

This is critically important for those with complicated cases. That involves a huge investment in the medical infrastructure in America, but if we use a situation like Hurricane Katrina or an outbreak of a pandemic in this Nation where the medical system of this country would be taxed beyond anything we can imagine. Again with Hurricane Katrina, hundreds of thousands of patients moving about, many psychiatric patients let out of hospitals with no recall of their medications. People had to start from scratch and diagnose them.

What if we had medical records on file that people could use in a secure and confidential way and could tap into. Or what if some individuals carry their own medical records in their wallet. It would be incredibly valuable in moments of need and help reduce health care costs.

This is not something that should just be in the best of hospitals or in the hands of those who can afford it. If we are going to lower health care costs, we need to put it in the hands of every American. RAND Corporation released a study a few weeks ago that said if our Nation switches to electronic medical records, we could save in the nature of $160 billion-plus per year. $160 billion per year. In a health care system where we are so concerned that costs are moving completely out of control, where people cannot afford health care, where businesses can no longer afford the double-digit increases in costs, we need something major, something comprehensive, something that completely shifts how we provide health care in this Nation. And electronic medical records is just that treatment.

Not only does it save money in terms of doctors not having to take time to review the chart, worry about mistakes they may have made, call for new MRIs, X-rays, CT scans, blood tests, not only that reduction in costs, and not only the savings of lives, because a mistake has not been made or a delay has not occurred in care; but Rand goes on to say you save massive amounts of money in terms of jobs, people not losing work because of complications or having to go back to a doctor to have tests done again.

Think of it this way: If a doctor asks for an X-ray and it is done, and he says did you bring the X-ray, no, they did not give it to me. The doctor says, we will take another one. You pay for that X-ray, the person's time who has to have another test done, all of that is duplication of work. But what if, again, that individual carried the X-rays, films of their surgeries, all of those details on a chip, or if it was on a computer screen in the physician's office. Not only would the doctor have instant access, but he would not be going page by page through the medical records, what did I prescribe before, because nobody can possibly remember the details of all of the patients they see.

But in an instant, tapping a button could call up those X-rays. Added to that, if the physician had questions and needed a consultation, he does not just call his old mentor in medical school, I need to call Dr. O'Hare and get his consult and mail him the X-ray and ask him to comment back. Literally, at the stroke of a key, he can have another doctor look at the X-ray, consult with him, and provide valuable information back in time faster than the speed of light. It saves valuable time, critical information, and saves lives.

But how do we get that into Medicaid, is my question. Well, first of all, let us look at what Medicaid has done here and look at some costs. In 2006, the Federal Government is spending in billions, about $190 billion. This is going to increase by $66.4 billion, or 34.8 percent, over the next 5 years. We are up to $200 billion in 2007; 2008 to $217 billion; 2009 is $237 billion; and by 2010 it is $257 billion. The Federal Government general increase in what it is spending on Medicaid is going to increase 7 percent over the next several years.

The budget package that Congress is putting together now to try to reduce some of the deficit is going to do some things that the Governors of States have asked for. The Governors of States have said that Medicaid spending, in some cases, is almost 20 percent of the State budget. They need some mechanisms by which to control this.

I was pleased that a bill I introduced has been put into the Medicaid package of our deficit reduction package, which will put $100 million in grants to go to hospitals that have high Medicaid populations, perhaps inner-city hospitals, perhaps community health centers, and nursing homes and other centers that have high Medicaid populations so they can partake in electronic medical reports.

Basically, a hospital has to convert their files into computer programs and be able to pull those up. There are a couple of nuances that go on. You have to make sure that different offices of doctors and hospitals can all speak to each other on this because otherwise there can be a medical Tower of Babel, that is, one hospital may use one type of computer program for their records

and another hospital another type of record.

But I want to call upon my colleague and ask the gentleman from Georgia (Mr. GINGREY) from a physician's standpoint on what he says our Nation can be doing to assist this transition, how it helps medical practice, and perhaps some experiences of your own work. I believe you have delivered 5,000 babies or so in your time, so how it makes a difference from being able to have information instantaneously as opposed to waiting for files or trying to make a best guess on a patient.

