Army and Marine officers say the rapid pace of deployments into Iraq has put the readiness of their troops into a ''death spiral''—with 40 percent of gear worn out and soldiers and marines left fatigued and undertrained. Our Nation owes our fighting forces better than this.

The 3rd Infantry Division, scrambling to meet deployment orders, reportedly has sent injured troops back to Iraq—including ones so badly injured that they could not put on their body armor. We owe our fighting forces better than this.

The Army's medical facilities are understaffed and underfunded—not just at Building 18 at Walter Reed—and its medical staff is overwhelmed. We owe our fighting forces better than this.

Some 1,800 Marine Corps reservists will get letters this week notifying them that they are being involuntarily recalled for a year, thanks to a shortage of volunteers to fill some jobs in Iraq.

This follows news that should make everyone in this Chamber take notice: The 82nd Airborne Division—the storied ''All-American'' Division—is so strained by this war that it can no longer respond on short notice to a crisis.

For decades, the 82nd Airborne has kept a brigade on round-the-clock alert—ready to respond to a crisis anywhere around the globe within 18 to 72 hours. But The New York Times reported on March 20 that the 82nd Airborne can no longer meet this standard—a standard it has long held with pride.

I believe the supplemental that we have before us today is the solution to the Iraq problem. It provides a vehicle for Congress to express its sense on Iraq and to require the President to take concrete, measurable steps forward. It sets clear deadlines and requires vigorous regional diplomacy. It sends a message to an administration marked by arrogance and declares to the Iraqi Government that their time has come.

Zalmay Khalilzad, the outgoing U.S. Ambassador to Iraq, said as much Monday, March 26, in his farewell news conference.

Mr. Khalilzad was direct: The Iraqi leadership must understand, he said, that time is running out.

Finally, most importantly, this legislation begins the process of bringing our troops home.

We have a choice today. We can vote for a clear-headed Iraq policy or do nothing. We can exercise our constitutional oversight duties or we can be a rubberstamp for a failed Iraq policy.

I urge my colleagues to choose the first path. To choose the other is to abdicate our responsibility.

(At the request of Mr. LOTT, the following statement was ordered to be printed in the RECORD.)

VOTE EXPLANATION

• Mr. ENZI. Mr. President, I would like to state my position on the Cochran amendment No. 643 voted on by the U.S. Senate.

I was unable to vote due to a family emergency but would have voted in favor of the Cochran amendment. I was pleased to be an original cosponsor of the amendment.

I do not support congressional micromanagement of military operations and I do not support the congressionally mandated phased deployment of our troops in Iraq.

Troop redeployment decisions should be made by military leaders and the combat commanders who are on the ground in Iraq. I do not favor a set redeployment date, reporting to our enemies in language ''cut in stone.''

Congress must provide our troops with the resources they need when they need it. I fully support our Armed Forces personnel in their current military operations in Iraq and Afghanistan.

I want our troops to come home as soon as possible. My goal has always been for American Armed Forces to stand down as the Iraqi forces stand up. The United States cannot abandon the efforts of the people who have sacrificed so much.•

MORNING BUSINESS

Mrs. MURRAY. Mr. President, I ask unanimous consent that the Senate now go into morning business, with Senators allowed to speak for 10 minutes on each side.

The ACTING PRESIDENT pro tempore. Is there objection?

Hearing no objection, it is so ordered.

Mrs. MURRAY. Mr. President, I ask unanimous consent that Senator COBURN be recognized for up to 1 hour.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

HEALTH CARE

Mr. COBURN. Mr. President, I understand that I am to be able to speak as in morning business for up to 1 hour.

The ACTING PRESIDENT pro tempore. We are in morning business, and the Senator is recognized for up to 1 hour.

Mr. COBURN. I thank the Chair.

Mr. President, if you go out in our country and you ask, besides the war, what is on people's minds, the No. 1 topic you will hear about is health care. And what are the questions that you hear? Why can't I choose my own doctor? Why can't I pick my own health insurance plan? Why do my premiums increase every year but my benefits don't increase? Why do I have trouble understanding which benefits my health plan offers? Why does my employer get a tax break from my health care but I don't? Who can make the best health care decisions for my family, us in Washington, the insurance bureaucrats, other people, my employer, or how about me? How about me getting to make a decision about my health care?

There is no question America's health care is broken. It is not that we are getting bad care, it is that we pay a tremendous amount for what we get in our care. The estimates are anywhere from $1 out of every $3 to $1 out of every $4 we spend on health care doesn't go to help anybody get well in this country and doesn't go to help anybody prevent having an illness. That is $2.2 trillion, and it will be over $2.3 trillion this year.

