

Continental Shelf bill that has been introduced by Congresswoman MYRICK of North Carolina.

I could go on and on. The point I am trying to make is we have American energy resources that could be developed and I think should be developed. We are not hopeless, we are not helpless, but right now we have a majority that, for some reason, has decided that it is okay for American citizens to pay these high energy prices, and, as I said earlier, if we sit here on our hands and do nothing, the prices are going to go up and up and up, which is not a good thing for our economy.

Mr. Speaker, with all due respect, we are planning a series of special orders. We are going to continue to try to educate the American people on the energy situation. But we are not just out here complaining and whining and bemoaning our fate. We have a positive solution that, if implemented and sent to the President and signed into law, would begin to bring immediate results in the terms of additional energy resources and lower energy prices.

Let's work together. As Daniel Webster says in the saying above the Speaker's rostrum, let us develop the resources of our land, call forth its powers, build up its institutions, promote its great interests, and see whether we also in our day and our generation can do something that will be seemed worthy to be remembered by future generations.

THE STATE OF HEALTH CARE IN AMERICA

The SPEAKER pro tempore. Under the Speaker's announced policy of January 18, 2007, the gentleman from Texas (Mr. BURGESS) is recognized for 60 minutes.

Mr. BURGESS. Mr. Speaker, I came to the floor of the House tonight to talk, as I frequently do, about the state of health care in this country and some things that may be on the cusp of change and some things that will never change. But I want to start off tonight by talking about what is going to happen to physicians across this country on July 1st, less than a month from now, as far as their Medicare reimbursements.

Now, you may recall I was on the floor of the House last December talking about the need for addressing the reduction of reimbursement rates for physicians across the country. The best we could come up with on the floor of this House was to stall that 10.7 percent reduction in reimbursement for Medicare patients. The best we could come up with was to stall that for 6 months' time. We told ourselves at the time that this gives us a little more time that we can work on a solution that is more meaningful. We want to work on a bigger and grander solution.

But, Mr. Speaker, what has happened? The days and months have ticked by, and now we are less than 4 weeks away from that day when physi-

cians will wake up and find that their reimbursement for seeing a Medicare patient is now 10.9 percent less than it was the day before.

Is this really a big deal? Well, yeah, it is a big deal, because everywhere across the country currently new Medicare patients call up physicians' offices trying to be seen and they find the same situation over and over again. They can barely get the word "Medicare" out of their mouths before they are told by that physician's office that we are not taking any new Medicare patients. And why? Why is that happening? Because of the activities, or, in this case, the inactivity of the United States Congress, of the United States House of Representatives.

It is imperative, it is imperative that we address this issue. It is imperative that we address it in a forward-thinking way so that we solve the problem once and for all and we don't have to come back here year after year and face the same problem over and over again, or, as is the case this year, every 6 months and face the problem over and over again.

I have advocated for such a fix many different times on the floor of this House. It has been very difficult to get colleagues on both sides of the aisle to embrace this concept and understand that we must move forward from where we are now. We need a short-term, mid-term and long-term solution to this problem.

What have we done? Again, we find ourselves just about to go over the cliff, just about to fall over the precipice, where once again we tell the Medicare patients of this country that we don't care about them. We tell the physicians who are seeing Medicare patients in this country that we don't value your service and we are going to hit you with a 10.7 percent cut. And that is not the end of it. December 31st, there will be another 5 percent reduction, so a grand total of 15 percent in reduction of Medicare reimbursement before we reach the end of this year.

Mr. Speaker, can you imagine any other business going into their banker and saying, you know what? I have got a great business plan here. I am going to start a business, or expand my business, because, after all, a physician's office is a small business. I am going to go into business or expand my business, and here is my business plan. And the banker looks at it and says, I see it says here you are going to earn 15 percent less this year than you are earning next year on each patient interaction. How in the world could you expect to be able to maintain your business with this type of business plan?

□ 2045

Reality is this type of business plan would not fly anywhere in this country, and yet we are asking over and over again our doctors, our clinics, our health care providers to live under this regimen.

Now, when I address the need for a short-term, mid-term, and long-term

solution, let me just lay out for you what I have in mind. The short-term solution is available to us right now. We could delay these cuts to the Medicare reimbursement rate. We could do that by passage of a simple measure that was introduced the last week of May, H.R. 6129. This is a bill that is fully paid for, fully paid for and would forestall the 10.7 percent cut July 1, and the 5 percent cut December 31, to February 1. That is not a great length of time, but it allows us a little more time to work on this problem, actually gets us past the first of the year so that we get to the organization of a new Congress. And maybe, if we did our homework and did our legislative work before we all went home and campaigned for reelection, maybe if we did that work in July and August and September of this year, we could actually have ready to go a package for the new Congress to pass shortly after the first of the year that would deal with this problem.

But it is a paid for solution. It doesn't expand the deficit. It actually uses the same mechanism that was used by the Medicaid moratorium that we all passed. I think there were 300 favorable votes for that Medicaid moratorium on the floor of the House a few weeks ago. This is the same mechanism of taking the money out of the physicians assistance quality initiative to pay for this fix on the physicians payment. It would not expand the deficit, and it would get us passed the first of the year.

The cuts that are looming ahead of us under a formula called the sustainable growth rate formula are going to be significantly pernicious, not just to keep our doctors in business, but to keep our doctors seeing our patients, our Medicaid patients, arguably some of the most complex patients there will be in any medical practice because they have multiple simultaneous conditions.

