

themselves and their families—all of that would not be in the plan. All of that would not be in the plan.

We can do this. Of course, that is in addition to the rebates for both single people and married couples and married couples who have children who are already a part of our package as well, building upon the House proposals.

So let's pass a package that has the widest possible impact. Let's pass a package that does not leave out 20 million seniors, that takes care of a quarter million disabled veterans, and provides rebates to as many Americans as possible.

That is acting wisely, and it can be done quickly. We need our colleagues to join with us in the sense of urgency that exists, and to say to those 20 million seniors, those quarter of a million veterans, the millions who are unemployed: We stand with you as fellow Americans in this time of need in turning our economy around for all of us.

That was the choice we had yesterday. I hope we will have that choice again. I hope the hearts of some will be softened in this process and that they will cast a vote to move in a much different direction.

With that, Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Rhode Island is recognized.

#### WIRED FOR HEALTH CARE QUALITY ACT

Mr. WHITEHOUSE. Mr. President, today I rise to speak for a few moments about health care and to recognize the extraordinary work four Members of this body have done to promote an integrated, interoperable health information technology infrastructure in this country. Senators KENNEDY and ENZI on the HELP Committee, Senator HILLARY CLINTON, and Senator HATCH, along with their talented staffs, have balanced a tremendous number of interests to put forward a very promising first step in our long journey toward reforming our ailing health care system. I commend their tremendous effort in drafting the Wired Act. I look forward to working to see strong health information technology legislation passed in the Senate, in the House, and signed into law by the President.

Adoption of health information technology is a vital part of saving lives and lowering costs in our health care system. The RAND Corporation estimates, in its most conservative estimation, that a national, interoperable HIT system could save \$81 billion per year. As Senators KENNEDY, ENZI, CLINTON, and HATCH are so aware, America's health care information infrastructure is decades behind where it should be. We are losing billions and billions of dollars—I sound like Carl Sagan: billions and billions of stars—billions and billions of dollars to waste, inefficiency, and poor quality care as a result of that failure. Ultimately, and most tragically, lives are lost to pre-

ventable medical errors because health care providers do not have adequate decision support for their determinations on medical treatment, medication, and so forth.

I am an enthusiastic supporter of health IT as one mechanism of fixing our broken health care system. In fact, one of the first bills I introduced as a Senator was the National Health Information Technology and Privacy Advancement Act, in which I proposed a national not-for-profit entity with Presidential appointment subject to advice and consent of the Senate, possessing rulemaking power to set national standards under the Administrative Procedures Act, and with the ability to set licensing and access fees to raise capital for necessary investments outside the Federal budget process.

I still believe that is the best and most effective kind of authority. I also recognize there are many good ideas out there. But time is short. We cannot snap our fingers and be an IT-enabled health care environment. Development, testing, buildout, and adoption will all take time. We do not have much time. A tsunami of health care costs is sweeping down on us, inevitably, as baby boomers age and costs increase.

The Comptroller General of the United States has warned us of what he called “unprecedented stormy seas ahead that threaten to swamp the ship of state.” He testified that “we've never seen anything like what we're headed into”—never in our history. Our present Federal health care liability, if nothing changes, is \$34 trillion. That is a “34” with 12 zeros behind it. It comprises the bulk of the \$53 trillion in Federal liabilities we are presently obliged to pay in coming years. Now—now—is the time to get started in humane ways to avert this fiscal crisis. Health IT is a baseline platform necessary to even try to respond humanely to the looming crisis.

Unfortunately, in moving toward our ultimate objective, we must realize that health IT adoption alone will not stop the tidal wave of health care costs. As I think we all know, our health care system is broken in more ways than one. Look at the signs of its failure.

The number of uninsured Americans is climbing and will soon hit 50 million. Despite the best doctors, the best nurses, the best equipment and procedures, and the best medical education in the world, as many as 100,000 Americans are killed every year by unnecessary and avoidable medical errors. Life expectancy, obesity rates, and infant mortality rates are a cause for national embarrassment compared to other industrialized nations. The annual cost of the system exceeds \$2 trillion, and is expected soon to double.

