

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 practitioner, 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 health-care 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