I mean it's been 2,399 days, Madam Speaker, since the September 11 attacks, 2,399 days, and Osama bin Laden still remains free. We have gone backwards in Afghanistan since we left and shifted our focus.

In July of 2007, a de-classified version of a National Intelligence Estimate on the terrorist threat to the U.S. homeland concluded that al Qaeda in Afghanistan and the border area with Pakistan has regained its strength over the last few years and has now reached the strength it had before 9/11.

We have put ourselves in jeopardy. The administration and this President talks about the war on terror, the supposed war on terror, and how committed we are to it and how we have to fight terror in every corner of the world. Well, it is incredibly disturbing that a National Intelligence Estimate, not a progressive think tank and not the critics of the administration but our own National Intelligence Estimate on the terrorist threat to the U.S. homeland, concluded that al Qaeda in Afghanistan has reached its strength that it had before 9/11. The Director of National Intelligence, Mike McConnell, testified in February that Afghanistan's President Hamid Karzai and his government control just one-third of the country now, Madam Speaker. The remaining majority is under control of either the Taliban or local tribes.

We have got to make sure that we refocus our energy and our effort on the priorities of the American people. I know our Democratic leadership, under the leadership of our Speaker, NANCY PELOSI, is focused and determined to move an agenda that is going to improve this Nation's economy. The economic stimulus package that she was able to negotiate with Leader BOEHNER to try to inject some stimulus into this economy, checks that are going to be coming to Americans very, very soon, those are the kinds of efforts and energy that we need to be putting in to deal with the crisis situation that Americans are facing. Not continue to insist, as the administration does, that they are right and we are wrong. Not continue to say that we need to keep the same troop strength that we have where we made absolutely no progress between now and before the surge. Basically it's almost as if we have run in place. It's just incredibly frustrating.

So, Madam Speaker, I'm going to end where I began. And that is to say, the toll that this war has taken on the individual troops who are fighting in Iraq and Afghanistan, on their families, on Americans, where our administration's priorities are not focused on what they should be, which should be improving our economy and making sure that we can reduce the deficit and get our fiscal house in order and make sure that Americans have access to health care and aren't having their homes foreclosed on and the skyrocketing cost of housing, and the list just goes on and on. But at the same time, we're taking care of the needs of the people in Iraq. They have a budget surplus. Their housing needs are being taken care of. Their children's schooling is being taken care of. Yet we still have the same 140,000 troops that the administration has committed to leaving in Iraq, as opposed to trying to bring these troops home and end this hopeless war that has not made progress. And at the end of the day, as Mr. RYAN stated, we need to ensure that the Iraqi troops can stand on their own and that they don't believe for generations to come that we are going to carry them throughout history. At some point we have to let them go and stand on their own, and we have reached that time.

With that, Madam Speaker, we appreciate the opportunity in the 30–Something Working Group that the Speaker has given us to talk about the issues that are important to the American people and to our generation and from our generation's perspectives. We hope that the people who have heard this presentation tonight will go to the Speaker's Web site and click on the 30–Something Working Group address. The charts that we have shown tonight are on that Web site, and they can feel free to e-mail us and contact us with any questions they have.

HEALTH CARE

The SPEAKER pro tempore. Under the Speaker's announced policy of January 18, 2007, the gentleman from Texas (Mr. BURGESS) is recognized for 60 minutes.

Mr. BURGESS. Madam Speaker, I come to the floor tonight to do what I often do, spend a little time talking about health care. The hour spent in this way, I think, delivers for the Speaker and other Members of the House perhaps perspectives on health care that you wouldn't hear in any other location. I've heard the hour that I spend down here talking about health care referred to as the ''House call.'' So perhaps that's a good way to look at it.

Madam Speaker, we have got a big job ahead of us here in this Congress and the next Congress. We are going to be talking about health care from all sorts of different perspectives. And really where we ought to be focusing our efforts, where we really ought to be channeling our efforts is delivering better care at a lower cost. And you know what? The good news is there are some examples out there in the real world. There are some examples in the real world that this House can embrace and expand upon and maybe accomplish this thing that we all want to accomplish, which is delivering more care to more people in our country at a better price. But we don't need to do it at the sacrifice of freedom because freedom is the foundation of life here in America. Without our liberty, we aren't America. So unlimited options, the unlimited opportunity that people have in this country, that's what makes this country great.

I always feel a little inadequate when I go into Starbucks because all I can do is order a cup of coffee. But other people go into Starbucks and are able to order from a wide variety of menu options. Who would have believed, when I was growing up, that there can be 57 different ways to spend your money in a coffee shop all to purchase a cup of coffee?

