have to sell is what's in their minds, what they have created from their brains. Guess whose country wrote it into their founding document that your intellectual property belongs to you? The United States of America. It is in our Constitution that what you create with your creativity belongs to you and you have an ownership right in it and you can enforce it in a courtroom. The rest of the world is coming around to that.

But what we have been given are so many blessings by forward-thinking people in our past, and I'm here tonight, as we talk about all of these issues of the economy and what's going on, don't let us forget that that is not a country of men. This is a country of laws. And the way we operate on this floor of this House and the way we operate at the courthouse and the way we operate as human beings is governed by the rule of law. And if we ever lose that, we lose our country.

We've got lots of issues going on right now. We've got health care. We've got this cap-and-trade or cap-and-tax bill that's supposed to be protecting the environment. We've got runaway spending. We've got mounds of debt that's mounting up in every direction. The debt figure is unbelievable. And all of these things should be dealt with through this body and its democracy and its democratic principles. That's the way it should be dealt with, the rule of law. And if we do that, we will have met our obligations to the people who sent us here. And I challenge both sides to let the rule of law reign here. Let's don't change the rules. Let's don't stop debate. Let's talk.

Everybody says we need bipartisanship. How can you have bipartisanship if one side writes a 2,000-page bill and the other side doesn't get to do anything but say, ''Yes, I like it'' or ''No, I don't''? How in the world is that bipartisan?

I think our Founding Fathers really thought that you are going to have liberals over here and conservatives over here and you're going to try to address an issue and you're going to sit down at a table and you're going to talk about what you can and can't do, and you're going to come up with a solution. I think that's what they thought we were going to do. We're not doing it right now. And I do honestly believe it would work, and I think there are an awful lot of people that sit in this room every day that feel the same way.

Let's have the courage to do that. Let's follow the direction of our Forefathers. Let's remember our history, and let's start talking to each other instead of imposing our will, one group of men and women imposing their will on another group of men and women. I really don't think that's what we intended when this House was created.

We like to say this is the greatest deliberative body in the world. It is the cradle of the democracy. It's the cradle of freedom, that liberty was born here and thrives here. Well, if liberty's born here and thrives here, it's up to us to continue to keep her breathing and keep her thriving. And I don't believe we do it by ignoring the rules or changing the rules. I believe we do it by working together to come up with solutions.

And probably kind of like the good verdict you get in the courtroom, if you give a verdict in the courtroom and both sides are not completely happy, you've probably got the best verdict you ever could create. But if you've got a verdict that only one side gets everything and the other side gets nothing, it probably wasn't the right thing, nine times out of ten. I was always happy if both sides walked out mad at me. I figured we did a pretty good job because at least both sides had some give-and-take in what happened in the courtroom.

That's where we ought to be in here. When it's over with, both sides ought to say, We didn't get all our way but at least we got something done and we didn't impose the will of man over the rule of law.

I guess I just felt like preaching this late at night. And that's probably enough of all of that.

I do ask that the people back home—I know we're not supposed to address the people back home, but I will say that every man and woman in this House are addressing life-changing issues now and will be in the very near future, that the amount of accumulated job loss and debt is getting critical for all of us whether we are in this House or whether we are at home, and let's all try to work together to come up with something that will work.

And with that, Mr. Speaker, I will yield back the balance of my time.

POPULIST CAUCUS

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

Mr. BRALEY of Iowa. Mr. Speaker, I'm here tonight on behalf of the Populist Caucus, which is a caucus that I founded this year, along with many of my colleagues, who felt that there was not enough emphasis in this Chamber on discussing values that promote and expand the middle class.

So one of the reasons that we founded this caucus was to find a voice that was going to be consistent in pursuing policies and adopting legislation that we're going to help promote opportunities for middle class families to survive, and also to expand opportunities for people to enter at the middle class because we all feel, and this country's history has shown, that this country does best when we have a large, robust middle class.

And that's why, when we passed the Populist Caucus values, these are the primary things that we wanted to focus on: good jobs, middle class tax cuts, affordable health care, quality education, fair trade, consumer protection, and corporate accountability.

Now, some of those basic values have been part of the ongoing discussion in terms of our health care reform bill that is currently pending in the House of Representatives. And as a member of the House Energy and Commerce Committee and the Health Subcommittee, much of my time this year has been consumed in making sure that the health care bill that we are putting forward addresses these values, particularly affordable health care, consumer protection, and corporate accountability.

So today, the Populist Caucus announced its health reform principles, and I'm going to spend some time tonight talking about those principles, talking about the importance of these principles to middle class families and those seeking to enter the middle class, and then sharing some stories from some constituents of mine back in Iowa's First District who are struggling right now to provide for their families, and address growing health care burdens that affect every American no matter where they live, no matter what they do.

