The gentleman from Texas.

Mr. BARTON of Texas. Mr. Speaker, I'd like to point out CBO scores this as $1.9 billion. So somebody is not telling the truth on the floor.

I yield 1 minute to a distinguished member of the committee, Mr. BURGESS of Texas.

Mr. BURGESS. Mr. Speaker, I thank the chairman. One minute is scarcely enough time to discuss what we need to discuss today. So I would, just like the chairman of the full committee, put my entire statement into the RECORD.

Mr. Speaker, I want to confine my comments today to issues that surround issues for physician reimbursement. I had two amendments last night in Rules Committee that were not made in order that would have vastly improved physician reimbursement. Instead, we have language in the Democratic underlying bill that provides a small uptick for the next 2 years, then you fall off the cliff, and then you're frozen for the next 10 years. Hardly measures that will encourage people to go into the practice of medicine in the future.

I also want to reference section 651, the whole hospital exemption. Mr. Speaker, I would just point out that in the Rules Committee it was made in order that several hospitals would actually be grandfathered out or carved out of that exemption, and most of these hospitals lie in Democratic districts. I have a letter from 75 constituents, physicians back in my home State of Texas, who strongly object to the whole hospital exemption in this bill, and I will submit that for the RECORD as well.

The Democratic party is prepared to take its first step toward cradle to grave government involvement in the lives of all Americans. The 40-plus page SCHIP bill that was unveiled to this committee in the wee hours of last Wednesday represents legislative malpractice. We shouldn't be surprised because we've been here before. A handful of Democratic staff, working behind closed doors, without any input from the real world have produced just what we should expect: a bloated and complicated proposal that grows the size of government, diminishes state fiscal accountability and an individual's personal responsibility, and likely erodes the independent practice of medicine.

I doubt anybody in this body, Republican or Democrat, really understands what is in this proposal. We've not had one legislative hearing on this bill and haven't even taken this bill through regular order in the Energy and Commerce Committee. As a member of the Health Subcommittee of that panel, I'm disappointed in that fact because the subcommittee has shown an ability to come together and work out partisan differences. I haven't spoken with Chairman PALLONE, but I imagine he shares that sentiment to some degree.

Just recently, Republicans and Democrats came together to report out a bill that improves drug safety and FDA review of new drugs and devices. We worked through our differences and produced superior legislation. But all that bipartisan comity has been thrown out the window. Any rationalization of how we can vote on this bill and report to our constituents that we conducted an in-depth review of this legislation would be farcical at best, especially when we have learned that the Rules Committee plans to report out a completely different measure in the dark and early hours this coming Wednesday.

Kids need a safety net, but the safety net shouldn't apply to those that can and should help themselves. Taking money from taxpayers to give it to families that have the resources to purchase health insurance for their children is irresponsible. And if affordable options don't exist for these families, well forget it, because this bill doesn't lift a finger to reform an insurance market burdened by regulation and lack of choice.

On immigration, this bill all but ensures that states like mine and other border states will be saddled with more cost as it rewards those that illegally enter our country. The debate on illegal immigration is often ruled by emotion but the provisions in this bill relating to immigrant health care are equally suited—this bill makes little to no effort to understand this dynamic and only serves to pour gasoline on an inferno.

On Medicare, this bill misses the mark widely. This bill would make a bad investment in an attempt to fix Medicare physician payment and in doing so, members will find themselves in the position of spending billions more in the future to fix the problem again.

We shouldn't fool ourselves that this is realistic policy making. For those members about to head home and face their constituents at coffees, lunches, and town halls they should be wary of what Speaker PELOSI is force feeding this body.

BAYLOR MEDICAL CENTER AT FRISCO,
Frisco, TX, August 1, 2007.

Hon. MICHAEL C. BURGESS, MD,
U.S. Congressman,
Washington, DC.

