

that's foreign policy implications, as my colleague pointed out in his comments earlier. It's one of the great issues we face as a country, and it's helpful to help drive forward that debate.

HEALTH CARE

The SPEAKER pro tempore. Under the Speaker's announced policy of January 18, 2007, the gentleman from Texas (Mr. BURGESS) is recognized for the time remaining before midnight.

Mr. BURGESS. Mr. Speaker, I do have a lot of material to cover in the time that is available.

I thought it was appropriate, as we end this legislative day here in the United States House of Representatives, that we talk a little bit about health care, because health care will be one of the central arguments, one of the central themes that consumes this country over the next 16 months as we lead up to the presidential election. Indeed, you are already hearing presidential candidates talk about their various visions for health care.

One of the things that concerns me greatly is the issue of the issue of the state of our physician workforce. In my home State of Texas, the Texas Medical Association puts out a periodical every month. In March the title of the magazine they put out was "Running out of Doctors," a great concern of mine.

A year and a half ago Alan Greenspan came and talked to a group of us right before he left as Chairman of the Federal Reserve board. And someone asked him about Medicare and about how we are going to pay for Medicare in the future. He acknowledged that it was going to be difficult, but at the appropriate time he felt that Congress would be able to step up to the job of doing what was going to be necessary to pay for Medicare. He paused, and he said, well, what concerns me greatly is will there be anyone there to provide the services that you need?

That's what I would like to address this evening. I think if I could, I am going to confine my remarks to the limited time I have to four areas. I want to talk a little bit about medical liability, I want to talk a little bit about the status of the physician workforce in regards to the developing physician, the person who may be in college or high school considering a career in health care, I want to talk about the physician in training, and I want to concentrate greatly on what I call the mature physician, the physician who is in practice, and some of the effects of current governmental policy where we reduce payments to physicians year over year and the pernicious effect that is having on the physician workforce.

First, just touching on liable, my home State of Texas had a significant problem with he had some call liability. In 2003, the State legislature passed a medical liability reform based off of a prior California law, the Med-

ical Injury Compensation Reform Act of 1975, which was passed by California, but we updated it for the 21st Century.

Indeed, the law passed by the Texas Legislature in 2003, was based off the California law, that had as its basis caps on noneconomic damages, but in California, that was a fixed \$250,000 cap for all noneconomic damages. As you can see from the visual aid, Texas trifurcated the cap. We have a \$250,000 cap on physicians for noneconomic damages, \$250,000 cap on a hospital for noneconomic damages and a \$250,000 cap on a second hospital or nursing home, if one has been involved.

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Well, this was passed back in 2003. How has the Texas plan fared? The year I first ran for Congress, 2002, we had dropped from 17 insurers down to two. It was almost impossible to get medical liability insurance at any price because of the effects of the legislation passed. There are now 14 insurers back in the State, and most of those have come back in without an increase in premiums.

Three years after passage, the Medical Protective Company had a 10 percent rate cut which was their fourth since April of 2005. Texas Medical Liability Trust, my last insurer of record, declared an aggregate cut over the past 4 years of 22 percent. Another company called Advocate MD filed a 19.9 percent rate decrease. And another company called Doctors Company announced a 13 percent rate cut, real numbers that affect real people and affect real access to care.

Probably one of the most significant unintended beneficiaries of this legislation that was passed in 2003 in my home State of Texas was the smaller not-for-profit community hospitals. These were hospitals that were self-insured and had to put large amounts of cash up as a cash reserve against a potential lawsuit. What has happened since this law has past is these hospitals have found they have been able to take more of that cash and invest it in capital, invest it in nurses' salaries, exactly the kinds of things you want your smaller, not-for-profit community hospital to be doing in your community.

Mr. Speaker, I took the language of the Texas plan and modified it so it would work within the constructs of our language here in the House of Representatives and actually offered this language to the ranking member of our House Budget Committee, who had the bill scored by the Congressional Budget Office. And the Texas plan, as applied to the House of Representatives to the entire 50 States, would have yielded a \$3.8 billion savings over 5 years. Now, not a mammoth amount of money in Congress speak; but when you talk about a \$2.99999 trillion budget, any savings that you could manage is in fact significant. And this is money that could have gone for a pay-for for many of the other things that we talk about doing for health care in this body.

Mr. Speaker, a lot of people ask me: Well, if Texas has solved the problem, so why are we even concerned about it on the national level? One is the savings that was demonstrated by the Congressional Budget Office. Another is this, Mr. Speaker: consider the cost of defensive medicine.

A 1996 study, 11 years ago, done by Stanford University revealed that in the Medicare system alone, just Medicare, not Medicaid, not the Federal prison system, but in the Medicare system alone the cost of defensive medicine was approximately \$28 billion to \$30 billion a year. Ten or 11 years ago it was at that expense, and I submit that that number is significantly higher today if anyone would rework those numbers.

Another consideration is young people getting out of school. They look at the cost of professional liability insurance and say, you know what, I am going to stay out of those higher risk specialties because it is just not worth it to me.