We spend more of our country's GDP on health care than any other industrialized country: 16 percent—double the average of the European Union. More American families are bankrupted by

health care costs than any other cause. There is more health care than steel in Ford cars. There is more health care than coffee beans in Starbucks coffee.

Hospitals are broke. Doctors are furious. Paperwork is choking the system. This system is crying out for reform.

I believe that comprehensive restructuring of our health care system must rapidly address three critical issues. As I have already said, the first is the development of a national, interoperable, secure health information technology infrastructure. But there are two other equally important issues: One, the American health care system must invest properly in quality and prevention, promising areas where better care actually lowers cost; and, two, the way we pay for all this, the way we pay for health care, sends perverse price signals that drive market behavior away from the public interest, that drive behavior away from what we want.

So these are the three critical issues at the core of the health care crisis in this country—inadequate health information technology, inadequate attention to quality and prevention, and a perverse price signal system.

Let us look first at how improved quality of care can lower cost. That intersection of where improved quality of care and lower cost intersect should be our national holy grail in health care. The Keystone Project in Michigan shows how effective this can be. It went into a significant number of Michigan ICUs—not all of them but a significant number—to improve quality and reduce, for instance, line infections and respiratory complications. Between March 2004 and June 2005, the project saved 1,578 lives—in just that year and 2 months. It saved 81,000-plus patient days that otherwise would have been spent in the hospital, saving over \$156 million. It is a win-win.

The Rhode Island Quality Institute in my State took this model statewide, with every hospital participating, and we are already seeing the number of hospital-acquired infections declining, and the costs declining as well. The same principles can be applied to prevention, as well as to quality improvement.

Local efforts around the country, such as the Rhode Island Quality Institute, Washington State's Puget Sound Health Care Alliance, and Utah's Health Information Network, are leading the way. We need, as a nation, to get behind these State and local efforts. As many Members of the Chamber know, any good business needs to do research and development and these local efforts are the R&D on which we can base reform of our broken health care system.

All across America, in local communities, where people know and trust each other, the reforms of our system are being dreamed, negotiated, tested, and implemented. We need to nourish this effort, and I thank my 15 bipartisan cosponsors for supporting a small grant program I proposed to do just that.

Now, consider why this quality reform is not happening spontaneously all over the country if those big savings are there waiting to be tapped. Think of Michigan: In 15 months, in one State, with not even all of the intensive care units participating, \$156 million was saved. A report out of Pennsylvania showed they spent over \$2 billion a year on hospital-acquired infections.

Why is quality reform not happening everywhere? Well, primarily because the economics of health care punish you if you try. For example, a group of hospitals in Utah began following guidelines of the American Thoracic Society for treating community-acquired pneumonia. Significant complications fell from 15.3 percent to 11.6 percent. Inpatient mortality—a nice way of saying fewer people died—fell from 7.2 percent to 5.3 percent, and the resulting cost savings exceeded \$500,000 per year.

Sounds like another success story. But the net operating income of the facilities participating dropped by over \$200,000 a year because the treatment that resulted in the healthier patients was reimbursed at \$12,000 per case less.

In Rhode Island, we saw the same thing. When we started the ICU reform, I talked to the Hospital Association of Rhode Island, and they estimated a \$400,000 cost per intensive care unit, but as much as \$8 million in savings—a 20-to-1 payback. I said: Why not go for this? They said: You don't understand. All the savings go to the insurers. For us, this is \$400,000 cash out of our pockets, and potentially \$8 million out of our top line in revenues.

Name a business that will sensibly invest \$400,000 out of its cash to lose \$8 million in revenues. With reimbursement incentives like those, it is no wonder reform is such an uphill struggle.

We are at such a primitive stage in developing cost-saving, quality measures, and the economics work against us, so we have to tackle this now. An idea that will get us started: In my Improved Medical Incentive Act, I propose that State medical societies and specialty groups be allowed to present "best practices" to their local State health departments. If they do, and a Health Department determines this is a best practice that will save money and save lives, then two consequences follow. CMS would be obliged to create a pricing differential favoring those best practices, and private insurers would be forbidden to deny claims for services consistent with the approved best practices. If people want to object, fine. Go to the hearing. Let's do this in a regular fashion.