DEAR CONGRESSMAN BURGESS: We are physicians that practice at Baylor Medical Center at Frisco. Today, we are writing to express our deep concern about the language in the S–CHIP bill (CHAMP Act) once again attempting to prohibit physicians from owning or investing in any hospital. While this legislation contains many important and generous provisions, such as the reauthorization of SCHIP and the SGR fix, Section 651 virtually eliminates physician owned hospitals for no reason other than the enmity of certain competitors.

Much has been written about the negative effect this ownership has had on our community hospitals where we also practice. Many of the large hospital systems claim they are being harmed by physician-owned specialty hospitals in their communities. Yet none of them has provided any factual data to support their claim that they are unable to provide "essential services" as a result of specialty hospitals. In fact each of the last 6 years the American Hospital Association has reported a 6% increase in profits in their member hospitals. And many of their arguments (e.g. "specialty hospitals typically do not provide emergency care") simply is not accurate.

The benefits of the physician ownership model are so convincing that a growing number of not-for-profit healthcare systems, including some of the largest members of the American Hospital Association, have embraced the concept of physician ownership.

MedPAC, CMS, and GAO have all studied this issue. Not one of them has concluded that physician owned hospitals represent a threat to the community hospitals where they exist. To the contrary, some have concluded that the overall increase in quality of care greatly benefits the communities in which they exist.

We believe that a major part of our success is due to the fact that individual physicians are partners in the ownership in the facility. As any business owner, we take pride in our facility and have worked hard to make sure the quality of medical care remains high. And frankly, we are much more aware of the costs and how to better deliver care more cost effectively. Through disclosure policies our patients are aware of the physician ownership and our surveys reveal very high patient satisfaction.

The best way to manage health care costs is to encourage physicians to become involved in the development of new models for the delivery of surgical and other health services. Maintaining the status quo by giving acute care hospitals protection from market forces will only lead to higher health care costs for us all.

When voting, please consider carefully the decision you will be asked to make regarding physician ownership, it will not only affect your constituents' rights as a patient to have the most convenient cost effective care, it will affect the delivery of health care for generations to come.

Sincere regards,

Benton Ellis, MD; James Gill, MD; David Layden, MD; James Montgomery, MD; Mark Allen, MD; Dawn Bankston, MD; F. Alan Barber, MD; Richard Bowman, MD; Dale Burleson, MD; Cameron Carmody, MD; John Schweers, MD; William Cobb, MD; Stephen Courtney, MD; A. Joe Cribbins, MD; Bruce Douthit, MD; Dennis Eisenberg, MD; Berry Fleming, MD; Richard Guyer, MD; Lloyd Haggard, MD; Stephen Hamn, MD; Andrea Ku, MD; Briant Herzog, MD; Stephen Hochschuler, MD; James Hudguns, MD; Fawzia Jaffee, MD; Warrett Kennard, MD; Adam Kouyoumjian, DO; Jimmy Laferney, MD; Stephen Lieman, MD; Samuel Lifshitz, MD; Earl Lund, MD; Gary Mashigian, DPM; Mark McQuaid, MD; William Mitchell, MD; Dr. Keith Matheny; William Montgomery, MD; John Moore, MD; Mickey Morgan, MD; William Mulchin, MD; John Peloza, MD; Ralph Rashbaum, MD; Jon Ricks, MD; Alfred Rodriguez, MD; Vince Rogenes, MD; David Rogers, MD; Ivan Rovner, MD; Michael Schwartz, MD; James Smrekar, MD; Robert Taylor, DPM; Ewen Tseng, MD; Gary Webb, MD; Stanley Whisenant, MD; Michael Wierschem, MD; Kathryn White, MD; Kathryn Wood, MD; Iddriss Yusufali, MD; Roger Skiles, MD; Scott Fitzgerald, MD; Leonard Bays, MD; Donald Mackenzie, MD; Lloyd Haggard, MD; David Holder, MD; Joe Hughes, MD; David Perkins; Robert Purnell, MD; Eddie Pybatt, MD; Elaine Allen, MD; Steven Michelsen, DO.