□ 2145

Madam Speaker, innovation goes hand in hand with the ability to make choices. The combinations that are available for all of us to choose from have, in fact, engendered that market, and the young folks of today wouldn't have it any other way. And I think that is exactly as it should be. The same kind of options, the same kind of inventive technology and the same kind of innovation should be what makes health care great, as well.

And, Madam Speaker, when it comes to innovation in health care, the United States is the world's leader in health care. Now in October of 2006, in the New York Times, no less, and please don't tell anyone back in my district that I read the New York Times, but in October of 2006 in the New York Times a piece by Tyler Cowen talked about just that issue. He talked about how 17 of the last 25 Nobel prizes in medicine have been awarded to American scientists. He talked about four of the six most significant breakthroughs in the last 25 years having been developed in the United States of America, things like the CAT scan, things like neuro treatments for hypertension, statins to lower cholesterol, coronary artery bypass surgery, all the product of the inventive American mind. And, as we all know, American scientists are not done with advances in medicine. And we are now counting on the next generation of doctors and scientists, a whole new generation, to produce whole new generations of breakthroughs, things like single gene therapy, advancements in protein science, and the incredible revolution in the way information is transmitted and handled. All of that is on the threshold. All of that is just over the horizon and going to have a significant impact on the delivery of health care in this country.

And these breakthroughs occurred because there was an environment that encouraged innovation, an environment that embraced innovation, and yes, an environment that sometimes tolerated a little bit of chaos because that, after all, drove some of that creative energy. And this environment is better known as a competitive environment and one based on individual choice. Innovation and choice are the hallmarks of our health care system. But it doesn't mean that we can't make a good thing better.

Now, Madam Speaker, as someone who has spent 25 years in the practice of medicine, I do believe I have a unique perspective on some of the issues that face our Nation's physician workforce, and certainly some of the

issues that face those of us in the House of Representatives here up on Capitol Hill. But I do have the unique perspective having lived in both worlds. I have had the pleasure, the opportunity and the high honor of sitting in an examination room and talking with a patient, being in the operating room or the emergency room or the delivery room with a patient. I have filed claims. I have filed claims with private insurance companies, Medicare and Medicaid, and dealt with the almost impossible bureaucratic nightmare that those claims have become, and also discovered that with the advent of electronic submissions for claims, some clever individuals delivered about 1,300 different codes for denying those claims.

I figured out how to build my business, sometimes in an environment that was quite hostile to small business. I figured out how to pay my employees, how to keep the lights on, how to provide health insurance for my employees. Sometimes I have the burden of being the only one in my committee, the Committee on Energy and Commerce, the Health Subcommittee, the only one who has had experience with the practice of medicine, the only one who has ever picked up a pen, written a prescription, looked a patient in the eye, counseled them for risks and benefits and costs, a significant burden to carry as we go through bills like the FDA Reauthorization bill that we went through this summer.

I have also had the benefit of some very good advisors along the way, some of my professors in Medical School, Jack Pritchard, who was the head of my residency program at Parkland Hospital, and my own mother, who told me, ''don't you ever let your office put me on hold on that telephone again. And further,'' she went on to say, ''don't let me ever hear that you refused to take a Medicare patient.'' And she never did have to hear that.

But what does this experience give me? Practical knowledge is absolutely critical when you delve into trying to craft the best public policy. And this practical experience is invaluable, especially in an environment that is as rapidly changing as our health care system and the focus of so many across the country.

Now, there is widespread recognition that there is some change in the air. You can scarcely turn on the television at night and not hear the word ''change'' mentioned over and over again. In fact, I told an audience of doctors the other day that I haven't heard the word ''change'' so many times since I was an intern in the newborn nursery at Parkland Hospital. There is a widespread recognition that change is coming in health care. There are a lot of different ideas on how to accomplish it. Presidential candidates have their ideas. A lot of Members of Congress have their ideas. And somehow we are all going to have to come together with these ideas to try to get the best policy going forward.

Now one of the things that has become absolutely apparent to me as I have spent a good deal of time studying this issue is that health care, not disease, but health care, the administration of health care, begins and ends with those who actually deliver the care. That means those that actually deliver the care, the doctors, the nurses, the technicians, really are the ones who should be on the front-lines leading that transformation in health care. A lot of health care professionals don't realize the critical role that they can play and, in fact, they must play in shaping the health care debate. If the professionals who work in health care, if the doctors and nurses are not active and engaged, they are going to be forced to play by the rules that someone in this House will set for them, someone in this House who may not have a clue as to what goes on in the day-to-day practice or administration of medicine.