Mr. GINGREY. Madam Speaker, there is no question what the gentleman from Pennsylvania is talking about is very important. He mentioned the potential of saving $160 billion a year. I am not sure if that figure includes the savings that would be affected from cutting down on medical errors and the liability costs, not just for the physician health care provider, but also for the facility provider, for the hospital systems, many of which are essentially what we call going bare. They have a huge deductible. In some instances, a huge hospital system, it would not be unusual to have $20 million for no insurance coverage for some of these claims for medical errors. So that $160 billion may be a very conservative estimate.

I think it is absolutely essential that we move in this direction. I know my colleague is a member of the Committee on Energy and Commerce, and they are working closely on trying to develop a system. We are working closely in Congress with Secretary Leavitt of Health and Human Services to make sure that we have one system. We have to have this ability to communicate.

I think it is important and I want to mention this, there are a lot of private vendors out there. There is a very excellent company in my district, the 11th Congressional District, which is essentially west Georgia. In the heart of my district there is a wonderful company, the Greenway Company. They have been working on this for a number of years. They have this software package, and we refer to it as electronic medical records; and we are not just talking about billing. That is kind of old hat. That has been around for a while, but this is taking it much beyond that so that no matter where you are in this country, indeed in the world, when you have that little radio frequency ID card that he is talking about or swipe card, if you can charge something on American Express when you are visiting India, certainly you ought to be able to go to the hospital if an illness overcomes you or you fall victim to some accident out of country, they would be able to clearly identify your entire medical record almost in an instant.

Some of these companies, like Greenway and others that have developed these systems, they want to make sure that they can connect and communicate with a hospital as well. So as our committees of jurisdiction, which of course would be Energy and Commerce and the Committee on Ways and Means, and our appropriators, we want to make sure whatever money we spend, that we give an opportunity for entrepreneurs to connect and be part of this; and it not just be hospital driven.

I have heard some discussion about giving some incentives to staff members who practice at a certain hospital so there is some benefit to get them to communicate with a hospital. But again, competitiveness, the free marketplace is usually important, but they have to have a similar system, at least one that speaks to the other. That is usually important.

Madam Speaker, the opportunity to communicate with Dr. Murphy on this issue, and let me just say this, we cannot overemphasize the importance of this. The gentleman described the cost of this Medicaid program which is running wildly out of control. In 2010 it is $257 billion. We all know there is a price to pay in the State budget, and in some States, of course, the Federal match can be as high as 75 percent. But that is just a couple of States, and many, many are 50/50. We have got to get this working and save money out of this system.

And more importantly, it is not just cutting down on the cost of these entitlement programs. It is also a matter of saving lives and increasing and saving productivity. You mentioned both of those points, and I think those are extremely well taken.

Mr. MURPHY. Madam Speaker, I would like to shift to a couple of areas of health care here and some other things that we are moving on and we need to continue to push for.

One has to do with some mental health issues. I mentioned earlier about Hurricane Katrina and some of the folks who had psychiatric illnesses, and as the hospitals were emptied, people did not know their medications; and I mentioned how those problems occurred.

We also have to pay attention not only in terms of using electronic medical records so people can find their record when they need to, but making sure we have the security so that people cannot get into the record when they do not need to. Part of what Dr. David Brailer, who the White House appointed to work on this issue, along with many companies, such as in Pittsburgh, the University of Pittsburgh Medical Center, and there are many private companies trying to come up with solutions, so we have a great many other aspects that we are working towards in order to make sure that these records are secure and confidential.

I want to ensure my colleagues that this is something that I am in complete agreement with, what Secretary Leavitt is working on in HHS and also Dr. Brailer, that these electronic records need to be secure and confidential so people can always trust that their records are not going to be viewed by somebody who should not get into them.

In the Committee on Energy and Commerce, we are working on some other technological aspects. We are working with the committee to offer some amendments to make sure we also have reporting.

