by George Washington and his troops, which swore allegiance to a country that was not even formed yet—an allegiance that would have caused him to be executed if we had lost the American Revolution. So there was a lot at stake when our country was founded, and so much of it was about liberty and about an ability to resist a king or an imperial leader.

George Washington himself imposed his own character upon the American character by his modesty and restraint, by his decision to step down as general of the American army. He could have been general for the rest of his life. He made the decision to step down as President of the United States after two terms. He could have been President for the rest of his life. But at the beginning of our country, liberty, to many people, meant avoiding an executive that was too strong, that didn't have proper checks and balances. And our Founders put into our Constitution checks and balances with the court and with the legislature.

Of course, as we like to point out, article 1 is about the Congress, about the legislature. And as I said earlier, perhaps the best known function the Senate has is the ability to advise and consent. The President may nominate, but those important people—men and women—may not take their offices until they have been confirmed by the Senate.

This administration, I am sorry to say, has not respected those checks and balances, as I had hoped it would. I would suggest maybe a retreat to Mount Vernon for President Obama and the White House staff. The Obama administration has appointed more czars than the Romanovs. We have always had some czars, such as the drug czars, but they have three dozen—three dozen who aren't subject to the usual restrictions that we have through the appropriations process.

The most blatant example of the imperial Presidency are the recess appointments at a time when the Senate, according to this court, was not in recess, in order to put into those positions men and women with whom the Senate would not agree. If the President could do what the President did on January 4, 2012, on a regular basis, we might take a recess break for lunch and come back and find we have a new Supreme Court Justice.

I am here to suggest the right thing to do would be to respect the tradition of checks and balances that is built into our Constitution. It is at work here, because the President took an action, we didn't like it, and the third branch of government has made a decision the President was wrong. The way to go forward is for the two remaining members of the National Labor Relations Board who were appointed unconstitutionally to resign their position and for the President to nominate as rapidly as he can men or women to fill the remaining vacancies on the board. And to the extent the committee on which I am the ranking Republican, which oversees labor matters, has anything to do with that, I will pledge speedy consideration of those nominees.

Let's get the National Labor Relations Board back in business. But it cannot be open for business today. It cannot be properly open for business today. Those two members should resign their positions and recognize the court has said we still have in America a Constitution that provides checks and balances. So take down the sign that says: Open for business, and put up the sign that says: Help wanted. Nominations accepted.

Mr. President, I commend my colleagues to read my floor remarks of February 2, 2012, about recess appointments, which I made following the President's so-called recess appointments and following my visit to Mount Vernon.

I yield the floor, and I suggest the absence of a quorum.

The ACTING PRESIDENT pro tempore. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

UNANIMOUS CONSENT AGREEMENT—H.R. 152

Mr. WHITEHOUSE. Mr. President, I ask unanimous consent that no points of order be in order to the Lee amendment or H.R. 152, prior to a vote on passage of the bill.

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

HEALTH CARE COSTS

Mr. WHITEHOUSE. Mr. President, we are now entering a postfiscal cliff phase of budget negotiations, and a troubling but familiar refrain is already beginning to echo through this Chamber which goes something like this: In order to fix our deficit, we must cut Medicare and Medicaid benefits. This is wrong. This is flatout wrong and it is factually wrong.

A recent Providence Journal editorial touched on the dangers of that misguided approach. The editorial read: We need a better run Medicare and Medicaid, not one that covers fewer people. Quality can be improved and costs contained without throwing people off the rolls and into the streets and back into the free care of emergency rooms mandated for the uninsured and into expensive private insurance. In the end, we all pay in some way, in quality of life and in money, for the gaps we tolerate in our health care system.

Attacking Medicare and Medicaid is consistent with a particular political ideology—it has been part of that political ideology for decades now—but it is not consistent with the facts. It ignores the fact that our health care spending problem is systemwide, not just in Federal programs. It ignores the fact that we operate in this country a wildly inefficient health care system. It is not just Medicare.

For example, Secretary of Defense Robert Gates said, in reference to the defense budgets: We are being eaten alive by health care.