Now, I do want to draw my colleagues' attention to a bill, H.R. 2583. This bill addresses graduate medical education. It is an enhancement for graduate medical education, and would develop a program that would permit hospitals, hospitals that do not traditionally operate a residency program, the opportunity to start a residency program to help again build physician the workforce of the future. On average, it costs \$100,000 a year to train a resident, and that cost for a smaller hospital can actually be an impossible barrier to entry. But because of this bill, that would create a loan fund available to hospitals to create residency programs where none has operated in the past; and it would require full accreditation and be generally focused in rural suburban or inner urban communities.

Another bill that I would direct my colleagues' attention to, H.R. 2584, this bill is designed to help medical students and those who have just recently graduated from medical school with a mix of scholarship, loan repayment funds, tax incentives to entice more students into medical school and create incentives for those students and newly minted doctors. The program will have an established repayment plan for students who agree to go into family practice, internal medicine, emergency medicine, general surgery, OB/GYN, and practice in an underserved area. It is a 5-year authorization. It is fairly modest at \$5 million a year and would provide additional educational scholarships in exchange for a commitment to serve in a public or private nonprofit health facility determined to have a critical shortage of primary care physicians.

Mr. Speaker, in whatever time I have left, I do want to address again the group that I call the "mature physician," and I want to address that from the perspective of the formula that is called the "sustainable growth rate

formula.” That is the formula under which Medicare reimburses physicians.

Why is that important? Let me show you this. If we look at how Medicare pays for the administration of care in this country, we have a situation where doctors are paid under a different formula from hospitals, from insurance plans, from drug companies, from nursing homes.

And look at this graph, Mr. Speaker. What you see is that physicians receive cuts year over year, unless Congress steps in at the last minute and does something, which we did for several years here right after I first got to Congress. But compare that with Medicare advantaged hospitals and nursing homes where every year there is a cost-of-living update, the Medicare economic index, if you will, that adjusts payments upward. But year over year there is a reduction in reimbursement, and the Center for Medicare and Medicaid Services for Physicians provides this cut for physicians who take care of the patients.

It is not a question of doctors wanting to make more money; it is about a stabilized repayment system for services that have already been rendered. And it is not just affecting doctors; it affects patients. Not a week goes by that I don't get a letter or a fax from some doctor, usually in my home State of Texas, oftentimes in my district but sometimes it is someplace far afield. But they say, You know what? I have just had enough of what Medicare is doing to my reimbursement schedule and I am going to retire early. I am no longer going to see Medicare patients in my practice, or I am going to restrict the procedures that I offer to Medicare patients.

In fact, I had a young woman come up to me that I trained with at Parkland Hospital and tell me what Medicare was doing to her wasn't right and, as a consequence, she was not going to be offering a certain set of high-risk procedures to her patients any longer.

And the question is, where will those patients go for that treatment? I saw it in the hospital environment before I left practice to come to Congress and, again, I hear it in virtually every town hall that I hold back in my district. Someone will come up to me, either as a question in the formal part of the meeting or afterwards, and say, how come in this country you turn 65 and you have got to change doctors? And the answer is, because the doctor they were seeing found it no longer economically viable to continue to see Medicare patients because this was happening to them, and year over year they weren't able to pay the cost of delivering the care, never mind taking a paycheck home to support their family.

Medicare payments to physicians are modified annually under this SGR formula. The process is flawed, it needs to be repealed, because it mandates physician fee cuts that have gone on in recent years be continued indefinitely,

and they become quite substantial over time.

Now, the quandary that you always hear quoted is that simple repeal of the SGR is cost prohibitive. But we could, Mr. Speaker, consider doing that over time. We could consider setting a date in the future by which the SGR would be repealed and perhaps bring that cost down to an attainable level.

The bill that I have recently introduced, H.R. 2585, would repeal the SGR in 2010. Now, in the new physician payment stabilization bill, 2 years from now the SGR formula goes away. But there are incentives provided to physicians in the year 2008 and the year 2009 based on some quality reporting and technology improvements.

More importantly, by resetting the baseline of the SGR formula, the CBO estimates that the practical effect of my bill would bring a 1.5 percent update in 2008 and a 1 percent update in 2009, and a complete elimination of the SGR by 2010. The CBO score calculates a savings of \$40 billion off the total price tag of an SGR elimination.

Again, there are also in addition to essentially what is a Medicare economic index update for 2008, a little less than that for 2009, and then elimination of the formula and a full MEI update starting in 2010, which would be a significant change from where we are now. In addition to that, bonus payments for physicians who are willing to voluntarily do some quality reporting and bonus payments for physicians who are willing to voluntarily participate in some health information technology upgrades, computerization of their practice, if you will.

One of the main thrusts of this bill, Mr. Speaker, is to require the Center for Medicare and Medicaid Services to look up, to ascertain the top 10 conditions that drive the highest percentage of payments, and then require CMS to adopt reporting measures relating to those conditions. In fact, those have already been developed. We are not going to reinvent the wheel here. The American Medical Association Physician Consortium has already developed those reporting measures that are driving spending so high.

