more and more strain, more and more tours of duty.

Here are our priorities. We passed the largest increase in veterans benefits in the 77-year history of the VA. We passed legislation to increase the minimum wage. We passed legislation to expand access to health care for 10 million children. We passed legislation to cut the student loan interest rate in half. The list goes on.

And what do you hear from the Republicans? Nothing. You hear, let's put more money into the war in Iraq. Let's lengthen the time that the men and women fighting on our behalf spend there. Let's send them over there for more and more tours of duty. Do you ever hear anything from that side of the aisle in terms of an agenda, in terms of getting anything done? All I hear is ''no.'' All I hear is, ''not going to do that.'' All I hear, again, is, ''Yes, Mr. President. Whatever you say, Mr. President.''

Our criticism of them, Mr. MEEK and Mr. RYAN, if you remember, in the 30–Something Working Group in the 109th was that they were the bobblehead Republicans who did nothing more than shake their head up and down and do whatever the President said. And nothing has changed. Well, guess what. A year from now, which is just about a year from now, they will be called to account just like you said, Mr. MEEK, and we will see just how many fewer Republicans there will be here that serve in this chamber, because I think the American people have had it up to here.

I would be happy to yield to the gentleman.

Mr. MURPHY of Connecticut. I just want to make a point. It is not like we are out on a limb here. We just saw a poll that came out a few days ago from CNN that shows that seven in 10 Americans oppose this war. That is the highest number, 68 percent, 70 percent of Americans oppose this war, the highest number since the war began.

□ 2315

We are seeing almost by the week, by the day, new generals, new senior retired American military officials coming out and breaking with this President. We have already seen the Iraq Study Group, we have already seen dozens of foreign policy experts come out and plead with this President. Even many of his best friends, many of his father's advisors have pleaded for a new course.

The Democrats are on the side of the American public. The Democrats are on the side of the foreign policy community on Iraq. The Democrats are on the side of an increasing number of retired military generals and officials on this issue. As you said, there is just a very loyal, very recalcitrant block of Republicans who refuse to abide by the growing will of the American public on this issue. There will be a price to be paid for this.

Ms. WASSERMAN SCHULTZ. If the gentleman will yield. What is clear here is there is a threat of panic running through the caucus on the other side of the aisle because we are up to 16 of their incumbent Members who have decided to bail and who recognize that the ship is listing and has been listing badly and is in danger of just completely going down. There doesn't appear to be any likelihood of the ship righting itself in the near future. They aren't expected and aren't expecting to get their act together and focus on an agenda that the American people support because they have been a one-note, tunnel-vision party for far too long.

So you have 16 that have decided to retire already, with, we are sure, more to come. It's just not surprising because they do not share the priorities of everyday working families, Americans who want the Congress to focus on a new direction and not give them more of the same.

Mr. RYAN of Ohio. It's interesting, and I think you made the right point. It seems like the President has one priority, and one and only one, and that is the funding of the war. What is interesting is when you look at the Labor-HHS bill, some of the other bills we are trying to pass that increase the Pell Grants and some of the other things, we are not getting the level of support we should.

These vets need those programs. These veterans that are coming back, it's not like they are making a lot of money, many of them with their kids they are trying to send to college. So why wouldn't this apply? The vets aren't just fighting for the Defense appropriations bill that passes out of the House or the VA benefit package that passes out of the House. The veterans are fighting for America. They are fighting for a strong country that does research and development. Veterans have family members who get cancer. So they are very concerned, I would think, Mr. Speaker, with investments at NIH to continue cancer research. They have kids that may need health care. They have kids that go to school. They may have a kid that wants to participate in a Head Start program. In each instance, Mr. ALTMIRE, our fearless leader in this 30-Something group tonight, these vets are fighting for what makes America great, and that is freedom, that is investment, that is a strong economy. Those are the kind of things we are investing in.

So to say your only priority is the war and spending what is now projected by the end of the year $1.3 trillion in the war. The President says, and a small group of recalcitrant Republicans say here in the House: We can't fund it because we don't have the money to put in the health care and everything else.

Mr. MEEK. Will the gentleman yield for a second? I know you're an appropriator and we are talking about appropriations. You and Mr. MURPHY are kind of throwing around these big words tonight. Let it be known that some of us in the room just want to break it down a little bit here in this Chamber.

