

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

HEALTH CARE EXPENDITURES

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

Mr. PRICE of Georgia. Mr. Speaker, I want to thank you so very much for allowing me to come to the floor. I want to thank the leadership for allowing me to come and talk about an issue that is extremely, extremely important and timely right now as we complete congressional business this week.

I would like to talk a bit about health care and health care expenditures and how the current system is set up that will, I believe, and many people believe, adversely affect how patients are treated across our Nation. And it has to do with the Medicare program, and it has to do with something called a sustainable growth rate, or SGR, which is currently the way in which it is determined on the part of the government how physicians are compensated for caring for Medicare patients.

Now, before I came to Congress, Mr. Speaker, as you know, and others, I was a physician, orthopedic surgeon; practiced over 20 years in private practice of orthopedic surgery on the north side of Atlanta. And there are probably another 10 or 12 physician Members of the United States House of Representatives, and each of us knows and appreciates and understands that the manner in which the government has decided reimbursement for physicians over the past number of years has resulted in, in many cases, in many cases across this Nation, a disincentive for physicians to be able to see patients.

And that is an important point that we need to think about, Mr. Speaker, because as that disincentive has increased over a period of time, and I, and many others would argue that it continues to increase. In fact, it is getting much, much worse. There is a decrease in the access that patients have to quality care all across this Nation, and we are seeing it in numbers that we will talk about today, time and time again, especially in many of the specialties, subspecialties.

So what has happened with the manner in which the government makes decisions regarding reimbursement, regarding how much physicians are paid for services, oftentimes what has happened is that patients can no longer find doctors, having difficulty finding doctors. So what we would like to do for the next few moments is to chat about, to discuss this issue of physician reimbursement as it relates to patient access to care and to talk about this SGR, sustainable growth rate.

I joke back home about how the SGR really is not a sustainable growth rate;

it is an unsustainable reduction rate, URR, and we will have some numbers that will back that up.

Oftentimes when we think about the expenditure of health care dollars in this Nation, we think, well, every single dollar is obviously going to doctors to take care of patients. In fact, that is not what happens. And this chart is a great example of that.

This is national health care expenditures in the year 2004, the most recent for which this kind of data is available. The total in 2004 was \$1.88 trillion, Mr. Speaker, \$1.88 trillion of money being spent on health care. And I always, whenever I present this kind of information in a forum where individuals can ask questions, they are always surprised to find that a relatively small portion of that health care dollar goes to their doctors. In fact, on this pie chart, only 21 percent goes for what are called clinical services; that has physician/clinical services, which means what it takes to take care of patients, ordering tests and prescription drugs and the like.

In fact, the amount of money going to physicians out of a given health care dollar is in the low teens, 12, 13, 14 percent on the dollar, which means that it really is pennies out of the health care dollar that we are spending in this Nation that goes to the individuals who are providing the vast majority of the care.

Now, that is not to say that these other things aren't important; but it is important to appreciate, Mr. Speaker, that the amount of compensation, the reimbursement, the providing of the cost for the services that are being provided by physicians is a relatively small portion of the health care dollar. And that is important, because what we have seen over the past number of years is that the way in which the Federal Government is reaching their targets as to how much they spend on health care is to decrease the reimbursement for physicians, and therein lies the significant problem.

So how did we end up in this boat?

Well, in 1965, middle '60s, Medicare was passed. And at that time, the manner in which it was determined how much physicians should be paid and therefore what kind of access patients had to physician care was that each individual physician would bill Medicare for certain services, and then the amount of difference between the amount that Medicare paid and what they had billed, the physicians were then allowed to then what's called balance bill or bill the patient. And initially this program compensated the physicians, as I mentioned, on the basis of their charges, and allowed them to balance bill.

What happened over a period of time, for a variety of reasons, and I would suggest, not necessarily physician related, but in 1975 the Medicare payments were continued to be linked to physicians. But the annual increase in cost, the annual increase in fees began

to be limited by what was called and is called the Medicare economic index or MEI. And because the changes were not enough to prevent the total payments from rising more than were desired at that time, from 1984 through 1991, the yearly change in fees was determined specifically by legislation.

So between 1984 and 1991, instead of allowing physicians to bill for certain procedures and certain activities that they would perform in taking care of patients, what happened is that Congress decided, between 1984 and 1991, what physicians in the Medicare program would be compensated for those procedures or that activity. And then starting in 1992, this charge-based system was replaced by what was called a physician fee schedule. And this fee schedule bases payment for individual services on measures of the relative resources provided to them.

Now, this is extremely important because in 1992 was the time when the Federal Government, and we as a Nation, decided, in essence, we will determine at the beginning of the year, January 1, how much money we will spend for health care for the entire year to come. Without regard to how many patients there were to be seen, what kind of health challenges and problems they had, we were going to set this finite pot of money as a Nation and say, this is what we will spend on health care. It doesn't make a whole lot of sense when you think about it, because those kinds of things are not necessarily predictable.

Now, at that time it was stated that that schedule, this physician fee schedule, was not intended to control spending; but it was designed to redistribute the spending among various physician specialties, so if it was determined by the Federal Government that thoracic surgeons were gaining too much of this small portion of the pie, then they would shift that money to another specialty, remembering that when those monies are shifted, what happens is that many patients oftentimes lose access to the care of a quality physician.

Now, the schedule was updated at that time, in 1992, using a combination of the Medicare economic index that I mentioned before and an adjustment factor that was designed to counteract changes in volume of services being delivered per beneficiary. That adjustment factor was known as the volume performance standard. And over a period of time, relatively short period of time, that led to significant variability in the amount of payment rates. And Congress then replaced, in 1998, all of this system with what is currently in place, which is called the sustainable growth rate.