So every chance I have, I meet with doctors, nurses, physical therapists, technicians, either here in Washington or my district back in Texas, listen to them about what their concerns are, try to understand the problems that they are having, problems that may have changed in the few short years since I left the clinics, and try to talk to them about how to not just complain about the problems of today, but how to craft the solutions of tomorrow and how to effectively communicate that to those who are policy makers, whether it be in a Federal agency or here in a legislative body. I am firmly convinced that if our health care professionals don't lead, we are going to have to accept the prescription given to us by those in the Federal agencies and those that may be sitting in the legislature this year, next year or the year after.

Now there is no sane person who would try to conduct their own operation. Most doctors, if they have controlling sense, wouldn't try to prepare their own income tax form. Doctors and nurses, health care professionals, need to be the ones to lead this change. And I will tell you something that just makes me stop dead in my tracks is when I hear people talk about a single payer government run system. It scares me to death. Now you stop and think, where is the largest single payer government health care system in the world? And it is here in the United States. It is our Medicare and Medicaid program. This body, the United States House of Representatives, currently controls about 50 cents out of every dollar that is spent in health care in this country, and that is an enormous amount that is spent on health care, 15, 16, 17 percent of our gross domestic product, upwards of $2 trillion a year, 50 percent of that originates on the floor of this House of Representatives. So government already controls 50 percent of the market. When people talk about expanding that role, I have to stop and ask myself, well, are we doing a good job with what we are already controlling? And I don't think there is anyone who would stand up and say, yes, you are doing such a good job, we want to turn more of it over to you.

But government can play a role by encouraging coverage and helping create programs that people actually want and empowering them to choose between options. And really, we just have to go back a year or 2 or 3 to look at the experience with the part D part of the Medicare program signed into law late in 2003. The prescription benefit became available in January 2006, and now we are coming into the beginning of our third year of experience with that program. And sure, there were some bugs early on. But if you look at some of the numbers now, and probably 90 percent of eligible seniors now have some type of health care coverage, which is an incredible change from when I took office in 2003. Eighty percent are happy with the program. Well, those are numbers that I will just tell you controlling practitioner would love to have.

When we crafted that program, the smart people over at the Center for Medicaid and Medicare Services put their sharpest pencils to the program and said, okay, here it is. We can devise a program that will provide coverage for seniors for $37 a month in premiums.

Well, now the average plan costs $24 a month. So what happened on the way to that $37 a month premium? Well, I will tell you what happened. The plans were opened up for competition and bidding. And guess what? The private sector found they could do things a little cheaper, faster and safer than those in the Federal agency. And I say more power to them. They have crafted different plans. Not everyone needs the same prescription drug plan. There is the ability to buy a prescription drug plan and change it once a year if your coverage needs change. It is a phenomenal tool to put at the hands of our seniors who are covered under Medicare.

Again, who is going to argue with something that delivers more health care, lower cost and better quality? It is just too simple to argue with. That is the type of program on which we need to be focused. But you hear so many people talking about, well, people won't do the right thing if you leave them to their own devices. You have to put a mandate on it. You have to put an individual mandate, or we have to put a State mandate, or we will have to put an employer mandate where we require people to take up this coverage; as opposed to creating programs that people actually want, pricing them in a reasonable range, making them available, and helping people understand the wisdom of taking up that coverage.

There are a variety of studies that have been done on mandates. Most recently there was one in Health Affairs

in November of 2007 looking at the experience and the history with mandates. I think the title of the article was ''Consider It Done'' because it was the opinion of the article that mandates would just simply have to be the next step.

But in this country, we have 50 percent of people with no health insurance and a voluntary program. Well, you say, we could do better with mandates, couldn't we? Well, for mandates to work, you have to have, of course, a widespread dissemination of knowledge that the mandate is required. You have to have widespread dissemination of the knowledge of the penalty for not taking up the good, service or product that has been mandated, and you have got to have a pretty strict enforcement mechanism, and people have to be aware that that enforcement is going to be swift, sure, and it is going to be painful when it happens. Well, where in real life in America today is there such a system? Hey, we are coming up on April 15. How about the Internal Revenue Service, for example? With the Internal Revenue Service, there is broad understanding throughout the population that you have to pay your taxes. There is a broad understanding of what will happen to you if you don't pay your taxes. Now there may be nuances, fine nuances to the Federal law, whether it is prison term or a fine, but people do understand there are a plethora of unpleasant circumstances for those who don't pay their taxes.

