out to be a bad recruiting tool for the United States but a great recruiting tool for al Qaeda and other terrorist groups?

I am encouraged, however, that a growing number of my colleagues on the other side of the aisle are turning against the occupation. But at the same time, the President gave a speech today in Cleveland that showed he isn't budging an inch from his failed escalation strategy. He said that Congress ''should wait'' for General Petraeus's report on the surge in September before making any decision about Iraq, while admitting at the same time that September is a meaningless goal. That is outrageous. The American people didn't send us to Congress to sit around and wait to do nothing. They sent us here to end the occupation, and that is what we must do.

I have proposed a bill that would achieve that, H.R. 508. It would fully fund bringing our troops home safely and soon. It would accelerate international assistance for reconstruction and reconciliation in order to keep Iraq as peaceful as possible. And it would use diplomacy. It would use diplomacy, not war, to achieve political solutions to regional problems.

We will have a golden opportunity in the days and weeks ahead to chart a new course. I urge my colleagues to heed the call and listen to history and listen to the American people and to bring our troops home.

□ 1845

FRANCIS SCOTT KEY AND SAM HOUSTON

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

Mr. POE. Mr. Speaker, Francis Scott Key is best known for being the author of our National Anthem, ''The Star Spangled Banner.'' During the second American revolution, the War of 1812, the British reinvaded the United States, captured Washington, DC, burned this building, the White House and most of this city.

The English then set sail for nearby Baltimore and were determined to take the city, but Fort McHenry was blocking and protecting Baltimore Harbor. Key, a lawyer, had boldly gone on board a British ship to seek release of a captured United States citizen. The Royal Navy held both Key and his client and refused to release either until after the British naval attack on the fort was completed. During the night, the British bombarded the fort with hundreds of shells and rockets, but at ''dawn's early light,'' the American defenders still held the fort, refusing to surrender, and a massive 30 foot by 40 foot American flag still flew defiantly over Fort McHenry. The unsuccessful British sailed away. Francis Scott Key, upon seeing the flag, wrote our national anthem that was sung this past 4th of July throughout the prairies and plains of America.

But, Mr. Speaker, Key also has a Texas connection. Before Sam Houston made his way to Texas, he served with Andrew Jackson in the Indian wars and was elected United States Congressman for Tennessee for two terms and served as Governor of Tennessee.

After his governorship, Houston spent time in Washington, DC, during the 1830s advocating on behalf of the Cherokee Indians and denouncing the corruption in the Bureau of Indian Affairs.

In 1832, Congressman William Stanbery from Ohio made slanderous accusations about Houston and the Cherokees on the floor of Congress. One morning, Houston was leaving a boarding house on Pennsylvania Avenue and saw Stanbery walking down the street. A confrontation occurred between the two men over Stanbery's statement. A street brawl resulted. Sam Houston thrashed and viciously beat Congressman Stanbery with his hickory walking cane for Stanbery's derogatory remarks on this House floor. Stanbery then pulled a pistol and put it to the chest of Houston, but the pistol misfired. Mr. Speaker, fate saved Sam Houston's life.

The United States Congress ordered the arrest of Sam Houston, charging him with assault and demeaning a Member of Congress. Houston was tried before Congress in a joint session with the Supreme Court acting as judges. The trial lasted a month. Houston spent one full day on this House floor in boisterous oratory stating his positions, that he was defending his honor; Stanbery was the aggressor; and anyway, Stanbery deserved the severe caning.

So what does Francis Scott Key have to do with any of this? Francis Scott Key was Sam Houston's defense lawyer. He did an admirable job in the defense of this later Texas hero, but after the trial was over, Houston was found guilty, publically reprimanded and ordered to pay a $500 fine. Houston refused to pay the fine and, rather than face more problems with Congress, left Washington that same year and began a new life and political career in Texas. And the rest, they say, is Texas history.

General Sam Houston was the successful commander of the Texas Army during the Texas War of Independence from Mexico in 1836. After defeating Dictator Santa Anna on the marshy plains of San Jacinto, Houston became the first president of the Republic of Texas. After Texas was admitted to the United States in 1845, he was a United States Senator and then Governor of the State. Houston is the only person to serve as Governor and Member of Congress from two different States.

Sam Houston's troubles with the legislative bodies continued, however. When Texas voted to leave the Union in 1861, the Governor, Houston, refused to take the oath to support the Confederacy. So the Texas legislature removed General Sam from the office of Governor. Too bad. Maybe if Francis Scott Key had been Sam Houston's lawyer before the Texas legislature, the outcome might have been different.

And that's just the way it is.

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

(Mr. JONES of North Carolina 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 Kansas (Mr. MORAN) is recognized for 5 minutes.

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

REVISIONS TO ALLOCATION FOR HOUSE COMMITTEES

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

Mr. SPRATT. Madam Speaker, under sections 211 and 320(c) of S. Con. Res. 21, the Concurrent Resolution on the Budget for fiscal year 2008, I hereby submit for printing in the CONGRESSIONAL RECORD a revision to the budget allocations and aggregates for the House Committees on Energy and Commerce, Ways and Means, and Education and Labor for fiscal years 2007, 2008, and the period of 2008 through 2012. This revision represents an adjustment to the Committees' budget allocations and aggregates for the purposes of section 302 of the Congressional Budget Act of 1974, as amended, and in response to the bill S. 1701—to provide for the extension of transitional medical assistance, TMA, and the abstinence education program through the end of fiscal year 2007, and for other purposes. Corresponding tables are attached.

Under section 211 of S. Con. Res. 21, this adjustment to the budget allocations and aggregates of the Committees on Energy and Commerce, Ways and Means, and Education and Labor applies while the measure—S. 1701—is under consideration. The adjustments will take effect upon enactment of the measure—S. 1701. For purposes of the Congressional Budget Act of 1974, as amended, a revised allocation made under section 211 of S. Con. Res. 21 is to be considered as an allocation included in the resolution.

