Health Care Primer for Members

Rep. Michael C. Burgess, M.D.

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prepared by

Rep. Michael C. Burgess, M.D.
Congressional Health Care Caucus

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Introduction

Too often Republicans are criticized for their lack of enthusiasm or knowledge when it comes to talking about health care. Whether that critique is fiction or contains a kernel of truth, the fact remains that we must overcome this perception. *Health Care 101* aimed to provide Republican Members of Congress with the tools to communicate effectively about health care to their constituents and the media.

Throughout the four sessions, discussions focused on the development of our hybrid system of health care, which combines the public funding from the government and the funding from private insurance companies. More in-depth conversations centered on government health care programs Medicare, Medicaid, and SCHIP, and the private and employer-based insurance markets – how they work and how they can be reformed to best serve the American public. The final session used polling data to demonstrate what Americans are looking for with regards to health care policy.

According to a recent poll by Dutko Worldwide, 47% of Americans trust Democrats more to handle health care, where only 32% trust Republicans more to handle the issue. This document not only contains information from the four *Health Care 101* sessions, but I have also included additional information that Republican members and their staff can utilize when crafting your health care message. We have a common-sense plan to lower costs while improving access and quality. Now is the time for Republicans to step out of the shadow of the Democrats-led health care discussion and go forth with our message of more affordable, portable, and innovative care.

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A Brief History of U.S. Health Care

McCarran-Ferguson

The modern health care system becomes most recognizable following the 1944 Supreme Court ruling *U.S. v. South-Eastern Underwriters*. *U.S. v. South-Eastern Underwriters* classified insurance as an item of interstate commerce and would therefore fall within Congress' Constitutional authority to regulate.

The McCarran-Ferguson Act, however, delegates Congress' regulative power to the various States, who have established their own regulatory entities. Under McCarran, the insurance industry is exempt from *some* federal anti-trust statutes, and the exemption primarily applies to gathering data in concert for the purpose of rate-making.

Otherwise, antitrust laws prohibit insurers from boycotting, acting coercively, restraining trade, or violating the Sherman and Clayton Acts. Effectively, McCarran delegates authority to the states to the extent that the states regulate the business of insurance, creates and maintains a broad insurance regulatory system, and balances regulatory objectives against antitrust policy objectives.

Employer-Based Coverage

Even though examples of health insurance in the U.S. go back more than 200 years, most Americans did not have health insurance coverage until the latter half of the 20th Century. The demand for more workers during World War II and a wage freeze imposed by the federal government generated great interest in employer-sponsored insurance as a worker recruitment and retention tool. Buoyed by legislation and court ruling declaring the tax exemption of fringe benefits, and support from unions for work-based coverage, health insurance became a pervasive employment benefit.

In 1974, President Ford signed the Employee Retirement Income Security Act (ERISA) into law. ERISA outlines minimum federal standards for private-sector employer-sponsored benefits. (Public employee benefits and plans sponsored by churches are exempt from ERISA.) Passed in response to abuses in the private pension system, the act was developed with a focus on pensions but the law applies to a long list of "welfare benefits" including health insurance. The act requires that funds be handled prudently and in the best interest of beneficiaries, participants be informed of their rights, and there be adequate disclosure of a plan's financial activities. ERISA preempts state laws that "relate to" employee benefit plans. (In other words, the federal law overrides state laws affecting private-sector employee benefits.) This portion of ERISA was designed to ensure that plans would be subject to the same benefit law across all states, partly in consideration of firms that operate in multiple states.

Federal Health Programs

Why did the federal government get into health care?

Medicare was enacted in 1965 in response to the concern that only about half of the nation's seniors had health insurance, and most of those only had coverage for inpatient hospital costs. The new program, which became effective July 1, 1966, included coverage for hospital and post-hospital services under Part A and doctors and other medical services under Part B. As was the case for the already existing Social Security program, Part A was to be financed by payroll taxes levied on current workers and their employers. Payments to health care providers under both Part A and Part B were to be based on the most common form of payment at the time, namely "reasonable costs" for hospital and other institutional services or "reasonable charges" for physicians and other medical services.

Medicare

At a Glance

Who is served?
Anyone aged 65+, certain disabled individuals, and those with terminal kidney diseases. A total of 37.4 million elderly are covered and 7.3 million disabled.