New data from the Centers for Medicare and Medicaid Services shows our national health care spending increased to $2.7 trillion in 2011, which is about 18 percent of America's gross domestic product. This is more than three times what it was in 1992, and it is about 100 times what it was back in 1960. The Presiding Officer, the new Senator from Virginia, and I were probably around in 1960. So in our lifetime it has gone up 100 times.

At this rate, by 2020, $1 out of every $5 in this country will go toward health care. This is a rocketing pace of increase.

In 1979, the year after I graduated from college, $221 billion; 1987, $519 billion; 1992, $857 billion; and now $2.7 trillion. Anybody looking at that graph of our exploding national health care costs who can think that Medicare is the problem simply does not have a grasp of the facts.

Let's compare U.S. spending to other developed countries. This is us, ''pre'' the last report when we were still at 17.6 percent of GDP. The next least efficient developed country is the Netherlands at 12 percent of GDP in 2010. Germany and France were at 11.6 percent of GDP.

This margin right here is the margin by which we are more inefficient than the least efficient of our industrialized competitors—$800 billion a year. We could save $800 billion a year on our national health care system just by becoming as efficient as the least efficient of our national competitors.

For all of this extra spending, the extra $800 billion a year, one might expect that we would have paid for and earned longer and healthier lives, but that is not the case. Our National Institute of Medicine recently compared the United States to 17 peer countries. We were worst for prevalence of diabetes among adults among those 17 countries, worst for obesity across all age groups of those 17 countries, and had the worst infant mortality of all 17 countries. We suffer higher death rates and worse outcomes for conditions such as heart disease and chronic lung disease.

This chart from that National Institute of Medicine report shows all these dots of the other countries grouped around cost—expenditure per capita—and life expectancy. That is the United States of America, the dot with the red circle around it. We are an outlier, below virtually all of these countries

except Poland and Turkey and Hungary, below them all on life expectancy. They are all above 78 and we are just below it, and we are wildly out of the grouping on cost. We are at way higher cost than the grouping of all of our industrialized competitors. We are wild outliers in a very bad direction of high cost and poor outcomes. This is a stark and unsettling disparity of us from virtually all the other nations. It is not to our benefit.

The real issue is the fact that we have to deal with the cost and the performance of our health care system. Another fact that I know the Presiding Officer is well aware of is how hard this is on American families. From 2000 to 2009 the average family premium for health insurance more than doubled from around $6,500 to more than $13,000. I can assure you the average family income did not double during that same period, unless maybe you were an average family on Wall Street.

Health care costs are a leading cause of family bankruptcy in this country. Thankfully, the Affordable Care Act will help millions of uninsured Americans purchase health coverage. But we should add, in addition to the kneejerk reaction to target Medicare and Medicaid being out of step with these facts, it will also hurt these families more without grappling with the real health care system cost problem.

Again, going after Medicare is wrong. It is a misdiagnosis of the problem, and, of course, when you miss the diagnosis you prescribe the wrong cure.

Medicare is actually one of the most efficient parts of our inefficient health care system. From 2007 to 2011, for the same set of health benefits, the annual growth rate in health spending per Medicare enrollee was 2.8 percent; for private plans, 5.6 percent, twice as much, a 100-percent higher cost than for Medicare.

The Congressional Budget Office has found that for every dollar we spend on Medicare, 98 cents of it goes through to people in the form of health care, actual health care. Spend $1, get 98 cents' worth of health care. For Medicare Advantage that the private insurance sector runs that operates under similar rules and treats the same population as Medicare, every $1 delivers only 89 cents in health care, with the rest spent on administrative cost and CEO salaries and marketing. So not only is Medicare not the problem, it is actually one of the best ways we have for delivering health care through this wildly inefficient outlier of a health care system.

I am not alone in saying that a correct diagnosis of the problem will lead us to health care system reform, not Medicare benefit cuts. Gail Wilensky, the former CMS Administrator under President George H.W. Bush, said in 2011:

> If we don't redesign what we are doing, we can't just cut unit reimbursement and think we are somehow getting a better system.

A lot of my colleagues give great credence to the private sector. In the private sector, one of the leaders in health care is George Halvorson, who recently stepped down as chairman and CEO of Kaiser Permanente, one of the biggest and best health care companies in the country. Here is what he said:

> There are people right now who want to cut benefits and ration care and have that be the avenue to cost reduction in this country and that's wrong. It's so wrong, it's almost criminal. It's an inept way of thinking about health care.