I can't go back to my district and tell Ms. Johnson and Ms. Rodriguez or Ms. Jones who worked their entire lives that because the President decides to veto the Labor-Health bill, and I think it's important that we share this with the Members, we can't tell those individuals to suck it up. I am sorry that you weren't in the Defense bill. I am sorry that it had nothing to do with Iraq and Afghanistan, that we can't be for you.

One thing I can say here in this House is that we are for them and that we are standing for those individuals, and they are Republicans and they are Independents and they are Democrats and they are nonvoters and individuals thinking about voting for the first time. They are the sick and shut-in on that sick and shut-in list when people go to wherever they worship, or whatever the case may be. They are the individuals counting on this Congress to stand for them.

The Congress is doing what we are supposed to do, Mr. ALTMIRE. But the bottom line is that the President has to do what he has to do, and he has to be the President of the United States of America, not just to secure the issue in Iraq. We have Americans here right now that need our support and our help.

I am glad that we are here and I am glad that we are putting the pressure on the minority party to do the right thing on behalf of their constituents and the American people.

Mr. ALTMIRE.

Mr. ALTMIRE. Thanks to all my colleagues who participated tonight. Thanks, especially, Mr. Speaker for the time allotted to us. Please, to continue the discussion, anyone can go to www.speaker.gov and go to the 30-Something Working Group and we can continue this discussion by e-mail.

I thank the Speaker.

AMERICAN HEALTH CARE SYSTEM

The SPEAKER pro tempore. Under the Speaker's announced policy of January 18, 2007, the gentleman from Texas (Mr. BURGESS) is recognized for the remaining time until midnight as the designee of the minority leader.

Mr. BURGESS. I thank the Speaker. The hour is late, the time is short. I do want to talk a little bit about health care this evening. Maybe, Mr. Speaker, in order to clear the air from the last 40 minutes, let's start off with a Bible verse. Let's start off reading from the Old Testament from the book of Habakkuk, Chapter 2. ''I will stand upon my watch, and I will set me upon the tower, and I will watch to see what he will say to me, and what I shall answer. And the Lord answered, Write the vision, make it plain upon tables, that he may run that readeth it. For the vision is yet for an appointed time, but at the end it shall speak and not lie. Wait for

it, because it will surely come. It will not tarry.''

Mr. Speaker, I think those are important words. We are going to talk a little bit about the vision for health care, the future of health care in America. Sometimes we will have to wait for it, but it will come. It's a universal problem in this country. Some people think it has a universal solution; others disagree with that. But those two philosophies of health care, that that can be solved by the government or that that is better solved by individuals, those two competing philosophies are really going to be played out front and center over the next 18 to 24 months, both in this Congress and on the national stage in Presidential elections.

I may be oversimplifying the issue a little bit, but it underscores the basic arrangements. We sometimes appear to discuss health care only in the realm of insurance, government systems, third-party systems. In fact, Mr. Speaker, if you recall back in 1993, when the attempt was made with the Clinton health care plan, a lot of us who worked in health care at the time were perplexed, we were concerned because at the time the plan seemed to be less about health care and more about the transactions involving health care, that is, more about insurance than actual health care.

You know, back not too terribly long ago health care meant you called your doctor, you saw your doctor, you paid your doctor on the spot. Now, we have this convoluted system of third-party payers, government payers, private employee and self-pay. It's a complicated plan. It works. Hardly can be described as efficient. But it does work.

Mr. Speaker, we have got to ask ourselves: Is our goal in reforming health care, is our goal indeed in transforming health care to protect our patients or are we here to protect that third-party system of payment? Is our goal to provide Americans with a reasonable way to obtain health care, a reasonable way to communicate with their physician, with their doctor, with their nurse?

We really need to proceed carefully because the consequences of any poor choices we make over these next 18 to 24 months, the consequences of those poor choices will reverberate for decades. Not just in our lifetime, but in our children's lifetimes.

Mr. Speaker, I often stress that the fundamental unit of production of this great and grand American medical machine, the fundamental unit of production is the interaction that takes place between the doctor and the patient in the treatment room. It is that fundamental unit of production which we must protect, we must preserve, we must defend. Indeed, anything we do to try to transform or reform the health care system in this country, first off, we need to ask: Is it going to bring value to that fundamental unit of production of the American health care machine?

The test before us is do we protect people or do we protect the special interest groups. Do we protect big government or do we protect individuals? Do we believe in the supremacy of the State or do we believe in the sanctity of the individual? An educated consumer makes for a better health care system. We need to make health care reform about patients.