DIRECT SPENDING LEGISLATION—AUTHORIZING COMMITTEE 302(a) ALLOCATIONS FOR RESOLUTION CHANGES

[Fiscal years, in millions of dollars]

House committee	2007		2008		2008–2012 Total	
	BA	Outlays	BA	Outlays	BA	Outlays
Current allocation:						
Education and Labor	$0	$0	$−150	$−150	$−750	$−750
Energy and Commerce	0	0	0	0	0	0
Ways and Means	0	0	0	0	0	0
Change in TMA extension bill (S. 1701):						
Education and Labor	13	4	0	5	0	8
Energy and Commerce	−1	−1	134	132	89	87
Ways and Means	0	0	−38	−38	−98	−98
Total	12	3	96	99	−9	−3
Revised allocation:						
Education and Labor	13	4	−150	−145	−750	−742
Energy and Commerce	−1	−1	134	132	89	87
Ways and Means	0	0	−38	−38	−98	−98

BUDGET AGGREGATES

[On-budget amounts, in millions of dollars]

	Fiscal year 2007	Fiscal year 2008 [1]	Fiscal years 2008–2012
Current Aggregates: [2]			
Budget Authority	$2,255,558	$2,350,261	n.a.
Outlays	2,268,646	2,353,893	n.a.
Revenues	1,900,340	2,015,841	$11,137,671
Change in TMA extension bill (S. 1701):			
Budget Authority	12	96	n.a.
Outlays	3	99	n.a.
Revenues	0	0	0
Revised Aggregates:			
Budget Authority	2,255,570	2,350,357	n.a.
Outlays	2,268,649	2,353,992	n.a.
Revenues	1,900,340	2,015,841	11,137,671

[1] Pending action by the House Appropriations Committee on spending covered by section 207(d)(1)(E) (overseas deployments and related activities), resolution assumptions are not included in the current aggregates.

[2] Excludes emergency amounts exempt from enforcement in the budget resolution.

Note.—n.a. = Not applicable because annual appropriations Acts for fiscal years 2009 through 2012 will not be considered until future sessions of Congress.

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 as the designee of the minority leader.

Mr. BURGESS. Mr. Speaker, this evening, I wanted to come to the floor of the House to talk once again a little bit about health care. Health care in this country is going to be something that is on the front pages during the next 18 months until the next Presidential election, I suspect, and something we're going to devote a great deal of time and energy to on the floor of this House, perhaps even this month.

As we debate the future of medical care in this country over the next 18 months and through the Presidential election that will follow in 2008 and the Congress that convenes in 2009, we've got to decide on the avenues through which our health care system will be based. And essentially, Mr. Speaker, right now we have a system that is based part on the government, part on the public sector, and partly on the private sector.

The issue before us is, do we expand the public sector? Do we expand the government's involvement in health care? Do we expand the government's involvement in the delivery of health services, as popularly referred to as universal health care, and back in the 1990s, it was termed ''Hillary care,'' or do we encourage and continue the private sector involvement in the delivery of health care? The two options bring about a significant number of questions and a significant number of concerns addressed on both sides of the aisle. But I'm hopeful that as we continue to study this problem and debate this problem in this body, we will shed some light on the direction that we should be taking.

And Mr. Speaker, I don't think there is any question that the United States has developed one of the best health care systems in the world. Access can be an issue, but the quality of health care practiced in this country is second to none. You have people coming from all over the world. When I was a medical student at the Texas Medical Center down in Houston, Texas, you would have people coming from all over the word to avail themselves of the medical care that was available at Texas Medical Center. And close to my district in north Texas, you have Southwestern Medical School in Dallas, a number of Nobel Laureates on the clinical faculty there. Unbelievable sources of talent and knowledge that are available to training the young physicians of tomorrow. So these are the types of things we've got to be certain that we preserve, protect and defend as we do things that will perhaps alter the way medicine is practiced in this country.

Now, there are a lot of people who take issue with the fact that I maintain that the United States has the best health care system in the world. Plenty of people here in this body would say that's an overstatement. They would say, you've got a large number of uninsured people in this country, or prescription drugs cost way too much. The issues are there, but you know what, Mr. Speaker? The old saying is that numbers don't lie, but if you torture them long enough, they'll admit to almost anything.

We've got to dispense with a lot of the platitudes and the soundbites and try to get to really what is causing the problems that we have here, and how can we best go about correcting those problems? Well, how about applying some American ingenuity to getting those problems solved.

So, tonight, in talking about the different principles that guide the debate about public versus private in the delivery of health care services, it's important to concentrate a little bit on the background on how we got to the system that we have today.

The idea that we have a problem to solve is not new. Secretary Leavitt, I certainly agree with him when he made the remarks in a speech not too long ago that tackling the division between the two philosophies, public versus private, recently the Secretary said in a speech and in an op-ed piece, he posed the question, should the government own the system, or should the government be responsible for some organization in the system and leave the proprietary standpoint to someone else?

Mr. Speaker, during World War II, this country was faced with some significant problems, and one of the problems was the specter of inflation. So Franklin Roosevelt said, look, we're going to have wage and price controls in this country so that inflation doesn't get out of control. Employees found themselves highly sought after because a lot of the workforce was overseas fighting the war. Employers wanted to keep their employees happy. They wanted to keep them employed. They wanted to keep them loyal to their respective companies, but they were unable to raise wages because there was a Presidential decree that we were under wage and price controls. So the Supreme Court rendered a decision that benefits, things we talk about now as a benefits package, health care, retirement, these things could be available and would not violate the spirit of President Roosevelt's wage and price controls. Thus, the era of health insurance benefits or employer-derived health insurance was born. And Mr. Speaker, it worked tremendously well, so well that it persisted well after the end of the Second World War.

Now, a lot of people will look at Western Europe and say, they've got a government-run system. Why don't we do what Europe did? How did Europe develop a system, a single-payer, government-run system? Even though some of the countries in Western Europe were victorious at the end of the Second World War, the war was fought in their back yard; their economies were devastated. It was important for their governments to stand up a medical care system quickly to avert a humanitarian crisis. That is what led to the institution of single-payer systems that you see in many countries in Europe today.

But America, by contrast, came through the war with a benefits package, if you will, that was available to employees. Employees like it. Employers liked it because the employees were happy. The employees stayed, to some degree, healthier and were able to work more effectively and less time off for sick leave. So the American system persisted and did very well for a number of years.

Now, fast forward some 20 years from the end of the war to the middle of the administration of Lyndon Johnson, fellow Texan, fellow House Member, albeit on the other side of the aisle, but during the tenure of President Johnson, he signed both the Medicare and the Medicaid programs into law. This was a large government program and represented a fundamental shift. It was the first time that the government got involved in a big way in running the practice of medicine. But it was created to focus on the elderly, to focus on their hospital care and their doctor care, and certainly make sure that persons who were then to be covered by Medicare weren't left in poverty in old age because of mounting medical bills.

But then fast forward another 40 years to the 108th Congress, and we had the Medicare system that was big and expensive and was very, very slow at change. It was like trying to turn a battleship. In 2003, in this House of Representatives, the President came to us, in the very first State of the Union message that I attended as a Member of Congress in my first term, and the President said he was going to, or this Congress was going to bring a Medicare prescription drug benefit to Medicare, that people had waited too long for this; it was too important to wait for another President or another Congress. And indeed, Congress set about the work of providing what we now know as the Part D benefit. And within the year, we voted on that package, and within the next year, it was, indeed, starting to be run. But the government system needed to address some of the inefficiencies that were built into the system.