AMENDMENT TO H.R. 3162

This amendment would modify Title III of H.R. 3162 that addresses Medicare physician reimbursement. While H.R. 3162 provides temporary relief to address scheduled Medicare physician payment cuts, it does nothing to address the problem in the long-term, and would in fact exacerbate the problem in the long-term. The amendment does the following:

1. Reset to 2007 the base year for application of the Sustainable Growth Rate (SGR), and eliminates the Sustainable Growth Rate in 2010. The practical effect of this on Medicare physician payment would provide physicians with over a 1 percentage increase in 2008 and

2009, and stable and sustainable growth rate in payment from 2010 and into the future.

2. Makes available incentive payments for increased quality reporting and implementation of health information technology.

3. Provides annual reports to physicians on billing patterns under Medicare.

4. Provides an annual report to Medicare beneficiaries on annual Medicare expenditures.

5. Mandates a study on whether quality reporting requirements on health care disparities.

AMENDMENT TO H.R. 3162, AS REPORTED [BY THE COMMITTEE ON WAYS AND MEANS] OFFERED BY MR. BURGESS OF TEXAS

(CHAMP amendment)

Strike sections 301, 302, 303, 304, and 307, and insert the following sections (and redesignate sections 305 and 306 accordingly):

SEC. 301. RESETTING TO 2007 THE BASE YEAR FOR APPLICATION OF SUSTAINABLE GROWTH RATE FORMULA; ELIMINATION OF SUSTAINABLE GROWTH RATE FORMULA IN 2010.

(a) IN GENERAL.—Section 1848(d)(4) of the Social Security Act (42 U.S.C. 1395w–4(d)(4)) is amended—

(1) in paragraph (4)—

(A) in subparagraph (B), by striking "subparagraph (D)" and inserting "subparagraphs (D) and (G)"; and

(B) by adding at the end the following new subparagraph:

"(G) REBASING TO 2007 FOR UPDATE ADJUSTMENTS BEGINNING WITH 2008.—In determining the update adjustment factor under subparagraph (B) for 2008 and 2009—

"(i) the allowed expenditures for 2007 shall be equal to the amount of the actual expenditures for physicians' services during 2007;

"(ii) subparagraph (B)(ii) shall not apply to 2008; and

"(iii) the reference in subparagraph (B)(ii)(I) to 'April 1, 1996' shall be treated, beginning with 2009, as a reference to 'January 1, 2007'."; and

(2) by adding at the end the following new paragraph:

"(8) UPDATING BEGINNING WITH 2010.—The update to the single conversion factor for each year beginning with 2010 shall be the percentage increase in the MEI (as defined in section 1842(i)(3)) for that year.".

(b) CONFORMING SUNSET.—Section 1848(f)(1)(B) of such Act is amended by inserting "(ending with 2008)" after "each succeeding year".

SEC. 302. QUALITY INCENTIVES.

(a) EXTENSION OF CURRENT QUALITY REPORTING SYSTEM AND TRANSITIONAL BONUS INCENTIVE PAYMENTS FOR 2008 AND 2009.—

(1) EXTENSION OF QUALITY REPORTING SYSTEM THROUGH 2009.—Section 1848(k) of the Social Security Act (42 U.S.C. 1395w(k)) is amended—

(A) in the heading of paragraph (2)(B), by inserting "AND 2009" after "2008"; and

(B) in paragraphs (2)(B) and (4), by inserting "and 2009" after "2008" each place it appears.

(2) EXTENSION OF AND INCREASE IN BONUS PAYMENTS FOR 2008 AND 2009.—Section 101(c) of the Medicare Improvement and Extension Act of 2006 (division B of Public Law 109–432) is amended—

(A) in the heading, by inserting ", 2008, AND 2009" after "2007";

(B) in paragraph (1), by inserting "(or 3 percent in the case of reporting periods beginning after December 31, 2007)" after "1.5 percent";

(C) in paragraph (4), by striking "single consolidated payment." and inserting "single consolidated payment for each reporting period. Such payment shall be made for a reporting period within 30 days after the date that required information has been submitted with respect to claims for such period."; and

(D) in paragraph (6)(C), by striking "the period beginning on July 1, 2007, and ending on December 31, 2007" and inserting "each of the five consecutive 6-month periods beginning on July 1, 2007, and ending on December 31, 2009".