Let me just spend a little time talking about what are some of the predominant plans that we hear talked about, some of those placed forward by the Presidential candidates, something that we hear talked about on the other side of the aisle here in this House. It's often referred to as a single-payer system or universal health care coverage. It's got a nice ring to it. It's almost seductive. Why shouldn't the world's strongest and best economy, the world's strongest and best health care system provide free health care to all? Well, perhaps the words of P.J. O'Rourke penned back in 1993 in the Liberty Manifesto, when he stated, If you think health care is expensive now, wait and see what it costs when it's free.

Mr. Speaker, the American health care system has no shortage of critics at home or abroad. But, Mr. Speaker, it is the American health care system that stands at the forefront of innovation, the forefront of new technology. These are precisely the types of systemwide changes that are going to be necessary to efficiently and effectively provide care for Americans in the future. There's no way we can pay for all the care we are going to need to buy if we rely entirely on today's systems and solutions. There have to be new systems and solutions developed for the future, and they will deliver on that promise. The price will come down, but only if we give the system the freedom to act and develop those measures.

Now, the New York Times, not something that I normally read, but just a little over a year ago the New York Times, renowned for its liberal leanings, published October 5, 2006, an article by Tyler Cowan, who wrote at the time, ''When it comes to medical innovation, the United States is the world's leader.'' Continuing to quote, ''In the past 10 years, for instance, 12 Nobel prizes in medicine have gone to American-born scientists working in the United States, three have gone to foreign-born scientists working in the United States, and seven have gone to researchers outside of this country.'' He goes on to point out that five of the six most important medical innovations of the past 25 years have been developed within and because of the American system.

Now, Mr. Speaker, comparisons with other countries may be useful, but it is important to remember that the American system is always reinventing itself and it's always seeking improvement. It is precisely because of the tension inherent in this hybrid public-private system that creates that tension and creates that impetus for change. A system that is completely and fully funded by a payroll tax or some other policy has no reason to seek improvement. Its funding and its funding stream is going to be reliable and predictable, occurring day after day. There's no reason to try to improve a system like that. It's always in complete balance, complete equilibrium, and faces stagnation. But if there does become a need in such a system to balance payments or control costs, where is that going to come from? We have already seen from our experience within our own Medicare system that is going to come at the expense of the provider. It always has, it always will.

□ 2330

The difficulties faced by providers within the Medicare system on an ongoing basis are truly staggering.

Mr. Speaker, 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 because our experience is different from other countries, this difference should be acknowledged and embraced, maybe even celebrated. But certainly when reform, either public or private, is discussed in this country, we need to be cognizant of that difference.

That is one of the many reasons why a universal health care system, or a single payer system, translate that to ''the government,'' to me seems almost inadvisable, and certainly doesn't seem sustainable over time as an option. So let's think about some of the principles that really should be involved when we talk about changes and improvements to our health care system.

Three principles that I focus on, and I think really form the crux of the basis of all activities regarding health care reform or transformation of the health care system, are affordability, accountability and advancements. Three things fairly easy to remember, almost an iteration when you put them right together.

Under affordability, one of the things I think we oftentimes forget is what does it really cost to deliver the care? How do we assign those costs? How do we allocate those costs? The pricing for health care services really ought to be based on what is indicated by the market. But that isn't always the case. Oftentimes it is what is assumed by administrators, and consumers and even physicians are completely insulated, completely anesthetized as to what the care costs or what it costs to deliver the care.

Now, an article or an op-ed from the Wall Street Journal earlier this year by Robert Swerlick, a dermatologist from Emory University, the title of his column was ''Our Soviet Health System.'' He laments the difficulty in finding a pediatric endocrinologist, but in turn it seems so easy to find a veterinarian who specializes in orthopedics for his Labrador Retriever. So he can't

find a doctor for his child, but he has no trouble finding one for his canine acquaintance.

Now, the reason for that is the administrative pricing system that really is dictated by our Medicare system. And I think Dr. Swerlick really hits the nail on the head. He says, ''The roots of this problem lie in the use of an administrative pricing structure in medicine. The way prices are set in health care already distort the appropriate allocation of efforts and resources in health care today. Unfortunately,'' he goes on to say, ''many of the suggested reforms in our health care system, including various plans for universal care or universal insurance or a single-payer system that various policymakers espouse, rest on the same unsound foundations and will produce more of the same.''

