Under the guise of streamlining the legislative process, the Senate majority has effectively blocked critical legislative priorities such as the National Defense Authorization Act. I urge my Senate colleagues on both sides of the aisle to work together to discharge the fundamental duties our constituents, servicemembers, and veterans demand of us. We should dispose of the fewer, faster, and later mentality and return Congress to regular order.

Leadership matters. No one knows this better than our men and women in uniform. The Constitution of the United States tasks us with providing for the common defense. I fear we have failed in our constitutional obligation, and this failure is a failure of leadership, plain and simple.

With that being said, I want to pay a particular compliment to Chairman LEVIN as well as to Ranking Member INHOFE for their leadership, which has not failed the country nor has it failed this body. They got together and produced a bill that came out of our committee in due course after a full and open debate on many critical issues, with the understanding we would have the opportunity on the floor of the Senate to file amendments, debate those amendments, and have up-or-down votes.

Chairman LEVIN has been more than accommodating throughout the process, before and after the time the bill came out of the Armed Services Committee. Likewise, Senator INHOFE has been more than accommodating in making sure Members on this side of the aisle had free and open access to the debate process. They have provided the kind of leadership we expect.

Unfortunately, the majority leader has made a decision to cram this down the throats of the Senate, and from a national security standpoint that is simply not the way this body is designed to work or should work.

I will support the passage of this bill, because I think the end product, amazingly enough, has turned out to be a pretty good product. Could it have been better? You bet. Could the process have been better? Without question. I just wish we had had the opportunity to debate the serious issues that are on the minds of a number of Members of the Senate when it comes to national security, and that we had had the opportunity to present amendments that would have made this strong bill even stronger and to provide our men and women in uniform and the leadership at the Pentagon with the tools they need to be sure we remain the world's strongest military power and that we are able to not only defend America and Americans but to provide for freedom and democracy around the world.

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

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

AFFORDABLE CARE ACT

Mr. WHITEHOUSE. Mr. President, I wish to engage for perhaps the next 20 or so minutes with Senator CANTWELL, who is arriving shortly. I will begin with some remarks and ask unanimous consent for us to engage in a colloquy.

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

Mr. WHITEHOUSE. I am here today to talk about the health care problem in the country, because I think the fixation of this body on the health care Web site has taken our eye off the fact we have a very significant and fundamental health care problem.

This graph represents how much we spend on health care as a country. It begins back here in 1960. I was 5 years old in 1960. So this is a lifetime: 50-some years, $27.4 billion. That is what we spent on health care. Now here we are. This is up to 2011, and $2.7 trillion is what we spend on health care. It is 100 times as much in 50 years. Granted, there are more Americans but not 100 times as many.

This has been an explosive cost growth curve. When we were trying to pass the health care bill, that is what we were looking at for costs. It is a big competitive problem for our country.

This is a really interesting graph. I wish every time anybody talked about health care they would take 1 minute and look at this graph. I will explain briefly what it is.

This column is the up access and measures life expectancy in years, country by country, 65 to 85, where countries fall in terms of their average life expectancy for their population, for their citizens. This along the bottom is the cost, the health spending per capita per person in that country. So if you measure it all out, what you see is a great raft of countries all through here: Japan, Great Britain, Netherlands, Switzerland, Norway, Italy, Greece. There is a whole large group of countries right here, and all of them have a life expectancy 80 or older and they all spend between $6,000 and $2,000 per person on their country's health care. Essentially the entire modernized, civilized world is in that zone, from here to here.

Guess where the United States of America is. Boom. Here. We are below them all in life expectancy. We are trailing the pack of modern industrialized nations in our life expectancy. We are competing with Chile and the Czech Republic. But Japan, Greece, Great Britain, France, Germany, Luxembourg, all manage with their health care systems to achieve longer lifespans for their people. And we are doing it at a cost of about $8,500 per person per year.

To give a comparison, here are Switzerland and Norway. They are the other two most expensive countries in the world per capita on health care spending, and they are at about $5,700 per year. If we could bring our per capita health care spending in this country down to the most expensive countries in the world, if we could compete head to head with the most expensive countries in the world, we would save more than $1 trillion a year.