We are going to prevent those patients from having access to a physician because we are telling the doctors that we don't value their service, and we are telling the patients that we don't value their ability to have access to their doctors who prescribe their treatments, who offer those treatments that are going to keep them living longer and healthier lives.

And there is an unintended consequence to this as well. The unintended consequence is that many of the private insurance companies across the country actually peg their rates to what Medicare reimburses. So they have a contract that says we will pay, in the case of TRICARE, 85 percent of the Medicare usual and customary. In the case of some of the other private insurers, it is a little more generous, they pay 110 percent or 115 percent of Medicare rates. But all of those rates are going to be reduced when Medicare rates in turn are reduced if we don't act by the first of July. And actually, the way things work in Washington, if

we don't have something pretty concrete on the table by the middle of June, the Center for Medicare and Medicaid Services is going to be required to go ahead and put forward their rules and regulations for when this new fee schedule goes into effect July 1.

And make no mistake about it. We can tell ourselves that, oh, we will have time to come back in July and fix this and we will make it retroactive. But we don't make it retroactive for the private insurers who peg to Medicare. And the reality is we are talking about such small volumes on every explanation of benefits that comes through the physician's office that it becomes extremely tedious and time consuming and expensive to track all of these and make certain that the government makes good on its promise and comes back and delivers that.

And how do I know this? I know this because when our side was in charge with the passage of the Deficit Reduction Act right at the end of 2005, because of a technical problem we didn't get actually the bill passed until the first part of January of 2006, and as a consequence the language in the Deficit Reduction Act that would have prevented a programmed reduction in Medicare reimbursement rates, that did not go into effect until well into the month of January 2006. And, again, we had to come back and retroactively make all of these practices whole. And just as a practical matter it becomes very, very difficult for the doctor's office to keep track of that and make certain that in fact those reimbursements were brought up to speed.

The other aspect of this, the mid-term and the long-term aspect, and I have advocated for this for some time. We need to pass legislation that will put us on a path to repeal the sustainable growth rate formula. This is a formula that year over year reduces the rate at which physicians are reimbursed. The reality is Congress almost never sees that through. We always come in and do something to keep our doctors from having to sustain those large cuts in their practice. But every year we come up against this precipice, we come up against this cliff, and every year the doctors' offices are having to make plans for their future. Do they buy new equipment? Do they hire a new partner? Do they bring on additional personnel? Well, they can't tell because they don't know what we are going to do to them in Medicare at the end of the year or, in this case, in the middle of the year.

So we need a method of repealing the sustainable growth rate formula. We have all discussed this. The cost associated with the repeal of that from the Congressional Budget Office is high. So what I have recommended in the past is we put ourselves on a path; we put ourselves on a trajectory to repeal this formula, do it over a couple year's time, get some savings in the meantime to offset that cost. And we all know that those savings are built into

the system and they are accruing every day. But rather than having those savings go to part A of Medicare, let's hold them in part B and reduce the cost of repealing the sustainable growth rate formula. And then ultimately, in 2 years' time or so, repeal the SGR formula once and for all and put the Nation's physicians on what is called the Medicare Economic Index.

This is not a formula that I derived; it was created by the Medicare Payment Advisory Commission, the MedPAC Commission several years ago, and it is essentially a cost of living adjustment, the same cost of living adjustment that hospitals receive, the same update that insurance companies receive, the same update that drug companies receive. Let's put part B, the physician's part of Medicare, on that same level playing field with the other participants in part A, part C, and part D of Medicare.

So I did want to get that out there. I encourage my colleagues to look at H.R. 6129. This is an important piece of legislation. It is a rope to throw to the Nation's physicians and patients that are already on their way over the cliff. It is a cliff that we created for them. We gave them the push over the edge. The least we can do at this point is to offer them a little bit of help so that they don't come crashing down at the bottom of that cliff.

Now, the reality is this is only for 7 months' time. This does not take any of the heat off of any of us, that we still need to work on that long-term solution. I actually offered this particular bill as an amendment to the Medicaid moratorium a few weeks ago in committee, and I was told, oh, no, no, no, we can't do that; because if we do that, then the people who might be working on solving this problem will know that the pressure is off and they don't have to work on it. I beg to differ. The pressure will still be on. The mid-term and long-term solutions still are out there to be had, and it will be incumbent upon this Congress, particularly here we are going into an election year, Do you want to go home and talk to your doctor groups around in your district and say: You know what? We just didn't think we had the time to fix this problem that you all are up against, so shortly after I am sworn in next year you will be looking at a 15 percent reduction in your payment rates. And, do you really want to go home and talk to your patients, who already call up their physician's office and say, I am sorry, I am not taking any new Medicare patients; do you really want to go home and face those patients in your town halls when they find out that you didn't lift a finger, you didn't lift a finger to keep this from happening when we all knew it was coming? We knew it was coming last December, and the best we could do was 6 months is the best we can manage. We knew it was coming all spring. We know it is coming now.

Let's fix this. This short-term solution is paid for. It is not going to ex-

pand the deficit. No tax increase has to result. It is there. The money is there. We took the money from the same place that the other side took the money for the Medicaid moratorium. Let's take that money and fix this problem short term, and then get on about fixing it long term.