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Now, the sustainable growth rate is something that has come under significant scrutiny, because in fact it hasn't been a growth rate; it has been, as I mentioned before, a reduction rate. It hasn't answered the true question of

how we are going to provide services as a Nation, how the physicians of this Nation are going to provide appropriate health care services to patients all across the Nation and what kind of compensation they should receive.

Many people, when I talk about this at home to folks and talk in health care conferences, many people really don't appreciate and understand that, in fact, the Federal Government is setting reimbursement rates for physicians all across this Nation, the kind of price-fixing that we have as a Nation said, no, it doesn't work in any other industry. But, in fact, that is the way we do it in health care.

The reason that it is important and not just related to Medicare is that the vast majority, Mr. Speaker, the vast majority of insurance companies tie their reimbursement rates of physicians to what the reimbursement rate is for Medicare. So what happens is that an individual insurance company will impose reimbursement for physicians of a certain percentage, 100 percent of Medicare, 90 percent of Medicare, 110 percent of Medicare. The result is that, de facto, the Federal Government is setting the reimbursement rates for physicians all across this country, and it hasn't worked well. It hasn't worked well.

The SGR mechanism aims to control spending on physician services provided under Part B of Medicare, which is where the physician block is, but it is also where other services are. It does so by setting, once again, an overall target amount of spending on certain types of goods and services, as well as payments that Medicare makes for certain items. As I mentioned, there are other things besides physician payment in this portion of this pie; for instance, laboratory tests and X-rays, imaging services and many of the physician-administered drugs.

Now, the Congress had two main goals in mind when it adopted the SGR mechanism: the sustainable growth rate mechanism, ensuring adequate access to physician services and controlling Federal spending on those services in a much more predictable way than that volume performance standard did. The problem is that the SGR accomplishes neither well.

We find ourselves now over the past few years in a very, very difficult situation. Since 2002, the spending measured by the SGR method has consistently been above targets established by the formula. As a result, the SGR mechanism under current law will substantially reduce payment rates for physician services over the next several years. Payment rates would decline by a total of somewhere between 25 and 40 percent, 40 percent, over that period of time.

I have got some charts that will demonstrate a few other matters as they relate to physician reimbursement and access to care and quality care.

This is a chart that compares the payments for varying aspects of our

health care delivery system, and each of these bars, there are four bars, for Medicare Advantage which is part of the Medicare program, hospitals, nursing homes and then physicians on the far right portion of the chart.

It is important to keep in mind that the physician portion of this was slated for a decrease in all of these years, but these are the actual payments that have gone out, increases in payments or decreases in payments over the past 4 years. The portion of the Medicare program Medicare Advantage has seen decreases in the 5 to 7 percent range over the past 4 years.

Hospitals, appropriately, they do it, they perform a wonderful service in our health care systems. What they have seen is increases in the range of 3, 3½ percent over the last 4 years. Nursing homes, a comparable level.

It is important that when we have this discussion that we get across the point that nobody, nobody is saying that these numbers necessarily ought to decrease, because hospitals and Medicare Advantage, nursing homes, all of them are providing an absolutely vital and imperative service. The problem comes, I and many others would suggest, in the final group of numbers, which is where the physicians have been over the last 4 years, remembering that the physicians were slated for a decrease every year.

What that means is when physician reimbursement goes down, physicians who have been contemplating retirement say, well, it is just not going to cover my costs anymore; I am not going to be able to practice, too many headaches from the Federal Government. And many of them retire prematurely.

I am a third-generation physician. My grandfather saw patients until he was 94 years old. I guess there are some that would argue that he ought not to have been seeing patients at that time, but physicians routinely, over the last 30 to 100 years of the history of our Nation, routinely retired at a much later date than the general population. They oftentimes practiced into their seventies and eighties.

That whole trend, that whole trend has changed completely, so that now we see physicians retiring, if not at the rate of their peers in other businesses and other endeavors, in fact, many physicians are retiring at a much younger age because of a combination of factors: litigation problems, reimbursement problems, aspects of governmental intervention, regulation kinds of things. But what that means is that when physicians retire is that patients have a decreasing likelihood of having access to care, and that is where the concern lies.

When you see this chart here and the past 4 years as it relates to physician reimbursement, what has happened is that physician increase in 2004 and 2005 was in about the 1.5 percent range last year. It was absolutely flat.

So the proposal for this next year, a 5.1 percent decrease that will take ef-

fect, Mr. Speaker, in less than 30 days, in less than 30 days unless this Congress acts, unless this Congress acts, and there are incredible surveys and statistics and information we have on what the consequences, what will be the consequences to American health care if that 5.1 percent decrease takes effect.

As I mentioned a little bit ago, that decrease is slated to be year after year after year for the next 6 to 8 years. So it is not that a 5.1 percent decrease in fiscal year 2007 would result in a significant increase in 2008 or 2009 or 2010 so that folks could plan their future in terms of their practice and caring for their patients; that would be followed by a 5 percent decrease in 2008, a 5 percent decrease in 2009, a 5 percent decrease in 2010 and so on and so on.

The challenges are huge, because what will happen if we allow this to occur is that patients, many patients across this Nation will have continuing and increasing difficulty in finding a physician to care for them. The information on the amount of the number of physicians who would see these decreases, because it isn't absolutely even 5 percent across the board for every single physician, is that the vast majority of physicians would see more than a 5 percent, a 1 to 5 percent cut.