When you see what happens—and these are not my numbers, by the way; these are Price Waterhouse numbers, a breakdown on health care dollars—what you see are some pretty interesting statistics. You see that when we go to spend $1 on health care, 35 percent of it goes to hospitals, 21 percent of it goes to doctors, 15 percent goes to prescription drugs, and 5 percent goes to equipment.

All the rest of that, the medical liability insurance—nobody realizes that is 10 percent. Ten cents out of every dollar we spend goes to medical liability. We are insuring against a problem in health care—10 percent. It costs us 6 percent to process the claims. One-half of all the claims filed against all the insurance companies in this country are denied because the people haven't met their deductible, and yet we keep sending the claims, keep spending the money.

One out of every three people who works in a hospital, one out of every three people who works in a doctor's office doesn't do anything to help anybody get well. Why is that?

It is because of the system we have set up. If you add this 10 percent for liability insurance, 6 percent for processing, 5 percent for marketing, 23 percent for the insurance industry profit—and I doubt seriously it is that low—what you come up with is 24 percent, as a minimum, that doesn't have anything to do with helping anybody get well.

Now, why is that? Why is it we have this system? It is because we have somebody besides the patient choosing what they will get in terms of health care. In Medicaid, it is your State. Oftentimes in Medicaid it is your State paying a very low rate, so now you get to choose from those who will accept the lowest rates. In Medicare, they tell you exactly what the price is. We spend all our time around here trying to change Medicare, because when we push on the balloon one way, something else pops out.

So whether it is the Deficit Reduction Act or some of the other things we have had, what we find is we cannot control this tiger because we have a bureaucratic maze that nobody understands. When we try to use price controls, when we try to limit expenditures, we end up losing control.

So what happens? Who makes your health care decisions? Either CMS, the Center for Medicare Services, in conjunction with your State, either for Medicare or Medicaid, your employer, or an insurance company.

Whatever happened to you making decisions about your health care, about which doctor, about which insurance policy, about which hospital you want to go to? And why is it that if you happen to be Medicaid, you get to choose less than somebody who doesn't happen to be Medicaid? Why is it we are treating in an unequal fashion those who are the poorest among us?

Why shouldn't we have the right to pick what insurance benefits are best for us? Why shouldn't we have the right to choose who is going to be our caregiver, whether it is a doctor, a nurse practitioner, a physician's assistant, a chiropractor, or an optometrist? Why shouldn't we get to choose that, rather than an insurance company or an employer deciding who we can or cannot see?

They also decide the price we are going to pay because we are trying to control all these costs. They are also going to decide which hospital we go to. But how is it that we have a system now where everybody except the patient gets to decide what happens to them in terms of their health care?

We can't afford the health care system we have today. For one thing, 16 percent of our GDP, the highest of any country in the world by 50 percent, is spent on health care. Although we have good health care, we don't have better health care than those countries that are spending less. We are spending 16.2 percent, or $2.3 trillion, per year on health care, so we should be 50 percent better off. We should have a 50-percent better life expectancy, 50 percent less heart disease, and 50 percent less cancer. Of the money we spend on health care, fully three-quarters of that is spent on five diseases.

Think about that: 75 cents out of every dollar that actually gets into health care, which is only 60 to 70 percent of the money we actually pay into health care, 75 cents of that goes for either heart disease, stroke, chronic obstructive pulmonary disease, diabetes, or cancer. Five diseases, most of which are readily preventable—not partially preventable but readily preventable—through increased prevention activities.

This Government this year will spend $20 billion on prevention in 12 different agencies, through 27 different programs, none of which are coordinated to try to maximize the education of the American people to what they need to know about their health care so they can make decisions on prevention. Consequently, we are very ineffective with prevention.

If you look down the road at what is coming in terms of Medicare and Medicaid, what you see is an unfunded liability of over $60 trillion—$60 trillion—we are adding. This isn't about health care now. That $60 trillion that is getting ready to hit our kids and grandkids in terms of Medicaid and Medicare that we have promised for the future, that we have no way to pay for now, one of the great ways of lessening that number is to change what we do on prevention. Prevention is the key.

Grandma was right: An ounce of prevention is worth a pound of cure. As a matter of fact, it is said in 2070 $1 out of every $2 that Medicare spends, at our current rates, will be spent on diabetes—$1 of $2. So when you look at this Medicare number, with the vast majority of the baby boomers who are going to retire and then their generation is going to retire, $1 of every $2 that will be spent by Medicare will be spent on one disease only, which means we only have $1 to spend on all the rest of health care for seniors, plus any attempts at prevention and at early diagnosis or new and modern treatments. We can't continue without a coherent plan on health care.