□ 2100

Interestingly enough, one of the areas we find loopholes as we are moving forward on issues is that right now if there is a breach in security of some kind of records, health records, unless someone reports that there is not something that is done and what we really want to make sure is happening is hospitals are regularly scanning their records as many of them do now and look for any sort of attempts people may have to get into those computer files. Similarly when we have our own paper records in our own office, we have to keep those under lock and key. We have to make sure that those who are not authorized to see them don't get in there to see them.

In the mental health area, I want to talk for a few minutes about a couple of aspects and again give my colleague time if he has some issues he wants to get into, but I want to talk about mental health care treatment for chronic diseases and how they can lower health care costs. For many individuals with chronic diseases like asthma, arthritis, heart disease, cancer, diabetes, lupus, and many other areas, interestingly enough, the incidence of depression can be double that of the general population. Whereas in any given life span, perhaps about 16 percent of the population may suffer from some severe depression, when you have a chronic illness like heart disease, those rates can double. And some cardiologists tell me that the numbers would really be even much higher than that. After all, when you are told you have a debilitating disease or something that can be life threatening, it is expected that a person would have a severe reaction. Many times it is overwhelming stress. Sometimes that can move into a sense of depression.

Depression is not just a sad feeling as we all feel at times. We have a bad day, the loss of a loved one, job stress. Depression is part of life in terms of having some sense of sadness. It reaches a point, however, in some folks where it really becomes a wall around them. It affects them physically. It affects them mentally. Thoughts are sluggish. Oftentimes they have a hard time getting out of bed in the morning but then a hard time sleeping once they are there. They may find themselves with no appetite. They may find themselves overeating. They may find themselves seeking other things to alleviate their depression such as drugs and alcohol. And I am not talking about prescribed drugs. It may be things where they are angry, they are edgy, they are moody.

It may be that they are withdrawn. All sorts of things can happen. What is interesting is how this really becomes not just a mood and an emotional reaction and this is not something that is just a sign of weakness, it is a real chemical, neurochemical reaction that occurs in the brain then that becomes debilitating. For someone who has heart disease or diabetes, I was mentioning, double the incidence, think of this: That the stress can be so prolonged on their body and their system and it depends on the individual, it is almost as if there is a point at which the body says, We can't handle the stress anymore and depression begins to overcome.

Why does it increase so much with things like heart disease? Perhaps because of the stress, but here is an interesting factor. Patients diagnosed with depression have higher rates of chronic medical illness and use health care services more often. Patients with chronic medical illness and untreated depression have higher health care costs in several categories of care: primary care, regular doctor visits, medical specialty care, medical inpatient care, pharmacy, lab costs, all increase, when compared to those with chronic medical illness and treated or with no depression. Much higher.

As I said before, clinical depression affects about 16 percent of the population at one time or another in their lives. Unlike the normal experience of sadness or loss or mood states, it becomes much higher. For example, 31 percent with diabetes have depressive symptoms. Interestingly enough, the increased psychological stress or depression increases platelet reactivity to thrombosis, or blood clotting. In other words, when you have heart disease, untreated depression in ways we are not quite clear yet can actually lead to an increases in clotting of those little blood cells, the platelets that we have. This can in turn lead to almost doubling the cost of health care for folks with heart disease.

Again, you have folks with and without heart disease. Those with heart disease may have double the incidence of depression. And those with untreated depression or not responding to treatments can have double the health care cost. Some are intuitively obvious: Perhaps the person is not following up with doctor visits; perhaps they are not following the treatment plan; they are not going through and taking medication; maybe they are not seeing the doctor; exercising; all the things they should be doing. But even in that case if they are doing that, there is something physical that is taking place in those patients that may actually contribute to increased medical complications.

Very often treatment for mental illness is not provided by a mental health professional. A person does not see a psychiatrist for their medications, maybe does not see a psychologist for other behavioral therapies that may go with that. Actually psychiatric medications are prescribed by nonpsychiatrists 75 percent of the time, most frequently by primary care, general and family physicians. But when we combine medical and behavioral health services to coordinate the diagnosis and treatment of the full spectrum of diseases, we can see some huge changes in that.