He goes on to say, ''The essential problem is this: The pricing of medical care in this country is either directly or indirectly dictated by Medicare.'' We have a system of Federal price controls in medicine in this country.

Again, continuing to quote, ''Rather than independently calculate prices, private insurers in this country almost universally use Medicare prices as a framework to negotiate payments, generally setting payments for services as a percentage of the Medicare fee schedule.''

This is an extremely important point, Mr. Speaker, and one that I don't think Members of this body truly grasp. It is so important, we are going to revisit it again in a minute when we talk about Medicare pricing and what is happening in the physician realm. But remember that, because that is an extremely important point.

Medicare administrators set the prices. Private insurance companies in this country tend to follow suit. So when you say we have got a market-based economy in health care, really nothing could be further from the truth.

''And,'' as Dr. Swerlick goes on to say, ''unlike prices set on market conditions, the errors created are not self-correcting. Markets may not get the prices exactly correct all of the time, but they are capable of self-correction, a capacity that has yet to be demonstrated by administrative pricing.''

Again, he goes on to associate this with the system that was in place in the old Soviet Union, and in fact correctly relates some of the problems in the old Soviet economy to the reason the old Soviet Union is not with us any longer. So we really need to pay careful attention to that.

Transparency, I think that is something that we talk about a lot, but we don't spend nearly the time focusing on the issue as we should. Transparency between pricing for physicians and hospitals is essential. We want to go to a system where there is more consumer-directed health care, where consumers are more informed. But in order for consumers to be informed, they have to have the ability to go and get the data.

Right now, the opacity built into the pricing structure between physicians and hospitals is significant, and, as a consequence, it becomes very, very difficult for the patient, the health care consumer, to be able to make those determinations.

The other aspect that enters into it, of course, is the issue of physician quality. Sometimes that is an intangible. Sometimes that is something that is difficult to know just from visiting a Web site or checking data that may be available, and that may be the word of mouth type of information that is delivered from one patient to another. A wait time, for example, in one office that is much longer than in another office, you might be willing to pay a little bit more to wait a little bit less time, or you might be willing to wait a little bit more time if the care delivered in that office is truly exemplary.

Now, Texas has taken some steps to make this more of a reality. I think people would like the ability for comparison. In fact, they would like to be able to go on-line for that comparison. I think Travelocity For Health Care, wouldn't that be a powerful tool to put into people's hands.

An example in Texas is what is called Texas Price Point. There is a Web site, www.txpricepoint.org, which was created to provide basic demographic quality and charge information on Texas hospitals and to promote additional or ready access to consumer and hospital information and the appropriate interaction that could occur as a result of that.

The program is very new. The data sometimes is a little too sparse, but it is a program that will build on itself over time and one that will I think provide significant utility to patients in Texas. And I believe other States have other programs. I think Florida has a program that is up and running. These are going to be critical. Some insurance companies have developed their own programs, and that will provide a critical knowledge base for patients who are covered by those insurance companies.

One of the things that is going to affect affordability, even accessibility as far as physicians are concerned, is what I alluded to earlier with the Medicare pricing.

Mr. Speaker, we had reported to us from the Center for Medicare and Medicaid Services the first of this month, not even 2 weeks ago, that the proposed physician payment cuts for next year will be just a little bit over 10 percent for doctors across-the-board in this country. That is untenable. Doctors cannot be expected to sustain that type of reduction.

There is no telling what it does to a physician's ability to plan. A physician's office, after all, is a small business, and if they are going to be facing this type of price reduction, it is very difficult to plan. Do you hire a new nurse, do you purchase a new piece of equipment, do you take on a new partner, when year over year the Medicare system visits this type of travesty upon physicians? And this Congress, through both Republican majorities and now Democratic majorities, and Democratic majorities that preceded 1994, have refused to deal with this issue in a way that corrects it once and for all and gets us past the problem.

The difficulty is that year over year, the physician pricing is set by a formula called the sustainable growth rate formula, and year over year for the past 5 years and projected for 10 years into the future, every year there is a cut to physician reimbursement.

Now, you might say that doctors earn enough money and it is the Medicare system, so what harm is there in that? Let's go back for just a moment to Dr. Swerlick's article about administrative pricing.

