The great statesman Adlai Stevenson once said:

Patriotism is not short, frenzied outbursts of emotion, but the tranquil and steady dedication of a lifetime.

I think it is fitting to speak about patriotism as symbolized by a plow, because the Federal employee I wish to recognize this week has worked in the Department of Agriculture for over 35 years. Pearlie Reed was raised on a farm in the rural town of Heth, AR, where he was the ninth of eighteen children. He worked hard to attend the State University of Pine Bluff, which was especially challenging for an African-American man in the South during the struggles of the Civil Rights movement.

Nonetheless, Pearlie received his degree, and he joined the USDA in 1968 as a student intern for the Soil Conservation Service. In the years that followed, Pearlie rose steadily in the Soil Conservation Service from an entry-level soil conservator to district conservationist, to deputy state conservationist, and he was eventually appointed as the state conservationist for Maryland in 1985. He served in that position for 4 years, after which he became the state conservationist for California.

As his career advanced, Pearlie also received a master's degree in public administration from American University. The Soil and Conservation Service was eventually transformed into the Natural Resources Conservation Service or NRCS. From 1994 to 1998, Pearlie served as associate chief, and his last year on the job also served as Acting Assistant Secretary of Agriculture for Administration.

In 1998, Pearlie was promoted to chief of the NRCS, and he held the position until 2002 when he was named Regional Conservationist for the Western United States. In that role, Pearlie was in charge of all natural resource conservation efforts by the Federal Government in 10 States and the Pacific Basin area.

Pearlie has said that one of his proudest moments in his career came when he was asked to lead the Agriculture Department's task force on civil rights in the 1990s. He led a team that issued a report containing 37 recommendations on how to ensure that the Department is a welcoming place for minorities. Pearlie briefed President Clinton personally, and the President issued an order that all 37 of his recommendations be implemented.

Pearlie retired from the USDA in 2003, but just this year Secretary Vilsack called him out of retirement and asked President Obama to appoint him as Assistant Secretary of Administration, the position he briefly held in an acting capacity 10 years ago. Pearlie was confirmed by the Senate on May 12, and he is now back at work for the farmers and ranchers of America.

One of his former colleagues said once that:

If you look up the term ''public service'' in the dictionary, you'd likely see a picture of Pearlie Reed right next to it.

Over the course of his long career, Pearlie has received the Distinguished Presidential Rank Award, the George Washington Carver Public Service Hall of Fame Award, and the USDA's Civil Plow Honor Award, among others.

Pearlie exemplifies the kind of patriotism Stevenson spoke about—the patriotism of steady work and perseverance represented by Cincinnatus's plow.

I hope my colleagues will join me in honoring Pearlie Reed's distinguished service and that of all Federal employees working in agricultural development, resource conservation, and rural advancement.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Connecticut.

HEALTH CARE REFORM

Mr. DODD. Mr. President, I want to speak, if I can, for a few minutes this evening on the health care bill. I suppose today or tomorrow will be the last time before we return in September to address the issue of health care reform, and I thought it might be worthwhile this evening—in the waning hours—to give our colleagues and others who are interested an idea of where we are in this debate and what options have been proposed.

As many have heard us say already, the committee for which I have been hired as sort of a pinch-hitter for Senator KENNEDY—the Health, Education, Labor and Pensions Committee, on which I am proud to serve—and I must say once again, with deep regret, that the chairman, Senator TED KENNEDY from Massachusetts, has not been able to be with us over the last number of weeks. I will tell you this. He is watching very carefully every meeting and markup and gathering that occurs, because he has invested so much of his public life and career to trying to reform the health care system of our Nation. So I was asked to step in for him, temporarily, until he gets back on his feet and can join us in this effort.

We have spent a long time over the last number of weeks and months on this debate. We have spent a tremendous amount of time in the committee, even a lot of time before the actual markup in preparing for the legislation. So this evening I wish to talk about sort of where we are with that bill, what is in that bill in very practical terms, and how it would affect individuals.

I also want to give my colleagues some opportunity to appreciate what will happen while we are away for 5 weeks in terms of those who will lose their insurance, as they will, between now and September. I have made the point over and over again that 14,000 people a day in our Nation lose health care coverage. Those are terrible numbers. They are more significant in some States than in others, but there is that erosion of coverage every day.

As long as nothing happens, as long as no health care crisis affects them or their families, they may be able to survive all of that until they find a job or find some other means by which they can afford health care coverage. If, unfortunately, they are caught—as so many are—with that unexpected accident, that unexpected health care crisis, that unexpected diagnosis of a major health care problem while they are in that period without coverage, the implications can be staggering, and not just because they lack the coverage that might allow them to take care of that emergency accident or injury. But if they are diagnosed with something in the absence of a health care plan, under the present circumstances, there is very little likelihood that they are going to be able to get a health care plan that will be within their means to afford it because they will have that preexisting condition once the diagnosis occurs. So the health care costs go right up through the ceiling.

So again, 14,000 a day, as we gather here, find themselves in that shape. I thought it might be worthwhile to get graphic about this, because by the end of the August recess, when we return, 756,000 of our fellow citizens will have lost their health insurance—while we are away over the next 4 or 5 weeks—and that is a staggering number.

Some may find a means to get it back. Some may have a spouse who gets a job that provides coverage. But those are the numbers if you take every day the loss of health care coverage.

My patient here, with these numbers, you can see the thermometer is now exploding. He is even having some beads of perspiration here because he is now worried that he or his family could be caught in that free fall, without the means to protect themselves against economic ruin. It could happen.

So as we begin a short discussion this evening of where we are, I thought it might be important to share with my colleagues that while we leave with the full confidence of a very good health care plan as Members of Congress, that should an accident, a diagnosis, a problem occur to any one of us—while we don't want that to happen—there is no likelihood we are going to be put in economic difficulty because of it. Certainly we will probably get good care because of who we are, what we do, but no worry about the sort of economic ruin that this crowd of 756,000 Americans may face if they are caught in a similar situation.

I have hope that all my colleagues have a good recess, that they will get around their States and districts. I also hope they will get an annual physical this year, as I hope everyone does. We provide an opportunity, under our health care plan, to do that at little or no cost. That is how I discovered earlier this summer, in June, that I have early stage prostate cancer, and I will

be going through a procedure in the next few weeks to deal with that matter, and I am confident, since I caught it in this early stage, that I will come out fine. I have had a chance to talk to people who have gone through this or had a family member and I know about the various options that are available. It is early stage. It hasn't metastasized. I am not going to be in tough shape. I believe I am going to come out of this fine. But that is what you get when you get an annual physical. You find out these things.