Mr. Speaker, the old bank robber Willie Sutton, when he was asked, Why do you rob the bank? He said, Because that's where the money is. Mr. Speaker, let's go where the money is. Let's go to those top 10 things where the greatest amount of money is spent, those top 10 diagnostic codes or top 10 diseases where the major amount of money is spent in Medicare, and it amounts to about 70 percent of the savings in Medicare, because that is where the greatest amount of savings is going to occur.

If we can deliver more care in a timely fashion and we can improve outcomes, you are actually going to spend less. And, again, that is the thrust of this bill. That is why you postpone the repeal of the SGR by 2 years, to get that savings that is going to happen by

doing things better, quicker, smarter, the same types of things we saw when we began to provide a prescription drug benefit under the part D part of Medicare. Those costs that were originally projected by CBO and the Office of the Management of the Budget of the White House, actually, those scores were way too high.

The actual figures for the first year of the operation of the Medicare prescription drug program came in lower. Why did it come in lower? Partly because of competition and partly because the cost-effective thing also turns out to be the right thing to do oftentimes in the practice of medicine. A lot of savings are in fact available in this system if we only again have the courage to do that.

Let me just speak briefly about health information technology, because it does receive a lot of attention. Here in the House of Representatives we worked on several bills last year. We will probably have an opportunity to have several bills this year. Indeed, a reform in health information technology is part of the bill that I introduced, H.R. 2585, to repeal the sustainable growth rate formula.

But let me just point out a couple of things. I don't know that I was a big believer in electronic medical records when I left the practice of medicine and came to Congress. They are expensive, a big cost for a small practice to set it up. They slow you down. When you are in practice, it adds minutes to each patient; and if you are seeing 30 patients a day and you add 2 minutes to each patient, that is an extra hour. How are you going to be compensated for that extra hour that you spend?

Mr. Speaker, this is a picture of the medical records room at Charity Hospital in New Orleans. It was taken in January of 2006, 5 months after Hurricane Katrina hit there. And this had been completely under water, of course, when the city was flooded. When the Corps of Engineers got the water out, this is what was left. And you see a typical medical records room with all of these paper charts. But this black discoloration is not from smoke or soot; that is black mold that has grown on these charts. It is not safe to let anyone go in there and try to retrieve data from those charts because of what has happened with the mold contamination.

All of those records are lost, tens of thousands of patients. A patient who might have been waiting for a bone marrow transplant or a kidney transplant, a patient who is in the middle of their cancer therapy. All of that was lost in those records.

Mr. Speaker, in January of this year we heard a lot of stories about Walter Reed Hospital, and I went out to Walter Reed to look for myself about what was happening with the treatment of our soldiers who are on medical hold. And Sergeant Blades took me around the complex and showed me the things that had been in all of the newspapers.

And then he said, You know what bugs me even more than anything else. I could live with all of the other stuff, but here is the real problem I have. He was trying to assemble his medical records so he could make his case to the VA about a disability claim he had.

He had been in the service for a number of years, he had suffered some injuries during his time in the service, and he wanted to be able to make his case for disability payments. He said he will spend probably 20 to 24 man hours on his medical records making the case, going through it with a yellow highlighter. And then he said, It goes and sits on someone's desk for 2 week's time and then it is lost. And the reason for that is there is not an electronic medical records system that the Department of Veterans Affairs and the Department of Defense can communicate with each other. So he has to go back and reconstruct the paper trail of his 20 years in the service and document all of the problems that he has had with his injuries over time in order to make his case for a disability claim.

And that is what was concerning him more than anything else that day, was that it took so much time to get these things assembled and he was at the mercy of someone misplacing that record off their desk, and he would have to go back to square one. His medical hold would be either extended or denied, and he would have to start all over again with assembling his medical record. He advised his men to make two or three copies of their medical records before they submitted it to the appropriate person in the infirmary.

Mr. Speaker, I know our time is about up. I appreciate the indulgence of the time this evening. Again, health care is an important topic. We are going to spend a lot of time on it in the weeks and months to come. And, again, it will be part of the central theme of Presidential elections on both sides of the political spectrum. And to be sure, I will be back here on several occasions talking about some of the things that I think are most important. But when you look at the problem with losing physicians, when you look at the problem with how we treat our Medicare physicians, the problems they have in getting their payment rates straightened out, what happens if you don't take care of that? You lose doctors. Patients don't have the physicians to see.

What will Congress do in that event? I don't know. Parliament over in Great Britain decided it was in their best interest to bring physicians in from overseas on visas and give them waivers. Someone else paid for their education and they worked cheap. But we also saw in Scotland over the 4th of July weekend, that didn't turn out to be a good idea.

HEALTH CARE

Introduction

This evening I will address my concerns about the delivery of health care services in this country. The future of medical care in this

country will be hotly debated in Congress and especially over the next 18 months as we approach the 2008 Presidential elections and the 111th Congress that convenes in 2009.

We will be deciding the avenue through which our system will be based—on the table exists two choices. First is to expand the government or public sector's involvement in the delivery of services—popularly referred to as “universal health care” or termed in the early 90s as “Hillary Care.” Or second, whether we encourage and continue the private sector involvement in the delivery of health care. These two options bring about a plethora of questions and concerns, and I am hopeful that my explanations tonight will shed light on the direction we should be taking to have the United States remain as the best health care system in the world.

