reducing overall efficiency, wasting time and paper resources, and disallowing any new starts in procurement. Fortune 100 companies do not walk away from difficult budget choices by taking a pass to the next fiscal year. Neither does Main Street USA. Regardless of whether you subscribe to the belief that CRs save money, this is no way to run an organization. It is part of our obligation to the American people to ensure our scarce resources are given to projects that produce results.

I want to share a few examples of the true impact of continuing resolutions, taken from a memo prepared by the Congressional Research Service and hearings before the Committee on Homeland Security and Governmental Affairs.

Let's take the Department of Education. The Impact Aid Program is an elementary and secondary education program that does not receive forward funding or advance appropriations and, therefore, is more easily affected by an interim continuing resolution. Payments for children with disabilities are delayed when the Department of Education is operating under a continuing resolution.

USAID: The delay of funding of the President's Malaria Initiative, which was enacted in order to reduce deaths due to malaria by 50 percent, lasted until February 15, 2007, 5 months or 138 days into fiscal year 2007. Doing the math, this delay in funding relates to the loss of, say, 198,000 lives unnecessarily. In other words, by delaying it, the money was not there. We did not get the job done, and this resulted in the deaths of individuals.

NASA: On June 8, 2009, the Federal Times reported the following from NASA Administrator Michael Griffin:

> Any time Congress passes a continuing resolution that holds agencies to their current spending levels at a time when the economy is experiencing inflation translates into a budget cut. And so we will be cutting the budget at NASA and the only question is how much. . . . And then the second question, after how much is decided, is will the continuing resolution be broadly applied and left to the discretion of agency heads to implement or will special programs be targeted to be either favored or disfavored.

FEMA: In fiscal year 2008, the Emergency Food and Shelter Program, which ''provides emergency food and shelter to needy individuals,'' did not receive funds under the CR. Thus, the program did not have funds available for communities and their respective homeless provider agencies during what many view as critical winter months until February 26, 2008, or 149 days into fiscal year 2008.

The judiciary: The judiciary has had to resort to hiring freezes or furloughing employees under continuing resolutions. In fiscal year 2004, the judiciary reduced 1,350 positions, with probation and pretrial services receiving significant cuts.

HUD: During fiscal year—I am just giving you examples that have been pointed out by CRS. During fiscal year 2004, the Department of Housing and Urban Development had to temporarily suspend the General Insurance and Special Risk Insurance Fund of the Federal Housing Administration because the continuing resolution did not provide a sufficient credit subsidy to continue with the programs. During the suspension, HUD was unable to meet the needs of the borrowers who would ordinarily be served by the respective programs, which created uncertainty among the lenders and potential borrowers. Mr. President, I think most of us have seen what happens when we have uncertainty in our mortgage system.

The Treasury Department: Continuing resolutions in fiscal year 2007 and fiscal year 2008 limited and delayed the IRS's ability to implement improvements in the taxpayer service. Also, these continuing resolutions prevented the agency from making job offers to highly qualified candidates until enactment of a full year's appropriation.

Just jerk them around.

Research and development: Most research and development programs continue to receive funding at the prior year's level when operating under a continuing resolution. However, this funding mechanism can only support existing R&D priorities rather than shifting to new ones because only existing programs retain funding. New and emerging technologies must be funded in real time.

The Social Security Administration: Operating under a continuing resolution for fiscal year 2010 will hamper efforts to reduce backlogs in the agency's disability program, which would result in decreased efficiency. Also, in previous years continuing resolutions caused the agency to implement a hiring freeze that contributed to service delivery problems. While Commissioner Astrue has gone to great lengths to send additional resources, for example, to my home State, Ohio still has people waiting more than 500 days for a decision on their Social Security disability claim.

I was very critical of SSA. I started looking back on the continuing resolutions that were passed. It was a chaotic situation. They were not able to keep the people they had. They were not able to hire more people, and we have a 500-day wait now. I am sure the Presiding Officer gets the same complaints from his people that they cannot get their disability appeals heard.