Now, the Medicare prescription drug plan has given seniors access to medications that, quite frankly, they just didn't have available before. And when you look at how medicine has changed from 1965 to 2005, when the Medicare drug plan took effect, the changes that had been brought about by the advances in medical research, my dad was a doctor as well, and I used to tease him that, back in 1965, doctors only had two pharmaceutical choices, penicillin and cortisone, and they were regarded as interchangeable. My dad didn't think that was very funny. But the fact is, you come to 2005, look at the lives that have been saved by the introduction of a medicine like statin, medicines that are used for reduction of cholesterol. Dr. Elias Zerhouni of the National Institutes of Health estimates that 800,000 premature deaths have been prevented between 1965 and 2005 with the introduction of medicines to manage cholesterol and lipid levels in patient's blood. That's a tremendous change. In 1965, some people simply had the heart attack and died. In 2005, 2007, that no longer happens. But they are required, in order to maintain that state of health, to be maintained on a medication. Well, if the medicine is too expensive for the patient to buy, they don't take it, and they suffer the health consequences. And as a consequence, the system becomes more expensive because people end up utilizing the system more frequently and the outcomes for disease management become much worse.

The Medicare Prescription Drug Program has been successful. There have been a certain number of people who have been critical, but it has been a great benefit for seniors. And the fact that it is up and running now well into its second year, there is a great deal of satisfaction, and the penetrance into the number of people who have had prescription drug benefits who are covered by Medicare is now at an all-time high.

Now, in this country, as I mentioned earlier, the government pays for about half of our health care expenditures. We have a GDP of roughly $11 trillion in this country. The U.S. Department of Health and Human Services states that Medicare and Medicaid services alone, in fact when we vote on our Labor-HHS appropriations bill this year, it will be significantly north of $600 billion.

□ 1900

So that is about a half of what we spend in health care.

The way the other half is broken down, primarily the weight is borne by commercial insurance, by private insurance. There is a significant number of dollars that are contributed as charity care or uncompensated care. Certainly there are some individuals who do still simply just pay for their medical care out of pocket, but about half are from the Government source and half from private sources or the goodwill of America's physicians.

The numbers are going to increase because the overall dollar expenditure in health care is going to increase. The baby boomers are aging. There are more and more advances discovered with every passing month. The Federal Government is going to continue to funnel taxpayer dollars into Medicare. We have to ask ourselves, are we getting value for the dollar? Are we doing the best that we possibly can do with that money? Is the government doing an excellent job of managing our health care dollars? Do we think that the government is better suited to be the arbiter of a person's health care needs, or are those decisions better left up to an individual and their family? And who, at the fundamental end of it all, who is better able, who is going to be able to handle the growing health care needs in this country?

I would argue that if you have a public only, a government-run system, a universal, single-payer system, that in America it is going to be a significant problem. In fact, it will have the perverse incentive of hampering our innovation and perhaps even hampering the delivery of the most modern health care services available.

As an example, I would suggest that we have a model that we can examine, and that is our neighbor to the north in Canada. Canada has a completely government-run system. The Supreme Court in Canada in 2005, however, said that the waiting times in Canada were unconscionable and access to a waiting list did not equate to the same thing as access to care.

Now, in Canada they actually have a safety valve, because if somebody needs a medical procedure or needs a medical test done, they actually do have an area where there is a surplus of medical care available, and that would be on their southern border, the United States of America. So if somebody has the ability to pay and wants to come from Canada and cross the border to Henry Ford Hospital in Detroit, they are very capable of doing that. I am certain that the good folks at Henry Ford Hospital welcome their neighbors from Toronto all the time to sell essentially excess capacity that they have, whether it be an MRI or a CT scan or even a mammogram, heart surgery, or an artificial hip. The things that are on the waiting list in Canada that might take months or even years can be accessed relatively quickly simply by crossing the border. The waiting list is significantly long for some procedures.

If we look across the ocean to the country of Great Britain, the National Health Service, of course, has long been established in Britain. The citizens of that country regard their health system with a good deal of affection. But there is, in fact, a two-tier system in England. If someone is on a list for a hip replacement and has the money to pay for it, they can go outside the system to a private orthopedic physician and have that surgery performed. Obviously, someone who doesn't have the means to provide that for themselves will simply have to stay on the waiting list. You get into a little trouble with the fact that when it takes so long, if someone is of a certain age, another year or two wait is a significant percentage of their remaining expected life years. In many ways that is not fair either. A sad reality that exists, but it is true.

So, in both instances, you can see that where the single-payer, government-run system has been oversubscribed, where they have a private system, either here in the United States for the country of Canada or a two-tiered system in the country of Great Britain, they have a private system to act as a backstop.

So, the question that I would ask is, if the private sector is more nimble and more able to provide care on a timely basis, why in the world would we do anything that would interfere with that system? It is a complex relationship.

How Congress does its job and how we react to the situation can, in fact, have a significant impact on making sure that we have the best health care possible. Certainly I think it is incumbent upon Congress to promote policies that keep the private sector involved in the delivery of health care in this country.

Now, you almost can't talk about health care in this country without talking about the problem of the uninsured. Regardless of the number you use, whether it is 42, 45 or 46 million, it does become a question of access for people without insurance.

But I would also point out that health care is rendered all the time in this country to people who don't have insurance or don't have the means to pay for it. It is not always rendered in the time frame that would be most propitious for the best health outcome, and certainly it is not always administered in the time frame where it is the least expensive type of care, but access to care in this country is, in fact, something that is generally available. But it can become very expensive and the time involved can be significant.

Now, we have a program in this country. It is about to turn 10 years old. In fact, it is a program that we have to reauthorize this year or it will expire at the end of September. This is a program that provides health insurance for children whose parents earn too much money for them to qualify for Medicaid and not enough money to purchase health insurance. So we have the SCHIP program that operates as a joint Federal-State partnership. It does provide some flexibility to States to determine the standards for providing health care funding for those children, again, who are not eligible for Medicaid and whose parents have not been able to get private insurance. The program has been very well thought of. It has been very successful across the board.

This year, in fact, before September 30, we have to reauthorize the State Children's Health Insurance Program. There is going to be a lot of debate. I suspect there will be a lot of debate this month. Certainly, in my Committee on Energy and Commerce and the Committee on Ways and Means, there will be a lot of debate on the best way to go forward with that.

One of the things I have had a problem with since coming to Congress and examining the SCHIP system is the fact that it is a program that was designed to cover children, but, in fact, we have some States that cover adults. Pregnant women, okay, it is reasonable to have them covered under the SCHIP system. But nonpregnant adults, it strains credulity to have a system that is there to provide health care for children, and in four States in this country we actually have more adults covered under the SCHIP program than we do children.

Certainly, where you have a State where all of the uninsured children have been covered by the SCHIP program, it may be appropriate to cover some adults. But until that trigger point is met, until that condition is met, to me it makes less sense to cover adults, when there are children who would benefit from having the coverage from the State Children's Health Insurance Program, to have them remain uncovered while we cover a population where the money was never intended to be used for that purpose.