There are people who, of course, don't do that. We even have had colleagues who didn't. A wonderful man I served with in this body for many years by the name of Spark Matsunaga from Hawaii did not discover it early enough, and he lost his life to prostate cancer. Almost 30,000 people in our country die every year of prostate cancer. In many instances, if not most, it is because it wasn't diagnosed early enough. It is very slow growing. There is ample time to respond to it, but you need to find out about it.

So when you get that physical, and I hope each of my colleagues remembers that if they do that and they find out they have a health issue, or if something happens in an accident to them, or if anybody in their family suffers a health crisis, they will be able to focus their attention on getting well because there is absolutely no risk that any Member of the Congress, or the millions of Federal employees who have the options—more than 20 of them each year, by the way—to choose what plan serves us best—no risk they will lose their economic security because they got sick or they had a bad diagnosis or they got hurt. Because as I said a moment ago, we all have great health insurance and we are not going to lose it any time soon.

But tens of millions of Americans have insurance that does not allow them to get the care they need. It is not just the uninsured; it is people with insurance I want to focus on this evening—people who have insurance when they need it, with the doctor of their choice, and while we are gone, nearly half a million of them will lose that coverage.

I understand we are all going to be patient on this effort of health care reform. It takes time to get it right. I acknowledge that. But 70 years is long enough. That is how long we have gone in our Nation without addressing in a holistic way the health care issues that must be addressed.

By the time we return from our recess, the number of Americans, I pointed out, who will have lost health insurance since our committee, the Health, Education, Labor, and Pensions Committee, passed the Affordable Health Choices Act more than 3 weeks ago, will be over three-quarters of a million people.

While a bill that will improve the quality and affordability of health care for every American sits waiting for action, as I said, 756,000 of our fellow citizens are going to lose that insurance before we come back from our recess.

Let me take a moment and show my colleagues what that means in their States. I have broken this down State by State so you get some idea of what the implications are because sometimes these numbers can be daunting. It may be hard for people to see this, but I have broken it down. I will run it down very quickly.

Alabama, 5,760 people will lose their health insurance over the next 5 weeks; Alaska, 640; Arizona, 8,960; Arkansas, 2,560; California, 70,080 people will lose their health care coverage before we reconvene in early September; Colorado, 3,200.

I know the Presiding Officer has been working hard on this issue. I commend him for this effort. I know he will be meeting with a lot of his constituents. In fact, Colorado and Connecticut lose the same number of people, 3,200 as well.

In Delaware, 960; in Florida, 27,200; Georgia, 13,760; Hawaii, 1,600; Idaho, 2,240; Illinois, 8,640; Indiana, 15,360 will lose health care coverage; Iowa, 2,240; Kansas, about the same number. In Kentucky it is 7,360; Louisiana, 5,760; Maine, 2,240 lose health care coverage; in Maryland, 7,360; Massachusetts, over 13,000 people, close to 14,000 people will lose health care coverage over the next 5 weeks; Michigan, 19,840; Minnesota, 6,080; Mississippi, 4,160; Missouri, 6,720; Montana, 960 people; Nebraska, 1,280; Nevada, over 7,000 people will lose health care coverage; New Hampshire, 960; New Jersey, 20,800 people will lose health care coverage; New Mexico, 2,560; New York, 38,080 people will be dropped from the health care rolls; North Carolina, over 16,000; North Dakota, 320; Ohio, 12,480; Oklahoma, 1,600; Oregon, 8,640; Pennsylvania, 16,320 people; Rhode Island—our colleague, SHELDON WHITEHOUSE is here from Rhode Island. He was such a valuable resource in our HELP Committee over the last number of weeks, and I commend him for his contribution, he and JACK REED both making significant contributions to our Affordable Health Choices Act. South Carolina, over 10,000 people will lose their health care coverage, South Dakota, 960; Tennessee, 12,800; Texas, 15,040; Utah, 3,840; Vermont, 960; Virginia, 10,560 people; in West Virginia, 960; Wisconsin, 7,360; Wyoming, 320.

I apologize for taking that time but sometimes you mention 14,000 and we don't break it down State by State. These are the projected losses in terms of health care coverage. They will not have the same degree of security that we do during the next 5 weeks.

When we leave here, I, of course, hope none of us suffer any kind of a diagnosis or any kind of an accident, but as I said a moment ago, as painful as that may be, none of us will suffer the pain of wondering whether you can afford to have your child covered, your spouse covered, or have the means to take care of yourself if something happens.

The people in these numbers, hopefully, will never have that problem, but if they do it is a major catastrophe. Roughly 65 percent of all bankruptcies in the last year have been caused because of a medical crisis—about 65 percent of all bankruptcies. Your first thought might be, as mine was, that is probably the uninsured who ended up in that shape. They didn't have insurance, they ended up with a serious problem and got drained of whatever few assets they had left and took the bankruptcy act to get out of trouble.

Mr. President, 75 percent of the people who were affected by bankruptcy as a result of the health care crisis have insurance; three out of four people who have insurance had ended up in bankruptcy. It was not the uninsured, it was the insured.

This evening—I know they are always out there marketing this idea that this bill we are talking about is not designed to help the insured, only the uninsured. Nothing could be further from the truth. Our major efforts are to try to bring down the costs of the insured. Many have such high deductibles and out-of-pocket deductibles they never get to engage their insurance policies.

At any rate, these are the numbers. I think it is important for my colleagues to look at it.

To my colleagues, think about constituents you are going to see over the recess facing these problems. Imagine a small business owner paying $1,000 a month on premiums with a $6,000 deductible. It is not an uncommon event for small businesses. Imagine this small businessman telling you that his insurance company dropped his daughter's coverage when their doctor suggested surgery to remove noncancerous tumors, forcing him to get a separate, more expensive policy for her.

It doesn't have to be this way. These facts happen all the time. Under our bill, under the bill we passed 3 weeks ago, this small business owner would be able to choose an affordable plan that he or she could rely on, wouldn't be denied coverage for the preexisting condition of their daughter, and that coverage would not be taken away once the policy is issued. That is the difference between the status quo, as it is today, and what we propose in our legislation we spent so much time crafting.