How much does it cost?
In FY08, the federal government spent approximately $388.9 billion – 13% of the total federal budget and 3% of GDP.

What services are provided?
(Part A) inpatient hospital services, post-hospital skilled nursing facility services, home health care, hospice care; (Part B) physician services, laboratory services, therapy services, durable medical equipment, ambulance services; (Part C) Medicare Advantage

Medicare is the nation's health insurance program for persons aged 65 and over and certain disabled persons. In FY2008, the program will cover an estimated 44.6 million persons (37.4 million aged and 7.3 million disabled) at a total cost of $459.4 billion.

Federal costs (after deduction of beneficiary premiums and other offsetting receipts) will total $389.9 billion. In FY2008, federal Medicare spending will represent approximately 13% of the total federal budget and 3% of GDP.

Medicare is an entitlement program, which means that it is required to pay for services provided to eligible persons, so long as specific criteria are met.

Since Medicare was enacted in 1965, it has undergone considerable changes. First, program coverage was expanded to include the disabled and persons with end-stage renal disease (ESRD).

Over time, increasing attention was placed on stemming the rapid increase in program spending, which outpaced projections, even in the initial years. This was typically achieved through tightening rules governing payments to providers of services and stemming the annual updates in such payments.

The program moved from payments based on "reasonable costs" and "reasonable charges" to payment systems under which a pre-determined payment amount is established for a specified unit of service. At the same time, beneficiaries were given the option to obtain covered services through private managed care arrangements.

Most Medicare payment provisions were incorporated into larger budget reconciliation bills designed to control overall federal spending.

In 2003, Congress enacted a major Medicare bill, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). This legislation placed increasing emphasis on private sector management of benefits.

It also created a new voluntary outpatient prescription drug benefit to be administered by private entities. Further, it introduced the concept of means testing into what had previously been strictly a social insurance program.

Congress continues to register concern about the rapid rise in Medicare spending and the ability of existing funding mechanisms to support the program over the long-term.

A combination of factors has contributed to the rapid increase in Medicare costs. These include increases in overall medical costs, advances in health care delivery and medical technology, the aging of the population, and longer life spans.

The issues confronting the program are not new; nor are the possible solutions likely to get any easier. For a number of years, various options have been suggested; however, legislative changes have focused on short-term issues. There is no

Medicaid

In existence for 43 years, Medicaid is a means-tested entitlement program that finances the delivery of primary and acute medical services as well as long-term care to more than 61 million people at an estimated cost to the federal and state governments of roughly $317 billion.

Of all federally supported programs, only Medicare comes close to this level of spending, and only Social Security costs more.

Each state designs and administers its own version of Medicaid under broad federal rules. There is significant variability in eligibility, covered services, and how those services are reimbursed and delivered among the states.

Medicaid was enacted in 1965 in the same legislation that created the Medicare program. It grew out of and replaced two earlier programs of federal grants to states that provided medical care to welfare recipients and the elderly. It has expanded in additional directions since that time.

In the federal budget, Medicaid is an entitlement program that constitutes a large share of mandatory spending. Two other federally supported health programs -- Medicare and the State Children's Health Insurance Program (SCHIP) -- are also entitlements, and are also components of mandatory spending in the federal budget.

All three programs finance the delivery of certain health care services to specific populations. While Medicare is financed exclusively by the federal government, both Medicaid and SCHIP are jointly financed by the federal and state governments.

Federal Medicaid spending is open-ended, with total outlays dependent on the generosity of state Medicaid programs. In contrast, SCHIP is a capped

At a Glance…

Who is served?
In general, Medicaid is targeted at individuals with low income and statute defines 50+ distinct population groups as being potentially eligible. Roughly 61 million people were enrolled in Medicaid at some point during the year in FY2007: 29.2 million were children, 16.2 million adults in families, 9.5 million individuals with disabilities, and 6 million people over the age of 65. Statute and regulations set forth who *must* be covered and who *may* be covered based upon financial requirements. Because Medicaid is a State-Federal partnership, states may request to cover more individuals through a waiver.

How much does it cost?
In FY2006, Medicaid spending totaled $314 billion, with a federal share of $179 billion and a state share of $135 billion.

What services are provided?
Primary and acute medical services and long-term care. Certain services are required, but states have some flexibility in requiring/providing additional services and benefits.

federal grant to states.