A bill that I introduced, H.R. 1013, would make certain that SCHIP funds are spent exclusively on children and pregnant women and not on any other group. I hope to be able to have that concept considered when we go through the reauthorization of the SCHIP program.

Last year in Congress we also debated and got through the committee process the reauthorization for Federally Qualified Health Centers. We did not finish the work on that legislation, so we are likely to have to take that up again this year.

But about someone who is not a child, not a pregnant woman, who doesn't have access to health insurance, there are many places in the country where Federally Qualified Health Centers exist that give the patients access to health care without insurance; gives them a medical home, gives them continuity of care, a place they can go and see the same health care providers, whether it be a physician or nurse practioner, can see that person over and over again; provides primary health, oral and mental health and substance abuse services to persons at all stages in the life cycle.

Federally Qualified Health Centers take care of 15 million people in this country every year, typically someone who does not have insurance and so would be counted as one of the uninsured, but the reality is that they do have access to the continuity of care, just as someone who has insurance. Both the SCHIP program and the Federal Qualified Health Centers are designed to help the poorest, youngest and neediest in our communities.

But what about for individuals who can afford to pay some for their health services but just choose not to? We need to get past that point, and certainly there are two things that would improve the access to health insurance for people who do have the ability to pay something for their health care, health savings accounts and health association plans.

Health savings accounts 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 a higher deductible than a traditional health plan. In the old days we used to refer to this as a catastrophic health plan.

Now, about 1996 or 1997, long before I ever thought about running for Congress, I was a physician in practice back in Texas. The Kennedy-Kassebaum bill was passed by the House and Senate and signed into law. It had in it what was called a demonstration project that would allow 750,000 people in the United States to sign up for at that time what were called medical savings accounts.

I subscribed to one of those. I purchased one of those for my family. The primary reason I did it was not even so much cost considerations but because it kept me in control of making healthcare decisions. Those were the days when HMOs and 1–800 numbers were the order of the day, and I wanted to be certain that the health care decisions made in my family were made by my family and not by a bureaucrat or an insurance executive at the end of a 1–800 number.

The medical savings account proved to have a lot of restrictions on them. For that reason, a lot of people shied away from them. So I don't know that they ever got to their full enrollment of 750,000, but to me it was another very viable form of insurance.

Again, the premiums were lower because the deductible was higher, and you were able to put money into an account like an IRA, called a medical IRA, that would grow tax-free. The interest in it would grow tax-free year over year. This money could be used only for legitimate medical expenses, but if you found yourself in a situation where you needed to pay for medical care, yes, you had a high deductible, but now you have saved some money that can offset the high deductible.

When the Medicare Modernization Act passed in 2003, we also did away with a lot of the regulations and restrictions on medical savings accounts, and the follow-on for that are what are called health savings accounts or HSAs.

For an HSA, the funds contributed to the account are not subject to the income tax and can only be used to pay for medical expenses. But one of the best parts about having an HSA is that all deposits stay the property of the policyholder. They don't go to the insurance company. They don't go to the government. They stay under the control and ownership of the person who has put those funds, regardless of the source of the deposit. So even if an employer makes a contribution to that, the funds belong to the person who owns the insurance policy. Additionally, any funds deposited that are not used that year will stay in the fund and grow year over year, different from the old use-it-or-lose-it programs that were so prevalent and popular during the 1990s.

The popularity of health savings accounts has grown considerably since its inception. The latest numbers I have are, unfortunately, a couple of years old. They are from 2005. But by December of that year, 3.5 million people had insurance coverage through an HSA. Of that number, 42 percent of the individuals are families who had income levels below $50,000 a year and were purchasing an HSA type of insurance. Additionally, about another 40 percent were individuals who previously had not been insured. So this allowed a way for people who were previously uninsured to access insurance. A good number of those folks were between the ages of 50 and 60, taking away some credence to the myth that HSAs are only for the healthy and wealthy.

These programs have been well-subscribed. Again, the numbers that I have are from 2005. I suspect they are much more robust at this point.

Well, when you consider a young person just getting out of college, roundabout age 25, if they don't want to go to work for a major corporation and therefore have employer-derived insurance, what are their options? I will tell you, 10 years ago, you didn't have many options. In fact, I tried to purchase a health insurance policy for an adult child just in that situation. You almost couldn't get an insurance policy for a single individual, regardless of the price you were willing to pay.

Fast forward to 2005 or 2007. You can go on the Internet, type ''health savings account'' into the search engine of your choice, and very quickly you will be given a plethora of choices from a variety of different health plans. In my home State of Texas, a male age 25 looking for health insurance can find a high-deductible PPO plan from a reputable insurance provider for between $60 and $70 a month. So that is eminently affordable.

Sure, there is a high deductible involved with that. That means every fall, if you go get a flu shot, you are probably going to pay for that flu shot out-of-pocket, or if you have money in your health savings account, you can make a draw on that.

□ 1915

So that type of expense is not going to be covered, but if that individual is in an accident and ends up spending 3 or 4 hours in the emergency room and a day in the intensive care unit, they will be covered because those expenses will rapidly exceed their deductible. That individual will be covered with health insurance. That is a concept that we need to make people aware of, that there are options. Even though you may work for a company that doesn't provide insurance or you are self-employed and are a small group and otherwise would not have access to employer-derived health insurance, the concept of a health savings account is available and marketed over the Internet, and there is a lot of competition for those products. As a consequence of that competition, the price on those has come down in the years since they were introduced.

Mr. Speaker, another concept that we have debated in this House at least every year I have been here is the concept of association health plans. Association health plans allow small employers to band together to get the purchasing power of a larger corporation when they go out and price insurance on the open market.

To date, we have passed that legislation four times that I can recall in the House of Representatives. It never passed in the Senate. I would like to see us take up and at least discuss that as a possibility this year. I don't know in fact if that will happen. But association health plans may not bring down the number of uninsured directly, but it certainly would help bend the growth curve that is going upward of the number of people not covered by insurance because it allows for small employers to get access to much more economic leverage in the market for buying insurance policies and allows them to be able to offer that insurance policy to their employees in the small group market.

It means that a group of perhaps Chambers of Commerce or a group of realtors could band together and offer health insurance to their employees where otherwise it might not have been available. All of these things are important.

Another factor to consider, and we have to be careful here, about a year and a half ago, Alan Greenspan was talking to us just before he left his position at the Federal Reserve. Someone brought up the topic of Medicare, and where is the funding going to come from? Mr. Greenspan said he was confident at some point in the future Congress will come to grips with this problem and will solve this problem.