This is an interesting graph because it shows basically all the modern industrialized nations here, and it shows us here as a way outlier. It is a big deal for us to be an outlier here, because it means we blow about $1 trillion a year in wasteful and unnecessary health care which could be building infrastructure, solving problems, reducing the deficit, and could be doing other work. Instead, we spend it on a health care system which doesn't produce good health care results—at least not measured by life expectancy, which is a pretty good proxy.

There is a huge $1 trillion a year cost to our society in being that bad of an outlier. The cost is also measured in lost lives and lost years of life, because we are averaging 77 years and these countries are averaging 82 years of life.

We have a real problem on our hands, and obsessing about a Web site is a complete distraction from getting after this problem—5 years off every human's life in this country and $1 trillion a year. That is worth paying attention to.

The health care changes we brought are actually making a difference. Here are some interesting graphs. Each one is a projection done by the nonpartisan Congressional Budget Office of what health care costs are going to look like in the future, and what you see is a progression. They did this graph in August of 2010. This was where they projected health care spending would go when they projected in August of 2010 for this period, from 2014 onward to the next decade. A year later they went back and they projected again, and they projected actually costs would be lower. Then they came back in August of 2012 and they did another projection, and their projection showed that these anticipated costs went down again, every year, lower and lower.

Here is the big one. In May of this year, the Congressional Budget Office went back and redid its projections for Medicare and Medicaid spending from 2014 to 2023. Look how far below what they had projected 1 year ago, 2 years ago, and 3 years ago the current projection. That is a saving of about $1.2 trillion in that decade.

That is a long way from $1 trillion a year we could be saving if we just got back to where we were on this graph, if we got back from here to where Switzerland and Norway, the most expensive countries in the world, are. That is $1 trillion over 1 year. This is $1.2 trillion over 10 years, but it is still a big change and it is still moving in the right direction. So we shouldn't be too quick to condemn ObamaCare when

that kind of savings is already being projected.

The last slide I will show before I go to Senator CANTWELL, who has been good enough to join us, is this one. Why might it be that those costs went down so far in May of 2013? Why might it be that graph of projected costs keeps going down? It is because of changes in what is going on in the health care system.

This is one good example. This shows the hospital readmission rate from January of 2007 until August of 2013. This is how often somebody was discharged from the hospital, went home, and then within 30 days had to come back and be readmitted.

That could potentially be for a completely new reason, but usually it is because the discharge planning wasn't done well enough and there was a bad handoff between the hospital and the primary care physician or the nursing home. What we found is you could make that transition much better for patients. When you do, guess what. They don't get sent back to the hospital. When they don't get sent back to the hospital, you save money.

That is just one way the kind of huge $1.2 trillion over 10-year savings CBO has already projected could be taking place, but this is clearly a part of it. It is improving the quality of care so people aren't going back into the hospital, aren't going to the emergency room, and you avoid that cost at all by having handled the patient better, by having given them better treatment and better care.

It is pretty astounding. In 2007, right through here until the end of 2011, it was a pretty steady readmission rate. Then when we changed the signal to the hospitals and cut their payment for readmissions, boom, down it fell. That represents a very significant savings in the system. And in the personal lives of those people and their families not having to go back to the hospital, that is a pretty big plus too.

It was Senator CANTWELL's idea that we should come down today and talk a little bit about the delivery system reform side of the health care discussion. I got started a little bit before she could get here, but my wonderful colleague now has arrived, so let me yield the floor to her. I will put this graph back because I want to leave this here for whenever the camera swings my way. I want people to see this graph. It is inexcusable that all of these competitive industrialized nations of ours should be able to deliver universal high-quality health care for what would be a $1 trillion a year savings if we could simply match them, and they produce a longer life expectancy for their people and we are stuck competing for life expectancy with Chile and the Czech Republic. Come on. We can do a lot better than that, and that should be the ball we have our eye on rather than obsessing about the ObamaCare Web site.

I yield the floor.

The PRESIDING OFFICER. The Senator from Washington.