(b) ESTABLISHMENT OF NEW QUALITY INCENTIVE SYSTEM EFFECTIVE IN 2010.—

(1) IN GENERAL.—Section 1848 of the Social Security Act (42 U.S.C. 1395w) is amended by striking subsection (k) and inserting the following:

"(k) PHYSICIAN QUALITY INCENTIVE SYSTEM.—

"(1) IN GENERAL.—The Secretary shall establish a reporting system (in this subsection referred to as the 'Physician Quality Incentive System' or 'System') for quality measures relating to physicians' services that focuses on disease-specific high cost conditions. Not later than January 1, 2010, the Secretary shall—

"(A) identify the 10 health conditions that have the highest proportion of spending under this part, due in part to a gap in patient care, and for which reporting measures are feasible; and

"(B) adopt reporting measures on these conditions, based on measures developed by the Physician Consortium of the American Medical Association.

"(2) ADD-ON PAYMENT.—

"(A) IN GENERAL.—The Secretary shall provide, in a form and manner specified by the Secretary, for a bonus or other add-on payment for physicians that submit information required on the conditions identified under paragraph (1).

"(B) AMOUNT.—Such a bonus or add-on payment shall be equal to 1.0 percent of the payment amount otherwise computed under this section.

"(C) TIMELY PAYMENTS.—Such a payment shall be made, with respect to information submitted for a month, by not later than 30 days after the date the information is submitted for such month.

"(D) DEDUCTIBLE AND COINSURANCE NOT APPLICABLE.—Such payment shall not be subject to the deductible or coinsurance otherwise applicable to physicians' services under this part.

"(E) USE OF REGISTRY.—In carrying out subparagraph (A), the Secretary shall allow the submission of the required information through an appropriate medical registry identified by the Secretary.

"(3) MONITORING.—The Secretary shall monitor and report to Congress on an annual basis physician participation in the Physician Quality Incentive System, administrative burden encountered by participants, barriers to participation, as well as savings accrued to the Medicare program due to quality care improvements based on measures established under the Physician Quality Incentive System.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to payment for physicians' services for services furnished in years beginning with 2010.

SEC. 303. HEALTH INFORMATION TECHNOLOGY (HIT) PAYMENT INCENTIVE.

Section 1848 of the Social Security Act is amended by adding at the end the following new subsection:

"(m) HEALTH INFORMATION TECHNOLOGY PAYMENT INCENTIVES.—

"(1) STANDARDS.—Not later than January 1, 2008, the Secretary shall create standards for the certification of health information technology used in the furnishing of physicians' services.

"(2) ADD-ON PAYMENT.—The Secretary shall provide for a bonus or other add-on payment for physicians that implement a health information technology system that is certified under paragraph (1). Such a bonus shall be equal to 3.0 percent of the payment amount otherwise computed under this section, except that—

"(A) in no case may total of such bonus and the bonus provided under subsection (k)(2) exceed 6 percent of such payment amount; and

"(B) such payments with respect to a physician shall only apply to physicians' services furnished during a period of 36 consecutive months beginning with the first day of the first month after the date of such certification.

The bonus payment under this paragraph shall not be subject to the deductible or coinsurance otherwise applicable to physicians' services under this part.".

SEC. 304. INFORMATION FOR PHYSICIANS ON MEDICARE BILLINGS.

(a) IN GENERAL.—Section 1848 of the Social Security Act, as amended by section 201, is further amended by adding at the end the following new subsection:

"(n) ANNUAL REPORTING OF INFORMATION TO PHYSICIANS.—

"(1) IN GENERAL.—The Secretary shall annually report to each physician information on total billings by the physician (including laboratory tests and other items and services ordered by the physician) under this title. Such information shall be provided in a comparative format by code, weighting for practice size, number of Medicare patients treated, and relative number of Medicare beneficiaries in the geographical area.