But he went on to say what concerns me more is, will there be anyone there to provide the service when you require it? Those words really struck me. What he is talking about, are there going to be doctors there in the future? Are there going to be nurses in the future to provide for us when we are the ones who are relying on Medicare for our health services?

Back in my home State of Texas, the Texas Medical Association puts out a journal called Texas Medicine, and last March they had a special issue called, ''Running Out of Doctors.''

Our country faces a potential crisis with a health care provider shortage or a physician shortage in the future. So when we work on health care issues in this body and on both sides of the aisle, this is going to be important; when we work on health care issues in Congress, we have to be is certain that we retain the doctors of today, that we encourage the doctors who are in training today, and that we encourage those young people who might consider a career in health care, that we encourage them to pursue that dream and realize that dream.

Certainly the doctors of today, those at the peak of their clinical abilities, it is incumbent upon us to make certain that they remain in practice and they continue to provide services, services to our Medicare patients and services to patients who typically have one, two, three or more medical problems. Some of the most complex medical issues that can face a practitioner today will occur in the Medicare population.

Well, what steps do we need to take to make certain that we have doctors in practice, that we have people there able to deliver those services that Alan Greenspan was talking about a year and a half ago? Well, Mr. Speaker, you almost can't have this discussion without talking a little bit about medical liability. Now, in the 4 years prior to this Congress, every year, again, we passed some type of medical liability reform bill in the House of Representatives. It never got enough votes in the Senate to cut off debate and come to a vote. I feel certain it would have passed had it come to an up-or-down vote, but they were never to muster the 60 votes.

We need commonsense medical liability reform to protect patients, to protect patients' access to physicians, to stop the continuous escalation of costs associated with medical liability in this country. And in turn, this makes health care more affordable and more accessible for more Americans because we keep the services available in the communities as they are needed, when they are needed.

Mr. Speaker, I believe we need a national solution. Our State-to-State responses to this problem, some areas, like my State of Texas, have gone a long ways towards solving the problem, but there are many areas in the country where the problem persists, and it does remain a national problem.

We have an example, I think a good example, in my home State of Texas of exactly the type of legislation that we should be considering in the House of Representatives. Texas, in 2003, brought together the major stakeholders in the discussion, included the doctors, patients, hospitals, nursing homes, and crafted legislation that was modeled after the Medical Injury Compensation Reform Act of 1975 that was passed in California in 1975. There were some differences with the California law, but basically it is a cap on noneconomic damages. In Texas, we had a significant problem as far as medical liability was concerned. We had medical liability insurers that were leaving the State. They were simply not going to write any more policies. They closed up shop and left town because they couldn't see a future in providing medical liability coverage in Texas. We went from 17 insurers down to two at the end of 2002, the year I first ran for Congress. The rates were increasing year over year. Running my own practice in 2002, my rates were increasing by 30 to 50 percent a year.

In 2003, the State legislature passed medical liability reform, again based on the California law of 1975. The California law in 1975 was also a cap on noneconomic damages. They had a single cap of $250,000 on all noneconomic damages.

In Texas, the cap was trifurcated. There was a $250,000 cap on noneconomic damages as it pertains to a physician, a $250,000 cap on noneconomic damages as it pertains to the hospital and a $250,000 cap on noneconomic damages as it pertains to a nursing home or a second hospital; so an aggregate cap of $750,000 on noneconomic damages.

How has the Texas plan fared? Remember, we had gone from 17 insurers down to two 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 without a premium increase.

In 2006, 3 years after the passage of the medical liability reform, an insurance company called Medical Protective, I had a policy with them for years and years, Medical Protective company cut their rates 10 percent, which was the fourth reduction since April of 2005.

Texas Medical Liability Trust, my last insurer of record when I left practice in Texas, has had an aggregate cut of 22 percent since the law was passed.

Advocate MD, another insurance company, has filed a 19.9 percent rate decrease. Another company called Doctor's Company has announced a 13 percent rate cut. These are real numbers, and they affect real people in real practice situations in Texas. It is a significant reversal.

The year when I first came to Congress, we lost one-half of the neurosurgeons in the metroplex because of the medical liability expense problem. The doctor looked at the renewal bill and said, I cannot work enough to pay for this and pay for my practice and support my family, so I will go elsewhere. The net effect is it put the whole trauma system in north Texas at risk because one neurosurgeon was going to have to do the work of two, and you cannot physically work 24 hours a day, 7 days a week, delivering that type of care. So the whole trauma system was put at risk before this law went into effect in Texas.

A young perinatologist whom I met during my first year in office, had gone on and gotten specialized training to care for those high-risk pregnancies, well, you can imagine what his medical liability premiums were. Mine were high as an obstetrician. His were even higher as a perinatologist who specialized only in high-risk cases. And, in fact, at a lecture in Texas, he came to me and said, you know, I am going to have to leave the practice of medicine altogether because I simply cannot get insurance.

Well, how are we furthering the cause of patient care if we take a young person who is very dedicated to taking care of the highest-risk pregnancies in the metroplex and we say, sorry, you can't practice because we can't get you insurance anywhere. Happily, in Texas, that situation reversed, and that doctor, I know, is in practice.

The problem with the neurosurgeon, because of the straightening out of the insurance in Texas, has been reversed. Our trauma system is protected, as is the young man who is practicing high-risk obstetrics and saving babies even as we speak.

One of the unintended beneficiaries of the legislation was the benefit for community, small, mid-sized community not-for-profit hospitals who were self insured as far as medical liability was concerned. They had to put so much money in escrow to cover potential bad outcomes that that money was just tied up, and it was not available to them. Now they have been able to back some of that money out of escrow because of putting stability into the system with the cap on noneconomic damages, and now they are able to use that money for capital expansion, nurses' salaries, exactly what you want your small community not-for-profit hospitals to be engaged in. They can, once again, participate in those activities because of the benefits from the medical liability plan that was passed in Texas.

So, Mr. Speaker, I took the language of the Texas medical liability plan, worked with legislative counsel and made it so it would conform with all of our constructs here in the House of Representatives. And although I didn't introduce that legislation, I offered it to the ranking member on our Budget Committee last spring when we offered our Republican budget here on the floor of the House.

Mr. RYAN, the ranking member, had that scored by the Congressional Budget Office, and the Texas plan as applied by the House of Representatives legislative counsel and applied to the entire 50 States would yield a savings of $3.8 billion scored over a 5-year time span. That is not a mammoth amount of money when we talk about the types of dollars we talk about in our Federal budget, some $2.999 trillion, but $3.8 billion over 5 years is not insignificant. And it is basically money that we left on the table because we did not include the language of that medical liability reform in the budget that was passed this year.