DHS: In testimony before the House Homeland Security Subcommittee on Management, the Department of Homeland Security's Deputy Procurement Officer, Richard Gunderson, spoke to the impact continuing resolutions have on the key homeland security programs. Gunderson testified:

> A CR would stop those programs in their tracks and we would not be able to grow the way that everybody is saying that we need to grow.

Mr. President, there are a lot more examples of what I am talking about. I think this has to be the year we do our job. The Senator from Nevada, our leader, and the Senator from Kentucky, our minority leader, have both publicly stated that we need to do our job on time. As I mentioned earlier, the need for it is more urgent than ever before.

If I were the President of the United States today, I would probably look at what the Congress is doing, and I think I would say: One of the greatest gifts you can give me, one of the greatest gifts you can give our country, is to do your work on time so we do not have this chaotic situation we have had for so many years.

None of our hands are clean. None of our hands are clean. I have been here when we have deliberately not passed appropriations with the idea that maybe our guy is going to get elected President or we are going to get the majority in the Senate or the Congress and so then we can tweak it the way we want to because a majority is no longer in the majority.

This game has been played for too long around here, and it is about time we recognized it and did something about it.

Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mrs. MURRAY. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mrs. SHAHEEN). Without objection, it is so ordered.

MORNING BUSINESS

Mrs. MURRAY. Madam President, I ask unanimous consent that the Senate proceed to a period of morning business, with Senators allowed to speak therein for 5 minutes each.

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

The Senator from Rhode Island.

Mr. WHITEHOUSE. Madam President, I ask unanimous consent that I be permitted to speak in morning business for up to 15 minutes.

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

Mr. WHITEHOUSE. Thank you, Madam President.

HEALTH CARE

Mr. WHITEHOUSE. Madam President, I have spoken many times on the floor of the Senate about the desperate need for reform of our broken health care system. Today the Congress stands at a moment of historic opportunity. The attention, hopes, and anxieties of the American people are focused on us like never before.

We have seen over the course of the last 60 years constant lament over the

system's flaws and failure—failure when true opportunities for reform arise. President Obama has now challenged this Congress to reform our Nation's health care system, to expand access to insurance, to improve below-average results, and to bring down its costs. It is about this last challenge—the challenge of our unimaginable and grotesque health care costs—that I speak today.

In his recent speech to the AMA, the President called escalating health care costs ''a threat to our economy . . . an escalating burden on our families and businesses . . . a ticking time-bomb for the federal budget, and . . . unsustainable for the United States of America.''

I hope all of us share his sense of urgency. Our country's economic future may well depend on it.

Over the past few weeks, I have been privileged to work with my HELP Committee colleagues to make long-awaited reforms and investments to control costs and wring savings from the system. In that process, much attention has been paid to the Congressional Budget Office's cost and savings estimates—estimates that, in many cases, have significant limitations.

CBO, as we know, plays a vital role in our legislative branch by ensuring that we have objective, nonpartisan estimates of the likely costs and savings to the Federal budget of legislation. These estimates can help us make responsible and efficient use of the taxpayers' money, but we must recognize that in the particular context of health care reform, they are fundamentally limited by CBO's professional restrictions.

CBO can only estimate health care costs and savings that have historic precedent. For example, since we have the experience of Medicaid and the Children's Health Insurance Program, CBO can estimate how much expanding coverage to all needy families will cost. These subsidies account for the vast majority of CBO's $600 billion estimate of the 10-year cost of the HELP Committee bill.

On the cost savings side, however, CBO's capability is limited. We know our health care system is on an unsustainable course, and there is broad agreement on which of the broken pieces need fixing, but it is impossible to estimate cost savings with the degree of certainty CBO requires to provide what we call a score.

CBO's Director has been refreshingly candid about this. In a recent letter to our budget chairman, Senator CONRAD, he writes the following:

> Changes in government policy have the potential to yield large reductions in both national health expenditures and Federal health care spending without harming health.

He continues:

> Moreover, many experts agree on some general directions in which the government's health policies should move, typically involving changes in the information and incentives that doctors and patients have when making decisions about health care. Yet many of the specific changes that might ultimately prove most important cannot be foreseen today and could be developed only over time through experimentation and learning.