As we have seen over and over and over again, health care costs continue to grow every year. They represent a larger and larger share of our gross domestic product. We see more and more families faced with the burden of bankruptcy because of unsustainable health care costs that aren't covered by their insurance plans. We see more and more Americans without any insurance at all, almost 50 million uninsured Americans. We also see many Americans who are underinsured; that is, they are taking policies out that don't provide them the type of coverage they need because they can't afford either to buy their own coverage if they're self-employed or if they're without employment, or many of them have insurance offered through their employers who are increasingly forced to put more and more of the burden of that insurance coverage on to their employees.

□ 2300

And so one of the reasons why we've been having this national conversation about health care reform is because we have to come up with a system that works for the American people and finally realizes the goal of universal coverage.

Now, some people who have health insurance and are sitting well in their own financial circumstances wonder why should I care about this; this doesn't affect me; this doesn't affect my family. But the reality is that each one of us in this country pays a hidden tax right now of $1,200 a year so that people with no health insurance who go to the hospital emergency room and will be given treatment, because those hospitals cannot turn them away, somebody pays for that care, and we all

pay for it in the form of higher tax burdens and in the form of higher insurance premiums for the coverage that we have.

So that's why this issue is so compelling, and it's something that we have to address, and the sooner we address it the better.

The reason why it affects us all is because 7 out of every 10 cents spent on health care goes to cover chronic diseases, things like diabetes and obesity and all of the complications that can come from them including congestive heart failure, high blood pressure, problems with vision and foot care and on and on and on.

Now, the thing about chronic disease is that most of them are preventable through education and early intervention, and that's why our system right now is broken, because we pay for health care on a fee-for-services basis, which means if you get sick and you seek medical treatment, we will pay for that treatment. But we don't provide incentives to individuals to get healthy before they need a doctor or have to go to the hospital.

And that's why a national health care policy that makes sense has to emphasize prevention and wellness. That has to be one of the cornerstones of how we reduce that enormous burden of chronic disease in this country.

So let me start by briefly reviewing the Populist Caucus health care reform principles, and then I will spend time talking more about the details of each one.

The first goal of the Populist Caucus in addressing health care is providing more affordable health care, and we recommend a values system in this health care bill that ensures that every American has access to affordable, quality health care coverage. Now, that sounds simple in theory. In reality, it is a challenge that has faced this country since its founding.

The second component of our health care reform principles for the Populist Caucus centers around choices for families, populist values. The first aspect of our values for health care reform under choices for family is keep your coverage if you like it, and that is included in the House version of the health care reform bill. It allows consumers to keep their current coverage if they like it.

So if you have an employer who's currently providing you high-quality health care at an affordable price, like maybe a company like John Deere which employs many people in the First District of Iowa, nothing in this health care reform bill is going to change your ability to keep that coverage. If you like it, you get to keep it.

Second, one of the most important factors in choices for families is no discrimination, and you have to have a populist value that says, in insurance coverage, you have to eliminate discrimination that allows insurance companies to exclude people from coverage based upon preexisting conditions.

Now, we know this is an enormous problem in many different ways. There are millions of Americans who are denied health insurance coverage right now because of preexisting conditions.

I have a nephew who lives in Malcolm, Iowa. He has a young son tamed Tucker Wright, and when Tucker was a year and a half, he was diagnosed with liver cancer, and he was very, very fortunate that he was diagnosed and had an opportunity to have two-thirds of his liver removed at a very young age to save his life. But Tucker also faces a very bleak future because he has a long history, a long life of expensive medical care ahead of him.

Many of the existing health care policies have a cap on lifetime benefits; and once you meet that cap, you get no more coverage, no matter how sick you are, no matter how old you are, no matter what your medical needs are. And if you have been diagnosed with a serious disease like liver cancer, and your family wants to move or your parents want to look at other job opportunities right now, there's very little chance that you're going to be able to make that switch and get coverage because they will write an exclusion in the policy based upon preexisting conditions that say we're not going to cover you because you have this expensive treatment.

That's one of the major problems with health care in America today, and it's not just on access to care. It has enormous implications for employers and employees because right now in this country, literally hundreds of thousands, if not millions, of workers are working in jobs they don't like. And the only reason they're there is because those jobs offer them some level of health care coverage, and they know that if they leave the job they have, there's a very good chance that a family member, a loved one, won't be able to get coverage under a new plan at a new employer because of preexisting conditions.

And this bill that we are considering in the House right now eliminates discrimination in health care coverage based upon preexisting conditions.

One of the other very important elements of our Populist Caucus family values emphasis is including a robust and meaningful public health insurance option that operates on a level playing field with private insurance companies, increases consumer choice through a public option for insurance coverage that does these things—and these are critical achievements—one, competes on a level playing field; two, maintains minimal levels of coverage that ensure quality care for its enrollees.