"(2) CONFIDENTIALITY.—Information reported under paragraph (1) is confidential and shall not be disclosed to other than the physician to whom the information relates.".

(b) EFFECTIVE DATE.—The Secretary of Health and Human Services shall first provide for reporting of information under the amendment made by subsection (a) for billings during 2007.

SEC. 305. INFORMATION FOR BENEFICIARIES ON MEDICARE EXPENDITURES.

(a) IN GENERAL.—Section 1804 of the Social Security Act is amended by adding at the end the following new subsection:

"(d) ANNUAL REPORT ON INDIVIDUAL RESOURCE UTILIZATION.—The Secretary shall provide for the reporting, on an annual basis, to each individual entitled to benefits under part A or enrolled under part B, on the amount of payments made to or on behalf of the individual under this title during the year involved. Such information shall be provided in a format that compares such amount with the average per capita expenditures in the region or area involved.".

(b) EFFECTIVE DATE.—The Secretary of Health and Human Services shall first provide for reporting of information under the amendment made by subsection (a) for payments made during 2007.

SEC. 306. COLLECTION OF DATA ON MEDICARE SAVINGS FROM PHYSICIANS' SERVICES DIVERSION.

(a) IN GENERAL.—The Secretary of Health and Human Services shall collect data on annual savings in expenditures in the Medicare program due to physicians' services that resulted in hospital or in-patient diversion.

(b) REPORT.—The Secretary shall transmit to Congress annually a summary of the data collected under subsection (a).

SEC. 307. STUDY OF REPORTING REQUIREMENTS ON HEALTH CARE DISPARITIES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall provide for a study of health care disparities in high-risk health

condition areas and minority communities about the impact reporting requirements may have on physician penetration in such communities.

(b) REPORT.—The Secretary shall provide for the completion of the study by not later than January 1, 2011, and shall submit to Congress a report on the study upon its completion.

"(m) HEALTH INFORMATION TECHNOLOGY PAYMENT INCENTIVES.—

"(1) STANDARDS.—Not later than January 1, 2008, the Secretary shall create standards for the certification of health information technology used in the furnishing of physicians' services.

"(2) ADD-ON PAYMENT.—The Secretary shall provide for a bonus or other add-on payment for physicians that implement a health information technology system that is certified under paragraph (1). Such a bonus shall be equal to 3.0 percent of the payment amount otherwise computed under this section, except that—

"(A) in no case may total of such bonus and the bonus provided under subsection (k)(2) exceed 6 percent of such payment amount; and

"(B) such payments with respect to a physician shall only apply to physicians' services furnished during a period of 36 consecutive months beginning with the first day of the first month after the date of such certification.

The bonus payment under this paragraph shall not be subject to the deductible or coinsurance otherwise applicable to physicians' services under this part.".

AMENDMENT TO H.R. 3162

This amendment would modify section 704 of H.R. 3162 that would require the Secretary of HHS to develop a plan to implement for never events. Never events, pursuant to H.R. 3162, are defined as an event involving the delivery of (or failure to deliver) physician services in which there is an error in medical care that is clearly identifiable, usually preventable, and serious in consequences to patients and that indicates a deficiency in the safety and process controls of the services furnished with respect to the physician, hospital, or ambulatory surgical center involved. This amendment would ensure that the identification of a never event is confidential in nature, as it applies to patient work product under Section 922 of the Public Health Service Act.

NEVER EVENTS

This amendment would ensure that the identification of never events as required by CHAMP does not lead to frivolous lawsuits against physicians.

While I may not agree with how "never events" are defined by this bill, I agree that physicians should be able to operate in an environment that supports improvement of processes and outcomes and not a punitive legal environment.

Under the bill, "never events" are defined as an event involving the delivery of (or failure to deliver) physician services in which there is an error in medical care that is clearly identifiable, usually preventable, and serious in consequences to patients and that indicates a deficiency in the safety and process controls of the services furnished with respect to the physician, hospital, or ambulatory surgical center involved.