CBO's professional discipline requires it to score legislation through a rear-view mirror, looking back, and basing its calculations on what it can chronicle has happened in the past. But when we propose to take the country in a new direction, when there is a turn in the road, when we seek to fulfill President Obama's promise of true change in America, the rearview mirror doesn't help much. We have not been where we need to go.

In addition, getting there will require leadership, creativity, and perseverance. It will require executive administration with constant adjustments and improvements as we work toward our goal. Those factors are beyond the capability of CBO to predict.

I speak not to criticize the hard-working public servants of the Congressional Budget Office. They do an exemplary job with the tools at their disposal. Americans owe them a particular debt of gratitude now for how incredibly hard they have worked over these past weeks, but their tools come with their own limitations. The point of this reform is to turn around a system that is spiraling out of control. We spent 18 percent of our gross domestic product on health care, the next highest spending Nation in the world—the next worst is Switzerland, at 11 percent. Even if our success in this reform is limited to shaving a few percentage points off our national expenditure on health care, that change will be worth hundreds of billions of dollars a year. Yes, there will need to be an initial investment in health care reform, but the potential savings are multiples larger. CBO's inability to score those savings does not mean that those savings are not both real and substantial.

One measure of the potential savings is the recent report of the President's Council of Economic Advisers, June 2009. I ask unanimous consent that the executive summary of this document be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

THE ECONOMIC CASE FOR HEALTH CARE REFORM

EXECUTIVE SUMMARY

The Council of Economic Advisers (CEA) has undertaken a comprehensive analysis of the economic impacts of health care reform. The report provides an overview of current economic impacts of health care in the United States and a forecast of where we are headed in the absence of reform; an analysis of inefficiencies and market failures in the current health care system; a discussion of the key components of health care reform; and an analysis of the economic effects of slowing health care cost growth and expanding coverage.

The findings in the report point to large economic impacts of genuine health care reform:

We estimate that slowing the annual growth rate of health care costs by 1.5 percentage points would increase real gross domestic product (GDP), relative to the no-reform baseline, by over 2 percent in 2020 and nearly 8 percent in 2030.

For a typical family of four, this implies that income in 2020 would be approximately $2,600 higher than it would have been without reform (in 2009 dollars), and that in 2030 it would be almost $10,000 higher. Under more conservative estimates of the reduction in the growth rate of health care costs, the income gains are smaller, but still substantial.

Slowing the growth rate of health care costs will prevent disastrous increases in the Federal budget deficit.

Slowing cost growth would lower the unemployment rate consistent with steady inflation by approximately one-quarter of a percentage point for a number of years. The beneficial impact on employment in the short and medium run (relative to the no-reform baseline) is estimated to be approximately 500,000 each year that the effect is felt.

Expanding health insurance coverage to the uninsured would increase net economic well-being by roughly $100 billion a year, which is roughly two-thirds of a percent of GDP.

Reform would likely increase labor supply, remove unnecessary barriers to job mobility, and help to ''level the playing field'' between large and small businesses.

WHERE WE ARE AND WHERE WE ARE HEADED

Health care expenditures in the United States are currently about 18 percent of GDP, and this share is projected to rise sharply. If health care costs continue to grow at historical rates, the share of GDP devoted to health care in the United States is projected to reach 34 percent by 2040. For households with employer-sponsored health insurance, this trend implies that a progressively smaller fraction of their total compensation will be in the form of take-home pay and a progressively larger fraction will take the form of employer-provided health insurance.

The rising share of health expenditures also has dire implications for government budgets. Almost half of current health care spending is covered by Federal, state, and local governments. If health care costs continue to grow at historical rates, Medicare and Medicaid spending (both Federal and state) will rise to nearly 15 percent of GDP in 2040. Of this increase, roughly one-quarter is estimated to be due to the aging of the population and other demographic effects, and three-quarters is due to rising health care costs.