The other problem that is facing us as a nation is right now we can't compete globally in many areas because of health care costs. When you compare GM and Toyota, there is a four times greater differential for what goes into a car made in this country by one of the Big Three versus what goes into a car made outside of this country by their competitors. So there is no way that we can, in fact, be competitive globally until we handle health care. There is no way we can handle Medicare and Medicaid until we change the health care system.

Myself and RICHARD BURR and several other Members of the Senate will be introducing a bill tomorrow that addresses every problem our health care system faces today, whether it is tort liability, and making sure people get awarded what they need when a mistake is made during the practice of medicine, or whether it is immunizations. The fact is, we have very few States where we have achieved 90-percent immunization.

We are going to address every problem we face, the liability that comes at us in the future through Medicaid and Medicare, the problems we face on liability, the problems on access, the inequality that somebody, because they happen to work at a very low-paying job, gets stamped with something on their forehead that says, you are of less value than somebody who happens to work someplace that has great insurance and a higher paying job.

Our bill changes all of that, and instead of going to the Department of Motor Vehicles to wait in line, we are talking about a health care system where you, the consumer, are No. 1. The government isn't No. 1, the doctor isn't No. 1, the hospital isn't No. 1, the drug company isn't No. 1, but you, the patient, become No. 1. You get to choose what insurance you want, you get to choose what kind of insurance you want, and you get to choose how much you will pay for it. We create a new insurance market where everybody gets to play by an even set of rules.

How do we do that? We do that by giving everybody the same advantage in this country when it comes to health care, and that is a refundable tax credit, $2,000 for every individual, or $5,000 for every family. What that means is, if you are earning about $120,000 a year or less in this country, you will gain in terms of your taxes off of this bill. If you are making $120,000 or less, what is going to happen is you are going to have the option of staying with your employer, if you like what they have, and that tax credit will be available to your employer. But if you decide you want something different, maybe it offers something you don't get covered today or doesn't cover a whole lot of things you think you need, you can take that tax credit and buy that insurance and save the difference in the money for your future health care. The Universal Health Care Choice and Access Act provides $2,000 for every one of the 45 million uninsured tomorrow, every one of them as an individual.

Now, what does that buy? People say: That won't buy much. Well, if you go to Kentucky and you happen to be 35 years of age, you can buy a $2,000 yearly deductible policy for $897 and have $1,300 or $1,100 left over between that and the deductible. If you try to buy that same policy in the Chair's State, it is almost $6,000 for that identical policy. Why? Because government has decided in New Jersey differently than what government has decided in Kentucky. Therefore, the cost of getting this minimal coverage, because of the mandates put on by government—not what a patient wants but by what government says patients should have—makes that unavailable in New Jersey.

How do we fix that? We allow people to buy insurance anywhere they want, just like they buy their auto insurance today; like they buy their homeowner's insurance. They can buy it from any company anywhere in America, as long as they have a registration with a State. We create a primary and a secondary location for that. So if you want to buy something that has a better price, that fits your needs, you have the capability to do that and put the difference into a health savings account, where you can use it for future health care needs, that you can use to apply to any deductible, or if you get enough money in it, you can bring it down to where, if you want to, you can have a zero deductible—if you want—but most people will not want to do that. We allow you to select a health plan that truly meets your family's needs, not what some Government bureaucrat says or some Senator says you must have. It is what you want. We allow individuals to choose what they want in terms of their health care.

What will that do in terms of the market? That is going to create innovation in the health care market all across this country. It is going to cause competition like crazy for the dollars. Once we truly have competition, which is something we do not have in health care today, which we tremendously need, then we are going to see a big change.

The other thing this does is it gives access for affordable health care for a ton of people who do not have it today. They get to choose their health care provider. The patient gets to choose who takes care of them. Not the Government, not their employer, not the Senate, not their State insurance commissioner, but they are going to get to choose who is going to take care of them. It is the right to choose who is going to care for you.

How do we do that for the States? We do not mandate anything for anyone. We do not say anybody has to do anything. But we create a lot of incentives. We tell the States that, if you want to, you can take your Medicaid funds and your disproportionate share funds and anybody who is Medicaid eligible, under the 133 percent of poverty level, you can take their $2,000, plus the Medicaid money, plus the DSH money, and you can help them buy an insurance policy in your State. If you want to stay with Medicaid, you can stay with Medicaid. There is no mandate from the Federal Government other than to get people into coverage.