And in the House plan, there are three basic forms of coverage that will be available: a basic plan, an enhanced plan, and a premium plan. And then there will also be something called the premium plus plan, and all of those plans will provide a minimal level of coverage designed to provide basic and emergency types of health care coverage for every person in America.

Another component that emphasizes these family values of the Populist Caucus is that this public plan option must reimburse health care providers adequately and equitably, and we're going to spend some time talking about what that means.

Another family value in the Populist Caucus health care package, it helps address current geographic disparities in health care. This is one of the most significant challenges that we face and one of the most significant problems with our health care delivery system.

Another key family value is that the existing infrastructure of Medicare which will be used under the current plan, a Medicare plus 5 percent reimbursement payment system, that that existing infrastructure has to be used to create a viable provider network; but it should only use Medicare as long as improvements are made in the way that Medicare's reimbursement structure and geographic disparity issues are addressed, and I'm going to be spending time talking about the challenges that we face and the problems we currently have in Medicare reimbursement.

Now, I want to move on to another key component of the Populist Caucus health care values: saving taxpayers money. Every medical economist who looks at our current health care delivery system is in agreement that the number one problem is a problem called overutilization, using too many medical services that aren't necessary, that waste money and result in worse outcomes. We have to address the problem of overutilization of care. It creates unnecessary costs and adds hundreds of billions of dollars and can lead to harmful medical errors.

Now, medical economists at the Dartmouth Atlas Project and places like the Commonwealth Fund who have looked at this estimate that every year in our health care delivery system we lose between $500 billion and $700 billion every year due to overutilization, and they have also analyzed patient outcomes arising from that overutilization, and the figures are shocking.

They estimate that every year 30,000 people die in this country because of too much medicine that exposes them to risks and actually results in their death. There are hundreds of thousands more who are injured because of overutilization, and it's not achieving the desired goal of medicine, which is to cure patients who need help and to provide it in a meaningful fashion.

□ 2310

One of the other concerns about saving taxpayer money is emphasizing prevention and quality care. We have talked about that. We need to shift to a health care delivery system that moves toward incentives, toward high-quality care prevention, nutrition, and wellness. And we have to reform Medicare part D, the drug package for seniors and people on Medicare. One of the most essential components of that is to

close the doughnut hole, give Medicare the ability to negotiate with drug manufacturers, and to seek rebates for all Medicare beneficiaries from those pharmaceutical manufacturers.

Now I want to talk for a moment about this problem that I mentioned called geographic disparities in payment for health care. This chart was prepared by The Commonwealth Fund to focus on the relationship between the quality of care and Medicare spending.

So, on this bottom axis it provides cost numbers to show annual Medicare spending per beneficiary in dollar amounts for every State in the country and places them on the chart according to that axis. The vertical axis has an overall quality ranking. And those quality rankings are taken directly from Medicare administrative claims data and the Medicare Quality Improvement Organizations Program data. So it's information already collected by Medicare.

The chart numbers are shocking in terms of showing the existing disparity in how we pay for Medicare and the direct correlation between how much we spend and the quality we get for our Medicare dollars.

Many of us who represent States who are up in the top 5 to 10—not top 5 to 10 percent, but the top 5 to 10 in rankings, these States right here inside this pink circle, States like New Hampshire, Vermont, Maine, North Dakota, Iowa, Wisconsin, Utah, Minnesota, Oregon, and Montana, are consistently providing the highest quality of care to Medicare patients at the lowest cost, because they also rank in the bottom 5 to 10 States in Medicare payments per beneficiary.

Then, contrast with what we see at this end of the chart. This chart reveals that the most expensive of States in terms of what we pay for Medicare per patient is the State of Louisiana, where we pay right now about $8,500 per patient. Guess which State is also ranking 50th in terms of quality outcomes, according to Medicare data? Louisiana.

That is the hallmark of an inefficient payment system for health care delivery and it's a symbol of what is wrong with our health care payment system in this country. That's why we have to address this problem of over utilization, which is directly driving up these costs; rein in unnecessary and wasteful spending so we can use those savings to pay for a comprehensive health care reform package that provides access to care for all Americans.

So I want to move on and talk about some of the stories from my district that have shaped my commitment to making change in health care delivery.

Since I was elected to Congress in 2006, and was sworn in in 2007, I have received almost 12,000 letters and e-mails on health care. Health care is the number one issue that my constituents write to me about. And this year alone, I have received over 4,000 letters and e-mails relating to health care. In fact, this small stack represents just a small portion of my constituents who have had serious issues with our health care system. And just in my hand I have over 200 stories from constituents of mine who have taken the time to write to me and explain their frustrations and concerns with our health care system.