So from Republican administrators to private sector leaders, the message is the same: We have to solve this as a system problem.

Let me give a couple of examples of how we might want to go about doing this. As one example of the significant savings to be found in our health care system, a Washington Post columnist recently wrote:

> Few people realize that Medicare spends wildly different amounts per senior depending on where the senior happens to live. . . . Medicare spends 2.5 times more per senior in Miami than in Minneapolis.

I repeat, 2½ times more per senior in Miami than in Minneapolis—

> Yet there is no difference in quality or health outcomes associated with this extra spending. In other words, Medicare redistributes billions from regions where doctors practice cost effectively to regions where the local Medical Industrial Complex pads its income with excess services and procedures.

Our colleague, Senator FRANKEN, often says: If we could just deliver health care the way we do in Minnesota, we could solve our problem. And this column and this information bears it out. If they are not getting better health care in Miami, then why do we tolerate letting Miami absorb 2.5 times the cost per senior than they are able to provide it for in Minneapolis? We should be driving Miami toward Minneapolis, where we know they can do it in Minneapolis. Make that the model and force the change.

This graph uses data from the Dartmouth Atlas Project to illustrate this point. Not only is there significant variation in health care cost and quality—each of these dots is a State, and they are rated on overall quality and spending per beneficiary. As we can see, they spread out from very high cost and very poor quality States, such as Louisiana, to very low cost and very high quality States, such as New Hampshire. But if we draw a statistical line through this array of dots, here is the line we get. It shows the reverse correlation: The more you spend the worse your care.

A second example, and it is consistent with this, is how poorly our health care system performs on basic measures of quality and safety and prevention. For example, according to the news magazine ''The Week,'' avoidable infections passed on due to poor hospital hygiene kill as many people in the United States—about 103,000 people killed every year—as are killed by AIDS, breast cancer, and auto accidents combined. We are killing more people in this country through hospital-acquired infection than through AIDS, breast cancer, and auto accidents combined. These deaths are tragic to those families, but they are tragic in another sense because they are preventable.

As we have shown, in Rhode Island, when hospital staff follow a checklist of basic instructions—washing hands with soap, cleaning the patient's skin with antiseptic, placing sterile drapes widely over the patient—rates of infection plummet and the costs of treating those infections disappear. The costs of treating the 100,000 Americans who die every year from those hospital-acquired infections are huge, and they would disappear if we do not have the infections in the first place and the cost of treating the hundreds of thousands who get those infections and do not die, who are not among the 103,000 who die but nevertheless have to be treated, those costs also disappear. It is a pretty big number. We don't know exactly what it is, but the Center for Disease Prevention reported that from 2001 to 2009, there were State and Federal efforts to improve these efforts to prevent hospital-acquired infections, and that contributed to a 58-percent decrease in the number of central line bloodstream infections among intensive care unit patients. That, in turn, represents up to 27,000 saved and approximately $1.8 billion in cost savings to our health care system. Let's do more of that before we go after Medicare benefits.

A third example is managing and preventing chronic disease. Compare the United States to France on the treatment of lung disease and you will find that although France has more smokers and therefore higher rates of lung disease than the United States, levels of severity and fatality are three times lower in France. France spends eight times less on treatment per person than we do.

Compare the United States to Britain on diabetes. You will find that Britain spent only half of what we spend per person on diabetes, but it is five times more productive in managing diabetes than we are.

Dr. Daniel Vasella, who is the chairman of Novartis, explains that ''in America, no one has incentives to make quality and cost-effective outcomes the goal.''

France and Britain give their health care providers incentives to focus on early detection and cost-effective treatment that make wellness the goal, not treatment. To paraphrase George Washington University Professor Thomas J. Schoenbaum: ''Make virtue profitable and everyone's a saint.''