Perhaps the most visible sign of the need for health care reform is the 46 million Americans currently without health insurance. CEA projections suggest that this number will rise to about 72 million in 2040 in the absence of reform. A key factor driving this trend is the tendency of small firms not to provide coverage due to the rising cost of health care.

INEFFICIENCIES IN THE CURRENT SYSTEM AND KEY ELEMENTS OF SUCCESSFUL HEALTH CARE REFORM

While the American health care system has many virtues, it is also plagued by substantial inefficiencies and market failures. Some of the strongest evidence of such inefficiencies comes from the tremendous variation across states in Medicare spending per enrollee, with no evidence of corresponding variations in either medical needs or outcomes. These large variations in spending suggest that up to 30 percent of health care costs (or about 5 percent of GDP) could be saved without compromising health outcomes. Likewise, the differences in health

care expenditures as a share of GDP across countries, without corresponding differences in outcomes, also suggest that health care expenditures in the United States could be lowered by about 5 percent of GDP by reducing inefficiency in the current system.

The sources of inefficiency in the U.S. health care system include payment systems that reward medical inputs rather than outcomes, high administrative costs, and inadequate focus on disease prevention. Market imperfections in the health insurance market create incentives for socially inefficient levels of coverage. For example, asymmetric information causes adverse selection in the insurance market, making it difficult for healthy people to receive actuarially reasonable rates.

CEA's findings on the state of the current system lead to a natural focus on two key components of successful health care reform: (1) a genuine containment of the growth rate of health care costs, and (2) the expansion of insurance coverage. Because slowing the growth rate of health care costs is a complex and difficult process, we describe it in general terms and give specific examples of the types of reforms that could help to accomplish the necessary outcomes.

THE ECONOMIC IMPACT OF SLOWING HEALTH CARE COST GROWTH

The central finding of this report is that genuine health care reform has substantial benefits. CEA estimates that slowing the growth of health care costs would have the following key effects:

1. It would raise standards of living by improving efficiency. Slowing the growth rate of health care costs by increasing efficiency raises standards of living by freeing up resources that can be used to produce other desired goods and services. The effects are roughly proportional to the degree of cost containment.

2. It would prevent disastrous budgetary consequences and raise national saving. Because the Federal government pays for a large fraction of health care, lowering the growth rate of health care costs causes the budget deficit to be much lower than it otherwise would have been (assuming that the savings are dedicated to deficit reduction). The resulting rise in national saving increases capital formation.

Together, these effects suggest that properly measured GDP could be more than 2 percent higher in 2020 than it would have been without reform and almost 8 percent higher in 2030. The real income of the typical family of four could be $2,600 higher in 2020 than it otherwise would have been and $10,000 higher in 2030. And, the government budget deficit could be reduced by 3 percent of GDP relative to the no-reform baseline in 2030.

3. It would lower unemployment and raise employment in the short and medium runs. When health care costs are rising more slowly, the economy can operate at a lower level of unemployment without triggering inflation. Our estimates suggest that the unemployment rate may be lower by about one-quarter of a percentage point for an extended period of time as a result of serious cost growth containment.

THE ECONOMIC IMPACT OF EXPANDING COVERAGE

The report identifies three important impacts of expanding health care coverage:

1. It would increase the economic well-being of the uninsured by substantially more than the costs of insuring them. A comparison of the total benefits of coverage to the uninsured, including such benefits as longer life expectancy and reduced financial risk, and the total costs of insuring them (including both the public and private costs), suggests net gains in economic well-being of about two-thirds of a percent of GDP per year.

2. It would likely increase labor supply. Increased insurance coverage and, hence, improved health care, is likely to increase labor supply by reducing disability and absenteeism in the work place. This increase in labor supply would tend to increase GDP and reduce the budget deficit.

3. It would improve the functioning of the labor market. Coverage expansion that eliminates restrictions on pre-existing conditions improves the efficiency of labor markets by removing an important limitation on job-switching. Creating a well-functioning insurance market also prevents an inefficient allocation of labor away from small firms by leveling the playing field among firms of all sizes in competing for talented workers in the labor market.