This simple amendment ensures that identification of these "never events" would not be used in a legal proceeding and would be considered patient work product as they are under other areas of federal law.

AMENDMENT TO H.R. 3162, AS REPORTED [BY THE COMMITTEE ON WAYS AND MEANS]

OFFERED BY MR. BURGESS OF TEXAS

(CHAMP Amendment)

Amend section 704 (relating to never events plan) by redesignating subsection (d) as subsection (e) and inserting after subsection (c) the following:

(d) LIABILITY PROTECTION.—

(1) IN GENERAL.—Section 922 of the Public Health Service Act (42 U.S.C. 299b–22) (relating to liability and confidentiality protections) shall apply to never event information under this section in the same manner as it applies to patient work product under such section 922.

(2) NEVER EVENT INFORMATION DEFINED.—For purposes of this subsection the term "never event information" means information required to be provided by a hospital, ambulatory surgical center, or physician under the never events plan with respect to a determination to reduce or deny payment under title XVIII of the Social Security Act for services furnished by the hospital, ambulatory surgical center, or physician, respectively, on the basis of the finding of a never event.

AMENDMENT TO H.R. 3162

This amendment would prohibit the Secretary of Health and Human Services from approving future State waivers that would cover adults other than pregnant adults under the State Children's Health Insurance Program. This amendment would also terminate existing State waivers that cover adults other than pregnant adults under a State's Children's Health Insurance Program. SCHIP is designed to cover uninsured children, and taxpayer funds used to cover adults cannot achieve that goal. This amendment would save State and Federal Governments hundreds of millions of dollars that could be used to cover more uninsured children.

ADULTS

Since Congress enacted SCHIP in 1997, States have been successful in making affordable health insurance available to millions of low-income children.

Prior to the enactment of SCHIP, low-income families that made too much money to be eligible for Medicaid coverage found it difficult to find affordable coverage for their children. Several million children were left without health coverage for important preventative health services, forcing their families to seek care in emergency departments and lacking vital continuity of care.

With the Federal and State partnership that is the cornerstone of SCHIP, needy families were able to obtain health coverage for their children that was previously just out of reach.

Unfortunately some States have extended coverage to adults under their SCHIP program, taking limited dollars away from the needs of the children the program was intended to meet. One dollar a State spends on an adult is $1 not spent on a needy child. This amendment would eliminate this inequitable development that needs to be stopped dead in its tracks.

My bill would prohibit States from spending even a single SCHIP dollar on anyone but a child or a pregnant woman. Currently, 14 States extend SCHIP coverage to adults and four of those States cover more adults than children in their programs.

We can debate coverage of adults and affordable options and States can take this responsibility upon their shoulders as well. But we shouldn't spend a dollar dedicated to a child on an adult. It does a disservice to the very needy children we're trying to provide coverage to.

AMENDMENT TO H.R. 3162, AS REPORTED [BY THE COMMITTEE ON WAYS AND MEANS]

OFFERED BY MR. BURGESS OF TEXAS

(CHAMP amendment)

At the end of subtitle D of title I add the following new section:

SEC. . PROHIBITION OF SECTION 1115 WAIVERS FOR COVERAGE OF NONPREGNANT ADULTS UNDER SCHIP.

(a) IN GENERAL.—Section 2107(f) of the Social Security Act (42 U.S.C. 1397gg) is amended, as added by section 6102(a) of the Deficit Reduction Act of 2005 (Public law 109–171) is amended—

(1) in the first sentence, by striking "childless"; and

(2) by striking the second sentence.

(b) CONFORMING AMENDMENTS.—Section 2105(c)(1) of the Social Security Act (42 U.S.C. 1397ee(c)(1)) is amended—

(1) in the first sentence, by striking "childless"; and

(2) by striking the second sentence.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

(d) TERMINATION OF FUNDING OF COVERAGE UNDER CURRENT WAIVERS.—In the case of any waiver, experimental, pilot, or demonstration project that would allow funds made available under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) to be used to provide child health assistance or other health benefits coverage to an adult (other than pregnant adult) that is approved as of the date of the enactment of this Act, on and after such date the Secretary of Health and Human Services shall not extend or renew such a waiver or project in a manner that permits funds under the waiver or project to be used for such purpose and shall otherwise take such action as is necessary to prevent the use of funds under the waiver or project to be used for such purpose on and after January 1, 2008.