Saving money by reforming how we deliver health care is not just possible, it is happening. A 2008 report from the Dartmough Atlas Project predicted that ''using the Mayo Clinic as a benchmark, the nation could reduce health care spending by as much as 30 percent for acute and chronic illnesses.'' A benchmark based on Intermountain Healthcare, which is a great

provider based in Utah, predicts a reduction of more than 40 percent. So we are doing it; it is happening. We just need to spread it more widely. During a 2011 Senate HELP hearing that I chaired, Greg Poulsen of Intermountain Healthcare said:

> Intermountain and other organizations have shown that improving quality is compatible with lowering costs and, indeed, high-quality care is generally less expensive than substandard care.

Take a look at what various experts estimate as the potential annual savings that could be found in our health care system. The President's Council of Economic Advisers says that we could annually save $700 billion a year. The National Institute of Medicine recently reported that we could save $750 billion a year. The New England Healthcare Institute has estimated that a savings of $850 billion a year is possible, and the Lewin Group—a private group that focuses extensively on health care and does research and analysis—together with George Bush's Treasury Secretary Paul O'Neill, have come up with an estimate of $1 trillion a year. We don't know what the exact number is. These are estimates, but for sure there is a huge potential for savings in our health care system.

These savings flow through to our Federal budget. The Federal Government does 40 percent of America's health care spending. If the estimate by the Council of Economic Advisers is correct, the national health care expenditure is $2.7 trillion, Federal health care spending is $1.1 trillion. After we do the math, it is 40 percent.

Of the four estimates, let's take the most conservative one. Let's take the Council of Economic Advisers' estimate of $700 billion—the lowest of the four—and multiply it by 40 percent. The Federal share would be $280 billion per year for the Federal Government. It would be $280 billion per year just by getting those kinds of savings.

Let's say we cannot get the $700 billion, that it is too hard to lift; we tried and cannot get there. Let's say we can only get half of those estimated savings. That is $350 billion times 40 percent. We could set a target of $140 billion of savings in the Federal budget in health care having assumed a 50-percent failure rate in getting there from the lowest of the four major estimates. That is pretty conservative to start from the lowest of the four major estimates, assume a 50-percent failure rate, and there we are, we still get $140 billion a year we could target as savings coming back into the Federal budget and the Federal health care system.

Let's say we set the target at $350 billion, the halfway target, and we failed at meeting even that target. Let's say we failed again by half, which is not close. That is a huge miss. Let's say the best we could do is to get $175 billion of the $700 billion in savings, which was the most conservative of those four estimates. If we multiply that by 40 percent, guess what. That is $70 billion a year.

What do we do when we get into budget discussions? We multiply by 10 because it is a 10-year budget estimate. If we are going to take that $70 billion and move into a budget discussion, it becomes $700 billion. So this is real money.

Let me add that most recently the Commonwealth Fund released a report that outlines a set of distinct policies that would accelerate health care delivery system reform and slow health spending by $2 trillion over 10 years. So that is not just $700 billion but $2 trillion over 10 years, from 2014 to 2023.

How do we get there? Well, many of the tools necessary to drive down costs and improve the quality of patient care are already in the law. The Affordable Care Act, the famous ObamaCare, included 45 provisions which have virtually never been discussed on this Senate floor—because they were not controversial—that were dedicated to redesigning how health care is delivered. These delivery system reforms cover five priority areas: payment reform, making sure that people are paid to keep us well and not wait until we get sick and have to treat us more; primary and preventive care, making sure we are taking care of chronic patients, less specialists, more care upfront; measuring and reporting quality so we are not dealing with the hospital-acquired infections so much; administrative simplification because for doctors it is a bear to try to keep up with the insurance companies that try to continue to deny them payment; and health information technology so we have an electronic health record that loads with data and is sensible and state of the art.

These Affordable Care Act delivery system reforms span our health care system and engage all stakeholders in the effort—for example, patients, physicians, hospitals, State governments, and the Federal Government—which is good because working together is the right way to achieve these reforms.

There is even evidence that the Affordable Care Act is already working to slow the growth of health care spending. In a Washington Post op-ed this summer, Secretary of Health and Human Services Kathleen Sebelius wrote:

> In the decade before the law passed, national health expenditures increased about 7 percent a year. But in the past two years, those increases have dropped to less than 4 percent per year.

At the top of this graph, it is actually starting to tip down a little bit, thanks to that. Dropping it to less than 4 percent per year has saved Americans more than $220 billion.