When you have, as I said before, untreated depression, it has been found to increase health care costs by complicating symptoms and treatments of such things as back pain, diabetes, headache and heart disease annually from $1,000 to $3,000 per patient. Very, very important when you are dealing with someone, for example, who is an employee who has some of these problems, when you see this untreated depression in them, increased costs. Untreated depression costs employers more than $51 billion per year in absenteeism and lost productivity, not including higher medical and pharmaceutical costs.

When we use information technology and much of what we have been talking about this evening, it can be used to track diseases and intervene with appropriate care. So now with a physician seeing a patient with a chronic illness and into that computer he types in or she types in the diagnosis, up in the screen should not only appear, here is confirmation of the diagnosis of this disease but up also arise some questions as prompts to the physician. Again if he types in coronary heart disease, what may also show up is, ask the patient the following questions: Ask about mood, ask about appetite, sleep problems, problems in their relationship with their spouse, to see if there is any indication of other psychiatric or psychological disorders for which that patient could be referred over for help. This information about provider system performance will be extremely valuable to have this. But unfortunately in many cases a physician may not have those prompts available and if they may only have a handful of moments to see a patient, it becomes very, very difficult.

If we saw depression as a medical condition for what it is and other psychiatric illnesses for the medical conditions they are, we could reduce health care costs and save lives. Unfortunately, and I know our colleagues as well, there are some folks here who believe there is no such thing as mental illness and I have heard such statements made, saying, oh, it's just a chemical reaction in the body, or there really are no other emotional components. We have heard Hollywood stars talk about this with an incredible amount of prejudice and ignorance. But it is true. There is such a thing as mental illness. As much as we want to pretend it is not there, as much as we want to ignore it, it does not make it go away. It does not help if we continue to treat mental ilness with the same level of insight and ignorance as the Salem witch trials. There are times that we have not advanced much beyond that. But when on the other hand we recognize this incredible integration between mental health treatments and other medical treatments, I say other medical treatments because they are both medical, we can see with those patients huge changes and huge cost savings. Increased psychological stress or depression increases platelet reactivity, as I said, thrombosis. But there are also aspects, too, with treatment here that we find really can save a great deal of money.

A 2000 report by the Office of Personnel Management for Federal health employees provides an example of several major employers who through managed care programs have discovered they can offer mental health benefits to their employees in order to maintain a higher quality workforce. These employers included companies like AT&T, American Airlines, Eastman Kodak, General Motors, IBM, Massachusetts Group Insurance Commission, Pepsico. The list goes on. The most important finding of this report was that employers who provide generous mental health and substance abuse benefits to their employees and their families are committed to providing these benefits because they are convinced that doing so is essential to the corporate bottom line. What they indeed found was the mental health coverage put on par with physical health coverage only costs employers about 1 percent or $1.32 per enrollee per month according to a 2004 analysis by Price Waterhouse. But they also found it actually saves a great deal of money for individual businesses.

As we are proceeding through efforts to save money through Medicaid, as we are looking at such things as Medicare, I call upon our colleagues to make sure we are saying, you don't just save money by cutting rates of growth. It is important we do that. It is important we work with States to reduce that. But it is also important we work with States to help them understand and employers to understand that when you deny an aspect of critical care, and that is mental health care, you can actually be harming the patient. And so it is vitally important that we look in all these areas now and other bills that may be before us in the future, that we use them in such ways, this huge amount of spending the Federal Government gets involved with health care, but also encouraging employers to do the same thing.

Congress budgeted $20 million for the development of comprehensive State mental health plans to improve the mental health services infrastructure in 2005. The amount we need to, however, spend is probably much more than that. Unfortunately, the way the Congressional Budget Office works in this Federal Government, it only tells you what you spend. It does not tell you what you saved. It would be much like if we looked at how much we are

going to spend in immunizations but did not see what we saved in lives and money for flu. It would be ridiculous if we did not say that that indeed would be a savings. We have to keep working at these aspects here. We have to look at how Medicare and Medicaid reimburse. We have to look at pay-for-performance incentives to help physicians and mental health professionals work together in a comprehensive and integrated way. We have to make sure we are helping businesses understand that these Medicaid transformation grants, for example, that I mentioned earlier are, I believe, going to be $100 million invested, but when we use these for such things as county nursing homes, skilled nursing facilities, federally qualified community health centers and similar facilities and inner city hospitals, we will see tremendous savings come through this whole system here.