You ask any government tomorrow if they would take $2,000 per eligible person in their Medicaid program, would they take a deal with them having the freedom to design what is best for their State? Every Governor will tell you yes. Every Governor will tell you yes. Why? Because now we are given the resources there to allow a Medicaid patient to be just like everybody else—a Senator, their mayor or somebody who works at the best factory in town. They have an option to not be discriminated against because they show a Medicaid card. Now they have an insurance card. People ask: What about the people who do not want to have insurance? We allow the States the opportunity to have a default mechanism. If the State of Tennessee—I see the Senator from Tennessee here. If the State of Tennessee wants to decide we will option, if we have people in our State who are going to be so irresponsible that they will not even buy themselves coverage and they have an opportunity to take tax money to do that, then we are going to create a default mechanism whereby the State of Tennessee—if you are a 25-year-old motorcycle rider and you don't want to buy insurance, they can take your tax credit and buy a high-deductible policy for you so when you go to the ER, all the rest of us don't have to pay all your costs. What is happening in our health care system is we keep transferring the costs so we have a rationale for jumping up the price because they are doing something for somebody else at a low price.

What the real facts are—and we never hear it—the real facts are, when you look at the hospitals out there, all—the vast majority of them—and this is a very key, important point—the vast majority are nonprofit entities. That means they pay no income taxes, they pay no payroll taxes. On order, the vast majority, and on average, offer 10 percent of their total billed care as indigent care.

But that is not a real number. The reason it is not a real number is because they bill the highest prices they have for that indigent care. If you look at the cost of that care, it would be far below that. I know in the State of Oklahoma, the hospitals there last year billed over $5 billion in revenue, made over $5 billion in profit, and out of that they billed another $400-some-odd million in care that was uncollectible to people who did not have insurance or couldn't pay. That was not really their cost. That was their billed price.

Remember, we give this nonprofit status to all these entities, this $500 million worth of profit in Oklahoma, for example, and they pay no taxes on that. They pay no real estate taxes. In essence, they offer about $100 million worth of charitable care.

What this bill does is it takes away all the cost shifting.

What are the other things we do? We incentivize high-risk pools. What about the person who gets a chronic illness and they say all of a sudden their insurance company drops them. We have incentivized so the insurance company is not going to do that. In every State we give a bonus if they set up a high-risk pool and then the high-risk pool is funded out of everybody who is insured in that State. So if you have an insurer insuring someone with complications from diabetes and they say we will drop this person because it is too costly, they go to the high-risk pool. Guess what. That insurance company is going to pay for them anyway. There is no benefit for them to drop them. There is all the benefit then for that insurance company to get busy and involved in managing the chronic disease, where we know we can eliminate complications, we can improve the quality of life, and we can also increase life expectancy by managing the chronic disease.

Here is what we do for Medicaid patients. They get a $2,000 check from the Federal Government plus from their State. They can go into whatever plan they want. If their State says we want to stay with Medicaid and take that in enhanced Medicaid, the State gets to do that. There is not a mandate in anything. What it says is: If you think a State Medicaid Program is better for your State, without choice, then you can do it. But all the rest of the States are going to say I think I would rather have our Medicaid patients have a true insurance, a real card where they have the same access, the same equality of access as anybody else.

All of a sudden you have everybody in the marketplace compete. They can stay in a State-run system. They get to save what they don't spend on their health care for future health care needs.

One of our problems is savings in this country. It is important. How do we fix our health care system? We know that, if we look at the liability costs that showed 10 percent of the health insurance dollar going for liability insurance, that is an underestimate. The American Hospital Association found, recently reestablished by another organization, I can't remember who, that repeated the study—what we know is each year, today, besides that 10 percent, providers order another 8 percent of the cost of health care for tests that patients do not need.

Why do they do that? They do that because they perceive they need to have everything on the books to defend themselves that they can have, so they fire a shotgun at it. We will get this test, this test, this test—knowing they don't need it but they operate under the ''what if'' scenario, this adversary system that we have.

Finally, we address liability. We give another percentage bonus to the States that will set up what is called a ''health court'' system. It is a real simple system. If you have a complaint against a provider, a hospital or a doctor, you can go to the health court. You don't have to go to the health court. But you can go to the health court and you can be seen in front of three lawyers, three doctors, and a judge who have their own expert witnesses. This judge is schooled in medical malpractice. They can make a decision for you right then.

If you accept the decision, then you give up your right to go to court. If you don't accept the decision, you can't ever come back to that court on that particular issue, but everything you do in court is admissible. We do not take away anybody's right to go to court. But what we do accomplish is making sure people get made whole quicker and cheaper—40 percent now doesn't go to the trial lawyer for you to get made whole.

There is no question we make mistakes in medicine every year. But why should we drag it out for 3 to 5 years, No. 1. Why should we pay 40 percent of whatever the ultimate award is to somebody who helped us accomplish that, where we can set up a system that will arbitrate that in front of a nonbiased group of peers, lawyers and doctors who say: Here is the right thing, here is the medical case, the legal case, let's make a decision and send it on.