The determination of what gets paid for in our health care system right now is made in back rooms of the claims denial operations of insurance companies in scattered fashion, largely without oversight or review and laboring under heavy conflict of interest. If we move that determination toward proper for-

mal hearings, we can expand statewide best practices in a way that the economics will support.

Our health care problem is serious, it is vast, and it is looming. Health care IT is a crucial instrument in the health care reform toolbox, but it is not an end in itself. To fully realize its benefits, it must be coupled with a focus on quality improvement and a realignment of payment incentives. These three elements must move forward together.

Let me emphasize in conclusion as energetically as I can: The time is now. Time is wasting now. The need is urgent. It may not feel like it, but solving this problem with system reforms such as this will take several years. If we don't start now, when the fiscal tsunami hits, we will be left with only fiscal solutions to the problem. It is immediate ones but unpleasant ones, including massive tax hikes or massive benefit cuts. If we are standing here, and if I am standing here 5 or 10 years from now having that tragic choice in front of me, well, shame on us if in our folly, in our improvidence, we were too intellectually lazy and too bereft of basic foresight to have taken the steps now that could have averted that sickening choice.

As my colleagues know, we are seeing the beginnings of this debate now. The Bush administration has squandered its opportunity for meaningful health information technology reform, has squandered its opportunity for meaningful quality reform, and has squandered its opportunity for meaningful reimbursement design reform. Now, in the 2009 budget the President presented, he is proposing deep cuts in Medicare. We have to get ahead of this problem. This is a wake-up call. The time is now.

I look forward to working with my colleagues on both sides of the aisle to get this important work done.

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

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

#### RECESS

The PRESIDING OFFICER. Under the previous order, the Senate stands in recess until 1:15 p.m.

Thereupon, the Senate, at 12:30 p.m., recessed until 1:17 p.m., when called to order by the Presiding Officer (Mrs. MCCASKILL).

#### MORNING BUSINESS

Mr. REID. Madam President, I ask unanimous consent that there be a period of morning business until 2 p.m., with Senators permitted to speak for up to 10 minutes each.

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

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

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

#### CELEBRATING BOY SCOUT DAY

Mr. BROWN. Madam President, 98 years ago today, William Dickson Boyce created one of this country's longest standing and most important community organizations—the Boy Scouts of America. Today, we join Scouting groups across the country and Ohio—Toledo and Cincinnati, Chillicothe and Lakewood—in celebrating Boy Scout Day.

The Boy Scouts of America has a rich tradition of teaching valuable skills to the young men of this country. The values which Scouting instills—fairness, honor, courage, and respect for others—prepare young men to serve their families and their Nation.

There are more than 3 million boys in the Scouting program, and in the past year alone Scouts have earned nearly 2 million merit badges and completed more than 33 million hours of community service.

As an Eagle Scout, I recognize the hard work involved in Scouting and commend the dedication and commitment of Boy Scouts and the Scouting movement across our country. The journey to Eagle is sometimes difficult, often fun, occasionally disappointing, and always rewarding. My time as a Boy Scout, in the end, provided me with opportunities to develop leadership and organizational skills, helped me to clarify and articulate my guiding principles, and instilled a commitment to public service.

The emphasis on community service I learned with Troop 110 in Mansfield, OH, has strongly influenced my lifelong commitment to public service. The memories and lessons of Camp Avery Hand and Philmont Scout Ranch, of success and failure in earning merit badges, will always remain with me.

The Scout Law is a framework that continues to inspire my work to this day:

A Scout is Trustworthy, Loyal, Helpful, Friendly, Courteous, Kind, Obedient, Cheerful, Thrifty, Brave, Clean, and Reverent.

I am a proud supporter of the Boy Scouts of America. I hope my colleagues will join me in celebrating Boy Scout Day.

#### TRADE POLICY

Mr. BROWN. Madam President, the United States should not be playing