In fact, some physicians would seek decreases in their reimbursement of 16 to 20 percent, 13 percent of those would see decreases up to 15 percent. So you see where the nationwide effect would be. Sometimes you will hear folks from the Center from Medicare and Medicaid Services saying, yes, but some folks would be getting increases. I think that is arguable.

However, even if that were true, it is only in the 6 percent range, and it is not among the primary care folks, the internists, family medicine specialists, family practitioners, those individuals all would be seeing a decrease.

Remember, Mr. Speaker, the consequence of a decrease in physician reimbursement rate in Medicare means that there is a ripple effect throughout the entire system, so that insurance companies reimburse physicians at a decreased rate, and consequently what happens is that patients, patients lose their ability to see physicians all across this Nation.

Now, any of that might be okay if, if there were decreases in the costs of providing the services. But you and I both know, Mr. Speaker, that when you go to your doctor, there are more tests that are oftentimes taken now, because the technology is available. I know when I go it oftentimes seems to me that there are more people in the office itself, and most often they are individuals who are not necessarily involved in the actual care, they are individuals who are involved in the administrative side of a medical practice; so they are filling out the paperwork for the insurance company or filling out the paperwork for the government. So the costs continue to increase.

This chart here is titled "The Gap Between Cost Increases and Payment Updates," and this goes from 2001 through 2007, so the past 6 or 7 years. If you take zero percent at 2001 as the baseline, what has happened to physician practice costs over that period of time is that the annual increase has bumped up each and every year. Each and every year the costs of providing the service to patients in any practice has increased, and that is just like anything else in our economy, by and large.

Now what has happened to physician payments or physician reimbursement over that period of time, and you see, Mr. Speaker, where the challenge is, because this line is not even flat, it is a continual, continual decrease over a period of time.

Again, the problem, the consequence of this, is that patients are not able to see the physicians that they desire oftentimes or they are not able to find a physician to take care of them. It has been estimated that fully a quarter of patients out there who are trying to find a primary care physician who will accept Medicare cannot do it. They cannot do it right now.

When you talk with physician groups about what are the consequences, again this kind of decrease in 2007, what is going to happen? Nearly half of the physicians who say if that decrease goes into effect, then what will happen is that they, their practice, will no longer be able to take new Medicare patients.

Mr. Speaker, you and I both know that as members of the baby-boom generation that we are demographically an aging population in this Nation, and there are more and more individuals who are reaching Medicare age. Now, if there are more and more individuals reaching Medicare age, and fewer and fewer physicians or physician practices who are able to take new Medicare patients into their practice, then, as you see, Mr. Speaker, it means that access to care is limited and consequently quality health care in this Nation will suffer. That is the magnitude of the challenge that we are talking about.

As I mentioned before, there are a dozen or so physicians in the United States Congress, and I am pleased to have, hopefully, many of them join us today, this evening, to talk about this issue. I am so pleased to have my good colleague and friend from Georgia, Congressman PHIL GINGREY, who is a fellow physician and obstetrician/gynecologist. Both he and I served in the Georgia State senate together, and we are both privileged to serve here in the United States House of Representatives.

I thank you so much for coming today and sharing some words about what is truly, truly a matter that we must address as a Congress this week.

Mr. GINGREY. Mr. Speaker, and Dr. PRICE, thank you for giving me the opportunity to weigh in on this. I appreciate Representative, Doctor PRICE,

leading this hour. It is such an important issue and time, of course, is of the essence. The physicians, the chart that Dr. PRICE is showing, is a clear indication that, as he points out, Mr. Speaker, the cost of doing business, in this instance, the business of providing medical care to our seniors especially, continues to go up, as does the cost of doing business in any other profession.

Yet the reimbursement is not even staying level. Our physicians, our providers, are not just running in place, they are losing ground each and every year, and that therefore the need is to try to fix this ultimately on a permanent basis by eliminating this flawed formula, this so-called SGR way of reimbursing our providers.

But at this point we have to do something about the scheduled 5.1 percent decrease update, a loss of reimbursement for the fiscal year, or calendar year 2007. And we have a very short period of time to do this. Dr. PRICE and Dr. BOUSTANY and Dr. BURGESS and the other physicians, medical and dental, doctors in this House of Representatives, hopefully on both sides of the aisle, understand the urgency of this.

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It is not about necessarily boosting the income of any of our providers, although those who practice the specialty of primary care, our pediatricians, our family practitioners, our general internists, their income is certainly not extravagant by any stretch of the imagination.

But it is really about, and I am sure that Dr. Price has already mentioned this, the availability of providers for our seniors. That pressure is getting greater each and every day. Thank God, they are living longer and healthier lives, and I think the Medicare part D provision that we passed in November of 2003 is really adding to that well-being, that our seniors are going to get the benefit of a prescription drug coverage that they never had.

But if we don't have any of these primary care physicians willing to accept these patients because we are not paying them enough to even reimburse their practice overhead, much less a small profit margin, as has been pointed out by my colleagues, then the situation gets worse and worse.

So thank you to my colleague and friend, Dr. Price. As a physician, Members are here today to try to emphasize the importance to each and every Member, to our leadership. Let's get this done. Let's make sure that we not only mitigate a 5.1 percent loss that is calculated on the basis of this flawed formula, but let's have a positive, a slight increase of maybe 1 percent for all of our providers. Then if voluntary reporting is a part of this bill, then, fine, increase it a little bit more. That is an issue that Dr. Price may want to discuss in more detail as we go forward in the hour.