These stories are the backdrop and provide the compelling evidence on why we need true health care reform in this country.

So let me start with this compelling story from Sandy Ingram in Davenport, Iowa, which is right on the Mississippi River, beautiful old city in Iowa, largest city in the First District.

Sandy starts her story: My story is not unlike many others who are struggling with their health insurance problem. In August of 2007, I was diagnosed with stage III breast cancer. Until that time, I was rarely ever ill, and I looked forward to retiring, like most other women in their sixties.

Until January 31, 2009, I worked for a company and was employed as an executive assistant to the CEO. I raised three children, all now educators, as a single mom and I finished a four-year degree at St. Ambrose University.

In the spring of 2007, I had my usual mammogram, and I told the technician I had a sore spot, and she made note of it. It came back as no change. As the weeks went by, it became more pronounced and painful, and I went to a nurse practitioner, who sent me for another mammogram immediately.

Over time, it was discovered that my mammogram test was positive and I received a call at my office with the news that every patient dreads: I'm sorry to tell you that you have cancer.

I set up an appointment with the surgeon and, with the help of my nurse practitioner, I found a wonderful young surgeon, Dr. Melinda Hass of Trinity Hospital. I met with her, went through all the necessary workup, and later received a followup phone call saying my cancer was much worse than they thought, and I could have cancer in both breasts. They found out the cancer had spread to my lymph nodes, and so I began chemotherapy.

The beginning of the third week, my hair began to fall out in the shower. I shaved my head, bought some caps and scarves, and moved on. I worked throughout the chemo by scheduling time off and going to work when I began to turn the corner from the side effects.

In December 26, 2007, I had bilateral breast surgery to remove both breasts. I made this difficult decision because I didn't want to have the chance of reoccurrence in the other breast. During the surgery, 22 lymph nodes were removed. However, 17 of the lymph nodes still had cancer. The feeling that I had that morning still gives me chills. My fight wasn't over yet.

I underwent another round of chemotherapy a few weeks after the surgery, followed by 36 radiation treatments. I was physically spent and took a medical leave of absence and returned to work in August of 2008, ready to hit the ground running. Needless to say, I love my job, the people that I worked with, and was looking forward to being there until I was old enough to retire.

I was so pumped up that I unlocked my office door and prepared for a busy day when I came back to work. About an hour later, I had a phone call from a friend in customer service saying their assistant had just been let go. A few minutes later, my phone rang and it was my boss, asking me to come to the conference room upstairs.

What happened is my boss greeted me with tears in her eyes, a big white envelope in front of her. Seated at the table was the VP of manufacturing and the two of them broke the news to me that my job had been eliminated. It was only weeks after I had been declared cancer free by the 60-day checkups.

I was stunned. They both assured me it had nothing to do with my performance. The response was predictable. They told me that I would have to leave the building immediately and could return to the office later to pack up my office. Everybody in the whole office was very shaken.

So now I'm unemployed. I have unemployment insurance and through COBRA continue to pay for health insurance on my own. That will last through July of 2010. At that point I will have to have some kind of insurance until my 65th birthday in November of 2010.

□ 2320

I continued to look for a new position. I have applied for several and may try to work part time to help pay for the COBRA coverage. I have done research about getting further coverage, and I have found I cannot get coverage due to my preexisting condition. There is some kind of stopgap health coverage through HIP of Iowa; however, since I paid health insurance premiums for nearly 20 years, I feel I should be able to keep it until I am old enough for Medicare. Health care reform is essential to all Americans. The time is now, and I am willing to help tell my story to get the bill passed.

Here is another story. This one is from Elle in northeast Iowa. She is 1 year old and has been diagnosed with cystic fibrosis. Her family had COBRA insurance, which is an extension of your insurance after you leave your job until you find more employment, from her dad's former employer in Minnesota. Her dad's employer offered a more affordable plan to the family, but when they realized the family resided in Iowa, they reversed the offer. Because of Elle's diagnosis, this family was unable to get private insurance in Iowa.

Her mother quit her job so that their income would decrease enough to get Elle on Medicaid. Quite understandably, Elle's parents are frustrated because they believed they shouldn't

have to quit their jobs to get health care coverage for their daughter. They believe that insurance needs to be accessible for all children, including those with chronic health conditions, and that is one of the number one objectives of the health care reform bill we're considering right now.

Here is another contact I got from Mark in Davenport. Mark was doing insulation in his mother's home so that she could take advantage of some energy savings rebates, which is something every American should be encouraged to do. Unfortunately, while Mark was putting the insulation in his mother's home, he fell through the ceiling and severely injured himself, suffering a collapsed lung, broken ribs, and dislocating most of the ribs from his vertebra. He was lucky to survive, but he had no health insurance because he was a self-employed private contractor. His medical bills were over $20,000, and because of those high costs, he was forced to file for bankruptcy so he could get out from under his debts.