Now, when I say the problem, although the problem in Texas is measurably better than it was when I took office here, consider a 1996 study done at Stanford University that revealed within the Medicare system alone the cost of defensive medicine, that is medicine that you practice so that you tone the chart and you look good if something goes wrong and the case is brought to trial; if you have practiced satisfactory defensive medicine, you will be able to defend yourself in the case of a medical liability suit. A couple of doctors and economists at Stanford got together and said, what does this cost Medicare? What does it cost for doctors to practice this type of defensive medicine? And it cost about $28 billion a year back in 1996. I would submit that the number is probably higher today if they were to revise and redo that study.

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So that is a significant amount of money, and the Medicare system is the one that pays for that. Remember, Medicare runs about $300 billion a year. That's almost 10 percent of its budget that is being spent on defensive medicine because of the broken medical liability system we have here in this country. We can scarcely afford to continue on that trajectory that we're on with the medical liability system in this country.

Another consideration, Mr. Speaker, I talked a little bit about young people who are perhaps considering a career in medicine or nursing, and the current medical liability system is a deterrent for going into the practice of health care because they look at the burden that's placed on young doctors and nurses for the payment for medical liability insurance, and we keep people out of the system and it's something we have to consider because, again, remember, we're talking about physician workforce issues and how we keep the doctors of today in practice, but how do we encourage that young person who's in middle school or high school today who's thinking about a career in one of the health professions, and we want them to be able to pursue that dream.

But currently, they get to the end of college and they look at the expense for getting medical training, they look at the money they will have to put up front to purchase their medical liability policy when they get out, and they say maybe it's not worth it.

And the problem, Mr. Speaker, with that is these are our children's doctors and our children's children's doctors who perhaps are not going to go into the healing professions because of problems within the medical liability system. I could talk about that a great deal longer, but let me get to three specific pieces of legislation that really get to the core of dealing with the physician workforce issues and I think the problems that we're going to face in the future if we don't get our arms around this problem.

A recent piece of legislation that I introduced is H.R. 2584, the so-called Physician Workforce and Graduate Medical Education Enhancement Act of 2007. Part of this legislation is to ensure this workforce in the future by helping young doctors with the availability of residency programs.

One thing about physicians is we tend to have a lot of inertia. We tend to go into practice where we did our residency. We tend to not go too far from home when it comes to setting up a medical practice.

So with that in mind, and in fact, that was one of the main thrusts of the article that was included in Texas Medicine, is to develop more residency programs in the communities where the medical need is greatest and develop those residency programs with the type of physician that's needed in those medical communities: primary care to be certain; obstetrics to be certain; general surgery; again, the types of physicians that we want to be on the front lines practicing in our medium-sized communities. We need to get young doctors in training in locations where they're actually needed.

This bill, the physician workforce bill, 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 and build a physician workforce of the future and build it from the ground up, start at home, start right where it's going to be needed.

On average, it costs $100,000 a year to train a resident, and that cost for a smaller hospital obviously can be prohibitive. Because of the 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 program would require full accreditation and be generally focused in rural suburban inner community hospitals and focus on those specialties that are in the greatest need, and that will, of necessity, be some of the primary care specialties that I just mentioned.

Well, what about those people who may not yet be in medical school but may be contemplating a career in health care? Locating young doctors where they're needed is just part of solving the impending physician shortage crisis that I think will affect the entire health care system nationally. Another aspect that must be considered is training doctors for high-need specialties.

The second bill, H.R. 2583, the High Need Physician Specialty Workforce Incentive Act of 2007, will establish a mix of scholarship, loan repayment funds and tax incentives to entice more students to medical school and create incentives for those students and newly minted doctors to stay in those communities.

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 a designated underserved area. It will be a 5-year authorization at $5 million per year. It will provide additional educational scholarships in exchange for a commitment, a commitment to serve in a public or private non-profit health facility determined where there's a critical shortage of primary care physicians.

Well, in addressing the physician workforce crisis, looking a little bit at residency programs, looking a little bit at medical students and, of course, medical liability but the placement of doctors in locations of greatest need and the financial concerns of encouraging doctors to remain in high-need specialties, the next bill, H.R. 2585, will address perhaps what is the largest group of doctors in this country, what I like to call the mature physician, and certainly the largest and still growing group of patients, our baby boomers, those who are just on Medicare and those soon to be on Medicare.

Now, before I get too far into this, I'm joined by my friend from Pennsylvania. Did you wish to weigh in on this subject this evening?

Mr. DENT. I would very much like to.

Mr. BURGESS. I'm happy to yield to my friend from Pennsylvania for a few minutes and give him time to talk.

Mr. DENT. Mr. Speaker, I first want to applaud you for your leadership on this issue. As an OB/GYN physician, you know this issue probably better than anyone in this institution.

But I just wanted to share with you a perspective from the Commonwealth of Pennsylvania, where we were a crisis State. And you're right on on some of these issues you just discussed, but the bad policy on medical liability reform was far too common in the Commonwealth of Pennsylvania for a very long time.

Our crisis actually originated back in the 1970s when no one would write medical liability insurance. So we created a State fund, and it was supposed to be a stopgap measure. We addressed that stopgap measure almost 30 years later in 2002, 2003.

But the point of the whole issue is you had to buy insurance from the State fund, we call it the MCAT fund, and it's been renamed the MCARE fund, and then you would buy additional insurance from the private sector.

The problem with the program was, though, you would buy your insurance basically today, if you're a young doctor you buy into the MCARE fund, and you're really paying for past claims, unlike a traditional insurance product where you pay your premium today to pay against a future claim, and so this has created an enormous retention problem for us because over the years there are so many unsettled cases in this MCAT fund that what would happen is these claims all collected and we started settling these cases rather aggressively in the late 1990s and 2001 and 2002. And so today's physicians were being assessed with an emergency surcharge to pay for previous medical liability incidents. A major, major problem.

And also, in a city like Philadelphia, where the average jury verdict was more than double that of anywhere else in the Commonwealth of Pennsylvania, where jury verdicts were in excess of $1 million on average, as reported by a jury verdict research, and the rest of the Commonwealth, the verdicts were less than half that.

But my point again is this: we created this State fund, an unfunded liability accumulates, today's doctors are paying for the liability situation of their predecessors, creates an enormous physician recruitment problem. Of course, there's always a retention problem, but the recruitment problem was enormously pronounced because of that policy change.

And so what ultimately happened, because the premiums became so high through this State fund, the people who ultimately had to solve this problem for the physicians were the taxpayers. And so cigarette taxes were used to pay for physicians' premiums, particularly in the high-risk areas, the OBs, the neurosurgeons and many other trauma surgeons and orthopods.

That's what happened in Pennsylvania, and I think many of the remedies you've discussed here, such as caps on noneconomic damages or collateral sources, structured payments, some of the things that you've done in Texas, I'm not as familiar with all those changes, but it certainly had an impact.