But I want to thank him again for taking the leadership on this issue and giving me an opportunity to weigh in.

Mr. PRICE of Georgia. Mr. Speaker, I thank my colleague for coming and joining us today and pointing out the importance of this, but also pointing out very clearly the urgency of this matter.

As I mentioned before, if this Congress doesn't act, then what happens on January 1, less than 30 days away, is that patients will have less access to high quality health care than they do today; patients all across this Nation, not just Medicare patients, patients all across this Nation, from birth to their last days.

It is extremely important that we as a Congress address this. Again, it is not just Medicare. It ripples into all sorts of other insurance company reimbursement to physicians all across this Nation. I think that is important to appreciate, because with the election results on November 7 of this year, what has happened is that the party in power will shift after the first of the year, and there are some on the other side of the aisle, some of my friends on the other side of the aisle believe we ought to move toward a Medicare system for all, for all people across this Nation. I personally believe that would be an absolute disaster in terms of the level of quality care available to patients all across this Nation. I believe that for a variety of reasons, not the least of which is this kind of issue.

What we see is a Congress that has been for years, not just 2, 3, 4, 5 years, for years, decades, has struggled with how to fashion reimbursement for health care across this Nation. I believe that as we continue to move in the direction of greater control at the level of the Federal Government, that what happens is that we actually decrease the access of patients to care and decrease the quality of care that is provided.

So I thank my colleague from Georgia so very, very much for doing this and for pointing out the urgency of this, the importance of acting while we are here this week.

There are a number of proposals that are available in order to allow us to solve this problem, and I urge my colleagues on both sides of the aisle to embrace one of these and try to make certain that we do so before we head home.

I am so pleased to be joined by a new Member of the United States Congress, another physician Member, Dr. SHELLEY SEKULA GIBBS from Texas, a practicing dermatologist before she came to Congress, who has great experience in the community back in Texas and served on the local city council and has struggled as well, I know, with the kind of ability to deliver high quality health care to her patients.

We appreciate you coming today and look forward to your insights and perspective as it relates to patient access to care and the sustainable growth rates.

Ms. SEKULA GIBBS. Thank you very much, Dr. Price. I appreciate you

bringing the subject up for the people at home so that they can understand where their Medicare premiums are going and how the Medicare dollars are being spent.

I want to also thank Congressman Dr. GINGREY, Dr. BOUSTANY, Dr. BURGESS and a number of the other physician Congress Members who have worked very diligently to bring this issue to the floor and ask the American people for their support and understanding of how to make health care more accessible to our seniors.

I think that having family members, like many of us, who are under the Medicare program, it is easy to see how Medicare has become more and more complex over the years and how each time there is one of these actions that you detailed chronologically, 1965 when it was implemented it was much simpler and easier. There were also fewer seniors at that time to cover. Then as time passed, the government looked for ways to reduce expenditures, reduce spending, but at the same time we saw other pressures coming to bear on the senior population.

We saw the fact that more and more people are living longer. They are having vigorous, active lives; and they want to have access to activities that will allow them to enhance those lives. They are working longer. They are active in sports.

In order to achieve that and to make sure that they can participate fully, and that is what I want when I hit those years as well, it requires a lot of work on the part of the physicians and the health care industry. That means that they have to have access to physicians; they have to have access to primary care doctors. And I was one of those before I was a specialist. I went through that residency. I know how hard that is, to take care of the whole person and to work and interrelate with a specialist. It is very difficult, and it requires the right kind of individual to do that.

We need to support it. And the primary care doctors are the ones who get hit sometimes the hardest. In your graph that you showed on which doctors are going to receive a little tiny bit more with that 5 percent cut, and the vast majority, 95 percent are going to get cut, quite frequently it is the primary care doctors who get stuck in that. And we want to encourage people to go into primary care and take that loving hand who will help our seniors.

But those patients are more complicated. They require more medical care when they do get sick, and they require more specialists to bring them out of those medical crises and restore them back to their health so they can get back to the business of living full quality lives.

I have been a physician for over 20 years, and I have watched as the Medicare situation has gone really from a situation of more and more complicated and the reimbursements now are going down, down, down. I have

watched it, how it affects my father and my mother.

My father, who recently passed away, was lucky enough to receive veterans benefits. That really moved him out of the Medicare arena and allowed him to have access to the benefits he deserved through the VA.

My mother, on the other hand, has witnessed something that I hope others never have to see, but she actually has had a physician, a primary care doctor in a small town in south Texas, go bankrupt, go out of business.

That is shocking, to think that someone who has spent all the years that this doctor did in training and becoming a quality physician could then lose their practice. It is predominantly because in a small town in south Texas many of the younger people who have private insurance, some of them move away. And who are left? A lot of the seniors.

Now, it is not to say that is all that is left, but whenever that balance of having a larger and larger Medicare practice goes out of kilt, sometimes the physician can't even keep their doors open because there are so many patients who are there, complicated, elderly patients who need that care, and they can't get the reimbursement to keep those doors open, to pay their staff, to keep the lights on and to pay the rising medical malpractice insurance that goes along with it these days.

So the notion, knowing that that already happened to my mother and she lost that doctor who she really trusted and he went out of business, knowing that that happened before this cut goes into place, I shudder to think what will happen across small towns all over the Nation if they are visited with a 5 percent cut, not only in 2007, but then a large cut in 2008 and another cut in 2009. What will that do to the primary care doctors who are trying to give that care across the small towns of our country? We can't let that happen.