The CEA report makes clear that the total benefits of health care reform could be very large if the reform includes a substantial reduction in the growth rate of health care costs. This level of reduction will require hard choices and the cooperation of policymakers, providers, insurers, and the public. While there is no guarantee that the policy process will generate this degree of change, the benefits of achieving successful reform would be substantial to American households, businesses, and the economy as a whole.

Mr. WHITEHOUSE. This report compares the share of America's gross domestic product spent on health care to the share spent by our international industrialized competitors. It also looks to the wide variation in health care expense and quality, region to region, within the United States of America. From each of these measures, the report comes to the same conclusion: They estimate excess health care expenditures of about 5 percent of GDP, which translates to $700 billion per year. Former Treasury Secretary O'Neill has written recently that the target is $1 trillion per year. Whether $700 billion or $1 trillion, that is a savings target that is worth an enormous expenditure of executive and legislative effort to achieve, particularly when all the evidence suggests that achieving it will actually improve health care outcomes for the American people.

Perfect examples of the savings that await us are in quality of care. I have spoken before about the Keystone Project up in Michigan which reformed care in a significant number of Michigan's intensive care units. It reduced infections, respiratory complications, and other medical errors. Between March 2004 and June 2005, just a little over a year, the project is documented to have saved 1,578 lives, 81,020 days patients otherwise would have spent in the hospital, and over 165 million health care dollars—just in a little over a year, just in intensive care units, just in one State, and not even all of the intensive care units in that State.

In my home State, the Rhode Island Quality Institute has taken this model statewide with every hospital participating, and we are already seeing hospital-acquired infections and costs declining.

Why aren't these quality reforms happening spontaneously all over the country? Because government and private insurers haven't set up the right rules for the game. When we began our intensive care unit reform in Rhode Island, the Hospital Association of Rhode Island estimated a $400,000 cost for a potential $8 million savings from the ICU reform program. That is a 20-to-1 return on investment. Super deal, right? Who wouldn't take that? Well, the hospitals pointed out that all the savings—the $8 million—went to the payers—to Medicare, to the insurance companies—and all the costs and all the trouble and all the risk came out of their own pockets. The savings actually cut hospital revenues. So with a lot of business experience around this Chamber, do we know a lot of businesses that would spend $400,000 in cash in order to lose $8 million in revenues? That is not a good economic proposition. We have made the rules such that it is not a good economic proposition for hospitals to invest that way.

That is why the HELP Committee bill changes payment incentives and invests in grant programs so it begins to make economic sense for doctors and hospitals to invest in lifesaving and cost-saving quality improvements. If we can make it an economic win for providers to improve quality this way, think of the torrent of American ingenuity that will unleash. Now we are stuck. We are stuck in a bog of market failure, with the connection between risk and reward—the fundamental connection between risk and reward that is the basic engine of American capitalism—interrupted and disabled. But CBO can't score that innovation because we haven't been down this road before. There is nothing in the rearview mirror for CBO professionals to work with to determine what those savings will be.

There is a similar problem in disease prevention. A study by the Trust for America's Health found that investing $10 per person per year in proven community-based programs to increase physical activity, improve nutrition, and prevent tobacco use could save the country more than $16 billion annually within 5 years. Out of the $16 billion in savings, Medicare could save more than $5 billion, Medicaid could save more than $1.9 billion, and private payers could save more than $9 billion, but those program providers don't get funded. That is why the HELP Committee bill establishes a prevention and public health investment fund to provide expanded and sustained nationwide investment in preventing illness. Well run, the savings could be enormous. But CBO can't score it because we haven't been down this road before, and there is nothing in the rearview mirror for CBO professionals to work with.

A third area for significant efficiencies and savings is the contentious, inefficient billing and approval process.

Right now, doctors and insurance companies are locked in an arms race. Private insurers delay claims and deny claims for reimbursement and throw up barriers to payment, and the providers, in turn, staff up and hire consultants and add people to fight back. This battle creates a colossal burden on the system, consuming perhaps 10 to 15 percent of all private insurance expenditure and then creating a reciprocal and probably actually greater cost shadow out in the provider community from having to fight back against that 10- to 15-percent expenditure. It all adds no overall health care value—none. It is pure administrative cost shifting. Even the insurance industry estimates that $30 billion per year could be saved through simplification of that process. That is why the HELP Committee bill has strong administrative simplification requirements. But again, CBO can't score it because this is another new road. Again, there is nothing in the rearview mirror for CBO to work with.