Just to wrap up my comments and I will turn back to the gentleman from Georgia if he has some other thoughts he wanted to say in wrapping things up tonight, it is so vitally important that we work together, not only the handful of health care professionals that are here in Congress but it is so important that as Members of Congress we work together to understand that health care is not just about what you spend, it is also about what you save by your spending. If we are ever going to get control of this juggernaut of health care costs, it is not just going to be by having the discussion go in terms of who is spending; it is not just a matter of saying we are going to have health care savings accounts so people can pay more attention to what they are spending, that is important; and it is not just in terms of saying, nobody can afford health care so let's have the Federal Government take over. It is about not just who is paying but what we are paying for. That is why the comments we have made tonight about what we are spending money and how we are going to spend it on dealing with the concerns about the avian flu be done in a careful and thoughtful manner. That is why other aspects I mentioned before about medical records, electronic medical records and also integrated health care and other aspects we can get into, too, about prevention, et cetera, it is so important we deal with these in a comprehensive manner to look at those savings.

I wish that we could get the Congressional Budget Office to do more aspects of looking at how we can save money in this, but that is going to be something that we are going to have to carry the torch on. I know my colleague has carried the torch on many of these aspects here. I think we have about 7 or 8 minutes left. I know you have a number of other aspects you would like to talk about. I always enjoy these colloquies with you about looking at this. It is an important aspect that we team up together on here to get this Nation thinking about other ways of saving lives and saving money by, and I will leave with this chart here, about the health transformation. We cannot just make reforms within the current framework. We have to look at our current health care system and if we fail to change, it will decay into a system we cannot afford anymore. If we work toward real change to a 21st century health care system, that is where we should be going. I believe our Nation, whether it is private employers or the Federal Government, will see tremendous changes that save tens of thousands of lives and tens of billions of dollars. I thank my colleague for being such an adamant supporter of moving this health care system forward.

Mr. GINGREY. I just want to say that what you have brought to the Members tonight regarding what I think you would agree we could call mental health parity is a hugely important issue. I think my colleagues in the medical profession who are still practicing, especially those whom I know so well back home in Marietta, Georgia, expected when I came to Congress that I would have all of the answers and be able to solve all of our problems but the truth is I have learned just about as much as I have contributed and realizing today after being out of the practice of medicine, the bedside care of patients for almost 4 years now, how important this issue of mental health parity is that you bring to our attention tonight. You are right, absolutely. There are so many people who suffer from mild, moderate, severe depression, they are not psychotic, they do not need to be institutionalized, they do not even need to be hospitalized, but their illness, their depression, results in decreased productivity. You mentioned that. Away from their job. It also is detrimental to their physical well-being whether, as you point out, it is heart disease, diabetes, or whatever. You talked about the effect on platelets. There is no question about that. And, of course, the very important point you made about their compliance with medical treatment, again, whether that is heart disease or diabetes. If they are depressed, they are not going to follow the regimen they need to follow and it is going to end up costing this country, particularly when the money is coming from the Federal revenue and John Q. Taxpayer, it is going to cost more.

□ 2115

As the gentleman points out, we get more credit for the fact that we are, overall, going to reduce health care costs by paying more attention to something like this.

I know a lot of my colleagues will try to treat mental illness and, really, I will use the expression ''on the fly,'' I think Dr. Murphy knows what I am talking about, in a hurry. You do not have time and you do not do a prolonged mental health inventory, a counseling session, with the patient, you just write a prescription for some antidepressant, whether it is Effexor or Zoloft or whatever, in many instances, not all. Certainly some general physicians, internists, family practitioners, even gynecologists take a special interest in mental health care and know a good bit about medications. But I think in many instances, those patients are better served by a mental health professional, a psychologist or a psychiatrist, but I really appreciate the gentleman bringing that point to us.