So I really support you today, Dr. Price, in asking the colleagues here on the floor, give the physicians an opportunity to continue to deliver care to the seniors. Don't make it so hard that they have to limit the flow of the seniors who are coming in their doors.

That will happen first. They won't out and out quit, but they will start to limit the numbers that they take. And that is also very disabling to a senior, when they call and say, do you take Medicare, don't make it so that they hear on the other end, I am sorry, we can't see you. That is not right, and we need to open the doors so that more seniors can have access to health care.

I join you in asking for that, and I hope that our colleagues will find a way to fix this situation and allow the seniors across the country to continue to receive the very best health care that is available in the world.

Mr. PRICE of Georgia. Thank you so very much for your comments and your participation and for your commitment

to service, to standing up and rising and being a Member of the House of Representatives. We commend you and thank you for what you have done and appreciate your perspective and your expertise.

You said it better than anybody could about this isn't about necessarily reimbursement or money for physicians, this is about access to care. Because when that physician closed his or her doors in small-town Texas, which is not unlike small-town America anywhere, then those patients, those citizens, those American citizens, lose their access to care.

So this is an urgent issue. It is absolutely imperative that we in this Congress address it. Once again I call on colleagues on both sides of the aisle to make certain that we do so this week.

I am pleased as well to be joined by some other physician colleagues. Dr. Boustany, Congressman BOUSTANY, is a fellow freshman Member from Louisiana, a cardio-thoracic surgeon, has great expertise in this area and an understanding and appreciation for the finances of what it takes to deliver health care, but more importantly for the finances and what it takes to provide that kind of access to quality health care that patients all across our Nation deserve and expect. So I welcome you, Congressman BOUSTANY, and look forward to your comments.

Mr. BOUSTANY. Mr. Speaker, I am pleased to be here today. I want to thank my colleague and friend from Georgia for organizing this hour and for yielding me time.

A December 1 Congressional Quarterly article mentioned that a colleague from California across the aisle shed crocodile tears, "crocodile tears for providers who faced a cumulative cut of almost 30 percent under the Medicare physician payment formula." This colleague quipped that he had difficulty sympathizing with providers who might be giving up their golf games.

Instead of revoking negative stereotypes to justify cuts under an artificial price control formula, Congress ought to consider the real injustice the formula imposes on patients, such as an 85-year-old caregiver who has to wait longer and drive further so her ailing husband can visit a physician.

While Medicare does not force providers to treat Medicare patients, especially when the cost of providing care exceeds declining payments, for seniors who turn 65, it is Medicare or no care. It is virtually impossible for someone at age 65 to find insurance coverage for physician services outside of Medicare part B.

Medicare needs to honor its commitment, and seniors need more than access to a waiting list. MedPAC, the independent Federal body created to advise Congress on Medicare reimbursement issues, calls the Medicare physician payment formula "a flawed inequitable mechanism for volume control." It says it could "threaten beneficiaries' access to care."

In fact, the agency already warns that subsets of beneficiaries report access problems. In 2005, more than one in five Medicare beneficiaries reported that they sometimes, usually or always experienced delays in getting an appointment. The same proportion indicated that they had difficulty finding a new primary care physician to treat them. MedPAC also writes that among the subset of people who reported any problems, Medicare beneficiaries were somewhat more likely in our 2005 sample to characterize the problem as big versus small than their privately insured counterparts.

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Also, the share of Medicare beneficiaries indicating that they experienced big problems accessing a primary care physician grew in both 2004 and 2005 samples. One in four seniors who faced access problems said that their problem finding a doctor was because they were covered by Medicare, and this is simply unacceptable.

Equally troubling is a recent survey reporting that 38 percent of responding physicians indicate that they would decrease the number of new Medicare patients they accept when the next physician payment cut occurs and Medicare payments continue falling below the cost of providing care.

Congress might avoid a cut this year, and it is imperative that we do that, while leaving the artificial price control intact, as it did for 2003, 2004 and 2005. Yet officials with the Congressional Budget Office have repeatedly explained that the formula requires these automatic cuts to be made up in future years. This kick-the-can approach might seem like the least expensive on paper, but it is clearly unsustainable. The formula must be changed. Otherwise, the annual cuts will become more difficult to avoid, and the problem of access will only grow worse.

Congress needs to look past government accounting gimmicks and realize that adequate payments will help to ensure timely care and be more cost-effective for the overall program than addressing serious health problems with more intrusive and costly medical procedures later.

Also, all Americans have a personal stake in this issue, and once informed of the cuts, people understand that cuts mean more than just a canceled golf game. Almost 9 out of 10 respondents agree that cuts would severely limit seniors' access to physicians.

Seniors want the freedom to access their physicians, but cuts will exacerbate projected provider shortages as the baby-boom generation, one-third of our workforce, becomes Medicare eligible. MEDPAC aptly warns that the formula's cuts could "discourage medical students and residents from becoming primary care physicians."

Today, fewer radiologists specialize in mammography and fewer surgeons complete breast cancer fellowships. In

addition, fewer students are entering the specialty of heart and lung surgery, while half of the heart and lung surgeons in the United States intend to retire within the next decade, and more than 70 percent plan to retire within 13 years.

Mr. Speaker, it is disappointing that some lawmakers want to expand price-fixing in Medicare under the false label of negotiation. Economists widely agree that artificial price controls lead to scarcity, which is why Americans do not rely on them in other sectors of our economy and why we must develop market-based alternatives in Medicare.