And what is the take-up rate, if you will, on this generous offer from the Internal Revenue Service? Well, it is about 85 percent. You have about 15 percent of people who don't comply, even with those relatively draconian and well-known practices within the IRS if you don't comply. So it does beg the question, if we simply go up there and say, you have to buy an individual insurance policy or there are going to be consequences to that behavior which will cost you, how do we know we are going to get up-take greater than the 85 percent up-take that we have today? And indeed, some of the experience early on with some of the States who have experimented with this have found that some people look at the cost of the insurance, and since it is now required, guess what? The cost went up because it is no longer a free market where you have a willing seller and a willing buyer. You have a buyer who is being coerced to buy that product, so the price goes up. And so some people look at that and say, that is pretty costly, I will just pay the fine, thank you very much. So then we are in a very difficult situation. We have someone paying a fine for not carrying health insurance. And if they get sick on top of it, then they are still a burden on the hospital, doctor, the State, whoever has to pick up the cost for that hospitalization.

So I would just urge my colleagues to be circumspect, to be careful when we talk about mandates and also look to the experience we had with Medicare part D where then a program was created that didn't exist before, and it was created in such a way as to put something out there that people actually wanted, put something out there that people actually saw as adding value to their health care coverage, put something up there that would be useful to people.

□ 2200

Not simply putting a requirement out there, a penalty if you don't comply, and then people are constantly gauging, well, would it be better just to pay the penalty and not comply and not have the more expensive health insurance, which I, after all, don't need, because I will never get sick.

So the part D program provides us a model that we could use when we are trying to see about developing those types of programs. And in a few minutes, let me cover with you some of the other models, some of the experience that has recently been gathered from the private sector, because I think that is useful to instruct, that is useful to inform this debate as well.

But the experience of part D in Medicare showed us that sometimes the best thing that government can do for health care is just simply get out of the way and let people, providers, third-party payers, work this out between themselves. If we create the right conditions, the right environment, the right set of circumstances and let the private sector develop the innovation, sometimes the cost savings can be substantial, the quality can be increased. And, after all, isn't that what we want, more care, better quality, lower cost? Who can be against those three things?

Now, Madam Speaker, I can remember a time when I was growing up that you could only have one kind of telephone. It was black, it was tethered to the wall and had a rotary dial. Over 10 or 15 or 20 years time we saw some technical innovation. It was still black, it was still tethered to the wall, but it had push buttons instead of a rotary dial.

Then came deregulation. Then came many phone companies that were able to compete on the open market, compete for the individual phone user's business. And the story tells itself, because nowadays you have cell phones on every belt buckle and hip pocket. You have text messages. You have a whole generation of young people who know how to text better than they know how to communicate with the king's English.

So change has come to this industry, not because the government said it would be a good idea for everyone to have a cell phone on their belt buckle or a cell phone in their hip pocket. It came about because industry, the private sector, was allowed to innovate, it was allowed to experiment, it was allowed to sometimes fail, and produce these products that people actually wanted and that deliver value, real value, to people's lives.

Many, many years ago I got a pilot's license. A lot of people learned to fly in a Piper Cub. The Piper Cub is truly a marvel of engineering science. But would anyone argue that the 737, the 787 that is new this year, would anyone argue that that is not a better way to move large numbers of people from one end of the country to another, rather than having each of us fly our own individual Piper Cub?

You know, you can't help but when you have this kind of discussion recognize that the invention of the Internet really changed a lot of things. Of course, now we have the Internet, we have e-mail, we have Web sites, we have YouTube, all of which were absolutely unimaginable as short as 20 years ago.

Here is the secret. Here is the secret to that success. The private sector, with its ability to tolerate innovation, with its ability to tolerate risk and reward, its ability to tolerate a little bit of experimentation, and, again, a little bit of chaos, can deliver that kind of value. I have personally experienced this in my years practicing medicine, and I have learned more about it since I have come here and worked legislatively.

Last fall, last November, I believe, there was a big health care symposium put on downtown by the periodical Health Affairs, and the morning panel was going to be four smart people. But one of them was a CEO of a large insurance company, an insurance company, quite honestly, that I had some trouble with when I was a practicing physician. So I thought, well, I want to go hear what Dr. McClellan has to say. I want to hear what Dr. Sarhuni from the National Institutes of Health has to say. But I will probably go for coffee when this CEO gets up to talk. But the CEO gave the most important part of the talk that morning.

This particular individual talked about running his large insurance company. He talked about his 45,000 employees, 15 percent of whom were devoted to the development of information technology. If that 15 percent had been a stand-alone software company, they would have been one of the largest in the United States of America.

Well, that is a pretty powerful notion. I stopped and did a little quick mental calculation of my own and I thought about my five or six physician practice back in Louisville, Texas. We were faced with the specter of Y2K and I had to upgrade my ancient and ailing computer system, and although at the time I thought it cost an incredible amount to do that, just doing a quick back-of-the-envelope calculation, I spent about .015 percent of my annual budget on information technology. So was it any wonder that that particular insurance company could run rings around a small practice when it came to the managing, the flow of information, the speed with which they could process information?