Ms. CANTWELL. Mr. President, I come to the floor to join my colleague from Rhode Island. I applaud him for his diligence, making sure this debate happened today, and for his leadership on this issue. It might sound kind of wonky to say there is a group of Senators that have a caucus called the Delivery System Reform Caucus, but we wear that banner with pride because we know that there are savings in our health care delivery system. We want to make sure that they are delivered for the American people.

While some want to talk about cutting people off of service or raising certain ages, we are focused on the fact that there are hundreds of billions of dollars of savings in the delivery system and that it is our job to improve upon them. I like to say to my office team: There is a reason why Ma Bell doesn't exist anymore. The challenge is I have so many young people, and some of them don't remember Ma Bell. But the issue is the delivery system for telecommunications changed, and look at what it unleashed—a lot of great technology.

Yes, change, but with ways to drive down costs and deliver better access. That is what we are talking about here with the health care system. My colleague from Rhode Island has had a group for more than a year that has been talking about these delivery system reforms. We are going to come out on a more frequent basis and try to have a dialog with our colleagues about why it is so important.

We have taken a small but very important step led by our senior Senator from Washington Senator MURRAY on the budget. But there is so much more we can do if we can include these delivery system reforms. So I thank Senator WHITEHOUSE, the Senator from Rhode Island, for his leadership.

I want to talk about one area today, the area of long-term care services. I authored a provision in the Affordable Care Act called the Balancing Incentive Payments Program. While that sounds in and of itself like a wonky title, Balancing Incentive Payments Program, this program is really there to promote home and community-based care over nursing home care. If you ask any senior they will say of course they would like to receive health care services in their home or in their community. No, they do not want to go to a nursing home. But the discussion has been limited on how much cheaper it is and how much better the care could be for delivery in the home as opposed to nursing home care.

According to a survey by AARP, over 90 percent of seniors age 50 or over desire to remain in their home as long as possible. We know that home and community-based care is 70 percent cheaper than nursing home care—70 percent cheaper. So for us in Washington State we thought about this long ago, and we decided that we were going to implement a system to reform our State and put more community-based care in our State and pull Medicaid patients away from nursing home care. We did that. We successfully made that transition. This chart shows you what I was just referring to, that home-based care can be as little as $1,200 a person versus the same person getting care in an institutional facility at $6,000.

We made the transition in Washington State to be predominantly a home and community-based care State. We did that with our own State dollars, our own program, and it was a transition that took place over many years. We are kind of the antithesis of what the Federal system is. It is still more weighted on a State by State basis towards nursing home care. That means people are going into nursing home care, and we are footing the bill for more expensive care at $6,000 per person when we could have services in the community that would allow them to stay in their home and get more efficient care. So in 2009, the long-term care budget overall for Medicaid accounted for 32 percent of the Medicaid expenditures or $360 billion a year. You can see that this is a very expensive area for us at the Federal level. If we could do anything to help change those numbers, we would be delivering an improvement to the system.

When we first made this transition from 1995 to 2008, the State of Washington saved $243 million from this investment. But more important, even, than the money—in an article in 2010, the Spokesman Review in Spokane ran a story called ''Dying to live at home,'' the family of Nancy and Paul Dunham, a couple of more than 60 years, said they wanted to age at home. Because of the Medicaid funding for in-home services, they were able to stay. Mr. Dunham was able to stay in his home until the age of 83.

I am sure many of my colleagues know people who are getting on in years who prefer to stay at home. But the Balancing Incentives Program, which was in the Affordable Care Act, was the first Federal effort that we had that tried to assist States to move away from nursing home care and move towards community-based care. We put some incentives in the program. Here are the States so far that have taken up the Federal Government in the Affordable Care Act on this incentive program: New Hampshire, Maryland, Iowa, Mississippi, Missouri, Georgia, Texas, Indiana, Connecticut, Arkansas, New York, New Jersey, Louisiana, Ohio, Maine, and Illinois.

It is a diverse group of States, I might add. Some States, probably, where Governors said they did not want to support the Affordable Care Act yet are taking advantage of this provision. Some States probably are forerunners of delivery system reform and have done lots of delivery system reform and want to do more. It is a mix

of States. I think we have a lot of great examples in those States and what we can do to transition away from institutional care to home and community-based care.