Congress, Mr. Speaker, has a duty to avoid the cuts and to replace the artificial price control formula with a realistic physician payment system that protects patient access.

Mr. PRICE of Georgia. Mr. Speaker, I thank Congressman BOUSTANY so much and appreciate your perspective and the stories that you told and the statistics you brought to us because it really puts a face on it. When we have the kind of divisive conversations that oftentimes occur on the floor of the House, it is not helpful, does not help patients all across this Nation. So I appreciate you bringing that perspective.

You mentioned again many of the ripples that occur when these kinds of decisions are made here. What happens in terms of access to care is maybe the most important thing, but what also happens is it ripples down the line of what bright young men and women across this country choose as a profession. Are they choosing to go into medicine; are they choosing to go into some of the more difficult subspecialties that many of us will require the care from over our lifetime? And what is indeed happening is that they are not choosing those things. They are not choosing to go into medicine in the numbers that they have in the past. So the ripple effect is huge.

All of it boils down to a decreasing access to care that patients have across this Nation and a decreasing access to quality care across this Nation.

I am so humbled by the participation of many of our physician colleagues in this hour on the floor of the House today. And Congressman BURGESS from Texas has joined us, an individual who has great expertise in the health care arena, a preeminent member of the Energy and Commerce Committee, and has a wonderful perspective and has talked about this issue since his arrival in Congress and has put on the table specific solutions.

So I welcome him today and thank you for your comments.

Mr. BURGESS. Mr. Speaker, I thank the gentleman for his kind comments. Of course, the gentleman from Georgia has already done a great task with the posters this afternoon, but let me just reuse one that was seen a little bit earlier today.

This one tells such a great story, but unfortunately, it only tells a portion of the story. The year I took office was

2003. That means my last active year in practice was the year 2002, and missing from this graph, the year 2002, is a similar downward bar when doctors received the 5.1 percent what we euphemistically called a negative update. So the actual physicians' compensation for the 5- or 6-year moving budgetary window that we are all so fond of talking about has in fact been much less than is actually shown on this graph. And that is an important point to be made because, as we can see, all of the other aspects that deal with health care reimbursement once a year receive a cost of living, a market-basket update, but physicians' offices are expected to bear the brunt of cost reductions on a year-by-year basis.

As you so eloquently pointed out a few moments ago, that is unsustainable for any small business. If you are losing something on every transaction, you do not make it up in volume and stay in practice for very long.

One of the things that I think is so important that we discuss, we spend some time discussing this afternoon, as hopefully we get to a resolution of this problem in the conference committee that is now going on, is to talk a little bit about the pay-for-performance aspect of it. So much of the physicians' reimbursement is tied up in the talk of the pay-for-performance concept.

I would just like to submit that if we drive the best doctors out of providing Medicare services, if we really let the train run off the tracks on this, we will not be able to pay enough for performance in the future if we do not recruit our best and brightest to be the physicians of tomorrow, as Dr. PRICE has so eloquently stated, or if we drive out doctors who are in their mid-forties to their mid-sixties, doctors who are at the peak of their diagnostic abilities, the peak of their skills in the operating room. If these individuals stop seeing Medicare patients, we then make the whole system more expensive to administer if we have only the second and third tier of providers involved in that care.

Well, one of the things that we hear talked about is a pay-for-performance indicator, one that has the initials PVRP that stands for Physician Voluntary Reporting Program. Now, this is a program that is going to be articulated by CMS some point later in this year, and the reason I am concerned about it is we are being asked to accept the PVRP performance indicators as the standard against which we are going to judge physician practices for years to come, and we have not yet seen them in their totality. These are rules that will be put out by CMS some time later this year, perhaps April, perhaps May or perhaps June.

My understanding of the PVRP program is that it is largely a structural program and not necessarily outcomes-based. That is, does every diabetic receive a hemoglobin A1C test every so many months, rather than do we look

at the world of diabetic patients within this physician's care and make certain that the emergency room visits and the out-of-control hospitalizations are, in fact, in line with what would be expected.

Earlier this year, I introduced bill, H.R. 5866, to repeal the SGR formula in its totality, in order to acknowledge that there is a growing sentiment out there that some type of performance measure has to be built in. I did ask that the individual quality organizations that are already in place be allowed to provide voluntary guidelines for physicians to follow. These quality measures taken as a whole provide a balanced overview of the performance of an individual doctor or clinic or billing unit, if you will.

The whole idea was that they would be consistent; they would be relevant. They would be not overly burdensome time to collect and they would account for patient satisfaction. The goal of the system was fair assessment to reduce health care costs, improve health care outcomes, but very importantly, not contribute to the problem that we already have in this country of health care disparities in some communities.

Therefore, in order to account for the differences in patient population, health status and compliance, these formulas would need to be very tightly drawn.

In addition, there would be a measure reported back to the physician himself or herself as to how they did in comparison with their peer groups. These report cards, if you will, would not necessarily be made generally available to the public, but whether or not a physician or a clinic complied with the data that was required, would be made public.

I think it is important to give providers, to give clinics, to give doctors some measure of flexibility in this regard, and whether it be the participation in a medical home, whether it be the participation in the PVRP program, whether it be the participation in the national quality forum programs, that any of these should be seen as complying with the intent of the legislation to provide quality measures. They should be voluntary, and any increase in reimbursement should not necessarily be tied to the baseline of quality reporting, but an additional increase in reimbursement would be provided to those physicians and clinics and offices that did indeed provide some type of reporting data.