Imagine, if you would, a small business owner who offers health coverage to his 20 employees. He is paying about 60 percent of the cost of the premiums but unable to afford family coverage. Imagine that small business owner telling you that one of his employees have left for a job that provides family coverage.

It doesn't have to happen. In fact, this case is one I am very familiar with. This was the case of a small employer in Hartford, CT, who employs not 20 people but about 10, and very loyal employees. I think most of them have been there 20 years. He had an

employee the other day literally almost in tears, if not in tears, announcing to his employer that he had to leave because his wife, who had the health care coverage, lost her job. So they were without health insurance.

He then went and took a job that paid 30 percent less than the job he had for more than 20 years in order to get the coverage. That would not happen under our bill. That does not have to happen. That family, if you will, small business, would be able to find affordable coverage for their employees using the same strong bargaining power and broad risk pooling that large businesses enjoy.

This is one of the major problems for small business. The average small business pays 18 percent more in premiums than large businesses—18 percent more—and they get a lot less coverage as a result of it because they don't have the opportunity to pool as much, come together. Our bill gives that small businessperson the same access, the same opportunity to that gateway, that place where these policies exist that they can shop for and determine what is best for them—what they can afford and what they want to have for their employees. That does not exist today. Unless we change the law, that small business operator is going to be faced with rising premium costs and less and less coverage for their employees. We change that. We fix that. That is important for people, I think.

Let me mention a third scenario. Imagine a single mother, self-employed, paying more than she can comfortably afford for an insurance plan—not uncommon—that has high copays and a high deductible, not uncommon at all. Imagine her telling you she rarely sees a doctor for preventive screenings for herself or well-child visits for her son because her plan doesn't cover those visits.

It doesn't have to be that way. Under our proposal this single mother would be able to find a plan that she can afford that covers important preventive care items at little or no cost. Our bill provides preventive screenings like mammograms or annual physicals at little or no cost. That is in the affordable health choices bill. That idea of making sure she is going to be OK, that her child is getting those vaccinations and so forth that they need—that is covered by our proposal.

Our bill would ban discriminatory pricing based on gender because that ban does not exist today. There can be a huge differential. If you are a woman getting health care coverage, you often pay a lot more than men do. Our bill eliminates insurance rating based on gender entirely. Men and women are treated equally going in, in terms of their health care coverage. If we do not change the law, those policies do not change. The inequity goes on.

Mary, in this case, wouldn't have to pay more than others her age in her area would, rather than just paying more because of gender.

Finally, imagine a woman who bought the best coverage she could afford based on monthly premiums because she knew going without insurance was a bad idea. Imagine her telling you she was just diagnosed with breast cancer at the age of 25, and only then realized her policy was inadequate. Imagine her telling you she now has more than $40,000 in medical debt.

Under our bill, this young woman would be able to stay under her parents' coverage through her 26th birthday, what we call the young invincibles, between the age of 21, when you are dropped from your parents coverage, and you are on your own. That is a very significant percentage of our population. A lot can happen. This woman was diagnosed with breast cancer late. But had she been in the same circumstances physically, with the adoption of our legislation she would have qualified for that young adults coverage, which is very reasonable in cost, or stay under her parents' plan until she was 26 and never have to worry about being denied because of a preexisting condition, which of course now she has. Having been diagnosed with breast cancer, those premiums for that woman will go through the ceiling, even as young as she is, because she has that preexisting condition.

We asked our colleagues to imagine these cases because they are so incredibly common. These are not extraordinary cases. They are rather routine in many cases. We will see people in these situations—I know my colleagues will, during the break we are on, real people who can suffer by our inaction.

Let me take a minute, if I can, to talk about what health reform means in my State of Connecticut as well. In the last month, an insurance company in my State proposed to raise rates by 32 percent on people buying insurance in the individual market. This news was shocking, given the debate going on at the Federal level, but the company went ahead with the proposed rate hike for Connecticut families. Today I received word that the Connecticut Insurance Department went ahead and approved a modification to the company's proposal that will raise the premiums for the residents of my State by up to 20 percent—a 20-percent increase.

I don't know many people in Connecticut who got a 20-percent pay raise in the last year. I suspect very few. People are going to struggle because of the rate hike. People are going to struggle across the Nation, of course, until we take action because the rates continue to go up.

Consider, if you will, what has happened in the last few years: an 86-percent increase in premiums, in rates since 1996. In my State they have gone up about 46 percent in 6 years, and that was before the news of this latest company increase.

We have a bill—again, that would reduce the cost for Americans, the Affordable Health Choices Act, which we adopted in our committee, which in fact addresses this very issue. I want to encourage all my colleagues to spend a little time looking at the bill we wrote over this August break.

I will take just a minute this evening to talk about how costs would be lowered under our proposal. Many ask the question: How do you lower costs? I will use my own State as an example.

According to America's Health Insurance Plans, which is the trade association for the health insurance industry, in Connecticut in 2007, the average monthly premium on the individual market for single coverage was $277 and the average monthly premium on the individual market for family coverage was $646.

I ask unanimous consent to be able to proceed for an additional 10 minutes.

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

Mr. DODD. Those are the numbers: monthly payment, individual market, $277; family premiums, family market, $646. Keep those numbers in mind, if you will. These numbers were for 2007. I presume in 2009 they have gone up a bit, but those are the latest numbers I could find from this trade association. They reflect what an individual making about $21,000, on average, paid in 2007. That is a lower income individual, but there are a lot of people who have incomes at that level working in our country. You try to pick up the cost of $277, or $646 a month with an income like that. You know the outcome. You are not going to be able to afford it. You could not come near it.

Under our legislation, a low-income worker at $21,000 would now pay $20 a month in health care premiums for individuals.

That is $277 a month under the status quo, $20 a month under the Affordable Health Choice Act—from $277 to $20. That person now—even at $21,000, that $20 a month becomes very affordable health care. That is a person who would now be able to shop for a plan in the insurance gateway and could have options in choosing health care to allow them to stay out the hospital, stay healthier, be able to keep working, take care of their family. That is the difference. That is the real difference.

For family coverage, a family of four who makes two times the Federal poverty level—approximately $44,000 a year—pays $646 each month for family coverage, as I mentioned earlier in my statement. Under our bill, that family would now pay $40 a month for their health care premiums; that is $646 under the status quo, $40 a month under the Affordable Health Choices Act.