AMENDMENT TO H.R. 3162

This amendment would require a State submitting a SCHIP waiver request to the Secretary of Health and Human Services to certify that children in that state have access to an adequate level of pediatricians, pediatric specialists and pediatric sub-specialists for targeted low-income children covered under the State's child health plan.

The State must include a survey conducted by the American Academy of Pediatrics, a state professional medical society, or other qualified organization and the Secretary may not approve a waiver application unless the survey is included in the State's submission.

ACCESS

This amendment would ensure that as states seek to expand their CHIP programs, that an adequate number of pediatricians, pediatric specialists and sub-specialists are available to meet increased demand by new patients.

To quote the American Academy of Pediatrics Workforce Committee, "an appropriate pediatrician workforce is essential to attain the optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults. To fully realize such a workforce requires careful examination of the needs of children and the consequences of policies that influence the pediatrician workforce."

This amendment would attempt to achieve this goal, by requiring adequate access to

these medical professionals as a condition approval of a waiver submission.

The amendment would require the American Academy of Pediatrics or other state medical society to survey and certify that the state's children have access to a sufficient number of pediatricians and specialists, should a state request a waiver from federal SCHIP requirements.

States have a variety of policy options to ensure that an adequate physician workforce is available in the state and this amendment would encourage those states to exercise those options.

The growth of the number of pediatricians per child has been positive over the past decade.

We should ensure that this momentum is sustained and this amendment will do just that.

I think this is an amendment that should have broad bipartisan support because its goal is ensuring access to needed medical professionals for our children.

More broadly, in the coming years this country will face a physician workforce shortage and this committee and this Congress needs to begin addressing this now.

I look forward to working with the members of this committee on this very broad and complicated issue, but this amendment would be a good first step.

AMENDMENT TO H.R. 3162, AS REPORTED [BY THE COMMITTEE ON WAYS AND MEANS]

Offered by Mr. Burgess of Texas

(CHAMP amendment)

Add at the end of subtitle E of title I the following new section:

SEC. . LIMITATION ON APPROVAL OF SCHIP WAIVERS.

The Secretary of Health and Human Services shall not approve any application submitted by a State for a waiver of any provision of title XXI of the Social Security Act unless—

(1) the State has certified that there is access to an adequate level of pediatricians, pediatric specialists and pediatric sub-specialists for targeted low-income children covered under the State child health plan under such title; and

(2) the State includes in such application the results of a survey, that may be conducted by the American Academy of Pediatrics, a State professional medical society, or other qualified organization, that establishes that such an adequate level exists on a per capita child basis.

Mr. DINGELL. Mr. Speaker, I yield to the distinguished gentleman from Virginia (Mr. MORAN) for purposes of a unanimous consent request.

Mr. MORAN of Virginia. Mr. Speaker, I ask unanimous consent to insert a statement for the RECORD refuting the fact that this has anything to do with undocumented children. The fact is that the current provision prohibits undocumented children from getting health care, but if we don't pass it, it will deny tens of thousands of children who are legally eligible.

Mr. BURGESS. I object.

The SPEAKER pro tempore. Objection is heard.

PARLIAMENTARY INQUIRY

Mr. BARTON of Texas. Mr. Speaker, parliamentary inquiry, where are we?

The SPEAKER pro tempore. Objection has been heard. The gentleman objected. It's for the gentleman from Michigan to yield time.

Mr. BARTON of Texas. So Mr. DINGELL controls the time?

The SPEAKER pro tempore. That's correct.

Mr. DINGELL. Mr. Speaker, I yield to the distinguished gentlewoman from California (Ms. ESHOO) 1 minute.

Ms. ESHOO. Mr. Speaker, I thank the distinguished chairman of the Energy and Commerce Committee.