The program authorizes grants to States to increase access to their non-institutional long-term care services, and it supports including structural changes that help streamline the system—conflict-free case management, core standardization of assessment instruments, single entry-point systems so it is not confusing, so that the system is very streamlined. States have until September of 2015 to increase their long-term care services in the community and support expenditures of these noninstitutional-based care facilities.

We are very excited that it has had a robust uptake by these States. I am encouraged that there has been so much interest shown in changing the political orientation, if you will, of States, to how do you deal with long-term care. We know everybody is living longer. We know as baby boomers retire, it is going to be a bubble to our health care delivery system. But this is an excellent idea, a way for us to deliver better care.

What does it do? As I said in the first chart, $1,200 versus $6,000 in nursing home care. It reduces costs. Reducing those costs has to be a key focus for us.

These Medicaid recipients are people who maybe even start on Medicare but because of the extreme cost of health care at the end of life, end up spending it out, end up on Medicaid, end up being a Federal responsibility. If we can reduce those costs by driving more community-based care, it is a win-win situation.

The second thing it does is it helps improve quality. If people can stay at home and get access to the delivery system by these new requirements, making sure it is case managed and has the single point of entry and standardization of the home care system, it helps us to be efficient about the quality of care that is being delivered. Again, when you have a community-based setting, either in the home or where care is delivered through the home, there are lots of ways for us to have checks and balances on the system.

I have talked to many people who are in the nursing home industry. They will say we like the idea that we are only going to take the sickest patients. We like the idea we are only going to serve people who really need to be there as opposed to some people who may not be ready for those facilities but end up there anyway just because there are not the community efforts to support it.

Besides reducing costs and improving quality, we save money. That is why we are here today, to talk about these important ideas that save money. This is a simple one, but it is already in place. It has already started. There are many States taking us up on this offer, but it is critical that we understand and score these costs because they can show how we can save billions of dollars in our health care delivery system.

I know my colleagues, some of them on the other side of the aisle—well, all of them on the other side of the aisle—didn't support the Affordable Care Act. Take a second look at what your States are doing. Your States are supporting the legislation, at least through one provision. I think when you check, you will see that one provision is going to save your State money. It is going to give your citizens better choice in their quality of care. It is going to help us reduce our Federal costs and expenditures as well, and that is what delivery system reform is all about.

Mr. WHITEHOUSE. Will the Senator yield for a question?

Ms. CANTWELL. Yes, I will.

Mr. WHITEHOUSE. Isn't it the heart of what the Senator said just a moment ago that there is an area that actually touches on a lot of health care—it is a big area—where you can do two things at once? You can save significant money for taxpayers and insurance ratepayers, and at the same time you can improve the quality of care that people receive.

So often in legislative matters it is a zero sum game. One wins so the other has to lose exactly by the same amount. This is not like that. This is a win-win situation. So there really should be energetic efforts to pursue these win-win opportunities.

Ms. CANTWELL. I thank the Senator from Rhode Island for that question. I think his charts pointed to the fact that he was articulating, the fact that everybody is arguing about the Web site. As somebody who has been involved in a software company that wrote code, what happened is very unfortunate, but writing code and fixing it is a straightforward task that can be achieved. It is a little less difficult than cleaning up oil in the gulf or something of larger environmental impact.

To me, we will get that fixed. In the meantime, there are a lot of things that have to happen, that need to change in our delivery system that are about saving costs, delivering better quality care, that we know are proven, successful answers to this question. We need to get more than just these States to take us up on this offer. We need to get CBO to actually give us a score on how much money this has the potential of saving, and then we have to figure out a way to incentivize all other States to implement this as soon as possible.

When you think about our senior population, this is what they want. They want to stay at home as long as possible. It is so much cheaper per Medicaid beneficiary to do this.

This is what we have to achieve. We hope by coming out here and educating people about the various aspects of the Affordable Care Act, the things in the delivery system reform that are on the agenda to improve access and help save costs, that this will start taking hold and we will get more people talking about these solutions. This is absolutely the direction we need to go.