When people say it does not make any difference, you are not bringing down costs, you tell that to that individual making around $21,000 a year or that family making $45,000 a year. That is a significant reduction in their health care premiums. That is the real

difference between the status quo and what our legislation offers. That is affordable coverage.

What is not captured in the numbers under the status quo is the fact that that family in Connecticut has no guarantee they will even be offered a policy. For that matter, they have no guarantee, if they are issued the policy, they will not see it cancelled or rescinded because they file a claim. And they have no guarantee that policy will be renewed the following year. Our bill changes all of that. Connecticut families and families across the country can at long last be assured they will be able to choose among quality, affordable health care plans.

Before my colleagues depart, let me say this: Let's come back to work here in September, come back ready to offer our thoughts and suggestions and constructive criticism. We are going to pass a bill this fall, and we are going to do it with the help of any Senator willing to contribute and be a part of the solution. But we are not going to continue to wait for the sake of waiting until the politics get right.

Between adjournment tonight and when we return around September 5 or 6, there are 756,000 people who will fall into the category of the uninsured. These are insured people. We ought to be doing everything we can reasonably and thoughtfully to put the brakes on this kind of hemorrhaging that is occurring in our country. It is bad for individuals and their families, and it is bad for the economy of our Nation. It is shameful that the wealthiest Nation on the face of this Earth takes the insured population of our Nation and puts them at such risk, and their families, wiping them out, as happens too often with financial ruin.

We have coverage. We are fortunate to have it. We ought to be able to do everything in our power to see to it that every American, regardless of their economic status, ought not to play roulette with their future and that of their families because they lack the economic security that others who are more fortunate financially have. That is not right. Health care ought not to be a choice only for those who can afford it, decent health care by the accident of birth. That you are born into a family who lacks the economic means should not place your child in a different situation than mine or someone else's because of those circumstances. That is not America. That is not America in the 21st century. We ought to be able to do better than that.

The demagogues out there, chirping away about government-run health care or socialized medicine—that is baloney from top to bottom, and they ought to be ashamed of themselves. In a nation as strong as we are, we place this many insured people at risk because we do not have the courage to stand up and do what needs to be done.

In our proposal we have crafted, we spent a lot of time working at it to provide relief and support on wellness and prevention and quality of care and to bring those costs down to the point I have described here this evening. Again, there may be other ideas and other ways of doing this. We think we have done a good job with our bill. But I wanted people across the country to know there are ideas out there.

There were 23 of us who worked on that bill. We spent 5 weeks, 60 hours, 23 sessions—the longest markup of a bill in the history of that committee and, we are told by some, maybe the longest markup in the history of the Senate on a single bill. We had 800 amendments filed, and 300 were actually considered. Some 160 amendments of my friends on the Republican side were agreed to and included in our bill, making it a better bill and a stronger bill. I welcomed their participation. But here we are, 3 weeks later, still stymied, unable to come together and shape a bill that would provide the relief so many people seek in our country.

I thank my colleagues for their efforts, particularly grateful to Senator HARKIN, who did a terrific job on the prevention parts of our bill; Senator MIKULSKI, who wrote the quality provisions; Senator JEFF BINGAMAN, who worked on coverage issues; Senator PATTY MURRAY, who worked on the workforce issues in the bill; and people such as Senator SHELDON WHITEHOUSE of Rhode Island, who joined our committee and did a fabulous job with KAY HAGAN, our new colleague from North Carolina, along with SHERROD BROWN of Ohio, to shape the public option that is included in our bill, which I am certain my friend from Rhode Island may describe in some detail this evening about what we have done. This was so creative that the Blue Dogs on the House side adopted our proposal on the public option as part of the House-passed bill. Of course, JACK REED and BERNIE SANDERS, as well as JEFF MERKLEY on our committee and BOB CASEY did a great job in helping us shape the legislation. I thank all of the members of the committee.

I thank MIKE ENZI, my colleague from Wyoming, the ranking Republican member, along with his colleagues on the Republican side. They did not vote for the bill in the end. I regret that. But they made contributions that made it a stronger and better bill.

But let's come back in September and get the job done. That is why we are here this evening in the closing hours of our session here before this break begins, so that we can highlight this most important issue that the President has committed his administration to, and that I believe the overwhelmingly majority of Americans—when you get sick at home and your child is in trouble, you do not wake up and wonder what party you belong to or what your political leanings are; what you want to know is, Do we have a plan that covers this? Is someone going to see my child or my spouse? Are they going to get good care? Am I not going to go into economic ruin from this? You do not wonder whether you are in a blue State or red State or what political party is in power. What you want to know is, Does anybody give a darn, and are they doing anything about it? I am in trouble, my family is in trouble, and are you helping us out to get us back on our feet? And that is what we tried to do in this legislation.

I yield the floor.

The PRESIDING OFFICER. The Senator from Rhode Island.

Mr. WHITEHOUSE. Let me thank Chairman DODD for his leadership and for his remarks. He said he would give us a discussion of where we are, and he has done a wonderful job of showing how this bill will improve the lives of regular Americans in a very concrete way, including particularly Americans who have insurance.

To supplement his discussion of where we are, I wanted to give a quick discussion of where we have been because the trajectory of where we have been to where we are tells us something about where we are going. And everybody in this country, insured or uninsured, should have some real concern about where we are going in health care in this country if we do not act.

The year I was born was 1955, and this was the headline from the New York Times in 1955. It is hard to read the little part here; I will read it to you. It says:

> The Problem of Cost. Millions of Americans cannot afford to pay the costs of medical care, and they are not protected by adequate health insurance.

That was 1955. This section says:

> In human terms, this meant that the American had to scrap his budget, dig into savings or go into debt, to pay some $7.5 billion for doctors, hospitals, dentists, nurses, and the myriad physical accessories of medical care.

That was 1955, when the Nation's medical bill ran over $10 billion. They were horrified to say over $10 billion. It is now over $2.5 trillion.

So that is the year I was born. We were already bemoaning the state of America's health care system.

This is 1979. I had just gotten out of college. And the HEW Secretary said: Health cost called unjustified. HEW Secretary Patricia Roberts said: The quality of American health care does not justify its price tag of more than $200 billion a year. Still bemoaning the health care problems, still not getting anything done about it.