Even though Medicaid is an entitlement program in federal budget terms, states may choose to participate, and all 50 states do so. If they choose to participate, states must follow federal rules in order to receive federal reimbursement to offset a portion of their Medicaid costs.

SCHIP

The Balanced Budget Act of 1997 established the State Children's Health Insurance Program (SCHIP) under a new Title XXI of the Social Security Act. In general, this program allows states to cover targeted low-income children with no health insurance in families with income that is above Medicaid eligibility levels.

The highest upper income eligibility limit for children in SCHIP is 350% of the federal poverty level ($74,200), in one state, New Jersey.

Under SCHIP, states may enroll targeted low-income children in an SCHIP-financed expansion of Medicaid, create a new separate state SCHIP program, or devise a combination of both approaches.

At a Glance…

Who is served?:
SCHIP is intended to serve low-income children (up to age 19) without health insurance. However, states may choose to expand eligibility to children at higher income levels and adults.

How much does it cost?:
In FY2007, total SCHIP spending was $8.7 billion, with the federal government paying the bulk at $6 billion and states contributing $2.7 billion.

What services are provide?:
Many states simply expand their Medicaid programs with SCHIP dollars and are therefore required to provide the full range of mandatory benefits under Medicaid. Some states create separate SCHIP programs and typically cover hospital visits, physician services, and age-appropriate immunizations.

States choosing the Medicaid option must provide all Medicaid mandatory benefits and all optional services covered under the state plan. In addition, they must follow the nominal Medicaid cost-sharing rules or apply the new state plan option for premiums and service-related cost-sharing as allowed under the Deficit Reduction Act of 2005 (DRA).

In general, separate state programs must follow certain coverage and benefit options outlined in SCHIP law. While some cost-sharing provisions vary by family income, the total annual aggregate cost-sharing (including premiums, copayments, and other similar charges) for a family may not exceed 5% of total income in a year. Preventive services are exempt from cost-sharing.

Nearly $40 billion was appropriated for SCHIP for FY1998 through FY2007 in BBA 97, with the annual allotments to states determined by a formula using a combination of the estimated

number of low-income children and low-income *uninsured* children in the state, adjusted by a state health cost factor.

Four continuing resolutions provided appropriations through December 31, 2007, for SCHIP allotments in FY2008. The Medicare, Medicaid, and SCHIP Extension Act of 2007 appropriated funds to ensure no state's SCHIP program runs out of federal SCHIP funds before March 31, 2009.

All states, the District of Columbia, and five territories have SCHIP programs. The territories, the District of Columbia, and 8 states use Medicaid expansions; 18 states use separate state programs; and 24 states use a combination approach.

At the national level, approximately 7.1 million children were enrolled in SCHIP during FY2007, up from 6.7 million in FY2006. In addition, 14 states reported enrolling about 587,000 adults in SCHIP through program waivers in FY2007.

Spending was slow in the early years of SCHIP, but that trend changed in more recent years and led some states to exhaust their federal SCHIP funds. Congress appropriated additional SCHIP funds to address states' shortfalls in FY2006 ($283 million) and FY2007 ($650 million).

Congress passed two bills that would "reauthorize" SCHIP -- providing SCHIP funding through FY2012 and making other changes to both SCHIP and Medicaid.

Both H.R. 976 and H.R. 3963 were vetoed by the President, with the Congress unable to override these vetoes. MMSEA was enacted to provide federal SCHIP funds through March 31, 2009, and did not make changes to the program.

Public Health Service Agencies

Food and Drug Administration (FDA)

The FDA plays a central role in protecting the public health in the U.S. by regulating most of the food supply and vitally important medical products, including drugs, devices, and biologics that affect American lives on a daily basis. FDA regulates products valued at more than $1 trillion in the U.S. economy. In the area of health care, the FDA is responsible for the safety and the effectiveness of human drugs, vaccines, medical devices, and animal drugs. About 25% of American consumer dollars are spent on FDA-regulated products.

Centers for Disease Control and Prevention (CDC)

The mission of the CDC is "to promote health and quality of life by preventing and controlling disease, injury, and disability." The CDC is the nation's principal public health agency, providing coordination and support for a variety of population-based disease and injury control activities.