Mr. Speaker, the real reason I came to floor tonight until this other problem took precedence was to talk a little bit about an event we had up here on Capitol Hill about 2 months ago now, and it was done to capture some of the successes that are happening out there in the real world as far as it relates to delivery of health care in this country. This was a symposium that was held on April 8 of this year, was done in conjunction with the Center for Health Transformation. Many people will recognize that organization. This is the organization that was founded and is still run by the former Speaker of the House, Newt Gingrich. He was very kind and generous with his time that day and came to this meeting over in the Rayburn Building, and we talked a little bit about some of the things that are working out there in the real world. Because, after all, Mr. Speaker, do we really want to give up a measure of our freedom in this country? And that is what it would entail if we go to a much more restrictive type of delivery of health care in this country.

Freedom is the foundation of life in America, and unlimited options, unlimited opportunities are something every single one of us on both sides of the aisle takes for granted and will embrace when we give our talks at home, whether it be on Memorial Day or Independence Day. We like to talk about how the freedom of America makes us the greatest country on earth.

Freedom is transformative. Freedom is the basis for what we should be doing when we look at how we can transform the Nation's health care system. And innovation goes hand in hand with those choices.

Come to think of it, Mr. Speaker, when I was a youngster in medical school many, many years ago, I would have never thought we would have seen the day where you could go on the Internet, just an average person, you don't need a doctor's order, you don't need a ton of money; you can go on the Internet and get your human genome sequenced for you individually for less than \$1,000. Never when I was in medical school would I have thought you would be able to go on the Internet and get such information. In fact, I wouldn't have known what the Internet was when I was medical school because Al Gore hadn't invented it then. At the same time, today you can go and get that information. We are putting that information in the hands of patients, which then they are going and sharing with their physicians. And this is powerful information for the individual to have.

The New York Times in October of 2006 published a piece by Tyler Cohen

when he talked about the ability to innovate and how it has made American medicine really the envy of the world. Seventeen of the last 25 Nobel Prizes have gone to American scientists working in American labs, and four of the six most important breakthroughs in the last 25 years have occurred because of the research of American scientists, things like the CAT scan, coronary artery bypass, statins for reduction of cholesterol. In fact, the National Institutes of Health will tell you statistics that 800,000 premature deaths from heart disease have been prevented in the last 25 years because of innovation that has in part been developed by the National Institutes of Health and then part developed by the private sector in this country.

So it is truly a good news story, and the reality is America is not done. We are not done with the advancements in medicine. The next generation of breakthroughs, I already alluded to what is happening with the human genome. Look at the speed with which information is now processed and transferred and disseminated. Who would have ever thought that we would be in this phase of rapid learning in which we find ourselves currently. This is truly likely to be the golden age of medical discovery. And the breakthroughs that occur have been a result of the environment that has fostered and encouraged competition and choice.

It doesn't mean we can't make a good thing better. It doesn't mean that everything about our system is perfect. But certainly, when we look at ways in which we might change the system, for heaven's sake, let's not do things that will harm the innovation that our system has brought us. American ingenuity prospers when we strive to be transformational. The reason we can be transformational is because of the degree of freedom we have. Remember, freedom is transformational.

So when we are advancing toward a goal and we are not focused on the transaction like we do with our Medicare reimbursement; when we are focused on the goal of being transformational, that is when good things can happen. But the present debate in Washington is focused on dollars and cents, and we are not focused on the transformational. We are not even looking at ways where we can fundamentally enhance the interaction that occurs between the doctor and the patient in the treatment room. We are simply looking at ways of moving dollars around on a balance sheet, and we do that and we think we have done a good job. And, again, I reference what has happened with the Medicare physician reimbursement rates that are going to go down so much in just a few weeks.

Mr. Speaker, I am one of the few policymakers on Capitol Hill that has also spent a lifetime in health care. For 25 years before I came to Congress, I had my own practice. I have sat in exam

rooms with patients, I have looked them in the eye, I have taken a prescription for them and counseled them as to risks and benefits and costs and written a prescription. I figured out how to build my business, how to expand my business. I figured out how to build my business in lean economic times back in the 1980s in Texas. I figured out how to expand my business in good economic times in the 1990s in Texas. I figured out ways to pay my employees and keep the lights on. But, again, if we don't have a commonsense approach to these health care issues, our solutions are going to be far short of the mark.

This experience gives me the practical knowledge to play some role in the development of this policy.

□ 2100

I think this comes in handy because, as we change health care in this country, we want to be certain that we do it in a way that allows health care to still be delivered in this country.

And there's widespread recognition that things need to change. There's different ideas as to how to accomplish it. The good news is that, regardless of what happens tonight, there is going to be a fundamental referendum on health care in this country come November, because whoever prevails on the Democratic side, of course Senator MCCAIN on the Republican side, the views are distinct from each other, and it is going to give the American people a clear choice about the direction to go in health care. One is focused on more government control, and one is focused on more patient control. I'll give you a guess as to which side that I would come down on.

And again, policymakers are focused on change, and the people who care for patients, the people who are involved in their practices, they need to be involved in this discussion as well because, in truth, health care begins and ends partly with patients, but truly with the people who are involved in the delivery of that health care, and specifically I reference physicians and nurses, hospital administrators and other health care personnel will figure into that equation. But those are the individuals who have to be involved in this grand national debate we're going to have about health care transformation in this country over the next 5 months.

And many of my friends who are health care professionals don't realize the critical role that they must play in shaping the health care debate. They must be active, they must be engaged, or otherwise you're going to be forced to sit on the sidelines and play by the rules that other people are going to make for you.