I just wanted to applaud you for this. You know, of course, that there's legislation pending in this Congress from some of the legislation last session, and I just want to thank you for yielding, but I just again want to applaud you for your leadership on this issue. I'm glad you're bringing this issue, once again, to the attention of the American people.

Mr. BURGESS. I thank the gentleman for his input. Certainly, the ability to recruit doctors to Texas from Pennsylvania has been greatly enhanced by the passage of the Texas medical liability bill, but you point up a very real problem that the physicians in Pennsylvania face. And, again, it points up the need for a national solution to wait and have the process work its way through every State legislature, State by State. It costs an enormous amount of money, costs an enormous amount of time, and just the effort, the efficiency of those doctors affected is going to be diminished.

So I really appreciate the gentleman taking the time to come down here and add his thoughts about what is happening in his home State of Pennsylvania.

Mr. Speaker, let me go on and talk just a little bit about H.R. 2585. That will address some of the problems that are faced by the physicians who are in practice now, the physicians who are the primary source of care for our Medicare patients. As baby boomers retire, the demand for services is going to go nowhere but up, and if the physician workforce trends of today continue, we may not be talking about a Medicare funding problem. We may be talking about why there is no one there to take care of our seniors.

Year after year, there's a reduction in the reimbursement payments from the Center of Medicare and Medicaid Services to physicians for the services they provide for Medicare patients. It's not a question of doctors just simply wanting to make more money. It's about a stabilized repayment for services that have already been rendered, and it isn't just affecting doctors. The problem also affects patients. It becomes a real crisis of access.

Not a week goes by that I don't get a letter from a physician from somewhere in the country or a fax that says, you know what, I've just had it up to here, and I'm going to stop seeing Medicare patients. I'm going to retire early. I'm no longer going to accept new Medicare patients in my practice, or I'm going to restrict those procedures that I offer to Medicare patients.

And, unfortunately, I know this is happening because I saw it in the hospital environment before I left practice 5 years ago to come to Congress, and I hear it in virtually every town hall that I have in my district. Someone will raise their hand and say how come on Medicare, you turn 65 and you've got to change doctors. And the answer is, because their doctor found it no longer economically viability to continue to see Medicare patients because they weren't able to pay for the cost of delivering the care. They weren't able to cover the cost of delivering the care.

Now, Medicare payments to physicians are modified annually under a formula that is known as the ''sustainable growth rate.'' Because of flaws in the process and flaws built into the formula, the SGR-mandated physician fee cuts in recent years have only been moderately averted at the last minute; and if long-term congressional action is not implemented, the SGR will continue to mandate physician cuts.

Now, unlike hospital reimbursement rates which closely follow the consumer price index that measures the cost of providing care, physician reimbursements do not. I have a graph here, again from the Texas Medical Association, that shows based on various calendar years what the cuts in the SGR formula have amounted to as far as physician reimbursement versus what the cost-of-living adjustment has been for Medicare Advantage, the Medicare HMOs, for hospitals, for nursing homes, for pharmaceuticals now would be the same type of formula.

Only physicians are asked to live under this formula. In fact, ordinarily Medicare payments do not cover or only cover about 65 percent of the actual cost of providing the patient services. Can you imagine going to any industry or company and ask them to continue in business when you're only paying them 65 percent of what it costs them to stay in business?

The SGR links physician payments updates to the gross domestic product and the reality is that has no relationship to the cost of providing patient services. But simply the repeal of the SGR has been difficult because it costs a lot of money; but perhaps if we do it over time, perhaps we can bring that down to a level that's manageable.

Paying physicians fairly will extend the career of practicing physicians who would otherwise opt out of the Medicare program, seek early retirement or severely restrict those procedures that they offer to their Medicare patients. It also has the effect of ensuring an adequate network of doctors available to older Americans as this country makes a transition to the physician workforce of the future.

In the new physician payment stabilization bill, the SGR formula would be repealed in the year 2010, 2 years from now, but would also provide incentive payments based on quality reporting and technology improvements. These incentive payments would be installed to protect the practicing physician against that 5 percent cut that is estimated to occur in 2008 and 2009.

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Note that this would be voluntary. No one would be required to participate in either program that dealt with quality improvement or technology improvement, but it would be available to doctors or practices who wanted to offset the proposed cuts that would occur in physician reimbursement until the 2 years time the physician repayment formally can be repealed.

Now I know that a lot of the doctors don't like the concept of postponing the SGR by 2 years. In fact, in the bill 2585, by resetting the baseline of the SGR formula, a technique that we used in this Congress back in 2003, by resetting the baseline, the amount of cuts contemplated for 2008 and 2009 are actually modified significantly, and, in fact, there may not be a cut at all in 2008 or 2009. This could translate into an actual positive update for physicians in those 2 years.

But the critical thing, in my mind, is that we have to be, regardless of what we decide to do over the next 2 years, we have got to be working on a long-term solution to get out from under the tyranny of the SGR formula.

Now, why do it this way? Why not just bite the bullet and get the SGR out of the way and get it repealed once and for all? The problem is, it costs a tremendous amount of money to do that. The problem we have in Congress is, if we are required to submit all legislation that we propose to the Congressional Budget Office to find out how much something costs, we are going to be spending the taxpayers' money, we have got to know how much we are going to spend, over what time will we spend it.

Because of the constraints in the Congressional Budget Office, we are not allowed to do what's called dynamic scoring. We can't look ahead and say, you know, if we do this, we are going to save money. The Congressional Budget Office doesn't work that way.

That's why postponing the renewal of the SGR by 2 years, take that savings that is going to occur over those 2 years, sequester it and aggregate that savings and put it towards paying for the repeal of the SGR and replacing it with a cost of living index, the Medicare, economic index that would be fundamentally much fairer.

One of the main thrusts of the bill is to require the Centers for Medicaid and Medicare Services to do just exactly that and to look at the 10 diagnostic codes for which most of the monetary expenditures are rendered. You know the old bank robber, Willie Sutton, when he was asked why he would rob the bank, he said, that's where the money is. Let's go to where the money is. Let's go to those top 10 procedures and diagnoses that spend the greatest amount of Medicare and look for where the greatest amount of savings can be found within that.

The same considerations actually apply to the Medicaid program as well, so it will be useful to go through this process in identifying those top 10 conditions and trying to modify things so that the delivery of care for those top 10 conditions actually ends up costing us less.

With the time that remains, I know I have talked about a lot of stuff tonight, a lot of it is technically very complex. I will admit it, a lot of it is actually very boring to listen to. But it is an incredibly important subject, and it is an incredibly important story that we have to tell here in Congress. It's a story of how the most advanced, most innovative and most appreciated health care system in the world actually needs a little help itself.

The end of the story should read, ''happily ever after,'' but how are we going to get to that conclusion? In fact, the last chapter may well read, ''private industry leads to a healthy ending.''