''Again,'' he said, ''the essential problem is this. The pricing of medical care in this country is either directly or indirectly dictated by Medicare, and Medicare uses an administrative formula, the sustainable growth rate formula, which calculates appropriate prices based upon imperfect estimates and fudge factors. Rather than independently calculate prices, private insurers in this country almost universally use Medicare prices as a framework to negotiate payments, generally setting payments for services as a percentage of the Medicare fee structure.''

So, let's think about that, Mr. Speaker. What happens on January 1 if this House does not take some action to prevent that 10 percent reduction in physician payments? What happens on January 1 is all of those insurance contracts that peg to Medicare reimbursement rates, all of those are going to be reduced by a factor of about 10 percent, or in some cases a little bit more. If a plan pays 120 percent of Medicare and Medicare is reduced 10 percent, that plan will reduce a concomitant amount, which will be a little bit in excess of 10 percent for their pricing on their physician services.

Again, it has ripples and effects far beyond, far beyond what it would be affected just by the Medicare system. And it leads to a problem, it leads to a problem of what happens with the physician workforce.

Now, just a little over 2 years ago, when Alan Greenspan, the former Chairman of the Federal Reserve Board here in Washington, DC, was retiring and sort of made a tour around the Capitol, sort of a one last victory lap around the Capitol, and came and met with a group of us one morning, the question was inevitably asked, what do we do about Medicare? What do we do about the liabilities, the future liabilities in Medicare? How are we going to meet those obligations?

The chairman thought about it for a moment and then said, you know, I think when the time comes, Congress will take the action necessary and that the Medicare system will endure, will

be preserved. There may be some difficult choices and trade-offs that have to be made, but Congress at the correct time will make those choices.

He stopped for a moment and then went on to say, what concerns me more, is will there be anyone there to deliver the services when you require them?

And that really comes to the crux of the matter here. If we have a system within our Medicare reimbursement schedule for physicians where within the whole Medicare system itself, parts A, B, C and D, if only part B is affected by this, part A, which is the hospitals, they have a cost of living adjustment, part C, which is HMOs, they have a cost of living adjustment, part D, which is prescription drugs, they have a cost of living adjustment, if the only ones living under this onerous formula are the physicians, what happens over time?

Well, what happens is people will retire early, people will restrict their practices so they no longer see Medicare patients, physicians will restrict the procedures that they offer Medicare patients, perhaps preferring office procedures to surgical procedures that tend to be more labor intensive and time intensive.

It certainly has an effect on the law of supply and demand, if you will, as far as physician services are concerned within the Medicare system itself. For that reason, for that reason, it has a significantly pernicious effect on the physician workforce.

Remember, I started out this talk and I said we always want to focus on are we delivering value to that doctor-patient interaction in the treatment room? Well, I will submit if you don't have a doctor there for that doctor-patient interaction in the treatment room, it is impossible to deliver value of any sort, if you don't have the physician there in the first place.

So that is a critical part. A critical part of establishing and creating value for the patient is ensuring that there is indeed a capable and trained and caring physician there for that patient in the treatment room. And I worry that what we are providing for physician compensation within the Medicare system, which has ramifications throughout the entire private pay structure through the health care system, I do worry if that is a condition that can indeed be sustained.

Now, one of the other things that I think we oftentime lose sight of when we talk about affordability, we always talk about the number of uninsured that exist in this country. Sure enough, it is too big a number. The number varies, depending upon who you read.

But if we talk about the number today, we are probably going to talk about a number of around 47 million uninsured. And we always stop there and say, well, we have to do something about the 47 million who are uninsured, as if that was one homogenous population and one solution would work for everyone who is caught up in that category.

But the reality is, one of the large insurance companies in this country did a little investigating to see who makes up, who is involved in this population, this universe of people who are uninsured.

□ 2345

It turns out 10 percent are university students. If you say we have 47 or 48 million people uninsured, 10 percent of that is 4.8 million, nearly 5 million, are university students. Students who may arguably have health coverage available through their university or college. But even if they don't, this is a group of people that is pretty easy to insure. It is pretty inexpensive to insure.

So a solution for that group would be vastly different than some of the other groups identified. Twenty percent of that population is already eligible for Medicaid or the State Children's Health Insurance Program. Why States with outreach efforts have not identified those individuals, I don't know. Perhaps we ought to make it incumbent for States to do that work.