Now, 1988. This was the year my wife became pregnant with our first child. And here it is. Prospects: Soaring health care costs. Joseph Califano said—he was the former Secretary of Health and Welfare—''The average jump in premiums could hit 30 percent in 1989.'' But at the same time, we are getting less for it.

Chairman DODD just talked about a 20-percent jump in his State recently. You think this was happening today? It is from 1988, 20 years ago. The more

things change in health care, the more they stay the same.

Here is 1992. Health care costs increasing at more than twice the rate of wages have made benefits so expensive it would be surprising if companies were not responding. ''Health care costs dampening hiring.'' And they dampen wages, as we have seen, and increasingly businesses are having to avoid health care because they cannot keep up with that cost. That from 1992.

So we took those stories and we put them together on this chart. This shows the increases in America's spending on health care in each of those years, starting back the year I was born, that first story, 1955, then 1979, then 1987, then 1992, then 2009. It increased from $12 billion, which seemed like a big number then, to $200 billion, to over half a trillion dollars, to $850 billion, nearly a trillion, and now $2.5 trillion.

Look how much it has bumped from 1992 to 2009. This, my friends and colleagues, is what is called a trajectory. It is going to keep going if we do not do anything about it.

The latest estimates for my home State of Rhode Island are that in 2016, which is not too far from now, in 2016, probably about this far up on the graph, $26,000 a year is what a family will have to pay for family coverage—more than $26,000 a year. That means if you are a comfortably earning hard-working individual pulling down a salary of $52,000, half of your income, pretax income, goes out the door for health care before you start anything else. That is not sustainable. That is why we talk about Thelma and Louise instead of Harry and Louise. That is why we need to change the direction of our health care system, not just for the uninsured but for everyone so that all Americans can have a secure health care future. No American will have a secure health care future if this trajectory is allowed to continue.

So if you are out there asking, How would a change in the direction of our health care system help me, think of Thelma and Louise headed off the cliff because that is what the American health care system is like right now. The cliff is coming, and we are all in the car together, and together we have to solve this problem. Because we have to solve it together, it is very disappointing that so many of our friends on the other side have refused to participate in this conversation and have reverted to labels and name calling: socialized medicine, government mandates—things that have nothing to do with our legislation but are designed to scare people and to provoke those who have not sat down and read the bill and do not know better. It is unfortunate.

What does it measure up against? Let me show you a couple of other things. We have had a lot of talk in recent days about the stimulus plan and how effective that has been—a $787 billion stimulus. There it is, that $0.88 trillion is the stimulus for all of the barking and moaning we have had about how much that cost this country. That is what it is. The $8.9 trillion is what George Bush ran up in debt for this country during his Presidency.

Three-quarters of the debt this country bears, George Bush ran up during his Presidency. It was an orgy of fair-weather borrowing. When we didn't need to go into debt to protect our economy, when things were humming along, that is what he did, $9 trillion. Here is our unfunded Medicare liability, $38 trillion. We don't have $38 trillion now. Unless we do something about this cost, we are truly going off the cliff in that car with Thelma and Louise, following that trajectory of cost I showed.

It is not all going for health care that makes everybody better. It is going to a lot of other things. Here is one thing it is going to. Insurance industry profits. Have you noticed your wages going up a lot in the last couple years? For a decade, from 1999 to 2009, wage growth has been 29 percent. That is less than 3 percent a year and way less than 3 percent a year compounded. That is what wage growth has been like. If you don't feel like your wages have gone up much in the last decade, you are right. They haven't. For many Americans, wages flat-lined for a decade. How about your insurance premiums? Did they flat-line? No, sir. The insurance premiums went through the roof, increased 120 percent, more than doubled in one decade. That is the steep curve I showed you, 120 percent. How about insurance industry profits? Up 428 percent in the same period that wages were up 29 percent. So there is something we can do something about.

On insurance, so many Americans are uninsured, it is worth taking a look at this. We have all used and heard the figure about 46, 47 million Americans who are uninsured. That is the people who are uninsured at any given minute. As I stand here at this desk right now, out there in America there are about 47 million people who are uninsured. But some people gain insurance and some people lose insurance. Over the course of a year, the number of people who lose their insurance, whose families lose their insurance, is nearly 87 million. If you started on the east coast and moved your way west, and when you got to the Mississippi and you started into Minnesota, Iowa, Missouri, Arkansas, and Louisiana and you took the population of every single State west of that all the way to California, the population of all these States is about 87 million, to give you an idea of how many Americans lose their health insurance and have to go without it at a point during the year.

Then there are catastrophic levels of waste in our health care system. Our former Treasury Secretary, a Republican, knowledgeable about this, ran the Pittsburgh Regional Health Initiative for years. He said $1 trillion of annual waste is associated with process failures. He has calculated $1 trillion a year of waste in our health care system.

The Lewin Group is a group many people talk about here. They are described on the Senate floor as the gold standard in health care information. Sources of potential excess costs: Excess costs from incentives to overuse services, from poor care management and lifestyle factors, excess costs due to competition and regulatory problems, excess costs due to transactional inefficiencies; $151 billion here, $519 billion here, $135 billion here, $203 billion here. As we say in Washington, a billion here and a billion there, and pretty soon it starts to add up. This adds up to over $1 trillion in waste in congruence with what the former Treasury Secretary said.

It is not just newspapers that are saying it. It is also President Obama's own Council of Economic Advisers. Their report on July 9 said that:

> Efficiency improvements in the U.S. health care system potentially could free up resources equal to 5 percent of U.S. GDP which is above $700 billion a year.

They also noted:

> [It] should be possible to cut total health expenditures by about 30 percent without worsening outcomes . . . [which] would again suggest that savings on the order of 5 percent of GDP could be feasible.

Again, two calculations coming to the same point, savings of over $700 billion a year.

That is one of the things we are trying to do. In addition to family-by-family improvements, small business-by-small business improvements, individual-by-individual improvements that Chairman DODD has wrought through this bill, we are also trying to turn around a health care system that has been out of control, that has not been reformed for my entire lifetime. So that now is our moment, and it is on a trajectory that will break this country if we don't do something about it. We simply cannot continue a cost curve such as this that is already at $2.5 trillion and is accelerating northward. We can't be competitive with our international competitors in trade if we do this. We can't sustain our families if we do this. We simply cannot keep this government fiscally solvent if we do it. We have to turn the car before it gets to the cliff. If we can't do that, then shame on us.

