

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

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

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

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

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

THE STATE OF HEALTH CARE: REPUBLICAN EFFORTS FOR HEALTH CARE REFORM

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

Mr. MURPHY. Mr. Speaker, I will be joined in a little bit by my friend and my colleague, Dr. PHIL GINGREY of Georgia, for this next hour. It is important that we lay out a large segment of what we believe is a critically important agenda to reform health care in America.

We know that few things are more valuable to us than the health of our families. When the health of our families is threatened, we feel frightened, we feel vulnerable, and we desperately search for help. I think few would challenge that the United States provides, as available, the best health care in the world, dedicated and caring physicians and nurses and hospitals and professionals, and we have made huge technological advances in fighting disease and prolonging life. Our research and medical technology is second to none. It significantly advances every year.

However, despite these many accomplishments, the American health care system is burdened by severe problems that lower quality and increase costs and too often make this system unaffordable and inaccessible for millions of Americans. Too many families, unfortunately, are only able to window-shop for health care coverage, and they feel as though they cannot go into the store.

Tonight, those colleagues of ours on our side of the aisle, who are part of our health care team, will be talking about a number of important issues to advance this cause. Mr. Speaker, before I go into this, let me pause, if I may, for a moment, and say usually when I have been here for Special Orders to talk about issues, I traditionally was walking up to the Capitol to make a call to my mother to let her know. She then would get on the phones and call

all her friends. My mother was a nurse, worked for many years at hospitals in Cleveland, as well as in industrial settings.

I am sad to say that since I last spoke in the Chamber, my mother had died, but I am sure she is still doing her own method of notifying her friends, and meeting my father now to talk to him and to say, make sure you pay attention to this message.

It is a message that I hope Americans will attend to as well. Because while there are those who talk about the costs of health care, what we are going to be talking about tonight is ways of changing health care and not simply shifting the burden of health care to one or the other.

Let me talk about a few of the costs that we need to pay attention to. Health care costs are skyrocketing. In 2005, the Federal Government spent over 45 percent of mandatory spending on health care programs, including almost \$300 billion for Medicare and \$181 billion for Medicaid. Medicaid costs now consume about 70 percent of States' budgets, and it is rising more than the rate of inflation. This, nearly half a trillion dollars, does not even include the billions that we spend at the Federal level in discretionary health care spending for Department of Veterans Affairs, \$31 billion; the National Institutes of Health, which has increased over 100 percent in the last 10 years under President Bush, to \$28.5 billion; the Centers For Disease Control and Prevention, \$8.2 billion; the Indian Health Services, \$4 billion; Early Head Start, \$6.8 billion; and the Women, Infants and Children program, \$5.3 billion.

□ 2015

When we add to this also the costs paid for by employers and paid for by families across the Nation, the numbers are staggering.

The Federal Government has made a number of attempts over the years to deal with some of these increased costs, such things as dealing with the budget, where we try and increase co-payments on prescription drugs, or we deal with premium costs in private or federally or State-funded health care programs, which have all been geared towards trying to share the costs.

This higher cost-sharing requirement, in many cases, is designed to not only reduce some of the overall costs to the Federal budget, but also to help encourage patients to change some behaviors, such as not going to expensive emergency room settings for common ailments, such as colds and flu and scrapes and bumps, but instead to see their doctor. These increased copays are usually enacted to change these behaviors, and yet we need to be doing other things in order to actually change some of the flaws in our health care system.

But let us make a point of this: whenever Congress has enacted those important issues to try and change

some behaviors and actually save money, unfortunately, the Congressional Budget Office, which is there to tell us how much we are spending and give us some accurate numbers, simply is unable to do this at all.

The Congressional Budget Office can only talk about savings when more money comes out of pocket, but they cannot and are unable to talk about savings that come from trying to prevent the problems we are talking about tonight.

Since the CBO does not provide what is called dynamic scoring, a potential cost savings, the Federal Government in essence ties its own hands so we can only focus on cost sharing and not directly change efficiency and reduce errors in health care. We do not deal with the biggest drivers of these costs. We did not have a way here to look at this.

Let me give you an example. If we were to ask the Congressional Budget Office how much it costs to immunize children in America or to inoculate them with several important inoculations that they receive in their infancy and young childhood, the CBO could give us that number. But ask them what this saves, what this saves in reduced hospital visits and the other medical complications, and they simply are not able to tell you.

Ask the Federal Government CBO what treatment programs for alcohol and drug abuse save, and they cannot tell you.

Ask them what Early Head Start's medical programs save when we get children to the doctor early. They cannot tell you.

Ask also what would happen if we made our medical records system more efficient and eliminated many of the costly errors in the system. They cannot tell you.

The CBO can tell us that, in the Deficit Reduction Act passed by the House, that \$150 million was placed in there, through efforts of my office and others, in order to help hospitals in high Medicaid areas use electronic medical records in order to reduce costs. But, unfortunately, the CBO cannot tell us what those costs are.

I am going to be talking a little bit more about these costs, but first I would like to yield to the gentleman from Georgia, Dr. PHIL GINGREY, to lay out some general outlines of some other things we are going to be talking about tonight. Dr. GINGREY, a friend and colleague, who we often are on the floor together talking on these health care aspects, will lay out in general some of the things we will be talking about.

As I said, I opened up naming some of the huge cost increases in health care, but Dr. GINGREY will lay out the general plan of where we need to go to make some substantive reforms in the health care system so that we are no longer talking about cost shifting, but really talking about saving money, and, more importantly, saving lives.

I yield to Dr. GINGREY.