Peter Orszag, the former Director of the Office of Management and Budget, said the same thing in a recent Providence Journal editorial. He said——

The ACTING PRESIDENT pro tempore. The Senator needs to begin to wrap up.

Mr. WHITEHOUSE. Mr. President, I ask unanimous consent for an additional 2 minutes.

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

Mr. WHITEHOUSE. Mr. President, I know the distinguished Senator from Alabama is waiting and I will wrap up.

Peter Orszag wrote in the Providence Journal:

> In January 2009, [CMS] projected that expenditures would reach 19.8 percent of gross domestic product in 2017. This year, the projection for 2017 is down to 18.4 percent of GDP. That difference amounts to a whopping $280 billion. In other words, relative to the projections issued three years earlier, today's forecasts suggest health savings of $3,500 per family of four by 2017.

I did this report for the Senate HELP Committee last year on the Affordable Care Act delivery system reform provisions. Anybody who is watching and wants a copy, contact my office; we will mail or e-mail it to you.

In the report we found that the administration has made fairly considerable progress on the 45 delivery system reform provisions in the law, but much more can and must be done. Specifically, the report calls upon the Obama administration to set a cost savings target for health care delivery system reform. A cost savings target will focus and guide and spur the administration's efforts in a manner that vague intentions to bend the health care cost curve will not. It would also provide a measurable goal by which we can evaluate the progress of the Affordable Care Act.

In a report I mentioned earlier, the Commonwealth Fund has reported that ''the establishment of targets . . . can serve both as a metric to guide policy development and as an incentive for all involved parties to act to make them effective.''

One of the best examples of a clear target was President Kennedy declaring that within 10 years the U.S. Government would put a man safely on the Moon and bring him home. That message and the mission that was outlined were clear. The result was a mobilization of private and public resources to achieve that purpose because the goal was clear and specific.

This administration has a similar opportunity, particularly now at the height of the implementation of the Affordable Care Act: Set a serious cost savings target for our Nation's health care system—none of this spongy bending the health care cost curve stuff—and put the full force of American innovation and ingenuity into achieving that target. That approach has a triple benefit: protecting Medicare and Medicaid benefits that don't need to be cut if we are doing this right; second, improving patient outcomes, making people healthier; and third, dialing back health care spending by potentially hundreds and hundreds of billions of dollars. The alternatives to that will harm seniors and those least able to afford adequate health care.

I conclude by urging the administration to set a real cost savings target with a number and a date, and then let's get to work to give the American families the health care system they deserve. Instead of waste and inefficiency and being a disgraceful outlier from all the rest of the world on quality and cost, let's make for America the health care system that is the envy of the world. That should be our goal and that could be our destiny.

I thank the Presiding Officer, and I yield the floor.

I express my appreciation to the distinguished Senator from Alabama for his patience during my remarks.

The ACTING PRESIDENT pro tempore. The Senator from Alabama.

IMMIGRATION REFORM

Mr. SESSIONS. Mr. President, I know there is a group of Senators who announced today that they have ideas, a plan, an outline, and a framework for a new comprehensive immigration bill. Indeed, the fact that our current immigration system is not working effectively and is failing on a daily basis cannot be denied. It certainly needs to be fixed. It is a challenge for us to do so and it will not be easy. I want to warn my colleagues that a framework is not a bill.

In 2006 and 2007, with the full support of the Republican President of the United States, a bipartisan group announced with great confidence that they had a plan that was going to fix our immigration system and we were all going to just line up and vote for it. The masters of the universe had decided, met in secret, had all the special interest groups gathered and worked out a plan that was going to change our immigration system for the better, and we should all be most grateful.

It came up in 2006, and it did not pass. It came back again in 2007 with even more emphasis, and it failed colossally. It failed because it did not do what they said it would do. It did not end the illegality, it did not set forth a proper principle of immigration for America, and it did not sufficiently alter the nature of our immigration system to advance the national interest of the United States. It did not, and that is why it didn't pass. They had all the powerful forces, including the TV and newspaper guys, the Wall Street guys, the agriculture guys, the civil rights group, La Raza, and the politicians. But the American people said no. It was a challenge, and there was a long debate, but it didn't pass. I thought the lesson learned from that was there needs to be a demonstration that the law is being enforced, end the illegality, and then we can wrestle with how to compassionately treat people who have been in America a long time. I thought that was kind of what we had decided.