Now some people may feel that is an overstatement. They will cite uninsured numbers of the cost of prescription drugs. But while these issues abound, they are statistics and the old adage remains, “there is truth, there are lies, and then there are statistics.” You can make the numbers say whatever you like or the outcome of polls can be manipulated just by massaging how you ask the question. So I will dispense with these avenues and simply explain the situation at hand and the solutions currently available.

I'll be discussing different principles guiding the debate about private versus public delivery of health care services, but let me give you a background on how we got to the system we have today. The idea that we must solve this problem is not new. Secretary Leavitt has even remarked the necessity tackling the decision between these two philosophies. As he said in an op-ed recently, “Should the government own the system or should we organize the system.”

History

Coming out of World War II, the United States had a flourishing economy and an upsurge in the birthrate clearly coining the phrase “Baby Boom” generation. The U.S., unlike many of our allies coming out of the war was able to benefit from the economic prosperity by developing a hybrid system for the delivery of health care including both a public and private involvement. Europe, in contrast, was suffering from depleted resources and fatigue after World War II. It was clear from the outset that their economies, in particular that of Great Britain, were unable, from the private sector, to uphold the delivery of health care. The government had to run the health care system.

Next we fast forward roughly 20 years to the mid-60s and the Presidency of Lyndon Baines Johnson, a fellow Texan from across the aisle. During his tenure, both Medicare and Medicaid programs were signed into law. These large, government-run programs were created to focus on hospital care for the elderly and basic health care services for the poverty-stricken respectively.

Decades later, it was evident that the government-run Medicare program was slow to change, a behemoth to operate and extraordinarily expensive. By 2003, Congress recognized that the outdated model of providing largely hospital-only care to the elderly was insufficient. The government system needed to catch-up to the robust private system that was already focused on prevention and disease management. Finally, Congress passed the

Medicare Prescription Drug Plan that gave seniors coverage for the medications. While the program has been successful, and has provided greater benefits for seniors, it did not come without considerable discussions and a massive push by the success of the private sector. And here is our crossroads today.

Currently the government pays for nearly half of all health care administered in this country. With a current GDP of roughly \$11 trillion, the U.S. Department of Health and Human Services states that Medicare and Medicaid Services alone cost \$600 billion. The other half of health care is broken down with primary weight being carried by the private industry, and charitable and self-pay accounting for the rest.

As these numbers increase, and the Federal Government continues to funnel the American taxpayer's dollars into its coffers, we must ask if this is the best use of taxpayer dollars? Is the government doing an excellent job of managing your money? Do you think the government is better suited to care for your health care needs? Who is better to handle the growing health care crisis in this country?

I argue that the government-only, or universal health care system, is unsustainable in America and will hamper our innovation and delivery of the most modern health care services available.

I can site two specific examples that support my premise that a private-based system is better equipped, more flexible, and less expensive (being driven by the market) than a government-based system. First we can look to our northern border at Canada. Canada boasts a universal health care system but what it fails to highlight is the tremendous wait list for treatment that patients must endure. Their access to care is limited. Now this is not a significant problem if you are a wealthy Canadian because you can take your money, cross the southern border in the U.S. and receive care immediately. If you were waiting for bypass surgery, would you prefer to get into the hospital as quickly as possible or be placed on a waiting list that could take months? Is your health, or the health of your loved ones something that you can take a gamble with?

My second example stems from the British Isles where they suffer so of the same fate. The British National Health Service is a 2-tier system that faces continued allegations of ageism. The system can simply no longer treat patients over 80 because the system recognizes that the patients at this age will simply not survive their wait time. It is a sad reality, but it is true.

So I return to my premise that the private sector is more nimble and financially a more stable arena from which to build our future health care system. Noting this complex relationship, how should Congress do its job to ensure we have the best health care system possible? Congress must promote policies that keep the private sector leading the way with some interaction by the well-run government programs.

Uninsured

One issue that springs to mind concerns the uninsured population, which the U.S. Census Bureau estimated at some 46 million back in 2005. Now I want to be specific . . . access to health care is not the issue. Those individuals classified as “uninsured” means they are not covered by a specific plan; it does not

mean they cannot seek health care services. In fact, no one is denied health care services in this country. Two specific examples of where access is available through the State Children's Health Insurance Program and Federally Qualified Health Centers.

SCHIP

In 1997, the Republicans introduced a new program designed to help provide medical coverage to every vulnerable child. The program, commonly referred to as SCHIP, operates a joint Federal-State partnership. It provides flexibility for States to determine standards for providing health care funding for those children who are not eligible for Medicaid but whose parents cannot truly afford health care insurance. The program has been very successful across the board.

As SCHIP is being reauthorized this year and heavily debated on both sides of the Capitol, I continue to push for clarification on two issues. First, the intent of SCHIP is clear—the acronym said CHILDREN. However, some States have opted to spend funds on others instead of children. To stop this process, I introduced H.R. 1013, making certain that SCHIP funds are spent exclusively on children and pregnant women—not on any other group.