Madam Speaker, if the gentleman will allow me to continue, I did want to just shift just for a few minutes to the issue of the Medicare Part D, the prescription drug part that is part of the 2003 Medicare modernization program. We are in tough budget times. My colleagues understand this, and of course we talked earlier in the hour during a colloquy about avian flu and the fact that the President has no choice but to bring to the Congress a request for money, in this instance an additional $7 billion, to help prepare for the possibility of a worldwide pandemic right on the heels of the need to spend $150 billion to $200 billion on the horrific hurricane that struck the gulf coast, Hurricane Katrina.

We just had tornadoes in Indiana and Kentucky with the loss of life. Last summer we had four hurricanes strike Florida, and we continue to spend necessary money fighting this global war on terrorism. I mean it is a tough, tough time. And people in my district, the 11th District of Georgia, and I feel sure the gentleman's constituents from Pennsylvania, are very concerned with fiscal responsibility and hopefully look for some offsets.

That is what we are about in the Congress this week. Hopefully, we will have an opportunity to exercise some fiscal discipline in regard to the growth rate. Not cutting mandatory spending, but just limiting the rate of growth from 5.7 percent to 5.6 percent, looking for $50 billion in savings over the next 5 years. These things are hugely important, and our constituents are demanding it.

But this suggestion that we find some savings by delaying or indeed canceling the Medicare Part D prescription drug benefit as a part of Medicare modernization I think would be a huge mistake, Madam Speaker. Because, as Dr. Murphy pointed out, we have heard this estimate of $750 billion additional Medicare costs over 10 years, but that is giving absolutely no credit to the fact that if this program works, and I truly, in the deepest depths of my being, feel that it is the right thing to do and that it will work and will shift some cost away from Part A and Part B, that part that pays for open heart surgery, it pays for an emergency room visit if you had a stroke. Indeed, it pays a little money under Part A and Part B for prolonged skilled nursing home care, possibly for the rest of your life.

Mr. MURPHY. Madam Speaker, if the gentleman will yield, one of the things that is in this Medicare bill we passed a while ago now, that many people are forgetting, has to do with the entry physical that people get, but there are also elements in there that have to do with some patient management, the pharmacist is working more monitoring the medication, and communication. I would ask my colleague to speak on that, because that may be a thing that we really are not quite used to, physicians and pharmacists working more closely together as part of that Medicare bill so that there is less hospitalization.

I know one hospital in my district, Washington Hospital, really found that by doing careful patient management of those with heart disease, they reduced rehospitalizations by 50 percent. That is a massive savings in costs and certainly much better for the patients, in many cases saving some lives. I wonder if the gentleman could comment about that.

Mr. GINGREY. Madam Speaker, I am very familiar with Washington Hospital, although I did not realize it was in the gentleman's district, the great work that they did. But there is no question about it, this issue.

I mentioned the cost-shifting from Part A and Part B, and I think that will be substantial. But this emphasis, and the gentleman is right, it is part of this bill, not just prescription drugs Part D, but also that entry level physical, that focus on disease management and making sure that people, whether they do it through Medicare Advantage, whether an HMO-type program, or even traditional Medicare, in screening for things like colon and rectal cancer, breast cancer with mammograms, prostate cancer screening, cholesterol screening so that we do not wait until the person has a heart attack and has to have that quadruple bypass that is very expensive. So again, I wanted to make sure, and I appreciate the gentleman from Pennsylvania giving me the opportunity to have time to discuss that, because we are hearing it. We are hearing it on the floor of the House, maybe from both sides of the aisle, and folks back home, naturally they want us to spend what we have to spend, but not a dime more, and I agree with that.

But I think this will be clearly the wrong message to send to our seniors. I mean, this President and this Congress were not the first elected folks to promise to deliver a prescription drug benefit for our seniors. Indeed, Medicare started in 1965, so what are we talking about is about 40 years of the program, and they have been waiting a long time. And to ask them to wait a couple of years or indeed maybe indefinitely so that we can offset some of these costs of responding to the bird flu or responding to Hurricane Katrina, I think would be a huge mistake.

Mr. MURPHY. Well, Madam Speaker, I think it is one of those areas that, again, I think that when one just looks at the numbers of costs up front, and we have some of those frightening numbers, I do not know how many hundreds of billions it may be. And I understand the concern of our colleagues who may have opposed the Medicare bill for Part D because they were concerned about the cost. But I believe this has some innovative aspects in it and some that we have to pay attention to.