Approximately 75% of the agency's funding is spent extramurally through grants, contracts, and cooperative agreements to various stakeholders, including state, local, municipal, and foreign governments, non-profit organizations, academic institutions, and others. The CDC coordinates, analyzes, and disseminates public health information derived from a number of health surveys and disease surveillance systems that it manages.

National Institutes of Health (NIH)

The NIH is the primary agency of the federal government charged with conducting and supporting biomedical and behavioral research. It also has major roles in research training and health information dissemination.

NIH is the largest of the Public Health Service agencies with an FY08 budget of $29.2 billion and total employment of more than 18,000 people. The NIH is organized into 27 institutes and centers focusing on various diseases and organs, including the National Cancer Institute and the National Eye Institute.

Private Sector

Employer Based Health Coverage

Section 106 of the Internal Revenue Code states that employer contributions to employment-based health insurance are not included in workers' gross incomes for tax purposes.

This tax preference encourages workers to sign up for ("take-up") health coverage within the work setting. A separate ruling by the Internal Revenue Service clarified that such employer contributions are business expenses and, therefore, deductible from employers' taxable income.

Both parties benefit: employers use health insurance coverage as a means to recruit and retain workers, while workers typically get access to more services at better rates (see discussion below). However, workers generally receive reduced wages to compensate for richer benefits.

The tax exclusion of health benefits is one of the primary reasons why health insurance coverage is provided mainly through the workplace in the United States. Approximately two out of three nonelderly (under 65) Americans have employer-sponsored insurance. Moreover, of nonelderly persons with private health coverage, approximately nine out of 10 obtain it through the workplace.

Individual Health Insurance Market

The individual insurance ("non-group") market is often referred to as a "residual" market. The reason is because this market provides coverage to persons who cannot obtain health insurance through the workplace and do not qualify for public programs. Consequently, the enrollee population for this private health insurance market is small. Individuals in this market also include the self employed and those purchasing coverage between jobs.

Applicants to the individual insurance market must go through robust underwriting. Insurance carriers in most states conduct an exhaustive analysis of each applicant's insurability. An applicant usually must provide his medical history, and often undergo a physical exam. This information is used by carriers to assess the potential medical claims for each person.

Rigorous underwriting results in an enrollee population that is fairly healthy, thereby excluding persons with moderate to severe health problems from the private nongroup insurance market. In general, premiums are higher for individuals in the nongroup market and individuals do not enjoy the same tax benefits as those who purchase coverage through an employer.

Important Areas of Reform

Portability Because of the tax treatment of health insurance, a vast majority of Americans get their insurance through their employers. While most Americans are pleased with the coverage they receive through their employers, when they change jobs they are forced to get new insurance. Republicans should support efforts to make individuals' health care portable from job to job.

Tax Equality The current tax code is heavily slated towards promoting an employer-based system, providing tremendous tax relief to employers who provide coverage for their employees. While employer-based coverage is important and popular, the tax system should be changed to provide equality for those wishing to buy their own insurance. With many Americans self-employed or periodically unemployed, it is nearly impossible, due to cost, for them to purchase their own health insurance.

Strengthen Hybrid System The American health care system is a hybrid system – financed by both public and private funds. Liberals are calling for the U.S. to abandon this system and move towards one run by the government. This would be a tragic setback to American medical innovation.

Cost Sharing With spending on entitlement programs like Medicare and Medicaid on the rise, one measure to save money in these programs is to get beneficiaries to share in the cost.

The Problem with Nationalized Medicine

Democrats wish to expand culture of dependence on the state while Republicans want to expand the number of individuals who can direct their own health care. A system fully funded by a payroll tax or other policy has no reason to seek improvement, and as a consequence faces stagnation. Additionally, in such a system if there becomes a need to control costs, that frequently comes at the expense of the provider.

Then there is the issue with the Democrat-proposed health care mandates. According to a recent poll by Dutko Worldwide, more than three-fourths of those polled oppose financial penalties for those who do not comply with a health insurance mandate.

Think of the largest mandate Americans are faced with today – taxes. Roughly 85% of Americans adhere to this mandate and pay their taxes. Currently 85% of Americans have health insurance coverage of some sort. Why should be believe that mandating health care would motivate that final 15% - the same amount of Americans who refuse to adhere to the other nation-wide mandate – to obtain health care insurance? This is an important question that we must be asking.