Second, it is imperative, as we move forward in this debate, that individuals have the flexibility to use SCHIP funds to procure health care coverage that works best for them. Some legislation I've seen would carve people out of the private insurance market; this was never the intent of SCHIP nor should it be an outcome from this debate.

SCHIP is an example where children and pregnant women can receive medical coverage. This eliminates a large number of those classified as "uninsured." As the differing bills appear from both House and Senate committees of jurisdiction, and I hope that this language is included.

FQHC

For those others that are not children or pregnant women, they too have access options, namely, Federally Qualified Health Centers. This patient access to health care even without "insurance" serves an estimated 15 million "uninsured." So what are FQHCs? An FQHC provides comprehensive primary health, oral, and mental health/substance abuse services to persons in all stages of the life cycle.

Both SCHIP and FQHCs are designed to help the poorest, youngest and underserved communities. But what about those individuals that can afford to pay some of their health care services? There are two programs available that assist individuals and companies in receiving health care coverage: Health Savings Accounts and Association Health Plans.

Health Savings Accounts

Health Savings Accounts (HSA) are a tax-advantaged medical savings account available to taxpayers who are enrolled in a high deductible health plan—a health insurance plan with lower premiums and higher deductibles than a traditional health plan. It is sometimes referred to as a catastrophic health insurance plan.

For an HSA, the funds contributed to the account are not subject to income tax, but can only be used to pay for qualified medical expenses. But perhaps one of the best parts of having an HSA is that all deposits to an HSA

become the property of the policyholder, regardless of the source of the deposit. Patients actually have a say in how and where they spend their health care dollars. Additionally, any funds deposited, but not withdrawn each year, will carry over into the next year.

The popularity of HSAs has grown considerably since its inception. Although numbers are only verified from 2005, by December of that year, some 3.2 million individuals had coverage. Of that number, 42% of individuals or families with income below \$50,000 were purchasing HSA-type insurance. This fact notes that HSAs are an affordable option. In addition, the number of previously uninsured HSA plan purchasers over the age of 60 nearly doubled, proving that the plans are also accessible to people of all ages.

Association Health Plans

Of the roughly 46 million Americans who are uninsured, nearly 60% of them are employed by small business. And some of these individuals prefer a more traditional health plan but their small business employers find offering a health benefit simply too expensive. To unburden small business owners, Congress devised the concept of association health plans.

AHPs allow small businesses to arrange their health benefits alongside other like-minded organizations there by spreading risk among a much larger group, lowering the administrative costs, and providing better benefit options to employees.

Physician Workforce Issues

But are we putting the cart before the horse? In a conversation with Alan Greenspan, before he stepped down as Chairman of the Federal Reserve, he was concerned about whether there would be an adequate labor supply to meet the demand for medical services in the future. The truth is our country faces an oncoming physician shortage. We need to ensure that doctors in practice today, those at the peak of their clinical abilities remain in practice and provide services to those with the most complex issues. So what steps do we need to take to ensure physicians remain in practice?

Medical Liability

First we must tackle an issue that continues to plague the medical community: medical liability. We need common-sense medical liability reform to protect patients, to stop the skyrocketing costs associated with frivolous lawsuits, to make health care more affordable and accessible for all Americans, and to keep necessary services in communities that need them most.

We need a national solution. Currently, our state-to-state coverage leaves us in jeopardy and tangles up the court system. Amazingly, we have an excellent example of the direction we should be taking on the Federal level by modeling legislation after what the State of Texas already has in place, which is getting ready to celebrate its 4th anniversary as law.

Texas brought together the major stakeholders in the discussion, including doctors, hospitals and nursing homes. Now some might point out that manufacturers were not present, but the State was clear to leave open the option for their participation at a later date.

My home State of Texas had a significant problem as far as medical liability was concerned. We had lost most of our medical liability insurers from the State. They had simply closed shop and left because they could not

see a future in providing medical liability insurance in Texas. We went from 17 insurers down to 2 by the end of 2002. Rates were increasing year over year. My personal situation, running my own practice, was that rates were increasing by 30 percent to 50 percent a year.

In 2003, Texas State legislature passed a medical liability reform based off the California law, but updated for the 21st Century. Instead of a single \$250,000 cap, there was a \$250,000 cap on noneconomic damages as it pertained to physicians, hospitals and to second hospitals or nursing homes—an aggregate cap of \$750,000.

So how has the Texas plan fared? Remember that I stated we dropped from 17 insurers down to 2 because of the medical liability crisis in the State? Now, we are back up to 14 or 15 carriers; and, most importantly, those carriers have returned to the State of Texas without an increase in premium.

In 2006, only three years after passage, Medical Protective had a 10% rate cut which was its 4th reduction since April of 2005. Texas Medical Liability Trust declared an aggregate of 22% cuts. Advocate MD filed a 19.9% rate decrease and Doctors Company announced a 13% rate cut. These are real numbers. That is a significant reversal. More options mean better prices and a more secure setting for medical professionals to remain in practice.