I think we need to be in this together. One of the ways we will do this is through a public plan. A public plan is important because there are a number of ways in which you change those cost curves. You don't have to take services away from people because of all that waste. What you have to do is deal with the waste. You build in electronic health records for every American so the efficiencies that other industries have enjoyed from the computer revolution finally hit health care which, according to the Economist, has the worst information infrastructure of any American industry except mining—the mining industry and then

health care. Huge improvements and huge savings from that.

Quality improvements can save money. It has been demonstrated over and over again, as in Senator STABENOW and Senator LEVIN's home State of Michigan. They did quality improvements in intensive care units. In 15 months, they saved $150 million and 1,500 lives, and it wasn't even in all the intensive care units. It was just in one State. It was that one kind of quality improvement program, just in intensive care units. So huge gains to be made from quality improvements.

Prevention. Senator HARKIN spoke the other day about what can be gained from preventing particularly conditions that arise from diabetes. Enormous savings, if we can focus on all that.

Transparency and improved administrative efficiency so doctors and insurers aren't fighting all the time. We can do all those things, but somebody has to lead. The question for us is, can we trust the private insurance companies to lead in all those areas. If you look back, you see they never have. We are way behind where we should be. They are not leading. It will take a competitive public option to pick up those issues and run with them and show what we can do.

I will close with this. One of the things we are hearing is you can't possibly have a public option. It is a line in the sand. The very distinguished ranking member of the HELP Committee has said it is intolerable to have a public option. It simply would not work. It can't happen. There are two ways we get health insurance in this country. One is through a private health insurance provider. The other is through workers' compensation, which the business community runs in order to protect itself against the injuries and illnesses and diseases and catastrophic harms that can happen to people at work and that they have to protect themselves against. All across America, there are State funds, public options that deliver health care insurance, State by State, over and over again. So when the ranking member goes home to his State of Wyoming, not only is a public option for delivering health insurance not anathema, it is what he goes home to.

He goes home to a single-payer public option for health care, one his business community appears perfectly satisfied with and he appears perfectly satisfied with.

Their Presidential candidate, JOHN MCCAIN, goes home to Arizona to a public plan with 56 percent market share. It competes in a lively workers' compensation health insurance market. The distinguished minority leader goes home to Kentucky, and in Kentucky his business community enjoys a public option for workers' compensation health insurance. So we should be able, in the spirit of coming together in the face of this national emergency, to put aside the old notion that a public option simply can't exist, can't happen. It happens in nearly half our States. It is supported by the business communities in those States. It delivers care efficiently, and none of the Republican Senators from those States have, to my knowledge, ever complained about it in that context.

I will conclude with that. I think we are at a turning point, and it is important, as we go, that we remember this is a long struggle we have been on. My entire lifetime, since 1955, it has gotten dramatically worse, and the rate at which it has been getting worse is increasing. It is worsening. We have to do something about it now—for everybody in this country, for businesses large and small, and for people and families, insured and uninsured, and we are pledged to do that.

I thank the very distinguished chairman and yield the floor.

Mr. DODD. Mr. President, I thank our colleague from Rhode Island. He has been very eloquent in talking about the historical framework of this debate, going back, even predating the 1950s, when we determined the need for a national health plan in this Nation, not only to deliver health care to people but also to deal with the economic problems associated with health care costs. I thought it might be worthwhile to invite my colleague to share some additional thoughts on this view. Today, as I am told, we are spending about 17 percent of the gross domestic product on health care costs. I am told, by those who are economists looking at this, that if we don't alter anything but merely sort of stumble along, that percentage of our gross domestic product will jump from 17 percent to 34 percent of the gross domestic product, which is a staggering amount when we consider how expensive that would be and the result, in practical terms, to the very premium costs the Senator from Rhode Island has identified.

I also talked the other day to a leading businessman in our country, the former chief executive officer of Pitney Bowes, a well-known, established company, headquartered in my home State of Connecticut but has facilities in many States across the country. It employs thousands of people. The former CEO is a man named Mike Critelli. He is no longer the CEO, but he was the CEO who was responsible for bringing a wellness plan to Pitney Bowes. I think my numbers are pretty accurate on this point. I think their premium reduction, as a result of putting a wellness plan in place there, reduced those costs by around 30 or 40 percent. They decided to alter the lifestyles of their employees by offering them incentives—the opportunity to reduce weight, quit smoking, improve diets, all these things.

Talking to Mike Critelli, he did it because, one, he thought it was the right thing to do. Certainly, improving the quality of the health of your employees is a decent thing to do. But Mike Critelli also pointed out to me that in addition to being the decent thing to do, it was a very sound practice for business. Very simply, he said: If I could increase the productivity of my workers, which is the critical element, if the United States is going to compete in the 21st century, if wage rates are not going to drop down to Third or Fourth World country levels, we are going to have higher wage rates. We are going to have higher costs to produce our products.

The one advantage we bring over third-rate and fourth-rate nations that don't pay as much for employment is the productivity of the American worker, which historically has exceeded that of almost any other worker anywhere in the world.

Mike Critelli's point is that having a good wellness plan in place increases the productivity of that worker, and that is our edge in a global economy. So we need to start thinking in these terms.

I hear people in the business community say we can't afford to do this. We can't afford not to do it. You can't have 34 percent of your gross domestic product be consumed with health care costs.

Our advantage is productivity. As Mike Critelli points out, if your workers are sick, if they are obese, if they have diabetes, if they have chronic illnesses at a young age, as many do today, then the ability of that worker to produce those products and services is going to be curtailed and we suffer.

So there needs to be some lights turned on for some in the business community about this debate. Some are having sort of a Pavlov's dog response to it. If you mention health care reform, they reach back decades to the age-old bromides and responses to this issue without thinking about what this means in the 21st century, freeing up the ability of workers to produce better products in a highly competitive marketplace.

Let me mention one other thing I do not think we have talked about. Forty-four years ago from last week, Lyndon Johnson signed Medicare into law. Last week was Medicare's birthday. Medicare was signed into law 44 years ago, in 1965. Obviously, that was a great benefit to people over the age of 65, and what a difference it made. It took that population, which was the poorest sector of our population, the elderly, and put them on a standard of living that allowed them to lead decent lives after productive years of working.