That same Dutko poll showed that Americans would rather pay higher costs for health care and have more choices. Senator Obama and Senator Clinton's plans would do just the opposite – costs would likely lower but choices would drastically decrease. The fact is, the United States is not Europe. American patients are accustomed to wide choices when it comes to hospitals, physicians, and pharmaceuticals.

Because our experience is unique and different from other countries this difference should be acknowledged and embraced when reform is contemplated in either public or private health insurance programs within this country.

A news story by a national Canadian television broadcaster showcased a Canadian member of Parliament who sought treatment for cancer in the United States. The story itself is not particularly unique but the online comments that followed the story I thought were particularly instructive.

As one writer summed it up, "She joins a lengthy list of Canadians who go to the United States to get treated. Unfortunately, the mythology that the state-run medicine is superior to that of the private sector takes precedent over the health of individual Canadians." The comments of another individual:

> "'The story here isn't about those who get treatment in the states. It's about a liberal politician that is part of a political party that espouses the Canadian public system and vowed to ensure that no private health care was ever going to usurp the current system. She is a Member of Parliament for the party that

relentlessly attacked the Conservatives for their "hidden agenda" to privatize health care. The irony and hypocrisy is that position supports the notion that the rich get health care and the rest of us wait in line, all because liberal fear mongering that does not allow for a real debate on the state of the healthcare system in Canada."

One final note from the online postings: "It's been sort of alluded to but I hope everyone reading this story realizes that in fact we do have a two tiered health care system. We have public care in Canada, and for those with LOTS of cash, we have private care in the United States, which is quicker and in many cases better."

The United States is indeed at a crossroads. It is incumbent that every one of us who believes in the private sector involvement in health care in the United States of America (and believes in the inevitable failure of government-run health care) to stay educated and involved and committed to being at the top of our game.

This is one of those rare instances where in it is necessary to be prepared to win the debate, even though we know we may lose the vote in the House of Representatives.

The Most Innovative Health Care in the World...

For 22 of the last 25 years, a Nobel Prize in Medicine was awarded to a researcher working in the U.S.A.

A Health Care Glossary

AHRQ (Agency for Healthcare Research and Quality) The lead Public Health Service agency charged with supporting research designed to improve the quality of health care, to increase the efficiency of its delivery, and to broaden access to the most essential health services.

ATSDR (Agency for Toxic Substances and Disease Registry) Tasked with investigating and reducing the harmful effects of exposure to hazardous substances on human health. Most of the administrative functions for ATSDR are provided by CDC and the Director of CDC serves as Administrator of ATSDR.

biologics A preparation, such as a drug or a vaccine, that is made from living organisms (*see also, follow-on biologic*).

CDC (Centers for Disease Control and Prevention) The nation's principal public health agency, providing coordination and support for a variety of population-based disease and injury control activities.

CDHC (Consumer Driven Health Care) A broad spectrum of approaches that give incentives to consumers to control their use of health services and/or ration their own health benefits.

CMS (Center for Medicare and Medicaid Services) Organization within HHS tasked with handling both Medicare and Medicaid. CMS is responsible for implementing and enforcing regulations.

community rating Insurance reform proposal that would require insurers to charge the same price to every policyholder, regardless of age, sex, or any other indicator of health risk; modified community rating allows for difference based on age and sex.

DME (Durable Medical Equipment) Certain types of equipment, like oxygen supplies, hospital beds, and wheelchairs, that will be paid for by Medicare for those who require them.

DSH (Disproportionate Share Hospital) A program designed to offset uncompensated costs incurred by no-pay patients and un-reimbursed Medicaid claims assumed by hospitals.

ERISA (Employee Retirement Income Security Act 1974) Established minimum standards for pension plans in private industry and provides for extensive rules on the federal income tax effects of transactions associated with employee benefit plans.

FDA (Food and Drug Administration) Regulates more than $1 trillion worth of products, which account for 25 cents of every dollar spent annually by American consumers. It regulates the safety of foods (including animal feeds) and the safety and effectiveness of drugs, biologics, and medical devices.

follow-on biologic Similar but not identical to the brand-name, or innovator, product made by the pharmaceutical or biotechnology industry.