What it does is it saves tons of money directly, but what will it do? As soon as you create confidence on the part of providers that they do not have to order this other 8 percent of tests, you are going to see that dropping about half. So we can gain 4 percent in this cost of health care by setting up health courts, by changing the dynamic under which we make sure people are made whole when something happens to them in the medical malpractice area.

Not every State has to do this. But if your State decides to do this, you get a 1-percent bonus on your Medicaid money—out of a large pool.

We have lots of ways in which we do not say we want the States to do this and now we are going to tell you how to do it. We are saying here are some ways we think you can also do it. Go figure out the best way for you, and by the way, if you do some of the things that we think will save some money, here is some extra money for you.

Ultimately, if we do not fix health care—everybody in this Chamber knows we are going to go the way of Western Europe and that is the following: We are going to decide that we are going to have a single-payer system run by the Government. As P.J. O'Rourke says: ''If you think medicine is expensive now, wait until it is free.''

We are going to control costs. We are going to do it the same way we are trying to control costs with CMS. What happens? What happens is we are going to start rationing care.

Let's take some real statistics. In England, diagnosis? Cancer. In England, if you get a diagnosis of cancer right now, the average starting time for your chemotherapy is 10 months after your diagnosis. Anybody here who wants that kind of medicine will vote against this bill. That is exactly what we get. We get rationing. What it means is people with great potential will not get the treatment in time to capture that great potential. What it means is great suffering. What it means is loss of innovation. What it means is a lack of available, fair access. It is everything in England in their health care system takes away all freedom.

It is also interesting to know this past year in Canada there was a lawsuit filed, which was won. What this individual said is the Canadian law says I can't go to anybody except a Canadian doctor who is owned and run by the Government. They challenged that. The Canadian supreme court ruled on the side of the patient: You ought to have the right and freedom to go wherever you want, to whomever you want if you are willing to pay the bill.

Paying the bill is the insurance part of this. If you want to be able to have that access, then you are going to want to be able to buy a policy that allows you to have it. If you don't want that access, you can buy a policy that says here is a straight HMO, here are the only four doctors you can go to, and here is the hospital you are going to get to go to.

We are talking about freedom in health care. How do we get to the bottom line, away from 16 percent of our GDP, down to 10 percent of our GDP? More importantly, how do we create a system that gives us better quality, at lower cost, with better value. That is what we are talking about.

I yield to the Senator from North Carolina.

Mr. BURR. Mr. President, I commend my colleague from Oklahoma, a dear friend and somebody who has been passionate about health care for years. He and I came to Washington together in 1995. We served on the Energy and Commerce Committee, and we recognized then that changes needed to be made. Every year we have seen the same response in Washington. We have seen the end of a calendar year come, the need to find savings in health care. Administrations, Republican and Democratic, turn to Medicare and Medicaid and say we are going to extract $60 billion, $70 billion out of savings in these health care systems. We have laughed as they called it ''waste, fraud, and abuse'' because there is waste, fraud and abuse in it. We just didn't get any money out of it because we have been reluctant to fix the health care system in this country.

What are we doing? What is this plan? This plan is universal health care. Let me say it again. This plan is universal health care. This is providing affordable, accessible health care, provided by the private sector, for every American in this country.

This is change in the design of health care that has been historically, up to this point, employer negotiated, the majority employer paid for, and an employee has very little input into the makeup of the policies that cover them.

It doesn't reflect their age, it doesn't reflect their health conditions, it does not reflect their income.

What we are talking about is shifting it away from employers over time. We are talking about creating real incentives for individuals. We are talking about making sure 47 million uninsured Americans today and tomorrow have tax credits that can be used for real insurance coverage. What does that provide for them? For the first time, it creates a relationship between a patient and a health care professional.

We have talked in this institution, we have talked in this town, and we have talked in this country about the need to project wellness and prevention in health care. Well, this does it. This, for once, accomplishes that because we as individuals can negotiate our plans, not through the group plan but as 250 million-plus Americans. We can negotiate what makes sense for us from the standpoint of the scope of coverage that reflects what we are willing to pay as it relates to premium—and, by the way, provides States the capability to do the same thing with their Medicaid beneficiaries, their Medicaid patients, if, in fact, they want to begin to change the way their care is delivered, by creating the same relationship between a health care professional and them, because they now have the same insurance we do.

Medicaid beneficiaries have this big ''M'' on their foreheads. They do not want to be on Medicaid, but they are there because it is the last resort. What we want to do is integrate them into what all of the rest of us have; that is, individual insurance.