Probably one of the most important unintended beneficiaries of this was the small community not-for-profit hospital, who was self-insured for medical liability. They have been able to take money out of those escrow accounts and put it back to work for those hospitals capitalize improvements, paying nurse's salaries, the kinds of things you want your small not-for-profit community-based hospitals to be doing, not holding money in escrow against that inevitable liability suit that might occur.

I took the language of the Texas plan, worked it so it would fit within our constructs here in the House of Representatives and offered it to the ranking member of the Budget Committee. He had scored by the Congressional Budget Office, and the Texas plan, as applied through the House of Representatives to the entire 50 States, would yield a savings of \$3.8 billion over 5 years. Not a mammoth amount of money when you are talking about a \$2.999 trillion budget, but savings nonetheless, monies that we will leave on the table in this budgetary cycle that could have gone to some of the other spending priorities that we hear so much about. You can look to me for legislative action on this issue in the coming months.

Consider this—a 1996 study done by Stanford University revealed that in the Medicare system alone, the cost of defensive medicine was approximately \$28 to \$30 billion a year. That was 10 years ago. I suspect that number is higher today. That's why we can scarcely afford to continue the trajectory we are on with the medical liability issue in this country.

Another consideration is those young people getting out of college who are considering medical school. The current system keeps young people out of the practice of a health care for their livelihood because of the burden that we put upon them. This is the thing that we have to consider. We have to focus on how we are affecting our physician workforce

for the future, how we are affecting the health care that you are our children and our children's children will receive.

Physician Workforce and Graduate Medical Education Enhancement Act of 2007

Part of ensuring this future workforce includes helping the younger doctors with residency programs. The funny thing about doctors is we to have a lot of inertia. A lot of us tend to practice very close to where we did our training. The bill I propose is designed to get more training programs in areas that are underserved, like rural or inner cities. We must get young doctors training in locations where they are actually needed.

The "GME," or Graduate Medical Education, Enhancement Act of 2007 would develop a program that would permit hospitals that do not traditionally operate a residency training program the opportunity to start a residency training program to build the physician workforce of the future.

On average, it costs \$100,000 a year to train a resident and that cost for a smaller hospital can be prohibitive. Because of this cost consideration, my bill would create a loan fund available to hospitals to create residency training programs where none has operated in the past. The programs would require full accreditation and generally be focused in rural, suburban, inner urban or frontier community hospitals.

A diverse group, including the American College of Emergency Physicians and American Osteopathic Association, supports my GME legislation.

High-Need Physician Specialty Workforce Incentive Act of 2007

Locating young doctors where they are needed is part of solving the impending physician shortage crisis that will affect the entire health care system. Another aspect that must be considered is training doctors for high-need specialties.

My High-Need Physician Specialty Act of 2007 will establish a mix of scholarships, loan repayment funds, and tax incentives to entice more students to medical school and create incentives for those students and newly minted doctors. This program will have an established repayment program for students who agree to go into family practice, internal medicine, emergency medicine, general surgery, or OB/GYN, and practice in underserved areas. It will be a 5-year authorization at \$5 million per year.

This bill would provide additional educational scholarships in exchange for a commitment to serve in a public or private non-profit health facility determined to have a critical shortage of primary care physicians.

Prominent groups such as AARP, the American College of Physicians, and the ERISA Industry Committee, support my High-Need Specialty legislation.

Physician Stabilization

So far we in addressing the Physician Workforce crisis we have discuss medical liability, the placement of doctors in locations of greatest need and the financial concerns of encouraging doctors to remain in high-need specialties. The next portion of my remarks is related to perhaps the largest group of doctors in this country and certainly, the largest and still-growing group of patients—our "Baby Boom" generation and the Medicare program.

As the baby boomers age and retire, the demand for services is going to go nowhere but

up. And if the physician workforce trends continue as they are today, we may be not talking about funding a Medicare program, we may be talking about there is no one there to take care of the seniors.

Year-after-year there is a reduction in reimbursement payments from the Center for Medicare and Medicaid Services to physicians for the services they provide their Medicare patients. This is not a question of doctors wanting to make more money; it is about stabilized repayment for services already rendered. And it isn't affecting just doctors—this problem affects patients. It becomes a real crisis of access.

Not a week goes by that I don't get a letter or fax from some physician who says, "You know what, I have just had enough and I am going to retire early. I am no longer going to see Medicare patients in my practice, or I am going to restrict the procedures that I offer Medicare patients."

Unfortunately, I know that is happening because I saw it in the hospital environment before I left the practice of medicine to come to Congress. But I also hear it in virtually every town hall that I do back in my district. Someone will raise their hand and say, "How come on Medicare, you turn 65 and you have got to change doctors?"

And the answer is because their doctor found it no longer economically viable to continue to see Medicare patients because they weren't able to pay the cost of delivering the care. They weren't able to cover the cost of providing the care.

Medicare payments to physicians are modified annually using the sustainable growth rate (SGR) formula. Because of flaws in the process, the SGR mandated physician fee cuts in recent years have been only moderately averted by last minute fixes. If no long-term congressional action is implemented, the SGR will continue to mandate fee cuts.