Here is another contact from Cynthia in Denver, Iowa, who 3½ years ago lost her husband to diabetes and heart disease. Since then, she's had to deal with major debts because they, like millions of Americans, did not have health insurance. When they tried to get coverage, they were told that because of her husband's preexisting condition, they would have to pay for premiums for a year without coverage for those claims. She continues to be without coverage because she is still paying off the bills from her husband's doctor and hospital costs.

Here is another story from Gus in Waverly. His daughter Jamie lives in Des Moines and works for a life insurance company. Jamie, like many Americans, has cerebral palsy and is confined full time to a wheelchair. But even with her limitations, Jamie chooses to work, and the only type of insurance help that she gets is through a Miller Medical Trust that allows her to work, but she can't work full time.

Because of the limitations of that trust, she has lost a much-deserved promotion. She hasn't taken a pay raise in years so she can choose to work and be a taxpaying citizen. Many of her advisers and social workers have told her that she should just go on full disability and her benefits would increase and be easy to get since she qualifies as a quadriplegic; yet Jamie is a perfect example of the American spirit. She wants to work, and she continues to work and does everything she can.

Her father doesn't understand why we would punish people like Jamie who want to work but still need critical access to health care. Let them earn more money that pays more taxes and help them support their own services. Who could argue with that? And that's what we want to do with comprehensive, meaningful health care that addresses these Populous Caucus values.

Here is another letter from Julie in Cedar Falls, Iowa. Several years ago when Julie was mowing her lawn, she was severely injured when a bolt on the lawnmower cut her arm. She had to go to the emergency room for stitches. Later she learned that her emergency room visit was not covered by her health care coverage because, according to them, she should have waited to cut her arm when the doctor's office was open instead of visiting the emergency room. Given the severity of her wound, she couldn't have waited until Monday to see her doctor. The emergency room was the only option available for her at the time. Julie believes that the problem with health insurance companies is they look for any excuse to deny payment for an existing claim.

This is a letter from Mic in Davenport who was born with congenital heart disease. Mic has had three open-heart surgeries, the first at age 3 weeks, the second at 16, and the last at age 45. He owns his own company, employs 11 people, and provides group health insurance to his employees because it's the right thing to do, but also because he can't buy an individual health insurance policy with his congenital heart disease because it would be a preexisting condition.

Mic says, We're charged at the highest rate possible, and our rates go up by the maximum amount allowed per year because of my heart disease. In the past 2 years, we've risen to 60 percent and 75 percent increases. In order to keep providing insurance to my employees, I will have to drop out of the program next year to keep the rates manageable.

This story is from Randal Wehrman from LeClaire, Iowa. His wife, Beth, died from pancreatic cancer in August 2008 at the age of 56. And like many couples, during her illness, Randal had his own health emergency. He was diagnosed with prostate cancer, and as he describes it, we were launched into a health care arena and were impacted dramatically by how our health insurance performed.

Randal, like many Americans, tells me that he was reasonably satisfied before this point with how his health care insurance carrier had functioned. His wife was a registered nurse, so she was a very good medical consumer. He was in the property and casualty insurance business and had been a certified paramedic in the State of Iowa for the last 25 years, and as he notes, this would suggest that Beth and I were above average medical consumers. It also means, according to his background and his business, including a BA with a business administration degree from Simpson College, that he would have been an above average medical insurance consumer.

Here is the problem: Even though the Wehrmans' health care plan said it had a maximum out-of-pocket of $1,500 per person in network and $3,000 per person out of network, we paid just over $10,000 out of pocket during calendar year 2008 for our health care. Here is how Randal describes it:

''You see, one has to read the fine print to find out doctor office copays, prescription copays and emergency copays do not fall under the maximum out-of-pocket expenses referred to in the bold print. While Beth's care included an out-of-pocket network expenses, mine did not, which means that we spent an additional $5,500 of out-of-pocket items that were not included in our limits. We are fortunate that we could pay the additional, although not easily, but some cannot. For some, this situation could be financially devastating. And we know that by the high number of medical expense-related bankruptcies we see every year. This should be clearer and more concise, as it can have a substantial impact on the financial futures of many citizens.''

Well, Randal, you are absolutely right, and one of the reasons why I introduced a bill to incorporate plain language into every insurance policy sold under the national health insurance exchange that's part of this health care bill is because I have had my own experience, not just as a consumer of health care, but helping clients, in the 23 years I practiced law before I came here, who had disputes with their insurance companies over coverage benefits.