So with prescription drugs, doctors visits, and the like, put aside the problems today with Medicare we know exist and we have to deal with, it did something else I do not think we have paid enough attention to. It was a source of relief and stability to a family. Because all of a sudden those parents—which a younger generation had to put aside resources to provide for that crisis that was inevitably going to happen to those aging parents—became less of a burden because Medicare existed. The cost of prescription drugs,

the visits to the doctor, the hospitalizations—all of a sudden, magically, 44 years ago from last week, a good part of that burden was lifted off the shoulders of the children of Medicare recipients.

And it unleashed a level of investment that allowed our economy to prosper and grow. For other reasons too, but not the least of which, all of a sudden, there was that security in a family. They were not going to face financial ruin because, all of a sudden, their parents had a crisis they were going to have to pay for out of their pockets.

I do not know if there are any economic models that examined that, but I do not think we attribute enough of Medicare's success to the contribution it made to the overall economy of our Nation 44 years ago because of that stability and certainty and security in a family, where your parents—that aging population—at least had a safety net that would protect them against that financial ruin that can befall a family.

I think we are missing a point in this debate in that what people are really worried about is that lack of certainty, that lack of stability. People are socking away money today because: If I lose my job, if I end up with a preexisting condition, if we move, I could lose my health care coverage, and all of a sudden my kids, my wife, myself are put in the danger of economic ruin. That uncertainty, that lack of stability, that lack of security has a negative impact on the consumer choices people make. I might like to buy that second car. We may need it but—do you know what—756,000 people are going to lose their health insurance in the next 5 weeks. I might be one of them. And if something happens, how do I pay for that problem? So—do you know what—we are going to delay that purchase or this other thing we might have done because I don't have the stability, the certainty, and the security there is a safety net there. Lord forbid a crisis hits my family.

So while there is the comparison between Medicare's recent birthday 44 years ago and what we are trying to achieve—we are thinking about it in a very small context: How much does that doctor visit cost? How much is that prescription drug? There are benefits to this that exceed the parameters of what we are trying to achieve because of the investments we are making that I think have a larger impact on the overall economy of our Nation.

So I wanted to say to my colleague from Rhode Island, by talking about these rising costs—and no end in sight, by the way—unless we find some way to put the brakes on all of this and begin to reduce the problems—how do you do that? If all of a sudden you have a child who is getting good dental care at an early age, that child is less likely to have a problem as they get older. If we can convince children and families to eat better because we make the incentives to do so—3,500 children today started smoking in the United States, and 3,500 start smoking every single day. And every single year, 400,000 people die because of tobacco-related illnesses—400,000 die—not to mention the number of people who have lifelong illnesses and die prematurely.

Of the 3,500 who start smoking today, 1,000 become addicted. You do not have to have a Ph.D. in medicine to know that if you are a user of tobacco products, you are consuming a product with 50 carcinogens in each cigarette.

Here we know if we can begin to change that lifestyle, which we have done, by the way—and, again, I thank my colleagues because, for the first time in 50 years since the Surgeon General pointed out that tobacco could kill you, only a few weeks ago we did what we have never been able to do before: Tobacco marketing, sales, and production are now under the control of the Food and Drug Administration. By the way, the Food and Drug Administration regulates mascara, lipstick, and pet food. But we could not get the Food and Drug Administration to regulate tobacco products. Now that has changed as a result of the actions of this Congress.

But that is an example of what I am talking about. If we can stop a child from smoking, then that child grows up with a far greater likelihood they are going to reach retirement age in far better shape, which means far less usage of that Medicare dollar and that hospital or that doctor's visit. So you may not see the benefits of some of this immediately but over the longer term we will. And that is bending that curve. We are all talking about bending that curve of cost. We can do that making these kinds of investments.

I am told only 2 percent of hospitals in this country have complete electronic medical records—2 percent. Yet we know that we lose about 100,000 people a year from medical errors in the United States. It is the fourth leading killer of Americans. Electronic medical records reduce those numbers significantly because you have clarity in the records, you have portability of those records as people move around, you have the opportunity to determine what other conditions a patient may have, and you avoid the kinds of errors that produce the tragedy of a lost life. That savings alone in lives and dollars, we are told by some, could be as much as $500 billion. Electronic medical records—that one issue—could produce those kinds of savings and results.

So when we have these debates and people talk about these things in such simplistic terms, without understanding the larger economic implications—and if we do not, the numbers our friend from Rhode Island have shown us, if history is any indicator of where we are going, those numbers will continue to skyrocket and skyrocket to the point that it will bankrupt and break this country financially.

What an indictment of a generation: Faced with a reality and the predictability of a situation, we are spending days around here with the inability to come together and make the tough, hard decisions the American people have elected us to do. That is the tragedy in some ways. I respect the fact we need a break and people are going home, but it is so troubling to me we are going to do this at a time and leave these issues hanging in the balance.

Mr. WHITEHOUSE. Mr. President, will the Senator yield for a moment?

Mr. DODD. Mr. President, I will be happy to yield to my colleague.

Mr. WHITEHOUSE. Mr. President, I want to respond to what the Senator was saying, that this trajectory is very likely to continue. Every signal and every prediction is it is going to continue and we will hit that 35 percent, spending a third of our entire economy just on health care, and that really does break our country. It is a terrible indictment of our generation if we allow it to happen.

But we also have a great opportunity here, which the chairman has also pointed out. As you know, over and over again, as the distinguished Presiding Officer knows, over and over again, in legislation, we are asked to make hard choices between two things, and if you go one way, you cannot go the other. Economists would call it a zero sum game. You cannot have both. There is no win-win.

This is a situation where there is a win-win. As the distinguished chairman pointed out, we are spending 17 percent of our gross domestic product on health care in this country. It is the worst record, the highest expenditure, of any country in the world. Most other developed nations spend 8 or 9 percent. That is the average of the European Union of their gross domestic product on their health care.

For that exaggerated expenditure, what do we get? Lousy health outcomes. We are way behind our developed competitor nations in obesity. We have far higher rates of obesity in our country. We are way behind in child mortality. We have far greater rates of child mortality in the United States than there are in our developed nations with which we compete. There is far greater longevity in those countries than ours. Americans do not live as long as people in our competitor nations, the developed ones, and a lot of it has to do with our health care system.

So by bending that curve, by investing in prevention, by improving the quality by investing in electronic health records, by eliminating those medical errors, we accomplish two things at once. We improve the health statistics of our Nation, we have people who live long, we have less babies who die in childbirth, we have a thinner and less obese and less ill nation, and we lower the costs, and we do it together.