Dr. COBURN hit on a real key; that is, an attempt to bring everyone's health care costs down. It is not to pick out a group and to say, We are going to reduce yours, and pick out a group over here and say, We are going to reduce yours. This is an attempt—it is the first real attempt—to bring everybody's health care costs down.

What we learned when we created Part D Medicare, the drug benefit for 35 million-plus seniors in this country, was that when we created real competition between insurers and we brought transparency to price, two very real things happened: In the first year, premiums dropped 28 percent over what we had projected, and drug pricing dropped 33 percent.

We have a model we have already tried that seniors across this country say: Do not mess with this plan. That, in fact, exemplifies what we are trying to do. We are trying to create real competition between insurance for our insurance business; we are not letting one employer negotiate the plan and then dump it on the employees. But the question is, Can we have the same results as Part D by seeing the cost of health care reduced for all Americans? Well, you start that process when you eliminate cost-shifting. You accelerate that process when you inject what this bill does; that is, transparency in the price of health care that is delivered to you.

Imagine the day that you can go online and you can actually see what your doctor's visit is going to cost, what the lab workup is going to cost, what a visit to the emergency room at your local hospital is going to cost. In markets in North Carolina today, some choose not to go to the hospital for the nonemergency care, even though that may be their primary provider; they choose to go to the community health center because the community health center actually delivers the same if not a better level of care. But one thing is for certain: They know exactly what it is going to cost them. And these are individuals who are insured.

For the first time, all Americans have an opportunity at prevention and wellness. What does that mean? It means we can make decisions about our health care that have an impact on the cost of our health care to us and consequently have a ripple effect across the marketplace, that as more and more Americans make healthy decisions, the cost of health care overall comes down.

It means we have freed up those valuable health care dollars to make sure they are there for the individuals who are going to be susceptible to disease—chronic or terminal illness.

It means the relationship we have now established between patient and health care professionals means we have recognized we can accumulate the data we need so that Medicare reimbursements are no longer a shot in the dark where we pull a number down that may not be reflective of the cost of delivering the service, may not be reflective of the value of the service.

The reality is that when we create that relationship, we are able to accomplish the accumulation of data that tells us what things really should cost.

In health care, those healthy decisions allow individuals to make decisions about disease management. The most costly part of the U.S. health care system is the chronic diseases that exist and our inability to manage those diseases. The most expensive is diabetes.

Today, we have electronic capabilities for diabetics and for coronary heart patients where, at different periods during the day, their vital signs can be transmitted over a telephone line to their doctor. The doctor can instantly know whether, if it is a diabetic, they are managing their insulin. If it is a coronary heart patient, they can determine whether the fluid buildup means they need to adjust their medication. What does that give us the ability to do? It means we can take a patient who up to that point got too much fluid on the heart, made an emergency room visit, and in all likelihood was admitted for 3 days as they get the medicine back in balance. Now, a doctor, 24 hours a day, as these reports come in, can change their diuretic, can work with a diabetic on checking their blood sugar and what their insulin intake is, can detect whether they took the right medication. We can extrapolate that across every disease because technology now lets us do it in a real way. If we are not able to do this, then we are not able to recognize the value of new technology.

So much technology today that would benefit us in the Medicare marketplace is not reimbursable by Medicare. It is a decision they make because it is not tested in the marketplace; therefore, it has no value because they do not know how to reimburse for it. Well, the reality is, when you have a health care system that responds to the benefits to individuals, all of a sudden you have the market that creates a value for the technologies and for the innovations.

So I am delighted to be here. There is so much to this bill. This bill is the most comprehensive transformation of the health care system in my lifetime.

One might say it is difficult to do so big a bite at one time. I made that mistake. The reality is that when you look at the timeline we are up against every year we do not adopt this type of transformation of our health care system, more Americans become uninsured, more individuals with preexisting conditions no longer can afford health care, and the cost of everybody's health care in America goes up because we have not eliminated cost-shifting.

With disease management we could do today if, in fact, people had incentives in their system to take the time to monitor their health, to take their medication, to counsel with health care professionals about changes they could make, the more money we can save not only for each one of us but for the total system.

I am convinced that if you could only pick one thing out of this plan that you highlighted for the American people, it would be this: For the first time, we are presenting a very real way to insure 47 million Americans, the people who are most at risk in this country. If all of us were the beneficiaries in some way of reduced prices, more access, the ability to have transparency in pricing, the accumulation of data, electronic medical records that enable us to find savings, if that is the byproduct of us finding a way to use savings in the system to insure 47 million Americans, I believe that is the right thing to do.