Again, I want to thank the gentleman from Georgia for bringing this very timely issue to the floor of the Congress. I do know there is a lot of work going on on this very issue right now, and my goal in this is to be helpful in the overall process and make certain that in the future we do not saddle physicians' offices and physicians' practices with additional reporting requirements that are not voluntary, that are mandatory, that are punitive in their nature and end up decreasing

the overall quality and character of medicine that we have grown to enjoy in this country.

I thank the gentleman from Georgia. Mr. PRICE of Georgia. Thank you so much for your perspective and for your wisdom in this area. It is extremely helpful and positive and productive for the debate that we are having or the discussion that we are having.

I think you point out a very important aspect, and that is, this voluntary reporting requirement that might come soon for physicians is an increase in the regulation. And as you so appropriately point out, it ought not be punitive in nature, because if it is, what we will see in addition to the challenges that we have with levels of reimbursement, decreasing access that patients have to care, we will see further decrease in physicians in the community, and that will significantly harm the ability of patients to see physicians and get the care that they so appropriately deserve and require.

Sometimes you will hear folks say in this debate or this discussion, well, there really is not an access problem. And in having some discussions with the folks at the Center for Medicare Medicaid Services, the high-level individuals in the department who are charged with making certain that physicians are there to take care of patients from a Federal Government perspective, I had a specific conversation with one of them.

I said it is imperative that you not continue to decrease the reimbursement to physicians because they will no longer be able to cover the costs of providing that care and they will decrease the number of Medicare patients, if not end seeing Medicare patients all together.

The response from that individual was chilling, Mr. Speaker. What that person said was, well, we have not seen it yet, and until we do, we have not cut them enough.

Mr. Speaker, that is not the kind of collegial activity that we know to be productive in health care. It also takes incredible advantage of the Hippocratic oath that all physicians take in this Nation.

I have come to a conclusion that has been very difficult over the past decade, and it is more so true now, I believe, than ever before, and that is, that our health care system is held together today by many things but not the least of which is the altruism of the physicians involved in caring for patients who understand and appreciate the importance of that care and also respect and recognize that the oath that they took to care for patients, oftentimes regardless of the reimbursement, is the most important thing, but that takes advantage of the goodwill of so many men and women who are highly trained and educated across this Nation and who each of us rely on for high-quality health care.

Because all of us are patients at some point, every single one of us. So it is

imperative that we do the right thing here as a Congress and make certain that we address this issue.

Sometimes you will hear folks say there is not an access problem, like the fellow at CMS who made that statement. Let me point out, Mr. Speaker, a couple items.

A recent survey, a recent study by the Medicare Payment Advisory Commission charged with looking into these things found that even before these cuts that we are talking about today might go into effect, 25 percent, fully one-quarter of Medicare patients looking for a new primary care physician are having difficulty finding one.

□ 1615

One out of every four new Medicare patients is having difficulty finding a primary care physician, and that is all the more important as we mentioned before, Mr. Speaker, that our population is aging. The demographics are making it such that we are seeing a graying of our population. So more and more Medicare patients will be coming online.

The congressionally created Council on Graduate Medical Education, which is the body charged with making certain that we have high quality physicians trained in this Nation, have reported existing or looming physician shortages. In fact, they are predicting that as again the baby boomers enter Medicare and more seniors are requiring health care, that the country will experience a shortage of 100,000 physicians over the next 15 years. 100,000 physicians over the next 15 years. And that is an important time frame to talk about because that is about the time that it takes to train a physician. From undergraduate school to medical school and through residency, it is somewhere between 10, 12, 15 years, sometimes even longer.

Mr. Speaker, it is appropriate that we are discussing this. It is urgent, it is urgent that we correct this remarkable, remarkable challenge that we have to make certain that all patients across this Nation have the opportunity to see and be seen and cared for by a caring, high quality physician.

In closing, Mr. Speaker, let me just say that you have heard much discussion about the problem, you have heard some discussion about the solution. I would point out that I think there is a short-term solution and a long-term solution. A short-term solution is to make certain that the cuts that have been envisioned and are on the books right now and will take place on January 1 if the Congress does not act, to make certain that those decreasing reimbursements don't occur. It is imperative that we make certain that those don't occur so that we maintain the opportunity for patients all across this Nation to see their physicians.

In the long term, it requires either a fix of the formula or truly changing the system that we have in place that

provides for reimbursement of physicians so that we can ensure into generations to come that we have a system in place that respects individuals who are caring for patients and, more importantly, respects patients' opportunity to receive access to the highest quality health care that is available.

And the system that we currently have will not provide for that. It will not deliver that kind of health care system not only today but into the future. And so I challenge and ask my colleagues on both sides of the aisle, we have so much opportunity to do good in this institution, this is one of those instances that ought not be a Republican challenge or a Democrat challenge. It is an American challenge, and we need to come together to make certain that we address this in a way that allows patients all across this Nation to continue to have access or to regain access to the highest quality health care that is available.

I thank once again the leadership for allowing me to organize this hour. I thank my colleagues who participated and brought so much wisdom and light to this issue. I appreciate the leadership for allowing me this time, and I thank you, Mr. Speaker.

VACATING 5-MINUTE SPECIAL ORDER

The SPEAKER pro tempore. Without objection, the 5-minute Special Order speech of the gentleman from Illinois (Mr. KIRK) is vacated.

There was no objection.

IRAN

The SPEAKER pro tempore. Under the Speaker's announced policy of January 4, 2005, the gentleman from Illinois (Mr. KIRK) is recognized for 60 minutes.