Finally, multiple studies show that the private insurance market is plagued by inefficiency and waste. While administrative costs for Medicare run about 3 to 5 percent, overhead for private insurers is an astounding 20 to 27 percent—charges that consumers pay for higher premiums. A Commonwealth Fund report indicates that private insurer administrative costs increased 109 percent—they more than doubled—private insurer administrative costs more than doubled from 2000 to 2006, just in 6 years. The McKinsey Global Institute and a leading health economist indicate that Americans spend roughly $128 billion annually on ''excess administrative overhead''—that is, $128 billion on excess administrative overhead—in the private health insurance market.

That is why the HELP Committee bill establishes a strong nonprofit public health insurance option that would compete on even terms with private insurance companies, bringing down premiums, negotiating more efficient provider payments, and increasing consumer access—all through the power of free market competition. All this is done through the power of free market competition. But, again, CBO cannot score it because we have not been down that road before. There is, again, nothing in the rearview mirror for CBO professionals to work with.

In the 1930s, Franklin Delano Roosevelt's proposal for an innovative program called the Tennessee Valley Authority faced this dour prediction from a Member of the House of Representatives:

> Mr. Speaker, I think I can accurately predict no one in this generation will see materialize the industrial empire dream of the Tennessee Valley.

Another Member remarked:

> The development of power in that particular locality of the Nation . . . can be of no general good.''

Had FDR been cowed and discouraged by such pessimism, by the difficulty and uncertainty and novelty of his task, the TVA would never have brought electricity, jobs, and prosperity to millions of Americans.

Likewise, today, it is precisely because our reforms are innovative and because they will take energy, commitment, and leadership to achieve that they are unscorable. That should be an inspiration to us, not a discouragement. Through this reform bill, we must challenge ourselves and the Obama administration to do that which economists and commentators cannot specifically score and analyze. With strong leadership and dedication, we can not only bend the cost curve, we can break it.

Let's set a hard target, say, $500 billion in annual savings, and see how fast we can get there. Let's make this the Apollo project of our generation. The stakes are high enough to justify that effort.

I thank the Chair and yield the floor.

The PRESIDING OFFICER. The Senator from Wyoming is recognized.

Mr. BARRASSO. Madam President, I ask unanimous consent to speak for up to 10 minutes in morning business and that Senator SESSIONS be recognized when I have finished.

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

Mr. BARRASSO. Madam President, most everybody knows I am an orthopedic surgeon. In Wyoming, many refer to me as ''Wyoming's doctor.'' That is because for over two decades folks have invited me into their home with statewide television and radio health reports, where I gave people information on how they can stay healthy and how to keep down the cost of their medical care. I ended each report by saying: ''Here in Wyoming, I'm Dr. John Barrasso, helping you care for yourself.''

That is also my philosophy for government—helping people help themselves. As medical director of the Wyoming Health Fairs, I worked to give people around the Cowboy State access to lifesaving preventive tests and low-cost medical screenings.

My goal was always to encourage families to eat right, exercise, manage chronic diseases, and stop smoking because prevention is one of the keys to a long and happy and healthy life.

As I travel home every weekend, I hear the concerns people have about health care and the cost of their medical care. They are concerned about the specific cost of their medical care and how it affects them and their family budgets. Many families across Wyoming and in this country worry that they will lose the health care coverage they currently have. Others cannot afford insurance today. That is what is wrong with our current health care system. That is what we need to fix.

I know from firsthand experience that doing nothing is simply not an option. We must be careful, thoughtful, and deliberate about the changes we make. Health care is a very complex and an intensely personal issue. It deserves a national debate—a serious, open, and transparent national debate.

I welcome the opportunity to talk about the concerns of people living longer and needing more care and more advanced care. The concerns are affordable care, access to care, and high-quality care.