The President came out in the State of the Union and he presented a very similar plan. Our plan expands on what the President said. Our plan goes to the heart of the health care system and says: If we are going to change it, then we have to go through total transformation. This is that total transformation that at the end of the day empowers every individual in this country to have custom health care coverage for themselves, for everyone in their family, for their health conditions, for their income and, more importantly, for their security.

So I commend the Senator for his work. I now look forward to working with him as we go through what I think will be a very intellectual debate about the future of health care in this country. As some look at Europe and look at other countries and say, Maybe we ought to do that in the future, I believe if we adopt this method we are going to have every country in the world looking at this model and saying, How do we do this? How fast can we do that?

Mr. COBURN. People may be saying: Well, how do you know this will work? There is a great little company named MedEncentive. They have been running pilot programs all across the country. Let me explain what they do. They get doctors to agree to follow a certain set of protocols called best practices, and they sign up communities, municipalities, and their employees, and then they do a couple of things. They take them under coverage, and they reward the employee—i.e, the patient—if they will use those doctors.

What is unique about this system? One is, after the patient has finished their office visit with the doctor, they have a patient-doctor interactive form they fill out that says: The doctor wants me to take this medicine. I understand this. Here is the reason he wants me to take this. So they have to fill out the form to say they really understood.

The other thing is, on the professional side, the practitioner side, they agree to follow the best-practice model in how they treat these patients. That was actually developed by Vanderbilt, where they followed a best-practice guideline which helps them decide what to order, what not to order, what to do, what not to do in terms of what is best for that patient. They can get off if they choose to, if they think in their medical judgment that they need to.

What has been the result? The three published results that I know of, in all three communities, in the first year of operating this where there was this competitive model, best-practice quality outline, patient followup, because the insurance company is involved in making sure the patient does that—what happened to their health care costs? One down 18 percent, one declined 22 percent, and one declined 12 percent. Now, that is just in three. Each one of them had 300 or 400 patients and took all comers, chronic disease or not.

How did their costs go down? The costs went down for a lot of reasons. One is they were practicing not defensive medicine, they were practicing real medicine. They were not throwing tests at a patient because they were worried but because they had the background of the excellence of Vanderbilt University as a practice guideline at their defense.

So what we know is that in the various test models where true marketing, true competition, true transparency as far as price, true concern for the patients' well-being, not just at the office visit but thereafter, wellness and prevention were modified, what happens is costs go down.

That is just in three cities in Oklahoma. It has been done all across this country. But what we do know is that if we attack it in a nonbureaucratic way, but we allow competitive forces—which would you rather have, an insurance company that is invested to try to make your health better or one that just wants to make a dollar on you and turn on you?

So going back, let me just kind of summarize. The system we have today limits our ability to do what we as Americans do well; that is, discern value for what we have purchased—discern whether we get value for it, discern how to do it, and we discern that on an individual basis.

Our health care is not designed on an individual basis. In many places, we get one-size-fits-all; what the Government says you will have or what the State says you must have, you must buy this. I believe a lot of our problems have come because we have tried to micromanage it from Washington and from the statehouse. What we are talking about is giving freedom of choice, not just to patients and providers but to insurance industries.

Imagine the tremendous possibilities that will come into a market that says: This is a new day. I get to market all sorts of different things that might match up with different people. All of a sudden, now I will have to compete not only with people in my State but all across the country for the best plan that gives me the best value that meets my needs. Why would we not want that? We have that in every other

thing. Why would we not want to capture the best aspect of the American consumer, which is discernment?

Not long ago I was sitting with some friends and put forth the fact that I believe Americans are smart enough to know what they want in health care. The idea got pooh-poohed. I thought, how insulting. We can figure out what computer to buy and how much memory we want and how big a hard drive we want and whether we want a photo section on it or a print lab. We can figure out all of those things—as a matter of fact, our 10-year-old kids can figure that out—but we can't figure out how to buy health care. We are going to say to the American people: You are not sophisticated enough, you are not smart enough to know what is good for you or to know what you need. So, therefore, the Government is going to tell you what you need. That is what we have today, whether it is the Government or your employer or somewhere else.

This bill changes all that. This is a bill that will create transparency so you as a consumer can know what something is going to cost. It is going to create a situation where you can perceive whether you have value. It is going to create an incentive to save for health care for the future and an incentive for wellness, not just by what the insurance company will come to sell you but by the $20 billion that we are now spending, of which less than $2 or $3 billion makes any difference at all in somebody's health care. We are going to focus that on true prevention. We are going to direct that the HHS relook at every one of these programs and develop a model to where we educate the American people about the risk.

Let me give a personal story. I am a colon cancer survivor. What we do know is with good prevention and good screening, one out of every two people who are going to get colon cancer we can keep from getting it. Why wouldn't we do that? Why wouldn't we prevent half the colon cancer in this country? We don't have a good reason. One of the reasons is because we have an ineffective prevention program.