I was very intrigued by the fact that this individual said we have learned a lot about the progress of disease and the course of disease, not by studying clinical data, but by simply analyzing the financial data available to us within our information technology system. For example, if we see A and B, we are very likely going to see C, and of those patients who have C, some are going to go on to D, and D costs a lot of money. So we are far better off intervening at A or B and not having to buy as many Ds as we might otherwise have to buy.

He gave the example, and, of course, my practice was not in taking care of heart disease, but he gave the example of a middle-aged individual suffering a myocardial infarction or heart attack. He said we know from studying our data that this individual is very likely to suffer about a bout of significant depression somewhere along the line in their recovery, and in fact that bout of depression may be so significant that it precludes that individual complying with their exercise program, their cardiorehabilitative program, and very likely puts them at risk for a second cardiac event, or perhaps even consigning them to congestive heart failure in the future, which is terribly expensive to treat within and out of the hospital and lots of expensive medications.

So he found that by intervening early on with an aggressive assessment for depression, an aggressive treatment for depression, that they were in fact able to get better compliance in their rehabilitation, and ultimately lowered their cost at the out end because of this very aggressive management program that they had developed.

Again, that is all done with financial data. They were just beginning to be able to incorporate clinical data. They have got some problems with that because of some of the constraints, regulatory constraints that we here in Congress have put on them. But, nevertheless, it told a great story about the types of things that can be done in managing information in this brave new world, where so much information is available and so much can be assembled and analyzed at a very rapid rate. We are coming up on a period of rapid learning unlike anything ever seen before in any branch of science, and certainly medicine is not going to be any stranger to that.

When I was in training in the 1970s, when I was in practice in the 1980s and 1990s and early 2000s, it was very difficult to encounter a patient late in pregnancy with an elevated blood pressure. You never knew whether this was going to go on to a much more serious condition or whether in fact this was simply a transient problem that would be self-limited and of no consequence, and you had to treat them all as if they were the most serious consequences, sometimes even requiring hospitalization for a period of observation until things got squared away.

There are tests that are just around the corner that will analyze for a couple of things in the bloodstream that have a very high predictive value as to whether or not someone will develop a condition called preeclampsia over the next 14 days. What a tremendously powerful tool to put in the hands of clinicians. And how many dollars is that going to save? It may well be an expensive test when it first comes out, but how many dollars is it going to save for unnecessary hospitalizations?

Sometimes we would have to take someone off from work, not knowing whether they had a more serious disease or whether this was going to be a benign self-limited event. But you just couldn't take a chance. You just couldn't take that risk of not counseling that patient to behave as if this was going to be the more serious of the two conditions. How great it will be for the next generation of doctors who practice my specialty of obstetrics to be able to have that test at their disposal so they can adequately counsel their patients, recommend to their patients the correct treatment course for them, and, in the process, not overtreat a large group of patients, and, very importantly, not undertreat a much smaller but potentially much more lethal condition in a smaller group of patients.

Yesterday up here on the Hill I was very fortunate to be able to host a panel with several speakers that included the former Speaker of our House, Newt Gingrich, who came up on the Hill to talk about change in health care reform and transformation in health care.

Everyone knows that former Speaker Gingrich is a real leader when it comes to health care transformation. In fact, he has made that now his life's work here in Washington. We are certainly grateful for, first off, for his service in the House, but we are very grateful that he has devoted his enthusiasm, his considerable energy, his considerable ability to generate new ideas and to recognize great ideas when they are presented to him. We are very fortunate to have his expertise in Washington. So it was really a great experience to have him involved in this panel yesterday.

Several companies came in. The whole premise of the seminar, the whole premise of the series, was, just as I started out this talk, better health, lower cost, examples from the real world. These were four individuals that came in and talked to us about real world experience and how they have been able to deliver their product, health care, in a more timely fashion, better quality, lower cost.

Let me share with you some of what I learned. It was a very action-packed hour-and-a-half that we had yesterday. But let me share with you just a little bit of what I have learned with talking to some of those innovative medical leaders.

One of the central themes that kept repeating itself over and over again was the issue of personal responsibility. It is important to have someone invested in the concept that it is a good idea to take care of their own health and to be personally invested in their own health care, and a lot of the discussion came around to a concept that is popularly called consumer-driven health care. We have talked about that a lot up here on the Hill.