And again, I reference the earlier part of my discussion. You see, the rules that we'll come up with here in Washington, DC, those rules are, let's take 10.7 percent away from our doctors this month, and in 6 months let's

take another 5 percent away from them, and then we'll figure something out in the meantime.

Well, I will just tell my friends who are involved with the delivery of health care, whether it's in Washington, whether it's at home in Texas, you need to be involved. You've got to act before all you can do is react. And if health care professionals don't lead, then we'll have to accept what the health care prescription is that is given to us by the people who sit in this body, the people who sit on the other side of the Capitol, whoever sits in the White House.

It doesn't make sense to have a body that is what, two-thirds lawyers, making all of the decisions about how the doctors are going to practice in this country.

One of the possible prescriptions that's out there, one of the things that I find very problematic is expanding the government role for health care.

Mr. Speaker, if I were to pose a hypothetical question, what is the largest single payer government health care system in the world? Well, you know what? It's right here in the United States of America. Our Medicare and Medicaid and all of the other systems that are involved and administered by the Department of Health and Human Services accounts for pretty much 50 cents out of every health care dollar that is spent in this country. That means 50 cents out of every health care dollar that's spent in this country originates right here on the floor of the House of Representatives. And I would just ask you, are we doing such a great job?

I reference my earlier remarks about what's happening to the Medicare system if we don't do something within the next 4 weeks. Are we doing a great job with what we control currently?

Now, the government can play a role by encouraging coverage and maybe help incentivizing and encouraging the creation of programs that people actually want. Rather than forcing them into a government-prescribed program, what if we build something that actually brings value to people's lives and offer that as an alternative as we try to expand access to health care and health care coverage in this country.

And the good news is we actually have a model within the very recent past that has worked, and worked very well, and that is the Medicare Part D program which began in this Congress my first year here in 2003, and rolled out on January 1, 2006. And as a consequence, now, 90 percent of the seniors in this country have some type of coverage for their prescriptions. Contrast that to when I took office and that number was somewhat below 60 percent. So that has been a good thing. It has moved in a positive direction.

Well, what do people think about this program that has now been in effect for a couple of years? Well, current polling shows about a 90 percent satisfaction rate with Medicare Part D. So that's a

good news story. We've got 90 percent of the people covered. We've got 90 percent positive ratings with various polls.

Well, what about the cost? We heard a lot about the cost on the floor of this House as we debated that bill and in the aftermath after that bill was passed, but the reality is when we passed that bill in the House, the Center for Medicare and Medicaid Services projected the cost per enrollee per month to be about \$37.50. The reality is, the cost currently is about \$24.50, and it has been stable over the time that this program has been in effect.

So here's a Federal program that, yeah, it has been a joint public/private partnership, but 90 percent coverage, 90 percent acceptance rate, and came in at a cost two-thirds of what was originally projected. I would say, from the limited time I've had here in Washington, that's the definition of a success story with a Federal program.

So 29 people are enrolled as of 2007, and the average cost is less than \$24 a month. The first Federal program to rein runaway medical spending by restoring savings incentives and leveraging the power of that public private competition.

So overall, some of the best things that government can do is, when they recognize that there's a problem in say the delivery of health care or even in arenas such as health care information technology, we can kind of set the stage and tell people what our expectations are, and then get out of the way. Don't put a lot of regulation. Don't put new causes for liability out there. Get out of the way, and let the private sector do what they do best, what they do every day of the week. If we can do that by creating the right environment to let the private sector deliver the kind of innovation, the kind of cost savings and the type of quality that realistically has been delivered to other industries over and over and over again, if we can do that then maybe we have done something worthwhile.

You know, these are the same market forces that took us from a single black rotary telephone to these fancy electronic devices that all of us carry with us 24 hours a day now. We cannot imagine being without our iPods and iPhones and BlackBerrys. But it wasn't too many years ago, in fact, the year I started in private practice where it was a single line black rotary telephone, and we thought it was the height of high technology when we got those little push buttons on our phone.

Look at the change that's happened in aviation in literally what has been now the first century of aviation, going from the type of plane that the Wright brothers flew to the Boeing 787 dream liner that is coming on-line now. We have seen fantastic change.

I already mentioned the inventor of the Internet, and in the short period of time, we've come to the age that's brought us things like iTunes and YouTube, things that most of us now

would find indispensable. If someone said we're going to take this away from you, we'd say that's not a good idea. We'd rather the government wouldn't do that.

But here's the secret. Here's the deal. The free market is delivering this same kind of value every day, day in, day out. Innovation and efficiency are hallmarks of what they're able to do. So why not? Why not allow them to participate in this grand plan that we call transformation of the Nation's health care system?

I've experienced it, and I'm excited about experiencing more of it and learning more about it, both as a legislator and as a professional in medicine.

But I just have to tell you, this past fall, Health Affairs did a symposium in downtown Washington, and I went to that symposium. I largely went because Dr. Mark McClellan was going to talk about his experiences with the Medicare program, Medicare Part D Program. Dr. Elias Zerhouni was going to talk about his experience with the National Institute of Health. But I had really no intention of sitting and listening to Ron Williams talk about—the new CEO of Aetna talk about what was happening within Aetna because I thought, well, Aetna's one of those private insurers who really, as a provider, we've oftentimes been at odds. But I listened to Dr. Zerhouni and I listened to Dr. McClellan. But it was Ron Williams who really talked about the biggest changes that are coming in medicine, particularly in the arena of health information technology, and the things that he was talking about were truly transformative.