Mr. WHITEHOUSE. If I could ask the Senator another question in response to what she just said, not only is it a win-win, being lower cost and better quality care, but I believe the Senator said that there is actually a third win here. There is the win of lower cost, there is the win of better quality care, but for seniors there is a huge win of maintaining your independence and being able to stay at home. It is hard to put a price on that, but if you are facing the choice of having to leave your home and having to go to a more restrictive health care setting, being able to stay at home is a very big plus.

Really, it is not win-win, it is win-win-win.

Ms. CANTWELL. Mr. President, I thank the Senator from Rhode Island. He is correct. There are the individuals who win. The State in this case saves Medicaid dollars, and the Federal Government saves dollars as well. But to the individual, if you ask them, this is their choice. They want to stay at home. Nobody says they want to go into nursing care.

We appreciate the nursing home care delivery aspect of health care. They deal with some of the most complex patients. But they do not need to deal with people who do not need to be there. We have to have a delivery system that helps support community-based care for long-term care. I hope that we will get more support for these ideas and that we will help figure out a way to get a score for them as well. I think that part of the misery in this whole issue of health care savings is figuring out ways to do things that are not so complex in what they are doing. Moving from nursing home care to community-based care, $1,200 versus $6,000, that is not the hard part of the equation. What is hard is to get CBO to guesstimate how much population would be affected.

We do know this. If you take the number of seniors to be affected as the baby boomer population reaches that retirement age, if you think they are going to be supported primarily by nursing home care—I think I am correct that our State has now made the shift so the majority of our people who are on Medicaid are taken care of by long-term care services in the community if they are seeking those services, versus the Federal numbers which are just the opposite. The majority of people seeking those Medicaid long-term care dollars, the average of those States is more towards nursing home care. We need to flip that. The Senator is right, it would be a win-win-win situation for all of us.

I thank the Senator from Rhode Island for his leadership on this issue.

Mr. WHITEHOUSE. Mr. President, in responding to what Senator CANTWELL

just said about the Congressional Budget Office, it indeed has been frustrating and bedeviling to run up against their inability to project these savings in a way that would allow us to—what we call in Washington—score them and get budget credit for them. But even though they have that difficulty, there are some very serious organizations that project that very significant savings of the kind I have mentioned—the $1 trillion savings—are possible.

Some years ago the President's own Council of Economic Advisers estimated that we could do savings of $700 billion without affecting the quality of care in any way for the worse.

The National Institute of Medicine has made several regular projections. The most recent one is $750 billion a year. The Institute of Medicine is pretty serious folks, and they are entitled to respect when they say we can have those kinds of savings.

RAND Corporation—a lot of people know a lot about it—is a very expert organization. They have done two things. They looked at what we can save in health care, and then they looked at what we can save in health care plus an additional bit for dealing with waste and fraud. They gave ranges for the two. The midpoint of the range for savings is about $730 billion. If we add their suggestions on waste and fraud, the midpoint of their range goes to about $910 billion a year.

The Lewin Group, which is another respected think tank that looks at health care issues, wrote a piece some time ago with George Bush's former Treasury Secretary, and they said it was $1 trillion.

So is it $700 billion a year? Is it $750 billion a year? Is it somewhere between $730 and $910 billion a year depending on how you score the waste and fraud? Is it $1 trillion a year? Either way, I will take it. Those are big numbers, and wherever it falls in that range, we should be energetically fighting for it.

I will close with the request I always make in these speeches—and this is a request to the President and to his administration—and that is to inspire us and set a bold national target. Sure, CBO, OMB, and our actuarial and accounting organizations cannot predict what these savings are going to be, but, by gosh, the President can direct his administration to target a savings goal and to go after it. I think if the President were to set a hard date and dollar target for delivery system savings—a couple of years out so we have a chance to do that—that would make a big difference.

The example that I use is of President Kennedy. Back in 1961, when it looked as if we were losing the space race to the Soviet Union, President Kennedy declared that within 10 years—he put a date on it—he would put a man on the Moon and bring him back safely. He had a hard target, something specific so you would know if it was or wasn't achieved. The message was clear, the mission that was outlined was clear, and the result was a vast mobilization of private and public resources to achieve that purpose.