The fact is that because of our third-payer system, so many people are actually anesthetized to the true cost of their health care. All they want to know is can they see the doctor when they need to, how big is the copay, and if I need an expensive test, well, is it covered by insurance? If is not, I don't want it. If it is, I will take two.

Now, my own staff tells me that when they receive an explanation of benefits, that little form, that little EOB form that you get from your insurance company after you have a medical event or an intersection with the health care system, whether it be doctor or hospital, most people take that explanation of benefits, it says on it ''this is not a bill,'' so what happens to it? It goes straight into the trash. They never look at it. They never try to assess what is or is not on it. So they are consuming the health care service, but not really are conscious as to the cost. As a consequence, there is little or no incentive for anyone to take any proactive stance on the health care that is delivered to them, the health care that is offered to them. There is very little incentive for someone to actually take an active role in that.

There is an old saying from P.J. O'Rourke, if you think health care is expensive now, just wait until it is free, and that is the concept. If it doesn't cost anything, then, again, yes, nothing but the best will do, and let's be sure we have plenty of it, and don't be too long about getting it to me.

In a consumer-driven health care system, people would be more conscious of their health care cost, more conscientious, and more likely to make wiser decisions about lifestyle choices, about things that they might do to alter a lifestyle choice, to be able to maintain their health.

There was a study take that was talked about yesterday that found that in one hospital group, the patients who were in a consumer-directed health care plan were twice as likely as patients in traditional plans to ask about the cost, and three times as likely to choose a less expensive treatment option. And this is just not for young healthy patients. Patients with chronic conditions, chronic disease states, were 20 percent more likely to follow the treatment regimen recommended to them, to follow that regimen much more carefully.

Now, there is no shortage of critics of consumer-directed health care up here on the Hill. People will argue that it will cause patients, consumers, perhaps those less wealthy, perhaps those less educated, to avoid needed and appropriate health care because of the cost

burden and the inability to make informed appropriate choices.

One of the companies yesterday that discussed this at the panel has data that they say directly contradicts that criticism. And I don't doubt that that is correct, because back in the late 1990s a comparison was done with a country that had a large component of what were then called medical savings accounts or consumer-directed health care, in contrast to the United States, which at that time had no high deductible consumer-directed health care options, no MSA options, and that was in a lead-up to the beginning of the MSA era in 1996 or 1997.

□ 2215

Experience with that country that had about a 50/50 mix of consumer directed plans and what might be called standard indemnity plans found that there was no dialing back on needed services. There was no pulling back on services that were critical for the maintenance of a person's health, but more optional types of treatments perhaps, were the ones that had a lower uptake.

Now, a Midwestern health care company introduced consumer-driven health care plans to its 8,600 employees. They also left their traditional PPO plan in place.

In the first year, 79 percent of their employees chose one of the four consumer-directed health care options. These health plans had several important features.

Preventive care is free. Now, what a concept. That means that the annual visit to the doctor, required screening exams, don't cost money. They are provided for you free of charge.

Employees also receive financial incentives to change behaviors like smoking or those who need to lose weight. They also receive financial incentives to manage chronic conditions like asthma and diabetes more carefully and become active participants in the management of their disease.

The results so far have shown that they had 7 percent of health care dollars spent on prevention compared to a national average that was about a third of that.

Nearly 40 percent of employees take an annual personal health risk assessment and earn $100 for their trouble. But a 40 percent uptake on an annual health risk assessment is a significant number. Five hundred employees have quit smoking, their employees have lost a total of 13,000 pounds through their weight management programs with appropriate monitoring, 13,000 pounds. Talk about your biggest loser or your biggest winner, clearly, that's a program that is paying off.

Now, the average claim increase of 5½ or 5.1 percent the last 2 years is compared to a national trend of over 8 percent, so there has been a 3 percent savings on the average claim. The company has, again, collected an impressive amount of data, and we could learn from their example, from their experience.

There are some other companies we can learn from as well. There was another very large health insurance company that was on the panel. Then, again, it was a health insurance company with which I used to have some differences, but they described their incentive-based benefit design. They provide or have available to their employees one of the high deductible plans. A high deductible plan with a large deductible is going to cost less than a plan with a lower deductible.

They offer a plan with a high deductible. But without an increase in premium, the individuals, the families can lower that deductible to $1,000 by changing things like weight, smoking, serial cholesterol measurements complying with annual screening exams.

A $5,000 deductible at a lower policy rate then becomes a $1,000 deductible at the same rate. It's a significant cost savings for that patient or that family, that employee, where they get the benefits of a very high deductible plan but the deductible comes to them in a much more manageable size.