I am a small government person; I admit that. But there is a legitimate role for the Federal Government when it comes to teaching America about our health needs, prevention, and wellness. We have plenty of money to do it if we take the same money we have now and redirect it in a way that educates the American people. Innovation works. We know that. Competition works.

Take, for example, a year ago a 46-inch plasma TV cost $11,526. Today you can buy the same thing for $2,300. Next year you will be able to buy it for $1,400. The next year you will be able to buy it for $700. Why? Competition. Competition breeds quality and value, only if you have a market under which you can operate. We don't have that today in health care. Innovation also works in health care.

Look at Lasik. Here is a procedure that is not paid for by the Government. It is not paid for by any of the insurance industry. But if you are nearsighted and you want to be able to look far away, you can get that done. When it first started, it was $4,000 an eye. Now there are places you can get it done—the same piece of equipment, the same computer—for $500 an eye. Why won't that work? It will work in health care. It will work. Innovation will come as a result of that.

What happens when we innovate. What we get is better quality at a lower price and better value. I am hopeful that as the American people look at this, they will be reminded of a couple things. This is universal coverage. Everybody in America gets treated the same by the Federal Government when it comes to health care. Everybody in America is on equal footing as far as the Income Tax Code is concerned when you go to buy your health care. No longer do we advantage the very rich with $2,700 a year in tax benefit and the very poor with $100. We totally neutralize that and say: Everybody ought to be treated the same under the Tax Code for health care. It is universal coverage.

No. 2, it takes away discrimination. Because you are poor, because you don't have the ability to have a job that has insurance coverage today, and if, in fact, you are at 133 percent of poverty, why should you be discriminated against because you are on the Medicaid Program? This is no offense to any practicing professional out there because there are great professionals who are taking care of Medicaid patients. But if you look at the marketeering, the ones with the best doctors, as a rule, because Medicaid pays so low, do they have time to take care of Medicaid patients? No. What happens is, somehow they don't have time. So what we have done is discriminated down with Medicaid patients.

Why shouldn't a Medicaid patient get the best doctor every time, just like a Senator? Why shouldn't they have access to capability? Why should they be discriminated against by having a Medicaid stamp on their forehead? We are talking about universal access, equality of care, and personal freedom and choice. You get to decide what is best for you and your health care and your family.

By the way, when you get this money and you haven't spent it all, you get to save it for next year and the year after and the year after. You can buy what is best for you with that money.

This money also goes to retirees. If you retire at 60 and are not eligible for Medicare, you still get your tax credit. We don't discriminate against anybody. Everybody gets the tax credit.

The final thing I would say, it doesn't cost the American taxpayer one additional dollar in income tax. There will be no increased cost with this plan. Actually, we have tried to make it revenue neutral. My worry is that it will save us money. We have tried to make it where it does not. We have tried to make it the most generous thing we can to get the most coverage for everybody out there. Again, prevention first, free choice, freedom, and liberty. You get to decide who cares for you, what insurance, what hospital, and every American gets that. It is the Government not telling you what you must do but saying here is what you can do if you want.

I yield to the Senator from North Carolina if he has any additional comments.

Mr. BURR. I would only use that time to thank the Senator from Oklahoma. This is a crucial debate that this country needs to have, this institution needs to have. More importantly, we are at a point where we have to stop talking about what we are going to do and actually start doing something. The Senator from Oklahoma has stated it very well. What we can do is bring a higher level of care to all Americans—not just some Americans, to all Americans. Through that effort, all Americans receive a financial benefit. Our system prospers because we are able to take care of more, and we are able to provide an unlimited opportunity in the future because we unleash innovation and technology in health care.

I have wondered what it would be like if we had innovation at the same level in health care as, say, in cell phones; that we would have a new platform every 6 years, and that platform would provide an array of opportunities to us that we are not forced to take, but they are available to us if, in fact, we want them. Health care has been starved of innovation, in large measure because it treats every American differently. This is the first real opportunity for universal coverage, universal access, where every American has an opportunity at the best coverage available.

I thank the Senator from Oklahoma.

Mr. COBURN. I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. BROWN). The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. REID. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

RENO-TAHOE YOUNG PROFESSIONALS NETWORK

Mr. REID. Mr. President, I rise today to honor the Reno-Tahoe Young Professionals Network, RTYPN. This important organization has been formed recently by local community leaders and will provide a significant service to northern Nevada. I am pleased to recognize the group here today.

The Reno-Tahoe area has been growing swiftly for the past decade. The region enjoys a strong and relatively diverse economy, offering a range of jobs