So my question to him later was to ask why is—what would you require, what is the environment that you require to be able to do these great things that you're talking about? And he outlined perhaps a program where there would be some certainty as to what the privacy regulations are.

We all talk about privacy in this body. We're going to have a hearing about it tomorrow. But does anybody really understand what we mean when we say we want some privacy provisions? What about the STAR clause that prevents a hospital from putting a computer line in a doctor's office? Is that really a good idea as we go forward with wanting to develop more and better situations where we can have advancement in health information technology? Is that truly such a good idea?

Maybe we would do better if we relaxed some of the regulations, if we provided some certainty in the areas of liability, provided some certainty in the area in the definition of things like privacy, maybe that would be a better way to go about it.

During that discussion with the CEO of a large insurance company, he talked about things, about the different algorithms they've developed purely from using financial data, no clinical data involved, but the types of

anticipation that they could now have about very expensive diseases that they might have to pay for and the clues they could get very early on in the process of this, and how they might be able to moderate or modify activities so that they didn't have to pay for that very expensive care at the end stage of the disease, they could actually work on that at an earlier stage and not only prevent the large expenditure for the more expensive disease, but also improve the quality of life because, after all, we're increasing the amount of time that a person has in a state of relative good health.

Another company that I talked to recently talked about a new test they're going to have for a disease called preeclampsia, pregnancy-induced hypertension. When I was in practice, and even just a few years ago, if you saw a patient where you were worried that this might be happening, about the only option you have was to put the patient in the hospital and observe them over time and see whether this was a real phenomenon or just a one-time event. But the price you paid for being wrong was severe, and certainly could result in severe injury to the patient and/or her baby. So we always erred on the side of caution with that.

But now there may be a new blood test that will elucidate very quickly whether someone is truly at risk for this problem, or if perhaps this one indication of elevated blood pressure was just an outlier, and, in fact, they aren't truly at risk for this problem. This would be a tremendous tool to put in the hands of clinicians. And look at the savings, not just in eliminating some of the unnecessary hospitalizations, but making certain that the people who really need the intensive care get that intensive care and get the intensive observation and scrutiny that their particular situation demands.

And a recent study out of Dartmouth outlined how hospitals can deliver better care and do a better job at a lower cost by embracing some measures of efficiency. This study demonstrated that Medicare could save as much as \$10 billion a year if all United States hospitals followed the example of the most efficient hospitals. These facilities didn't cut costs at the expense of patient care, but focused on better coordination of care and better avenues of communication between doctors and specialists and better avenues of communications between hospitals.

Now, again, earlier in the month of April I was fortunate to co-host a panel with former Speaker Newt Gingrich which focused on some of the real world examples of success in health care transformation. And Mr. Speaker, I'll just tell you, it's no secret to people in this body that former Speaker Gingrich is a real leader when it comes to leading the charge for change in the arena of health care. He's involved in a great many other things, but certainly, in the arena of change in health care, former Speaker Gingrich has really

pushed this to the forefront, and has really—I am so grateful for his involvement in that, and his bringing new ideas and new people to the table on a constant basis that help us, are going to help us evolve into this system that we all would like to think that we can help deliver to our country.

Now, he brought in several companies that demonstrated how free market choice and competition can lead to more options at a lower cost, when it comes to health care. And let me just share a little bit about what we learned that day. Since there weren't many Members who were able to attend, let's talk a little bit about some of the companies that are relying on innovation to save lives and save money and to actually save time in the process.

Overall, there was agreement that we can get better results with what—we don't have to pay more money. With the money that we're paying right now, we can get better results by actually engaging patients in their own care. And you know, this goes back to what Dr. Zerhouni has talked about at the National Institute of Health.

Because of what we've learned about the human genome, medical care is going to be personalized to a level that no one ever thought about before. You're going to be able to know, no longer will it be a course, a question of, well, we're going to try this particular medication because we'll see how it works. If it doesn't work, we've got an alternate.

□ 2115

You will actually know that beforehand because of knowing about a person's genetic makeup. So medicine will become a great deal more personalized.

Because of that, it's going to be also, it's going to be, of necessity, focused on prevention. We know what diseases you're at risk for so we're going to recognize that and focus on the preventive aspects of that. And as a consequence, it has to become more participatory. That is, the patient can no longer simply be a passive recipient of health care services and the expense of health care doctors. The patients themselves need to be involved in the maintenance of their health and the decisions surrounding the delivery of health care.

Now, in industry circles, this is what is known as consumer-directed health care, consumer-driven health care. The goal of consumer-directed health care is to kind of eliminate the middleman, in our case the government, or it could be the insurer in the private sector who tries to find their way in as a wedge.

Remember I talked about that fundamental interaction between the doctor and patient in the treatment room? What of the barriers to enhancing that relationship? Well, it can be the government, it could even be a private insurance company. If we can somehow remove the middleman, number one, the patient will not be so insensitive, so anesthetized as to the cost of their care; and they will be more in tune to

the benefits that can accrue to them should they work harder on participating in their own health care.

If people are anesthetized, Mr. Speaker, they're anesthetized to the true cost of health care. All they want to know is when and if they can see their doctor and what their co-pay will be and if you order expensive tests, like a CAT scan or an MRI, the only question is is it covered; not is it necessary, is it truly something I need, how is this truly going to benefit my care in the future. It's, well, will insurance pay for it, and if it does, do I have to pay a co-pay.