If we are providing Federal funds at all sorts of levels, maybe we ought to make it incumbent on States to do that outreach work so those individuals are enrolled in Federal programs to provide that. Again, think about it: 20 percent of 47 or 48 million people, that is almost 10 million people that could be taken off the rolls of the uninsured tomorrow because the programs already exist to take care of them. You don't need to create a new program or do something different from what you are doing right now. Current Medicaid, current SCHIP will cover 20 percent of that population.

And 20 percent earn almost $80,000 a year. That is not a huge sum of money, but certainly a group of people that might be considered to be able to provide something toward their own health care. I am not a fan of mandates. I don't think you get anywhere by telling people what they have to do. But if we allow insurance companies some freedom to create the types of programs that would be of value to that segment of the population, that would be affordable to that segment of the population, if we would perhaps remove some restrictions, maybe remove some mandates, or decide what are those things that are going to comprise a basic package of benefits so we can make it affordable and marketable to that group of individuals who arguably have some disposable income that they could use towards their health care rather than creating a huge, new Federal structure to bring them in. Maybe that is a tactic that could be taken.

Mr. Speaker, we don't like to focus a lot of time and energy on this, but we have to talk about it, and that is 20 percent of the people who fall into the category of the universe of uninsured people in this country are individuals who are in the country without the benefit of a Social Security number. Again, that is something that we as a country and we as a Congress do need to deal with. Whether that is increased efforts at controlling who is coming into our country and increased efforts at controlling our borders, but this is part of the problem that we as a Congress have yet to really face and deal with.

We made some efforts, to be sure, in the current State Children's Health Insurance Program. One of the recent legislative proposals that came through Congress and was passed by Congress that is still tied up in negotiations wanted to relax the verification required for someone being able to document or verify that they are in this country legally. I don't know. I think this body needs to decide what direction it wants to go on this. I don't know that is a terribly useful activity from my perspective. It might engender more people wanting to come into this country to get benefits, but that is something that this Congress has to take up and face no matter how difficult it is.

Mr. Speaker, we have talked about 10 percent university students, 20 percent already eligible for Medicaid or SCHIP, 20 percent who earn nearly $80,000 a year and 20 percent who are noncitizens. If we add those all together, that is approximately, 10, 20, 30, plus 5, so 35 million out of 47 million uninsured. We may have some solutions that are really just at our fingertips if we would expend a little bit of effort. And this is very frustrating to me. We never seem to want to do the effort to break down who is included in the population.

We are all too content to take the number 47 million uninsured and use it as a political bludgeon to beat each other over the head, but we are never willing to do the work that a private insurance company did in a relatively short period of time. We never seem to be willing to do the work. With all of our Federal agencies and bureaus that count numbers and people, we never seem to be able or willing to do the work to get this number, break it down into the smaller subsets, the smaller populations where, in fact, we may be able to provide some significant benefit.

Now, one of the things that I think we do need to talk about is on the aspect of accountability. First off, in any system that we talk about devising or implementing, we surely have to keep freedom of choice. We want to see the doctors we want to see when we want to see them. When hospitalization is required, freedom of choice has to remain central.

One of the things that oftentimes gets lost in the discussion when you look at the breakdown of how health care expenditures occurs in this country, approximately half is paid for by the Federal Government. When you look at the Medicare and Medicaid programs, we heard some discussion of the

HHS appropriations bill, $680 billion, almost $700 billion spent by this country every year by Medicaid and Medicare. Add to that the money spent in the veterans health service and add to that the money spent in the Indian health service and add to that the money spent in the Federal prison system, and you come pretty close to 50 cents out of every health care dollar that is spent in this country has its origin here on the floor of this Congress. So that is a pretty big chunk that comes from the Federal Government already.

The other half is not entirely private insurance, but certainly there is a large portion accounted by private or commercial insurance in this country. A portion, a portion is paid for by the patient out of their pocket.

I would include the growing number of people who are covered by health savings accounts in this group. Health savings accounts being a high-deductible insurance policy where a person is able to accumulate dollars, pre-tax dollars in a savings account dedicated to their health care. Those dollars are owned by the individual. They are dollars that would, if something happened to the individual, they would stay in the family. They don't go back to the Federal Government like Social Security. These are dollars that would stay around and be there to help your family. They would be there to help someone when they transition into the Medicare system.

Mr. Speaker, I had a medical savings account back in the 1990s when I was in the private practice of medicine back in Texas. I thought it was a great thing, not so much because of the money I was accumulating in this medical IRA. I thought it was a great thing because that was the time when HMOs were making big inroads into our medical practice in north Texas, and I liked the idea of being in charge of my health care decisions because I owned my own health insurance policy. As an individual policy, I felt I had much more power over what decisions were made for my health care and my family's health care.