In the midst of this debate, we cannot stand for rural Americans to be left behind. They need access to high-quality, affordable health care like everybody else.

When I first came to the Senate, I promised the people of Wyoming I would fight each and every day to protect and modernize our rural health care delivery system. I committed to do my part to strengthen our rural hospitals, rural health clinics, and community health centers. I committed to do my part to increase rural America's access to primary health care services and to aid in the successful recruitment and retention of nurses, nurse practitioners, doctors, and physician assistants all across rural and frontier America.

There are obstacles faced by our hospitals, clinics, and our providers—obstacles they have to overcome to deliver quality care to all the families in rural America. They end up having to do it in an environment of markedly limited resources. The Federal Government needs to recognize these important differences and then respond with appropriate policy.

The people of Wyoming know I am here not just as their Senator but also as a rural doctor who has practiced medicine, fighting on their behalf.

Recently, I joined three of my colleagues to introduce S. 1157, the Craig Thomas Rural Hospital and Provider Equity Act.

Today, I rise to talk about a different bill that I have introduced alongside my colleague from Oregon, Senator RON WYDEN. It is called the Rural Health Clinic Patient Access and Improvement Act.

This legislation is a great example of what true bipartisanship can produce. I thank Senator WYDEN and his staff for working so hard to collaborate with me on this very important bill. I commend him for his dedication to helping rural Americans have equal access to the high-quality medical care they deserve.

This legislation strengthens America's 3,500 rural health clinics that serve rural and frontier communities.

Rural health clinics are a highly valued medical provider in communities all across this country. In Wyoming, we have rural health clinics located in communities that many people have never heard of, such as Baggs, Glenrock, Hulett, Lovell, Medicine Bow, Saratoga, and my wife Bobbie's hometown of Thermopolis. These clinics make sure people have access to primary care as close to home as possible. That is not easy to.

To give you a snapshot of Wyoming's health care landscape, we have only 26

hospitals and 18 rural health clinics spread over nearly 100,000 square miles, which is a remarkably large distance. With vast distances, complex medical cases, and increased demand for technologically advanced medical care, the rural health care system is certainly not one size fits all.

Let me explain what this Rural Health Clinic Patient Access and Improvement Act actually does.

First, the rural health clinics currently receive an all-inclusive payment rate that is capped at $76. That payment has not been adjusted—except for inflation—since 1988. We all know that medical inflation has gone up at a much greater rate than regular inflation.

This bill addresses this problem by raising the rural health clinic cap from $76 to $92. Rural health clinics are a key component of the rural health care delivery system, and we need to make sure there is fair pay for patients who are taken care of in those facilities.

We also need to give them enough flexibility to meet their community's health care needs.

Additionally, this measure would establish a new quality reporting program for rural health clinics.

Three years ago, Congress required the Centers for Medicare and Medicaid to create a physician quality reporting system. This program offers bonus payments to doctors who report quality measures on Medicare services.

The quality incentive program is linked to the Medicare physician fee schedule. Rural health clinics, though, are not paid using the physician fee schedule. If Congress wants to pay doctors based not on volume but on the quality of care, then it is important to remember that the one-size-fits-all approach will not work here.

That is why this bill ensures that a comparable quality incentive is available to rural health care providers.

Third, the Rural Health Clinic Patient Access and Improvement Act would create a provider retention demonstration project. It is a five-State project that will study the extent to which a medical professional can be encouraged and enticed to practice in an underserved rural and frontier area.

The States would be given grants to help physicians, physician assistants, nurse practitioners, and certified nurse midwives to help them pay a small portion of their medical liability costs.

I believe these incentives will help draw more providers—especially those who deliver babies—to work in an underserved area because their malpractice insurance is the same whether they deliver 1 baby or 100. In these small areas, there aren't that many babies being born each year, so the cost, while it is the same for malpractice insurance, has to be distributed over a fewer number of patients. This will encourage them to practice in underserved areas.

Wyoming has too few primary care providers for the population we must serve. My State is not alone. This bill that Senator WYDEN and I have introduced reflects our commitment to ensure rural Americans have access to high-quality health care services.