Now, I know from personal experience, and certainly my staff has told me this as well, you know, you receive one of those forms. It's called an EOB, explanation of benefits. You receive one of those from the insurance companies. Most people toss it. It's so confusing. It really has no bearing on reality anyway. It doesn't have anything to do with the ultimate cost or the ultimate bill that was paid either by the insurance company or the individual so most people just simply pay no attention to that; and yet this is the one piece of paper that actually tells the patient what it costs to deliver the care that they have just received.

So that means they're consuming health care services but they're not conscious of the costs. So there's little incentive on their part to modify their behavior to do things better next time, to be active participants in their own health care.

So consumer-directed health care says if people aren't anesthetized, if people are fully awake and fully conscious, they're more likely to make sound and wise decisions about their lifestyle and about maintaining their own health.

Now, there was a McKenzie study that found that consumer-directed health care patients were twice as likely as patients in traditional plans to ask about costs and three times as likely to choose a less expensive treatment option, and chronic patients were 20 percent more likely to follow their outlined regimen very carefully.

Now critics argue that consumer-directed health care will cause consumers, particularly those who might be less wealthy or less well-educated, to avoid appropriate and needed health care because of the cost burden and the inability, the inability to make informed and appropriate choices.

Now, one of the companies that was at the panel we did in April had data that actually contradicted that criticism. The Midwestern Health Care Company introduced a consumer-directed health plan to its 8,600 employees. They also left their traditional PPO, their regular insurance, in place. In the first year, 79 percent of employees chose one of four consumer-directed health plans. These health plans had several important features, but two of those were preventive care was free and employees received financial

incentive to change behaviors like smoking and weight control.

In addition, they also received some incentive to manage chronic conditions like asthma and diabetes, that is, see their physicians at the prescribed time, take the prescribed medicines according to the directions and do the appropriate follow-ups.

So this has been in place for a couple of years. Do we have any statistics, are there any metrics that would indicate an overall direction of improvement? And in fact, 7 percent of health care dollars were spent on prevention compared to a national average of a little less than 2½. So that's a significant increase. And nearly 40 percent of the employees now take an annual personal health risk assessment and earn \$100.

Nearly 500 employees have quit smoking, and as a group, that 8,600 employees have lost 13,000 pounds through weight-management programs.

From a cost standpoint has there been a difference? And the answer is yes. The average claim increase of 5.1 percent in the past 2 years compared with those who are in traditional PPO-type insurance where the claims increased 8 percent. So a 3 percent reduction for an increase in claims activity for people who were taking a more active role in the involvement of their own health care.

This company has a lot of impressive data. Policymakers can, in fact, learn from the example that was brought to us that day. And we can learn from some of the other companies as well.

One of the largest for-profit health insurance companies featured on the panel described their incentive-based health benefit design. Now, they have a plan that is a high-deductible plan. It's a \$5,000 deductible for a family. I don't think anyone would argue that that's a fairly high deductible for a family to have to face if they have an illness. But the good news is that family, with that \$5,000 deductible, and of course they get a break on their premium with such a high-deductible plan, their premium costs less than some of the other plans. So they do save money on the premium.

But also if they're willing to participate in some things like weight control, smoking cessation, cholesterol screening, exercise management, if they're willing to participate in those, they can reduce that \$5,000 deductible in \$1,000 increments down to a \$1,000 deductible with no increase in their premium. So they still have the very low premium associated with a \$5,000 deductible plan, but now they've reduced their deductible to \$1,000 for that family, which is a much more manageable figure.

And how did that they do that? Because they voluntarily enrolled in a smoking cessation plan, they voluntarily enrolled in a plan to measure cholesterol, and because they voluntarily enrolled in a plan to actively manage their weight and increase their

exercise. So positive things that the individuals can do themselves that result in an actual benefit as far as the insurance expenditure is concerned.

Now, there were also some very positive results from some of the other consumer-directed health care options. 88 percent of health savings account holders carried a balance from 2006 into 2007. That means they didn't spend all of their money that was set aside for health care expenditures, and they were actually able to carry that forward into the next year. And you can imagine doing that year over year over year along with the miracle of compound interest, as long as you start young, that can be a powerful way to put some savings in place for payment for health care later on.

I actually say this from personal experience. I was one of the first people to get a medical savings account. This Congress, under the leadership of former chairman Bill Archer of the Ways and Means Committee, passed a medical savings account bill in 1996. In 1997, I signed up for one. I had it until I came to Congress at the beginning of 2003, and that money now sits there and grows year in and year out and is a substantial amount of money that is now available for treating health-related conditions well into the future. That is a powerful tool to put in the hands of someone. And the actuality is the earlier you start, the more powerful is that concept.

So 88 percent of health savings account holders had a carryover balance from 2006 to 2007. And the average balance among people who were judged to be of low income was almost \$600, \$597 on average. So that's not insignificant.

Now, how many Americans are encouraged to live healthier lives and to conserve their health benefits like these individuals that we've just described? People that are making personal decisions about prevention and lifestyle and managing chronic conditions and cost. Most people with other private health insurance are not because there is no reason for them to. They just simply pay their insurance premium every month. They hope that they don't have to use it. They hope that their health is not threatened and they have to rely on this insurance company, and if they do, they hope that they will in fact be covered when that illness strikes.