Oftentimes, people say that one of the definitions of insane behavior is doing the same thing over and over again, expecting the same results, but this patient management aspect and the integration of care between physicians and pharmacists is vitally important. I am hoping that as people review their Medicare Part D options that they also ask questions about that, when they call 1–800–Medicare or go to medicare.gov, or particularly when they call 1–800–Medicare, feel free to ask about that, or ask Members' offices to talk about that. It is something that is so very, very important. It is going to be a different aspect of health care that we follow up on.

Mr. GINGREY. Yes. And I think too it needs to be said that when we had this debate, a huge debate, in December of 2003, as my colleague recalls, we were freshmen at that point in our political careers, both of us, but there were a lot of folks, particularly on the other side of the aisle, that were very angry, very angry with AARP, the American Association of Retired Persons, because they had the unmitigated gall, the audacity to support this President and this Republican leadership in trying to get this Medicare modernization prescription drug bill passed and to fulfill this promise that was made. They even suggested that people tear up their AARP card as an act of defiance and protest against this bill, and discourage people, the working poor who could get the prescription drug discount card in that transitional program, and get $600 worth of credit for each of 2 years during that program's existence, $1,200. To think that they discouraged people, and many of them were discouraged and did not get that benefit. I hope now that for Medicare Part D, and the sign-up is beginning soon, that they will be encouraging them, not discouraging them, to sign up.

Mr. MURPHY. Madam Speaker, I thank the gentleman for his time tonight and also the indulgence of our colleagues in listening to this. We will continue to push these health care issues so vitally important for the health of our constituents and of all Americans.

On my own Web site at murphy.house.gov I have further information on health care, FYIs, as I call them and sent to my colleagues every week. I hope people will look at that, and I hope my colleagues will continue to work with us, but really all Members of Congress, not only those with a health care background, but together, we will see some major changes in not only saving lives, but saving money.

REPUBLICAN BUDGET CUTS BAD FOR AMERICA

The SPEAKER pro tempore (Mrs. DRAKE). Under the Speaker's announced policy of January 4, 2005, the gentlewoman from California (Ms. WOOLSEY) is recognized for 60 minutes as the designee of the minority leader.

Ms. WOOLSEY. Madam Speaker, I am the cochair, along with BARBARA LEE from Berkeley, California, of the 62-member Congressional Progressive Caucus. Our progressive promise includes a fair and balanced budget that represents all people in this country. So I am pleased to take this time in this special order this evening to talk about the cruel and shameful budget and the tax cuts the Republican majority wants to ram through this House on Wednesday or Thursday of this week.

After hearing my Republican colleagues in the first hour special order tonight, I would hope that they are paying a great deal of attention to what is going on with this reconciliation budget. Otherwise, there is not going to be any money for all of those good ideas they have for health care. It was a pleasure to hear their good ideas, now that we are going to talk about where the money will be and where the money is going in our budget, and it is something we are going to be dealing with straight up Wednesday or Thursday of this week.

It is also time for the people of this country to know what is going on. It is time to stop this railroad and help the American people learn just what the Republicans are up to. They keep acting as Robin Hood in reverse. It comes out in the various committees, and in bringing up this vote this week on the House Floor, a vote that will hurt hard-working Americans because of a package of bills in the billions of dollars, at least $50 billion, that will include hurtful budget cuts.

But make no mistake about it. These budget priorities are outrageous. They, meaning the Republicans, want to provide $70 billion to $100 billion in new tax cuts for the powerful and the privileged in America who need them the least, while cutting programs for the rest of the country. And they are going to pay for these irresponsible tax cuts for the most well off by shredding the safety net for the most vulnerable in our society, those who live under or near the poverty line, and by breaking the social contract with hard-working, middle-class Americans as well.

And, oh, yes, what the Republicans do not wring out of the blood, sweat, and tears of working and impoverished Americans through budget cuts will just be added to the debt of the next generation of Americans. Can you believe it? This is the first budget reconciliation package in the history of our country that actually increases