We also heard about some of the very positive results driven by consumer-driven health plan options. Now, the speaker who talked about that actually took me back a little bit, because I do remember back 1976 and 1977 the MSAs first became available. They were called the Archer Medical Savings Account after Bill Archer, chairman of the Ways and Means Committee from this body who had worked so hard on that over the years.

Phil Gramm, then a Senator from Texas over on the other side of the rotunda, had worked on that on the Senate side. As part of a large bill that was passed to increase insurance portability, they got a demonstration project, a pilot project that was going to allow 750,000 so-called high deductible policies or medical savings accounts to be sold. I heard about that, and I thought I don't know if I can sign up quickly enough to be in that first 750,000.

But the reality was I needn't have worried. There were so many restrictions placed on that insurance that the uptake was, in fact, probably only one-tenth of what were available.

There weren't many insurance companies that offered it. The premiums had to be paid for with after-tax dollars. Many of the things that we now think of as being associated with a health savings account just weren't available back in those early years.

But, still, although the amount that you could put away in a medical IRA or a medical savings account wasn't nearly as large as what you could do today, still, it was a significant amount of money. I purchased one of those myself back in 1976 or 1977, keeping it until I started service here in the House of Representatives, where at that time it wasn't available.

But that chunk of dollars has sat there, and with the time value of money, earning interest, compound interest, the miracle of compound interest, year over year now is a sizeable sum of money that is available to my wife and I for health care needs. Whether it be pre-Medicare or post-Medicare age, that money is still going to be available to us as additional cash that can be spent on health problems.

The doctor that talked to us about the nuances of the newer health savings account talked about how in his experience 88 percent, that's nearly nine out of ten account holders, carried a balance from 2006 to 2007. The actual percentage of people who either did not contribute or used up all the money that they had contributed to their medical IRA or their health savings account was only about one in 10, and the average balance for people across all income levels was $597 at the end of that carryover from year to year.

Now, you have to ask yourself how many Americans, how many families are encouraged to live a healthier life, conserve their health care dollars, like these individuals have done. These guys are making personal decisions about prevention, they are making personal decisions about life-style changes, they are managing chronic conditions, actively engaged in the management of those chronic conditions. As a consequence of those behaviors, they are holding down costs.

Now, most other populations with regular private indemnity insurance are not. The key is bringing about the necessary change to effect that transition from an individual who is really indifferent as to the cost of the expenditure on health care to one that is actively managing the cost of their health care.

But there are other tools we can put in the hands of people. We hear people talk about transparency. I have, in fact, introduced legislation dealing with transparency.

We have got some good things going on back home in my home State of Texas as far as some of the web-based transparency information and data that's out there as far as hospitals are concerned. The Centers for Medicare & Medicaid Services has, in fact, published their own data up on the web.

So as more and more information is gathered, patients, individuals, can have access to greater and greater amounts of information detailing what is available to them as far as what if the difference between one hospital and another is substantial as far as the cost of rendering a particular service, regardless of what it is. But the ability to go on the Internet and be able to compare the cost of those two services, that's a tremendous tool to put into someone's hands.

If you can further refine that to allow an individual to put in information about their particular health insurance or their health plan, or if they are a self-pay, to make that information available, to then go on and compare between the institutions, where

would their best benefit be derived? Where can they most adequately get the type of care that they want and, of course, there does have to be quality data published alongside that.

It can't just simply be the cheapest care at the cheapest cost. You want the best care at the most reasonable cost, or, as Dr. McClellan, former administrator of Centers for Medicare & Medicaid Services always talks about the four Rs, the right care for the right patient at the right time and the right price.

These are going to be critical aspects of any health care policy that we craft in this House. We simply have to keep those basic tenets in mind.

One of the speakers yesterday talked about in education the fundamentals of the three Rs, reading, writing and arithmetic. He went on to say in health care the fundamentals should be risk, responsibilities and reward, because, indeed, the risks are those that must be balanced against the possible benefit.

The patient needs to be an active participant in that. They can no longer simply be passive passengers on the journey through the health care system. They actually have to play a role in taking responsibility for their own care. The rewards, the reward aspect, the incentive aspect is often given. Well, while we are real good about being punitive in this body, we are pretty stingy when it comes to rewards or incentives. I could give you several examples of that.

One that comes to mind is the bill that was introduced late December as far as trying to encourage physicians for e-prescribing. The reward was a 1-percent increase in Medicare fees for a physician who participated in e-prescribing. The penalty 4 or 5 years later was a 10-percent reduction if they don't.

On a $100 procedure, and I will tell you there are not many office procedures under Medicare that pay $100, but let's use that number because it makes the math easy. In a $100 procedure administered in a physician's office if they utilize an e-prescribing module to administer that patient's care, they are going to get $1 extra for that $100 procedure or interaction, visit, whatever it was. That's okay, $1 is $1, and it's better than nothing.