I strongly encourage all my colleagues with an interest in rural health to cosponsor this bipartisan piece of legislation.

I yield the floor.

The PRESIDING OFFICER. The Senator from Alabama is recognized.

HOMELAND SECURITY APPROPRIATIONS

Mr. SESSIONS. Madam President, I offered an amendment to the Homeland Security legislation that is before us which would make that system permanent, and make its use mandatory for contractors that do business with the U.S. Government.

Essentially, employers all over America are accessing the E-Verify online system that allows them to have an instant check to determine whether the person who has applied for employment with them is legally in the country. They simply check their Social Security number and other data against the Social Security Administration and Department of Homeland Security databases. When the system determines a person is not here legally, employers don't hire them. Over 96 percent of the people are cleared automatically when a business checks. Of the remaining 3.9 percent of queries with an initial mismatch, only .37 percent of those were later determined to be work authorized. A certain percent of applicants are found to be here illegally, and they should not get a job or any taxpayers' money from a part of the stimulus package. Stimulus funds were set aside to help us reduce our unemployment rate in this country and to hire American workers. The prospect of jobs should not be a magnet to draw more illegal workers into the country.

The first thing you do, if you have an immigration problem, is stop rewarding those who break the law. One of the things you do not do is reward people who come illegally with jobs. You do not have to arrest them or do anything unkind. You simply do not hire them, especially with taxpayers' money that is designed to create American jobs.

This has been a matter we have talked about for some time. It is very important in this time of economic slowdown because the Bureau of Labor Statistics reported that the unemployment rate for June, just a week or so ago, had jumped to 9.5 percent, 467,000 jobs lost, the highest unemployment rate in 25 years. We have massive job losses. A lot of good people are out of work, they need work and are willing to work.

E-Verify is not a perfect system. People can find ways beat it, no doubt, but it actually works. One study by the Heritage Foundation concluded that as much as 13 percent of the jobs created under the stimulus plan would go to people illegally in the country the way we were operating. By utilizing the E-Verify system, I have no doubt we could drop that percentage dramatically. I am very concerned about it. I am a bit baffled by the difficulty we have had in moving forward with this amendment.

I will say that two bits of progress—small progress, I know—have occurred. The House Homeland Security appropriations bill for fiscal year 2010 has come over to the Senate, and it includes a 2-year extension of E-Verify. That is better than letting it expire. In addition, the Senate version of the bill includes a generous 3-year extension of this proven system. I have to say that is OK, but neither bill has any language that would make this system permanent. It leaves it on very shaky ground, making businesses that might voluntarily want to utilize it wonder if it really is the policy of our country to use it. Madam President, over 1,000 businesses a week are now voluntarily signing up to use the system.

Failing to make the system permanent also raises questions about the sincerity of our commitment. More significantly, neither one of the bills has any language that says that government contractors, people who are doing work for the U.S. Government, paid for by us, the taxpayers, must use this system. I ask, Why not? What possible, justifiable, rational reason can we give to pass legislation designed to help deal with this recession, to try to create American jobs and not make sure federal contractors only hire lawful workers? What basis could we utilize to say that those contractors should not at least take about 2 minutes—that is about all it takes to punch in a Social Security number into the system—to see whether a person applying for a job is legally in the country.

There is a long history on this amendment. For some reason, interest groups have been lobbying against permanent authorization and mandating use of E-Verify by federal contractors. Certain business groups oppose this amendment. It scares them. Why? I suggest there is only one logical conclusion: They like the idea of hiring illegal workers. But how can we as Members of the Senate representing the American taxpayers possibly justify using their money that is designed to create jobs for American citizens to hire people who are here illegally, creating an even greater magnet to attract more people to come into our country illegally?

I have offered this amendment to the appropriations bill to ensure this successful program be made permanent. And, of course, any time in the future if it ceases to be practical, we could end it. But this amendment would make it permanent, sending a signal—that is part of what we want to do—and it would also be mandatory for government contractors. If a Federal contractor gets a contract to do work, at