Mr. Speaker, today is one of the most exciting days since I've come to the Congress, having been elected first in 1992. I think today is a day of history, a day of history for the children of our country, because the fact is that there are nearly 9 million American children without guaranteed access to health care in our Nation today. I think that is a national shame.

Today, we correct that. We build on a successful bipartisan program of Republican and Democratic Governors, of leaders in the Congress past, of a program that has worked.

It has not been riddled by fraud, and what we do today very simply is add 5 million American children in the rolls of health care. It is private insurance for almost all of the States.

We also strengthen Medicare. I would suggest that my friends on this side of the aisle are on the wrong side of history.

□ 1500

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to the distinguished gentleman of the committee from the great State of Florida (Mr. STEARNS).

(Mr. STEARNS asked and was given permission to revise and extend his remarks.)

Mr. STEARNS. Mr. Speaker, I would say to the gentlelady from California who said this is a great day in history, it was a great day in history when, in 1997, the Republicans, who had the majority, initiated and started this program. The Democrats are saying this is a great day, what a great day, when the Republicans started the SCHIP program.

Now, this bill, you have heard it all before. Obviously, it creates a new entitlement, crowds out private insurance with government coverage, offers perverse incentives to States; and, my friends, it contains a huge tax increase, with more on the way. Lastly, it punishes Medicare beneficiaries. This is very troubling, particularly in Florida. We have so many seniors that actually use Medicare Advantage.

The fact that they are going to eliminate this program to pay for this is really outrageous. It will disproportionately harm racial minorities and rural senior citizens by taking funds away from Medicare Advantage, a successful, lower-cost option for health care for seniors and use it to enroll and federally insure adult men and women who have the ability to work and receive health care from their employers in the open market.

Mr. STARK. Mr. Speaker, I yield to the distinguished member of the Ways and Means Committee, a member of the Health Subcommittee, the gentleman from Georgia (Mr. LEWIS).

Pending that, I would explain that he knows that the NAACP, in a letter of endorsement, has said that this legislation fills a much-needed gap that currently exists in health care services for some of the most vulnerable citizens, low-income children, seniors and the disabled.

Mr. LEWIS of Georgia. Mr. Speaker, health care is a basic human right. It is unacceptable to see a young child die because his family could not afford for him to see a dentist. This should never, ever, happen in the United States of America. It is wrong. It must not be tolerated any longer, and today we said "no more".

This bill would give 6 million children access to health care. For our seniors who rely on Medicare, this bill helps our low-income seniors and makes prevention more affordable.

I applaud the work of Chairman RANGEL and Chairman STARK for making these important improvements. I am proud to have worked on this bill to help those who suffer from chronic kidney disease and end-stage renal disease receive the highest quality care and to take the first of many steps towards preventing these terrible diseases.

Until we can make health care right for every American, we have a moral mission, a mission and a mandate to start with the most vulnerable among us, our children and our seniors. We can do no less. Vote "yes" on the CHAMP Act. Do it now. Do it today.

Mr. BARTON of Texas. Mr. Speaker, could I inquire of the time remaining on each side on this part of the bill?

The SPEAKER pro tempore. The gentleman from Texas has 18 minutes remaining, and the gentleman from Michigan has 22½ minutes remaining.

The gentleman from California has 19 minutes remaining, and the gentleman from Louisiana has 30 minutes remaining.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to a distinguished member of the committee from the great State of Illinois (Mr. SHIMKUS), the winning pitcher on the congressional baseball team.

(Mr. SHIMKUS asked and was given permission to revise and extend his remarks.)

Mr. SHIMKUS. Mr. Speaker, under the current Illinois SCHIP program, it covers up to 200 percent of poverty, $41,300 in annual income for a family of four; 26,830, or 31 percent of all families with children under the age of 18, in my district are already eligible for either Medicaid or SCHIP.

In this bill, Democrats have opposed cutting at least $194 billion in Medicare spending. Specifically, the Democrats have proposed cutting Medicare spending for 6,070 seniors in my district who