One of the things I learned is that when you force insurance companies to write those policies in language that insureds can understand, you eliminate the type of confusion that highly sophisticated health care consumers, like Randal and Beth Wehrman, brought to the table and still wound up with unfair treatment based upon language in their policy that was difficult to understand and not part of the clearly stated coverage.

□ 2330

I'm very proud of the fact that my plain language amendment is incorporated in the American Health Care bill that we are currently considering in the House of Representatives. And I want American health consumers like Randall and Beth Wehrman to be able to look at that policy and see it written in language that is specifically intended to be understood by them so they have a deep appreciation for what they have, and they also have the ability to go into that National Health Insurance Exchange and compare it to other policies that provide the same basic types of coverage and say, is this policy a better policy for me than the one next to it? Does it provide better coverage? Does it have fewer exclusions? Does it cost less? And will it guarantee me the access to health care that my family needs? That's one of the major focuses of the populist values approach to health care reform.

So what else is important? Well, we spent time talking about how we can move from a system that rewards volume of medical care to a new model, a new system that rewards value outcomes. And we pay for performance.

And I am very proud to be introducing an amendment, along with my friends LEE TERRY from Nebraska, a Republican, and BART STUPAK from Michigan, who is the Chair of the Oversight and Investigations Committee on the Energy and Commerce Committee, the Medicare Payment Improvement amendment, which has a very simple goal, to increase the quality of health care in America and create long-term substantial cost savings.

So what will this amendment do? Well, it starts by restructuring the Medicare payment system that I talked about earlier, by finally adding an incentive for physicians to provide high-quality care and decrease costs. And the way the bill does it, it adds a figure that measures value and includes it in the Medicare reimbursement equation. That value figure measures both quality of care and the cost of care, two components that directly relate to the overutilization of medical services that dries up our national health care costs.

One of the things we know is that regions that provide high-quality care at low cost will see their Medicare reimbursements improve and increase because it's a reward for providing value in the system. In contrast, regions that provide low-quality care at high cost will see their reimbursements decrease.

Now, this may come as a shock to most people, but that's the way an economic system is supposed to work: you provide incentives so that people in a marketplace who provide the highest quality at the lowest cost will create the most demand and drive consumers to their product or services. Every student of economics 101 can tell you that's the way economic models are supposed to work in this country.

But our health care payment system is flawed and it's reflected in this chart, and it's reflected in the hundreds of billions of dollars of waste in the system.

Now, one of the things that we can do is to shift from a fee-for-service reimbursement model to one that rewards quality and shifts the focus to provide efficient care.

Now, a lot of people mistakenly believe that when you're talking about efficiencies, you're only talking about cutting cost. That is not what I'm talking about, and that is not what the Populist Caucus values are based upon, because true efficiency in a health care delivery system is a system that consistently provides the lowest possible cost for the highest possible value over the lifetime of a patient's care. That is efficiency in health care delivery.

So this bill, the Braley-Terry-Stupak Medicare Payment Improvement amendment accomplishes that and provides a transition from our current quantity-based system to a value-based system.

How do we do that? Well, here's how: our amendment instructs the Secretary of Health and Human Services to measure quality and cost for hospital fee schedule areas, which have already been established, or other more narrow areas if the Secretary deems that appropriate. That could include hospital referral regions or even on down to the individual provider.

Two, our amendment instructs the Secretary to create a quality component to measure quality and to do that in consultation with the already existing Agency for Health Care Quality and Research, and an advisory group consisting of health care providers, health care plans, and other government agencies and other knowledgeable entities, including consumer groups that have knowledge about how to build efficiency and reward value.

Three, the Braley-Terry-Stupak Medicare Improvement amendment ensures an open and transparent process in the development of this quality component. And during some of our conversations about how you could possibly do this, we hear concerns expressed from people in this part of the country: you're not taking into account this factor. We hear concerns expressed from people in another part of the country: you're not taking into account this factor.

Well, the harsh reality is the medical economists who've been studying this issue for decades have already looked at every possible racial, ethnic, socioeconomic, regional, cost-of-living, cost-of-workforce factor and can find nothing to justify the reimbursement disparities we see right now.

To give you an example of that, one of the most significant factors contributing to overutilization in this country is what we pay for end-of-life care. And one of the things that researchers have discovered is spending more for end-of-life care does not yield better results and does not make people more satisfied and their families more satisfied with the care that they got. And, in fact, the exact opposite is true.

So let's talk about geographic disparities and how it relates to this problem of overutilization. Researchers and medical economists who looked at the last 2 years of spending in the life of Medicare patients at Garfield Hospital in Los Angeles, concluded that, on average, we were spending $106,000 per Medicare patient in the last 2 years of their life. That was contrasted with the Mayo Clinic in Rochester, Minnesota, 2 hours from where I live, another world class medical facility, a teaching hospital. At the Mayo Clinic, patients in their last 2 years of life, Medicare paid, on average, $33,000, a three-fold decrease from what's being spent in Los Angeles.