In fact, Mr. Speaker, within my own family, I have a youngster who teaches school. He teaches middle school there in Denton, Texas. Once I said, You know, you have gotten to an age where you need to think about preventative health care. You need to think about going to see the doctor once a year for a physical and having some lab work done and having a few things checked. He said, I don't need to do that. I thought he was going to tell me because he was young and indestructible. He said, I don't have to do that because they came to our school and did a bunch of blood tests and told me I was fine.

I said, What do you mean they came to your school and did a bunch of blood tests? He said, Yeah. If we went out and had the nurse draw our blood, they would actually give us \$20 a month off of our health insurance premium, and I did the math. That's \$240 a year. I'll take that in exchange for having a little blood work done.

How forward-thinking for this independent school district to provide that type of service. That way if someone in fact does have an elevated cholesterol but it's entirely silent and they have no idea that they have it, that person can be identified and have some treatment started that will prevent the problem down the road. And in fact if there are no problems, then the school district also benefits because they know they have a very healthy workforce, and they are very fortunate to have a very healthy workforce working for them.

But the closet diabetic, the person with high cholesterol that is otherwise not known, the person with other medical conditions that is otherwise not known, the person with even illnesses that would lead to electrolyte imbalances may be discovered by those types of screening tests.

So this, all in all, is a good thing and a way for, yes, the independent school district to save money on some of those higher dollars, just like the CEO at Aetna described, being able to save money on those higher-dollar diagnoses by paying a little bit of money on the front end to, in this case, to elucidate those conditions, and then if they are found, to encourage that person to perhaps seek some treatment for that.

So there is, of course, a quote that we're all familiar with about the fundamentals of learning being reading, writing, and arithmetic. Perhaps for Congress our fundamentals for health care should be risk, responsibilities, and rewards. And if we will focus on those—after all, on both sides of the aisle, who can be opposed to more care, lower cost, better quality? I mean, how can you be opposed to those three things? That's what we all talk about in all of these lofty terms about what we're all for.

Well, let's be for that. Let's be for that and ensure that we put the tools in the hands of the American people so that they can actually participate themselves in the blessings that the American health care system is likely be able to provide for them in the years to come.

So, that's the right prescription for health professionals, and it's the right prescription for them to push for when it comes to real system reform, and it's the right prescription for Members of Congress to subscribe to as well.

So let me just finish by once again stressing the importance that we've got some immediate work in health care ahead of us. Forget all of the stuff that's going to happen in the presidential election. If we don't fix this problem with the Medicare physician

reimbursement rate, if we don't fix or stop those cuts that are going to go into place in just a few weeks time, then a lot of this discussion will be for nought because we will have driven doctors out of practices and we will ensure that patients don't have access to care of any type. Whether it is expensive care, whether it is quality care, it doesn't matter. We will just have ensured that our Medicare patients don't have access to that care.

So I do urge my colleagues to please pay attention to this. Look into whatever bill you want. I urge to you look into H.R. 6129, which is a paid-for short-term solution to the cliff about which we're fixing to go over the edge. And I do want to encourage my colleagues to focus on this because this is extremely important. This is important to the doctors and patients back in your district.

Nothing is more personal to a person than their medical care and their relationship with their physician, and this hits right at the heart of that relationship if we allow these cuts to go into place and oh, yeah, by the way, there's another 5 percent reduction where that came from waiting for you at the end of the year.

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Make no mistake about it, Mr. Speaker, this is a presidential election year. All eyes tonight are going to be on what is billed as the last presidential primary, and then we'll start the fall campaign literally tomorrow morning.

Make no mistake, it's going to be difficult for things to rise to the top of the national discussion, which is why I encourage my colleagues to take the time and trouble now to look at this legislation, look at H.R. 6129, do the right thing and get behind this bill, if you can, and let's deliver to the Speaker of the House of Representatives a significant number of cosponsors, 200 or 300 cosponsors, so that we will actually get this legislation done in what remains of the days between now and the 4th of July break. And perhaps we can also, too, get some attention over in the other body on the other side of the Capitol so they will take this up as well.

There's probably no more important thing, perhaps with the exception of passing the Foreign Intelligence Surveillance Act, but there's probably no more important or intense piece of legislation that we can take up these next 4 weeks. This is an immediate concern. This is a clear and present danger to the physicians who practice in this country and the patients who depend on those physicians for their health care, the access for those patients to their physicians. This is the number one issue of this Congress this month, and we should not shirk our responsibility.

Please, let's don't do what they did in December and just simply walk away from this responsibility. Let's

take charge of this. We have it within our power to affect this.

Again, this is a paid-for provision. This is not going to expand the deficit. It doesn't create a tax increase. It doesn't take money away from anyone else. This is the right thing to do. And this Congress, this Congress ought to stand up and do the right thing when it comes to the patients and the physicians of this country.

On the larger issue of the health care referendum that we're going to be facing in this country, I urge my colleagues to listen very carefully to the arguments that are going to come from both political parties as we go into the fall presidential election. Please remember that that which grows the government side of health care may not be in the best interests of patients in the long term. And those programs that tend to encourage the involvement of the private sector and tend to encourage the participation of the patient in the maintenance of their own health care, those are programs that are likely to deliver value and allow us to continue what has been the greatest health care system the world has ever known.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. ELLISON (at the request of Mr. HOYER) for today.

Mr. KANJORSKI (at the request of Mr. HOYER) for today on account of personal reasons.

Ms. MCCOLLUM of Minnesota (at the request of Mr. HOYER) for today.