Unlike hospital reimbursement rates, which follow closely the Medicare Economic Index (MEI), which measures the increasing costs of providing care, physicians reimbursements do not. In fact, Medicare payments to physicians cover only about 65% of the actual cost of providing patient services. Can you imagine any industry or company that would continue in business if they received only 65% of what they spent.

But the simple repeal of the SGR is simply too cost prohibitive. But if we do that over time, perhaps we can bring that cost down to a level where it is manageable.

Paying physicians fairly will extend the careers of many physicians who are now in practice who would otherwise opt out of the Medicare program, seek early retirement, or restrict those procedures that they offer to their Medicare patients.

It also has the effect of insuring an adequate network of doctors available to older Americans as this country makes the transition to the physician workforce of the future.

In my new physician payment stabilization bill, the SGR formula would be repealed in 2010, 2 years from now, but would also provide incentive payments based on quality reporting and technology improvements.

Recently, CBO estimated that the practical payment effect from my bill would bring a 1.5% update in 2008, a 1.0% update in 2009, and a complete elimination by 2010. The CBO score calculates a savings of \$40 billion off the total price tag of an SGR elimination.

These incentive payments would be installed to protect the practicing physician against that 5% cut that will likely occur in 2008 and 2009. That would be voluntary. No one would be required to participate in the quality program or the technology improvement, but it would be available to those doctors or practices who wanted to offset the proposed cuts that will occur in physician reimbursement in the 2 years until the formal repeal of the SGR happens.

Now I know this is perhaps a frightening thought to some physicians—I'm sure I would have been wary at first when I ran my own practice. But step back and view the long-term solution. This is the only logical, economically viable and I reiterate long-term solution.

Now, why do it that way? Why not just bite the bullet and let's go ahead and get the SGR out of the way and get it repealed? Remember, it costs a tremendous amount of money to do that. Another problem that we have in Congress is we are required to submit all legislation to the Congressional Budget Office to find out how much it costs. If we are going to be spending the taxpayers' money, how much are we going to spend? Over what time will we spend it?

Because of the constraints of the Congressional Budget Office, we are not allowed to do dynamic scoring. Unfortunately, we can't do look-ahead and say, "You know, I think if we do this, we are going to save some money."

But, by postponing the repeal of the SGR by 2 years' time; taking the savings that occurs during that time and applying it to the SGR formula; we may actually get a number that is doable as far as releasing the SGR and replacing it with the Medicare Economic Index similar to the way hospitals are reimbursed.

One of the main thrusts of this bill is to require the Center for Medicare and Medicaid Services to look at their top 10 conditions that drive the highest percentage of payments. The bill would require CMS to adopt reporting measures relating to these conditions that have already been developed. It is not reinventing the wheel. The American Medical Association Physician Consortium has already developed those reporting measures that drive that spending so high.

You know, the old famous bank robber Willie Sutton, when he was asked why do you rob the bank, he said that is because that is where the money is. Let's go to those top 10 things where the greatest amount of money is spent, because that is where the greatest amount of savings can occur. If we can deliver care in a more timely fashion and if we can improve outcomes, we are actually going to spend less. And by focusing on those top 10 programs, at least initially, that will be the greatest return on investment for CMS and ultimately will be the greatest return on investment for retiring the SGR.

The same considerations may apply to the Medicaid program as well, so it will be a very useful exercise to go through that and identify those top 10 conditions. And where cost savings may be most easily gathered, not only will it have an improving effect on Medicare, but I suspect on Medicaid as well.

This will also include a report back to doctors on what their volume and intensity is. This information will not be made generally public, but it will be made available to the individual physician so they can see how they are doing; how they are doing relative to other doctors in

their practice, other doctors in their community, and other doctors around the country. Physicians are a competitive group; I assure you these reports will be read.

Health Information Technology

There is also going to be a provision in the bill to help physicians' offices bring their information technology, their infrastructure, hardware and software, up to a standard where it will begin to derive benefit not only the patient and the practice but also to the Medicare system in general.

The provision will also create a safe harbor that will allow clinics, physicians' offices, and hospitals to share health information technology platforms. These standards will be established and available to physicians' practices so they will understand how they need to comply. The standards must be established no later than January 1, 2008.

Back in the day, I wasn't always a big proponent of things like electronic records. I wasn't sure if it would deliver the payoff that people said it would. But here is a picture of the medical records department in Charity Hospital in New Orleans. This picture was made in January 2006, about 4 or 5 months after Hurricane Katrina and the downtown flooding that occurred. It is the medical records room. These records are ruined. You can see this is not smoke or soot damage; this is black mold that is growing on the records. You look there and it almost goes on to infinity, tens of thousands, hundred of thousands of records that were active, ongoing charts of people's medical conditions absolutely now unavailable. No one is going to get into that medical records department and risk inhaling the spores from the mold that is covering those charts.

This is the kind of problem that you can get into with a paper medical record. Of course the youngsters of today, the college students of today, the young physicians of today, they understand this very well. They are all connected and wired in. They would no more imagine turning in or doing a paper for one of their classes where they just had a single copy, a single paper copy, the old adage "the dog ate my homework," most students will have a paper on a CD or on a flash drive readily accessible and retrievable in many forms. We should do no less with our medical records.