And you can look at all those other factors I laid out earlier, and none of them can justify that kind of a payment disparity. And, in fact, when you look at the regions of the country that are spending the most on those last 2 years of patient care in a patient's life, and you look at the quality assessments that are used, you'll learn that patients in the areas that spend much less are much more pleased with their quality of life at that end-stage phase because more attention is placed on providing hospice care, providing a way for those patients to interact with their family on a meaningful basis, to be able to return to their homes and spend as much time there as possible without a lot of unnecessary tests and medical procedures that are very costly and do very little to improve the length of the patient's life or the quality of their life.

□ 2340

That's why this bill, this amendment—the Braley, Terry, Stupak Medicare Payment Improvement amendment—focuses on how we motivate health care providers to get better outcomes, to spend less and to get better quality care.

So, going back to my example, according to the 17 existing quality factors that Medicare uses to assess facilities, the Mayo Clinic ranked above Garfield Hospital in every single one of those quality assessments. That is what we're focusing on—quality outcomes at the best possible price over the life of a patient. That is efficiency.

Another component of the Braley, Terry, Stupak Medicare Payment Improvement amendment is that it instructs the Secretary to create a cost component to measure cost based upon the hospital fee schedule area or upon other more narrow areas. That cost component is the cost per Medicare beneficiary compared to the national average, which should be a reasonable thing for anybody looking at how we spend money and at how we decide who is outside the norm, who is below the norm, and whether they're getting the types of results that they should.

The Braley, Terry, Stupak Medicare Payment Improvement amendment also includes a risk adjuster in determining the cost component. This ensures that any area with a significant at-risk population—high rates of obesity and other socioeconomic risk factors that bill into the system—shall have them taken into account when determining the cost for that area.

Then the sixth component is to provide a transitional period from 2012–2014 when this quality cost figure is applied to the Medicare part B reimbursement equation in place of the current work geographic practice index. The work gypsy, as it's known, is currently used to measure the value of a physician's work only through the amount of inputs. Our amendment shifts the emphasis to a measure of value that is quality and cost.

So you may be asking yourself: Well, how in the world do you measure for quality in a system that has so many variables? Here is how the Braley, Terry, Stupak Medicare Payment Improvement amendment measures quality:

First, we look at health outcomes and at the health status for the entire Medicare population. We also focus on patient safety, which could fill up another hour by itself. Why? Because the

Institute of Medicine has published three seminal reports on patient safety, and it has identified the enormous problem in this country with patient safety. In fact, the Institute estimates that, every year, as many as 98,000 patients die because of preventable errors. This is the Institute of Medicine, which is not a partisan entity. They also estimate that, each year, over 1.5 million medication errors occur and that every hospital patient is subjected to some type of medication error every day they're in the hospital.

Patient satisfaction. This gets back to what we were talking about with end-of-life treatment. Increasingly, how patients receive care and respond to care is directly related to how they perceive their access and quality of care. It also measures hospital readmission rates because we know that one of the biggest drivers of cost is that of patients who are discharged from the hospital and who are later readmitted for conditions that may have been prevented if there had been better information communicated to them or if there had been better coordination of care upon their discharge.

Another factor we look at is mortality related to health care. Are patients dying in greater numbers as a complication of a specific problem? We know, for example, that hospital infections are an enormous problem. They lead to many hospital readmissions, to prolonged patient stays, to increased costs of care, and in the worst outcomes, to death. We also know that many hospital infections are entirely preventable from standard, simple precautions like hand-washing procedures that are not only adopted but that are enforced.

Then other things that we use to measure quality are other items determined by the Department of Health and Human Services, and if the advisory group has other recommendations, we certainly want the Secretary to take those into account.

How do you measure cost? Well, the cost component is measured through the total annual, per-beneficiary Medicare expenditures under part A for that area, and it also allows the Secretary to use other methods if it's appropriate.

So how much cost savings are we talking about? Hundreds of billions of dollars. We know that, by changing the incentives away from a fee-for-service toward a fee-for-high-quality and low-cost model, we create incentives for health care providers to improve their outcomes and to decrease their costs. We can use those cost savings to build a health care system that truly is universal and that helps us all.

Nobody said this challenge would be easy. Yet those of us who are committed to comprehensive, universal health care that is paid for, that is reliable, affordable, efficient, and high quality are committed to spending the time necessary to improve this bill and to make it work the way it needs to work. It has to work if we are to function as a country.