Mr. PEARCE (at the request of Mr. BOEHNER) for today on account of official business.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

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

Mr. DAVIS of Illinois, for 5 minutes, today.

Ms. WOOLSEY, for 5 minutes, today.

Mr. CUMMINGS, for 5 minutes, today.

Ms. KAPTUR, for 5 minutes, today.

Mr. DEFazio, for 5 minutes, today.

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

Mr. POE, for 5 minutes, today and June 4, 5, 6, 9, and 10.

Mr. JONES of North Carolina, for 5 minutes, today and June 4, 5, 6, 9, and 10.

Mr. DEAL of Georgia, for 5 minutes, June 4.

Mr. BURTON of Indiana, for 5 minutes, today and June 4, 5, and 6.

Mr. BRUN of Georgia, for 5 minutes, today and June 4.

Mr. BURGESS, for 5 minutes, today.

Mr. McCOTTER, for 5 minutes, June 4.

Mr. MORAN of Kansas, for 5 minutes, today.

Mr. MCHENRY, for 5 minutes, today and June 4, 5, and 6.

Mr. TANCREDO, for 5 minutes, today.

Mr. KUHLL of New York, for 5 minutes, today and June 5.

SENATE BILL REFERRED

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

S. 1965. An act to protect children from cybercrimes, including crimes by online predators, to enhance efforts to identify and eliminate child pornography, and to help parents shield their children from material that is inappropriate for minors; to the Committee on Energy and Commerce.

ENROLLED BILLS SIGNED

Ms. Lorraine C. Miller, Clerk of the House, reported and found truly enrolled bills of the House of the following titles, which were thereupon signed by the Speaker on May 22, 2008:

H.R. 2356. An act to amend title 4, United States Code, to encourage the display of the flag of the United States on Father's Day.

H.R. 2517. An act to amend the Missing Children's Assistance Act to authorize appropriations; and for other purposes.

H.R. 4008. An act to amend the Fair Credit Reporting Act to make technical corrections to the definitions of willful noncompliance with respect to violations involving the printing of an expiration date on certain credit and debit card receipts before the date of the enactment of this Act.

Ms. Lorraine C. Miller, Clerk of the House, further reported and found truly enrolled a bill of the House of the following title, which was thereupon signed by Speaker pro tempore, Mr. HOYER, on May 27, 2008:

H.R. 6081. An act to amend the Internal Revenue Code of 1986 to provide benefits for military personnel, and for other purposes.

SENATE ENROLLED BILLS SIGNED

The Speaker announced her signature to enrolled bills and a joint resolution of the Senate of the following titles:

S. 2829. To make technical corrections to section 1244 of the National Defense Authorization Act for Fiscal Year 2008, which provides special immigrant status for certain Iraqis, and for other purposes.

S. 3029. To provide for an additional temporary extension of programs under the Small Business Act and the Small Business Investment Act of 1958, and for other purposes.

S. 3035. To temporarily extend the programs under the Higher Education Act of 1965.

S.J. Res. 17. Directing the United States to initiate international discussions and take necessary steps with other nations to negotiate an agreement for managing migratory and transboundary fish stocks in the Arctic Ocean.

BILLS PRESENTED TO THE PRESIDENT

Lorraine C. Miller, Clerk of the House, reports that on May 23, 2008 she presented to the President of the United States, for his approval, the following bills:

H.R. 2356. To amend title 4, United States Code, to encourage the display of the flag of the United States on Father's Day.

H.R. 2517. To amend the Missing Children's Assistance Act to authorize appropriations; and for other purposes.

H.R. 4008. To amend the Fair Credit Reporting Act to make technical corrections to the definition of willful noncompliance with respect to violations involving the printing of an expiration date on certain credit and debit card receipts before the date of the enactment of this Act.

ADJOURNMENT

Mr. BURGESS. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 9 o'clock and 33 minutes p.m.), the House adjourned until tomorrow, Wednesday, June 4, 2008, at 10 a.m.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 8 of rule XII, executive communications were taken from the Speaker's table and referred as follows:

6830. A letter from the Administrator, Department of Agriculture, transmitting the Department's final rule — Rules of Practice Governing Formal Adjudicatory Proceedings Instituted by the Secretary Under Various Statutes [Docket No. AMS-L&RRS-08-0015] received May 23, 2008, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

6831. A letter from the Administrator, Department of Agriculture, transmitting the Department's final rule — Avocados Grown in South Florida and Imported Avocados; Revision of the Maturity Requirements [Docket No. AMS-FV-07-0054; FV07-915-2 FR] received May 23, 2008, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

6832. A letter from the Administrator, Department of Agriculture, transmitting the Department's final rule — Sorghum Promotion, Research, and Information Order [Docket No. AMS-LS-07-0056, LS-07-02] received May 23, 2008, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

6833. A letter from the Administrator, Department of Agriculture, transmitting the Department's final rule — National Dairy Promotion and Research Program; Section 610 Review [Docket No. AMS-DA-08-2004; DA-06-04] received May 23, 2008, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

6834. A letter from the Administrator, Department of Agriculture, transmitting the Department's final rule — Peanut Promotion, Research, and Information Order; Amendment to Primary Peanut-Producing States and Adjustment of Membership [Docket No.: AMS-FV-08-0001; FV-08-701 IFR] received May 23, 2008, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

6835. A letter from the Administrator, Department of Agriculture, transmitting the