At the beginning of this hour, we talked about the debate that will forever change the face of health care in this country. Again, I think it's important to understand, that we understand here in Congress, that we understand what's working in our system and what is not. We can't delay making the changes and bringing health care into the 21st century.

I believe the only way we can make this work is if we allow the private sector to be involved, to stay involved and, in fact, lay the foundation for the improvements that we all want.

The pillars of this system are that we are going to have, be rooted in, the bedrock of a thriving private sector, not the tenuous ground of a public system that has proven costly and inefficient in other countries.

I believe we need to devote our working Congress to building a stronger system and involving the private sector within that system. History has proven this to be a tried and true method. We can bring down the number of insured. We can increase patient access. We can stabilize the physician workforce, and we can modernize through technology, and we can bring transparency into the system. Each of these goals is within our grasp if we only have the foresight and the determination, the political courage to achieve each goal.

Again, I referenced when I was a medical student in Houston, people would come from around the world to come to the Texas Medical Center for their care. There is a reason that people come from around the world to the United States for their health care and for their treatment. We are the best, but we must make adjustments to remain at the top of the game.

POTENTIAL LOSS OF INTERNET RADIO

The SPEAKER pro tempore (Mr. WILSON of Ohio). Under the Speaker's announced policy of January 18, 2007, the gentleman from Washington (Mr. INSLEE) is recognized for 60 minutes as the designee of the majority leader.

Mr. INSLEE. Mr. Speaker, I come to the floor of the House this evening to discuss the potential loss of Internet radio by Americans, a tremendous service that, because of Internet software and musical geniuses, 70 million Americans now enjoy the ability to listen to music by Web broadcasters over the Internet.

It is a tremendous service. It is as ingrained in a lot of Americans' daily lives as a cup of coffee and the morning newspaper.

Unfortunately, I have to inform the House that that service may be gone in a matter of a few weeks if we don't reach a resolution of a, frankly, wrong decision decided by the Copyright Royalty Board. What I am disturbed to report to my colleagues is that some time ago, March 2, 2007, we had a decision by a Federal agency, the ramifications of which would be to shut down the ability of Americans, on a realistic basis, to continue to enjoy Internet-based radio.

The reason this happened is that this board was given the authority to set the royalty that should be paid by Webcasters who stream out this great music, by the way, tremendously diverse music. One of the great things Americans love about Internet radio is you have such eclectic, different types of music, not just top 40. You know, I haven't progressed past the Beach Boys in the 1960s, but there are a lot of kinds of other music. Internet radio has been tremendous by allowing people to enjoy thousands of different genres and types of music.

But now this Copyright Royalty Board has issued a decision which will explode the royalty that these Webcasters are forced to pay to those who generated the music, to the extent that it will make it totally economically impossible for these businesses and these Webcasters to continue to stream music to the 70 million Americans who now enjoy it.

We need to fix this problem. We need to fix it urgently, because the decision will, this guillotine will come down on July 15 if either Congress doesn't act or an agreement is not reached between the parties to adjust this copyright fee that will have to be paid by the Webcasters.

So we need to fix this problem, and, in doing so, we need to do it in a way that is fair to the musicians and artists who create the music that 70 million Americans enjoy over the Internet. These artists work hard in producing this music. They share their genius. It's an artistic gift they have, and they share it with Americans. They need to be compensated fairly to allow them to maintain their business model as well.

Unfortunately, this was a wildly disproportionate decision by this board that is grossly unfair to the distributors of music and simply will allow them not to continue in business. And to give folks a feeling of how distorted this decision will be, I would like to refer to this graph which shows Internet radio per-song royalty rates under preexisting law starting in 2005, that started at \$.00008 dollars in 2005, and by 2010, we will have foisted on us 149 percent increase in these royalty rates.

I am not sure any business model can tolerate a three-fold increase just in the per-song royalty rates that these folks are having to undergo. Unfortunately, this royalty rate means about a 300 percent increase for big Webcasters. But because of the particular rules here, it's a 1,200 percent increase for small Webcasters, so the small Webcasters, which are the vast majority of Webcasters will be hit potentially by 1,200 percent increases.

Now, this board, this Copyright Royalty Board has refused to reconsider their decision. What it means in the real world is the Internet going silent. Many of the stations a few days ago went silent to demonstrate and to protest its decision. I know Americans are disturbed by this, and they are now talking to my colleagues. I know thousands of them have communicated with my colleagues as a result of this, so we need to fix this problem.

I know in my district, I am from an area just north of Seattle, First District in the State of Washington, we have a Webcaster called Big R Radio. They stream to over 15,000 listeners who enjoy their product. But because of this decision, their rates are going to go up to a level, and you have got to understand how bad this is, the rates they would have to pay just for their royalties, not for their overhead, their rent, their salaries, the royalties they would have to pay for this exceed by 150 percent the revenues that this business is getting in.

Well, obviously, that's untenable, and this company will have to either go offshore or simply shut down if some change is not made. That is bad for Big R Radio, the company, and it's bad for the 15,000 people that enjoy their music right now. We need to fix this problem.

So the first damage that was done is this per-song radio royalty, but there was another, perhaps even more odious thing that this board did, the preexisting rule required a \$500 charge, or, excuse me, a per-station minimum fee. This new ruling required a \$500 charge for each streaming station that they offered. Webcasters, of course, stream under certain channels. But under this decision, there was no limit on the amount total in this per streaming channel that would be placed. Many, if not most Webcasters, have multiple channels.

So, if you look at what it will cost, just three of these Webcasters, Pandora, RealNetworks and Yahoo, because they are getting socked with this \$500 per channel, and they broadcast literally thousands of channels with no limit, just those three Webcasters would have to pay \$1.15 billion, with a B. These rates will dwarf the radio-related revenues by substantially more than \$1 billion.

In other words, it will charge these businesses more than \$1 billion more than the revenues they generate from this business. That's absurd. It's ridiculous. It has no relationship to economic reality, and it is a government glitch, a foul-up of the highest order that needs to get repaired.

This would result in 64 times more the total royalties collected by the group called SoundExchange that collects these royalties in 2006, an increase of more than, this is a pretty amazing number to me, 10 million percent over the minimum fee of \$2,500 per licensee. Clearly, this is beyond the realm of economic reality.

Finally, this royalty board, the third thing that they did, they eliminated the percentage of revenue fees that many small Webcasters use to determine their performance royalty, which would be severely damaging to small Webcasters. So, to put this in perspective, in a global sense, I want to refer to what this will mean in total royalties.

If you look at this chart, you show total royalties in 2004 of \$10 million. The estimated fee under the old royalty rule in 2006 would be \$18 million. But under this decision, this flawed decision, it will actually be \$1.150 million. So if you want to see the difference graphically of what the old royalty would be in 2006, this bubble would go to this supernova, I would call it, in 2006. This is untenable. It needs to be fixed.