GME (Graduate Medical Education) Clinical training in an approved residency program following graduation from schools of medicine, osteopathy, dentistry, and podiatry; Medicare, and in some states Medicaid, make payments to teaching hospitals for GME costs.

group market Health insurance provided to groups of people drawn together by an employer or another organization, like a trade union.

guaranteed issue Insurance reform proposal that would require insurers to issue a policy to an individual regardless of health status.

HSA (Health Savings Account) Tax-advantaged medical savings account available to individuals enrolled in High Deductible Health Plans (HDHP, *see below*); funds contributed to the account are not subject to tax at the time of deposit and funds used to pay for certain medical expenses are exempt from federal tax liability; important component of Consumer Driven Health Care.

HDHP (High Deductible Health Plan) A health insurance plan with lower premiums and higher deductibles than a traditional plan; also known as a catastrophic health insurance plan; requirement for Health Savings Accounts; minimum deductible is $1,100 for individuals and $2,200 for families.

HHS (Department of Health and Human Services) Cabinet-level department with the goal of protecting the health of all Americans and providing essential human services; oversees Public Health Service Agencies.

HIPAA (Health Insurance Portability and Accountability Act 1996) Guarantees the availability and renewability of health insurance coverage for certain employees and individuals, and limits the use of patient information.

HIT (Health Information Technology) Allows comprehensive management of medical information and its secure exchange between health care consumers and providers; broad use of HIT will improve quality, prevent medical errors, reduce costs, increase efficiency, decrease paperwork, and expand access.

HRSA (Health Resources and Services Administration) Provides leadership and support for health services and resources for people who are uninsured, isolated, or medically vulnerable; also known as the Access Agency.

IHS (Indian Health Service) Provides, or funds the provision of, direct health care services to members of the nation's 562 federally recognized Indian tribes (totaling about 1.8 million Indians in 35 states).

individual market Consumers not associated with a group purchase their own insurance in this market; consumers in the individual market usually face rigorous health screening; also know as the non-group market.

IPA (Independent Practice Association) An association of independent physicians, or other organization that contracts with independent physicians, and provides services to managed care organizations on a negotiated per capita rate, flat retainer fee, or negotiated fee-for-service basis. IPAs are generally risk-bearing entities and regulated by the FTC.

Medicaid Federal-state partnership to provide health coverage for primarily poor adults.

Medicare Federal program to provide health insurance for individuals age 65+.

MEDPAC (Medicare Payment Advisory Commission) An independent Congressional agency established by the Balanced Budget Act to advise the Congress on issues affecting the Medicare program.

MEI (Medicare Economic Index) Measures the weighted average annual price changes in the inputs needed to produce services; updated by CMS annually; more accurate than SGR (*see below*).

NHSC (National Health Service Corps) Committed to improving the health of the nation's underserved by uniting communities in need with caring health professional and supporting communities' efforts to build better systems of care. Part of HRSA.

NIH (National Institutes of Health) Primary agency of the federal government charged with conducting and supporting biomedical and behavioral research. It also has major roles in research training and health information dissemination.

PBM (Pharmaceutical Benefits Manager) Negotiates drug discounts with manufacturers and act as the intermediary purchaser of prescription drugs for businesses as part of the health benefits they may offer.

Physician Owned Hospital Hospitals partially owned and run by physicians; concerns exist about conflict of interest and self-referral.

Substance Abuse and Mental Health Services Administration (SAMHSA) Supports states' efforts to enhance prevention and treatment programs for substance abuse and mental health disorders through block, formula, and discretionary grants.

SCHIP (State Children's Health Insurance Program) Federal-state partnership intended to provide health coverage for poor children.

SGR (Sustainable Growth Rate) A volume-based payment mechanism that adjusts Medicare physician payments on an annual basis. Because the volume and intensity of physician services often exceed the targets established by SGR, negative payment updates are scheduled for Medicare physicians on an annual basis.

SNF (Skilled Nursing Facility) Nursing homes; commonly called "sniffs"; Medicare pays for a beneficiary's SNF services if he or she has been discharged from a hospital after a three day stay and/or per a doctor's orders.

supplemental coverage Usually a product sold to cover benefits not included in a primary health plan. Prior to the implementation of Medicare Part D, for example, supplemental policies would provide seniors with drug coverage.

Prepared by
Representative Michael C. Burgess, M.D. (TX-26)
Health Subcommittee, Committee on Energy and Commerce
229 Cannon HOB
Washington, D.C. 20515
202-225-7772