So the whole concept of ownership, owning that medical IRA and being allowed to accumulate those savings to offset future medical expenses, that is a fundamental desire of many Americans. And I think that is a desire that should be encouraged and embellished. Why not be able to accumulate a few dollars dedicated toward your future health care needs? That is a pretty powerful tool to put into people's hands.

Again, for me the issue was being able to be in charge of my own health care, that individual freedom that comes with increased sovereignty. That was critical for me when I went out and looked for a medical savings account when they were first offered back in 1996 or 1997.

Certainly, Mr. Speaker, whenever we talk about accountability within the health care system, independence of the patient, the patient as an independent agent is something that must be preserved. That preservation of autonomy for the patient or the patient's designee if a medical power of attorney is exercised, but that is who should be responsible for the care, to be able to accept care, to be able to decline care if a particular medical intervention is either sought or someone wishes to not participate in the medical intervention that is offered. That is a fundamental right that we really should not take away from people.

Advancements within the system. Again, the science of our medicine here in the United States is superior to that anywhere else in the world. You might say that our system of allocation or delivery system needs work, but no one can argue about the science that is present in the medical system in this country.

So, high standards. We want to keep those high standards. The underpinnings of the American medical system has always been that we have high standards and we enforce standards of excellence, and nothing in the future should change that or undermine that. In fact, pathways to facilitate future growth in excellence should be encouraged.

When you talk about expanding the role of the Federal Government in health care, you look at some other places where the Federal Government has a really big footprint, like our Social Security system, or the IRS. Are those systems administered with the highest standard? Or is it lowest common denominator? That is certainly a question worth asking before we increase that segment that is taken over by the Federal Government.

As far as innovative approaches, American medicine has always been characterized by embracing innovation, developing new technologies and treatments. The transformational times we have had in medicine in the last century, development of anesthesia and blood banking in the 1910–1920 time frame, development of large-scale production of antibiotics and anti-inflammatory agents in the 1940s, the development of antipsychotic and antidepressant medications in the 1960s, development of newer hypertensive agents in the 1960s, the beginning of the development of medicines or the recognition that elevated cholesterol levels could lead to disease, and the beginning of medicines that would begin to impact that in the 1960s, all of those transformational events. And during those same times, in the 1910 to 1920 time frame, you had a congressional investigation or commission to investigate the vast discrepancy between curricula in medical schools in one part of the country versus another, and the standardization of medical school curricula which was so critical for establishing that knowledge base of science that was going to carry us forward through the last century.

In the 1940s, you are the introduction of employer-based insurance because of a reaction to wage and price controls that were in existence in the 1940s. And finally in the 1960s, you had the interjection of Medicare and Medicaid, for the first time the Federal Government having a big footprint in paying for health care.

So all of those transformational times were where the science changed rapidly and the public policy changed rapidly. I think we are on the cusp of such a time right now. Things are going to be changing in the realm of the whole arena of personalized medicine. The threshold of that stretches just before us.

The whole concept of far earlier prevention than anyone has thought possible. We have all heard that an ounce of prevention is worth a pound of cure. Well, we are going to get to use those ounces of prevention because of the studies and work that has gone on with studying the human genome and the whole phenomenon of genomic medicine. We are going to be able to get that ounce of prevention administered so much earlier. So we will get the equity from that pound of cure in so many ways that really we can't even fathom them at this point.

What is critical is that this Congress not get caught up in the transactional, not always get caught up in the insurance and the Medicaid and the Medicare. Don't be so caught up in the transactional that you block the transformational because that is the real tragedy. That is the real difficulty. That is the real danger to the generations for a decade from now, two decades from now, three decades from now.

That is why this Congress needs to be so focused on this issue. That is why all of us on both sides of the aisle need to make ourselves students of health care policy. We need to find out as much as we possibly can about it. We need to come to this floor every day and every night prepared to debate this on the merits and science. Leave the politics on the side. This is one of those issues that is too important to leave to politics.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. SESSIONS (at the request of Mr. BOEHNER) for today on account of personal reasons.

Mr. WELLER of Illinois (at the request of Mr. BOEHNER) for today and the balance of the week on account of a death in the family.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Members (at the request of Ms. WOOLSEY) to revise and extend their remarks and include extraneous material:)