Now my colleagues say: Don't worry, this is going to be a better piece of legislation that can work for us. I hope that is true. We do need to fix the immigration system. There are things we can do on a bipartisan, nonpartisan basis which would make our country's immigration policy better and more effective, and I hope that is what will result from this.

But no one should expect that Members of the Senate are just going to rubberstamp what a group of Members have decided. We are not going to just rubberstamp what the President of the United States has just decided because we need to analyze it. Each one of us, every Member of this Senate has a responsibility, a firm duty to evaluate this proposal to ensure that it enhances our ability as a nation to do the right thing.

We are a nation of immigrants, and we are going to continue to be a nation of immigrants. We admit over 1 million people into our country every single year legally. But now we are told that after 1986, when they had that immigration bill, that amnesty bill, that we have allowed 11 million more people, give or take a few million, into the country illegally. They have entered the country illegally. In 1986 Congress promised the American people that if they would give amnesty to the people who were here and who entered illegally, they would stop illegal immigration in the future and we wouldn't face this challenge again. In fact, our colleagues basically said that in their piece they put out promoting the bill: We are never going to have to worry about immigration again if Members pass our legislation. That was the promise made in 1986 when the bill did pass, but it did not fulfill its promise.

So once again I think we are in a situation where the promise will be made that people will be given immediate regularized status and they won't be given full rights of citizenship until certain laws are enforced, and don't worry about it—it is all going to work out sometime off in the distant future. But questions do need to be asked, and we will ask those questions, and it will be important for us to do the right thing.

I know there are people who like low wages. I know there are people who believe that it is hard to get Americans to do certain jobs and that we can use immigrants and they will do those jobs at less pay and ask fewer questions and demand fewer benefits. I know that is out there. We have talked about that in the past. I am hoping this legislation is not designed for the special interests but designed to advance American interests.

What are some of the principles I think need to be in this system? I like Canada's system of immigration. It seems to work very well. They ask a number of questions. They give points when one applies to come into Canada, and a person gets more points for meeting the goals they have. One of the goals they have is that the potential immigrant speak the language. In Canada, they have two—French and English. If a person speaks French or English, they get more points or maybe they don't even get in if they don't have some grasp of the language before they come in on a permanent basis. Then they give more points, more preference to people with education, skills they need in Canada.

This proposal suggests it does that. It should do that. It should be a major part of any immigration reform that focuses on trying to get people who will be most successful in America, the ones we know are going to be able to do better here.

The plan should not admit a person who is likely to be a public charge. However, that is already the current law. A person is not supposed to be admitted to America if they are likely to be a public charge; that is, they will need government aid to take care of themselves. Some people will be turned down because of this. We should take the ones who are not going to be a public charge.

We discovered in looking at the numbers recently that less than one-tenth of 1 percent of applicants that come to the United States are turned down on the basis that they might be a public charge. So, in effect, that is not being enforced. Basically, it is just not being enforced.

So how can we be sure of that? My friend Stephen Moore was on the TV today. He is at the Wall Street Journal. He said: You don't have to worry about people coming in and being a public charge. There is a law against that.

Well, Mr. Moore, there may be a law against it, but it is not being enforced. We need to know it is going to be enforced in the future.

Younger people in Canada get a priority. Pretty soon, people will be on Social Security and Medicare when they reach those ages. Shouldn't we as a rational nation look to give priority to younger people who will work a little longer and pay more into the system before they draw these benefits?

They give preferences to investors, those who create jobs and bring factories and manufacturing to their country. Those are the kinds of things I think we ought to be talking about.

This proposal makes reference to guest workers. It is a very delicate issue. Let me tell my colleagues what was in the bill in 2007 and the reason. In my mind, it was one of the greater errors in the legislation. People would come into the country for 3 years. They could bring their families. If they were still working at the place at which they came in to work, they could extend for another 3 years and then another 3 years and then another 3 years. So I would ask, somebody who had been in the country 8, 9, 10 years, could we just easily ask them to leave? Not likely. What if they have had two children and the children are automatic citizens?

This is a very impractical system. So we need to examine how a guest worker