So it should be something we could agree on, on both sides of the aisle, but, unfortunately, these old canards about socialized medicine and how we

could not possibly have a public option—except for the fact we already have it in half our States, including our own; but we are not going to talk about that right now, we are just going to say we could never have it—that is the quality of the debate, when we have this huge win-win in front of us.

I hope everybody has a chance to sort of think about this over the break when we are gone and that we can come back with a new spirit of bipartisanship to really address this problem, seize that win-win, change the cost curve down, and solve this problem for the American people.

I will make one last point.

We have misled the public a little bit in our discussion, and we have done so because of the Congressional Budget Office and its professional capabilities. The Congressional Budget Office is very good at predicting what costs are going to be. So everybody has heard that our bill might be $600 billion, that the Finance bill might be $900 billion. They see the costs and they say: Well, how could you possibly be talking about savings when all we hear about are costs? All CBO can say about savings is that—and this is a quote—large reductions in health care costs are possible—large reductions. But they cannot quantify it. They cannot give us a number. And they have told us why they cannot give us that number.

They cannot give us that number because we can give the Obama administration, here in Congress, the tools to solve this problem. We already passed the electronic health records legislation. If, God willing, we pass the chairman's legislation from the HELP Committee, they will have the tools to improve the quality and turn the curve. They will have the tools to improve prevention and turn the curve. They will have the tools to reduce the unnecessary, wasteful administrative fighting between doctors and hospitals and insurance companies, that try not to pay them. That whole fight can disappear or at least shrink a lot, and that will help turn the curve.

But CBO cannot predict how effectively the Obama administration will do that. Like any CEO, the President of the United States and his staff are going to have to manage this problem, and that is where the savings will come. So people should not be misled that there are not real savings possible. Not only are they possible, they are mandatory. We have to turn this curve, and we have to do it dramatically. We can do it because we could drop our GDP expenditure of this by 50 percent and still have health care as good, if not better, than all of our competitor nations: France, New Zealand, Canada, England, Holland—all these countries—Japan. We can do it.

The promise is out there. We should not let the CBO scoring fool the public. That is my last point.

Mr. President, I yield the floor, and I will relieve the distinguished Presiding Officer so he can speak as the Senator from Colorado.

Mr. DODD. Mr. President, I will do the same. And, again, my thanks to SHELDON WHITEHOUSE of Rhode Island. He has just been a stellar advocate of the kind of change we need.

I know the Presiding Officer, as well, as a new Member of this body, has spent an inordinate amount of time on these questions, as well, in his own State and has listened to people in Colorado talk about this issue and what we can do together to get it right. I welcome his participation immensely as well.

I wish all of my colleagues a very healthy and safe break in the month of August, as I do for all Americans. But I hope my colleagues will keep in mind, I did not recite these numbers to put anyone on the spot. But sometimes we need to talk about numbers that are real to people, and these are real numbers that will potentially affect many of our fellow citizens. So we need to come back here with a renewed commitment to get this done.

We have the capability. We have good people here who care, I know, about these issues. And none of these decisions we can make are going to necessarily predict with absolute certainty that everything is going to work as well as we hope they would. But you have to begin. And we have to take a chance and work forward and hope these ideas we put on the table work. And to the extent they do not, you modify and change it, as will certainly be the case in the years ahead. But inaction, just saying no, is unacceptable. The answer ''no'' to health care ought to be rejected by every citizen in this country. This is a difficult problem, but being too difficult is an excuse that history will never forgive us for. It will never tolerate that excuse: This was too hard to do. When you think about previous generations and hard choices and difficult decisions, we wouldn't be here today if those generations had quit because it was too hard. We are here today because they made hard choices, they made the difficult decisions, and we have no less of a responsibility as a generation to do it on this issue. This is hard and it is difficult, but that will never be an acceptable answer to future generations if we bankrupt our country because we couldn't figure out how to solve this problem.

Mr. President, I yield the floor.

COMMENDING RICHARD BAKER

Mr. LEAHY. Mr. President, I rise today to speak about a man who has been serving the U.S. Senate for almost 35 years. Now that is how I and many other Senators may begin remarks about a colleague who is retiring. My remarks today are indeed about a colleague but not about a fellow Senator. These remarks are about Senate Historian Richard Baker, an important member of the Senate community who has made the Senate a better institution during his tenure.

Remarkably, until 1975 the U.S. Senate did not have a Historical Office charged with preserving the institutional memory of this great body. Dick Baker is the original and only Director and the Chief Historian for the past 34 years. Under his leadership, the Historical Office of the Senate has worked to recover, catalogue and preserve the history of the Senate.

Building this office from the ground up required Dick Baker and his team to collect and maintain records on current and former Senators, record oral histories, document important precedents, statistics and Senate activities. And as a photographer I must point out that this work included the cataloging and preservation of a huge trove of Senate-related photographs.

From the beginning, Dick Baker knew his responsibility at the Historical Office was not only to preserve the history of the Senate but to make it more accessible. That included providing access to records for members, staff, media and scholarly researchers. He exposed more of the Senate and its rich history to the general public through exhibits in the office buildings, presenting materials via the Web and working with C–SPAN to incorporate Senate history into its programming. And as an author, Dick Baker disseminated information with his publications on Senate history, including a biography of the former Senator from New Mexico, Clinton P. Anderson.

His greatest impact on me, however, and I believe the Senate as a whole, has been his placing of our work here in proper context. Most Senators and I look forward to the historical ''minutes'' that he presents at the opening of many of our caucus lunches. He has also been accessible to me and other Senators in providing presentations of the Senate history at many different venues. My staff and I thoroughly enjoyed a presentation he provided to us on the history of the Vermont Senate delegation. His alacrity and care for describing Senate history has reminded all of us about the significance of our work here.

As much as visitors feel the weight of history when they enter this building, it is no less important for those of us who represent them to be well aware of the 200-year history of the Senate. It is important to remember that although great men and women preceded us, and even greater ones will undoubtedly follow, our words and actions will continue to echo through these halls long after we are gone. Dick has reminded us of that regularly, and for that we thank him and wish him well.

COMMENDING RON EDMONDS

Mr. LEAHY. Mr. President, it is fitting that we in the Senate take note of the retirement of Ron Edmonds of the Associated Press, a veteran news photographer who has long and superbly documented public life in the Nation's Capital, including here on Capitol Hill.