But if you don't participate in 4 years time, 5 years time, that's going to be a 10-percent reduction. That same $100 procedure or test or interaction now will pay $90.

We are so focused on the punitive in this body, and we never focus on the front end of the problem, which is assigning the appropriate dollar amount or the appropriate incentive.

Now, go back to my earlier example of that large insurance company, and again an insurance company in the past which I have had great difficulty with, but what innovative thinking they have. They are offering a patient the ability to reduce from $5,000 to $1,000 their risk, their cost, on a deductible with no increase in premiums if they will do four simple things, lose a little weight, stop smoking, exercise regularly.

If you have asthma or diabetes you participate in a disease management program, and your deductible falls from a $5,000 deductible down to $1,000, and, oh, by the way, that premium that was less because you had a $5,000 deductible, it doesn't go up. It doesn't go up when that policy changed. That's the kind of innovative thinking I am talking about when I say we must balance the risk and rewards, because we haven't been good about doing that.

Everyone likes to quote the Rand study when they talk about information technology and programs like e-prescribing. The Rand study says that if we go to electronic prescribing in our health care system in this country, we are going to save $77 billion in 15 years, a tremendous amount of money.

Now, most of that savings is, in fact, out toward the end of that 15-year time. They don't really talk very much about who is going to pay for the cost of the implementation, putting the software, the hardware, the training, the upkeep of the software, the maintenance of the software, the time spent on the learning curve for all of these small offices across the country that have to make that investment. That's just going to be a given, but it will be worth while because we get a $77 billion savings at the end.

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What is missed so often in this study is the last paragraph. At the end of a very large study, it talks about the incentives to make this happen, to get us to this happy place where we are saving $77 billion with e-prescribing.

The incentives have to be early. The late innovators are going to be rewarded, so you have to have the incentives arrive early, and they have to have a time limit otherwise people will wait and see if the technology doesn't improve because, after all, they know they will have to pay for the hardware, software, the training, the upkeep and maintenance of the software.

Finally, the third thing is the incentives must be substantial. And again, on both sides of the aisle, we forget that very important point. So while we hear the Rand study quoted over and over again, please remember the incentives are early, they are time limited, and they are substantial. That was the economic modeling that got them to the happy place where they were saving $77 billion in the 15th year of that study.

If we concentrate on the fundamentals, getting back to the fundamentals, focusing on the risk, talking to our patients about responsibility, that is not so hard to do; but we should obviously compensate the health care professional for their time, for counseling about that responsibility, so that we don't forget the reward for the provider, to be sure; for the patient, to be sure; for the taxpayer, the American taxpayer if it is on that 50 percent of every health care dollar that is spent in the largest single-payer, government-run health care system in the world, which is Medicare and Medicaid today.

So the right prescription for health professionals has to be focused on these three areas when it comes to providing the real direction for health care reform.

I know I am not alone when I say that I am going to use these principles as my guiding star as I continue to work on health care policy. I hope I can convince my colleagues both in committee and here in the House of Representatives to focus on those same issues as well.

IRAQ WAR

The SPEAKER pro tempore (Mr. PERLMUTTER). Under the Speaker's announced policy of January 18, 2007, the gentleman from Kentucky (Mr. YARMUTH) is recognized for 60 minutes.

Mr. YARMUTH. Mr. Speaker, it is a great honor once again to come to the floor of the House as a representative of the landmark class of 2006 known as the majority makers, a group of 41 Democrats elected from 23 States who were sent here by the American people to change the direction of the country.

Of course one of the primary issues that was at the heart of the campaign in 2006 was our involvement in Iraq and Afghanistan. And this week that effort, national effort, has taken greater significance because we once again heard from General Petraeus and Ambassador Crocker about the progress or the situation, I should say, in Iraq. They testified before two congressional committees, two Senate committees yesterday and the House committees today. Their testimony, I think, raises two issues that I want to address tonight.

Of course the first is what the situation is in Iraq and what the prospects for success are in that part of the world. And, secondly, what is the cost to the American people and to the American economy because as we all know, the costs are varied and they are significant. They rise to magnitudes that we are not used to discussing in this country, both in human cost which of course is our top priority, and also the economic cost. And then there is the future cost as well because what we are doing is incurring obligations for our future generations that are real, that are incredibly large, and that the American people need to focus on because as we go forward and try to establish policies and have a national debate about what the appropriate course of action is in Iraq, we have to discuss again not just the human costs but also the cost to future generations of the American people, juxtaposed against the benefits and potential benefits of our continued involvement.