Mr. KIRK. Mr. Speaker, our American body politic is turning to a renewed examination of Iran, its government, and our relations with that country. It has become an important member of the OPEC oil-producing cartel. Iran is also a state sponsor of terrorism and a leading voice for one part of Shia Islam.

Recently, Iran elected a new president, a leader who replaced a moderate but ineffectual office holder who had presented Iran in a softer light, hiding a continuing policy of supporting terrorism and a nuclear program largely hidden from the view of the Nuclear Non-proliferation Treaty that Iran signed and the U.N. inspectors who enforced it.

Iran's new president, Mahmoud Ahmadinejad, has presented an entirely new face for the government of Iran. We have heard various quotes by the Iranian president in news media sources, but nowhere have all of President Ahmadinejad's statements on key topics been presented in one place for a review by the American public and our allies. Recently, I asked the Congress-

sional Research Service to compile a list entitled "Ahmadinejad In His Own Words" and I present it to the House today. History can be a very good guide in informing us on the direction of countries, of movements of dictators. When we are well informed, we may see the warning signs of dangers ahead so that the American people, our government, and our allies can respond with the most effective and least costly policies to avoid a coming danger. Our past teaches us that we failed to see the coming danger from Germany and Japan, and that mistake led us into a very costly Second World War. Conversely, President Truman saw the threat of the Soviet Union, and his response, including the Marshall Plan, the Voice of America, and NATO, helped the United States avoid a third and costly world war.

Our lessons teach us that tyrants or would-be tyrants often tell us what they are going to do long before they do it. And if we listen, if we truly listen, then the warnings that we are given can move us to action to avert a humanitarian crisis or even a future war involving the United States or our allies. President Ahmadinejad has been prolific on the subject of Israel, of Jews, and of the Holocaust.

And who is this new president of Iran? Mahmoud Ahmadinejad was born in Garmsar, southeast of Tehran in 1956. He is the fourth son of an Iranian iron worker who had seven children. He and his family migrated to Tehran when he was one year old. He got his diploma and was admitted to the University of Science and Technology in the field of civil engineering, where he ranked 130th among nationwide university entrance exams in 1975. He was accepted as an MS student at that same university and in 1986 got his doctorate in the field of engineering and traffic transportation and planning.

Following the 1979 Iranian revolution, he became a member of the ultra-conservative faction of the Office for Strengthening Unity. Between universities and theological seminaries, the OSU was established by Ayatollah Mohammad Beheshti, one of Khomeini's key collaborators, to organize Islamist students against the rapidly growing Mojahedin-e Khalq. When the idea of storming the American embassy in Tehran was raised by Ahmadinejad's OSU, he also suggested storming the Soviet embassy as well.

With the start of Iraq's war against Iran in 1980, Ahmadinejad rushed to the western fronts to fight against the enemy, and he volunteered to join the special forces of the Islamic Revolution's Guard Force in 1986. He served in the Revolution Guards Corps in intelligence and security operation.

Ahmadinejad was a senior officer in the Special Brigade of Revolutionary Guards stationed at the Ramazan Garrison near Kermanshah in western Iran. It was there at his headquarters of the Revolutionary Guards' extraterritorial operations that he

helped mount attacks on Iran's borders. His work in the Revolutionary Guards was related to the suppression of dissidents in Iran and abroad, and he personally participated in covert operations in Iraq around the city of Kirkuk.

With the formation of the elite Qods, Jerusalem, Force of the Iranian Revolutionary Guards, Ahmadinejad became one of its senior commanders. He directed assassinations in the Middle East and Europe, including the assassination of Iranian Kurdish leader Abdorrahman Qassemlou, who was shot dead by senior officers of the Revolutionary Guards at a Vienna apartment in July of 1989. Ahmadinejad was a key planner of that murder. He also is reported to have been involved in planning an attempt to assassinate author Salman Rushdie.

Ahmadinejad served as a governor of Maku and Khoy cities in the northwestern West Azarbaijan province for 4 years in the 1980s, and he was an adviser to the governor general of the western province of Kurdistan for 2 years. While serving as a cultural adviser to then Ministry of Culture and Higher Education in 1983, he was appointed as governor general of the newly established province of Ardebil. He was elected as the exemplary governor general for three consecutive years, but in 1997 the newly installed Khatami moderate administration removed Ahmadinejad from his post as a governor general.

Ahmadinejad returned to university to teach in 1997, and there he also became involved in the cultural and political work of Ansar-i Hizbullah, the Followers of the Party of God, a violent Islamic vigilante group.

In April of 2003, Ahmadinejad was appointed the mayor of Tehran by the capital's municipal council, dominated by hard-line Islamic Iran Developers Coalition. As mayor, he reversed many of the policies of previous moderate and reformist mayors, placing serious and religious emphasis on the activities of cultural centers, turning them into prayer halls. He also closed fast-food restaurants and required all male employees to have beards and wear long sleeves. He instituted the separation of elevators for men and women in municipal offices and also suggested the burial of bodies of the martyrs of the Iran-Iraq war in the major city squares of his capital, Tehran.

Ahmadinejad was also a member of the hard-line Islamic Revolution Devotees' Society. While they endorsed another candidate in the 2005 election, it was Ahmadinejad that emerged out of that flawed process, for it was during the elections in 2005 in Iran that thousands of moderate candidates were knocked off the ballot by Iran's ruling council of clerics. As one of the candidates still allowed to be on the ballot, Mahmoud Ahmadinejad won the presidency on June 24, 2005.

Now, since being elected the president of Iran, Ahmadinejad has left no