It is not enough to talk about bending the health care cost curve. That catchphrase should be jettisoned and discarded. We should have a hard date and dollar figure, and that should be a target the entire administration aims toward.

Had President Kennedy given that speech back in 1961 and declared as his purpose to bend the curve of space exploration, I very much doubt we would have put that man on the Moon within 10 years. It was his exercise of Presidential leadership and challenge—ahead of what the scientists knew could be done but with confidence and faith in our ability to achieve big things—that put the executive branch of government into focus so we could achieve exactly what he had directed. We can do the same with health care. We should do the same with health care. There is no downside to it because this is a win-win area, as I discussed with Senator CANTWELL.

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

The PRESIDING OFFICER. The clerk will call the roll.

The assistant bill clerk proceeded to call the roll.

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

The PRESIDING OFFICER (Mr. HEINRICH). Without objection, it is so ordered.

Mr. BLUMENTHAL. Mr. President, I asked my colleague from Rhode Island to stay on the floor for a couple of minutes because I wanted to thank him for the erudite and eloquent explanation he has just given for why our focus should be so aggressively and unrelentingly on the tremendous opportunities for saving health care costs and raising health care quality at the same time. I am very proud to have joined him and other colleagues in a task force that is seeking commonsense solutions to lower the costs of health care and at the same time increase its efficiency and quality. The two go together.

The phenomenon he just discussed of reducing readmissions to hospitals once patients are discharged also means that the quality of those discharges, the rehabilitation plans and hand-offs to primary physicians, and the suffering and pain for those patients is reduced, and that is just a microcosm of one example of how this goal can be accomplished.

We are late in this year, and we have no real time remaining before the end of this year to do the kinds of reforms legislatively that will help advance this ball. But the attention we need to devote to this issue is clearly beyond this year and beyond the next year.

We are making progress, and the graphs show it, but there is so much progress to be made in extending lifespans and quality of life as well as reducing the cost of health care.

We need to make sure we seize this historic moment to show the rest of the world that we can do better and we will do better in providing health care delivery. The cause of health care delivery reform is one that cries out for a focused effort involving both branches of our government, executive and legislative, and both parties, as well as both Houses of this legislature.

The kind of focus given by Senators CANTWELL and WHITEHOUSE so penetratingly and powerfully today is the kind of focus we should maintain. I hope in the days or months ahead we will devote more attention by coming to the floor, doing events in our States, and making sure the administration is aware of our concern in meetings. I look forward to continuing that effort in the time ahead.

Again, I thank my colleague Senator WHITEHOUSE, as well as others, such as Senator SCHUMER and my colleague from Connecticut Senator MURPHY, as well as Senator CANTWELL, for their devoted efforts. I am very proud to be working with them.

I see my colleagues are on the Senate floor. It is late in the day, and I yield the floor.

The PRESIDING OFFICER. The Senator from Mississippi.

Mr. WICKER. Mr. President, I would point out that the distinguished Senator from Delaware was on his way to speak and has graciously offered to defer for moment or two while I make my brief remarks.

U.S. DELEGATION TO THE SOCHI OLYMPICS

Mr. WICKER. Mr. President, I rise this evening to speak briefly about the delegation chosen by President Obama to represent the United States at the opening and closing ceremonies of the 2014 Olympic Winter Games in Sochi, Russia. I would also like to offer a few suggested additions to the delegation.

As Members know, Janet Napolitano, former Secretary of Homeland Security, will lead the U.S. delegation to the opening ceremonies on February 7. Our Deputy Secretary of State, William Burns, will lead our delegation to the closing ceremonies on February 23. Our two delegations will include tennis legend Billy Jean King, gold medalist figure skater Brian Boitano, gold medalist figure skater Bonnie Blair, silver medalist hockey player Caitlin Cahow, and Olympic gold medalist speed skater Eric Heiden. These individuals are American sports figures who should be lauded for their contributions. I am confident they will represent us well.

May I suggest with all seriousness that this delegation could well be expanded. Some have asked what message the President might be trying to send to Russia in choosing this delegation. White House Press Secretary Jay Carney asserted this morning that ''in the selection of the delegation, we are