But it costs money to do this. It is going to require a push from the private sector. I prefer to think of a bonus payment as being an inducement, an enticement for physicians' offices to participate in this type of program. But it is also just good medicine. It is good patient care.

We all heard about the troubles at Walter Reed Hospital a few months ago. I went out to Walter Reed probably the week after the story broke in the Washington Post and talked to this young man who took me around Building 18. Yes, there was some concern. It was a crummy building. But his biggest concern was spending hours and hours with his medical record, his service record, going through the various parts and highlighting things. He had a yellow marker, a highlighter, highlighting parts of his medical record because this is how he was going to establish the benefits that he was going to receive in the VA system for his disability.

He said "I can spend 20 man-hours putting this medical record together and it ends up on

someone's desk and it doesn't get picked up, and then no one can find it and I have to start all over again." That was his main message to me that day.

Now the VA system has been indeed very forward-thinking in its embrace of electronic medical records and its investment in information technology. The problem is the medical records from the Department of Defense and the Department of Veterans Affairs do not possess the interoperability necessary to make this type of activity unnecessary.

Delivering value to the patient is of paramount importance. And it is my contention that if we do make the bonus payment generally available to physicians, this will be something that they will embrace. There is a learning curve, to be sure. It is going to slow people down a little bit initially. But ultimately, the rapidity of the system will be impressive. And even in a smaller physician's office the ability to never have to wait while they find your medical records would be amazing. Once physicians and medical offices become used to this technology, they will embrace it.

Another unintended benefit to providing incentives for health information technology is the rapidity with which the health care system itself can learn. When I say the health care system, I specifically address the possibility that treatments and the delivery of quality health care services can be faster, cost less and simply be better. Wouldn't it be great to have that information and know what treatments were effective and what treatments were only marginal? That information can be literally at a physician's fingertips with the right type of computer architecture and technology environment. I believe the time has come that we do need to embrace that.

So the physician payment stabilization bill will include a federal incentive to implement health information technology along with provisions providing safe harbors for the sharing of software, technical assistance and hardware, as well as the creation of consortiums.

Health Care Price Transparency

Once you have established measures that will allow for a medical workforce in the future—through a nation medical liability law, ensuring a medical workforce in areas that you need and in locations that need them, and by stabilizing physician reimbursements, you can refine other health care projects.

Perhaps the foundation of understanding health care is to understand its costs. The average consumer has little understanding about how much any service or prescription drug costs because they are supplemented by the government and often their employer. This must change.

In August 2006, President Bush issued an executive order calling for increased transparency within the federal government's health care agencies. The legislation I have proposed in the past is an extension of that executive order, giving States the tools to become part of a necessary solution for health care consumers.

The bill would require states establish health care transparency requirements for hospitals and health plans, as well as conduct a study on what information is most useful to consumers.

For example, the Texas Hospital Association has created a web-based tool that allows consumers to compare hospital-to-hospital cost called Texas PricePoint. This website as-

sists consumers that are considering non-emergency procedures at area hospitals. Texas health care consumers now can view and compare charge data on inpatient hospital services. Couple this data with hospital quality information and consumers will be able to truly shop for health services based on quality and cost. What a remarkably simple idea that is literally educating and engaging the consumer in making his or her health care choices. Knowledge is an essential tool for making informed decisions.

This type of planning tool should be made available to all patients, across the country, at any time. Think of it like a "Travelocity" or "Priceline" for health care services. Wouldn't that be terrific? The long and the short of it is that this is possible. And Congress can make this happen if we commit ourselves to the process.

Conclusion

I recognize that all of this information is technically complex, sometimes even boring to listen to, but it nonetheless tells an incredibly important story. It is the story of how the most advanced, most innovative and most appreciated health care system in the world needs help. The end of the story should read "happily ever after." So how do we reach that conclusion? The last chapter should read, "A Private Industry Leads to a Healthy Ending."

As I stated in the beginning of this hour, we are in a debate that will forever change our health care system. We must understand what is working in our system and what is not. We cannot delay making changes and bringing health care into the 21st Century.

I believe that the only way this can work is if we allow the private sector to lay the foundation for improvements. The pillars of the amazing health system we have now must be rooted in the bedrock of a thriving private sector, not on the shaky ground of a public system that has proven costly and inefficient in other countries.

We must devote our work in Congress to building a stronger private sector in health care. History has proven this is a tried and true method. We can bring down the number of uninsured, increase patient access, stabilize the physician workforce, modernize through technology and bring transparency to the system. Each of these goals is within our grasp. We must only have the foresight and determination to achieve each goal.

There is a reason why people come from around the world to the United States for health care treatments—we are the best, but we must make adjustments to remain at the top of the game.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Ms. CORRINE BROWN of Florida (at the request of Mr. HOYER) for July 16 and the balance of the week on account of a death in the family.

Ms. BORDALLO (at the request of Mr. HOYER) for today and the balance of the week on account of official business in the district.