So I ask you to join the Populist Caucus, to call your Representative or your Senator and to make sure that they know how important health care is to you, just the way my constituents called me, wrote me and sent me e-mails.

This is a challenge. The time has come for bold action. Americans deserve better. Americans demand better, and it is our responsibility in this Chamber, Mr. Speaker, to finally deliver on the promise of health care for all that is high in quality and that is low in cost.

With that, I yield back the balance of my time.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. LUCAS (at the request of Mr. BOEHNER) for July 20 on account of bad weather and travel delays.

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 Mr. LYNCH) to revise and extend their remarks and include extraneous material:)

Ms. WOOLSEY, for 5 minutes, today.

Ms. KAPTUR, for 5 minutes, today.

Mr. DEFAZIO, for 5 minutes, today.

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

Mr. SOUDER, for 5 minutes, today.

Mr. JONES, for 5 minutes, July 28.

Ms. FOXX, for 5 minutes, today.

Mr. BILIRAKIS, for 5 minutes, today.

Mr. BROUN of Georgia, for 5 minutes, today.

SENATE BILL REFERRED

A bill of the Senate of the following title was taken from the Speaker's table and, under the rule, referred as follows:

S. Con. Res. 11. Concurrent resolution condemning all forms of anti-Semitism and reaffirming the support of Congress for the mandate of the Special Envoy to Monitor and Combat Anti-Semitism, and for other purposes; to the Committee on Foreign Affairs.

ADJOURNMENT

Mr. BRALEY of Iowa. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 11 o'clock and 47 minutes p.m.), the House adjourned until tomorrow, Wednesday, July 22, 2009, at 10 a.m.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 2 of Rule XXIV, executive communications were taken from the Speaker's table and referred as follows:

2745. A letter from the Acting Administrator, Risk Management Agency, Department of Agriculture, transmitting the Department's final rule — Common Crop Insurance Regulations, Basic Provisions (RIN: 0563-AC23) received July 1, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

2746. A letter from the Director, Office of National Drug Control Policy, Executive Office of the President, transmitting notification that the Office has designated thirteen new counties in eight states as High Intensity Drug Trafficking Areas (HIDTA), pursuant to Public Law 109-469; to the Committee on Appropriations.

2747. A letter from the Chairman, Board of Governors of the Federal Reserve System, transmitting the System's annual report to the Congress on the Presidential $1 Coin Program, pursuant to 31 U.S.C. 5112 Public Law 109-145, section 104(3)(B) (119 Stat. 2670); to the Committee on Financial Services.

2748. A letter from the Director, Office of Legal Affairs, Federal Deposit Insurance Corporation, transmitting the Corporation's final rule — Special Assessments (RIN: 3064-AD35) received June 25, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Financial Services.

2749. A letter from the Director, Office of Legislative Affairs, Federal Deposit Insurance Corporation, transmitting the Corporation's final rule — Interest Rate Restrictions on Insured Depository Institutions That Are Not Well Capitalized — received June 25, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Financial Services.

2750. A letter from the Acting Director, Pension Benefit Guaranty Corporation, transmitting the Corporation's final rule — Allocation of Assets in Single-Employer Plans; Benefits Payable in Terminated Single-Employer Plans; Interest Assumptions for Valuing and Paying Benefits — received July 1, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Education and Labor.

2751. A letter from the Assistant Legal Adviser for Treaty Affairs, Department of State, transmitting copies of international agreements, other than treaties, entered into by the United States, pursuant to 1 U.S.C. 112b; to the Committee on Foreign Affairs.

2752. A letter from the Secretary, Department of the Treasury, transmitting as required by section 401(c) of the National Emergencies Act, 50 U.S.C. 1641(c), and section 204(c) of the International Emergency Economic Powers Act, 50 U.S.C. 1703(c), a six-month periodic report on the national emergency with respect to Lebanon that was declared in Executive Order 13441 of August 1, 2007; to the Committee on Foreign Affairs.

2753. A letter from the Inspector General, Department of Commerce, transmitting the Inspector General's semiannual report to Congress for the reporting period October 1, 2008 through March 31, 2009, pursuant to 5 U.S.C. app. (Insp. Gen. Act) section 5(b); to the Committee on Oversight and Government Reform.

2754. A letter from the President and Chief Executive Officer, Federal Home Loan Bank Seattle, transmitting the 2008 management report of the Federal Home Loan Bank of Seattle, pursuant to 31 U.S.C. 9106; to the Committee on Oversight and Government Reform.

2755. A letter from the President and Chief Executive Officer, Federal Home Loan Bank of Topeka, transmitting the 2008 Statements on System of Internal Controls of the Federal Home Loan Bank of Topeka, pursuant to 31 U.S.C. 9106; to the Committee on Oversight and Government Reform.